

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 12, 13, 14, 15, 16, & 19, 2014</p> <p>Facility number: 011150 Provider number : 155760 AIM number: 200831020</p> <p>Survey Team: Debora Kammeyer, RN-TC Amber Bloss, QIDP (5/12, 5/13, 5/14, 5/15, 2014) Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: SNF: 40 SNF/NF: 19 Total: 59</p> <p>Census payor type: Medicare: 20 Medicaid: 15 Other: 24 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 24,</p>	F000000	<p>The preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual Recertification and State Licensure Survey on May 12-19, 2014. Please accept this Plan of Correction as The Maples at Waterford Crossing's credible allegation of compliance effective June 18, 2014. The Maples at Waterford Crossing respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
---------	--	---------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000157 SS=D	<p>2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician and family were notified of a significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident #62)</p> <p>Findings include:</p> <p>On 5-16-14 at 10:55 A.M., a review of the clinical record for Resident #62 was conducted. The resident's diagnoses included, but were not limited to: acute cerebrovascular accident (CVA), depression, urinary tract infection with dehydration and hyperlipidemia.</p> <p>Physician orders indicated on 12-4-13, Speech Evaluation and treatment was ordered. On 12-5-13, the physician ordered mechanical soft diet and moistened ground meats. On 12-6-13, a physician's order was made for nectar thick liquids secondary to coughing on thin. On 12-7-14, remeron (dietary stimulant and antidepressant) was started due to no appetite and 2 Cal (nutritional supplement-60 ml (milliliters) QID (4 times a day) with medication pass. On 12-28-13, 2 Cal was increased to 90 ml QID. On 1-2-14, the resident was referred to hospice.</p>	F000157	<p>1) Resident #62 has been discharged. 2) Current resident weights have been reviewed for past 30 days. Any significant weight loss noted, the resident physician and family and registered dietician have been notified and recommendations noted as indicated. 3) Nursing staff re- inserviced in regards to weighing residents and any resident that has a weight that seems out of normal range will be re-weighed to determine the accuracy of the weight. If significant weight loss is noted a re-weight will be completed for verification of the weight. Physician, family and registered dietician will be notified of the significant weight loss. Residents will be monitored weekly at Clinically At Risk meeting by Director of Health Services (DHS)/designee until weight stable then removed from clinically at risk meeting. Clinical at risk meeting weekly is ongoing. DHS/designee will review weights weekly for six months. DHS/designee will notify registered dietician weekly of any significant weight loss. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	06/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The weights for Resident #62 were as follows: Weight at Admission (Adm) (12/03/2013): 168 lbs. (pounds) Weight at 15 days after Adm (12/17/2013): 151 lbs. (which is 17 lbs. less than at Adm. or a 10.1% [percent] weight loss) Weight at 30 days after Adm (12/31/2013): 154 lbs. (which is 14 lbs. less than at Adm. or a 8.3% loss)</p> <p>The care plan, titled "Heights/Weights," dated 12-6-13, indicated the following: "...My current weight is around 168. My weight about a month ago was 176. My goal is to maintain my current weight without any significant change. Please weigh me weekly x 4 weeks then monthly. Please review my weight history on or before 90 days...." Another careplan titled "Meals/Snacks/Fluids," dated 12-6-13, indicated the following: "...I am on a mechanical soft with ground meat diet as I have difficulty chewing and swallowing because of my recent stroke. I can feed myself but may need some assistance with cutting and such as my left arm doesn't work so good because of the stroke. I don't have much of an appetite as I am feeling sad and want to go home. Please encourage me to eat. The dietitian is going to recommend nutritional supplement for increase</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>calories and protein. My goal is to eat adequate calories and protein to maintain my weight and get stronger so I can return home. Please review my nutrition plan of care on or before 90 days...."</p> <p>A form titled "Nutrition Assessment and Data Collection," dated 12-6-13, indicated the resident was on a regular mechanical soft diet with moistened ground meat. The Nutrition Progress Note, dated 12-13-13, indicated the resident's weight was 164 which was a decrease of 4 pounds and resident's intakes were poor. The resident had recently started on remeron to help with mood and appetite. The dietician's note further indicated she would discuss nutritional concerns with social services and possible option of placing a feeding tube.</p> <p>A review of the Speech Therapy Plan of Care, dated 12-3-13, indicated "... referred to therapy due reports from therapists of swallowing difficulties during meals since admission. Patient had no history of dysphagia. Swallowing difficulties were caused by increased weakness from CVA... Swallowing status: moderate impairment (50-75% impairment; combination of oral and nonoral nutrition; requires thickened liquids; difficulty masticating foods)...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an interview on 5-17-14 at 1:18 P.M., the Social Service Director indicated she had no written documentation of conversion with the family regarding the tube feeding. She further indicated the family wasn't interested in giving the resident tube feedings and placed the resident with hospice.</p> <p>During an interview on 5-17-14 at 2:15 P.M., the Director of Nursing (DON) explained that all weights were completed on Sundays, then on Mondays the ADON (Assistand Director of Nursing) and himself would put the weights in the kiosk/caretracker (electronic charting). If there would be a significant change in a resident's weight a "Significant Change Form" would be generated and the physician and family would be notified.</p> <p>On 5-19-14 at 3:20 P.M., a review of the policy titled " Guidelines for Weight Tracking," dated 6/2012, indicated "...7. Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...8. The physician, responsible party and dietician shall be notified of a weight variance of >5% (unless on a planned weight loss program)...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000166 SS=D	<p>3.1-5(a)(2)</p> <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on interviews and record reviews, the facility failed to promptly respond and/or resolve grievances regarding missing clothing and the behavior of another resident for 1 of 1 residents reviewed for grievance response. (Resident #70)</p> <p>Finding includes:</p> <p>During an interview on 05/13/14 at 9:15 A.M., Resident #70 indicated she had concerns about a resident across the hallway who would yell "shrilly" at night for long periods of time and wake her and her roommate up. Resident #70 indicated she had spoken with the former administrator and the former administrator had only told her, "We're working on it." Resident #70 indicated she had given the DON (Director of Nursing) a copy of a log book with specific times and durations of the yelling done by the resident across from the hallway. She indicated the yelling had</p>	F000166	<p>1) Resident #70 was reimbursed for the cost of the missing articles of clothing. Resident #70 has told the Social Service director that she has been sleeping better and the resident across the hall has been less disruptive during the night. 2) Social Service Director has interviewed current alert and oriented residents regarding any missing clothing and if any residents are yelling out during the night causing disruption with their sleep. Any concerns noted during interviews have been noted on a concern form and followed up. An audit of concern forms for the past 30 days was completed and any forms found to have not been resolved have been addressed, resolved and communicated to necessary individuals. 3) Campus staff will be re- inserviced on service recovery process and completion of concern form for follow up. Social service will review any concern forms during clinical care meeting Mon-Fri and follow up timely. Executive Director will review weekly to ensure concern is resolved. This process is</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>continued until the resident had been discharged to the hospital on the evening of 05/12/14.</p> <p>In addition, Resident #70 indicated several weeks ago she had notified the laundry staff regarding a missing pair of blue silk pajamas her son had gotten her from Hong Kong, and a missing brown sweater. She indicated the missing laundry had not been found as far as she knew and she had not been reimbursed and no one had specifically came to inquire about her concerns.</p> <p>During an interview on 5/14/14 at 10:45 A.M., the Social Service Director (SSD) indicated a missing items report had been filed for the missing clothing for Resident #70. Review of the Resident Concern Form, dated 05/12/14, indicated the resident was missing a pair of silk pajamas and her favorite sweater. The concern form indicated the resident tad been looking for the things but she thinks they were taken. The concern form indicated if she did not locate the items they would find out about reimbursing the resident. The concern form was completed by the payroll coordinator, Employee #2.</p> <p>During an interview on 5/19/14 at 11:00 A.M., Employee #3, the Laundry</p>		ongoing. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Supervisor, indicated she was unaware of the missing items for Resident #70 until the Concern form was brought to her last Wednesday (05/14/14). She indicated she asked her "girls" about the items and one of them was aware and had written the missing items down on a spiral note tablet in the laundry room. The supervisor indicated the procedure was that as soon as a resident or family member expresses concerns about a missing item, the laundry staff were to notify her and she would then have Employee #2 assist the resident in filling out a concern form. She indicated the copy of the documented missing items was not dated and she did not even remember which of her staff were aware of the missing items. She indicated the resident had since been reimbursed for the items and the documentation in the tablet was not there anymore.</p> <p>During an interview on 5/14/14 at 10:45 A.M., the SSD indicated there had been a concern form filled out for Resident #70 regarding the yelling behaviors of another resident. She indicated the issue had also been discussed during a care plan conference for Resident #70.</p> <p>Review of a Resident Concern Form, dated 01/22/14, indicated the following: "Pt [patient] and her roommate are</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>being kept awake by a resident across the hall in [Resident room number] . Pt was yelling very loudly this morning and pt said it was like that all night." The resolution portion of the form indicated the staff member listened to the resident's concern and told the resident "All I can do was fill out this form and turn it in." There was a portion of the form titled "Resolution and communication " which indicated a "face to face" response was given to the resident. The form indicated the following: "Resident very loud all night. Some profanity noted. This has been going on for a long time. Apologized to resident and she states she felt sorry for the screaming resident. Promised to go in and calm resident down when she starts yelling." The response was dated as completed on 01/23/14. It was unclear as to what staff member had completed the "Resolution and Communication" section of the form. The Social Service Director had signed her initials. There was no documentation of the concern or any resolution for the January concern in the Social Service notes.</p> <p>Review of a "Resident First Conference Notes," dated 04/03/14, indicated the following: "Family and resident only concern they voiced was that the resident across the hall is still loud on evening</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>/night shift- calling out. SW (social worker) assured resident the staff is working closely with that residents family to assist with situation. SW discussed moving rooms but explained right now there was no other (specific payor source) beds available. Resident and children stated they understood."</p> <p>Another Resident Concern Form was completed for Resident #70 on 04/19/14, with the following documented: "Unable to sleep regarding 'loud screaming, outburst' from resident [last name]. Hours of most disturbance 6 p, 10 cp, 2 a. Very frustrated with inability to sleep. Resident states she does not eat lunch in dining room due to only place/time she can rest."</p> <p>The resolution, signed by the former Administrator on 04/21/14, indicated the following: "discuss possible room changes with Social Services. Review interventions for [resident's name that screams] and Resident #70. In the "Resolution and Communication" portion of the form the following was documented "Social worker met with family and resident previously and there is no other room available at this time."</p> <p>During an interview on 5/14/14 at 10:45 A.M., the Social Service Supervisor</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the facility did not have a different room available for Resident #70 due to her payor source. In addition, the Social Service Supervisor indicated she had talked with the family of the resident who was screaming and disturbing the sleep of Resident #70. She did not indicate any resolution to the issue except that the screaming resident had been discharged to an acute care facility on 05/12/14 and prior to being discharged the family of the screaming resident had decided to discharge her to their home on 05/16/14. She did not provide any constructive interventions which actually materialized to alleviate or address the concerns of Resident #70 who expressed the same concern on 01/22/14 through 04/19/14.</p> <p>Review of the facility policy and procedure, dated 03/01/12, provided by the Administrator, indicated an algorithm which indicated once a resident voiced a concern, a concern form was completed, and given to the Executive Director or placed under their door if the concern did not allege abuse. The concern would be reviewed in a Morning Meeting and the specific department head would be given a copy and Social Service would be given a copy for a follow up. The Department leader then was to investigate the concern and implement and educate to prevent</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000250 SS=D	<p>reoccurrence. The resolution was to be documented and followed up with the person who had issued the concern or complaint. A call was to placed to a family member or the resident was to be asked during a Resident First meeting if they had any further concerns.</p> <p>3.1-7(a)(2)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interviews, the facility failed to ensure the behaviors of 1 of 1 residents reviewed for behaviors were effectively managed . (Resident #65)</p> <p>Finding includes:</p> <p>During an interview, on 05/13/14 at 9:15 A.M., Resident #70 indicated Resident #65, who lived across the hallway, would</p>	F000250	<p>1) Resident #65 has been reviewed for behavior of yelling out night and plan of care updated with interventions.</p> <p>2) Current residents have been reviewed for yelling out during the night and no other residents were identified.</p> <p>3) Nursing staff re-inserviced regarding complete documentation</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>become loud and agitated in the late afternoon and evening hours and yell in a "shrill" voice for long periods of time. She indicated she had been a resident for a little over 4 months and Resident #65 had yelled at night the whole time. She indicated she had spoken to the former administrator about the issue and the former administrator had just said, "I'm working on it." She indicated she had also documented the timeframe's of the yelling over several nights and had given the documentation and her concerns to the DON (Director of Nursing). She indicated for a little while it got slightly better but it did not last very long. She indicated on the evening of 05/12/14 the resident was sent to the hospital.</p> <p>During an interview, on 05/13/14 at 1:30 P.M., Resident #46 indicated when she was first admitted in March 2014 she had been in a room on the far end of the 300 hall. She indicated there was a confused resident who would yell and scream, especially at night, which made it hard to sleep.</p> <p>During an interview, on 05/13/14 at 9:57 A.M., Resident #91, whose room was located towards the far end of the 300 hallway, indicated there was a resident who constantly "yelled out" and it got on her nerves.</p>		<p>of interventions attempted and their effectiveness with residents that yell out during the night. Any residents identified for yelling out through the night will be reviewed during clinical care meeting Mon.-Fri. for six months to ensure a behavior plan with interventions is reflective of residents behavior.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The clinical record for Resident #65 was reviewed on 05/15/14 at 10:20 A.M. Resident #65 was admitted to the facility on 10/28/11, with diagnosis, including but not limited to aphasia, diabetes mellitus, hypertension, cerebrovascular disease, cognitive communication, cardiac arrhythmias, hypercholesteremia, neuropathy, acute seizure activity, anxiety, and gastroesophageal reflux disease, and dementia with aphasia.</p> <p>The admission Minimum Data Set (MDS) assessment for Resident #65, completed on 12/30/13, indicated upon the resident's readmission to the facility, she displayed both verbally abusive and other behavior symptoms not directed towards others 1 - 3 days during the assessment period. The assessment indicated the behaviors had not negative impact on the resident and did not negatively impact the activities or privacy of other residents. The assessment also indicated the resident rejected care 1 - 3 days during the assessment period. The form indicated the resident's behaviors were the same as previously noted.</p> <p>The quarterly MDS assessment, completed on 03/18/14, indicated the resident had only demonstrated other behaviors not directed at other 1 - 3 times</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>during the assessment period and her behaviors had no negative impact of her or other residents. The assessment indicated there had been no change in Resident #65's behaviors.</p> <p>The resident was hospitalized, from 12/10/13 to 12/13/13, due to acute urinary tract infection and acute seizure activity. The resident was readmitted to the facility on 12/13/13. The resident's medication on readmission included Zyprexa (an antipsychotic utilized to address behavioral issues) 2.5 mg (milligrams) IM (intramuscular) q (every) 12 hours for dementia. On 12/14/15, the Zyprexa medication was changed from an intramuscular injection to the tablet form.</p> <p>During an interview on 05/16/14 at 9:45 A.M., the SSD (Social Service Director) indicated when the resident was readmitted to the facility in December 2013 she was receiving Zyprexa due to "Dementia with behaviors." She indicated the medication was being utilized to address the resident's behaviors of "yelling out and verbally abusive" behaviors.</p> <p>On 12/22/14, a medication to treat dementia, Namenda was started and Ativan, an antianxiety medication, was ordered three times a day as needed.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The Nursing notes, on 12/27/14 at 7:00 A.M., indicated the resident had been found on the floor and was exhibiting increased confusion. The physician was notified of the resident's fall and increased confusion.</p> <p>On 12/27/14, an antibiotic for a urinary tract infection was ordered, a stool softner was ordered, and the Ativan was ordered to be given twice a day routinely. Chair and bed alarms were also ordered.</p> <p>An Individual plan report, the care plan on the computerized system to be reviewed by direct care nursing staff, initiated on 12/30/14, indicated the following: "At times, due to my dementia, I become physically or verbally abusive toward staff or resistant to care. It helps me when staff validate my feelings, approach with an alternate caregiver, or remove me from the agitation. I do have an anti-anxiety medication that can help me with my anxiety and behaviors and my goal is to have no adverse side effects from theses medications (all staff). I enjoy visiting with other people and residents. I have family that visit often and I enjoy my time I get to spend with them. Please review my goals by 03/30/14. (Nursing) I frequently yell out phrases such as 'I'm</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>hungry' or 'I'm cold". Please assess me for pain at that time and fulfill my requests or offer diversional activities to reduce the amount of yelling that I do. Please review by 05/20/14."</p> <p>The behavior detail report of the computerized documentation completed by nursing staff indicated on 12/15/13 at 3:08 A.M., the resident had displayed socially inappropriate behavior and the one to one intervention was not effective. On 12/16/13 at 9:22 P.M., the resident was verbally abusive cursing at staff, yelling out waking other residents, the resident was toileted and reassurance was given but the interventions were not effective. On 12/20/13 at 2:48 A.M., the resident was documented as rejecting care. One to one was attempted but was not effective. On 12/25/13 at 7:41 A.M., the resident was verbally abusive yelling out for family. There were no interventions documented as attempted to address the behavior. On 01/01/14 at 1:34 A.M., the resident was verbally abusive screaming and cursing at staff trying to change the resident., the resident was also documented as having exhibited socially inappropriate behavior of screaming for someone. Toileting and 1 to 1 was attempted and was not effective. On 01/02/14 at 2:39 A.M., the resident was documented as exhibiting socially</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>inappropriate behavior, yelling out for help all night. Toileting, 1:1 interventions, diversion activities and medication was attempted and were all ineffective in addressing the behaviors. On 01/03/14 at 2:39 A.M., the resident exhibited verbally abusive behaviors and medication was the only intervention attempted but it was effective.</p> <p>There was no documentation alternative care givers, validation of feelings, pain assessments and diversion activities were consistently attempted as care planned.</p> <p>On 01/07/14, the evening dose of the Zyprexa medication was increased and a medication to treat dementia, Aricept was ordered.</p> <p>On 01/08/14, the Zyprexa medication was discontinued and the antipsychotic medication Seroquel xr 50 mg at 6 p.m. was ordered. In addition, an Exelon (antidepressant) patch was ordered</p> <p>A late entry nursing note, dated 01/09/14 and untimed indicated the resident was calling out in a loud voice, "I'm hungry! I'm hungry!" ...fed resident yogurt and juice. Resident then continued to call out frequently...resident asleep at 0330 [3:30 A.M.] and awakened at 0500 [5:00 A.M.]</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>calling out loudly."</p> <p>Another late entry nursing note, dated 01/09/14 for 01/07/14, indicated the resident was calling out repeatedly, had been given a cookie and her feelings were validated, but there was no change in the calling out behavior. The note indicated she was going to speak with the physician regarding the behavior.</p> <p>The resident was documented as having exhibited either socially inappropriate and/or verbally abusive behaviors at the following dates and times: 01/08/14 at 2:56 A.M. - redirection with food was helpful 01/12/14 at 1:02 A.M.- no interventions attempted 01/25/14 at 3:01 A.M.- diversional activites were effective 01/26/14 at 12:08 A.M.- diversional activities were effective</p> <p>On 01/11/14, the Seroquel dose was doubled from 50 mg to 100 mg at bedtime.</p> <p>Nursing notes, dated 01/30/14 and untimed, indicated the following: "Received reports from several residents that this resident screams out "all night long" Writer has noted Resident yelling out frequently especially when one on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>one care is not given. Hospice agency notified."</p> <p>On 01/30/14, Haldol, (an antipsychotic) was ordered as needed three times a day for increased agitation.</p> <p>On 02/04/14, the Haldol was discontinued.</p> <p>Nursing notes on 02/06/14 at 1800 (6:00 P.M.) indicated the resident was yelling out at supper time, was given an anxiety medications and was somewhat calmer.</p> <p>The resident was documented as having exhibited either socially inappropriate and/or verbally abusive behaviors on the following dates and times: 02/08/14 at 3:53 A.M. - diversional activities were attempted but were ineffective</p> <p>On 02/10/14, the Seroquel was changed to 25 mg twice day at 8 AM and 2 PM, and 50 mg at bedtime.</p> <p>On 02/10/14 at 3:30 A.M., the resident was documented as having been screaming/yelling for husband, food, and water since 2:30 P.M. The resident was given snacks and an antianxiety medication.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 02/22/14, an order was received to hold the Ativan on 02/22/14, and resume the Ativan on 02/23/14.</p> <p>On 02/26/14, the Exelon patch (a medication to treat depression) was discontinued and the 2 PM Seroquel dose was changed to an as needed basis.</p> <p>The resident was documented as having exhibited the following behaviors for the following dates and times: 03/02/14 at 1:40 A.M. - 1:1 was attempted and was effective 03/03/14 at 9:58 P.M. - toileting was attempted but was ineffective 03/07/14 at 3:06 A.M. - 1:1 was attempted and was effective 03/07/14 at 9: 58 P.M. - no interventions were attempted 03/08/14 at 4:12 A.M. - 1:1, toileting, diversional activities, medication and outside consultation was attempted but all were ineffective 03/08/14 at 6:51 A.M. - 1:1 was attempted along with a snack and resident eventually fell asleep.</p> <p>A nurses note, on 03/06/14 at 1700 (5:00 P.M.) , indicated the nurse had spoken with Hospice related to the resident escalating anxiety during the evening hours.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 03/07/14, Zyprexa, an antipsychotic medication, was ordered on an as needed basis for agitation. Three doses were allowed in 24 hours.</p> <p>On 03/08/14, the Zyprexa was discontinued and the Seroquel was changed to 25 mg in the morning and 50 mg at 7 PM.</p> <p>The resident exhibited the following behaviors on the following dates and times: 03/10/14 at 3:24 A.M. - 1:1, diversional activities, toileting, validation, and redirection were attempted but were ineffective. 03/14/14 at 1:45 A.M. - 1:1, diversional activities, redirection, validation, and toileting, and medication were attempted but were ineffective. 03/18/14 at 4:22 A.M. - 1:1 was attempted and was effective</p> <p>Nursing notes, on 03/10/14 at 6:00 A.M., indicated the resident had been yelling and agitated since midnight. She had been given an antianxiety medication, a snack, a shower, gotten up and put back to bed several times. The note indicated other residents were complaining.</p> <p>There was a physician's order, dated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>03/28/14, for Morphine 20 mg/ml (milligrams/milliliter) 5 mg po (by mouth) q 4 hours as needed for pain and to change the 1200 PM Ativan time to 6:30 P.M.</p> <p>The resident exhibited behaviors on the following dates and times: 04/06/14 at 8:49 P.M. - 1:1 and medication were attempted but were ineffective 04/07/14 at 1:01 A.M. - 1:1, diversional activities, redirection, validation, toileting, outside consultation, and medication were attempted but all were ineffective 04/10/14 at 12:35 A.M. - redirection, toileting, and medication were attempted but were ineffective 04/12/14 at 9:26 P.M. - 1:1 and redirection were attempted but were ineffective</p> <p>There was an order, dated 04/16/14, to discontinue the morning Seroquel.</p> <p>Resident #65's care plan regarding behaviors was updated, on 04/20/14, with the following: "At night time I have a difficulty sleeping and may yell out repeatedly to staff. I have a body pillow with my husband's scent/clothes on it, which at times helps me. Nursing staff please offer this to me to help me sleep.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>My goal is to sleep 6-8 hours at night and to have fewer episodes of yelling out. At times when I am agitated, stating repeatedly "cover me" and yelling out repeatedly for staff I have a magic blanket that helps calm me down. Please all staff offer this to me. My goal is to have fewer episodes of yelling out and agitation. Please review this by 07/14."</p> <p>On 04/30/14, the resident's Seroquel time was changed from 7 PM to supertime to reduce anxiety earlier in the evening.</p> <p>Resident #65's behavior care plan was again updated, on 05/02/14, with the following: "I have behaviors at night time of yelling out. A monitor has been added to my room to allow staff to hear when I first start calling for help so they can come check on me. My goal is that this will help me not get verbally louder and disruptive to other residents. My goal is to have fewer episodes of yelling out. Please review this by 08/14."</p> <p>On 05/04/14 at 1:10 A.M., the resident was documented as resisting care. 1:1 was attempted but was not effective. On 05/10/14 at 2:49 A.M., the resident was documented as crying out and yelling. The only intervention documented was medication and it was not effective</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Nursing notes, dated 05/04/14 at 6:00 A.M., indicated the resident was at the nurses desk yelling off and on. The television had been attempted, the resident was put back to bed but continued to yell, and pain medication had been given.</p> <p>On 05/11/14, a physician's order was received to discharge the resident home on Friday 05/16/14.</p> <p>There was a subsequent physician's order to transfer the resident to the emergency room on 05/11/14 at 1800 (6 P.M.).</p> <p>During an interview on 05/15/14 at 11:00 A.M., the Social Service Director indicated she thought the behaviors documented as "verbally abusive" and/or "socially inappropriate" were the yelling and screaming out. She indicated it did take a while to get the "magic" blanket. She indicated she was "working with the family" regarding the issue. She also indicated the resident did have nights when she was not documented as having the episodes of yelling. She indicated she herself had sat with the resident 1:1 in the early morning and that intervention would work for a short time and then was also ineffective.</p> <p>During an interview on 5/16/14 at 10:35</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A.M., the Social Service Director indicated, from 12/13/13 - 12/30/13, the nursing assistants may have had an assignment sheet with interventions for behaviors but there was nothing concrete the SSD could produce or show other than what staff were documenting during the time frame in the computer and the nursing notes. In addition, she indicated the facility had worked with the family, Hospice, and had implemented interventions in response to the resident's behaviors. There was no explanation as to why the updated interventions were not always documented as implemented by the direct care staff. Although there were a few new care plan interventions attempted and multiple medication interventions, there was documentation the resident's yelling out behaviors, which was disruptive to other residents, continued from December 2013 through May 2014, when the resident was discharged to an acute care center.</p> <p>3.1-34(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to accurately assess 2 of 2 residents reviewed for Activities of Daily Living-Dressing. (Resident #80 and Resident #139)</p>	F000278	1) Resident #80 MDS (minimum data set) for Activity of daily living for dressing was reviewed and it is reflective of the resident current status. Resident #139 is discharged.	06/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Finding includes:</p> <p>1. On 5-15-14 at 10:19 A.M., a review of the clinical record for Resident #80 was conducted. The resident's diagnoses included, but were not limited to: hypertension, cerebrovascular accident with left nondominant hemiparesis, and sleep apnea.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated on 12-25-14, indicated the resident required supervision only for dressing. The next quarterly MDS assessment, dated, 3-25-14, indicated the resident required extensive assist, staff provide weight bearing support with one person physical assistance.</p> <p>During an interview on 5-14-14 at 10:40 A.M., CNA #20 indicated the resident required little assistance. The only assistance that she provided was to place the brief over the resident's feet and ankles. CNA #20 further indicated the resident was capable of pulling up the brief himself.</p> <p>The electronic care plan, indicated the following: "...ACTIVITIES OF INTEREST- I prefer to be called [resident's name] and have a diagnosis of CVA so am living here for LTC [long term care] as I need some assistance in</p>		<p>2) MDS coordinator has reviewed current residents MDS for activity of daily living- dressing to ensure accuracy of coding for dressing on the MDS. Any discrepancies will have a modification of the MDS completed to reflect accurate coding of ADL - dressing.</p> <p>3) MDS coordinator will observe three residents per week for six months to ensure accurate coding of ADL's for dressing. If any discrepancies noted re-education of nursing staff in regards to ADL's -dressing will be completed.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>everyday ADL 'S [Activities of Daily Living]. I enjoy walking, outings, talking in person and on my cell phone, helping others and I have an excellent sense of humor that I love to share jokes with others. I attend church on Sundays with close friends and my daughter visits me occasionally. My goal for activities is to remain engaged in things that bring me pleasure. Please review my interventions by 7/30/14 to determine if any changes are needed. I am able to take myself to activities that I choose to participate in. 01/24/2014. ADLS-I can walk through the facility by myself and prefer to wear my shoes untied or not all the way on my feet. I do not like to have the side rails up. I like to choose my clothing for the day. I like to do as much for myself as I can. I like to take showers twice during the week and at other times on occasion. Undated...."</p> <p>Review of Monthly Nursing Assessment and Data Collection, dated 2-4-14, indicated the resident was independent with dressing, needed limited assist of one person. The 5-8-14, monthly nursing assessment indicated resident was independent with transfers, ambulation, toileting, dressing, and eating.</p> <p>During an interview on 5-15-14 at 11:00 A.M., MDS Coordinator indicated on the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>7 day look back period, from 3-19-14 thru 3-25-14, the resident required some type of weight bearing assistance from the staff 5 times during that time frame. The MDS Coordinator further indicated he pulls the information from the kiosk (electronic charting) ADL report to document into the resident's MDS assessments. He further indicated he had not assessed or observed the resident himself. He inputs the information from the kiosk into the MDS assessments. When asked about the resident requiring weight bearing assistance with dressing and no other assistance, he stated "maybe he was receiving assistance with Ted hose (anti-embolism hose) as that would qualify for extension assist". He could not recall if the resident wore Ted hose. He indicated he only works a few hours a day and he was assisting the facility to keep the billing up to date. He indicated the CNA's had an in-service regarding Kiosk documentation recently but wasn't sure on those dates.</p> <p>A review of the nursing notes, from 3-19-14 thru 3-25-14, did not contain any assessments indicating the resident had required additional assistance with dressing.</p> <p>During an interview on 5-15-14 at 4:15 P.M., the Administrative Consultant</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated she was unable to locate the March and April Monthly Nurse Assessments.</p> <p>During an interview on 5-16-14 at 10:20 A.M., CNA #21 indicated she does no weightbearing for resident. She further indicated she only offers to assist the resident with pulling his brief on or off his ankles/feet. CNA #21 has never assisted the resident with Ted hose, she stated, "He has never had to wear them."</p> <p>During an interview on 5-16-14 at 2:30 P.M., Resident #80 indicated the only assistance he received from the staff included putting his brief over his feet and up high enough so he can grab the brief. He then pulls the brief up himself. The resident had no recall of staff bearing his weight except when he had fallen and staff assisted him up. The resident further indicated he had taken a shower this AM without any assistance. The resident was observed walking in his room with no assistance.</p> <p>During an interview on 5-16-14 at 2:37 P.M., LPN #22 indicated he remembered a time when he had to give the resident more assistance but could not recall when. He further indicated the resident was independent and had never worn Ted hose.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>2. On 5/19/14 at 9:30 A.M., record review indicated Resident # 139 was admitted to the facility on 3/14/14, and discharged to home on 4/3/14, with diagnoses included, but were not limited to, "...status post right rotator cuff repair, left upper extremity cerebral palsy, diabetes mellitus, morbid obesity and myocardial infarction...."</p> <p>A patient transfer form, dated 3/14/14, indicated "...Brief review of hospital stay...Needs to be fed, left arm cerebral palsy from birth, no function. Right shoulder surgery 1 week ago...Two screws out of place in right shoulder from fall, unable to move right arm to eat or raise it up...."</p> <p>A nursing admission assessment, dated 3/14/14, indicated "...Mobility and ADL's dressing: dependent with assist of 1...."</p> <p>An occupational therapy plan of care note, dated 3/17/14, indicated "...ADL self care upper body dressing current level: maximum assistance (76-99% assist). ADL self care lower body dressing current level: dependent (100% assist)...."</p> <p>A physical therapy/occupational therapy</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>recommendations to caregivers note, dated 3/18/14, indicated "... non-functional use of left arm, right rotator cuff surgery with no active or passive movement allowed at shoulder. Tasks: Patient needs help with all self-care tasks including opening containers and cutting food for eating if needed. Unable to manage toileting, hygiene and pants management. Unable to shower self or dress self. Approaches:...Resident is motivated and active and prideful therefore he does not like to ask for help, however needs assist to protect arm...."</p> <p>The admission MDS assessment, completed on 3/21/14, indicated Resident #139 required supervision only for dressing. The 14 day assessment, completed on 3/28/14, indicated the resident required extensive assistance for dressing.</p> <p>The care plan, dated 3/14/14, indicated the problem: ADL self care deficit needs assistance or is dependent in: dressing related to left sided cerebral palsy and right shoulder fracture. Interventions included but were not limited to "...assess/record self-care status changes. Report significant changes in ADL status to physician and responsible party...assist with personal care hygiene as</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000279 SS=D	<p>needed...provide restorative nursing for dressing and grooming...."</p> <p>A review of an undated individual plan report, indicated ..."ADL'S: I have problems providing my own care related to torn rotator cuff to right arm and unable to use left arm...Provide set up assist for my grooming and hygiene needs...Assist me as needed to complete each task..."</p> <p>During an interview on 5/19/14 at 11:30 A.M., the MDS Coordinator indicated, he believes there was a coding error on this resident because he required more assistance than just supervision upon admission. The MDS Coordinator further indicated a problem was identified in the CNA's coding for resident's ADL's in the Kiosk. He indicated when the problem was identified an inservice was conducted with all CNA and nursing staff and the coding had improved. The MDS Coordinator indicated he takes the information from the CNA's coding in the Kiosk regarding ADL's and that is how it is decided if a resident is supervision or extensive assist.</p> <p>3.1-31(i)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to ensure care plans were developed for 2 of 24 residents reviewed for care plans.(Resident #46 & Resident #62)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #46 was reviewed on 05/14/14 at 1:31 P.M. Resident #46 was admitted to the facility on 03/13/14 with diagnosis, including but not limited to, status post closed fracture of the left femur, sleep apnea, hypertension, diabetes mellitus, hypothyroidism, osteopenia,</p>	F000279	<p>1) Resident #46 and #62 are discharged.</p> <p>2) An audit of admissions/readmissions in last 30 days to ensure care plans are reflective of resident current status. An audit of all residents with current pressure ulcers completed and careplan updated to reflect current status.</p> <p>3) Licensed nurses re- inserviced to complete the initial careplan on admission/readmission assessment form reflective of resident skin status and document skin assessments on pressure wound</p>	06/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>gastroesophageal reflux disease, depression, anxiety, degenerative joint disease, pancreatitis, and history of knee prosthetic.</p> <p>The admission physician orders for medications, on 03/13/14, included but were not limited to: Atenolol (a blood pressure medication) , Vitamin d2 50 (a supplement to increase bone density), simvastatin (a medication to prevent gastric reflux issues) , Synthroid (a medication to treat hypothyroid issues), Claritin (a medication to treat allergies), Protonix (a medication to treat esophagitis), Januvia (a medication to treat diabetes mellitus).</p> <p>The Simvastatin was discontinued on 03/13/14.</p> <p>A physician's order, dated 03/17/14, added the medication Vytorin for hyperlipidemia.</p> <p>A physician's order , dated 04/07/14, added the medication Flexeril (a muscle relaxant).</p> <p>The initial care plans for Resident #46, located in the clinical record and initiated on 03/13/14, included plans to address the following issues: activities of daily living needs, potential for falls, Potential</p>		<p>condition form when a pressure area is identified and update the careplan. DHS/designee will review admissions/readmissions skin assessment and careplan along with any pressure wound noted and review of careplan Mon-Fri during clinical care meeting for six months.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for weight loss related to pain, Potential for impaired skin integrity, Potential for constipation, Pain, Anticoagulant use, Anxiety and "Depression, and Nutrition needs. The Nutrition care plan did not mention the resident's diabetes or any other medication use There was a typed care plan for the risk for decreased cardiac output but it was not completed regarding the resident's disease processes which put her at risk for decreased cardiac output and there were no interventions implemented for the care plan.</p> <p>An electronic care plan, titled "Individual Plan Report," copied on 05/15/14 at 1:54 P.M., included a plan to address the resident's abnormal bleeding tendencies related to the use of anticoagulant therapy. The pain care plan indicated the resident was receiving flexeril. The electronic care plan regarding nutrition, which was dated 03/21/14, indicated the resident was receiving a regular diet and had an allergy to MSG. There was no mention of diabetes or Januvia medication use, or the Vitamin use, or the medication to prevent gastric reflux and other stomach issues.</p> <p>There was no plan to address the resident's hypothyroidism and Synthroid use, the resident's hyperlipidemia and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Vytorin use, the resident's hypertension and Atenolol use, or the resident's osteopenia, diabetes and Januvia use and Vitamin D2 use.</p> <p>2. On 5-16-14 at 10:55 A.M., a review of the clinical record for Resident #62 was conducted. The record indicated the resident was admitted to the facility on 12-3-14. The resident's diagnoses included, but were not limited to: acute cerebrovascular accident, depression, and hyperlipidemia.</p> <p>A review of the physician's progress note, dated 12-24-14, indicated the resident has a "...blister on her L [left] lower leg from pressure also not eating...." The physician ordered a treatment for the wound - Mepilex to left outer ankle, change every 3 days and as needed until healed.</p> <p>A review of the resident's undated care plan, titled "Potential Alteration in Skin Integrity", indicated the Problem: ..."Potential for alteration in skin integrity R/T [related to] Immobility, Incontinence...." The intervention part of the plan was left blank. The electronic chart was reviewed and had no skin integrity care plan nor a pressure ulcer careplan after the pressure ulcer was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>identified.</p> <p>On 5-16-14 at 11:07 A.M. a review of the Skilled Nursing Assessment and Data Collection, dated 12-23-14, indicated Resident # 62 had a skin impairment: "Blister, pus filed." The nursing assessment did not include area of the skin the blister was on nor measurements of the area. Another nursing assessment, dated 12-24-14, indicated the resident had a skin impairment: "open lesion" The 12-25-14 nursing assessment indicated the resident had a skin impairment: "abrasion." Nursing notes stated, "Tek (sic) reposition q [every] 2 hours, ankle dressing dry et [and] intact." There were no skin assessment sheets located on the clinical record.</p> <p>During an interview on 5-16-14 at 2:07 P.M., the DON indicated there were no skin assessments completed in regards to the resident's left lower leg/ankle pressure wound that the physician had identified on 12-24-14. He further indicated a careplan for the prevention of pressure ulcers was not completed as it had no interventions document to prevent skin ulcers. After the pressure ulcer was discovered a careplan to address the ulcer was not completed.</p> <p>On 5-16-14 at 2:15 P.M., a review of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000280 SS=D	<p>policy titled "Pressure/Stasis Wound Condition Report Guidelines" undated indicated "... Purpose: to provide documentation of wound measurements and condition. 2. Initiate the form when an area of impairment...is identified. 3. Complete the section titled "Initial Identification" in its entirety making sure to include identification upon admission or not, notification of MD and responsible party. 4. Document description of wound using the Documentation Key...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interviews, the facility failed to ensure care plans were updated to reflect the resident's plan of care for 1 of 24 residents reviewed for revision of care plans in the Stage 2 review. (Resident #62)</p> <p>Finding includes:</p> <p>On 5-16-14 at 10:55 A.M., a review of the clinical record for Resident #62 was conducted. The resident's diagnoses included, but were not limited to: acute cerebrovascular accident (CVA), depression, urinary tract infection with dehydration and hyperlipidemia.</p> <p>Review of the care plan on 5-16-14 at 11:07 A.M., titled "Heights/Weights," dated 12-6-13 ,indicated the following: "...My current weight is around 168. My weight about a month ago was 176. My</p>	F000280	<p>1) Resident #62 is a discharged resident.</p> <p>2) Residents who have mechanically altered diets care plans have been reviewed and updated to reflect resident current diets.</p> <p>3) Licensed nurses re-inserviced to update resident diet on careplan. DHS/designee will review resident diet order to ensure it is noted on careplan during clinical care meeting Mon - Fri.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>goal is to maintain my current weight without any significant change. Please weigh me weekly x 4 weeks then monthly. Please review my weight history on or before 90 days...." Another careplan titled "Meals/Snacks/Fluids" dated 12-6-13 indicated the following: "...I am on a mechanical soft with ground meat diet as I have difficulty chewing and swallowing because of my recent stroke . I can feed myself but may need some assistance with cutting and such as my left arm doesn't work so good because of the stroke. I don't have much of an appetite as I am feeling sad and want to go home. Please encourage me to eat. The dietitian is going to recommend nutritional supplement for increase calories and protein. My goal is to eat adequate calories and protein to maintain my weight and get stronger so I can return home. Please review my nutrition plan of care on or before 90 days...."</p> <p>On 5-16-14 at 11:20 A.M., a review of the physician orders indicated, on 12-4-13, a Speech Evaluation and Treatment was ordered. On 12-5-13, the physician orders indicated a change in the resident's diet to a mechanical soft diet with moistened ground meats. On 12-6-13, the physician ordered nectar thick liquids secondary to coughing on thin. On 12-7-13, Remeron (medication</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>to stimulate appetite and an antidepressant) was started due to no appetite. This order also contained a nutritional supplement - 2 Cal 60 ml (milliliters) QID(4 times a day) with medication pass. On 12-28-13 the 2 Cal was increased to 90 ml QID. Then on 1-2-14 resident was referred to hospice.</p> <p>On 5-16-14 at 1:55 P.M., a review of form titled "Nutrition Assessment and Data Collection," dated 12-6-13, and was completed by the Dietician, indicated the resident was on a regular mechanical soft diet with moistened ground meat. The physical assessment indicated the resident was eating with some assistance, had inadequate oral intake, limited food acceptance, states she doesn't want to eat, appeared depressed, cried frequently, had left sided weakness secondary to the stroke and would benefit with with increase calories and protein. The Dieticians interventions included 2 Cal supplement 60 milliliters and referral to MD to address mood. The Nutrition Progress Note completed by the Dietician on 12-13-13, had no documentation that resident was currently using thickened liquids.</p> <p>On 5-16-14 at 2:10 P.M., a review of the Speech Therapy Plan of Care dated 12-3-13 indicated "... referred to therapy</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>due reports from therapists of swallowing difficulties during meals since admission. Patient had no history of dysphagia. Swallowing difficulties were caused by increased weakness from CVA... Swallowing status: moderate impairment (50-75% impairment; combination of oral and nonoral nutrition; requires thickened liquids; difficulty masticating foods)...."</p> <p>During an interview, on 5-16-14 at 2:07 P.M., the Dietician indicated the careplans are initiated by her and nursing adds to the careplan when new orders are received. She further indicated the diet order and communication forms are filled out by the nurse and sent to the Dietary Manager to notify him of any diet changes the physician has ordered. The dietician was unable to recall if she was aware of the order for thickened liquids. The Dietician did not indicate that she reviewed the careplans.</p> <p>During an interview on 5-17-14 at 2:35 P.M., the Administrator Consultant indicated the facility had not updated the resident's careplan with the current physicians orders.</p> <p>3.1-35(d)(2)(B)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interviews, the facility failed to ensure 2 of residents interviewed were given a minimum of two bathing opportunities a week consistently as scheduled. (Resident #17 and #135)</p> <p>Findings include:</p> <p>1. During an interview with Resident #17, conducted on 05/13/14 at 10:53 A.M. she indicated she was supposed to be given two showers a week but it "doesn't always happen."</p> <p>During an interview, on 05/15/14 at 9:35 A.M., CNA #10 indicated there was a book with the shower schedule in it on the unit. Review of the CNA book, on</p>	F000312	<p>1) Residents #17 and #135 were assisted with showering/bathing. Resident #17 and #135 were asked preference of time and type of showering and/or bathing they preferred. Careplan and resident profile were updated with individual needs and preferences for showering and bathing. 2) Review of current resident personal preferences to ensure each resident s are showered/bathed at times requested by resident. Careplan and resident profile updated. 3) Nursing staff re-inserviced regarding resident personal preferences for showering/bathing and to interview resident for their showering/bathing preference and careplan and resident profile to reflect resident personal</p>	06/18/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the unit, indicated the resident was scheduled during the day shift on Tuesdays and Saturdays. However interview with CNA #10 and written documentation on the side of the shower schedule lists indicated Resident #17 desired to receive her showers at 5:00 A.M. so she was actually supposed to be showered by the third shift.</p> <p>Review of the electronic documentation regarding bathing, completed on 05/14/14 at 2:00 P.M., for Resident #17, indicated she had received two showers on 12/07/13 and then did not receive another shower, bed bath, or tub bath until 12/17/13, 10 days later. The resident received a bed bath on 12/19/13, and then did not receive another bathing opportunity until 12/31/13, 11 days later. The resident received a shower on 01/04/14, and then did not receive another bathing opportunity until she received a bed bath on 01/11/14, 7 days later. The resident was documented as receiving a shower on 03/05/14, and then did not receive another bathing opportunity until 04/15/14, 40 days later.</p> <p>During the interview on 05/13/14, Resident #17 indicated most of the time, she just washed herself the best she could in the bathroom. She did not recall ever receiving or requesting a bed bath. She</p>		<p>preference. DHS/designee will review electronic showering/bathing documentation three times per week times six months to ensure personal preferences are followed. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated she preferred to be showered.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment, dated 03/25/14, for Resident #17, indicated she was moderately cognitively impaired and required total staff assistance of one staff member for bathing needs.</p> <p>2. The clinical record for Resident #135 was reviewed on 05/14/14 at 11:00 A.M. Resident #135 was admitted to the facility on 03/09/14, with diagnosis, including but not limited to status post fractured right hip, hypothyroidism, hypertension, diabetes, dementia, and constipation.</p> <p>During an interview on 05/12/14 at 2:38 P.M., Resident #135 indicated she had only had three showers since she had been admitted in March. The resident indicated it was not her choice to miss her scheduled showers.</p> <p>Review of the initial MDS assessment, completed on 03/16/14, indicated it was somewhat important for the resident to choose the bathing method. The assessment indicated Resident #135 was alert and oriented, and she required total staff support for bathing.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Review of the electronic bathing type chart, on 05/14/14 at 2:00 P.M., indicated since the resident was admitted, indicated she had received both a bed bath and a shower on 03/12/14, a bed bath on 03/17/14, and a shower on 03/20/14. The resident was not documented as having receiving any more bathing opportunities until 04/11/14 when she was documented as having received a shower. She was documented as having received showers on 04/15/14, 04/18/14, 04/22/14, 04/25/14, and 04/29/14. From 04/30/14 - 05/14/15, she was not documented as having received any type of bathing opportunities.</p> <p>Review of the CNA book, on 05/16/15 at 2:45 P.M., indicated the resident was to receive her showers on Wednesday and Saturdays during the second shift. Interview with LPN #8, the unit manager indicated there was no system to ensure the bathing and showering was completed as scheduled. She indicated she ensured all the new residents were placed on the CNA bathing schedule and the book was kept up to date. She indicated she was unaware of the large gaps between the times residents were bathed and/or showered. She indicated Resident #17 would refuse to take a shower if she was not approached at exactly 5:00 A.M. on her shower days.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000314 SS=D	<p>She indicated she had to reinservice staff regarding being on time for Resident #17's showers. There was no other information available regarding why showers and/or bathing was not occurring timely for Resident #17 and #135.</p> <p>3.1-38(b)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to implement specific interventions to prevent a pressure ulcer for 1 of 3 residents reviewed for pressure ulcer. (Resident #62)</p> <p>Findings include:</p> <p>On 5-16-14 at 10:55 A.M., a review of the clinical record for Resident #62 was</p>	F000314	<p>1) Resident #62 is a discharged resident.</p> <p>2) Current residents have been reviewed for specific interventions for preventative measures related skin integrity and careplans updated to reflect resident current status.</p> <p>3) Nursing staff re-inserviced regarding preventative guidelines to</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>conducted. The record indicated the resident was admitted to the facility on 12-3-14. The resident's diagnoses included, but were not limited to: acute cerebrovascular accident (CVA), depression, and hyperlipidemia.</p> <p>A Nursing Admission Assessment & Data Collection form, dated 12-3-13, indicated the resident was at risk for developing a pressure ulcer.</p> <p>A review of the physician's progress note, dated 12-24-13, indicated the resident had a "...blister on her L [left] lower leg from pressure also not eating..." The physician ordered a treatment for the wound - Mepilex to left outer ankle, change every 3 days and as needed until healed.</p> <p>The resident's undated care plan, titled "Potential Alteration in Skin Integrity" indicated the Problem: ..."Potential for alteration in skin integrity R/T [related to] Immobility, Incontinence..." The intervention part of the plan was left blank. There was no documentation in the electronic chart related to Resident's pressure ulcer.</p> <p>On 5-16-14 at 11:07 A.M., a review of the Skilled Nursing Assessment and Data Collection, dated 12 23-13, indicated the</p>				<p>ensure areas of potential skin breakdown have preventive measures noted on the careplan. DHS/designee will monitor weekly skin assessments for completeness and accuracy three times a week for three months and then weekly for three months.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>resident had a skin impairment: "Blister, pus filed" The assessment did not include the area of the skin the blister was on. Another nursing assessment dated 12-24-13 indicated the resident had a skin impairment: open lesion, blister opened, white pus, no odor. The 12-25-13 nursing assessment indicated the resident had an abrasion; dressing checked and changed; repositioning every 2 hours; dressing dry and intact. There were no additional skin assessments located in the clinical record.</p> <p>During an interview on 5-16-14 at 2:07 P.M., the Director of Nursing indicated there were no skin assessment sheets or careplan interventions located in regards to the pressure wound on Resident #62's left lower leg/ankle.</p> <p>On 5-16-14 at 2:15 P.M., a review of policy titled "Pressure/Stasis Wound Condition Report Guidelines" undated indicated "...2. Initiate the form when an area of impairment...is identified. 3. Complete the section titled "Initial Identification" in its entirety making sure to include identification upon admission or not, notification of MD and responsible party. 4. Document description of wound using the Documentation Key...."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000323 SS=D	<p>3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision and assistance for a resident with Dementia with a history of falls for 1 of 30 residents reviewed for accidents. (Resident # 71)</p> <p>Finding includes:</p> <p>On 5/14/14 at 11:24 A.M., record review indicated Resident #71's diagnoses included, but were not limited by, Dementia, delusions, urinary incontinency, and degenerative joint disease.</p>	F000323	<p>1) Resident #71 fall careplan has been reviewed and updated and is reflective of resident and current interventions. 2) Current residents that have had falls past 30 days have been reviewed for interventions and plan of care updated to ensure interventions are reflective of resident current needs. 3) Nursing staff re-inserviced on fall prevention guidelines to put an intervention in place when resident has a fall and update the careplan with the intervention. DHS/designee will review resident that has fallen and ensure interventions are updated on the careplan reflective of the resident status during clinical care meeting Mon - Fri for six months. 4) QAA will monitor</p>	06/18/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Review of Resident #71's "Fall Circumstance, Assessment and Intervention" form indicated Resident #71 had the following falls:</p> <p>-11/21/13 fall report indicated Resident #71 fell while walking but was "unable to state" the cause of fall. The prevention update indicated call bell, night light in bathroom, and bed in low position."</p> <p>-12/17/13 fall report indicated Resident #71 was "found on floor w/ (with) chair pushed across room." The report did not indicate any new preventions.</p> <p>-12/3/13 fall report indicated Resident #71 "was speaking to wife et (and) attempted to sit down, missing chair." The report indicated Resident #71 sustained an injury to the "top of his head, R. (right) arm." The report indicated "resident had put pants on but had not pulled them up to waist."</p> <p>-1/24/14 individual monitoring sheet indicated Resident #71 fell on 1/22/14. The recommendations were "bed/chair alarm" and "continue current interventions." The follow up form indicated Resident #71 fell again on 1/27/14 with "new interventions are to encourage w/c (wheelchair)."</p> <p>-2/15/14 report indicated Resident #71 "stumbled and was lowered to floor."</p> <p>-3/24/14 report indicated Resident #71's fell 7:30 PM and it was "not observed." The "Change of Condition" form dated</p>		findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3/24/14 indicated "resident observed on floor with his wife (sic) bed alarm beside him. No injuries noted. No c/o (complaint of) pain." The "Clinically at Risk, Individual Monitoring Sheet" dated 3/28/14 indicated fall on 3/24/14. The recommendations were "continue current interventions to minimize injury from falls."</p> <p>-4/14/14 report indicated Resident #71 fell at 6:55 PM and "resident stated 'dizzy' after falling."</p> <p>-5/3/14 and 5/4/14 report indicated Resident #71 fell at 12:10 AM on 5/4/14 and at 8:40 PM on 5/3/14. The report indicated Resident #71 sustained a scrape on his right elbow. The fall report indicated Resident #71 was found on the floor. The report indicated "Resident [#71] needs more supervision unsteady on feet." The report indicated an IDT (interdisciplinary team) review, dated 5/5/14, which indicated "balance issues, rapidly progressing dementia." The IDT note indicated "continue present CP [care plan] "falls c [with] significant injury."</p> <p>-5/1/14 report indicated Resident #71 "RN [Registered Nurse] was discharging resident, aide called to help out on other unit, res [resident] needs more supervision/unsteady at times on feet." The report indicated "prevention update" indicated "WC [wheelchair] and increase supervision."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Review of Resident #71's a fall care plan, dated 1/22/14, which indicated the following interventions:</p> <ul style="list-style-type: none"> -Use fall assessment to identify risk factors. -Report falls to physicians. -Monitor for side effects of any drugs that can cause gait disturbances... -Report to physician any negative side effects associated with the residents medication use. -Provide the following environmental adaptations: half rails as an enabler, call light within reach, adequate glare free lighting, area free of clutter. -Provide/monitor use of: walker/cane. -Remind resident and reinforce safety awareness... -Addendum, dated 1/22/14, included intervention of bed and chair alarms and to ambulate with staff to and from meals. <p>Review of Resident #71's care plan for "acute care needs" (falls) indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> -11/21/13 "Today I had a fall walking in my room. I do not want to fall with a major injury. I like to be independent with my walking, but lately, I have been weak, and therefore unable to walk as well as usual. I need staff members to put an alarm on my bed to alert them when I attempt to walk without 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>supervision." The entry indicated this prevention was reviewed on 12/5/13 which indicated "I do not like bed alarms. They are disruptive to me and therefore counterproductive. My family agree alarms do not help me."</p> <p>-12/3/13 "Today I had a fall I lost balance and fell. I do not want to fall again. I need nursing staff to put a bed and chair alarm to alert staff when I get out of bed unsupervised. I do not understand my balance is bad, and I do not want to do therapy. I am more comfortable walking behind my wife's wheelchair, so please remind me if you see me walking without my wife or her wheelchair."</p> <p>-1/22/14 "Today I had a fall. I lost my balance and fell. I do not want to fall again. I do not want to fall again. I need nursing staff to put a bed and chair alarm to alert staff when I get out of bed unsupervised. I wish to be escorted to and from the dining room because I am getting more unstable but refuse to use a wheelchair... "</p> <p>-1/27/14 "Today I took a fall in the dining room. I do not want to fall again. I would like to remain as independent in ambulation and in the dining room for as long as possible...."</p> <p>-3/24/14 "Today I took a fall. I know I am going to continue falling because I do not follow the interventions previously</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>put in place for me. My goal is to not have any serious injury related to any of my falls. I would like the therapy department to screen me for any possible interventions to prevent injury from falls...."</p> <p>-04/14/14 "Today I took a fall. I do not want to have any serious injury related to fall. If I fall please assess me for any injuries...."</p> <p>-05/1/14 "Today I had another fall. I do not want to fall with a serious injury related to a fall. I had no injury with fall. I do not use my call light or wheelchair as I do not remember. I have rapidly developing alzheimers dementia. Please observe me for continued balance issues. I need nursing staff to attempt to redirect me to use the wheelchair. I do resist being redirected, but do attempt as I tend to be safer on the wheelchair...."</p> <p>-5/5/14 "I have had 2 falls over the weekend. I have balance issues and non complaint with alarms and wheel chair (sic) usage. Please remove alarms as they tend to agitate me. My goal is not to have serious injuries with any falls. I need nurses to continue observing me and attempt to redirect me...."</p> <p>Review of Resident #71's "Physician's Progress Notes" indicated the following (not all inclusive):</p> <p>-12/4/13 "laceration scalp from last night</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>from fall, tripped. Seems to be getting weaker...."</p> <p>-1/22/14 "2 abrasions top scalp from fall. No other injuries. Use Neosporin (antibiotic cream)."</p> <p>-1/28/14 "R. (right) hand swollen, tender from fall. Use ice. Check X-ray."</p> <p>Record review indicated Resident #71 received Physical Therapy treatment between the dates 6/14/13 to 7/9/13. Record review indicated no Physical Therapy screening after Resident' #71's 3/24/14 fall as indicated in his plan of care.</p> <p>On 5/15/14 at 1:25 PM during an interview, the Director of Health Services (DHS) stated Resident #71 "is very independent, he doesn't like to be assisted...." The DHS indicated Resident #71 prefers to walk behind his wife's (another resident) wheelchair rather than be physically assisted while walking. The DHS stated Resident #71 was heard of hearing and "we have also discovered the alarms do not stop him, they agitate him." The DHS stated Resident #71 "wasn't compliant with the alarms, we've tried to maintain his independence." The DHS stated "we have changed the care plan to state he will have falls but we are attempting to prevent injury, maintain independence while watching him as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>closely as possible." The DHS stated the "last update [of care plan] of redirection has worked because if you assist and he resists, then he will push" and potentially fall. The DHS stated "we've tried several times with PT [physical therapy], he is noncompliant with PT, it hasn't gone anywhere because he would not follow through, we do interventions lightly due to his dementia."</p> <p>On 5/15/14 at 2:41 PM during an interview, the Program Director of Rehabilitation (PDR) stated Resident #71 was "therapeutically inappropriate for therapy because he does not take direction, tried different staff, and his main therapist also agreed, he won't let us touch him and will not follow requests." The PDR indicated she could not locate a PT screening since one dated 6/2013. The PDR stated "when I screen him, it's just for stability." The PDR stated Resident #71 was "unable to lock his wheelchair brakes" for safety and he would not continually use his wheelchair. The PDR stated Resident #71 was not assessed for use of gaitbelt for staff to assist his balance while walking because "they use gaitbelts just for care" but the PDR indicated she didn't "think it would have helped because he is always alone when he falls and so, I had not considered that kind of intervention." The PDR</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>indicated she did not have documentation Resident #71 had a PT screening after his 3/24/14 fall.</p> <p>On 5/15/14 at 3:50 PM, the Program Director of Rehabilitation located documentation that Resident #71 had a PT screening dated 4/16/14 (Resident #71 had a fall on 4/16/14) which indicated "PT [patient] has experienced recent multiple falls. Pt (physical therapy) is inappropriate for skilled therapy services at this time. 2 [due to] pt's [patient's] inability to follow instructions and (decreased) cognition." No further documentation was available to review which indicated the PT screening recommended further fall prevention techniques as indicated in the care plan note dated 3/24/14. No further documentation was available for review which indicated the facility continued to place additional interventions and/or techniques to prevent Resident #71 from falls.</p> <p>3.1-45(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>1. Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents reviewed for weight loss was assessed and interventions implemented to prevent further weight loss after a significant amount of unplanned weight was lost. (Resident #135)</p> <p>2. Based on record review and interview, the facility failed to ensure the current diet order was communicated to the Dietary Manager for 1 of 3 residents reviewed for current diet orders. (Resident #119)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #135 was reviewed on 05/14/14 at 11:00 A.M. Resident #135 was admitted to the facility on 03/09/14, with diagnosis, including but not limited to status post fractured right hip, hypothyroidism, hypertension, diabetes, dementia, and</p>	F000325	<p>1) Resident #135 current weight is stable. Resident #119 is discharged.</p> <p>2) Current resident weights have been reviewed for past 30 days. any significant weight loss noted, the resident physician, family and registered dietician have been notified and recommendations noted as indicated. Current resident diet orders have been reviewed and been communicated with dietary manager to ensure resident diet matches dietary communication form.</p> <p>3) Nursing staff re-inserviced in regards to weighing residents and any resident that has a weight that seems out of normal range will be re-weighed to determine the accuracy of the weight. If significant weight loss is noted a re-weight will be completed for verification of the weight. Physician, family and registered dietician will be notified of the significant weight loss. Licensed nurses inserviced to write</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>constipation.</p> <p>The initial Minimum Data Set (MDS) assessment for Resident #135, completed on 03/16/14, indicated the resident was alert and oriented, required supervision for eating needs, was to receive a therapeutic diet, was 60 inches tall and weighed 121 pounds and had not experienced any recent weight loss.</p> <p>The initial physician's orders for Resident #135, dated 03/09/14, indicated orders for a "diabetic" diet, a multivitamin once a day, Vitamin C twice a day. There were no orders for any high protein or high calorie nutritional supplement.</p> <p>The resident's admission weight was documented on 03/09/14 as 120.5 pounds. However, a subsequent weight, dated 03/27/14, indicated the resident's weight had dropped to 111 pounds, an 8.3 % [percent] weight loss in 15 days. On 04/06/14, the resident's weight had dropped to 109 pounds, a 9.9 % weight loss in 1 month.</p> <p>The initial dietary assessment, completed on 03/14/14, indicated the resident was 60 inches tall and weighed 120.5 pounds, which was documented on the acute care centers transfer records, and had a Body Mass Index of 23. The assessment</p>				<p>resident diet order on the dietary communication form for dietary manager. Residents will be monitored weekly at Clinically At Risk meeting by DHS/designee until weight stable then removed from clinically at risk meeting. Clinical at risk meeting weekly is ongoing. Resident diet order and dietary communication form will be reviewed three times weekly during clinical care meeting for six months.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated the resident was receiving vitamin C and a multivitamin as well as thyroid medication and a diuretic. The assessment indicated the resident was receiving a CCHO (controlled carbohydrate) diet, consumed an average of 78 % of her food, required greater than 1375 kcal (kilocalorie) per day, greater than or equal to 44 grams of protein per day, and greater than or equal to 1375 ml (milliliters) per day. In addition, the assessment indicated the resident would benefit from a liberalized diet due to her advanced age and "fair" intakes. The recommendation was made for a "regular diet." The monitoring plan indicated weight and intakes should be monitored. There were no further notes or assessments from the dietician regarding the resident's weight loss.</p> <p>During an interview, on 05/14/14 at 11:49 A.M., Resident #7 indicated she was going to check in another place for any further dietary assessments, notes, or recommendations. When asked why they would not be on the clinical record, she indicated they kept them possibly several different places. Review of the physician's rewrites for May 2014 indicated a diabetic diet was still ordered for Resident #135 and there were no physician's orders clarifying diet orders or adding any supplements.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an Interview, on 05/14/14 at 1:30 P.M., the Director of Nursing indicated the resident had edema when she came and also desired to lose weight to get to her previous weight of around 112 pounds. A physician's progress note from November 2013, over 4 months prior to the resident's admission to the facility indicated the resident's weight, on the physician's office scales, was assessed to be 112.5 pounds. In addition, a physician's progress note, dated 03/19/14, indicated "R [right] leg swelling yesterday none today...." There were no medication changes or orders given to promote fluid loss. It was also unclear where the physician got the information if there was no edema visible on 03/19/14 and no charting of any assessed edema in nursing notes or assessments around 03/19/14.</p> <p>Review of the initial care plans for Resident #135, located in her clinical record, initiated on 03/10/14, indicated a plan for the potential for weight loss due to her weakened state. The only intervention implemented was to weight the resident.</p> <p>An "Individual Plan Report" for Resident #135 was presented on 05/14/14 at 1:30 P.M. The plan indicated the following</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>nutritional plans: "Heights/Weights 03/14/14 My weight on discharge from the hospital was around 121 pounds. My goal is to maintain a healthy weight without any significant change. Please weight me monthly and as needed. Please reviewer my weight history on or before 90 days. [staff initials]. My pre-hospitalization weight was approximately 112 pounds. I am experiencing some edema and would like to return to my pre-hospitalization weight. Please monitor my weight as indicated and report any continued swelling, or failure to lose weight to my physician. Please review by 06/20/14. Meals/Snacks/Fluids 03/14/14 I am on a diabetic diet because I have diabetes. I can feed my self and have a fair appetite. I would benefit from a more liberalized diet so the dietician is going to recommend that my diet be changed to regular. My nutrition goal is to eat adequate calories and protein for healing and weight maintenance. Please review my nutrition plan of careitalization (sic) weight on or before 90 days [dietician's initials]."</p> <p>Review of the clinical record, nursing assessments on admission and skilled nursing assessment through March and April, and initial care plans indicated there was never any documented edema</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>for Resident #135. There was no care plan for planned or expected weight loss except for an I care plan which did not match concerns or assessment documentation from the initial record.</p> <p>During an interview, on 05/14/14 at 1:56 P.M., Resident #135 indicated she was not trying not did she desire to lose weight. She indicated she was aware she was losing weight. She indicated she was not trying to lose weight and although the food was good at the facility it was not like the food she was used to eating and she knew she was not eating as well as when she lived at home.</p> <p>Review of a "Profile History Report" for the electronic individual care plan, which had been presented on 05/14/14 at 1:30 P.M., by the Corporate Administrator, indicated the initial nutrition plans, had been initiated on 03/14/14 by the dietician. The initial plans were for the resident to maintain her weight and to receive a liberalized diet instead of a diabetic diet. On 05/14/14, RN #7 had updated the plans and added the information regarding the edema and resident's desire to lose weight.</p> <p>Review of a "Resident First Conference Notes," completed on 03/19/14, for Resident #135 indicated her weight was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>stable and there was no documentation of any edema or desired weight loss.</p> <p>During an interview on 05/16/14 at 2:00 P.M., the Dietician indicated she had not care planned any expected weight loss due to edema or the resident's desire to lose weight. She indicated she had not been notified, on 03/27/14 or 04/06/14, of any significant weight loss for Resident #135. She also indicated she had completed her initial dietary assessment utilizing the acute care center's weight for the resident rather than the facility's weight. She indicated there was no facility assessed weight available for her use on 03/14/14, when she had completed the assessment. However, the initial nursing assessment, completed by the facility upon admission, indicated Resident #135's weight was 120.5 pounds.</p> <p>Review of the facility's policy and procedure, dated 06/12, for "Guidelines for weight tracking" indicated the following: "1. Residents will have their weight taken and recorded upon admission to establish a baseline. 2. Unless otherwise indicated or ordered by the physician the resident have their weight taken and recorded monthly. 3. The facility dietician will review the resident's nutritional status, usual body</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>weight an current weight to implement a nutritional program when warranted...6. The weights should be recorded in the individual resident medial record utilizing the monthly weight tracking form and in the computerized system to provide an 'at a glance' report to the dietician. 7. Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight...8. The physician, responsible part and dietician shall be notified of a weight variance of greater than 5 % (unless on a planned weight loss program)."</p> <p>2. On 5-15-14 at 1:30 P.M., a review of the clinical record for Resident #119 was conducted. The record indicated the resident was admitted to the facility on 12-9-13 . The resident's diagnoses included, but were not limited to: Right hip fracture (fall at home) hypertension, hypothyroidism, dementia and pacemaker. The resident had a follow up in 4 weeks with an orthopaedic physician and was readmitted to the hospital to have an intramedullary nailing of right intertrochanteric hip fracture on 1-21-14.</p> <p>A review of form titled "Nutrition Progress Note," dated 1-31-14, indicated resident was readmitted on 1-23-14 s/p (status post) right hip surgery, with a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>weight of 171. The resident on a low sodium diet and on megace (medication) to help with appetite. The plan was to monitor the resident's intakes and liberalize the diet to regular. The next dietician note was on 2-7-14 and indicated the resident's weight was 165. The intakes were fair and dietician recommend to start megace for appetite stimulation, fortified foods, and a 2 Cal supplement 60 ml (milliliters) BID (twice a day) with med pass for 4 weeks. A note from "Nutritional Assessment and Data Collection dated 3-21-14 indicated weight now stabilized at 169. The resident received additional calories & protein from fortified foods. The intakes were good/improved. The current diet was regular with fortified foods.</p> <p>A review of form from the local hospital, titled "Patient Transfer Form," dated 1-23-14, indicated an order for a low sodium diet, megace 400-800 mg [milligrams] po [by mouth] every day and Ensure as needed. The "Brief Review of Hospital Stay" section indicated..."needs assist w [with] eating. No appetite. Megace ordered..."</p> <p>Review of the electronic care plan, titled "Meals/Snacks/Fluids" dated 12-6-13 indicated the following: "... 2-7-14 I am on a low sodium diet and tolerating. I</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>have a fair appetite and I do need help with eating. My husband usually is here to help me with eating and filling out my menus. I do have a pressure ulcer. I am on megace to help with my appetite. I would benefit from additional calories and protein to help with healing so the dietitian is going to recommend a nutritional supplement. My nutrition goal is to eat adequate calories and protein to promote healing and weight maintenance. Please review my nutrition plan of care on or before 90 days...."</p> <p>On 5-15-14 at 2:50 P.M., a review of form titled "Resident Listing Report," dated 5-14-14, from the Dietary Manager indicated resident was on Regular, 2 Gram Sodium, Fortified foods diet.</p> <p>During an interview on 5-15-14 at 4:40 P.M., the Administrative Consultant indicated she was unsure why the current diet list provided by the Dietary Manager indicated Resident #119 was receiving a 2 gram sodium regular diet with fortified foods, when the order for regular diet with fortified foods was ordered on 2-7-14. She further indicated there was no policy regarding the dietary communication forms.</p> <p>During an interview on 5-16-14 at 2:07</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>P.M., the Dietician indicated the careplans are initiated by her and the nurses add to the careplan when new orders are received. She further indicated the diet order and communication forms are filled out by the nurse and sent to the Dietary Manager to notify him of any diet changes the physician had ordered. The dietician was unaware that the resident was still receiving a 2 gram sodium diet. The Dietician did not indicate that she reviewed the careplans.</p> <p>During an interview on 5-19-14 at 3:05 P.M., the Dietary Manager indicated the resident's current diet was Regular with 2 Grams (Gm) Sodium with fortified meals. He further indicated he gets his information from the nurses when they fill out a Diet Order Communication form. The dietary manager was informed the nurses had completed a Dietary Order & Communication form on 2-7-14 to stop the 2 Gram Sodium limit. The Dietary Manager had no idea why this form nor the order had been communicated to him. The Dietary Manger then looked at the resident's current Menu Choice Form and it also contained the 2 Gm sodium limit indicating the resident was still receiving a sodium restricted diet.</p> <p>3.1-46(a)(1)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>1. Based on record review and interviews, the facility failed to ensure adequate monitoring was in place to support the use of medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #46)</p> <p>2. Based on record review and interview, the facility failed to ensure non-pharmacological interventions and medical issues were resolved before initiating and/or increasing anti-anxiety</p>	F000329	<p>1) Resident #46 no lab ordered for Lovenox as it was D/C on 5/27/14. Resident #46 no order for any additional labs as resident discharged 6/6/14. Resident #65 was a closed chart. 2) Current residents have been reviewed to ensure medications requiring lab monitoring have labs ordered for those medications that require monitoring. 3) Licensed nursing staff re- inserviced on medications that require lab monitoring and to request order for lab monitoring when checking orders with physicians to inquire</p>	06/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and antipsychotic medications for 1 of 1 residents reviewed for behaviors. (Resident #65)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #46 was reviewed on 05/14/14 at 1:31 P.M. Resident #46 was admitted to the facility on 03/13/14 with diagnosis, including but not limited to, status post closed fracture of the left femur, sleep apnea, hypertension, diabetes mellitus, hypothyroidism, osteopenia, gastroesophageal reflux disease, depression, anxiety, degenerative joint disease, pancreatitis, and history of knee prosthetic.</p> <p>Admission physician orders for medications, on 03/13/14, included the following medications: Lovenox (a medication to reduce blood coagulation), Atenolol (a blood pressure medication), Cymbalta (an antidepressant), Vitamin d2 50 (a supplement to increase bone density), simvastatin (a medication to prevent gastric reflux issues), Synthroid (a medication to treat hypothyroid issues), Claritin (a medication to treat allergies), Meloxicam (a medication to treat swelling and pain), Protonix (a medication to treat esophagitis), Januvia (a medication to treat diabetes mellitus),</p>		<p>about labs. DHS/designee to review physician orders Mon - Fri in clinical care meeting to ensure medications requiring lab monitoring have labs. 4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Klonopin (a medication to treat seizures or panic disorder), and Percocet (a medication to treat pain).</p> <p>The Simvastatin was discontinued on 03/13/14.</p> <p>A physician's order, dated 03/17/14, added the medication Vytorin for hyperlipidemia.</p> <p>A physician's order, dated 04/07/14, added the medication Flexeril (a muscle relaxant).</p> <p>There were no specific laboratory tests order for Resident #46 on her admission to the facility.</p> <p>The initial care plans for Resident #46, located in the clinical record and initiated on 03/13/14, included plans to address the following issues: activities of daily living needs, potential for falls, Potential for weight loss related to pain, Potential for impaired skin integrity, Potential for constipation, Pain, Anticoagulant use, Anxiety and Depression, and Nutrition needs. The Nutrition care plan did not mention the resident's diabetes or any other medication use. There was a typed care plan for the risk for decreased cardiac output but it was not completed regarding the resident's disease processes</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>which put her at risk for decreased cardiac output and there were no interventions implemented for the care plan.</p> <p>An electronic care plan, titled "Individual Plan Report," copied on 05/15/14 at 1:54 P.M., included a plan to address the resident's abnormal bleeding tendencies related to the use of anticoagulant therapy. The pain care plan indicated the resident was receiving flexeril. The electronic care plan regarding nutrition, which was dated 03/21/14, indicated the resident was receiving a regular diet and had an allergy to MSG (monosodium glutamate/food flavor enhancer). There was no mention of diabetes or Januvia medication use, or the Vitamin use, or the medication to prevent gastric reflux and other stomach issues.</p> <p>There was no plan to address or physician's order to monitor any laboratory tests to monitor the resident's hypothyroidism and Synthroid use, the resident's hyperlipidemia and Vytorin use, the resident's hypertension and Atenolol use, or the resident's osteopenia, diabetes and Januvia use and Vitamin D2 use. There was also no laboratory tests to monitor the resident's anticoagulant use.</p> <p>On 05/15/14 at 2:30 P.M., a review of the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>PDR (Physician's Desk Reference) 2014 edition nurses drug handbook, located at the 200 hall nurse's station, on 05/15/14 at 2:30 P.M., indicated monitoring recommendations for the Lovenox medication was to monitor a CBC (complete blood count) periodically and monitor for hyperkalemia, for the Synthroid medication use, the book recommended to monitor TSH (Thyroid Stimulating Hormone) levels periodically, and for the Vytorin, baseline and periodic lipids, creatinine, and hgA1C levels were to be monitored. The book indicated the fasting blood glucose levels, hgA1C levels, and renal function laboratory tests should be ordered periodically.</p> <p>A pharmacy recommendation, completed on 03/14/14, indicated the pharmacist was asking for the stop date for the Lovenox medication and reminding the facility to "be sure to monitor Vit D levels."</p> <p>During an interview on 05/16/14 at 9:15 A.M., LPN #8, the Nursing Unit Manager, indicated the medical director was responsible for ordering laboratory tests to monitor specific medications. She indicated the medical director was responsible for following up on the pharmacy recommendations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>During an interview on 05/19/14 at 9:00 A.M., the DON (Director of Nursing) indicated he gets the original copy of the pharmacist recommendations and then he disseminates them to the ADON (Assistant Director of Nursing) and unit managers, so they can then give them (the recommendations) to the physicians.</p> <p>There was no documentation available, on 05/19/14 at 9:00 A.M., to indicate if the physician had noted the pharmacy recommendations or had been approached regarding the need to order laboratory tests to ensure adequate medication monitoring occurred for Resident #46.</p> <p>2. The clinical record for Resident #65 was reviewed on 05/15/14 at 10:20 A.M. Resident #65 was admitted to the facility on 10/28/11, with diagnosis, including but not limited to aphasia, diabetes mellitus, hypertension, cerebrovascular disease, cognitive communication, cardiac arrhythmias, hypercholesterolemia, neuropathy, acute seizure activity, anxiety, and gastroesophageal reflux disease, and dementia with aphasia.</p> <p>The admission Minimum Data Set (MDS) assessment for Resident #65,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>completed on 12/30/13, upon the resident's readmission to the facility, indicated she displayed both verbally abusive and other behavior symptoms not directed towards others 1 - 3 days during the assessment period. The assessment indicated the behaviors had not negative impact on the resident and did not negatively impact the activities or privacy of other residents. The assessment also indicated the resident rejected care 1 - 3 days during the assessment period. The form indicated the resident's behaviors were the same as previously noted.</p> <p>The quarterly MDS assessment, completed on 03/18/14, indicated the resident had only demonstrated other behaviors not directed at other 1 - 3 times during the assessment period and her behaviors had no negative impact of her or other residents. The assessment indicated there had been no change in Resident #65's behaviors.</p> <p>The resident was hospitalized, from 12/10/13 to 12/13/13, due to acute urinary tract infection and acute seizure activity. The resident was readmitted to the facility on 12/13/13. The resident's medication on readmission included Zyprexa (an antipsychotic utilized to address behavioral issues) 2.5 mg IM (intramuscular) q (every)12 hours for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dementia. On 12/14/15, the Zyprexa medication was changed from an intramuscular injection to the tablet form.</p> <p>During an interview on 5/16/14 at 9:45 A.M., the SSD (Social Service Director), indicated when the resident was readmitted to the facility in December 2013 she was receiving Zyprexa due to "Dementia with behaviors." She indicated the medication was being utilized to address the resident's behaviors of "yelling out and verbally abusive" behaviors.</p> <p>The behavior detail report of the computerized documentation completed by nursing staff indicated, on 12/15/13 at 3:08 A.M., the resident had displayed socially inappropriate behavior and the one to one intervention was not effective. On 12/16/13 at 9:22 P.M., the resident was verbally abusive cursing at staff, yelling out waking other residents, the resident was toileted and reassurance was given but the interventions were not effective. On 12/20/13 at 2:48 A.M., the resident was documented as rejecting care. One to one was attempted but was not effective.</p> <p>On 12/22/14, a medication to treat dementia, Namenda was started and Ativan, an antianxiety medication , was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>ordered three times a day as needed.</p> <p>There was no indication the resident was exhibiting anxiety issues and no care plan to address any anxiety issues with nonpharmalogical interventions.</p> <p>On 12/25/13 at 7:41 A.M., the resident was verbally abusive yelling out for family. There were no interventions documented as attempted to address the behavior.</p> <p>Nursing notes, on 12/27/14 at 7:00 A.M. indicated the resident had been found on the floor and was exhibiting increased confusion. The physician was notified of the resident's fall and increased confusion.</p> <p>On 12/27/14, an antibiotic for a urinary tract infection was ordered, a stool softner was ordered, and the Ativan was ordered to be given twice a day routinely. Chair and bed alarms were also ordered. There was no documentation of increased anxiety or any documentation to support the physician's order for the routine Ativan medication. In addition, the resident was experiencing two medical issues which could have contributed to her behavioral issues.</p> <p>3.1-48(a)(6)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based observation, record review, and interviews, the facility failed to ensure the chicken casserole was prepared in a manner which was palatable for the 10 residents who were to receive a mechanical soft during one of one meal observations. This potentially affected 10 of 10 residents with physician's orders for a mechanical soft diet.</p> <p>Findings include:</p> <p>1. During the Kitchen Sanitation Tour, conducted on 05/12/14 between 10:30 A.M. - 10:45 A.M., Cook #4 was noted to be pulling apart chicken pieces with his gloved hands.</p> <p>Observation of the Noon meal, conducted on 05/12/13 between 11:45 A.M. - 1:00 P.M., indicated there were two pans of prepared chicken divan casserole. The pans, which were prepared identically, contained large, non chopped broccoli</p>	F000364	<p>1) No specific residents listed.</p> <p>2) All residents who have physician order for mechanical soft diet have the potential to be affected by this practice. Dietary team expected to provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. No adverse effects noted.</p> <p>3) Director of Food Services will re-inservice dietary staff on the Indiana Diet Manual: Consistency Modification - Mechanical Soft diet and procedure for following recipes. Director of Food Services or designee will monitor preparation of mechanical soft recipes five times per week for three months then three times per week for three months. A report of any findings will be reviewed weekly by Executive Director and concerns addressed immediately.</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>florets, and large, long pieces of chicken. While observing Cook #4 obtain food temperatures, he was asked about the casserole for the mechanical soft diets and he indicated he had "shredded the chicken by hands finely." He indicated he had not needed to prepare a separate pan of casserole for those residents on a mechanical soft and/or ground meat diet.</p> <p>During the meal, several residents in both the assist and main dining room were noted to be attempting to eat and then spitting out large pieces of chicken and broccoli. An unknown female resident was overheard telling her table mate "Be careful the broccoli, it is too hard to chew because it is in a huge hunk."</p> <p>Review of the recipe and cooking instructions for the ground chicken divan casserole and the regular chicken divan casserole indicated frozen broccoli cuts and shredded chicken were to be utilized for the regular casserole recipe and the instructions for the ground casserole included "remove amount of cooked meat to be ground and grind to desired texture and add aback to the rest of the the ingredients."</p> <p>During an interview on 5/15/14 at 2:47 P.M., the Food Service Supervisor, Employee #6, indicated the meat in the</p>		4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000371 SS=F	<p>ground casserole was ground in the food processor. Employee #6 seemed unaware that the chicken had not been ground in the food processor but rather shredded by hand by Cook #4.</p> <p>Review of a list of diet types for the facility, current on 0512/14, indicated there were 10 residents with physician's orders for a mechanical soft diet.</p> <p>3.1-21(a)(2) 3.1-21(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interviews, the facility failed to ensure food was prepared and stored in a sanitary manner for 1 of 1 kitchen. This potentially affected all 59 residents in the facility who consumed food.</p> <p>Findings include:</p>	F000371	<p>1) No specific residents listed.</p> <p>2) Dietary team expected to store, prepare, distribute and serve food under sanitary conditions. No adverse effects noted.</p> <p>3) Drainage pipe for ice machine fixed immediately on 5/12/14. Director of Food Services will</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. During the Kitchen Sanitation Tour, conducted on 05/12/14 between 10:30 A.M. - 10:45 A.M., the drainage pipe for the Ice machine was observed to run from the ice machine, located in dry storage room through the wall and drained into a floor drain, located between the stoves in the kitchen. The end of the 1 1/2 inch plastic pipe was noted to be less than 1/4 inch away from the grates on the floor drain.</p> <p>There were three large plastic bins on wheels utilized to store flour, sugar, and another staple which were noted to have dust and grimy substances on the lids.</p> <p>An open shelf, underneath a food preparation counter, utilized to store muffin pans and cutting boards, was noted to have food splatters, dust, and bits of food, such as carrot peelings, on the shelf, pans, and cutting boards.</p> <p>2. During the observation of the meal preparation and serving for the noon meal, conducted on 05/12/14 between 11:45 A.M. - 1:00 P.M., the following was observed:</p> <p>Cook #4 was noted to handle dirty dishes, carry them into the dish room, spray them off, place them in a rack for the dishwasher, and then without washing his</p>		<p>re-inservice dietary staff on kitchen sanitation generally and specifically to storage bins and shelves under food preparation counter. Director of Food Services will also re-inservice dietary staff on proper handwashing, use of gloves and not holding items against uniform.</p> <p>Director of Food Services or designee will observe sanitation rounds five times per week for three months then three times per week for three months. A report of any findings will be reviewed weekly by Executive Director and concerns addressed immediately.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>hands picked up a stack of clean dishes from a cart in the dish room and carried them out near the steam table in the dining room.</p> <p>Cook #5 was noted carrying 5 unwrapped frozen hamburger patties out of the freezer with her bare hands, she then placed the frozen patties on a plate, donned a pair of gloves, and turned on the grill knobs with one gloved hand, while handling the deep fryer basket handle with the other gloved hand, and then placed two hamburger patties onto the grill with her contaminated gloved hands.</p> <p>Cook #4, who was preparing a cart with salad supplies was noted to go into the dining room, retrieve a stack of clear salad plates and carry them back into the kitchen, holding the stack against his uniform, and eventually placed the plates near the steam table back out into the dining room.</p> <p>Cook #5, who had been in the dining room, entered the kitchen and without washing her hands proceeded to obtain a package of thickener to thicken soup broth, and carried the package back out into the dining room.</p> <p>Cook #5, later donned a pair of gloves,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and then handled the packaging of a box, and the handle of the deep fryer, contaminating both of her gloved hands before reaching inside the box and grabbing a handful of shrimp directly with her contaminated gloved hands.</p> <p>Cook #4, who was in the dining room, was noted to touch a roll with his bare hands after handling menus, the edge of the steam table, and spoon handles. He was noted to touch his face with his hands. He also pushed a carrot ball into place with his bare hands while arranging it on the plate. In addition, he balanced the plate of food, which was eventually served to a resident against his uniform.</p> <p>Cook #5, who was still in the kitchen, was noted to be walking out of the walk in freezer carrying a handful of breaded chicken with her bare hands. After placing the chicken into the deep fryer basket, she was noted to go directly to a stack of cheese slices and touched them with her bare hands. As Cook #5 prepared cook to order food items, she was noted to touch her glasses, a plate, a paper menu, and then touch cheese slices to place them onto hamburger patties with her bare hands. She was noted to touch the outside of a bread bag package with one gloved hands and then touched hot dog buns with the same contaminated</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000428 SS=D	<p>gloved hand.</p> <p>During the set up and early part of the meal service, Cook #4 was noted to be entering and exiting the kitchen, touching various items and did not always wash his hands when reentering the kitchen.</p> <p>3.1-21(1)(3)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interviews, the facility failed to ensure there was timely follow up regarding a pharmacy recommendations for 1 of 5 residents reviewed for unnecessary medications. (Resident #46)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #46 was reviewed on 05/14/14 at 1:31 P.M. Resident #46 was admitted to the facility on 03/13/14, with diagnosis, including</p>	F000428	<p>1) Resident #46 is discharged.</p> <p>2) Licensed nurses re- inserviced related to pharmacy recommendations and timeliness of orders.</p> <p>3) DHS/designee will monitor pharmacy recommendations monthly for timeliness of follow up regarding pharmacy recommendations .</p> <p>4) QAA will monitor findings monthly for any trends and make</p>	06/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>but not limited to, status post closed fracture of the left femur, sleep apnea, hypertension, diabetes mellitus, hypothyroidism, osteopenia, gastroesophageal reflux disease, depression, anxiety, degenerative joint disease, pancreatitis, and history of knee prosthetic.</p> <p>Admission physician orders for medications, on 03/13/14, included but was not limited to: Lovenox (a medication to reduce blood coagulation) , Vitamin d2 50 (a supplement to increase bone density)., simvastatin (a medication to prevent gastric reflux issues) , Synthroid (a medication to treat hypothyroid issues), Claritin (a medication to treat allergies),</p> <p>There were no specific laboratory tests order for Resident #46 on her admission to the facility</p> <p>A pharmacy recommendation, completed on 03/14/14, indicated the pharmacist was asking for the stop date for the Lovenox medication and reminding the facility to "be sure to monitor Vit D levels."</p> <p>During an interview, on 05/16/14 at 9:15 A.M., LPN #8, a unit manager, indicated the medical director was responsible for</p>		<p>recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>ordering laboratory tests to monitor specific medications. She indicated the medical director was responsible for following up on the pharmacy recommendations.</p> <p>During an interview on 05/19/14 at 9:00 A.M., the Director of Nursing indicated he gets the original copy of the pharmacist recommendations and then he disseminates them to the ADON (Assistant Director of Nursing) and unit managers, so they can then give them (the recommendations) to the physicians.</p> <p>There was no documentation available, on 05/19/14 at 9:00 A.M., to indicate if the physician had noted the pharmacy recommendations or had been approached regarding the need to order laboratory tests to ensure adequate medication monitoring occurred for Resident #46.</p> <p>During an interview on 05/19/14 at 9:00 A.M., RN #9, the corporate nursing consultant, indicated the pharmacy recommendation was on the chart and the physician was supposed to look at the recommendations when he visited the resident. She did not know if the physician had actually viewed the recommendation. There were no physician's orders to indicate a stop date</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	for the Luvenox and no blood laboratory test to monitor the vitamin D levels. 3.1-25(i)						
F000496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014	
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 27 nursing assistants reviewed for current certification had a valid nursing assistance certificate. (CNA #1)</p> <p>Findings include:</p> <p>During review of the facility employees for current certifications, conducted on 05/19/14 at 11:00 A.M., there was no nursing assistant certificate noted for CNA #1, with a hire date of 02/09/12.</p> <p>During an interview on 05/19/14 at 1:45 P.M., Employee #2, the Payroll Coordinator, indicated CNA #1's certification had "lapsed."</p> <p>Review of a copy of the most recent state nursing assistant certification for CNA #1 indicated his certification had lapsed in August 2013.</p>	F000496	<p>1) No specific residents listed and no adverse outcome noted. CNA has reapplied for certification and remains off the schedule until certification is obtained and verified.</p> <p>2) Licenses/certifications of employees requiring licensure/certifications have been audited to ensure that all are current .</p> <p>3) Inservicing for employees that require licensure/certifications in regards to renewal process of licensure/certifications and importance of being timely and keeping up to date and active in order to continue employment.</p> <p>4) QAA will monitor findings monthly for any trends and make recommendations to the plan of correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>	06/18/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/19/2014
NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	Review of the past months time card and work schedule for CNA #1 indicated he had worked 6 shifts without a current certificate. 3.1-14(a)				