

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00199460.</p> <p>Complaint IN00199460 - Substantiated. Federal/State deficiency related to the allegation is cited at F353.</p> <p>Survey dates: February 24, 25, 26 and 29, 2016 and March 1, 2 and 3, 2016</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Census bed type: SNF: 2 SNF/NF: 118 Residential: 55 Total: 175</p> <p>Census payor type: Medicare: 13 Medicaid: 90 Other: 17 Total: 120</p>	F 0000	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p>	
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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.

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F 0221 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on March 7, 2016 by 17934.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview and record review the facility failed to ensure 1 resident (Resident #126) was free from physical restraint.</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #126 on 2/29/16 at 3:42 p.m., indicated the following: diagnoses included, but were not limited to, Alzheimer's disease, weakness, and repeated falls.</p> <p>A Progress Note for Resident #126, dated</p>	F 0221	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>We respectfully request the opportunity to have POC reviewed /accepted / approved</p>	04/01/2016	

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	<p>12/3/15, indicated she was very anxious after supper and transferred herself from the wheelchair to the recliner at one point. The note also indicated the resident could not seem to get comfortable and the writer and the QMA (Qualified Medication Aide) had to transfer her from the wheelchair to the recliner and back 6 times.</p> <p>A Minimum Data Set (MDS) assessment for Resident #126, dated 2/2/16, indicated a score of 3 out of 15 on the Brief Interview for Mental Status, indicating severe cognitive impairment. The MDS also indicated she required extensive assistance with the physical assistance of 2 staff for transfers. The MDS did not indicate any restraints were used for Resident #126.</p> <p>During an observation of the Tulip Lane lounge area on 2/25/16 at 1:34 p.m., Resident #126 was observed resting in a recliner chair with the footrest elevated. A wheelchair had been placed at an angle under the footrest of the recliner. The seat of the wheelchair prevented the footrest of the recliner from being lowered by Resident #126.</p> <p>During an observation of the Tulip Lane lounge area on 2/29/16 at 3:20 p.m., Resident #126 was observed resting in a</p>		<p>with paper compliance if possible. Thank you, Corrective Actions to be accomplished for those residents affected: Lutheran Life Villages is considered a restraint free facility. On 3-2-2016, once the nursing staff realized that the w/c impeding the movement of the recliner was considered a restraint, the w/c was immediately removed from obstructing the recliner's movement, and thus allegedly restricting the resident's. The Nurse Manager spoke with staff regarding this type of restraint; and staff shared they had put the w/c in that position under the recliner (the recliner is located in the resident/family lounge directly across from the Tulip Lane nursing station) because they thought that would help stabilize the recliner as the resident rocked a lot and was a high risk for falls; the nursing staff thought that they were protecting her from possible falls. This was not on the resident's CNA assignment sheet. The Nursing Managers made rounds on all units to assure that no other residents had restraints, of any type, none were found in the facility. The staff involved with the w/c and recliner issue were provided with educational counseling (Attachment F221-A) regarding what constitutes a restraint, resident rights and following the</p>				

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	<p>recliner chair with the footrest elevated. A wheelchair had been placed at an angle under the footrest of the recliner. The seat of the wheelchair prevented the footrest of the recliner from being lowered by Resident #126.</p> <p>During an observation of the Tulip Lane lounge area on 3/1/16 at 2:02 p.m., Resident #126 was observed resting in a recliner chair with the footrest elevated. A wheelchair had been placed at an angle under the footrest of the recliner. The seat of the wheelchair prevented the footrest of the recliner from being lowered by Resident #126.</p> <p>During an observation of the Tulip Lane lounge area on 3/1/16 at 3:53 p.m., Resident #126 remained in the recliner chair with the footrest elevated. The wheelchair remained under the footrest of the recliner, preventing Resident #126 from lowering the footrest.</p> <p>The Administrator was interviewed on 3/2/16 at 8:42 a.m. During the interview he indicated the facility did not use restraints.</p> <p>A facility care plan for Resident #126, with a review date of 2/3/16, indicated the problem area of falls. Approaches to the problem included, but were not</p>		<p>careplan/CNA assignment sheet. In addition, all staff were presented with an inservice (See attachmentA) regarding resident rights and Lutheran Life Villages restraint free facilityphilosophy.</p> <p>Other residents having thepotential to be affected and the corrective actions: The Nursing Managers maderounds on all units to assure that no other residents had restraints, of anytype; none were found in the facility when this concern was voiced on 3-2-2016.The staff involved with the w/c and recliner issue were provided witheducational counseling (Attachment F221-A) regarding what constitutes arestraint, resident rights and following the careplan/CNA assignment sheet. In addition, all staff were presented with an inservice (See attachmentA) regarding resident rights and Lutheran Life Villages restraint free facilityphilosophy.</p> <p>What Measures were putinto place to ensure this does not happen again: To assure the staff arefollowing the restraint free facility ofLutheran Life Villages, the Nurse Managers will provide weekly residentrestraint observation/round audits (See attachment F221-B) on all nursingunits, with a focus on at least 3 residents, per unit, each week through theend of April 2016. Starting in May 2016, the Nurse Managers will makemonthly audits/round</p>		

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	<p>limited to, assist with transfers as needed.</p> <p>Review of the facility care plans for Resident #126 indicated there was no care plan for the use of restraints.</p> <p>A Tulip Lane CNA (Certified Nursing Assistant) Report Sheet, provided by the Administrator on 3/2/16 at 10:25 a.m., indicated Resident #126 liked to sit in the recliner in the day room and she required the assistance of 1 staff to transfer. The CNA report sheet did not indicate to place her wheelchair under the footrest of the recliner.</p> <p>Social Service #11 was interviewed on 3/2/16 at 10:10 a.m. During the interview she indicated Resident #126 did not have any physician orders or a care plan for restraints and she did not know why the resident's wheelchair was being placed under the footrest of her recliner. She also indicated the recliner was fairly new so there should not be any problem with the footrest.</p> <p>CNA #12 was interviewed on 3/2/16 at 10:18 a.m. During the interview she indicated she had heard staff say Resident #126's wheelchair was placed under the footrest of her recliner so it would not tip forward.</p>		<p>observations, and will focus on at least 5 residents, per unit, each month for the next 60 days, through the end of June, 2016. The results will be reviewed/discussed in our monthly QA meetings. How the corrective actions will be monitored: The results from the resident restraint observation/round audit (See attachment F221-B) will be reviewed at our monthly QA meetings for compliance. ADON will monitor for compliance. DON will monitor for ongoing compliance. Please find the following attachments: F221-A Educational counseling forms provided to staff/Nursing Inservice F221-B Restraint observation/round audit forms A All staff inservice</p>	

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	<p>The Administrator was interviewed on 3/2/16 at 1:19 p.m. During the interview he indicated the wheelchair placed under the footrest of the recliner of Resident #126 was considered a restraint.</p> <p>Unit Manager #13 was interviewed on 3/2/16 at 1:26 p.m. During the interview she indicated she had been on leave for several months and during her leave Resident #126 experienced a fall from her recliner. She also indicated Resident #126 would rock back and forth in her recliner and staff felt by placing her wheelchair underneath the footrest of the recliner would prevent her from rocking the recliner back and forth and prevent another fall. She further indicated the wheelchair underneath the footrest of the recliner of Resident #126 was a restraint.</p> <p>A current facility policy "Resident Rights", provided by the Administrator on 3/1/16 at 10:16 a.m., indicated "...The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms...."</p> <p>3.1-3(w) 3.1-26(o)</p>				

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F 0248 SS=D Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure 1 resident who expressed a desire to attend an activity was included in the activity of 16 residents who met the criteria for activities. (Resident #104)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #104 on 3/1/16 at 10:57 a.m., indicated the following: diagnoses included, but were not limited to, dementia, Alzheimer's disease, hypertension, depressive disorder, and anxiety disorder.</p> <p>During observations in the facility on 2/24/16, 2/25/16, and 2/27/16, Resident #104 was not observed attending any activities.</p> <p>An Activity Progress Note for Resident #104, dated 8/5/15, indicated he was able</p>	F 0248	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible Thank you,</p> <p>F248</p> <p>Corrective Actions to be accomplished for those</p>	04/01/2016

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	<p>to communicate his wants and needs.</p> <p>An Activity Progress Note for Resident #104, dated 12/22/15, indicated he had been attending some group activities of his interest. The note also indicated he had some confusion and needed daily reminders and escorted to and from the activities.</p> <p>A Resident Activity Assessment for Resident #104, dated 2/10/16, indicated a past history of arts and crafts.</p> <p>A Daily Activity Attendance Record for Resident #104, dated for the month of February 2016, indicated he participated in Kick or Push Ball and Games on 2/24/16, and he participated in Games on 2/25/16.</p> <p>Review of the Daily Activity Attendance Record for Resident #104, indicated on 2/18/16 he was asked if he wanted to go to the Water Color class. The entry indicated he was excited and said he loved that class and wanted to try. The entry also indicated nursing would not let him go because "he would not stay."</p> <p>Activity Assistant #14, was interviewed on 3/1/16 at 9:50 a.m. During the interview she indicated Resident #104 really enjoyed going to the Water Color</p>		<p>residents affected:</p> <p>Lutheran Life Villages provides activity programs, of various types, events, etc. to meet the needs of each resident. The resident in question had been declining in health recently, and from the clinical aspect of safety and overall health, thenursing staff felt the resident was unsafe, and that it was not in his best interest (pain and comfort wise) to attend this activity.</p> <p>In speaking with the activity staff, they were unclear of the situationsurrounding his decline. Additionally, an accurate depiction of the situation was not communicated effectively between activity staff and nursingstaff. To assure the staff have accurate, effective communication in the best interest of all residents, the staff involved were provided with educational counseling (see attachment F248-A) on resident rights surrounding activities, effective communication between the activity staff and</p>	

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	<p>class since the instructor only came to the facility 1 time per month. She also indicated he would attend the class when he lived in Assisted Living and his family had framed some of his art work to hang on his walls. She further indicated staff did not want to get him out of his recliner chair and then have to get him back in it.</p> <p>The Administrator was interviewed on 3/1/16 at 2:33 p.m. During the interview he indicated Resident #104 was confused and really not safe to attend activities. He did indicate residents should be allowed to attend activities of their choice.</p> <p>Activities Assistant #14, was interviewed on 3/1/16 at 2:55 p.m. During the interview she indicated she was instructed to get Resident #104 out of his room more to attend activities. She also indicated it was frustrating when she tried to take him to activities, but was denied by nursing staff.</p> <p>A facility care plan for Resident #104, with a review date of 1/25/16, indicated the problem area of diagnosis of senile dementia with behavior, depressive disorder, Alzheimer's disease, and at risk for falls. The goal indicated the resident enjoys activities.</p>		<p>nursingstaff & accurate reporting of events, not assumptions. Additionally,an all staff inservice (See attachment A) is planned for 3-16-2016, in regardsto the appropriate resident needs regarding activities & effectivecommunication in assuring our residents receive the very best in activities& events according to each resident needs.</p> <p>Other residents having thepotential to be affected and the corrective actions: The Director of Activitieshas audited all residents 1 on 1 records and all residents activity attendancerecords to assure compliance, completed by 3-16-2016. No other residentswere found to be affectedby this issue as identified by the State Surveyor. No other concerns werevoiced from any resident. The activity staff were also in serviced (F248-B) on 3-15-2016 regarding compliance with optimal resident activities</p>	

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	<p>A current facility policy "Resident Rights", provided by the Administrator on 3/1/16 at 10:16 a.m., indicated "...The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident...."</p> <p>3.1-33(a)</p>		<p>being provided, offered & delivered to all residents. To assure the staff have accurate, effective communication in the best interest of all residents, the staff involved were provided with educational counseling (see attachment F248-A) on resident rights surrounding activities, effective communication between the activity staff and nursing staff & accurate reporting of events, not assumptions. Additionally, an all staff inservice is planned for 3-16-2016 (See attachment A) in regards to the appropriate resident needs regarding activities & effective communication in assuring our residents receive the very best in activities & events according to each resident needs.</p> <p>What Measures were put into place to ensure this does not happen again: The Director of Activities will be auditing the resident attendance records on a</p>	

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			<p>Monthly basis, starting April 1, 2016 through the end of June 2016, to assure residents are offered and invited to the activities of their choice. The activity staff will continue providing residents 1 on 1 socialization opportunities, asking specific questions regarding interest and their ability to attend (See Attachment F248-C). The Director of Activities will also audit the 1 on 1 activity (See attachment 248-C), by reviewing 2 residents, per nursing unit each month, starting on April 1, 2016 through the end of June, 2016, for compliance. Additionally, an all staff in service (See attachment A) is planned for 3-16-2016, in regards to the appropriate resident needs regarding activities & effective communication in assuring our residents receive the very best in activities & events according to each resident needs.</p>	

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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</p>		<p>How the corrective actions will be monitored: The results from the Activity Audits (See attachment F248-C) will be reviewed at our monthly QA meetings for compliance. The Activity Directors will monitor for compliance. The Director of Activities will monitor for ongoing compliance.</p> <p>Please find the following attachments: F248-A Educational counseling forms. F 248-B Activity Inservice on 3-15-2016 F248 -C Activity Audit for 1 on1 activities A All staff inservice</p>	

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	<p>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 interview and record review, the facility failed to develop an Activity care plan with approaches for 1 of 16 residents who met the criteria for activities. (Resident #104).</p> <p>Findings include:</p> <p>Review of the clinical record for Resident #104 on 3/1/16 at 10:57 a.m., indicated the following: diagnoses included, but were not limited to, dementia, Alzheimer's disease, hypertension, depressive disorder, and anxiety disorder.</p> <p>An Activity Progress Note for Resident #104, dated 12/22/15, indicated he had been attending some group activities of his interest. The note also indicated he had some confusion and needed daily reminders and escorted to and from the activities.</p> <p>A Resident Activity Assessment for Resident #104, dated 2/10/16, indicated current interests of games, exercise, sports, music, parties/social events, radio,</p>	F 0279	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible.</p> <p>Thank you, F279 Corrective Actions to be accomplished for those residents affected:</p> <p>Lutheran Life Villages uses the results of the activity assessment to develop, review and revise each resident activity care plan which includes a problem, goal and approach. Per interview with Activity Director, the resident's care plan in question was assessed and updated by an Activity Director, but inadvertently left the approach section blank for</p>	04/01/2016

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816		
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	<p>spiritual/religious activity, grooming, watching television, movies, talking/conversing, and clergy visits.</p> <p>A facility care plan for Resident #104, with a review date of 1/25/16, indicated the problem area of diagnosis of senile dementia with behavior, depressive disorder, Alzheimer's disease, and at risk for falls. The goal indicated the resident enjoys activities. The care plan did not include any approaches to achieve the goal.</p> <p>The Administrator was interviewed on 3/1/16 at 3:43 p.m. During the interview he indicated the approaches to the activity care plan were missed. He also indicated each care plan should contain the problem, goal, and approaches.</p> <p>3.1-35(a)</p>		<p>the resident in question. The missing approach to the care plan was added after reviewing the assessment on 3-1-2016 (See Attachment F279 – D) The comprehensive activity care plan is now complete for this resident. The Director of Activities provided educational counseling (See attachment F279-A) to the Activity Director responsible for the missing approach in the care plan. The Director of Activities also provided an inservice to the Activity staff on 3-15-2016 regarding appropriate completion of activity care plans (See attachment F279-B). Additionally, an all staff inservice (See attachment A) is planned for 3-16-2016, in regards to the appropriate resident needs regarding activities, appropriate/completed care plans & effective communication in assuring our residents receive the very best in activities & events according to each resident needs.</p> <p>Other residents having the potential to be affected and the corrective actions: The Director of Activities & her staff will be auditing all residents comprehensive activity care plans for the completion of the care plan including the problem, goal and approach to assure compliance, completed by 3-16-2016. These audits have all been completed, with no other incomplete activity care plans found; or affected by this issue as</p>		

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			<p>identified by the State Surveyor. No other concerns werevoiced from any resident. The Director of Activities also provided aninservice (See attachment B) to the Activity staff on 3-15-2016 regarding appropriate completion of activity careplans. Additionally, an all staff inservice(See Attachment A) is planned for 3-16-2016, in regards to the appropriateresident needs regarding activities, appropriate/complete careplans & effective communication in assuring our residents receive the very best inactivities & events according to each resident needs.</p> <p>What Measures were putinto place to ensure this does not happen again: The Director of Activities& her staff will be auditing all residents comprehensive activity careplansfor the completion of the careplan including the problem, goal and approach toassure compliance, completed on 3-16-2016. The Director of Activitieswill audit 2 resident activity careplans, per nursing unit, per month, for thecompletion of resident careplans (problem, goal and approach) (See AttachmentF279-C). This will start on April 1, 2016 and end on June 30, 2016, toassure resident careplans are complete (problem, goal, approach). TheDirector of Activities also provided an inservice to the Activity staff on3-15-2016 regarding</p>	

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure	F 0282	appropriate completion of activity careplans (See attachment F279-B). Additionally, an all staff inservice (See Attachment A) is planned for 3-16-2016, in regards to the appropriate resident needs regarding activities, appropriate/complete careplans & effective communication in assuring our residents receive the very best in activities & events according to each resident needs. How the corrective actions will be monitored: The results from the Activity Audits (See attachment F279-C) will be reviewed at our monthly QA meetings for compliance. The Activity Directors will monitor for compliance. The Director of Activities will monitor for ongoing compliance. Please find the following attachments: F279-A Educational counseling form. F279-B Activity inservice on 3-15-2016 F279-C Statement for the completion of careplan audit (problem, goal & approach) F279 -D Completed careplan for said resident, including the approach A Staff inservice on 3-16-2016 Please accept this as our credible allegation of compliance to our recent ISDH annual survey.	04/01/2016	

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	<p>the plan of care was followed for 1 of 3 residents reviewed for pressure sores. (Resident #73)</p> <p>Findings include:</p> <p>On 2/29/16 at 10:00 a.m., the clinical record of Resident #73 was reviewed. Diagnoses included, but were not limited to, the following: chronic kidney disease stage 3, Diabetes Mellitus, pressure ulcer unstageable, pressure ulcer stage 2, hypoxemia and heart failure. The MDS (minimum data set) assessment dated 12/3/15, indicated the following: moderately impaired cognition, bed mobility required extensive assistance, 1 unhealed, unstageable pressure ulcer, and pressure ulcer was present on prior assessment.</p> <p>A current care plan with an initiation date of 1/7/16, addressed the problem of "pressure ulcer...Approaches...monitor skin for redness, blanching or discoloration and report to...NP (Nurse Practitioner)..."</p> <p>A progress note dated 2/25/16, by the Nurse Practitioner (NP) included, but was not limited to, the following: "...SDTI (suspected deep tissue injury) to bil (bilateral) buttocks...Seen by NP on this visit...Foley (urinary catheter) anchored</p>				<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible.</p> <p>Thank you, Corrective Actions to be accomplished for those residents affected: The Facility Wound Care Nurse was contacted, along with the Wound Care Nurse Practitioner to evaluate, obtain orders, treat and over see the area in question on Resident #73. A skin assessment was completed on 3-2-2016 by nursing staff regarding Resident #73 (see attachment F282 - A). Treatment orders were obtained, notifications were made and treatment started on the indicated site on the right top great toe. No other issues were identified with any other resident in facility. The small area on Resident #73's right great toe was healed by 3-4-2016, the area to the right great toe tip is closed, per nursing note (See attachment F282-A). In addition, staff were presented with an inservice (See attachment A) regarding resident</p>		

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	<p>to promote wound healing due to incontinence...strict side to side rotation and bedrest..."</p> <p>On 3/1/16 at 2:00 p.m., the resident was observed during a dressing change. LPN #1 was observed to change the resident's dressing to the stage 2 pressure sore to her coccyx. As CNA #2 turned the resident to her side, a dark black/brown area was observed to the resident's bottom and tip of her right great toe. The black/brown area to the bottom/tip of the toe was similar to the size of a dime.</p> <p>On 3/2/16 at 8:31 a.m., the resident was observed in her bed on her back/left side and was observed to have bilateral, padded heel boots on. The bottom side and tip of the resident's right great toe was observed to be dark black/brownish. This was the same area which was observed on 3/1/16 at 2:00 p.m.</p> <p>On 3/2/16 at 8:33 a.m., the ADON (Assistant Director of Nursing) was interviewed. She indicated the resident currently had an open area to her coccyx. She indicated the resident had had an open area to her left heel, which had been healed on 2/25/16. The ADON indicated documentation was lacking of any assessment of or treatment for, the area on the bottom side and tip of the</p>		<p>assessments, residentcondition changes, policy/procedure on assessments (See attachment F282 – B),when complete head to toe resident assessments are completed @ LLV – per the resident shower schedule, which is at least twice a week.</p> <p>Other residents having thepotential to be affected and the corrective actions: The Nursing Managers havebeen reviewing all skin assessments, for all the residents, on all units toassure the skin assessments are accurate and complete. This will becompleted by 3-25-2016. The Nurse Managers will also be conducting nursingrounds on at least 2 residents, per nursing unit, per week, through the end ofApril to assure staff stay in compliance with our assessment policy &procedure (See attachment D282 – B). In addition, staff were presentedwith an inservice (See attachment A) regarding resident assessments, residentcondition changes, policy/procedure on assessments (See attachment F282 – B)when complete head to toe resident assessments are completed @ LLV – per the resident shower schedule, which is at least twice a week. If any new issues arise, the resident careplanwill reflect the change in condition with the treatment ordered; notificationswill be made and the CNA assignment sheet will be updated as appropriate.</p> <p>What Measures were putinto</p>		

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	<p>resident's right great toe.</p> <p>A current copy of the CNA (certified nursing assistant) Report sheet was received from the Administrator on 3/2/16 at 10:25 a.m. The sheet included, but was not limited to, the following: "...Braden (scale) ...moderate risk ... (pressure reducing) boots on at all times..."</p> <p>On 3/2/16 at 3:38 p.m., the ADON provided a current copy of physician orders which included, but were not limited to, the following: 2/3/16: ace wrap toe to knee right lower extremity on in am (morning) off at hs (bedtime), check placement three times a day...12/17/15: heel boots bilat (bilateral) three times per day...2/25/16: skin prep (preparation) to bilat heels every shift..."</p> <p>On 3/2/16 at 3:38 p.m., the ADON provided a current copy of the Braden scale for predicting pressure sore risk: a total of 11 which indicated a high risk.</p> <p>On 3/2/16 at 3:38 p.m. the ADON provided a current copy of the facility policy and procedure for "pressure ulcers and skin lesions reporting and documenting protocol." This policy was dated 8/22/14 and included, but was not limited to, the following: "It is the policy</p>		<p>place to ensure this does not happen again: To assure the staff are following the policy and procedure (See attachment F282-B) of Lutheran Life Villages, the Nurse Managers will provide weekly skin assessment audit observations/round audits (See attachment F282-C) on all nursing units, with a focus on at least 3 residents, per unit, each week through the end of April 2016. Starting in May 2016, the Nurse Managers will make monthly audits/round observations, and will focus on at least 5 residents, per unit, each month for the next 60 days, through the end of June, 2016. The results will be reviewed/discussed in our monthly QA meetings. How the corrective actions will be monitored: The results from the skin care audits observation/round audit (See attachment F282-C) will be reviewed at our monthly QA meetings for compliance. ADON will monitor for compliance. DON will monitor for ongoing compliance. Please find the following attachments: F282-A Skin assessment for Resident #73 F282-B Policy & procedure for assessments F282-C Skin care audit for compliance A Staff inservice on 3-16-2016</p>				

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	<p>of this facility to monitor skin conditions of all residents and document the presence of pressure sores/ulcers and other skin lesions, providing treatment and prevention interventions...Procedure...skin observations are made during resident care. CNAs (Certified Nursing Assistants) are responsible for reporting all observed changes to Unit Coordinator on assigned wing..."</p> <p>On 3/2/16 at 3:39 p.m., the ADON provided a copy of the CNA bath and skin report dated 3/1/16 and 3/2/16. The report had documented on 3/1/16 and 3/2/16 the following: bedbath, normal skin integrity, no redness, no peeling blisters, no open areas, no bruise. The form documented the following instructions: "CNA and charge nurse will perform skin check during the resident's bath/shower. Record information above, place a checkmark under any skin condition that applies. Check normal if no abnormal skin conditions are noted..."</p> <p>A skin condition report, dated 3/2/16 at 12:31 p.m., included but was not limited to, the following: "New (1st recording)...present o the right top great toe is a pressure ulcer...unable to accurately stage, suspected deep tissue</p>			

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F 0323 SS=E Bldg. 00	<p>injury in evolution length in cm (centimeters) =2.3, width in cm = 1.5. skin in not blanchable...this wound was not present on admission...resident with sdti (suspected deep tissue injury) to R (right) great toe distal tip...Eschar tissue type=100%..."</p> <p>On 3/3/16 at 8:55 a.m., the ADON was interviewed. She indicated between the staff performing applications of skin prep every shift, two bed baths, application or and removal of the ace wrap to the resident's lower extremity daily the staff should have observed the unstageable area to the tip and underside of the resident's right great toe.</p> <p>3.1-35(g)(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 observation and interview, the facility failed to ensure hazardous</p>	F 0323	Please accept this as our credible allegation of compliance to	04/01/2016

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	<p>chemicals, personal care products and medications (over the counter and prescription) were maintained in a safe and secure manner from independently mobile and confused residents. This deficient practice had the potential to affect 7 of the 19 residents who resided on Magnolia Place (secured memory care unit) and 12 of 101 residents who resided outside of Magnolia Place.</p> <p>Findings include:</p> <p>On 2/24/2016 at 9:17 a.m., the unlocked, A wing shower room was observed. In an opened cabinet, the following was observed: 2 ounce speed stick antiperspirant, 11 ounce can of shaving cream, 1.5 ounce bottle of roll on anti perspirant, 8 ounce bottle of (brand) lotion and body splash. All of these products had "keep out of reach of children" on the label.</p> <p>On 2/24/16 at 9:44 a.m., the unlocked shower room on Magnolia Place was observed. The shower curtain was open and a prescription medication patch (used for treatment of dementia) 13.3 mg (milligrams/24 hours) was observed on the floor of the shower by the drain. Another prescription medication patch (used for treatment of dementia) was observed adhered to the right wall of the</p>		<p>ourrecent ISDH annual survey. Submission of this Plan of Correction does notconstitute an admission or agreement by the provider of the truth of facts allegedor the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because ofrequirements under State & Federal Law. We are also scanning inseveral attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible.</p> <p>Thank you, Corrective Actions to beaccomplished for those residents affected: The toiletry items(toothpaste, mouthwash, lotion, hair gel, etc.) as identified in the 2567, oneach unit, in resident rooms and the shower rooms were immediatelyremoved. The items in question from room 110 were immediately removed aswell. The facility made rounds on each hall, in each unit, in each showerroom auditing for such items that are considered potentially harmful; if itemswere located, they were also removed or stored more appropriately. Staff were communicated with during these rounds so they understood theimportance of this issue. To assure the staff have a good understanding of thepolicy/procedure (See</p>		

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	<p>shower 4 feet from the floor. Also observed on top of a metal cabinet unit attached to the wall beside the shower, was "One step disinfectant and cleaner (brand) 256 spray bottle (Keep out of reach of children on the label), 10 ounce bottle of skin lotion (external use only on the label) and a 7.5 ounce bottle of skin and hair cleanser (keep out of reach of children on the label). The metal cabinet had an open, accessible area in front of the cabinet which had the following: a can of shaving cream (label said to keep out of reach of children) ; 7.5 ounce bottle of skin and hair cleanser (keep out of reach of children on the label) and a bottle of skin cleanser, (label indicated external use only).</p> <p>On 2/24/16 at 9:46 a.m., a container of (brand) disinfectant wipes was on the nurse's computer station by the medication cart in the B hall with 1 resident in a wheelchair watching TV.</p> <p>On 2/25/16 at 1:19 p.m., the unlocked shower room on Magnolia Place was observed. The prescription medication patch used for treatment of dementia, remained stuck to the interior right side of the shower stall wall. The spray bottle of (brand) disinfectant cleaner was observed to be on top of the metal box on the wall by the shower, accessible and</p>		<p>attachment F323- A) & the importance of storingsuch items to protect the best interest of all residents, the staff involvedwere provided with educational counseling (see attachment F323 - B). In addition, staff were presented with an inservice (See attachment A) regarding ,policy/procedure (See attachment F323 – A). Other residents having thepotential to be affected and the corrective actions: The Nursing Managers havebeen reviewing all skin assessments, for all the residents, on all units toassure the skin assessments are accurate and complete. This will be completedby 3-25-2016. The Nurse Managers will also be conducting nursing roundson at least 3 residents, per nursing unit, per week, through the end of Aprilto assure staff stay in compliance with our assessment policy & procedure(See attachment F323 – B). In addition, staff were presented with aninservice (See attachment A) regarding resident assessments, resident conditionchanges, policy/procedure on assessments (See attachment F323 – B) whencomplete head to toe resident assessments are completed @ LLV – per theresident shower schedule, which is at least twice a week. If any newissues arise, the resident careplan will reflect the change in</p>				

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	<p>unsecured.</p> <p>On 2/25/16 at 1:41 p.m., the following personal care products were observed in an unlocked resident's bathroom on Magnolia Place: toothpaste (which had keep out of reach of children under 6 years of age) and dry skin cream (which had external use only). These personal care products were sitting on a shelf directly over the hand sink in the resident's bathroom.</p> <p>On 2/25/16 at 1:53 p.m., a tube of toothpaste was observed on the shelf over the sink in the resident's unlocked bathroom on Magnolia Place. The toothpaste tube had written on the label "keep out of reach of children under the age of 6 years old."</p> <p>On 2/25/16 at 2:02 p.m. the following personal care product was observed in room 605 on Magnolia Place: 16 ounce bottle of Argan oil, which the label indicated "for external use only."</p> <p>On 2/26/16 at 9:22 a.m., Room 110 was observed with the following items unsecured in the room: a bottle of Acetaminophen, bottle of antacid tablets, bottle of rubbing alcohol on top of the bedside table; 1/2 ounce tube of double antibiotic cream with pain relief (with</p>		<p>condition withthe treatment ordered; notifications will be made and the CNA assignment sheetwill be updated as appropriate. What Measures were putinto place to ensure this does not happen again: To assure the staff arefollowing the policy and procedure (See attachment F323-B) of Lutheran LifeVillages, the Nurse Managers will provide weekly skin assessment auditobservations/round audits (See attachment F323-C) on all nursing units, with afocus on at least 3 residents, per unit, each week through the end of April2016. Starting in May 2016, the Nurse Managers will make monthlyaudits/round observations, and will focus on at least 5 residents, per unit,each month for the next 60 days, through the end of June, 2016. The resultswill be reviewed/discussed in our monthly QA meetings. How the corrective actionswill be monitored: The results from the skincare audits observation/round audit (See attachment F323-C) will bereviewed at our monthly QA meetings for compliance. ADON will monitor forcompliance. DON will monitor for ongoing compliance. Please find the followingattachments: F323-A Policy & procedure storing resident items F323-B Nursing Staff Inservice on 3-18-2-16, regarding the</p>		

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	<p>keep out of reach of children on the label); 4 ounce tube of Arthritis pain relief lotion (with keep out of reach of children on the label); antacid acid tablets 72 tablet bottle; 1 ounce bottle of (product name) intensive healing cream (with keep out of reach of children on the label); a bottle of Extra Strength Acetaminophen, 500 milligrams; a 15 milliliter bottle of skin tag remover; 4 ounce tube of Vitamin A and D ointment (with keep out of reach of children on the label) and (product name) of pain relief cream, 2 ounce tube. On the over bed table were observed to be two, 1/2 ounce bottles of over the counter eye drops.</p> <p>On 2/26/16 at 9:50 a.m., the Magnolia Place shower room was observed unlocked. The medication patch was still observed stuck to the right side of the interior of the shower. The (brand) disinfectant cleaner 256 spray bottle was still on top of the metal square on the wall, unsecured.</p> <p>On 2/26/16 at 10:19 a.m., the following was observed in room 214 at the handwashing sink: 1 liter bottle of mouthwash (keep out of reach of children on the label).</p> <p>On 2/26/17 at 10:27 a.m., the following was observed in room 217: on a ledge in</p>		<p>proper storage of resident products for resident safety. F323-C Audit for compliance A Staff inservice on 3-16-2016</p>	

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	<p>the bathroom was a bottle of 250 milliliter bottle of mouthwash (which had keep out or reach of children on the label); a 7.5 ounce bottle of skin and hair cleanser (which had keep out of reach of children on the label); 4 ounce bottle of mouth wash (which had keep out of reach of children on the label); 2.4 ounce package of denture adhesive; a tube of denture cleanser and a tube of toothpaste.</p> <p>On 3/1/16 at 8:27 a.m., the Magnolia Place shower room was observed. The medication patch remained stuck to the right side on the inner portion of the shower stall.</p> <p>On 3/2/16 at 2:00 p.m., the Resident Council Minutes were reviewed. The Resident Council Minutes from July 14, 2015 included but were not limited to, the following: "Certain residents are wandering into resident rooms and taking things, even when the door is shut..."</p> <p>On 3/3/16 at 8:48 a.m., the Administrator was interviewed. He indicated the personal care products, chemicals and medications should not have been left out and accessible to residents. He indicated this concern would be corrected immediately.</p> <p>On 3/3/16 at 8:52 a.m., the ADON</p>			

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F 0353 SS=E Bldg. 00	<p>(Assistant Director of Nursing) was interviewed. She indicated when nursing applied a new medication patch, they were to remove the used one from the resident. She indicated the CNAs (certified nursing assistants) should inform the nurse when they observed a medication patch come off of a resident.</p> <p>3.1-45(a)(1)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other</p>			

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	<p>nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff provided the necessary care and services to meet the needs of the 120 residents who resided in the building. Including: (Residents B, C, D, E, F, G, H, J, K)</p> <p>Findings include:</p> <p>An observation in the 100 hall (A hall) on 2-26-2016 at 9:26 a.m., indicated a resident was sitting at the nurse's station and the resident indicated she needed to go to the bathroom "right now." There was not a way for the resident to alert staff that she needed assistance and there was not a staff member in sight in the hall or at the nurse's station. A CNA (Certified Nursing Assistant) was found in a room down the hall, as she was assisting another CNA with a resident who required 2 staff assists. At the same time, a call light was observed on at a room at the other end of the hall. At 9:29 a.m., LPN #17 came from that room with the call light still on and indicated the resident needed 2 staff assists to go to the bathroom. At 9:30 a.m., another call</p>	F 0353	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible. Thank you, Corrective Actions to be accomplished for those residents affected: Lutheran Life Villages (LLV) works to assure that sufficient nursing staff are available to provide nursing services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by the resident assessments and individual care plans. LLV works to schedule an appropriate number of nursing staff to meet the resident needs,</p>	04/01/2016

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	<p>light was observed to go off in another room. The activities staff was observed to answer the light but could not assist the resident as the resident needed the assistance from the nursing staff to go to the bathroom. At that time, there were no staff available to assist the resident. At 9:32 a.m., LPN #17 left the resident in the room who needed 2 assists to go help the resident get to the bathroom in the other room.</p> <p>An observation in the 100 hall (A hall) on 2-29-2016 at 9:31 a.m., indicated there was LPN #18 and CNA #19 as the only 2 staff working in the 100 hall with 20 residents. Further observation, indicated while LPN #18 was trying to pass medications, she had to stop several times, put away her medications and answer the call lights and assist CNA #19. The activities staff was observed on the unit trying to get residents who wanted to go to the activity. The residents had to wait until the medications were passed before the activities staff could take them.</p> <p>An observation in the 200 hall (B hall) on 3-1-2016 at 6:12 a.m., indicated LPN #20 was on the unit as the only staff member for 17 residents.</p> <p>A confidential interview with a family</p>		<p>provide excellent nursing care according to the care plan that has been developed by the interdisciplinary team as well as work to serve the residents (and their families) with excellent customer service. This occurs through great teamwork of the charge nurse & their nursing assistants. On 2-29-16, it was brought to the administrators attention, that a nurse was working alone with a CNA on A Wing. A nursing assistant had called off for the day, who was scheduled for A Wing. Another nursing assistant, who was working a different unit, should have been reassigned that morning. This nursing assistant was working with another nursing assistant and a charge nurse on a different unit with 9 residents. The Nurse Scheduler did have another CNA coming in that morning @ 9:30am to work on A wing – she was going to replace the CNA that had called in. Additionally, the Charge Nurse from A Wing was providing resident care to a resident, who needed more than their normal care this morning due to the resident circumstances, and the Charge Nurse was fulfilling that care need. Charge nurses are expected to provide care with their CNA's throughout the shift they are assigned to and responsible for. Typically, A wing is scheduled with a Nurse and 2 CNA's. This was an unusual situation; and the</p>		

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	<p>member indicated the facility needed more staff as the "staff here work too hard."</p> <p>A confidential interview with a family member indicated their loved one had fallen once each of the last two weeks. The family member indicated her loved one had a wet bed last weekend when she came as the sheet had not been changed.</p> <p>A confidential interview with a family member that visited her loved one frequently, indicated the facility needs more staff, especially CNAs. The family member indicated she felt sorry for how hard the staff had to work.</p> <p>A confidential interview with Resident #B indicated there was not enough staff on her hallway. Resident #B indicated the facility was short staffed all the time especially on 2nd shift.</p> <p>A confidential interview with Resident #C indicated the facility was short staffed on nights.</p> <p>A confidential interview with Resident #D indicated it took a long time to answer the call light and had to wait 30 minutes for someone to answer the call light. The resident indicated the waiting happened all the time.</p>		<p>staff were working to assure the residents received the care they normally provide. All of the residents did receive their AMcare in an appropriate manner and their scheduled meds on time. Additionally, there were no resident falls during am care on this date on Awing. Administrator spoke with Nurse Scheduler regarding this situation & the specifics surrounding it; and how to address more quickly for future situations. It is also the expectation of all LLV staff, regardless of their role, to answer resident call lights. Regarding the situation on 2-26-2016, on A Wing, where the Activities staff did answer a call light, that is the expectation of any LLV Staff member, to find out what the resident needs/wants and if it is their scope of practice, to assist the resident or to get the appropriate assistance while communicating that to the resident. LLV works to assure the residents needs are addressed and the residents well being, needs are being met. When there are staffing call offs, typically a Nurse Manger steps in to assist with and work with staff to assure the residents are cared for, while an appropriate replacement is found. This occurs 7 days a week. LLV employs a Nursing House Supervisor for 2nd and 3rd shifts, as well as the weekends, to assure resident needs are being met. Additionally,</p>		

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	<p>A confidential interview with Resident #E indicated she had an incontinent accident because no one answered her call light.</p> <p>A confidential interview with Resident #F indicated the facility was understaffed.</p> <p>A confidential interview with Resident #G indicated the facility needed more staff. The resident indicated it was not the fault of the staff working in the facility as they worked very hard. Resident #G indicated the facility needed more staff to assist the staff already working here.</p> <p>A confidential interview with Resident #H indicated she had to wait 2 hours for her call light to be answered. The resident indicated the staff were too busy and there might only be one girl in the hall.</p> <p>A confidential interview with Resident #J indicated the facility was short of staff in the evenings as she has had to wait at least 30 minutes for her call light to be answered while seated on the toilet.</p> <p>A confidential interview with Resident #K indicated sometimes he needed help</p>		<p>the nurse management has a weekend on-callrotation. Regarding the resident council minutes from almost 1 year ago, in March 2015, those issues were addressed and resolved by the DON. Regarding the resident council minutes from the summer of 2015, in July 2015, those issues were resolved as well. LLV had a complaint survey come in the evening of August 6, regarding scheduling needs, etc. After numerous resident and staff interviews, that complaint was not verified. LLV received a letter of substantial compliance on August 10, 2016, stating substantial compliance with no findings. Furthermore, at that time, the facility was hiring staff & had hired numerous staff over the previous month in July of 2015 and has continued to hire qualified staff since then. The facility has an extensive orientation and training program for nursing staff (nurses and nursing assistant'); an extensive Mentoring program for new staff and also conducts the basic nurse aide (BNA) training class on a routine basis. There were no staff/scheduling concerns in the residents council minutes since July 2015. On January 7, 2016, LLV had a complaint survey. Again, as is usual, the staff and residents are interviewed, along with the resident council president; walking rounds were made throughout the day with</p>	

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	<p>and he would wait 30 minutes and the staff still did not come.</p> <p>Confidential interview with Staff #B and Staff #C indicated there were not enough staff working to meet the needs of the residents.</p> <p>A confidential interview with Staff #D indicated there was not enough staff. Staff #D indicated she was pulled from another unit to cover for a staff member that did not show up to work. Staff #D indicated she was concerned that her residents on the unit she was pulled from would not get their showers. Further interview with Staff #D, indicated every 6 weeks the staff had to pick up a mandatory 16 hours to cover the holes in staffing and if they did not pick up, the hours were assigned. Staff #D was asked if that was how the facility handled the short staffing and Staff #D indicated it didn't work anyway, because staff don't show up or staff would call in.</p> <p>A confidential interview with Staff #E indicated there was not enough staff as she sometimes had to cover 2 halls (37 residents) when a QMA (Qualified Medication Aide) would work the other hall. Staff #E indicated she had to review the blood sugars, would give the insulins and the breathing treatments and would</p>		<p>observations, etc. In the exit for that complaint, it was again unsubstantiated however an issue was verified. Administrator reviewed the resident council minutes for August 2015, September 2015, October 2015, November 2015, December 2015, January 2016, February 2016 and March, with no concerns for staffing noted in any of those months. The interview with the resident council president on 3-2-2016 regarding bed pans and lifts was already investigated & resolved during the complaint survey on January 7, 2016. A CNA had transferred the resident council president with a 1-person, not a 2-person, as was determined by the IDT and was on her CNA assignment sheet. In the follow up with the CNA, she knew this specific resident was a 2-person transfer and made the decision to transfer her on her own, not asking for assistance, although, there was a staff member to help, as she stated further. This was deemed a performance / decision making issue, not a staffing issue. The employee was counseled on the LLV proper transfer policy; with no further incidents from this employee. In further discussions with staff, the Administrator asked staff on this unit, where the resident council president resides, is this an issue – in regards to getting assistance for transfers with other staff</p>		

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	<p>take care of any orders that were not processed. Staff #E indicated it had been this way a long time.</p> <p>A confidential interview with Staff #F and Staff #G indicated there was not enough staff to meet the needs of the residents.</p> <p>A confidential interview with Staff #H indicated there was not enough staff with the call ins. Staff #H indicated if there was a call in, they would be expected to stay over 4 hours. Further interview with Staff #H, indicated the staff were required to pick up 16 hours every 8 weeks or the hours would be assigned. Staff #H indicated with a family this was too much to do.</p> <p>A confidential interview with Staff #J indicated during the night shift she has had to work her unit (20 residents) by herself or with help during half of the shift. Staff #J indicated meeting the needs of the residents was very tricky.</p> <p>A confidential interview with Staff #K indicated she worked the unit (17 residents) half of her shift alone. Staff #K indicated there was just not enough staff to meet the needs of the residents. Staff #K indicated she normally did not work this unit and was pulled from her</p>		<p>members helping; the staff responded no. Typically, this unit, where the resident council president resides is staffed by a nurse and a CNA. Furthermore, the Administrator reviewed all family complaints back to November of 2015, there were no staffing complaints by any family members from that date forward through the survey time period. We do get concerns regarding missing clothing, damaged items, food choices, etc. – which LLV follows up immediately to resolve as can be seen by these records. As requested by State surveyor, the Administrator did provide the actual worked staffing schedule and clocked in times for the nursing staff on 3-2-2016, for the previous 3 days from 2-27-16 through 2-29-2016. Those staffing hours showed the nursing schedule was fully staffed. Copies were given to the State Surveyor. Other residents having the potential to be affected and the corrective actions: The nursing schedule is reviewed on a daily basis to assure the appropriate number of staff are scheduled to provide the care the residents are requiring per their care plan as established by the IDT team. The Nurse Managers make rounds daily, to assure the scheduled staff are present & to see if there are any issues or unmet needs & that the residents are being cared for appropriately. The</p>		

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	<p>normal unit.</p> <p>A confidential interview with Staff #L indicated there was not enough staff to meet the needs of the residents. Staff #L indicated over the weekend she worked with a BNA (Basic Nursing Assistant-successfully completed the 105 hour class and waiting to take the state test) who was assigned residents and was told to assist the BNA as much as possible. Staff #L indicated she did not know what happened but the BNA walked out.</p> <p>A confidential interview with Staff #M indicated she normally worked 1st shift but came in at 1:00 a.m., due to the unit being short staffed. Staff #M indicated there was not enough staff to meet the needs of the residents.</p> <p>A confidential interview with Staff #N indicated she came in at 2:30 a.m., due to not having enough staff and was the only aide for 31 residents.</p> <p>A confidential interview with Staff #O indicated there was not enough staff to meet the needs of the residents. Staff #O indicated the medication pass gets pushed back because she was answering call lights and trying to prevent falls. Staff #O indicated the facility assigned the</p>		<p>HouseSupervisor on 2nd and 3rd shift, also make rounds,communicating with staff to assure the appropriate scheduled staff are presentand if there are any problem solving issues with the schedule that needaddressed. A staff inservice (See attachment A) regarding appropriatestaffing levels, the importance of staff fulfilling their schedule, attendancepolicy, etc. was provided on 3-16-2016 and on 3-20-2016. A review of thenursing schedule has occurred daily, to assure that appropriate staff levelsare scheduled to meet resident needs. LLV continually works torecruit, interview, hire, train and retain the very best nursing staffpossible. As partof our staff retention, LLV has anorientation for all new staff, which occurs every 2 weeks. All new staffreceive company training, the required training for safety, patient care, etc.on day 1 (approx. 8 hours); and on day 2 (approx. 8 hours) all staff go througha departmental training with each Department Head. Nursing staffspecifically go through another 2 days of nursing orientation for skillscompetency, policy training, equipment use, inservicing, appropriate EMRtraining for both CNA's and Nurses. Afterwards, typically the new staffare put with an approved staff mentor for training. A CNA may take from 5– 7 days of training on the nursing unit, to</p>	

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	<p>BNA their own residents and the BNA worked alone. Staff #O indicated the BNA quit because the BNA was afraid they were going to hurt someone.</p> <p>An confidential interview with Staff #P indicated there was a time when several residents were up during the night in the memory unit and that made it difficult for one aide. Staff #P indicated it just depended on the type of residents there were and how much the residents needed as to whether the scheduled staffing was enough.</p> <p>A confidential interview with Staff #Q indicated she stayed over last night due to staffing issues. Staff #Q indicated there was a staffing problem.</p> <p>A review of the Resident Council Minutes provided by the ADON (Assistant Director of Nursing) on 3-1-2016 at 1:30 p.m., indicated during the February 2016 meeting, "...one resident stated that when there is only one CNA per hall it takes nursing staff to [sic] long to answer the call light..." Further review of the minutes indicated on the January 5, 2016 meeting "...a couple of the residents felt that sometimes bedpans were being left under the resident too long..." The minutes from the July 14, 2015 meeting indicated</p>		<p>learn the residents and the routine of the shift they will be placed on. A Nurse may take from 1 week to 2 weeks, depending on their comfort level with our EMR system, to learn the residents and the routine of the shift they will be working on. The Mentors (along with the appropriate Nursing Manager) will continue to train and oversee them as a new staff member. New staff members training schedule is communicated to each new employee. Additionally, a change in the scheduling responsibility occurred on March 7th, 2016, to assure appropriate staffing levels were achieved.</p> <p>What Measures were put into place to ensure this does not happen again: A review of the nursing schedule occurs daily, to assure that appropriate staff levels are scheduled to meet resident needs. LLV continually works to recruit, interview, hire, train and retain the very best nursing staff possible. LLV has an orientation (See attachment F353 – B and F353- C) for all new staff, which occurs every 2 weeks. All new staff receive company training, the required training for safety, patient care, etc. on day 1 (approx. 8 hours); and on day 2 (approx. 8 hours) all staff go through a departmental training with each Department Head. Nursing staff specifically go through another 2 days of nursing</p>		

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	<p>"...resident council members would like to know if there could be more nursing help on each hallway...." The minutes for March 2015 indicated "...nursing staff are often to [sic] busy to toilet a resident who needs frequent toileting because of a diuretic medication...."</p> <p>An interview with the Resident Council President on 3-2-2016 at 1:30 p.m., indicated staffing had been a concern on weekends and evenings. The President indicated some residents told her they had to wait up to an hour to get off of the the bedpan after turning on their call light. She indicated Tulip Lane had the most complaints. The Resident Council President indicated she told the Administrator that some of the CNAs were using the lift to transfer residents by themselves.</p> <p>An interview with the nursing staff scheduler on 3-1-2016 at 1:17 p.m., indicated the 1st and 2nd shifts had the same number of staff assigned. The A (20 residents) and B (17 residents) halls had a nurse and 2 CNAs assigned to each hall. The C (12 residents-300 hall) and D (10 residents-400 hall) halls had a nurse and a QMA or 2 nurses and 2 CNAs, one CNA for each hall. Tulip Lane was assigned 2 nurses and 3 CNAs for 30</p>		<p>orientation for skills competency, policy training, equipment use, inservicing, appropriate EMR training for both CNA's and Nurses. Afterwards, typically the new staff are put with an approved staff mentor for training. A CNA may take from 5 – 7 days of training on the nursing unit, to learn the residents and the routine of the shift they will be placed on. A Nurse may take from 1 week to 2 weeks, depending on their comfort level with our EMR system, to learn the residents and the routine of the shift they will be working on. The Mentors (along with the appropriate Nursing Manager) will continue to train and oversee them as a new staff member. New staff members training schedule is communicated to each new employee. The nursing schedule is reviewed on a daily basis to assure the appropriate number of staff are scheduled to provide the care the residents are requiring per their care plan as established by the IDT team. The Nurse Managers make rounds daily, to assure the scheduled staff are present & to see if there are any issues or unmet needs & that the residents are being cared for appropriately. The House Supervisor on 2nd and 3rd shift, also make rounds, communicating with staff to assure the appropriate scheduled staff are present and if there are any problem solving issues</p>		

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	<p>residents. The Rehab hall was assigned a nurse, QMA and a CNA. If the Rehab census was below 11, then the Rehab hall would have a nurse and a CNA. The memory unit, Magnolia, was assigned a nurse and 2 CNAs for 19 residents. For the 3rd shift, the nursing staff scheduler indicated the A and B (100 and 200) hall had 1 nurse and 1 CNA for each hall. The C and D (300 and 400) hall shared a nurse and was assigned a CNA for each hall. The residents on Tulip Lane were assigned a nurse and 2 CNAs. The Rehab and memory unit, Magnolia, were assigned 1 nurse and 1 CNA each.</p> <p>Further interview with the Nursing Staff Scheduler, indicated there were holes in the schedule and the facility would contact staff that were not scheduled and request their help to fill in the open shifts. The Scheduler indicated at the beginning of this year, the facility required all full and part time staff to pick up 16 hours during a 6 week period to help fill in the open shifts. The Scheduler indicated the facility recently had an unusual number of staff quitting and leaving in the middle of their shift. She indicated the night shift had several staff quit in the last month.</p> <p>An interview with the Staff Development Coordinator on 3-1-2016 at 2:00 p.m.,</p>		<p>withthe schedule that need addressed. Additionally, a change in thescheduling responsibility occurred on March 7th, 2016, to assureappropriate staffing levels were achieved. A nursing assistant trainingcourse (Called the BNA class) is provided at least every quarter to thecommunity, for those people that want to learn how to become a BNA/CNA. The Staff Development Director, who is an approved Director and Instructor isresponsible for conducting this 105 hour class. LLV spends 3 full weeks @120 hours per BNA. LLV is currently recruiting and hiring for the nextBNA class, which is scheduled to start on April 4, 2016. Typically, theBNA class will have 10-12 students in the class. A staff inservice(See attachment A) regarding appropriate staffing levels, the importance of stafffulfilling their schedule, attendance policy, etc. was provided on 3-16-2016and on 3-20-2016. To assure that LLV has appropriate staffing levelsSocial Services will survey at least 2 residents, per nursing unit, per weekthrough the end of April 2016 to get feedback on staff attentiveness toresident needs, staffing levels, etc.. Starting in May and going throughthe end of June, 2016, Social Services will survey at least 5 residents, perunit, per month to get resident feedback on staff attentiveness.</p>		

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	<p>indicated the BNA staff were assigned to work on the units after successfully completing their 30 hour classroom and 75 hour clinical work. The BNAs, who were hired by the facility would go through an orientation where they are placed with a CNA mentor for a week. The BNA would then work on the unit under the supervision of the nurse and other CNA until they tested.</p> <p>A review of the current "Resident Census and Conditions of Residents" provided by the ADON (Assistant Director of Nursing) on 2-25-2016 at 1:00 p.m., indicated the following number of residents required an assist of one or two staff for the following ADL (Activities of Daily Living), 112 residents for transferring, 115 residents for toileting and 116 residents for eating and dressing and 50 for bathing. The following number of residents were dependent for the following ADL tasks, for bathing 45 residents, for dressing 4 residents, for transferring 7 residents, toilet use 3 residents and 1 resident for eating.</p> <p>An interview with the ADON on 3-1-2016 at 2:04 p.m., indicated staff were to call in to the scheduling coordinators number when calling off on their shift. The ADON indicated she would try to replace the staff that called</p>		<p>SocialServices will continue asking family members if their loved ones needs arebeing met during routine careplan meetings, occurring according to the careplanschedule. Additionally, Human resources will do a survey (See attachmentF353-C)for nursing staff in regards to staffing needs, scheduling needs, workload, suggestions for improving resident care, policy thoughts, etc. Thissurvey will be conducted in April, 2016 – gathering nursing staff feedbackbetween April 4, 2016 and April 22, 2016. Administrator will ask to beinvited to the resident council meeting in April and May, to gather feedbackfrom residents on staffing attentiveness, staffing patterns & staffresponse times; feedback obtained from the resident council meetings will beevaluated and discussed at the following QA monthly meetings. How the corrective actionswill be monitored: To assure that LLV hasappropriate staffing levels Social Services will survey at least 2 residents,per nursing unit, per week through the end of April 2016 to get feedback onstaff attentiveness to resident needs, staffing levels, etc. This will beincorporated into their monthly QIS surveys they conduct with residents. Starting in May and going through the end of June, 2016, Social Services willsurvey at least 5 residents, per unit, per</p>		

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	<p>in and for the most part staff could be replaced. The ADON indicated if a staff person could not be found to replace the call in, the staff would be re-arranged and pulled from another area. The ADON indicated if a replacement was not found, a nurse or manager would stay.</p> <p>An interview with the Administrator on 3-1-2016 at 2:36 p.m., indicated there was not a policy for the nurse staffing as the facility would use the schedules for the nursing and CNA staff (Certified Nursing Assistant).</p> <p>A list of residents who required 2 assists was provided by the Administrator on 3-2-2016 at 8:35 a.m., and indicated there were 8 residents in A (100) hall, 5 in B (200) hall, 3 in C (300) hall and 1 in D (400) hall who required 2 staff assists with transfers. Furthermore, there were 9 residents in Tulip Lane, 2 in the Rehab unit and 1 in the Magnolia unit with a total of 29 residents who required 2 staff assists from the nursing staff for transfers.</p> <p>This Federal tag relates to complaint IN00199460.</p> <p>3.1-17(a)</p>		<p>month to get resident feedback onstaff attentiveness, staffing patterns, etc. Social Services willcontinue asking family members if their loved ones needs are being met duringroutine careplan meetings, occurring according to the careplan schedule. Additionally, Human resources will do a survey (See attachment F353-C) fornursing staff in regards to staffing needs, scheduling needs, work load,suggestions for improving resident care, policy thoughts, etc. Thissurvey will be conducted in April, 2016 – gathering nursing staff feedbackbetween April 4, 2016 and April 22, 2016. The results from the Social Serviceresident surveys, feedback from families during the careplan meetings, HumanResources staffing survey will be reviewed at our monthly QAm meetings for compliance. The DON willmonitor for compliance. The Administratorwill monitor for ongoing compliance. Please find the followingattachments: F353 -A Orientation schedule for day 1 and day 2 F353 –B New staff orientation / training schedule for new nursing staff starting on 3-9-16 and 3-23-16 F353 –C Human Resources staffing survey A Staff inservice on 3-16-2016 & 3-20-2016</p>				

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F 0465 SS=E Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure the environment was maintained in a clean and homelike manner for 7 resident rooms and 2 common shower rooms located on 4 of 7 units in the facility.</p> <p>Findings include:</p> <p>On 2/24/2016 at 9:51 a.m., the shower room in the 200 hall was observed to have a brown ring at water level in the bowl of the toilet.</p> <p>On 2/24/16 at 9:59 a.m., the 300 hall shower room toilet seat was observed to have scratches and scrapes throughout.</p> <p>On 2/24/16 at 3:50 p.m., in room 215-2, the wall next to the bed was observed to be scratched.</p> <p>On 2/25/16 at 10:26 a.m., room 108-1 was observed. The paint behind the head of the bed was missing and there were some holes in the wall.</p>	F 0465	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed / accepted / approved with paper compliance if possible. Thank you Corrective Actions to be accomplished for those residents affected: The areas in question have all been addressed. The toilet stains have been cleaned/removed; this includes the 300 hall shower room, the 200 hall shower room & rooms: 209, 116, 406, 112, this was completed by 3-4-2016. The rooms in question that needed the paint touched up have been repaired/painted; this includes</p>	04/01/2016

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	<p>On 2/25/16 at 11:10 a.m., the following was observed in the bathroom of room 406: the finish/paint was missing off 20 tiles on the bathroom wall along the base and up the bottom edge of the wall. Black mars were also observed on the tiles near the bottom of the wall.</p> <p>On 2/25/16 at 11:10 a.m., the bathroom of Room 112 was observed to have stains in the toilet bowl and also stains to the floor tile under the toilet on a 12 inch square tile.</p> <p>On 2/25/16 at 11:38 a.m., the following was observed in room 109: the entry door was observed to have gouges with a rough surface on the lower 2 feet of the door. This rough area had the potential to cause injury to the skin if rubbed against. There was missing blue paint on the wall at the head of the resident's bed. The bathroom tile was cracked and broken underneath on the left side of the toilet.</p> <p>On 2/25/16 at 11:45 a.m., room 109 was observed. The paint was observed to be missing from the wall around the bed and also the bedside table.</p> <p>On 2/25/16 at 1:23 p.m., room 317 was observed. The floor was soiled behind the toilet as well as a stain on each side of</p>		<p>rooms:215, 108, 109, 209, these were also completed by 3-4-2016. The dirty tiles around the toilets were also cleaned; this includes rooms 109, 317, 116,209, 112; this was completed by 3-4-2016. The door with the rough edges,room 109, will have a new door guard put on the bottom 2 feet of the door tocover the rough edges. This has been ordered. The scratched/missingpaint on the wall tiles in room 406 have been painted as well, completed on3-4-2016 and touched up again on 3-17-2016. The Environmental servicesstaff and Maintenance staff were in serviced (F465-A) on 3-14-2016 regardingthese deficient practices and the plan to correct and maintain, propercommunication utilizing the TELS System, etc. Additionally, an all staff in-service (See attachment A) is planned for 3-16-2016, which will include these issues and the corrective actions regarding these environmental concerns. Other residents having thepotential to be affected and the corrective actions: The facility currently has a system where any staff member can report items that need repairs of any sort(TELS). All staff are trained on the TELS system in orientation. In addition, the Director of Maintenance and the Director of EnvironmentalServices will be</p>	

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	<p>the toilet. The stain pattern resembled the result of a leak.</p> <p>On 2/25/16 at 1:58 p.m., room 116 was observed. The interior bowl of the toilet was stained and the edges of the flooring around the base of the toilet bowl was also observed to be stained.</p> <p>On 2/25/16 at 2:32 p.m., room 209 was observed. Scratches were observed on the wall below the call light box and also on the wall at the foot of the resident's bed. The toilet bowl was observed to have stains present as well as a broken tile underneath the left side of the toilet.</p> <p>On 3/2/16 at 10:42 a.m., the Maintenance Supervisor was interviewed. He indicated the facility utilized a (name of work order system) to be made aware of issues that need to be repaired. He indicated the facility does not have a preventative maintenance schedule for resident rooms but they rely on the staff to alert the maintenance department of the needed issues which need to be addressed and repaired. The Maintenance Supervisor indicated various department staff, for example nursing and housekeeping, are in the rooms daily. He indicated when a repair need was identified, a work order was completed and this was how the</p>		<p>inspecting/auditing each resident room, living area using the room inspection audit form (F465 – B), this will be completed by April 1,2016. The room inspections will continue on a monthly basis. Furthermore, we have purchased 4 new toilets to be replacing any toilets that are found needing replacing; here is the confirmation order (F465 – C). We have also purchased the kick plate material, here is the confirmation order(F 465 – D) to repair the gauged doors. We also decided to replace the bathroom tile floors in rooms 109, 112, 116, 209, 316, invoice included(F465-E). This will be completed by 4-1-2016. The Environmental services staff and Maintenance staff were in serviced (F465-A) on3-14-2016 regarding these deficient practices and the plan to correct issues,maintain things in good repair, proper communication utilizing the TELS System,etc. Additionally, a staff inservice (See attachment A) was presented on3-16-2016, which will include these issues and the corrective actions regarding these environmental concerns. What Measures were put into place to ensure this does not happen again: In addition, the Director of Maintenance and the Director of Environmental Services will be inspecting/auditing each resident room, living area using the room inspection audit form (F465 – B),</p>	

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	<p>maintenance department was made aware of the need. He also indicated at times, the staff verbally alert the maintenance department of a repair need. He indicated when an repair need was brought to their attention in a resident's room, the maintenance staff would also observe the room and repair any other identified concerns. He indicated when a resident room was vacated, the room was repainted and the room was thoroughly checked and repaired.</p> <p>On 3/2/16 at 10 50 a.m., room 406 was observed with the Maintenance Supervisor. He indicated if he would have been made aware of the condition of this resident's bathroom, it would have been repaired. He indicated some of the stains in the toilets can't be removed because the finish was worn off and the toilets would need to be replaced.</p> <p>3.1-19(f)</p>				<p>this will be completed by April 1, 2016. The roominspections will continue on a monthly basis as part of our PM program(preventative maintenance). The Environmental services staff and Maintenance staff were in serviced (F465-A) on 3-14-2016 regarding these deficient practices and the plan to correct issues, maintain things in goodrepair, proper communication utilizing the TELS System, etc. Additionally, a staff inservice (See attachment A) was presented on3-16-2016, which will include these issues and the corrective actions regarding these environmental concerns. How the corrective actionswill be monitored: The results from the Inspection Audit tool audit (See attachment F465-B) will be reviewed atour monthly QA meetings for compliance & ongoing correction/repairs. The Asst. Maintenance Director & the Environmental Services Director will monitor for compliance. The Director of Maintenance & Administratorwill monitor for ongoing compliance. Please find the followingattachments: F465 –A Environmental / Maintenance Services In service 3-14-16 F465 –B Inspection Audit tool / monthly F 465 –C Confirmation of toilet purchase F 465 –D Confirmationof kick plate order purchase F 465 –E</p>		

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 55 Sample: 8 This State Residential finding is cited in accordance with 16.2-5.	R 0000	Confirmation of bathroom tile flooring purchase A Staff in service on 3-16-2016 & 3-20-2016 Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.		
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be				

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	<p>contacted in the event of an emergency or death.</p> <p>(6) Information on any known allergies.</p> <p>(7) A photograph (for identification of the resident).</p> <p>(8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to maintain a complete emergency information file containing a photograph of each resident, potentially affecting 11 of 55 residents in the facility.</p> <p>Findings include:</p> <p>The facility's emergency information file was reviewed on 3/3/15 at 1:15 p.m. During the review, it was noted photographs of 11 residents were missing of the 55 residents currently residing in the facility. Their admission dates into the facility of the 11 residents ranged from 9/30/09 to 12/14/15.</p> <p>The Residential Nurse Coordinator was interviewed on 3/3/16 at 1:30 p.m. During the interview, she indicated all residents should have photographs in the facility's emergency information binder. She indicated the 11 resident's photographs were not in the emergency binder and further indicated the resident's photographs were in the MARS (Medication Administration Record Sheet). The Nurse Coordinator further indicated the photographs were provided</p>	R 0356	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>We respectfully request the opportunity to have POC reviewed /accepted / approved with paper compliance if possible Thank you,</p> <p>R356</p> <p>Corrective Actions to be accomplished for those residents affected: The facility did have pictures of each resident, as per policy regarding identification, in the MAR (medication administration record). The</p>	04/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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	<p>by the Admission's Department.</p> <p>A current facility policy, "Residential Care Clinical Records", dated 01/25/2011, and provided by the Residential Nurse Coordinator on 3/3/16 at 2:20 p.m., indicated, "...It is the intention of Lutheran Life Villages to maintain clinical records that are accurate and meet regulatory and professional standards....A current emergency information file shall be created at the time of admission and immediately accessible for each resident, in case of emergency, that contains the following:..A photograph (for identification of the resident)...."</p>		<p>missing pictures in the emergency information file were added immediately when this issue was identified on 3-3-2016. The Nursing Manager and Social Service Director assured the emergency information file were completed per policy on 3-3-2016. In addition, the nursing staff, social service staff and Admissions Coordinator, were represented with an in-service (See attachment A) regarding the necessary emergency information policy (See attachment R356-B) for all residents on 3-16-2016.</p> <p>Other residents having the potential to be affected and the corrective actions: The facility reviewed /audited (See Attachment R356-C) all other residents emergency information files for all current residents in assisted living with no other missing pieces identified – this occurred on 3-3-2016. The Admissions Coordinator is responsible to assure all</p>	

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			<p>residents (upon admission) have the appropriate andcomplete emergency information on file. Social Services will audit allnew assisted living admissions emergency information file each month. Additionally, Social Services will audit 10% of the current assisted livingresidents emergency information files each month (See attachment R356-C). The results will be reviewed/discussed in our monthly QA meetings.</p> <p>What Measures were putinto place to ensure this does not happen again: The Admissions Coordinator isresponsible to assure all residents (upon admission) have the appropriate andcomplete emergency information on file. Social Services will audit allnew assisted living admissions emergency information file each month. Additionally, Social Services will audit 10% of the current assisted livingresidents emergency</p>	

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			<p>information files each month (See attachment R356-C). The results will be reviewed/discussed in our monthly QA meetings.</p> <p>How the corrective actions will be monitored: The results from the residents emergency information files audits (See attachment R356-C) will be reviewed at our monthly QA meetings for compliance. Social Services and Medical Records will monitor for compliance. Director of Social Services will monitor for ongoing compliance.</p> <p>Please find the following attachments: R356- B Emergency information policy. R356- C Monthly log/audit from the emergency information policy A Staff in service on 3-16-2016</p>	