

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155796	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/12/2013
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NAME OF PROVIDER OR SUPPLIER CEDARS THE	STREET ADDRESS, CITY, STATE, ZIP CODE 14409 SUNRISE CT LEO, IN 46765
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 9, 10, 11, and 12, 2013</p> <p>Facility number: 001215 Provider number: 155796 AIM number: 100450890</p> <p>Survey team: Tim Long, RN-TC Rick Blain, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: NF: 16 SNF/NF: 34 Residential: 12 Total: 62</p> <p>Census Payor type: Medicaid: 16 Other: 46 Total: 62</p>	F000000		

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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 13, 2013 by Randy Fry RN.</p>				

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F000221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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 observations, interviews, and record review, the facility failed to ensure a resident's wheelchair seat belt was unfastened at 2 meals. This deficiency affected 1 of 1 residents reviewed for restraints (Resident #32).</p> <p>Findings include:</p> <p>The clinical record of Resident #32 was reviewed on 12/11/13 at 8:30 a.m., and indicated Resident #32 had diagnoses including, but not limited to, organic brain syndrome and anxiety.</p> <p>The Physician's Order dated 10/10/13 indicated "D/T (due to) resident decrease ability to unfasten safety belt seat belt is considered a restraint. Seat belt is necessary D/T (increase) in falls et (and) (decreased) safety awareness."</p> <p>The Care Plan dated 10/11/13 indicated the resident was unable to release the seat belt consistently.</p>	F000221	<p>1. At thsi time, no other residents have restraints.2. Staff in-servicing was done, reviewing the policy directive that the seat belt is, indeed considered a restraint and, most importantly, the necessity of unfastening the seat belt at meals. The resident profile was updated to reflect this part of her care.3. Disciplinary write-ups were completed for staff members involved in this issue.4. Director of Nurses and MDS Coordinator will be responsible to insure that this deficient practice does not occur again. adendum: Charge nurses will report any deviations from this plan of correction to the D.O.N. and place this information on the 24 hour report on a daily basis.Results of effectiveness of our corrective measure will be followed for one year through the Quality Assurance meeting process.</p>	12/30/2013	

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	<p>The Care Plan indicated the seat belt should have been released at meals.</p> <p>On 12/11/13 at 9:45 A.M., Resident #32 was observed in the main dining room seated in a wheelchair with the seat belt fastened. Interview with CNA #2 indicated the seatbelt should have been unfastened when the resident ate her breakfast. CNA #2 indicated she was unsure of why the resident's seatbelt was still fastened.</p> <p>On 12/11/13 at 12:15 P.M., Resident #32 was observed in the main dining room seated in her wheelchair with her lunch tray in front of her and her seat belt was fastened. CNA #3 was seated next to the resident and indicated the resident still had her seatbelt fastened.</p> <p>3.1-26(h)</p>				

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F000224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interviews and record review, the facility failed to implement their Abuse Policy and Procedure for reporting to the Indiana State Department of Health (ISDH), an allegation of verbal abuse for 1 of 2 resident's reviewed for abuse. (Resident #32)</p> <p>Findings include:</p> <p>During a confidential interview on 12/09/2013 at 11:08 A.M., Resident #32 indicated she had complained to her son a CNA had been mean to the her.</p> <p>On 12/11/13 at 11:00 A.M., an interview with the Director of Nursing Service (DNS) indicated on 4/24/13, the son of Resident #32 had called and reported his mother had complained to him a CNA had been mean to her. The DNS indicated she did not report the alleged allegation to ISDH because she did not consider this to be abuse.</p>	F000224	<p>1. The CNA in question no longer is employed by The Cedars. At the time of the incident, no other residents or their families had reported complaints about her.2. Interviews with other residents and their families revealed no additional complaints about her care.3. In order to guard against a similar incident from occurring again, The Cedars policy has been amended to provide for immediate reporting to the Administrator and to the Indiana State Department of Health. An in-service on abuse with special focus on verbal abuse will be held December 26 at the all-staff in-service meeting.4. The Social Service Director will be responsible for insuring that this practice does not occur again; and this process will be followed through our quality assurance program for one year.Addendum: Social Service Director will ensure that any concerns regarding this type of issue are addressed at the monthly resident council meetings for the next year. All residents will be encouraged to express concerns regarding this type of issue at</p>	12/30/2013	

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	<p>The Abuse Policy and Procedure updated 1/2012 was received from the Social Service Director on 12/11/13 at 10:15 A.M., and included, but was not limited to the following: "...the Administrator or Social Service Director will report any allegation of abuse...to the appropriate persons/agencies...within 24 hours of the allegation..." There was no procedure for immediate reporting to the Administrator or the ISDH in this current policy and procedure.</p> <p>3.1-27(b)</p>		<p>their one on one visits with Social Service department as an on going procedure.Results of effectiveness of our corrective measures will be followed also for one year through the Quality Assurance process.</p>		

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interviews and record review, the facility failed to ensure the Abuse Policy and Procedure was accurate in regard to who any allegations of abuse are reported to. The facility also failed to implement the Abuse Policy and Procedure and report to the Indiana State Department of Health an allegation of verbal abuse for 1 of 2 residents reviewed for abuse. (Resident #32).</p> <p>Findings include:</p> <p>1. The current Abuse Policy and Procedure updated on 1/2012 was received from the Social Service Director on 12/11/13 at 10:15 A.M., and included, but was not limited to: "...the Administrator or Social Service Director will report any allegation of abuse...to the appropriate persons/agencies...within 24 hours of the allegation..." There was no procedure for immediate reporting to the Administrator or the ISDH in this policy and procedure.</p>	F000226	<p>1. In order to insure that this deficient practice does not occur again, the abuse policy has been amended to mandate immediate reporting of all allegations of abuse to the Administrator. (see attachment)2. This deficiency did not involve care or service to clients, so this does not apply.3. Any changes to abuse policies will be reviewed as needed at the quarterly quality assurance meetings and changes made to reflect any newly mandated state regulations.4. Administrator, Social Service Director and Director of Nurses shall be responsible to insure that this finding does not recur.</p>	12/20/2013			

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	<p>On 12/11/13 at 11:00 A.M., the Administrator was interviewed and indicated he thought the previous Social Service Director had updated the Abuse Policy and Procedure in regard to who was to report any allegation of abuse to the appropriate agencies.</p> <p>2. During a confidential interview on 12/09/2013 at 11:08 A.M., Resident #32 indicated she had complained to her son a Certified Nursing Assistant (CNA) had been mean to her and the facility had fired the CNA.</p> <p>On 12/11/13 at 11:00 A.M., an interview with the Director Nursing Service (DNS) indicated on 4/24/13, the son of Resident #32 had called and indicated his mom had complained to him a CNA had been mean to her. The DNS indicated she did not report the alleged allegation of verbal abuse to ISDH because she did not consider this to be abuse . The DNS also indicated on 4/24/13 the CNA was terminated from employment due to previous write ups unrelated to this current alleged allegation of verbal abuse.</p> <p>The Abuse Policy and Procedure dated 1/2012 was received from the Social Service Director on 12/11/13 at</p>				

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	10:15 A.M.. and indicated any allegation of abuse will be reported to the appropriate agencies. 3.1-28(a) 3.1-28(c)				

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F000279 SS=D	<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 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 ensure 1 of 2 residents (#30) reviewed for behavioral symptoms had a care plan for behavioral symptoms.</p> <p>Findings include:</p> <p>Resident #30's clinical record was reviewed on 12/9/13 at 1:30 P.M.. The record indicated the resident was admitted to the facility on 8/1/13 with diagnoses including, but not limited to, dementia and anxiety.</p>	F000279	<p>1. A care plan was immediately written to address Resident #30's behavioral symptoms.2. All resident care plans have been reviewed and/or revised/updated as needed to address behavior issues in accordance with The Cedars care plan policy.3. The policy was reviewed and deemed appropriate. Twenty-four-hour sheets will be reviewed daily by the Social Services Director.4. Care plans will be reviewed by the care plan team on at least a quarterly basis. The Social Services Director will be ultimately responsible for oversight of care plans</p>	12/30/2013	

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	<p>Review of Resident #30's admission Minimum Data Set (MDS) on 8/12/13, indicated the resident did not have behavioral symptoms of "physical behavior symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)." Review of resident #30's quarterly MDS of 11/11/13 indicated behavioral symptoms of "Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)." occurred every 1-3 days.</p> <p>Review of Resident #30's Behavior Detail Reports from 8/1/13 through 12/2/13, indicated seven incidents of the resident being physically abusive towards staff, including episodes of hitting, kicking, pinching and scratching staff.</p> <p>Review of Resident #30's care plans did not indicate care plans had been started for behavioral symptoms of physical behaviors directed towards others.</p> <p>An interview with the Social Service Director (SSD) on 12/11/13 at 11:20 A.M., indicated Resident #30 did not have any specific care plans for behavioral symptoms of physical behavior directed towards others.</p>		<p>addressing behaviors to insure this deficient practice does not recur. Addendum: The 24 hour sheets will be reviewed by the Social Service Director on a daily basis. This process will be on going. Results of effectiveness of our corrective measures will be followed thru the Quality Assurance process.</p>	

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	<p>Review of the facility policy provided on 12/11/13 at 2:30 P.M. by LPN #4, entitled, Care Plan Policy, dated 10/26/07, indicated "Resident care plans are initiated upon admission and updated as resident needs change. They are reviewed at initial care plan meeting, every 90 days, and PRN (as necessary). During weekly 'At Risk' meetings, residents' care needs are discussed and changes in care plans initiated."</p> <p>3.1-35(g)(2)</p>			