

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/27/2015
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180480.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00180480 - Substantiated. Federal/State deficiencies related to the allegations are cited at F278, F 279, F282, and F312.</p> <p>Survey dates: August 20, 21, 24, 25, 26, and 27, 2015.</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 18 Medicaid: 100 Other: 24 Total: 142</p> <p>Sample: 6</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The Facility requests a desk review</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0278 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to develop accurate MDS (Minimum Data Set) assessments</p>	F 0278	F 278 ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED I.	09/23/2015

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	<p>related to urinary incontinence for 2 of 3 residents reviewed for urinary incontinence in a total sample of 43 residents reviewed. (Resident #D &amp; #B)</p> <p>Findings include:</p> <p>1. The quarterly MDS (Minimum Data Set) assessment, dated 07/24/2015, indicated Resident #D was severely cognitively impaired. The assessment indicated the resident was occasionally incontinent of bladder and bowel.</p> <p>The CNA (Certified Nursing Aide) monthly "Flow Sheet Record", dated 07/01/2015 through 07/31/2015, indicated Resident #D was incontinent every day on the 6:00 A.M. to 2:00 P.M. shift, 2:00 P.M. to 10:00 P.M. shift and the 10:00 P.M. to 6:00 A.M. shift.</p> <p>The clinical record for Resident #D was reviewed on 08/26/2015 at 10:42 A.M. Diagnoses included, but were not limited to, dementia, manic depression, psychotic disorder, schizophrenia, chronic obstructive pulmonary disease, hypertension, and cerebrovascular accident.</p> <p>During an interview on 08/26/2015 at 9:12 A.M., CNA #14 indicated Resident #D was always incontinent of bladder</p>		<p>Resident # B no longer resides in the facility. Resident # B's assessments were modified to reflect accurate urinary incontinence status. Resident #D's MDS assessments were reviewed for accuracy and modified to reflect accurate urinary incontinence status.</p> <p>II. All residents residing in the facility have the potential to be affected. III. MDS Nurse received education regarding coding all MDS sections correctly. MDS Nurse received education regarding how to correct documentation found to be incorrect during the assessments and interviews performed by MDS. New CNA ADL sheets will be provided to ensure clear and accurate documentation and nursing staff will be educated regarding completion. Education regarding documentation will include how to document incontinent episodes and continent episodes. Education also includes when documentation is to be completed. Newly hired staff will receive same education during orientation. IV. The Director of Nursing Services or designee will randomly audit for MDS accuracy, 5 MDS assessments per week indefinitely. Any MDS that has incorrect information will be modified to reflect accurate documentation immediately. The results of the audits will be presented to the monthly</p>		

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	<p>and bowel.</p> <p>During an interview on 08/26/2015 at 11:33 A.M., CNA #6 indicated Resident #D can sometimes ask to use the restroom, but she was incontinent of bowel and bladder.</p> <p>During an interview, the MDS coordinator indicated the CNA's did not understand how to document correctly for urinary incontinence and "most of the CNA documentation was marked incontinent for Resident #D which was wrong".</p> <p>During an interview on 08/27/2015 at 11:02 A.M., the MDS coordinator indicated she spoke with the CNAs on duty in Harmony Way and had the CNA on duty place a C (Continent) on the CNA monthly "Flow Sheet Record", dated 08/27/2015 for the shift of 6:00 A.M. to 2:00 P.M., implying Resident #D was continent of bladder. This was documented at 11:02 A.M. when the shift was not completed till 2:00 P.M.</p> <p>During an interview on 08/27/2015 at 11:10 A.M., the DCO (District Director of Clinical Operations) when asked about the CNA documentation for 08/27/2015, the shift from 6:00 A.M. to 2:00 P.M., the DCO indicated it was incorrect and</p>		<p>Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of completion: 9/23/2015</p>		

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	<p>she would "handle it".</p> <p>2. The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was listed as occasionally incontinent of bladder and bowel.</p> <p>The CNA monthly "Flow Sheet Record" indicated Resident #B was incontinent on all days of June, 2015.</p> <p>The closed clinical record for Resident #B was reviewed on 08/27/2015 at 9:37 A.M. Diagnoses included, but were not limited to, diabetes mellitus, cerebrovascular accident, hypertension, hypernatremia, hyperosmolality, and atrial fibrillation.</p> <p>During an interview on 08/27/2015 at 11:10 A.M., the DCO (District Director of Clinical Operations) indicated the MDS coordinator used the CNA monthly "Flow Sheet Record" when assessing the incontinence or continence of a resident.</p> <p>This Federal tag relates to complaint IN00180480.</p> <p>3.1-31(d)</p>			

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) <b>DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans related to urinary incontinence for 1 of 3 residents reviewed for urinary incontinence, in a total sample of 13 residents reviewed for care plans. (Resident #E)</p> <p>Findings include:</p>	F 0279	<p><b>F 279 DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>1.Resident # E's documentation, MDS's and careplans were reviewed and added care plan for management of resident's incontinence.</p> <p>2.All residents residing in the facility have the potential to be affected.</p>	09/23/2015

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	<p>An interview was conducted on 08/26/2015 at 1:47 P.M. with LPN (Licensed Practical Nurse) #4. LPN #4 indicated Resident #E was usually incontinent but at times was aware of the need to use the bathroom. LPN #4 further indicated Resident #E came to the unit 4 months ago, was sent out to the hospital for frequent falls and a decline in condition. Resident was diagnosed with Clostridium Difficile and a Urinary Tract Infection while in the hospital. Resident returned to the facility on Hospice care with an increase in incontinence, confusion and a decline in overall health. Resident was wheelchair bound with incontinence checks upon rising, before and after meals and before bed.</p> <p>The significant change MDS (Minimum Data Set) assessment, dated 07/27/2015, was reviewed on 08/27/2015 at 8:42 A.M. The MDS indicated Resident #E was occasionally incontinent of urine. The care plan, updated on 08/18/2015, was reviewed. Resident #E had a care plan for falls related to incontinence, a care plan for impaired skin integrity related to incontinence, but no care plan for managing incontinence. Resident #E also had a stage 1 pressure ulcer on her coccyx measuring 1.6cm X 1.3cm.</p>		<p>1.MDS Nurse and Nursing Managers were provided education regarding care plans. MDS Nurse is to ensure that care plans are in place for triggered Care Assessment Areas (CAA's) when initial assessment is completed, during Annual assessments, Significant Change Assesments and during each care plan review. Care plans will be updated during Interdisciplinary Meetings by Nursing Managers as needed.</p> <p>2.The Director of Nursing Services or designee will randomly audit for accuracy in all areas 5 complete MDS Admission, Annual or Significant Change in Condition Assessments and resident care plans weekly indefinitely. Any MDS that has incorrect information will be modified to reflect accurate documentation immediately. Residents with missing or incorrect care plans will be corrected. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of completion: 9/23/2015</p>		

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F 0282 SS=E Bldg. 00	<p>This Federal tag relates to complaint IN00180480</p> <p>3.1-35(a)</p> <p>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, record review and interview, the facility failed to ensure the plan of care was followed as written or physician orders were followed related to behavior/interventions of psychotropic agents, administration and monitoring of medications for hypertension and oxygen, and urinary incontinence for 3 of 5 residents reviewed for care plans. (Resident #F, #B, &amp; #D)</p> <p>Findings include:</p> <p>1. During an observation on 08/24/2015 at 9:26 A.M., Resident #F was sitting in a wheelchair in the 300 hallway by the shower room door. The resident's head was hanging down to his chest. Resident</p>	F 0282	<p><b>F 282 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b></p> <p>1. Resident # B no longer resides in the facility. Resident # D and Resident #F were assessed and found to have no issues related to the alleged deficient practice. Resident # D will be assessed for necessity of oxygen. Resident # D's care plan was updated to reflect that resident is non-compliant with oxygen and removes oxygen at times. Resident #F was assessed and found that a GDR or discontinuation of any of his psychoactive medication would be contraindicated and the risks outweighed the benefits of discontinuing his medication due to alleged inappropriate documentation.</p> <p>2. All residents residing in the</p>	09/23/2015	

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	<p>#F would lift his head and make comments to other resident's walking past, then CNA #24 walked up to Resident #F and moved the resident out of the hallway and into his room.</p> <p>The clinical record for Resident #F was reviewed on 08/24/2015 at 9:39 A.M. The diagnoses included, but were not limited to, dementia, hypertension, malaise, and anemia.</p> <p>Resident #F's Behavior Care Plan, which was initiated on 04/23/2015, indicated a potential to demonstrate physical behaviors of refusing care and hitting at staff. The interventions included, but were not limited to, "Administer and monitor the effectiveness of medications per physician order."</p> <p>Resident #F's Inappropriate Behaviors Care Plan, which was initiated 05/06/2015, indicated a potential to demonstrate sexually inappropriate behaviors. The interventions included, but were not limited to, "...monitor, redirect and return the resident to his room...."</p> <p>The "Behavior/Intervention Monthly Flow Records", dated May, June, July, and August, 2015, were reviewed on 08/24/2015 at 11:02 A.M. The following</p>		<p>facility have the potential to be affected.</p> <p>3.Nursing staff were provided education regarding behavior management, documentation of behaviors present, oxygen treatments,importance of and signing off medication and treatments as ordered. Documentation on behavior flow sheets will be changed to reflect documentation by exception. To document by exception on the flow sheets will mean that if the behavior was not present, it will be left blank. Any documentation on behavior flow sheets by the licensed nurse will be noted in the progress notes. Review of behavior documentation in nursing notes is a practice already in place during morning meeting. Side effect monitoring is already in place and charted by exception. During monthly behavior meetings, behavior monitoring sheets and behavior notes will be compared to ensure accurate documentation of behaviors. This information is shared with the Psychologist/Psychiatrist during the monthly behavior meetings.Nursing staff were provided education regarding documentation of services provided including medication, treatments, oxygen, toileting, bathing and grooming</p> <p>4.The Social Services Director and Director of Nursing Services or designee will randomly audit</p>		

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	<p>dates and times were left blank with no documentation of behavior monitoring for Resident #F: August 1, 2, 7, 8, 10, &amp; 11, 2015 (A.M.) August 2 &amp; 17, 2015 (P.M.) July 1, 4, 9,10, 16, 18, 20, 21, 24, 29, &amp; 30, 2015 (A.M.) July 23, 2015 (P.M.) June 4, 6, 12, 16, 19, 22, 24, &amp; 30, 2015 (A.M.) June 7, 16, &amp; 18, 2015 (P.M.) May 12, 19, , 23, &amp; 24, 2015 (A.M.) May 4, 7, &amp;17, 2015 (P.M.)</p> <p>During an interview on 8/24/2015 at 10:08 A.M., CNA #24 indicated Resident #F had inappropriate behaviors and had to be watched around other residents.</p> <p>During an interview on 08/24/2015 at 1:33 P.M., LPN (Licensed Practical Nurse) #19 indicated all behaviors and interventions were documented on the "Behavior/Intervention Monthly Flow Record". The current month flow chart was kept in the MAR (Medication Administration Record) and documented in the A.M. and P.M. every day for Resident #F. When a progress note pertains to the behavior a code was to be placed on the "Behavior/Intervention Monthly Flow Record".</p> <p>During an interview on 08/24/2015 at</p>		<p>for accuracy behaviors present on behavior monitoring flow sheet daily 5 of 7 days per week for 60 days, then 3 days per week for 60 days. Any incorrect information will be modified to reflect accurate documentation immediately. The Director of Nursing Services or designee will audit MARs and TARs daily 5 of 7 days per week for complete and accurate documentation of services. Any missing or incorrect documentation will be corrected. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of Completion: 9/23/2015</p>				

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	<p>1:41 P.M., the SSM (Social Service Manager) indicated the team met monthly to go over the resident's behaviors. During these meetings, the "Behavior/Intervention Monthly Flow Record" and physician's medication orders were reviewed. The SSM indicated Resident #F had episodes of inappropriate behaviors and was currently being monitored for those behaviors.</p> <p>During an interview on 08/27/2015 at 9:37 A.M., the DON (Director of Nursing) indicated the "Behavior/Intervention Monthly Flow Record" was where nursing staff were to document behavior/intervention signs and symptoms. The DON indicated the A.M. documentation designated box on the flow record was from 7:00 A.M. to 7:00 P.M. and the P.M. documentation designated box on the flow record was from 7:00 P.M. to 7:00 A.M.</p> <p>2. A. During an interview on 08/18/2015 at 9:51 A.M., Resident #B's family member indicated the resident was left incontinent of urine.</p> <p>The closed clinical record for Resident #B was reviewed on 08/27/2015 at 09:37 A.M. Diagnoses included, but were not limited to, diabetes mellitus,</p>			

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	<p>cerebrovascular accident, hypertension, hypernatremia, hyperosmolality, and atrial fibrillation.</p> <p>Review of Resident #B's care plans, on 08/27/2015 at 10:00 A.M., indicated a care plan for hypertension related to a stroke dated 12/16/2014. The interventions included, but were not limited to, monitor/document abnormalities for urinary output.</p> <p>Review of the CNA (Certified Nursing Aide) monthly "Flow Sheet Record", dated 06/01/2015 to 06/30/2015, under Bladder indicated the staff was to document the number of times Resident #B was continent or incontinent.</p> <p>The CNA "Flow Sheet Record" for bladder assessment contained no documentation for the 6:00 A.M. to 2:00 P.M. shift for the following dates: June 12, 13, 14, 16, 17, 19, 20, 21, 23, 24, 26, 27, 28, 29, and 30, 2015.</p> <p>The CNA "Flow Sheet Record" for bladder assessment contained no documentation for the 2:00 P.M. to 10:00 P.M. shift for the following dates: June 5, 6, 8, 9, 10, 11, 15, 17, 18, 20, 21, 25, 26, 28, 29, and 30, 2015.</p> <p>The CNA "Flow Sheet Record" for</p>			

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	<p>bladder assessment contained no documentation for the 10:00 P.M. to 6:00 A.M. shift for the following dates: June 30, 2015.</p> <p>The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was listed as occasionally incontinent of bladder and bowel.</p> <p>2. B. Resident #B's care plans were reviewed on 08/27/2015 at 10:00 A.M. The care plan for coronary artery disease, dated 12/16/2014, included interventions, but were not limited to: "Give all cardiac medications as ordered by the physician, monitor and document side effects, give medications for hypertension and document response to medications and any side effect, and monitor blood pressure and notify physician of any abnormal readings."</p> <p>Review of Resident #B's "Medication Administration Record", dated 06/01/2015 through 06/30/2015, indicated Resident #B did not receive his Lisinopril 20 milligrams by mouth daily on 06/17/2015 and 06/19/2015, and Resident #B did not receive his</p>			

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	<p>Amlodipine 5 milligrams by mouth daily on 06/17/2015 and 06/19/2015.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/16/2015, indicated the resident's blood pressure was 177 systolic and 90 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/19/2015 indicated the resident's blood pressure was 199 systolic and 98 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/27/2015, indicated the resident's blood pressure was 217 systolic and 99 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary". dated 06/28/2015, indicated the resident's blood pressure was 211 systolic and 94 diastolic.</p> <p>Review of Resident #B's "Progress Notes", from 06/16/2015 through 06/30/2015, indicated no documentation pertaining to blood pressure trending upward or abnormal.</p> <p>Review of Resident #B's "Progress Notes", dated 07/02/2015 at 15:17 (3:17 P.M.), indicated the resident had increased mumbled speech and incontinence.</p>			

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	<p>Review of Resident #B's "Progress Notes", dated 07/02/2015 at 16:40 (4:40 P.M.), indicated the physician was notified of the resident's change in condition.</p> <p>3. The clinical record for Resident #D was reviewed on 08/26/2015 at 10:42 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cerebrovascular accident, dementia, manic depression, psychotic disorder, schizophrenia, and hypertension.</p> <p>The physician's order, dated 04/14/2015, indicated Resident #D was to have oxygen therapy at 2 liters per minute by nasal cannula. The resident's condition for oxygen therapy was shortness of air.</p> <p>The care plan, dated 04/15/2015, indicated Resident #D had a diagnosis of COPD (Chronic Obstructive Pulmonary Disease). The interventions for COPD included, but were not limited to, "Administer medications as ordered, monitor for signs and symptoms and give oxygen as ordered."</p> <p>The MDS (Minimum Data Set) assessment was reviewed on 08/26/2015 9:26:25 AM. The quarterly MDS</p>			

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	<p>assessment, dated 07/24/2015, indicated Resident #D was severely cognitively impaired.</p> <p>During an observation on 08/26/2015 at 8:37 A.M., Resident #D was sitting in the small dining room located on Harmony Hall. The resident's nasal cannula was not in her nasal passages and was lying on the resident's right shoulder. CNA #14 walked up to Resident #D at 9:10 A.M., and placed the nasal cannula on Resident #D's face for proper oxygen administration.</p> <p>During an observation on 08/26/2015 at 11:00 A.M., Resident #D's nasal cannula was not in her nasal passageway. The ADON (Assistant Director of Nursing) walked up to Resident #D and asked the resident if she was ok, then walked back to the nurses desk without placing the resident's nasal cannula back in place. LPN #17 walked by Resident #D at 11:17 A.M., and placed Resident #D's nasal cannula back on the resident's face.</p> <p>During an observation on 08/26/2015 at 11:19 A.M., Resident #D's nasal cannula was not in the resident's nasal passages. CNA #6 walked up to Resident #D at 11:32 A.M., and placed Resident #D's nasal cannula back on the resident's face.</p>			

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F 0312 SS=D Bldg. 00	<p>The current "Comprehensive Care Plan" policy was provided on 08/26/2015 at 3:25 P.M. by the Executive Director. The policy was dated 01/07/2012. The policy indicated, "...Care plan in chart ...address the patient's needs..."</p> <p>This Federal tag relates to complaint IN00180480. 3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to provide ADL (Activities of Daily Living) care to residents who were unable to perform ADL's for themselves for 3 of 7 residents reviewed for ADL's. (Resident #C, #B, &amp; #G)</p> <p>Findings include:</p> <p>1. Review of the nursing assistant's "Flow</p>	F 0312	<p>F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>I. Resident #B no longer resides in the facility. Residents # C and #G were assessed and no issues found related to the alleged deficient practice. Resident #C care plans were updated to reflect current needs for ADL care. Resident #G has care plans in place regarding refusal of care including oral care. II. All residents residing in the facility have the potential to be affected.</p>	09/23/2015

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	<p>Sheet Record" for ADL's, dated July, 2015 through August, 2015, indicated oral care was to be performed twice daily and as needed, once on first shift and once on second shift. Resident #C's "Flow Sheet Record" was left blank on the following dates: 08/05/2015 2nd shift, 08/01/2015 2nd shift, 07/31/2015 1st shift, 07/30/2015 1st shift, 07/27/2015 2nd shift, 07/23/2015 1st shift, 07/22/2015 2nd shift, 07/20/2015 2nd shift, 07/17/2015 2nd shift, 07/16/2015 1st shift, 07/15/2015 1st shift, 07/08/2015 2nd shift, 07/05/2015 1st shift, 07/02/2015 1st shift.</p> <p>Review of Resident #C's care plan for ADL's (activities of daily living), dated 08/02/2012, indicated Resident #C had self care performance deficits related to ADL's with a diagnosis of Alzheimer's Disease. The interventions for Resident #C included, but were not limited to, "Provide oral care and encourage the resident to assist with daily care."</p> <p>Review of the clinical record, on 08/26/2015 at 09:13 A.M., indicated Resident #C's last dental exam was performed on 06/10/15. The exam indicated that Resident #C had fair oral hygiene.</p> <p>During an interview on 08/20/2015 at</p>		<p>III. It is the policy of the facility that care is provided to residents to meet their highest potential. Nursing staff received education regarding documentation of ADL care provided. ADL care sheet was modified to ensure clear and accurate documentation of ADLs provided. CNA's are to report to nurse any refusals of ADL care. Families and outside care providers (<i>such as hospice</i>) of residents that have history of consistent refusals or are resistive to care will be notified of resident's refusals. Residents that consistently refuse ADL care that may affect their psychosocial well-being and health will have a care plan in place that reflects that behavior. Attempts will be made to determine reasons for refusal and interventions will be put into place to encourage residents to participate and allow ADL care. IV. The Director of Nursing Services or Designee will audit ADL records for missing or incomplete documentation daily for 5 of 7 days per week for 60 days, then 3 of 7 days per week for 90 day then weekly indefinitely. Any missing documentation will be immediately corrected to reflect care provided or refusal of care, whichever is accurate. There will be random visual audits of 5 dependent residents per week for cleanliness and grooming daily and any deficiencies corrected. The results of the audits will be</p>				

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	<p>2:20 P.M., Resident #C's family member indicated, Resident #C had bad breath on some occasions and was unsure if their family member had received oral care on a regular basis.</p> <p>During an interview on 08/26/2015 at 11:22 A.M., LPN (Licensed Practical Nurse) #16 indicated after all ADL's were performed they were to be documented on the "Flow Sheet Record". LPN #16 indicated Resident #C had not been able to self perform oral care without assistance since arriving to the facility.</p> <p>The MDS (Minimum Data Set) annual assessment, dated 06/02/2015 and reviewed on 08/26/2015 at 9:00 A.M., indicated Resident #C was severely cognitively impaired. The resident required extensive assistance of one for hygiene. The resident's diagnoses included, but were not limited to, hypertension, Alzheimer's Disease, and dementia.</p> <p>2. During an interview on 08/18/2015 at 9:51 A.M., Resident #B's family member indicated the resident did not receive the number of baths necessary.</p> <p>During an interview on 08/26/2014 at 10:49 A.M., CNA # 25 indicated residents received a minimum of two</p>		presented to the performance improvement meeting monthly to determine when the audit frequency may be changed.	

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	<p>showers/complete baths a week. The residents could have more than two baths a week when requested.</p> <p>Review of the nursing assistants "Flow Sheet Record", dated 06/01/2015 through 06/30/2015, indicated Resident #C should have received two complete baths/showers a week. Resident #C received a complete bath/shower on the following dates: 06/03/2015, 06/22/2015, 06/24/2015, and 06/27/2015.</p> <p>The CNA (Certified Nursing Aide) "Flow Sheet Record" for bathing indicated Resident #B received showers on 06/03/2015. Resident #B received a complete bath on 06/03/2015, 06/17/2015, 06/21/2015, 06/22/2015, and 06/24/2015 for the thirty days in the month of June.</p> <p>3. During an interview on 08/18/2015 at 9:51 A.M., Resident #B's family member indicated the resident was left incontinent of urine.</p> <p>During an interview on 08/26/2015 at 9:12 A.M., CNA #14 indicated the resident's ADL (Activity of Daily Living) care was documented on the nursing assistants "Flow Sheet Record".</p> <p>Review of the CNA "Flow Sheet Record"</p>			

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	<p>under "Bladder" indicated the staff was to document the number of times a resident was continent or incontinent.</p> <p>On the CNA "Flow Sheet Record" for bladder assessment, indicated there was no documentation listed for 15 days during June, 2015 for the 6:00 A.M. to 2:00 P.M. shift, no documentation listed for 16 days during June, 2015 for the 2:00 P.M. to 10:00 P.M. shift and no documentation listed for one day during June, 2015 for the 10:00 P.M. to 6:00 A.M. shift.</p> <p>The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was listed as occasionally incontinent of bladder and bowel. Diagnoses included, but were not limited to, diabetes mellitus, cerebrovascular accident, and atrial fibrillation.</p> <p>4. During an interview with the family member of Resident #G, on 08/20/15 at 8:35 P.M., the family member indicated that on many times she had visited; the resident's teeth were unclean. She indicated at times the resident's teeth were brown with "gunk" on them. She</p>			

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	<p>indicated on one visit, she asked the staff to clean the resident's teeth while she was present. The staff looked in the resident's dresser drawers and was unable to locate a toothbrush or toothpaste. The family member indicated she has had to ask repeatedly for the resident's teeth to be cleaned.</p> <p>The clinical record for Resident #G was reviewed on 08/25/15 at 2:51 P.M. The diagnoses for Resident #G included, but were not limited to, dementia and Alzheimer's disease.</p> <p>The most recent annual MDS (minimum data set) assessment, dated 05/04/15, indicated Resident #G was severely cognitively impaired. The MDS also indicated Resident #G required extensive assistance with personal hygiene needing physical assistance of one staff person.</p> <p>During an interview at 10:45 A.M., on 08/26/15, the CNA (Certified Nursing Assistant) #1 indicated she provided care for Resident #G and the resident was supposed to receive oral care daily on each shift. The CNA indicated when oral care was provided, the CNA's documented the provided care on the resident's "Flow Sheet" . If a resident refused care, the nurse was notified and the nurse performed the care and</p>			

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	<p>documented it. CNA # 1 indicated Resident #G did not usually refuse care, he/she "takes some encouragement on some days" but would allow us to help.</p> <p>During an interview at 2:50 P.M., on 8/26/15, CNA #2 indicated she provided care for Resident #G on evening shift. CNA #2 indicated oral care was provided at bedtime and should be done daily.</p> <p>The Flow Sheet Record for August, 2015, for Resident #G, was provided by Unit Manager #7 on 08/26/15 at 8:40 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN The following dates were blank, indicating care was not provided: August 3, 14 and 15, 2015 on first shift and August 3, 7, 9, 11, 14, 15, 18, 22, and 25, 2015 on second shift. There were no PRN (as needed) incidents of oral care being provided for the month of August, 2015.</p> <p>The Flow Sheet Record for July, 2015, for Resident #G, was provided by the Director of Nursing (DON) on 08/26/15 at 8:55 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN</p>			

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	<p>The following dates were blank, indicating care was not provided: July 6, 7, 10, 14, 15, 19, 25, 26, 29, and 30, 2015 on first shift and July 1, 2, 3, 4, 5, 7, 10, 11, 12, 15, 26, 27, 28, 29, and 30, 2015 on 2nd shift. There were no PRN (as needed) incidents of oral care being provided for the month of July, 2015.</p> <p>The Flow Sheet Record for June, 2015, for Resident #G, was provided by Unit Manager #7 on 08/26/15 at 8:40 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN</p> <p>The following dates were blank, indicating care was not provided: June 8, 12, 13, 14, 16, 17, 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30, 2015 on first shift and June 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 22, 24, 25, 27, 28, 29, and 30, 2015 on second shift. There were no PRN (as needed) incidents of oral care being provided for the month of June, 2015.</p> <p>This Federal tag relates to complaint IN00180480.</p> <p>3.1-38(a)(3)(C) 3.1-38(b)(2)</p>			