

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155381	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/04/2014
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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00142676.</p> <p>Complaint IN00142676: Substantiated. Federal/State deficiencies related to the allegations are cited at the F282 and F323.</p> <p>Survey dates: February 24, 25, 26, 27, and 28, and March 1, 3, and 4, 2014.</p> <p>Facility number: 000551 Provider number: 155381 AIM number: 100267400</p> <p>Survey team: Sandra Nolder RN--Team Coordinator Gloria Bond RN Janet Stanton RN (2/24, 25, 26, 27, 28, 3/3, 4, 2014) Michelle Hosteter RN (2/24, 25, 26, 27, 28, 3/3, 4, 2014)</p> <p>Census bed type: SNF--20 SNF/NF--87 Residential--48 Total--155</p>	F000000	<p>March 25th, 2014 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on March 4th, 2014. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and Living's credible allegation of compliance. We are also respectfully requesting a desk review as the follow up to Plan of Correction We request the desk review based on the corrections, changes and audit tools made by this facility listed below: 1. F225,F226 Abuse Reporting Pre Test-Post Test 2. F225, F226 Abuse Prevention Policy 3. F225, F226 Reportable Policy and Procedure 4. F225, F226 Abuse Investigation Checklist 5. F225, F226 Abuse Resident-Responsible Party Interview 6. F225, F226 Abuse Education 7. F225, F226 Incident Reporting Audit Tool 8. F225, F226 Staff Abuse Interviews 9. F242 Personal Preference Interview-Test 10. F242 Bathing Preference Form 11. F242 Personal Preference Audit Tool 12. F279 Vision Care</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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	<p>Census payor type: Medicare--26 Medicaid--58 Other--71 Total--155</p> <p>Residential Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on March 12, 2014.</p>		<p>Plan Audit Tool 13. F279 Vision Care Plan In-service-Test 14. F282, F323 In-service-Test 15. F282, F323 Rounding Audit Tool 16. F314 Wound Documentation In-service-Test 17. F314 Pressure Wound Audit Tool 18. F329 Behavior Management In-service 19. F329 Behavior Management Program 20. F329 Medication Management Meetings 21. F329 New or Worsening Behavior Event Form 22. F329 Behavior Management Team Assignments 23. F441 Handwashing Policy 24. F441 Handwashing Skills Check 25. F441 Blood Glucose Policy 26. F441 Blood Glucose Skills Check We ask the division to review our plan of correction and our corrections, changes, audit tools and education logs, in our effort to meet the expectations of making our facility 100% compliant in, meeting the plan of correction and holding all areas from the 2567. We do want to continue to improve in our documentation and with the new corrections, changes in audit tools and education; we believe we will continue to move forward in giving our residents the care that they so deserve.</p> <p>Respectfully, Justin P. Vogt, H.F.A., Executive Director Harbour Manor Health and Living &amp; The Lodge</p>		

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F225 I. The corrective	04/03/2014			

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	<p>review, the facility failed to thoroughly investigate, and immediately report to the Administrator and/or the Indiana State Department of Health, allegations of physical abuse and misappropriation of property, for 2 of 4 allegations reviewed. (Residents #11 and #70)</p> <p>Findings include:</p> <p>1. In an interview on 2/24/14 at 2:32 P.M., Resident #11 indicated a female CNA #5 and a male CNA #6 were in her room a couple of months ago, watching T.V. with her. She indicated CNA #6 touched her breast two times. The first time he did it, she brushed his hand away, thinking maybe it was accidental. When the CNA did it again, she told him that he should not do that. The resident indicated CNA #6 told her he had not done anything. The resident indicated she had reported this incident to the DNS (Director of Nursing Services), but felt it was her word against a CNA. She indicated the DNS did change the CNA's assignment; and although he was no longer helping her with her daily care, he had assisted her to the toilet a few times since the incident. The resident indicated she thought</p>		<p><b>actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #11 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 2/24/14. CNA #6 was suspended on 2/24/14. CNA #6 no longer works in the facility. The DNS (Director of Nursing Services) no longer works in the facility. Resident # 70 showed no negative outcomes, physical evidence, or mental anguish from the alleged incident reported to the Noblesville Police Department and ISDH 2/8/14. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents who reside at Harbour Manor Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and or families/responsible parties will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according to Federal, State and CarDon policy and procedures. No other concerns were identified. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> The administer and director of nursing will be</p>				

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	<p>other CNAs had held it against her because she had reported him, but things "have calmed down a bit."</p> <p>On 2/24/14 at 3:30 P.M., the Executive Director was advised of the alleged incident, and was requested to provide the facility's investigation.</p> <p>In an interview on 2/25/14 at 8:45 A.M., the Executive Director indicated he had started the investigation of the allegation of sexual abuse yesterday, after he was informed, because there had been no prior investigation done. He indicated he had suspended CNA #6, and had informed the Indiana State Department of Health (ISDH).</p> <p>The Executive Director indicated he had spoken with the DNS, who reported the resident had told her CNA #6 had touched her breast. The DNS indicated she interviewed CNA #6 after the resident reported the incident to her, and CNA #6 indicated it was accidental touching during a transfer. The DNS indicated the incident had happened six months ago.</p> <p>In an interview on 2/25/14 at 11:06</p>		<p>re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist A CQI abuse investigation checklist is currently utilized by the administrator and director of nursing for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana.</p> <p>QIS interview tool will be utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. Staff members who are suspended</p>		

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	<p>A.M., the DNS indicated she had daily conversations with Resident #11. The day the she came to report the incident to the DNS, the resident was not angry or tearful when she told the DNS that CNA #6 had touched her breast. When the DNS asked the resident when the incident had occurred, Resident #11 indicated CNA #5 and CNA #6 were providing morning care, and had transferred her to her chair. The DNS indicated that Resident #11 did not act like it was a real concern to her. The resident never indicated the CNA had touched her intentionally.</p> <p>The DNS indicated she talked to CNA #6 immediately. The CNA indicated he and CNA #5 were in the resident's room to help get her up that morning . CNA #6 indicated the transfer sling was bunched up around the resident's chest area, and he had to reposition it. He may have had to touch her breast during that time. He further indicated that that he had maybe touched her breast during care due to lotion, showering and etc. The DNS indicated this resident had stiffness due to cerebral palsy, and was big-busted. Her breasts would have to be touched somewhat on the side when doing a transfer.</p>		<p>related to abuse allegations will be reviewed by the corporate clinical consultant, corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur. <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Clinical Specialist for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the CS or Designee monthly to total 12 months. The Clinical Specialist or Designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration</p>				

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	<p>The DNS indicated she had not felt the resident was alleging abuse, and had not perceived it as an allegation of abuse.</p> <p>On 2/25/14, the Executive Director provided written information which was used at a staff inservice on 12/4/13. The training was titled "Recognizing Abuse" and included a large group activity with "situation cards." One of the cards addressed "Uninvited contact with genitalia. Anyone-staff, family, other residents who touch who (sic) without permission or inappropriately, including during personal care...."</p> <p>The DNS had attended the inservice.</p> <p>2. On 3/3/14, the Executive Director was requested to provide 2-3 examples of investigations for allegation of abuse, neglect, or misappropriation of property that had been conducted in the past 3 months.</p> <p>The Executive Director provided an investigation from an incident that occurred on 2/8/14. A family member reported "some cash was missing from [Resident #70's]</p>		<p>of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. <b>V. Plan of Correction completion date.</b> Plan of Correction date is April 3rd, 2014.</p>		

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	<p>purse."</p> <p>The report indicated the facility notified the local police, ISDH, and started the investigation. Interviews were conducted by the Social Service Director on 2/9/14 at 10:30 A.M. The report indicated he interviewed 5 residents living near the room where Resident #70 resided, and none had ever experienced missing items in the facility.</p> <p>The investigation did not include any interviews of staff who were working at the time.</p> <p>In an interview on 3/3/14 at 3:25 P.M., the Executive Director indicated he had not gotten staff interviews for the allegations of missing money for Resident # 70.</p> <p>3.1-28(c) 3.1-28(d)</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 interview and record review, the facility failed to follow their policy regarding investigation, and immediate notification of the Executive Director of an allegation of sexual abuse, for 1 of 4 abuse investigations reviewed. (Resident #11)</p> <p>Findings include:</p> <p>In an interview on 2/24/14 at 2:32 P.M., Resident #11 indicated a female CNA #5 and a male CNA #6 were in her room a couple of months ago, watching T.V. with her. She indicated CNA #6 touched her breast two times. The first time he did it, she brushed his hand away, thinking maybe it was accidental. When the CNA did it again, she told him that he should not do that. The resident indicated CNA #6 told her he had not done anything.</p> <p>The resident indicated she had reported this incident to the DNS (Director of Nursing Services), but</p>	F000226	<p><b>F226 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #11 showed no negative outcomes physical evidence or mental anguish from the alleged incident reported to the ISDH on 2/24/14. CNA #6 was suspended on 2/24/14. CNA #6 no longer works in the facility. The DNS (Director of Nursing Services) no longer works in the facility. Resident # 70 showed no negative outcomes, physical evidence, or mental anguish from the alleged incident reported to the Noblesville Police Department and ISDH 2/8/14. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents who reside at Harbour Manor Health and Living have the potential to be affected by the alleged deficient practice. Resident's with a BIMS of 10 or greater and or families/responsible parties will be interviewed using the ISDH QIS abuse questionnaire to ensure all abuse allegations are identified and handled according</p>	04/03/2014			

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	<p>felt it was her word against a CNA. She indicated the DNS did change the CNA's assignment; and although he was no longer helping her with her daily care, he had assisted her to the toilet a few times since the incident. The resident indicated she thought other CNAs had held it against her because she had reported him, but things "have calmed down a bit."</p> <p>On 2/24/14 at 3:30 P.M., the Executive Director was advised of the alleged incident, and was requested to provide the facility's investigation.</p> <p>In an interview on 2/25/14 at 8:45 A.M., the Executive Director indicated he had started the investigation of the allegation of sexual abuse yesterday, after he was informed, because there had been no prior investigation done. He indicated he had suspended CNA #6, and had informed the Indiana State Department of Health (ISDH).</p> <p>The Executive Director indicated he had spoken with the DNS, who reported the resident had told her CNA #6 had touched her breast. The DNS indicated she interviewed</p>		<p>to Federal, State and CarDon policy and procedures. No other concerns were identified. III. <b>The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> The administer and director of nursing will be re-educated by the CarDon Clinical Nurse Specialist on the Abuse reporting policy and procedure and CQI abuse investigation checklist A CQI abuse investigation checklist is currently utilized by the administrator and director of nursing for each investigation to ensure future investigations have the necessary documentation to determine the decisions of reinstating employees, terminating employees and reporting employees to the ISDH and licensure boards of Indiana.</p> <p>QIS interview tool will be utilized to interview residents within the facility and family members to ensure no further risks of harm exists in the current care environment for those residents potentially affected In-service staff and contracted services on the abuse reporting policy and procedure including; identifying multiple and various forms of abuse, reporting immediately, and overall review of abuse prevention. A post- test was utilized to ensure the staff and contracted services comprehended the abuse</p>		

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	<p>CNA #6 after the resident reported the incident to her, and CNA #6 indicated it was accidental touching during a transfer. The DNS indicated the incident had happened six months ago.</p> <p>In an interview on 2/25/14 at 11:06 A.M., the DNS indicated she had daily conversations with Resident #11. The day she came to report the incident to the DNS, the resident was not angry or tearful when she told the DNS that CNA #6 had touched her breast. When the DNS asked the resident when the incident had occurred, Resident #11 indicated CNA #5 and CNA #6 were providing morning care, and had transferred her to her chair. The DNS indicated that Resident #11 did not act like it was a real concern to her. The resident never indicated the CNA had touched her intentionally.</p> <p>The DNS indicated she talked to CNA #6 immediately. The CNA indicated he and CNA #5 were in the resident's room to help get her up that morning. CNA #6 indicated the transfer sling was bunched up around the resident's chest area, and he had to reposition it. He may have had to touch her breast during that time. He further indicated that</p>		<p>guidelines and policy/procedure to protect the residents and families from harm. Social services will assess the resident and families to ensure mental anguish does not exist and refer those affected for appropriate treatment if indicated. Staff members who are suspended related to abuse allegations will be reviewed by the corporate clinical consultant, corporate director of operations and corporate human resources director prior to being reinstated into the workplace to ensure the alleged deficient practice does not reoccur. <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> A CQI audit tool will be utilized to audit allegations of abuse to ensure the facility enacts all the necessary steps of investigation conducted daily, when allegation occurs, by the Clinical Specialist for 30 days and at the end of the 30 days the frequency will be continued until compliance is 100% and then performed monthly by the CS or Designee monthly to total 12 months. The Clinical Specialist or Designee will conduct weekly QA audit by randomly interviewing a minimum of 5 staff members weekly for 4 weeks and the results will be discussed with the director of clinical services to determine the ongoing frequency into the next 90 days to ensure staff are complying and</p>				

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	<p>that he had maybe touched her breast during care due to lotion, showering and etc. The DNS indicated this resident had stiffness due to cerebral palsy, and was big-busted. Her breasts would have to be touched somewhat on the side when doing a transfer.</p> <p>The DNS indicated she had not felt the resident was alleging abuse, and had not perceived it as an allegation of abuse.</p> <p>On 2/25/14, the Executive Director provided written information which was used at a staff inservice on 12/4/13. The training was titled "Recognizing Abuse" and included a large group activity with "situation cards." One of the cards addressed "Uninvited contact with genitalia. Anyone-staff, family, other residents who touch who (sic) without permission or inappropriately, including during personal care...."</p> <p>The DNS had attended the inservice.</p> <p>An undated policy, titled "Reportable Policy and Procedure," indicated the following:</p> <p>"...(Name of Corporation) expects</p>		<p>understand and can identify abuse situations. The Administrator or designee will audit all allegations of abuse five times per week x 30 days, to monitor for comprehensive and complete investigation. This audit will continue weekly for duration of 12 months. Any concerns will be addressed. The QIS abuse questionnaire will be integrated into the facility routine customer service/care program and utilized monthly with residents to create an environment of freedom to report potential abuse without the fear of retaliation. This QIS abuse tool will be performed on at least 10 residents with a BIMS of 10 or higher monthly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. <b>V. Plan of Correction completion date.</b> Plan of Correction date is April 3rd, 2014.</p>				

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	<p>that employees will immediately report the following incidents to their administrative staff and administrative staff (sic) will immediately report the following incidents to the Indiana State Department of Health and any other official(s) according to (Name of Corporation) policy:</p> <p>1. Any/all alleged violation involving mistreatment, neglect or abuse...Physical abuse (State and Federal mandate) includes, but is not limited to, staff to resident abuse with or without injury...Sexual abuse...includes staff to resident...NO staff to resident sexual acts are considered consensual and therefore prohibited at all times...</p> <p>V. ABUSE INVESTIGATIONS...1. Should an incident or suspected incident of resident abuse, neglect or injury of unknown source be reported, the administrator or his/her designee, will appoint a member of management to investigate the alleged incident. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident</p>				

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F000242 SS=D	<p>when applicable:</p> <p>a. The State licensing/certification agency responsible for surveying/licensing the facility immediately...ADMINISTRATOR...It is the responsibility of our employees, facility consultants, attending physicians, family member, visitors, etc. to immediately report any incident or suspected incident of neglect or resident abuse...to the Administrator or designee if the Administrator is unavailable...</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview, and record review, the facility failed to honor a resident's choice for the number of baths per week, for 1 of 2 residents reviewed for bathing choices. (Resident #45).</p>	F000242	<b>F242 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #45 is being offered a shower/bath per her preferred time. The C.N.A.</b>	04/03/2014			

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	<p>Findings include:</p> <p>During an interview on 2/25/2014 at 9:51 A.M., Resident #45 indicated she did not choose how many baths or showers a week she received. She indicated, "They tell you 2 times per week you get a shower." She indicated she would like 3 showers per week.</p> <p>During an interview on 2/27/2014 at 11 A.M., LPN #3 indicated the resident's shower preferences were asked upon admission. She indicated she did not routinely ask about whether the shower schedules were working for the residents.</p> <p>Resident #45's Annual Minimum Data Set (MDS) assessment dated 7/29/2013, under daily preferences indicated, the resident felt it was very important for her to choose between a tub bath, shower, bed bath or a sponge bath.</p> <p>Record review on 2/27/2014 at 11:10 A.M., of the CNA work sheet indicated Resident #45 was scheduled to receive a shower on Tuesdays and Fridays on the day shift.</p>		<p>assignment sheets were updated to reflect the resident's time preference. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Resident's residing in the facility had the potential to be affected. The facility has completed an audit of current residents to determine their choice of shower / bath and preferred bathing times. C.N.A. assignment sheets were updated to reflect the preferences of shower / bath and preferred bathing times. <b>III. The facility will put into place the following systematic changes to ensure that deficient practice does not recur.</b> New admissions will be interviewed upon admission to determine their choice of shower / bath and preferred bathing time. Nursing personnel were re-educated on the importance of giving choice of a bath / shower, preferred bathing times and following the C.N.A. assignment sheets. New nursing personnel will be educated on the importance of giving resident's choice of a bath / shower and preferred time of day. Resident preferences will be discussed during MDS assessment periods and during resident Care Plans, updating the C.N.A. assignment sheets as needed. Resident preferences will be discussed during Resident Council Meetings and the information will presented to the appropriate Department for</p>				

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	3.1-3(u)(1)		<p>follow up. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> The DON or designee will audit new admissions for bathing preferences 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. Results of audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is April 3rd, 2014.</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a Care Plan addressing impaired vision for 2 of 3 residents reviewed for impaired vision (Residents #18 and #144)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #144 was reviewed on 3/3/14 at 11:09 A.M. Diagnoses included, but were not limited to, after-care for non-surgical repair of a left femur fracture, muscle weakness, history</p>	F000279	<p><b>F279 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #144 care plan has been updated to reflect resident's poor vision. Resident #18 care plan has been updated to address the resident's problem of moderately impaired vision with specific approaches to intervene and assist the resident with his impaired vision. <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Resident with poor and/or impaired vision could be affected.</p>	04/03/2014			

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	<p>acute pain from trauma, anxiety state, senile dementia, and depressive disorder.</p> <p>The Admission MDS (Minimum Data Set) assessment, dated 10/17/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "10" (a score of 8-12 indicating moderately impaired cognition); and impaired vision with corrective lenses.</p> <p>The CAA (Care Area Assessment) summary indicated the resident had "Vision--Balance problems exacerbated by vision problem; increased risk for falls due to vision problems or due to bi- or tri-focal's [glasses]. Impaired vision per MDS interview. She does wear glasses. Unknown when her last eye exam was completed. She does not receive eye medications. No redness, drainage or swelling noted. Assisted with daily activities as needed. Proceed to Care Plan. Will refer to physician as needed."</p> <p>The Quarterly MDS, dated 1/13/14, indicated the resident had a BIMS score of "15" (a score of 13-15 indicating intact cognition); and impaired vision with no corrective lenses.</p>		<p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> IDT/MDS Staff were re-educated on the development of comprehensive care plans. IDT/MDS associates have been provided education on the requirement to update the care plan for any residents who have poor and /or impaired vision and/or when the intervention in place needs to be changed for more appropriate care and treatment of a resident. Care plans are reviewed and revised, upon admission, quarterly, with significant changes, or as needed to ensure they reflect the resident's individualized plan of care. <b>IV The facility will monitor the corrective action by implementing the following measures.</b> The DON or designee will audit new admissions for care plans for residents with poor and/or impaired vision 3 times a week for 4 weeks, weekly times 4 weeks, monthly times 1 month then quarterly thereafter for a total of 12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date</b> Plan of Completion date is April 3rd, 2014.</p>				

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	<p>The resident had signed a consent to receive services from the facility consultant eye doctor, which was not dated by the resident, but with a FAX date of 10/16/13.</p> <p>A "MDS Nursing Assessment" form, dated 11/18/13 indicated "Adequate vision with corrective lenses."</p> <p>A "MDS Nursing Assessment" form, dated 1/13/14, indicated "Impaired [vision]--sees large print, but not regular print. No corrective lenses."</p> <p>No Care Plan related to the resident's poor vision was found.</p> <p>On 3/3/14 at 1:38 P.M., the Consultant Nurse Specialist indicated the MDS Coordinator completed the CAAs, and "everyone" did the Care Plans. She was given the opportunity to submit any documentation related to care planning for the poor vision for Resident #144.</p> <p>On 3/3/14 at 9:00 A.M. and 1:12 P.M., the resident was observed in her room. She had a pair of glasses on, and was reading some printed material.</p>						

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	<p>In an interview on 3/4/14 at 10:30 A.M., the Consultant Nurse Specialist indicated they could not find a Care Plan for the resident's vision. She indicated the resident had just seen the optometrist last week. A copy of the Consultant Optometrist visit was provided, and was dated 2/28/14.</p> <p>2. Resident #18's record was reviewed on 2/27/14 at 9:04 A.M. Diagnoses included, but were not limited to, lack of coordination, hemiplegia left side, difficulty in walking and muscle weakness.</p> <p>The resident's Quarterly Minimum Data Set (MDS) Assessment dated 12/18/13 indicated the resident's vision was moderately impaired ("limited vision, not able to see headlines, but can identify objects"). The resident did not have any corrective lenses.</p> <p>There was no Care Plan found to address the resident's problem of moderately impaired vision with specific approaches to intervene and assist the resident with his impaired vision.</p> <p>During an interview on 3/4/14 at 12:00 P.M., the MDS Consultant indicated the MDS department was</p>			

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F000282 SS=D	<p>responsible for initiating the Care Plan for the Care Area Assessments (CAA's) and the Care Plan had not been initiated.</p> <p>3.1-35(b)(1)</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.</p> <p>2. The record for Resident C was reviewed on 2/27/14 at 10 A.M. Diagnoses included, but were not limited to, metastatic renal cancer with brain and lung metastases, anxiety, arthritis, asthma, depression, and diabetes.</p> <p>The Admission MDS (Minimum Data</p>	F000282	<p><b>F282 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident C's call light was placed immediately by staff member Resident B's alarm box was reconnected immediately by staff member Resident B's straw was removed from bedside</p>	04/03/2014
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	<p>Set) Assessment, dated 11/20/13, indicated the resident had a fall in the last 2-6 months prior to admission. The most recent assessment, dated 2/13/14, indicated no changes.</p> <p>Progress notes included the following:</p> <p>1/4/14--The resident was indicated to be high risk for falls. New immediate intervention was placed, call light on transfer bar where resident can see it.</p> <p>2/13/14-The resident was indicated to have a high fall risk score of 14.</p> <p>A Care Plan entry, dated 11/14/13, addressed a problem of falls. Interventions included the following: "...Keep personal items and frequently used items within reach; keep call light within reach at all times...."</p> <p>A Care Plan entry, dated 11/14/13, addressed a problem of "...Resident is unable to complete ADL's independently due to weakness, renal cell carcinoma with metastases, pain, dizziness, diabetes, neuropathy, restless leg syndrome, anemia." Approach</p>		<p>cup Resident B's did not receive any other candy M&amp;M's Resident B's assignment sheet was reviewed and updated with any new information <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents that utilize call light for assistance, have an alarm, or use special utensils are potentially at risk by the alleged deficient practice <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Facility staff will be re-educated on call light placement Nursing staff will be re-educated on alarm attachment and function Nursing staff will be re-educated on providing resident with diet per order/plan of care Nursing staff will be re-educated on following plan of care/assignment sheet Resident care plans will be reviewed for interventions upon admission, quarterly, with significant change, and as needed <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> The DON or designee will audit perform random audits of residents for call light placement, alarm attachment/function, proper diet, and assignment sheet interventions weekly for 4 weeks, monthly x 2 months, then quarterly thereafter for a total of</p>		

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	<p>included "Keep call light within reach...."</p> <p>On 2/28/14 at 1:57 P.M., the resident was observed laying in bed. The call light was not within her reach at that time.</p> <p>On 2/26/14 at 9:26 A.M., the resident was observed laying in bed. In an interview at that time, she indicated she needed to use the restroom, but did not know where her call light was. The call light was observed to be lying on her recliner chair and out of her reach.</p> <p>In an interview on 2/26/14 at 9:30 A.M., CNA #4 indicated the call light should have been on the bed instead of on the arm of the recliner.</p> <p>This Federal tag related to Complaint IN00142676.</p> <p>3.1-35(g)(2)</p> <p>Based on observation, interview and record review the facility failed to</p>		<p>12 months. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b> Plan of Completion date is April 3rd, 2014.</p>		

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	<p>follow Care Plan interventions for 2 of 4 residents considered at risk for falls and failed to follow Care Plan interventions and Physician's orders for 1 of 6 residents reviewed for hydration and nutrition, in a sample of 35 residents reviewed. (Residents B and C)</p> <p>Findings include:</p> <p>1. Resident B's record was reviewed on 2/28/14 at 1:10 P.M. Diagnoses included, but were not limited to, hemiplegia affected dominant side left, tremor, convulsions, subdural hemorrhage with craniotomy, history of personal falls, abnormal posture, history of poliomyelitis, dysphagia, asphasia, hand contracture and cerebrovascular disease.</p> <p>The resident had a Care Plan dated 1/12/12, that addressed a problem that he was at risk for falling related to a history of falls, CVA, history of Polio, weakness and left hemiplegia. The interventions included, but were not limited to, "... 9/25/12-Observe frequently and place in supervised area when out of bed... 2/29/12-Personal alarms on bed and wheelchair...."</p>			

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	<p>The resident had a Care Plan dated 1/12/12 that addressed a problem the resident is at risk for aspiration due to a recent cerebrovascular accident (stroke). The interventions included, but were not limited to, "2/29/12--Ensure resident has proper adaptive equipment at meal times...1/12/12--No straws...."</p> <p>A medication list dated March 2014 indicated Physician orders included, but were not limited to the following: 1/13/12-"Pressure pad alarm to be on at all times when in wheelchair. Check every shift for working condition".</p> <p>A document titled, "CNA Sheet 2 of 3" indicated the resident was a fall risk and he was to have a wheelchair alarm.</p> <p>A. On 3/1/14 at 5:07 P.M., Resident B was observed sitting in his wheelchair in the main dining room without his alarm wire being connected into the alarm box on the back of his wheelchair. The cord with the connector was dangling down behind the wheelchair seat back. The blue light on the alarm box was not blinking to indicate that it was on and functioning properly.</p>			

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	<p>On 3/1/14 from 6:40 P.M., to 6:55 P.M., the resident was sitting in front of the East 100 nurses station. There was no facility staff in the area during this time and the alarm box wire remained unconnected.</p> <p>During an interview on 3/1/14 at 7:00 P.M., the Director of Nursing indicated the resident's alarm wire was not connected into the alarm box on the resident's wheelchair. She connected the connector into the alarm box and the blue light started blinking and she indicated the wheelchair alarm was functioning properly.</p> <p>B. On 02/28/14 at 2:31 P.M., no water was observed on Resident B's bedside stand.</p> <p>On 02/28/14 at 5:10 P.M., no water was observed on the resident's bedside stand.</p> <p>On 03/1/14 at 4:45 P.M., the resident had a Styrofoam cup 3/4 full of water without ice with a straw in the cup sitting on his bedside stand.</p> <p>A "Physician's Order Report" dated 11/28/13 to 2/28/14 indicated the resident's Physician's orders included, but were not limited to the</p>			

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	<p>following: 2/19/14-Pureed diet with no straws</p> <p>A document titled, "CNA Sheet 2 of 3" indicated the resident was at risk for aspiration (food or fluids were accidentally swallowed into the lungs), choking and no straws. .</p> <p>A "Dehydration Assessment" dated 1/29/14 indicated the resident's risk factors for dehydration were functional impairment, which prevents independent access to fluids and he used diuretics and/or laxatives and he was at risk for dehydration.</p> <p>During an interview on 2/28/14 at 5:12 P.M., LPN #2 indicated the resident was to have water at his bedside to drink.</p> <p>During an interview on 3/1/14 at 7:00 P.M., the Director of Nursing indicated the resident was not to have a straws in his drinks.</p> <p>C. On 02/28/14 at 2:31 P.M., multi-colored round M &amp; M candy pieces was observed in a small white stryofoam cup, which was 1/2 full sitting on Resident #B's bedside stand.</p>				

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	<p>On 02/28/14 at 5:00 P.M., the resident was observed in the main dining room eating multi-colored round M &amp; M candy pieces from a small white Styrofoam cup that was 1/4 full of candy pieces.</p> <p>On 3/1/14 at 5:37 P.M., the resident was served his pureed food on a divided plate with a regular spoon. His meal ticket had a date of 3/1/14 with dinner at the top of the ticket and it indicated he was to have a divided plate and left handed adaptive utensils.</p> <p>On 3/1/14 at 5:48 P.M., the resident was given left handed built up utensils at this time.</p> <p>A "Physician's Order Report" dated 11/28/13 to 2/28/14, indicated the resident's Physician's orders included, but were not limited to the following: 2/19/14-Pureed diet with no straws</p> <p>A "Nutritional Assessment" dated 2/4/14, indicated the resident used a divided plate and angled utensils for assistance to eat.</p> <p>During an interview on 2/28/14 at 5:12 P.M., LPN #2 indicated the resident was on a pureed diet and</p>			

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F000314 SS=D	<p>he was not suppose to be eating M &amp; M candies.</p> <p>During an interview on 3/4/14 at 1:54 P.M., LPN #13 indicated the resident used curved built up utensils in his left hand due to hand weakness.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to ensure pressure ulcers were identified, assessed, prevented, and treatment administered, for 2 of 4 residents reviewed for pressure ulcers. (Residents #74 and #76)</p> <p>Findings include:</p> <p>1. Resident #76's record was reviewed on 2/28/14 at 9:32 A.M. The resident was admitted on 10/18/13 with diagnoses that included, but were not limited to,</p>	F000314	<p><b>F314 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #74 no longer resides in the community Resident#76 no longer resides in the community <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents admitted with pressure ulcers or are at risk for pressure ulcers could be affected. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not</b></p>	04/03/2014	

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	<p>diabetes type II, pressure ulcer coccyx, clostridium difficile enteritis, end stage cardiovascular disease, muscle weakness and anemia.</p> <p>A medication list for October 2013 indicated the resident's Physician's orders included, but were not limited to the following:                      10/21/13-Cleanse coccyx with Normal Saline then apply a thin layer of Hydrogel (water based gel to keep the wound moist) to the coccyx wound daily then cover with a pad. (Discontinued 10/22/13)                      10/22/13-Apply skin prep (Skin protective barrier wipes) to eschar (brown or black hard tissue covering a wound) on the coccyx. (Discontinued on 10/22/13)                      10/22/13-Santyl (Debridement medication) 250 unit/gram. Apply nickel thick amount topically to coccyx and buttocks wound after cleansing the areas with Normal Saline then apply a dry dressing daily. (Discontinued on 10/27/13)                      10/27/13-Santyl 250 unit/gram. Apply nickel thick amount topically to coccyx and buttocks wound after cleansing with normal saline. Apply dry dressing every shift and change as needed for soilage. (Discontinue 10/28/13)                      10/28/13-Cleanse right buttock and</p>		<p><b>recur.</b> Licensed Nurses will be re-educated on appropriate documentation and assessments of wounds upon admission                      Licensed Nurses will be re-educated on entering admission treatment orders into matrix upon admission                      Licensed Nurses will be re-educated on obtaining and entering treatment order upon identification of a wound.  <b>IV The facility will monitor the corrective action by implementing the following measures.</b> DON or designee will audit new admissions with pressure ulcers and residents with new pressure ulcers for documentation, assessment, and treatment weekly for 4 weeks, then monthly 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the rounds will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>V. Plan of Correction completion date.</b> Plan of Completion date is April 3rd, 2014.</p>		

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	<p>coccyx area with Normal Saline and pat dry. Apply Silvasorb (An Antimicrobial medication to prevent infection) then cover the wound with a foam dressing and secure the dressing every shift and as needed.</p> <p>No Physician's orders were found to treat the coccyx or right buttock wounds from 10/18/13 to 10/21/13.</p> <p>The resident's "Admission/Readmission Nursing Assessment" dated 10/18/13 indicated she had redness to the right side of her back, both legs, tops of her feet and an open area to her coccyx.</p> <p>The "Medicare A" documentation dated for 10/19/13 indicated the resident's skin was warm and dry, but no documentation was found to indicated there was an open area to the coccyx or right buttock.</p> <p>The "Medicare A" documentation dated for 10/20/13 indicated the resident's skin was warm and dry, but no documentation was found to indicated there was an open area to the coccyx or right buttock.</p> <p>The "Medicare A" documentation dated for 10/21/13 indicated the</p>			

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	<p>resident's skin was warm and dry, but no documentation was found to indicated there was an open area to the coccyx or right buttock.</p> <p>The "Skin Integrity Events--Pressure Sore/Stasis Ulcer" Evaluation document dated 10/21/13, indicated the resident had an unstageable (unable to determine the stage of the ulcer due to it was covered with yellow or black tissue and the true depth of the ulcer cannot be determined) pressure ulcer to her mid coccyx area. The wound measured 3.0 x 2.6 cm (centimeters). The wound bed was covered with necrotic (dead tissue) eschar. The eschar to the wound was 60% with a small amount of bloody drainage. The wound had scant (very little) to moderate serosanguineous (watery bloody) exudate(drainage).</p> <p>The "Skin Integrity Events--Pressure Sore/Stasis Ulcer" Evaluation document indicated the resident dated 10/22/13, indicated the resident had an unstageable right buttock pressure ulcer to her right buttock. The wound measured 0.9 x 0.8 cm. The wound bed was covered with 40% eschar with a small amount of blood drainage.</p>			

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	<p>The wound had a scant amount of serosanguineous exudate.</p> <p>The "Skin--Pressure Ulcer Evaluation" dated 10/28/13, indicated the pressure ulcer to the coccyx was present on admission to the facility. The date of onset for the wound was 10/18/13 and the wound was unstageable.</p> <p>The "Skin--Pressure Ulcer Evaluation" dated 10/28/13, indicated the pressure ulcer to the right buttock was present on admission to the facility. The date of onset for the wound was 10/18/13 and the wound was unstageable.</p> <p>No measurements or assessment was found for 10/18/13 for the resident's pressure area to her coccyx or right buttock wounds.</p> <p>During an interview on 2/28/14 at 5:30 P.M., the Clinical Nurse Consultant indicated she expected the nurses to measure and assess a resident's wounds upon admission. She indicated she had started as the Clinical Nurse Consultant in December and she was aware there was problems with the wound documentation.</p>						

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	<p>During an interview on 3/3/14 at 4:25 P.M., the Director of Nursing indicated the admitting nurse should complete the assessment of a resident's wounds and document the assessment the day of the admission to the facility.</p> <p>During an interview on 3/3/14 at 4:45 P.M., LPN #12 indicated she did not know if the resident's wounds had gotten worse from 10/18/13, when she was admitted, until the wounds were measured for the first time since the wounds were not measured on the day of admission.</p> <p>2. In an interview on 2/24/14 at 1:35 P.M., LPN # 3 indicated Resident #74 had a Stage II pressure ulcer on her left buttock, which was acquired in-house on 1/16/14.</p> <p>The record for Resident #74 was reviewed on 2/27/14 at 10 A.M. Diagnoses included, but were not limited to, metastatic renal cancer with brain and lung metastases, anxiety, arthritis, asthma, depression, and diabetes.</p> <p>The resident's weight on admission 11/13/13 was 175 pounds. On 2/5/14 her weight was 161.7 The resident experienced a 13 pounds/7.6% weight loss over 84</p>			

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	<p>days.</p> <p>"Weekly Skin Assessment" forms were completed weekly by different nursing staff, and had information documented as follows:</p> <p>12/5/13--"...Description: Friction area to upper right buttock...Interventions: Cleansed with soap and water, topical ointment..."</p> <p>12/17/13--"Patient has a pink area of shiring [sic] skin or right buttock..."</p> <p>12/24/13--Friction area to right buttock.</p> <p>1/14/14--Skin was dry, warm and intact. There was a friction area to upper buttock.</p> <p>1/21/14--The resident's skin was assessed as "Moisture Associated Skin Damage."</p> <p>2/4/14 and 2/11/14- --The resident's skin was assessed as "Moisture Associated Skin Damage."</p> <p>2/18/14--"Moisture Associated Skin Damage."</p> <p>2/25/14----The resident's skin was assessed as "Moisture Associated</p>			

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	<p><b>Skin Damage" with superficial open areas to right and left buttocks.</b></p> <p>The Wound Nurse progress notes varied from the nursing skin assessments and included the following:</p> <p>1/16/14--Open area right buttock, Wound Nurse to assess weekly. 1.5 cm. (centimeters) by 1 cm by less than 0.1 cm. Stage II pressure.</p> <p>1/22/14--Right gluteal Stage II pressure ulcer. 1.5 cm by 1 cm.</p> <p>1/29/14--Right gluteal, Stage II pressure. 1.3 cm by 0.8 cm.</p> <p>2/5/14--Right gluteal Stage II, 1 cm by 0.8 cm.</p> <p>2/12/14--Right gluteal, Stage II pressure. 1.3 cm by 1 cm. Area deteriorated. Physician and family notified..</p> <p>(No date)--Right gluteal, Stage II 0.8 cm. by 0.6 cm.</p> <p>2/19/14--Left gluteal, Stage II pressure; onset date of 2/12/14. 0.6 cm by 0.6 cm.</p> <p>2/26/14--Left gluteal, Stage II</p>			

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	<p>pressure 0.4 cm. by 0.3 cm. Right gluteal Stage II, 0.5 cm. by 0.3 cm.</p> <p>Physician's orders for January, 2014 included the following:</p> <p>1/15-1/19/14 -Derma Septin (menthol zinc oxide OTC ointment 0.5-20.65%) apply thin layer as needed for bottom.</p> <p>1/19/14-2/12/14--Derma Septin (menthol zinc oxide OTC ointment 0.5-20.65% apply thin layer. To be applied each shift for the right buttock open area.</p> <p>On 3/4/14 at 12:13 P.M., the Assistant Director of Nursing provided a timeline for the pressure sore. The timeline indicated the resident had a friction area to right buttock on 12/5/13. An order for treatment was not written at that time. She indicated application of a topical ointment would be documented in the progress notes.</p> <p>The progress notes from November, 2013 through February, 2014 had only one entry regarding application of Dermaseptine (a house stocked barrier creme).</p> <p>On 3/4/14 at 11:40 A.M., the</p>						

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	<p>resident's left and right gluteal wound was observed. The wound on the left gluteal was not open and was slightly larger than an eraser tip. The right gluteal wound was open, and pinkish-red and beefy in appearance with no slough, and was also slightly larger than an eraser tip. The ADON cleansed the wound with normal saline, applied the Vasolex ointment via a cotton swab, and covered with foam padding and secured in place.</p> <p>The policy, dated 4/2011 and titled "Skin Care and Pressure/Non Pressure Ulcer Management Program," indicated "...There are certain clinical conditions along with limited mobility that may contribute to the development of pressure ulcers...8. Terminal cancer...Risk Interventions...Vitamins and mineral supplements per physician order...Assessment and Documentation When assessing a wound and documenting findings, include the following factors, -Classification by degree of tissue layer destruction known as staging, -Anatomic location, -Size that includes length, width, depth, and tunneling, using centimeters as consistent units of measurement. Appearance of the wound bed and</p>			

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F000323 SS=D	<p>surrounding skin- Drainage, specifying amount, color and odor. -Pain, tenderness or warmth to touch may indicate infection...Assessment frequency: Consistency is very important...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to ensure fall precaution interventions were implemented for 1 of 4 residents reviewed for Accidents. (Resident B)</p> <p>Findings include:  On 3/1/14 at 5:07 P.M., Resident B was observed sitting in his wheelchair in the main dining room without his alarm wire being connected into the alarm box on the</p>	F000323	<p><b>F323 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident B has an alarm box on his wheelchair that is attached to a pressure sensing pad. The DON immediately connected the alarm box. Resident B now has an alarm on his bed and wheelchair to prevent the alarm not being connected to alarm box when transferring the alarm with the resident. <b>II. The facility will identify other residents that may potentially</b></p>	04/03/2014			

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	<p>back of his wheelchair. The cord with the connector was dangling down behind the wheelchair seat back. The blue light on the alarm box was not blinking to indicate that it was on and functioning properly.</p> <p>On 3/1/14 from 6:40 P.M., to 6:55 P.M., the resident was sitting in front of the East 100 nurses station. There was no facility staff in the area during this time and the alarm box wire remained unconnected.</p> <p>Resident #B's record was reviewed on 2/28/14 at 1:10 P.M. Diagnoses included, but were not limited to, hemiplegia affected dominant side left, tremor, convulsions, subdural hemorrhage with craniotomy, history of personal falls, abnormal posture, history of poliomyelitis and cerebrovascular disease.</p> <p>A medication list dated March 2014 indicated Physician orders included, but were not limited to the following: 1/13/12-"Pressure pad alarm to be on at all times when in wheelchair. Check every shift for working condition."</p> <p>The resident had a Care Plan dated 1/12/12, that addressed a problem that he was at risk for falling related</p>		<p><b>be affected by the deficient practice.</b> Residents with a sensor alarm/alarm box could be affected by the alleged deficient practice. <b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b> Nursing staff will be re-educated on following nurse aide assignment sheets. Nursing staff will be re-educated on attaching sensor alarms/alarm box <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> Unit manager/designee will conduct walking rounds to audit alarms in place three times a week for 4 weeks, weekly for 4 weeks then monthly thereafter for a total of 12 months. Any identified concerns from the rounds will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b> Plan of completion date is April 3rd, 2014</p>				

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	<p>to a history of falls, CVA, history of Polio, weakness and left hemiplegia. The interventions included, but were not limited to, "... 9/25/12-Observe frequently and place in supervised area when out of bed... 2/29/12-Personal alarms on bed and wheelchair...."</p> <p>A document titled, "CNA Sheet 2 of 3" indicated the resident was a fall risk and he was to have a wheelchair alarm.</p> <p>A "Fall Event" dated 3/18/13 at 6:00 A.M., that indicated the resident had an unwitnessed fall beside his bed. He had been up in his room in his wheelchair. There were no injuries. The fall risk score after the fall was a 10, which indicated he was a high risk for falls.</p> <p>A "Fall Event" dated 5/20/13 at 10:30 A.M., indicated the resident had a witnessed fall in the main dining room. He was attending a music program and he fell asleep and fell out of his wheelchair. He had a right hand skin tear that measured 1.5 x 2.9 x 0.1 cm (centimeters) and steri strips were applied. He also had a right forehead hematoma (large hard knot full of blood) that measured 3.5</p>			

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	<p>x 2.8 x 0 cm. His fall risk score was 10, which indicated he was a high risk for falls.</p> <p>A "Fall Event" dated 5/30/13 at 11:10 A.M., indicated the resident had a witnessed fall in the hallway. He was sitting in his wheelchair and fell out onto the floor. He had a bruise to the right side of his forehead that measured 3.0 x 2.5 cm and a skin tear proximal to his left elbow that measured 2.1 x 1.5 cm, which was closed with steri strips. He also had a skin tear to his left wrist that measured 2.0 x 0.4 cm, and three lacerations. The resident had two lacerations to the bridge of his nose and required 3 sutures. The upper laceration measured 1.5 x 0.1 cm and the lower nose laceration measured 0.5 x 0.1 cm. He had a laceration to the right upper lip that measured 1.0 x 0.3 cm. His fall risk score after this fall was 12, which indicated he was a high fall risk. The resident was sent to the hospital for evaluation and treatment.</p> <p>A current policy titled, "Fall Management Program" provided by the Executive Director on 3/3/14 at 12:30 P.M., indicated "Purpose: To reduce the number of falls and</p>						

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	<p>minimize injuries related to falls...A score of 10 or above on the fall risk assessment places the resident at a high risk for falls and high risk fall precautions may be initiated. The following interventions may be considered...Chair Alarms..."</p> <p>During an interview on 3/1/14 at 7:00 P.M., the Director of Nursing indicated the resident's alarm wire was not connected into the alarm box on the resident's wheelchair. She connected the connector into the alarm box and the blue light started blinking and she indicated the wheelchair alarm was functioning properly.</p> <p>This Federal tag related to Complaint IN00142676.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure specific behaviors were identified and quantitatively monitored to support the use of psychotropic medications. This deficient practice affected 5 of 5 residents reviewed for Unnecessary Medications. (Residents #65, #87, #2, #93 and #145).</p> <p>Findings include:</p>	F000329	<p><b>F329</b></p> <p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #65 antipsychotic,</p>	04/03/2014			

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	<p>1. Resident #65's record was reviewed on 2/28/2014 at 11:00 A.M. Diagnoses included, but were not limited to, dementia with behavior disturbance, depressive disorder, insomnia, Alzheimer's disease and debility.</p> <p>The physician's order recapitulation for February 2014 indicated the resident's medications included, but were not limited to, the following:</p> <p>9/3/2013 -- Lorazepam (anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day.</p> <p>9/3/2013 -- Seroquel (anti-psychotic medication) 100 mg by mouth once a day.</p> <p>9/3/2013 -- Trazodone (anti-depressant medication) 50 mg by mouth at bedtime.</p> <p>9/3/2013 -- Zoloft (anti-depressant medication) 50 mg by mouth once a day.</p> <p>10/5/2013 -- Seroquel 25 mg by mouth once a day.</p> <p>In an interview on 2/28/2014 at 10:35 A.M., the Social Service Director (SSD) indicated at this time the behavior management program consists of a behavior sheet, that anyone in the staff can fill out, if the resident has a behavior.</p>		<p>antidepressant, and antianxiety medication were reviewed and targeted behaviors have been identified per the plan of care.</p> <p>Resident #87 antidepressants were reviewed and targeted behaviors have been identified per the plan of care.</p> <p>Resident #2 antipsychotics, antianxiety, and antidepressants were reviewed by attending physician. GDR was not recommended due to the diagnoses of senile psychosis and attending physician stating that resident #2 'is stable and is doing the best he has seen her do in years.' Physician will consult with community psychiatrist for further recommendations. Targeted behaviors have been identified per the plan of care.</p> <p>Resident #93 antipsychotics and antidepressants were reviewed by attending physician. GDR was not recommended due to diagnoses of senile dementia with delusions, depressive disorder and recent episodes of psychosis (delusions and paranoia), cannot rule out delirium etiology. Targeted behaviors have been identified per the plan of care</p>				

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	<p>On 2/28/2014 at 2:40 P.M., the SSD provided a list of the residents that have been monitored for behaviors in the past 6 months. Resident #65's name was not on the list.</p> <p>On 3/3/2014 at 3:45 P.M., the SSD provided the resident's progress notes that included notes from 5/3/2013 to 3/3/2014. He highlighted entries that he indicated were related to behavior episodes.</p> <p>Highlighted entries included the following:</p> <p>5/3/2013 1:03 P.M., -- "Since current psychotic sx (symptoms) are distressing for her, will do trial with Seroquel 25 mg PO (by mouth) q1700 (every day at 5:00 P.M.). F/u ( follow up) at next visit."</p> <p>5/16/2013 2:23 P.M., -- "Tolerating Seroquel with improvement in psychotic sx's. F/u prn (as needed)."</p> <p>7/30/2013 9:48 A.M., --"Increased confusion appears related to dementia progression ...."</p> <p>9/16/2013 3:26 P.M., --"[Resident #65 / first name of resident's]</p>		<p>Resident #145 antidepressant/antianxiety were reviewed by attending physician. Targeted behaviors have been identified per the plan of care.</p> <p><b>II. The facility will identify other residents that my potentially be affected by the deficient practice.</b></p> <p>Residents currently receiving antipsychotic, antidepressant, and/or antianxiety medications could be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>IDT team will be re-educated on the Behavior Management Program by Clinical Specialist</p> <p>Facility staff will be re-educated</p>	

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	<p>lethargy and slurred speech has decrease since the reduction of Seroquel ...."</p> <p>11/15/2013 1:40 P.M., -- " The Psychiatrist visited on 10/18/13, stating that resident is having 'further dementia progression'. "</p> <p>There were no specific behaviors that were identified and quantitatively monitored to support the use of psychotropic medications for this resident.</p> <p>2. Resident #87's record was reviewed on 2/28/2014 at 9:50 A.M. Diagnoses included, but were not limited to, dementia, hypertension, depressive disorder, insomnia, and sleep apnea.</p> <p>The physician's order recapitulation for February 2014 indicated the resident's medications included, but were not limited to, the following:</p> <p>11/17/2013 -- Trazodone tablet 50 mg; 1/2 tablet by mouth at bedtime 1/7/2014 -- Celexa (anti-depressant medication) 10 mg by mouth once a day</p> <p>No individualized behavior monitoring was found for this</p>		<p>on the behavior program</p> <p>All residents currently in the facility and receiving antipsychotics, antidepressants, and/or antianxiety medications will be reviewed by the physician for a potential GDR.</p> <p>All residents currently in the facility and receiving antipsychotics, antidepressants, and/or antianxiety medications will have targeted behaviors reviewed and identified and updated to the plan of care.</p> <p>The Social Service Director and/or her designee will maintain a log of all antipsychotics, antidepressant, and antianxiety medications being used within the facility with order date, diagnosis for use, and gradual dose reduction history. The log will be updated and discussed monthly at facility behavior management meeting.</p> <p><b>IV. The facility will monitor the</b></p>				

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	<p>resident. A care plan dated 11/11/13 was found but it did not include the specifics of the medication being used or the behaviors or symptoms the resident was to be monitored for.</p> <p>The care plan indicated the following: "Resident #87 has diagnosis of depression which requires the use of antidepressant. The medication (name of medication) is being used to treat the diagnosis (diagnosis) and the targeted symptoms of (list behaviors resident is / has demonstrated)" The goal: " the resident will use the lowest possible dose of antidepressant while maintaining the highest practical level of psychosocial well being."</p> <p>No individualized behavior monitoring was found for this resident nor specific behaviors this resident demonstrated when they were depressed.</p> <p>3. The clinical record for Resident #2 was reviewed on 2/28/14 at 9:27 A.M. Diagnoses included, but were not limited to, pain in limb/chronic</p>		<p><b>corrective action by implement the following measures.</b></p> <p>The Social Service Director or designee will audit documentation and care plans on residents receiving antipsychotics, antianxiety, and antidepressant medication, with emphasis on an adequate indication for the use of the medication and targeted behaviors weekly x 4 weeks, and monthly thereafter.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Correction date is April 3rd, 2014.</p>		

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	<p>pain syndrome, osteoarthritis, chronic kidney disease, cerebrovascular disease, chronic obstructive pulmonary disease, anxiety state, depressive disorder, chronic frontal lobe syndrome, aphasia, and psychosis. A description of how the psychosis was displayed by this resident was not found.</p> <p>An Annual MDS (Minimum Data Set) assessment, dated 12/3/13, indicated the resident had a BIMS (Brief Interview for Mental Status) scored of "01" (with a score of 0-7 indicating severe cognitive impairment); had some indicators for Mood (trouble sleeping, feeling tired); had no indicators of psychosis, and had no behaviors. The MDS indicated the resident was receiving antipsychotic, antianxiety and antidepressant medications.</p> <p>A Quarterly MDS, dated 12/27/13, indicated the resident had a BIMS score of "00", had no indicators of psychosis, had no behaviors; and was receiving the antipsychotic, antianxiety, and antidepressant medications.</p> <p>A Quarterly MDS, dated as "in process" on 2/24/14, indicated the</p>				

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	<p>resident had a BIMS score of "02"; had one indicator of Mood (feeling down, depressed); had no indicators of psychosis, and had no behaviors.</p> <p>The CAA (Care Area Assessment) Summary, dated 12/3/13, indicated the following for "Mood State"--"no psychosocial changes in indicators of mood; resident has DX [diagnosis]: transient insomnia and senile psychosis which seem to be a major contributing factor in her mood.</p> <p>There was no CAA for "Behaviors"</p> <p>Current physician orders included, but were not limited to, the following: 2/18/13, with reorder date of 8/11/13 for same dosage --Clorazepate Dipotassium (Tranzene--an antianxiety medication) 3.75 mg. (milligrams)--one tablet orally twice a day. 12/27/12, with a reorder date of 8/11/13 for the same dosage-- -Duloxetine (Cymbalta--an antidepressant medication) Delayed Release 30 mg.--one capsule orally twice a day. 5/14/13, with a reorder date 8/11/13 for the same dosage--Olanzapine (Zyprexa Zydis--an antipsychotic medication) 10 mg.--one tablet orally</p>				

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	<p>at bedtime. 5/14/13, with a reorder date of 8/11/13 for the same dosage- -Olanzapine (Zyprexa Zydis) 5 mg.- -one tablet orally once a morning.</p> <p>A progress note, dated 12/18/13, 2:12 P.M., indicated "MD [Medical Doctor] in and does not want a GDR [Gradual Dose Reduction] on Cymbalta. He stated that 'she is doing the best in the past year'."</p> <p>A progress note, dated 2/27/14 at 9:15 A.M., indicated "Spoke with MD via telephone today regarding a GDR for antipsychotic medications due to diagnosis of senile psychosis. MD does not want a GDR at this time. He stated that resident is 'stable' and is doing the best he has seen her do in years. MD stated that he will document this next time he is in facility."</p> <p>In an interview on 2/28/14 at 2:57 P.M., LPN #11 indicated the facility had just changed the system to monitor behaviors. She indicated she would like to have the Social Service Director explain behavior management system.</p> <p>In an interview 2/28/14 at 3:00 P.M., the Social Service Director indicated</p>						

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	<p>he reviewed all of the "Events" computer entries and progress notes daily for general issues for all residents, and then would narrow his focus to review any behavior issues. He indicated he also reviewed any paper "Behavior" report forms that had been completed. The Social Service Director provided a copy of the "New or Worsening Behavior Report" form, and indicated any staff person could fill one out when they observed a resident displaying a behavior episode. He indicated he did not summarize, or otherwise track, the specific behaviors or the number of episodes displayed. He indicated episodes of behaviors would be documented in the progress notes in the computer system.</p> <p>On 3/3/14, the Social Service Director provided copies of progress notes for Resident #2, from 1/10/13 through 2/27/14. He indicated he had high-lighted the entries related to the behaviors displayed by Resident #2. The high-lighted entries from 4/16/13 indicated the following:</p> <p>4/16/13--"Behavior Meeting; in 90 day review, [resident's name] had 5 incidents socially inappropriate</p>						

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	<p>behaviors, 3 incidents of physical aggression, 2 incidents of verbal aggression, 2 episodes of delusions, and 2 incidents of choosing NOT to allow staff to care for her at times. Nursing indicated she was started on Zyprexa. [resident's name] is paranoid at times..."</p> <p>4/17/13--"Displayed behaviors on 4/14/13 on disconnecting the wheelchair and bed mobility alarms. Later that day, was berating other residents...."</p> <p>5/16/13--"Dr. [facility Consultant Psychiatrist] here to see [resident's name] and the following is the treatment plan: Continues to have episodes of psychosis (paranoia) despite Zyprexa Zydis. Increase on 5/2/12... Likely current URI [upper respiratory infection] is exacerbating symptoms."</p> <p>5/22/13--"[resident's name] had displayed behaviors on 5/2/13 of yelling and having delusions thoughts that staff was talking about her. Resident threw coffee mug...."</p> <p>6/4/13--"Dr. [facility Consultant Psychiatrist] here to see [resident's name] on 5/31/13 and the following is the treatment plan: Tolerating</p>						

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	<p>increase in Zyprexa, SSD [Social Service Director] reports improvement in paranoid delusions."</p> <p>7/8/13--"Behavior meeting on 7/5/13. In a 90 day review, [resident's name] had 1 incident of physical aggression and 1 episode of delusions...."</p> <p>10/17/13--"[resident's name] participated in the Annual MDS interview. Resident was frequently nonsensical with responses...."</p> <p>Quantitative monitoring of specific behaviors to support the use of the psychotropic medications this resident was receiving, in order to determine effectiveness and track progress toward a therapeutic goal, was not found.</p> <p>4. The clinical record for Resident #93 was reviewed on 2/28/14 at 2:38 P.M. The resident was readmitted to the facility on 12/13/13, following an acute care hospital stay. Diagnoses included, but were not limited to, hypoxemia, pneumonia, congestive heart failure, ischemic heart disease, dementia without behavior, non-organic psychosis, senile dementia with delusions, and depressive disorder.</p>						

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	<p>Quarterly MDS (Minimum Data Set) assessments, dated 10/16/13 and 1/8/14, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "02" (with a score of 0-7 indicating severe cognitive impairment); no indicators of psychosis, and no behaviors.</p> <p>Current physician orders included, but were not limited to, the following:</p> <p>12/13/13--Citalopram (Celexa--an antidepressant medication) 20 mg. (milligrams), one tablet by mouth once a day. Prior to the December 2013 hospital admission, a previous order was dated 3/21/13 for same dosage of 20 mg. daily.</p> <p>12/13/13--Mirtazapine (Remeron--an antidepressant medication) 15 mg., one tablet by mouth once a day. Prior to the December hospital admission, a previous order was dated 6/10/13 for same dosage of 15 mg. at bedtime.</p> <p>12/13/13--Olanzapine (Zyprexa--an antipsychotic medication) 5 mg. one by mouth once a day. Prior to the December hospital admission, two previous orders were dated 8/7/13 for Zyprexa 2.5 mg. 1 po BID (twice</p>			

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	<p>a day) PRN (as needed); and 8/7/13 for Zyprexa Zydys 5 mg. once a day.</p> <p>The facility Consultant Psychiatrist progress notes included the following:</p> <p>8/7/13--"Senile dementia (by history), likely Alzheimer type with depression and delusions; R/O [rule out] delirium. GDR [Gradual Dose Reduction] not indicated at this time. TREATMENT PLAN--recent episodes of psychosis (delusions and paranoia), cannot rule out delirium etiology. UA, C&amp;S [urinalysis with culture and sensitivity] results pending. 1. Zyprexa 2.5 mg. po BID PRN [as needed] psychosis/agitation, time limited for 2 weeks."</p> <p>8/23/13--"UM [Unit Manager] reports resident continues to have wandering and exit-seeking behaviors. Staff report resident continually thinks she has to go someplace. Res. talked about feeling her mind is wandering and that she thinks she does things she wouldn't normally do. States she knows her father has been gone a long time but she still sometimes thinks he is still living. States she sometimes sees people (relative).</p>				

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	<p>Appears anxious and distressed about decreasing mental faculties. Current meds--Remeron, Celexa. TREATMENT PLAN--1. Will schedule Zyprexa Zydys 5 mg. This is not for wandering or exit seeking behaviors since these are symptoms that are inherit (sic) with dementia. The purpose of starting Zyprexa is due to perceptual disturbances (visual hallucinations) and delusions (psychosis) that are distressing to the resident."</p> <p>9/10/13--"Continue current dosage of Zyprexa Zydys. Delusions of believing people who have passed are still alive, are common in patient with dementia. As long as resident is not very distressed about this would not recommend further titration of dose."</p> <p>There were no further psychiatric visits documented following the 9/10/13 note.</p> <p>In an interview on 2/28/14 at 2:57 P.M., LPN #11 indicated the facility had just changed the system to monitor behaviors. She indicated she would like to have the Social Service Director explain behavior management system.</p>			

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	<p>In an interview 2/28/14 at 3:00 P.M., the Social Service Director indicated he reviewed all of the "Events" computer entries and progress notes daily for general issues for all residents, and then would narrow his focus to review any behavior issues. He indicated he also reviewed any paper "Behavior" report forms that had been completed. The Social Service Director provided a copy of the "New or Worsening Behavior Report" form, and indicated any staff person could fill one out when they observed a resident displaying a behavior episode. He indicated he did not summarize, or otherwise track, the specific behaviors or the number of episodes displayed. He indicated episodes of behaviors would be documented in the progress notes in the computer system.</p> <p>On 3/3/14, the Social Service Director provided copies of progress notes for Resident #93, from 12/10/12 through 1/22/14. He indicated he had high-lighted the entries related to the behaviors displayed by Resident #2. The high-lighted entries from 3/4/13 indicated the following:</p> <p>3/4/13--"...Resident had behaviors</p>						

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	<p>on 1/29 and 1/20/13 of hallucinating. At that time, [resident's name] thought that children were in her room during the night and on the 20th, resident thought she was peeling potatoes while in bed...."</p> <p>8/2/13--[resident's name] followed a housekeeper out of the building on 7/29/13 [and returned immediately to building]... Generally very pleasant, sweet-natured... Can become fixated on needing to 'go home.'"</p> <p>8/7/13--"Dr. [facility Consultant Psychiatrist] visited on 8/6/13 and the following is his treatment plan: recent episodes of psychosis (delusions and paranoia), cannot rule out delirium etiology. UA and C&amp;S [urinalysis and culture &amp; sensitivity) results pending. Zyprexa 2.5 mg. by mouth twice a day PRN [as needed] psychosis/agitation, time limited for 2 weeks."</p> <p>8/12/13--"...[resident's name] has displayed behaviors of exiting the facility, on 7/29 and 8/3/13 times 2. At those times, the resident had exited when employees had left the building and the door had not locked. [resident's name] was observed by the door and returned to the facility... On 8/7/13, Dr.</p>			

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	<p>[Consultant Psychiatrist] evaluated [resident] and stated that recent episodes of psychosis (delusions/paranoia) --cannot rule out delirium etiology...."</p> <p>8/25/13--The progress note listed the information from the Consultant Psychiatrist's visit on 8/23/13.</p> <p>8/26/13--[resident's name] completed the interview for the Annual assessment on 8/26/13. [resident's name] told this writer that her mother and father are still alive. This writer asked how old her parents are now. [Resident] said 'Oh, I guess in their 90's.' [Resident] was then asked how old she is. [Resident] had SSD [Social Service Director] subtract her birth year from this year. When told that, that would make [Resident] 95; resident said 'Well, I guess they (parents) aren't alive'. [Resident] was not upset...."</p> <p>1/22/14--"...During this interview resident smiled at writer and said 'You must be my Mother-In-Law'...."</p> <p>Quantitative monitoring of specific behaviors to support the use of the psychotropic medications this resident was receiving, in order to determine effectiveness and track</p>			

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	<p>progress toward a therapeutic goal, was not found.</p> <p>5. Resident #145's record was reviewed on 3/3/14 at 4:21 P.M. Diagnoses included, but were not limited to, abnormal posture, muscle weakness, hemiplegia nondominant side left, paralysis agitans, anxiety state, depressive disorder, and cerebrovascular disease right basal ganglia.</p> <p>A medication list for March 2014 indicated Physician's orders included, but were not limited to the following: 01/09/14-Alprazolam (An anti-anxiety medication) 0.5 mg. (milligrams) by mouth twice a day 01/09/14-Trazadone (An antidepressant medication) 50 mg. by mouth every bedtime</p> <p>The resident had a Care Plan date 2/26/14, that addressed a problem that she received Alprazolam due to anxiety. The interventions included, but were not limited to, "2/26/14-Administer medication as ordered and record, Monitor for drug use effectiveness and adverse consequences, and Monitor resident's mood and response to</p>						

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	<p>medication..."</p> <p>The resident had a Care Plan dated 2/26/14, that addressed a problem that she had a diagnosis of insomnia and required Trazadone. The interventions included, but were not limited to, "2/26/14-Monitor for side effects to this medication and document...Provide medication as ordered"</p> <p>On 3/4/14, the Social Services Director (SSD) provided copies of Psychiatric progress notes for Resident #145 from 1/9/14 to 2/25/14. He indicated he had highlighted the entries to the behaviors displayed by Resident #145. The behaviors from the progress notes included, but were not limited to the following:</p> <p>1/9/14-"...She had talked at length about frustrations and concerns about her finances...States she is so frustrated she does not know what to do...States currently she gets more stressed every day. Poor sleep at night due to worry and pain in her shoulder..."</p> <p>2/25/14-"...Discussed the feelings of being overwhelmed and feeling out of control...Discussed the concept of</p>						

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	<p>a worry box to help at night time. [Placing ruminating worries there to "set aside" while she sleeps]...Discussed relaxation exercised and imagery to help with night time anxiety..."</p> <p>On 3/4/14, the SSD provided copies of progress notes for Resident #145 from 1/9/14 to 3/4/14. He indicated he had highlighted the entries to the behaviors displayed by Resident #145. The following behaviors from the progress notes included, but were not limited to the following:</p> <p>1/20/14-"...Resident's name mood issues revolve around concern for her husband and her own medical condition...."</p> <p>2/3/14-"...Resident has mood issues due to recent CVA, husband's battle with Pancreatic Cancer and recent death...."</p> <p>2/17/14-"...New dx [diagnosis] of Insomnia added for Trazodone."</p> <p>2/19/14-"...she felt that she couldn't cope with all the things going on with her right now. She expressed some sadness over the recent loss of her husband, her financial concerns and what was going to happen if she</p>						

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	<p>could not afford to stay here until she got better and if the doctor..."</p> <p>2/27/14-...that is a great burden off my mind."</p> <p>During an interview on 3/4/14 at 12:30 P.M., the SSD indicated he did not have specific targeted behaviors that he had been monitoring the resident for her Alprazolam and Trazadone. He indicated he had some progress notes written by a Physician, but there were no targeted behaviors the staff was monitoring the resident for.</p> <p>3.1-48(a)(3)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to</p>	F000441	F441			04/03/2014	

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	<p>ensure 2 of 3 licensed nurses performed proper handwashing and proper sanitization of a glucometer, to prevent the possibility of cross contamination during blood glucose testing, for 2 of 3 residents reviewed for blood glucose testing and 1 of 25 residents observed for medication observation. (RN #1 and LPN #2; Residents #29 and #32 )</p> <p>Findings include:</p> <p>1. On 3/3/14 at 4:43 P.M., R.N. #1 was observed while performing a finger-stick blood glucose test for Resident #29. The nurse gathered her supplies and the glucometer, and placed them on the bare top of her medication cart without a barrier. After she entered the resident's room, she laid her supplies on the bedside table without a barrier. She donned clean gloves, removed a reagent strip from a multi-strip container, and placed it into the glucometer. After she cleansed and lanced the resident's finger, she obtained the sample of blood onto the reagent strip. She placed the glucometer on the bedside table. She cleansed the resident's finger, and cleaned the area of trash and sharps, and placed into a plastic cup which she disposed of in the sharps</p>		<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #29 clinical record was reviewed and no negative outcomes were noted.</p> <p>Resident #32 clinical record was reviewed and no negative outcomes were noted.</p> <p>RN #1 were re-educated regarding the proper procedure for hand hygiene and glucose blood monitoring equipment procedure guidelines.</p> <p>LPN #2 were re-educated regarding the proper procedure for hand hygiene and glucose blood monitoring equipment procedure guidelines.</p> <p><b>II. The facility will identify other residents that may potentially be affected by the</b></p>				

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	<p>container. She removed her gloves and washed her hands.</p> <p>In an interview following the procedure, RN #1 indicated she did not know she was supposed to use a barrier under supplies when checking blood glucose.</p> <p>2. On 3/3/14 at 4:17 P.M., LPN #2 was observed while performing a finger-stick blood glucose for Resident #32. LPN # 2 gathered her supplies and glucometer and placed them on the bare top of her medication cart without a barrier. After she entered the resident's room she placed her clip board down on the bed with the glucometer on top of plastic bag and her supplies. She donned clean gloves , then she removed a reagent strip from a multi-strip container, and placed it into the glucometer. After she cleansed and lanced the resident's finger, she obtained the sample of blood onto the reagent strip. She placed the glucometer on the bedside table. She cleansed the resident's finger, and cleaned the area of trash and sharps which she disposed of in the sharps container. She removed her gloves and placed into the trash basket. She sanitized the glucometer with "PDI Bleach</p>		<p><b>deficient practice.</b></p> <p>Residents who receive blood glucose monitoring could be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Licensed nursing staff will be re-educated on hand hygiene and blood glucose monitoring equipment procedure guidelines to prevent cross contamination.</p> <p>Licensed nursing associated will continue to receive education on hand hygiene and blood glucose monitoring equipment procedure guidelines during initial orientation and as needed.</p> <p><b>IV The facility will monitor the corrective action by implementing the following</b></p>				

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NAME OF PROVIDER OR SUPPLIER  HARBOUR MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 SHERIDAN RD NOBLESVILLE, IN 46060		
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	<p>Wipe," for 30 seconds, and then set it on top of a plastic bag to dry.</p> <p>Instructions on the "PDI Bleach Wipe Disinfect" container indicated, "...surface must remain visibly wet for 4 minutes...."</p> <p>LPN #2 then prepared the resident's medications. The nurse touched the medication cart, the pitcher of water, and the resident and then went back to her cart and signed medications off in the computer. LPN # 2 did not sanitize or wash her hands in between resident blood glucose check and passing of medication.</p> <p>In an interview at 4:30 P.M., LPN # 2 indicated she had not washed her hands and that she forgets to do that sometimes.</p> <p>3. The "Blood Sampling-Capillary (Finger Sticks)" policy, dated 2001, indicated: "...1. Wash hands. 2. Don gloves. 3. Place blood glucose monitoring device on clean field...7. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use...9. Wash hands...."</p> <p>The "Handwashing/Hand Hygiene"</p>		<p><b>measures.</b></p> <p>Staff Development Coordinator or designee will audit by observation of blood glucose testing rotating shifts 3 times per week for 4 weeks, then weekly for one month, then monthly for a total of 12 months. Any identified concerns from the audits will be addressed immediately.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is April 3rd, 2014.</p>		

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R000000	<p>policy, dated April 2010, indicated, "...5. Employees must wash their hands for at least twenty -20 seconds using antimicrobial or non-anti-microbial soap and water under the following conditions:...d. Before and after performing any invasive procedure (e.g., fingerstick blood sampling)...."</p> <p>3.1-18(l)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>March 25th, 2014 Kim Rhoades, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on March 4th, 2014. This letter is to inform you that the plan of correction attached is to serve as Harbour Manor Health and Living's credible allegation of compliance. We are also respectfully requesting a desk review as the follow up to Plan of Correction We request the desk review based on the corrections, changes and audit</p>	

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			tools made by this facility listed below: 1. F225,F226 Abuse Reporting Pre Test-Post Test 2. F225, F226 Abuse Prevention Policy 3. F225, F226 Reportable Policy and Procedure 4. F225, F226 Abuse Investigation Checklist 5. F225, F226 Abuse Resident-Responsible Party Interview 6. F225, F226 Abuse Education 7. F225, F226 Incident Reporting Audit Tool 8. F225, F226 Staff Abuse Interviews 9. F242 Personal Preference Interview-Test 10. F242 Bathing Preference Form 11. F242 Personal Preference Audit Tool 12. F279 Vision Care Plan Audit Tool 13. F279 Vision Care Plan In-service-Test 14. F282, F323 In-service-Test 15. F282, F323 Rounding Audit Tool 16. F314 Wound Documentation In-service-Test 17. F314 Pressure Wound Audit Tool 18. F329 Behavior Management In-service 19. F329 Behavior Management Program 20. F329 Medication Management Meetings 21. F329 New or Worsening Behavior Event Form 22. F329 Behavior Management Team Assignments 23. F441 Handwashing Policy 24. F441 Handwashing Skills Check 25. F441 Blood Glucose Policy 26. F441 Blood Glucose Skills Check We ask the division to review our plan of correction and our corrections, changes, audit tools and education logs, in our effort to meet the expectations of	

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			making our facility 100% compliant in, meeting the plan of correction and holding all areas from the 2567. We do want to continue to improve in our documentation and with the new corrections, changes in audit tools and education; we believe we will continue to move forward in giving our residents the care that they so deserve. Respectfully, Justin P. Vogt, H.F.A., Executive Director Harbour Manor Health and Living & The Lodge	

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure that a minimum of 1 staff person was available on-site at all times who had current certification in both CPR (Cardio-Pulmonary Resuscitation) and First Aid. This deficiency had the potential to impact 48 of 48 residents residing in the Residential facility.</p> <p>Findings include:</p>	R000117	<p><b>R117 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> No residents were adversely affected by the practice  <b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Current residents could be potentially be affected by the practice.  <b>III. The facility will put into place the following systematic changes to ensure</b></p>	04/03/2014			

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	<p>Following the entrance conference on 2/24/14, the Executive Director provided the completed "Employee Records" forms, listing all employees working in the facility campus.</p> <p>Copies of the wallet cards issued for current certification in CPR were found in the License Log binders for 7 licensed or certified nursing staff in the Health Care building, and 4 licensed nursing staff in the Residential building.</p> <p>None of the employees certified in CPR had documentation of certification in basic First Aid.</p> <p>On 3/4/14 at 1:45 P.M., the Director of Nursing Services and the Consultant Nurse Specialist were requested to provide any documentation related to employees who would be certified for both CPR and basic First Aid.</p> <p>In an interview on 3/4/14 at 3:00 P.M., the Director of Nursing Services indicated she had checked, and found that the certification program for CPR did not include training in basic First Aid.</p>		<p><b>that the deficient practice does not recur.</b> Licensed nursing personnel in the Assisted Living will become first aid and CPR certified. <b>IV. The facility will monitor the corrective action by implementing the following measures.</b> Facility will off first aid and CPR training and certification annually to licensed nursing personnel. Upon hire new licensed personnel will submit a copy of their first aid and CPR certification. If new employees have not received first aid training they will be signed up for earliest certification class upon hire. <b>V. Plan of Correction completion date.</b> Plan of Correction date is April 3, 2014</p>	
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