

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey-immediate jeopardy.</p> <p>This visit was in conjunction with the investigation of complaint #IN00116282.</p> <p>Survey dates: September 19, 20, 21, 24, 25, and 26, 2012 Extended survey dates: September 27 and 28, 2012</p> <p>Facility number: 000009 Provider number: 155022 AIM number: 100274760</p> <p>Survey team: Karina Gates, BHS TC Courtney Mujic, RN Beth Walsh, RN</p> <p>Census bed type: SNF/NF: 90 Total: 90</p> <p>Census payor type: Medicare: 12 Medicaid: 61 Other: 17 Total: 90</p>	F0000	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State law.	

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

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 10/5/12 Cathy Emswiller RN</p>				

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F0156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>			

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure a Medicare beneficiary resident was notified timely of the end date of coverage of her skilled nursing services and the potential liability amount for those non covered services. This affected 1 of 3 Medicare beneficiaries who were reviewed for appropriate liability and appeal notices. (Resident #26)</p> <p>Findings include:</p> <p>The Notice of Medicare Non-Coverage for Resident #26 was provided by Medical Records/Central Supply on 9/28/12 at 11:30 a.m. The notice indicated, "The Effective Date of Your Current Skilled Nursing Services Will End: July 26, 2012".</p>	F0156	<p>Corrective action addresses resident 26. On the ISDH 2567 there is a reference to a resident 20 which is not listed on the Stage 2 Sample Resident List so it is felt that resident 20 is actually resident 26. The corrective action will also address all residents with the potential of being affected by this finding. Resident 26 had not received the referenced Denial of Coverage letter (attachment 10) indicated in this finding due to resident 26 Medicare replacement insurance provider not having notified facility of non-coverage until after coverage had ended making it impossible to have sent the denial of coverage notice in advance of coverage ending. Once insurer provided dates of coverage, the denial of coverage letter was then prepared and sent. The billing office and medical records are coordinating anticipated dates of</p>	09/28/2012

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	<p>The notice was not signed by the patient or representative. A written note on the bottom of the notice indicated, "Unable to talk to (name of Family Member #1) 8-7-12. ? telephone # for (name of Family Member #2) Talked to (name of Family Member #3) 8-8-12 11:15 a.m. then talked to (name of Family Member #2)".</p> <p>During an interview with Medical Records/Central Supply on 9/26/12 at 12:52 p.m., she indicated she issued the above notice on 8/7/12 indicating services would end on 7/26/12 and that she didn't put the potential liability amount because she did not know what the amount was.</p> <p>3.1-4(f)(3)</p>		<p>non-coverage with the therapy department and MDS Coordinator daily. Denial of coverage letters are being sent between 2-5 days prior to end of Medicare/Medicare Replacement coverage. Medical records is including on the Denial of Coverage letter the liability amount provided by the billing specialist. Medical Records maintains a "In & Out" tracking form that reflects date for admissions, discharges, and pay status change. This form identifies each resident who is eligible to receive a Denial of Coverage letter. A separate list is maintained to show date of level of care change and date Denial of Coverage letter was sent to resident and or responsible party. Medical Records can compare the In & Out tracking form (attachment 11) with the Level of Care change list (attachment 12) to confirm those eligible have received the Denial of Coverage letter. On review there were no instances found where a letter failed to be sent when required. Any issues identified will be corrected immediately, recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring. The process for monitoring and tracking Denial of Coverage Letters being provided to residents and or legal representative as required will be ongoing.</p>		

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F0167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interview, the facility failed to ensure survey results were located in a manner readily accessible to residents. This deficient practice had the potential to affect 90 of 90 residents residing in the facility. (Resident #49)</p> <p>Findings include:</p> <p>An interview with Resident #49 was conducted on 9/27/12 at 10:35 a.m. He indicated he was unaware of the location of the most recent survey results.</p> <p>An observation was made on 9/27/12 at 11:00 a.m. of a sign posted in the main hallway of the facility indicating that survey results were posted in the hallway at the business office. Upon observation of the business office on</p>	F0167	<p>Corrective action will address all residents with the potential of being affected by this finding. The stated location for the survey results was available to the general public and residents. The location in the lobby of the business office where the survey results were available, had remained unchanged for several years without previously being identified as a concern. As a result of this finding the binder containing the survey results has been relocated to the resident library which is centrally located in the facility and accessible to residents. The new location is posted and will be reviewed with the neighborhood (resident) council. An additional copy of the survey results will be located at the Heritage Haven (memory care unit) and will be available to all residents. The dual locations will provide a copy of survey results to all residents without requiring pass through the memory care unit in order to access the</p>	10/01/2012			

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	<p>9/27/12 at 11:03 a.m., the survey results were, in fact, located there. To reach the business office from the location in the facility in which Resident #49 and sixty-four other residents resided, one must go through a set of locked doors leading into the dementia unit, through the dementia unit, out another set of locked doors, and turn left down a hallway. Both sets of locked doors had a keypad and required a code to open. All 25 residents on the dementia unit must go through the second set of locked doors to reach the location of the survey results.</p> <p>3.1-3(b)(1)</p>		<p>results. Administrator will monitor survey results availability and that the results are updated in accordance with requirement. This process will be monitored and reviewed in the facility QA meetings with any new recommendations implemented.</p>	

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F0174 SS=E	<p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on record review, interview, and observation, the facility failed to provide a telephone for private usage for 1 of 3 residents reviewed for privacy. This had the potential to affect 90 of 90 residents living in the facility. (Resident #99.)</p> <p>Findings include:</p> <p>Clinical record reviewed on 9/26/12 at 11:20 a.m. Diagnoses included but were not limited to; hypoglycemia, hypertension, hypothyroidism.</p> <p>Interview with Resident #99's family member on 9/21/2012 at 1:00 pm indicated the resident is capable of conversing on the phone but cannot do so without being overheard. "They don't have phones in the rooms."</p> <p>Interview with RN #3 on 9/26/2012 at 1:00 pm indicated there is a phone residents can use in private located in the library. She was unaware of any admission orientation related to phone usage. To use the phone on</p>	F0174	<p>Corrective action will address all residents with the potential of being affected by this finding. A phone for resident use has been placed in a small lounge area accessible to residents at Five Points neighborhood which is identified by signage. The designated area can be used privately and the phone does not require an access code or special function in order to place a call. Room is available to residents 24 hours, 7 days a week. The dementia care unit has access to a cordless phone that can be made available on request and has less potential for misuse by a dementia resident. Residents will be informed on admission of location for phone access. Neighborhood (resident) council meeting currently and annually will include notification to residents of phone placement and availability. The administrator will monitor phone access and any issues will be reviewed in the facility QA meeting.</p>	10/01/2012	

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	<p>the unit, where Resident #99 lives, means that she would have to come up to the nursing station and ask. Its not cordless, so the resident would have to sit next to the counter.</p> <p>Observation of the library on the main hallway on 9/26/2012 at 1:14 pm indicated there is no phone available for use in the library.</p> <p>Interview with the Administrator on 9/26/2012 at 3:23 pm indicated a resident would have to ask a staff member to use an office phone for privacy, there are none available in any common areas. Otherwise, they can use the phone up at the nurses station. There used to be a phone available in the activity room but he had to remove it because a couple of residents were racking up high long distance phone bills.</p> <p>3.1-3(p)(3)</p>			

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F0225 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>	F0225	Corrective action will address all	10/15/2012			

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	<p>Based on record review and interview the facility failed to immediately report allegations of abuse to the facility Administrator for 1 of 3 incidents reviewed for abuse. (Resident #106.)</p> <p>Findings include:</p> <p>Resident #106's record was reviewed on 9/26/2012 at 2:10 p.m. Diagnoses included but not limited to; acute pyelonephritis (kidney infection,) dehydration, severe debility, congestive heart failure. Date admitted to facility was 8/17/12, and discharged from facility on 8/24/2012.</p> <p>Interview with the Administrator (ADM) on 9/26/2012 at 2:50 pm indicated the staffing coordinator was the one who was notified of an issue concerning Resident #106's care, she did the initial report on the concern. The staffing coordinator was made aware of a complaint from a family friend regarding an allegation of potential abuse of Resident #106 on a Friday night, after the ADM had left for the day. Actual statements from staff began on Monday. On Monday they established that nothing was matching up, the complaint could not be substantiated. The staffing coordinator should have called the Director of Nursing or the ADM</p>		<p>residents with the potential of being affected by this finding. Resident 106 referenced in this finding is no longer a patient of this facility. Administrator on 8/27/2012 completed one on one education with the Staffing Coordinator to the facility abuse prohibition process and reporting requirements. All on call staff were reeducated to abuse prohibition and reporting. Education included that Administrator will be notified of potential abuse allegation reports immediately. In-servicing provided to all staff at least annually was repeated on 10/15/12 for Resident Abuse Prohibition. The in-service includes a review of the facility policy for Abuse Prohibition and importance of timely notification to Administrator and DON. New employees are oriented on hire, to the facility abuse prohibition policy (attachment 13) with signed acknowledgment of understanding. A QA review of past allegations and potentially reportable incidents did reflect administrator was notified immediately and timely. Administrator does monitor each allegation for compliance and will continue to direct investigations as required. State survey and certification agency notification will be made by administrator or designee as applicable and within reporting requirements. Any issues identified will be corrected immediately,</p>		

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	<p>immediately. The ADM was first made aware of the incident on Monday morning.</p> <p>Interview with the Staffing Coordinator on 9/27/12 at 10:52 a.m. indicated, "One of the nurses on evening shift was talked to by the son of the resident (on the phone) and the nurse reported it to the Staffing Coordinator. She (the Staffing Coordinator) had the nurse write everything down on a form called the 'report of concern.' On the following Monday she came in and talked to ADM and told him about it and started investigating. She felt it was okay to wait until the weekend was over because she knew the staff members involved in the allegation were off until Monday. She is aware of the policy for reporting suspicions of abuse, she should have called ADM right away. She felt like she was doing the right thing at the time, she felt like she was helping out the Director of Nursing (since she was home sick.) She would definitely immediately report to ADM in the future if this happened again. She feels all the staff now know the policy to immediately report allegations of abuse.</p> <p>An investigative report titled, 'report of concern', dated 8/24/2012, indicated,</p>		<p>recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring. This process will be monitored on an ongoing basis.</p>		

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	<p>"Staff involved in Resident #106's care off on 8/25/2012 and 8/26/2012." Investigations were dated 8/27/2012.</p> <p>A policy titled 'Abuse Prohibition, Reporting, and Investigation', was provided by the ADM on 9/26/2012 at 3:15 pm indicated, "3. Heritage House has policies and procedures in place that ensures 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."</p> <p>3.1-28(a)</p>			

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F0226 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 record review and interview the facility failed to implement their policy in regard to immediately reporting allegations of abuse to the facility Administrator for 1 of 3 incidents reviewed for abuse. (Resident #106.)</p> <p>Findings include:</p> <p>Resident #106's record was reviewed on 9/26/2012 at 2:10 p.m. Diagnoses included but not limited to; acute pyelonephritis (kidney infection,) dehydration, severe debility, congestive heart failure. Date admitted to facility was 8/17/12, and discharged from facility on 8/24/2012.</p> <p>Interview with the Administrator (ADM) on 9/26/2012 at 2:50 pm indicated the staffing coordinator was the one who was notified of an issue concerning Resident #106's care, she did the initial report on the concern. The staffing coordinator was made aware of a complaint from a family</p>	F0226	<p>Corrective action will address all residents with the potential of being affected by this finding. Resident 106 referenced in this finding is no longer a patient of this facility. Administrator on 8/27/2012 completed one on one education with the Staffing Coordinator to the facility abuse prohibition process and reporting requirements. All on call staff were reeducated to abuse prohibition and reporting. Education included that Administrator will be notified of potential abuse allegation reports immediately. In-servicing is provided to all staff at least annually was repeated on 10/15/12 for Resident Abuse Prohibition. The in-service includes a review of the facility policy for Abuse Prohibition and importance of timely notification to Administrator and DON. New employees are oriented on hire to the facility abuse prohibition policy (attachment 13) with signed acknowledgment of understanding. A QA review of past allegations and potentially reportable incidents did reflect administrator was notified immediately and timely.</p>	10/15/2012			

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	<p>friend regarding an allegation of potential abuse of Resident #106 on a Friday night, after the ADM had left for the day. Actual statements from staff began on Monday. On Monday they established that nothing was matching up, the complaint could not be substantiated. The staffing coordinator should have called the Director of Nursing or the ADM immediately. The ADM was first made aware of the incident on Monday morning.</p> <p>Interview with the Staffing Coordinator on 9/27/12 at 10:52 a.m. indicated, "One of the nurses on evening shift was talked to by the son of the resident (on the phone) and the nurse reported it to the Staffing Coordinator. She (the Staffing Coordinator) had the nurse write everything down on a form called the 'report of concern.' On the following Monday she came in and talked to ADM and told him about it and started investigating. She felt it was okay to wait until the weekend was over because she knew the staff members involved in the allegation were off until Monday. She is aware of the policy for reporting suspicions of abuse, she should have called ADM right away. She felt like she was doing the right thing at the time, she felt like she was helping out the</p>		<p>Administrator does monitor each allegation for compliance and will continue to direct investigations as required. State survey and certification agency notification will be made by administrator or designee as applicable and within reporting requirements. Any issues identified will be corrected immediately, recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring. This process will be monitored on an ongoing basis.</p>		

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	<p>Director of Nursing (since she was home sick.) She would definitely immediately report to ADM in the future if this happened again. She feels all the staff now know the policy to immediately report allegations of abuse.</p> <p>An investigative report titled, 'report of concern', dated 8/24/2012, indicated, "Staff involved in Resident #106's care off on 8/25/2012 and 8/26/2012." Investigations were dated 8/27/2012.</p> <p>A policy titled 'Abuse Prohibition, Reporting, and Investigation', was provided by the ADM on 9/26/2012 at 3:15 pm indicated, "3. Heritage House has policies and procedures in place that ensures 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...4. Heritage House has policies and procedures in place that alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress."</p> <p>3.1-28(a)</p>				

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F0242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure a resident was provided a shower and hair washing as preferred and failed to assess a resident's bathing preference for 2 of 3 residents reviewed who met the criteria for choices. (Resident #86 and 99)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #86 was reviewed on 9/25/12 at 10:00 a.m.</p> <p>An interview with Resident #86 was conducted on 9/21/12 at 10:03 a.m. regarding whether or not she chose how many times a week she took a shower or bath. Resident #86 indicated she did not choose how many times she received a shower and only had one good shower in the month of September.</p>	F0242	<p>A further investigation for resident 86 indicated she had received showers and shampoo by preference and as requested, however staff did not code the care appropriately on the ADL form to support the care given. Nursing staff was in-serviced on 10/10/12 and instructed how to properly code shower and shampoo care for all residents when completed. Resident 99 who has a diagnosis of altered mental status and early cognitive decline vs dementia, and has had the option available for a tub bath but she repeatedly refused when offered giving various reasons for refusal. Resident will state tub bath preference and time of day but has either changed mind or refused when staff attempt to provide. Tub bathing remains available to all residents when they indicate this as a preference. Staff will continue to offer the tub bath option and C.N.A. assignment sheets will be updated to reflect most current preferences stated. For non-interviewable residents, the family</p>	10/15/2012			

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	<p>The CNA (Certified Nursing Assistant) assignment sheet indicated Resident #86 was to receive showers twice weekly on Wednesday and Saturday evenings. It indicated her hair was to be shampooed at the beauty shop as needed.</p> <p>The 7/19/11 ADL (activities of daily living) care plan, reviewed 8/3/12, indicated Resident #86 needed assistance with showers.</p> <p>During an interview on 9/25/12 at 10:45 a.m. with Resident #86 and LPN #2, Resident #86 indicated she only had one shower and hair washing since she'd been on her current unit, the dementia unit. She indicated she would like her hair washed at least once a week and a shower twice a week.</p> <p>During an interview with the Unit Coordinator at 10:54 a.m. on 9/25/12, she indicated Resident #86 should be going to the beauty shop once a week and getting her hair washed.</p> <p>The ADL book indicated a shower and shampoo was given on 9/16/12. No other shower or shampoo was indicated as given for Resident #86 in the month of September, 2012.</p>		<p>and or responsible party will be asked if a bathing preference for resident is known. The stated bathing preference will be honored when determined safe given the residents physical and mental status. If the bathing choice is found to result in behavioral or safety concerns, an alternative bathing method will be utilized for the overall wellbeing of the resident. On 10/12/12 all residents were re-interviewed to determine their most current bathing preferences. Only one resident stated a tub bath preference and the assignment sheet was updated to reflect their choice. An in-service conducted on 10/15/12 on Resident Rights reinforces the importance for resident preferences in their daily care and choices. Resident rights and their ability to make choices in their daily care will be reviewed in the next neighborhood council meeting and annually thereafter. The C.N.A. assignment sheets will be monitored for QA by DON weekly x 4 weeks for completeness. On admission resident and or legal representative are asked bathing preference using Neighbor Preference for Bathing form with information collected then indicated on C.N.A. Assignment sheet. On an ongoing basis assignment sheets will be updated to reflect changes in care and stated resident preferences.</p>				

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	<p>The Unit Coordinator provided 2 shower sheets for Resident #86. One was dated 9/16/12 and indicated a shower was given and hair was washed. The other shower sheet was dated 9/19/12 and indicated a shower was given and that the beauty shop was responsible for hair. No other shower sheets were provided for the month of September, 2012.</p> <p>During an interview with Accounts Receivable Staff Member on 9/25/12 at 11:42 a.m., she indicated there were beauty shop charges for Resident #86 for 9/17/12 only and there were no other charges during the month for her. She indicated, if Resident #86 got her hair washed at the beauty shop, there would be a separate charge.</p> <p>During another interview with LPN #2 on 9/25/12 at 12:40 p.m., she indicated she spoke with Resident #86's family member/responsible party, and she said Resident #86 went to the beauty shop for perms and trims only, not for washes. She indicated Resident #86's daughter/responsible party informed her that Resident #86 can have her hair washed twice a week in the shower. LPN #2 indicated that</p>			

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	<p>moving forward, that was the plan because "everyone seemed to think something different".</p> <p>2. Resident #99's clinical record was reviewed on 9/26/12 at 11:20 am Diagnoses included but were not limited to; hypoglycemia, hypertension, hypothyroidism.</p> <p>Interview with the Administrator on 9/26/12 at 11:16 am indicated there are two bath tubs in the building, one on the hall on which Resident #99 resides, and one in the dementia unit. The bath in the dementia unit is, "rarely, if ever used, and its probably the same for the other one. I've never seen it being used."</p> <p>Interview with Resident #99's family member on 9/21/2012 at 8:40 am indicated, "She used to take a tub bath at home, as far as he knows they don't have tubs here," (at the facility.) When questioned, 'Is [resident's name] bathed according to his/her past preferences?' The resident's family</p>			

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	<p>member responded, "No, she doesn't get a tub bath and she doesn't like showers, so she washes herself up at the sink everyday instead."</p> <p>A 'Resident-data collection' admission nursing assessment dated 7/6/12 and reviewed on 9/26/12 at 11:20 am indicated, "Personal hygiene/grooming: 'Assist' was marked for the following categories; tub, shower, bed bath, oral hygiene, shave, grooming, dressing, shampoo."</p> <p>Observation on 9/26/12 at 11:39 am indicated there is a bath tub in a room labeled 'Bathing' located on the same hallway on which Resident #99 resides, it is located between a men's bathroom and room number 87.</p> <p>A care plan titled, 'ALD's dated 7/13/12 indicated, "Problem/Concern/Need: Minimal to limited assist needed with ADL's. Approach/Intervention: 5. Staff assist with transfers, toileting, and bathing."</p> <p>Interview with RN #3 on 9/26/2012 at 12:54 pm indicated there is a bath tub on the unit .The aides are the ones who would know someone's preference for bathing, they are the ones who fill out the sheets for ADL</p>			

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	<p>care. They would have to let a nurse know if a resident indicated a preference, and then the MDS Coordinator would fill out a new care plan. The nurses don't ask bathing preference on admission as far as she is aware.</p> <p>Interview with CNA#4 on 9/26/12 at 1:20 pm indicated Resident #99 likes to wash up herself, this is why there are no showers listed on the ADL sheet for her for September. She needs set up assistance only. She has had quite a few bed baths before. He (the CNA) was not aware of her preference for tub bath over a shower, if she mentioned it to him he would help her get in and out of the tub. She could take a tub bath whenever she wanted. Her preference should be on her CNA assignment sheet, he doesn't know who would ask her initially what her preference is regarding bathing.</p> <p>A 'CNA assignment sheet' indicated, "shower day: Wednesday and Saturday day shift." No bathing preferences were listed.</p> <p>3.1-3(u)(3)</p>			

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F0248 SS=E	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide an appropriate, effective activity program on the dementia unit for 2 of 3 residents reviewed who met the criteria for activities and 2 residents randomly observed for activities. (Resident #92, #75, #74, #109 and #110)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #92 was reviewed on 9/25/12 at 2:00 p.m.</p> <p>The resident's diagnoses included, but were not limited to: Alzheimer's dementia.</p> <p>The 4/30/12 admission MDS (minimum data set) assessment indicated it was very important for Resident #92 to have books, magazines, and newspaper to read, to go outside when weather is good, to do favorite activities, and to keep</p>	F0248	<p>Corrective action will address residents #92, 75, 74, 110, and 109. The corrective actions will also address all residents with the potential of being affected by this finding. The activity department staff and nursing staff have been in-serviced that all interested residents are included in group activities and that one on one activities are being provided as scheduled and as needed for those who do not attend group activities. In-service includes ideas and access to materials for one on one and small group dementia programs and how activities can be used as a behavior intervention. Supplies for independent activities have been placed on the dementia care unit (Heritage Haven) that includes: memory boxes, sensory boards, sorting objects, and materials that can be used for assembly. Activity items used and available for independent activities are chosen based on safe use, varied potential interests, and skill levels. Activities and hobbies of interest are determined for residents when completing an Activity Assessment on admission with resident and or legal representative.</p>	10/12/2012	

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	<p>up with the news.</p> <p>The 4/30/12 activity care plan for Resident #92 indicated the problem/strength was Resident #92 would attend a few group activities sometimes if he was in the mood and that he was invited to group activities almost daily but usually refused. The goal was for him to attend at least 3 group activities a week and to stay for at least 15 minutes during each activity that he attended. The interventions were to post a large monthly activity calendar in his room, to invite/encourage/lead him to group activities that were of his interest, to provide encouragement supplies and set up of independent activities that were of his interest daily, and to provide him with activities that are of his interests.</p> <p>The September, 2012 activity calendar for Resident #92 provided by the Activity Director on 9/24/12 at 2:45 p.m. indicated Resident #92 did not participate in any of the scheduled activities indicated on the calendar thus far in the month.</p> <p>Resident #92 was not observed to participate in any scheduled activities from 9/19/12 through 9/21/12 between the hours of 10:00 a.m. to</p>		<p>The assessment identifies areas of activity interest, religious preferences, and hobbies. The dementia care activity calendar has been revised to reflect increased Alzheimer appropriate activities (attachment 6) with ongoing training with the activity department staff. Activity care plans have been audited, reviewed and updated to ensure all residents have a current care plan available that reflects interests, appropriate activities programs, and interventions. Dementia care unit staff will utilize activities of interest as a behavior intervention and when residents are asking what they (resident) can do. Activity director will provide continued education to activity department staff and dementia care unit staff with ideas that will potentially engage residents who may have short attention spans and who do not participate in group activities. The activity director will monitor as ongoing QA using the Independent Activity Tracking log (attachment 7) to show resident interests in independent activity and modify their program as needed to find areas of interests. This process will be monitored and reviewed in the facility QA meetings with any new recommendations implemented.</p>		

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	<p>3:00 p.m.</p> <p>An observation on 9/24/12 at 1:08 p.m. was made of Resident #92 watching television in his room alone.</p> <p>A movie was playing in the dining room on 9/24/12 at 2:29 p.m. Resident #92 was not in attendance.</p> <p>A casino game was being played in the dining room on 9/25/12 at 1:40 p.m. Resident #92 was not in attendance.</p> <p>An exercise session was occurring in the dining room on 9/26/12 at 1:25 p.m. Resident #92 was not in attendance.</p> <p>During an interview with Activity Assistant #8 on 9/24/12 at 2:12 p.m., she indicated Resident #92 liked to converse with people, but other than that she didn't see him do anything. She indicated he came in and out of group activities and that he was a "wanderer". She stated, "He's always wanting to leave and to go. He should be on one on ones. I think he is." She indicated the Activity Director would know for sure.</p> <p>During an interview with the Activity Director/Social Services Director on</p>				

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	<p>9/24/12 at 2:55 p.m., she indicated, "I didn't put (nickname of Resident #92) on one on ones because he's so busy." She indicated he was busy watching television, socializing with peers, and counting tile on the floor. She indicated, "It is hard to get them to do activities down there (on the dementia unit). They don't want to stay or come down. I try to keep the calendars a variety of things. I do feel like I'm out of options with some of them. Some are wanderers and that's all they'll do. She indicated Resident #75, Resident #74, Resident #109, and Resident #110 "wander and do nothing". I don't know how to get them to stay in there. I've tried everything I can think of. I'm overwhelmed with doing both jobs."</p> <p>During an interview with Resident #92 on 9/25/12 at 11:18 a.m., he indicated when someone is not in his room talking to him he gets confused. He indicated he walks around for an hour or two at a time.</p> <p>On 9/25/12 at 2:00 p.m., Resident #92 was standing at the nurses station, talking incoherently. No staff were around. A CNA walked by and smiled.</p> <p>On 9/25 at 2:39 p.m. LPN #2</p>			

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	<p>redirected Resident #92 back to his room. She came back to the nurse's station and stated, "It's hard to find things for him to watch on TV"</p> <p>2. The clinical record for Resident #75 was reviewed on 9/24/12 at 1:00 p.m.</p> <p>The diagnoses for Resident #75 included, but were not limited to: Alzheimer's disease and manic depression.</p> <p>During review of Resident #75's care plans on 9/24/12 at 1:10 p.m., no activity care plan could be found.</p> <p>The September, 2012 activity calendar for Resident #75 provided by the Activity Director on 9/24/12 at 2:45 p.m. indicated Resident #75 did not participate in any of the scheduled activities indicated on the calendar thus far in the month.</p> <p>Resident #75 was not observed to participate in any scheduled activities from 9/19/12 through 9/21/12 between the hours of 10:00 a.m. to 3:00 p.m.</p> <p>An observation on 9/24/12 at 11:20 a.m. was made of Resident #75 lying in bed watching television, alone.</p>			

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	<p>A movie was playing in the dining room on 9/24/12 at 2:29 p.m. Resident #75 was not in attendance.</p> <p>A casino game was played in the dining room on 9/25/12 at 1:40 p.m. Resident #75 was not in attendance.</p> <p>An exercise session was occurring in the dining room on 9/26/12 at 1:25 p.m. Resident #75 was not in attendance.</p> <p>During an interview with Family Member #4 on 9/25/12 at 2:25 p.m., she indicated Resident #75 didn't really participate in any activities at the facility, but that he liked to take things apart. "He always worked in his shop. He likes electrical things. Always wants to work on his bed. He's not interested in puzzles. He doesn't like cards, bingo, stuff like that. I don't know what they could offer him."</p> <p>During an interview with Activity Assistant #8 on 9/24/12 at 2:12 p.m., she indicated Resident #75's (relationship of Family Member #4 to Resident #75) visited daily. She indicated Resident #75 went to meals and slept almost all day everyday. She indicated, "Aside from one on</p>			

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	<p>ones, he doesn't do anything."</p> <p>An interview was conducted with the Activity Director on 9/26/12 at 1:35 p.m. regarding lack of an activity care plan for Resident #75. She indicated, "He should have one. I have one for everyone else...I don't have one for him."</p> <p>She indicated Resident #75 liked to drink beer and that he used to like to work on things, like woodworking, and to "mess with" the handrails and baseboards. She indicated he still watched TV and visited with Family Member #4. She indicated her plan to address his lack of involvement in activities was to "just keep trying to invite him."</p> <p>3. On 9/25/12 at 2:00 p.m., Resident #92 was standing at the nurses station, talking incoherently. No staff were around. Resident #74 walked up and started talking incoherently as well. She indicated she did not know her name. A CNA walked by and smiled.</p> <p>On 9/25/12 at 2:04 p.m. Resident #109 was standing by the door near the nurse's station and stated, "I don't know where I'm supposed to be or what I'm supposed to be doing." Medical Records/Central Supply Staff</p>			

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	<p>told Resident #109, "Maybe there's some sort of activity you could do." She asked CNA #9 what Resident #109 could do. CNA #9 responded, "You can do what ever you want."</p> <p>During an interview with the Activity Director/Social Services Director on 9/26/12 at 1:35 p.m., she indicated she chose the activities on the September, 2012 activity calendar because "They love bingo, crafts, and to cook. I ask them what they like to do and for suggestions." She indicated the sensory stimulation activities on the calendar are the ones specific to Alzheimer's dementia. She proceeded to highlight the activities on the September, 2012 Dementia Unit activity calendar specific to Alzheimer's dementia. It appeared as follows:</p> <p>9/3/12 - 1 activity at 1:30 p.m. 9/4/12 - 1 activity at 1:00 p.m. and 1 activity at 5:00 p.m. 9/5/12 - 1 activity at 5:00 p.m. 9/10/12 - 1 activity at 10:30 a.m. and 1 activity at 1:30 p.m. 9/11/12 - 1 activity at 4:00 p.m. 9/12/12 - 1 activity at 5:00 p.m. 9/13/12 - 1 activity at 1:00 p.m. 9/17/12 - 1 activity at 1:30 p.m. 9/18/12 - 1 activity at 1:30 p.m. and 1 activity at 4:00 p.m.</p>			

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	<p>9/19/12 - 1 activity at 5:00 p.m. 9/20/12 - 1 activity at 1:00 p.m. 9/21/12 - 1 activity at 3:00 p.m. 9/25/12 - 1 activity at 1:00 p.m. and 1 activity at 4:00 p.m. 9/26/12 - 1 activity at 5:00 p.m. 9/27/12 - 1 activity at 1:00 p.m., 1 activity at 3:00 p.m., and 1 activity at 6:00 p.m. 9/28/12 - 1 activity at 3:00 p.m.</p> <p>When addressing why more activities on the calendar weren't specific to Alzheimer's dementia, since the calendar was specifically for the dementia unit, and whether or not she thought the current activity program was working, she indicated she thought the program was working, "except with those few people" (Resident #74, #92, and #109).</p> <p>3.1-33(a)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a resident on the dementia unit had an activity care plan for 1 of 3 residents reviewed who met the criteria for activities. (Resident #75)</p> <p>Findings include:</p> <p>The clinical record for Resident #75 was reviewed on 9/24/12 at 1:00 p.m.</p> <p>The diagnoses for Resident #75 included, but were not limited to:</p>	F0279	<p>Corrective action will address resident 75 whose care plan has been updated and completed. The corrective actions will also address all residents with the potential of being affected by this finding. The activity department staff and nursing staff have been in-serviced that all interested residents are included in group activities and that one on one activities are being provided as scheduled and as needed for those who do not attend group activities. In-service includes ideas and access to materials for one on one and small group dementia programs and how</p>	10/12/2012	

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	<p>Alzheimer's disease and manic depression.</p> <p>On 9/24/12 at 1:10 p.m., during review of Resident #75's care plans, no activity care plan could be found.</p> <p>During an interview with Family Member #4 on 9/25/12 at 2:25 p.m., she indicated Resident #75 didn't really participate in any activities at the facility, but that he liked to take things apart. "He always worked in his shop. He likes electrical things. Always wants to work on his bed. He's not interested in puzzles. He doesn't like cards, bingo, stuff like that. I don't know what they could offer him."</p> <p>An interview was conducted with the Activity Director on 9/26/12 at 1:35 p.m. regarding lack of an activity care plan for Resident #75. She indicated, "He should have one. I have one for everyone else...I don't have one for him."</p> <p>3.1-35(a)</p>		<p>activities can be used as a behavior intervention. Supplies for independent activities have been placed on the dementia care unit (Heritage Haven) that includes: memory boxes, sensory boards, sorting objects, and materials that can be used for assembly. Activity items used and available for independent activities are chosen based on safe use, varied potential interests, and skill levels. The dementia care activity calendar has been revised to reflect more activities Alzheimer appropriate (attachment 6). Activity care plans have been audited and updated to ensure all residents have a current care plan available that reflects interests, changes in status, and behavior interventions as applicable. All residents have a care plan for activities available with a back copy maintained by activity director. Activity director will provide continued education to activity department staff and dementia care unit staff with ideas that will potentially engage residents who may have short attention spans and who do not participate in group activities. The activity director will monitor resident interests in independent activity as an ongoing QA using the Independent Activity Tracking Log (attachment 7) and will modify program as needed for areas of interests and function. Dementia care unit staff will use utilize activities of interest as a</p>	

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			behavior intervention and when residents are asking what they (resident) can do. This process will be monitored and reviewed in the facility QA meetings with any new recommendations implemented.	

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to update an activity plan of care in order to reflect the resident's current medical status for 1 of 3 residents reviewed for activities. (Resident #43.)</p> <p>Findings include:</p> <p>1. Resident #43's clinical record was reviewed on 9/25/12 at 10:20 a.m. Diagnoses included but were not limited to; hypertension, diabetes, dementia, Stage 4 chronic renal disease, dysphagia (difficulty swallowing,) depression.</p>	F0280	<p>Corrective action will address resident 43 whose care plan has been reviewed and updated. The corrective actions will also address all residents with the potential of being affected by this finding. The activity department staff and nursing staff have been in-serviced that all interested residents are included in group activities and that one on one activities are being provided as scheduled and as needed for those who do not attend group activities or have specific areas of interest. In-service includes importance for scheduling, and notifying residents who have interest in religious activities and services. Religious services</p>	10/15/2012			

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	<p>A 'Interview for activity preferences' dated 7/20/12 indicated, "very important ' to participate in religious services or practices."</p> <p>An 'activity assessment' dated 7/14/12 indicated, "Religious affiliation: [Name of Religious affiliation] Degree of involvement: Went all the time. Desire for pastoral visits: Husbands a pastor. Desire and willingness to participate: not interested."</p> <p>A care plan dated 7/26/12 indicated, "Strengths: enjoys interacting with others, positive interaction with family, positive spiritual practice, strong identification with past, participates in care, cheerful. Goal: Residents strength will be utilized to improve quality of life. Res strength will be drawn upon in interactions, activities, and care. Interventions: Offer choices for care and activities that emphasize residents strength."</p> <p>A care plan dated 7/16/12, indicated, "Activities: Approach/intervention: Post a large monthly act calendar in resident's room. Invite, encourage, transport resident to group activities that are appropriate and of her interest. Provide resident with</p>		<p>offered will vary to reflect varied faiths based on known beliefs of current residents. All residents have been audited. Residents with interests in religious activities are identified and a list is available at each neighborhood (unit). Resident 43 has been reminded that there are at least weekly scheduled religious services and/or activities available. Activity director will update the religious interest neighborhood lists using a Religious Activity audit form (attachment 8) and monitoring participation. Resident reminders for religious service participation will be made as needed. Resident refusals will be honored and if refusals are ongoing the resident interest in participation will be updated to reflect any changes in resident preferences.</p>		

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	<p>supplies for independent activities if needed. Monitor residents activity level."</p> <p>Observations of the resident on the following dates and times indicated she was asleep in her room; 9/19/2012 at 2 pm, 9/20/2012 at 10:30 am, 9/25/2012 at 11:15 am and at 3 pm, 9/26/2012 at 1:50 pm.</p> <p>Resident #43's August and September activity log was provided by DON on 9/26/2012 at 9 am. No religious activities provided for month of August. During September she attended one 'bible study.'</p> <p>Interview with Activity Director (AD) on 9/26/12 at 2:40 p.m. indicated she wasn't aware of Resident #43's activity preferences. The AD indicated the residents husband is a pastor and he visits every day. The resident has been sick lately, not feeling well and therefore sleeping a lot, she was in the hospital recently. The resident is, "someone that needs to put on her list of people" she needs to "re look at and figure out activities for them to do."</p> <p>3.1-35(b)(2)</p>				

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F0323 SS=J	<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.</p> <p>1. Based on observation, interview, and record review the facility failed to supervise a resident with known wandering and exit seeking behaviors to prevent an elopement from the locked dementia unit and failed to implement a plan for supervising another resident on the dementia unit with known wandering behaviors for 1 of 3 residents reviewed for elopement risk. (Resident #108)</p> <p>This deficient practice resulted in Immediate Jeopardy. The Immediate Jeopardy was identified on 9/27/12 and began on 9/19/12. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 9/27/12. The Immediate Jeopardy was removed on 9/28/12, but the facility remained out of compliance at the level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>2. Based on observation, interview, and record review, the facility failed to</p>	F0323	<p>This facility is providing the plan of correction as required however it should be known and established that no injury was identified in this finding. 1. Resident 108's care plan was reviewed and updated to include "need for placement on the secured unit" and "elopement risk". The existing "potential for elopement" care plan was adjusted to include immediate interventions added: 1. Monitor dressing daily to ensure resident is in appropriate indoor clothing. Avoid jacket and hat to avoid resident from looking like a visitor. 2. Red identifier bracelet is placed on the resident. C.N.A. assignment sheets updated to identify resident 108 as an elopement risk. Red identifier bracelet was placed on elopement resident. Staff was educated about the bracelet and to check placement every shift. Placement of the bracelet was placed on the TAR and is to be checked every shift. All residents on the secured unit had need for secured unit added to the care plan. All residents on the secured unit had an elopement risk assessment completed. See</p>	10/22/2012	

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	<p>ensure potentially hazardous materials were locked up with the potential to affect 7 of 25 residents residing in Heritage Haven/memory care unit, during an random observation (Resident #63, #109, #97, #41, #54, #60, #75)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #108 was reviewed on 9/27/12 at 11:30 a.m. Resident #108 was admitted to the facility on 9/19/12.</p> <p>The diagnoses for Resident #108 included, but were not limited to: senile dementia.</p> <p>Review of an incident report faxed to the ISDH (Indiana State Department of Health) by the DON (Director of Nursing) on 9/22/12 at 3:13 p.m. indicated, "At approximately 2:40 p.m. unit nurse was aware that visitors on memory care unit were leaving and without direct observation she heard south door to unit close. At 2:45 p.m. an employee of (name of facility next door) adjacent to south facility parking and entrance, notified unit nurse that resident was at parking lot stating he was looking for his car. Unit staff without incident escorted resident back into facility. This resident newly</p>		<p>attachment #1. Once the risk assessment was completed all residents identified to be at risk were given an elopement care plan. Families will receive a typed letter from administrator at next billing statement explaining to families the newly developed measures to decrease potential for elopement and need for their assistance. New Signs have been made to replace existing ones, to alert visitors and staff to watch for residents who may be trying to exit the unit. These are bigger and brighter signs to get visitors and staffs attention. New interventions for exit seeking behaviors worksheet was developed, see attachment #3. Staff will be in-serviced on this worksheet and need to carefully monitor newly admitted residents. On admission all residents will have an elopement risk assessment completed. Any resident who has been identified as an elopement risk will have an elopement risk care plan put into place. All residents identified as an elopement risk will be assigned a red identifier bracelet. All unit nursing staff will be in-serviced on the elopement risk assessment see attachment #1, prior to working. Elopement risk assessment updated to included changes. This system will be monitored using the QA elopement tool, see attachment #2. This tool will be used weekly X4 weeks, and then monthly for 6</p>	

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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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	<p>admitted to facility on 9/19/12."</p> <p>Review of a prescription dated 9/17/12 by Resident #108's doctor indicated, "Rx: Emergency admit to skilled facility (lock unit) -dx: Dementia severe 290.0 (wandering)..."</p> <p>Review of the 9/19/12 admission assessment entitled "Resident-Data Collection" indicated, "Orientation To Facility...Unable To Orient (reason)...Need to be told often were (sp) room is @ this time." The assessment also indicated Resident #108 was independent in ambulation.</p> <p>No information could be found in the clinical record to indicate an elopement risk assessment was completed for Resident #108.</p> <p>A care plan for elopement potential was dated 9/22/12, the day Resident #108 was found in the parking lot by a staff member from another facility .There was no care plan developed for the resident's elopement risk prior to 9/22/12 and no specific approaches developed or implemented to prevent the resident's actual elopement on 9/22/12.</p> <p>During an interview on 9/28/12 at</p>		<p>months. This tool will be completed by the DON or her designee. Results of audit will be reviewed at the quarterly quality assurance committee meeting and all recommendations will be followed. This education includes the need for careful monitoring on admission and for at least 72 hours as these behaviors may be more prominent during that adjustment period. Attachment #4 (pages a, b, c, and d) contains in-service content and sign in sheet. 2. The corrective action will address resident 63, 109, 97, 41, 54, 60, and 75. The corrective action also addresses any ambulatory resident of the dementia care unit who has the potential to be affected by this finding. On 9/19/12 the personal care items in the shower room were removed immediately when discovered. All staff on 9/19/12 were reeducated by DON that personal care items are not to be left unattended and in reach of residents. An in-service for all staff was presented on 10/22/12 that restated the need to watch for and prevent personal care items from being accessible and in reach of unsupervised residents who may not have ability to use products appropriately and safely. Rounds were also conducted throughout facility on this date with no other instances of personal care items left unattended. Shelves have been placed in a locked room</p>	

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	<p>10:40 a.m. with the Care Plan Coordinator, she indicated she would create a care plan for elopement if staff told her the resident was trying to get out or that they did get out, when it's brought to her attention. She indicated no one brought anything to her attention until after Resident #108 eloped from the building on 9/22/12. She indicated she made the elopement care plan on 9/22/12 after his elopement.</p> <p>Review of the nurses notes indicated the following:</p> <p>9/20/12 7:21 a.m. "Res (symbol for "up and down") many x's (symbol for "throughout") NOC (night).</p> <p>9/20/12 10:25 a.m. "Res (symbol for "up") et (and) about on unit. Ambulatory (symbol for "with") steady gait."</p> <p>9/20/12 12:15 p.m. "Res (resident) has begun questioning nurse re: how to get out, why he has to stay, why family did this, etc. Reassurance offered by all staff present."</p> <p>9/20/12 7:00 p.m. "Stands @ door frequently asking</p>		<p>adjacent to the dementia care unit shower for keeping the personal care items for individual residents. The supplies can now be accessed readily from and stored in the locked room adjacent to the shower room when staff has completed resident bathing assist. All managers will complete designated neighborhood (unit) rounds to inspect for personal care items left unattended. The focus rounds will continue daily x 4 weeks, weekly x 4 weeks, then will resume as awareness in making routine rounds and monitoring. This process will be monitored and reviewed in the facility QA meetings with any new recommendations implemented.</p>		

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	<p>staff to unlock door so he can go home."</p> <p>9/21/12 6:24 a.m. "Res. restless @ start of shift. Wanting to leave & go home. More difficult to redirect than from prev. (previous) NOC."</p> <p>9/21/12 10:20 a.m. "Upon first awakening this AM, res. reported to be irritable (sp) and refused to go to DR (dining room) for meal."</p> <p>9/22/12 2:45 p.m. "Resident left the unit through south doors, staff from children's center informed writer there was a man looking for his car in parking lot, redirected resident in easily."</p> <p>9/22/12 2:50 p.m. "Resident placed on 15 min. checks."</p> <p>9/22/12 3:58 p.m. "Wanderguard placed on resident."</p> <p>9/22/12 4:30 p.m. "Resident continues (symbol for "with") 15 min (minute) (symbol for "checks") stated "do what you got to do, I'll get it off (wonder guard) (sp) - one way or another", resident continues trying doors @ south east</p>			

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	<p>et (and) west halls..."</p> <p>During an interview with LPN #1 on 9/27/12 at 12:25 p.m. regarding Resident #108's elopement , she indicated, "I was standing at the nurse's desk. He (Resident #108) was nearby and I could see him." She indicated she saw visitors going towards the south exit doors. She heard the door click, but was down the hallway at the time, and Resident #108 was out of her vision when she heard the door click. She indicated she came back to the nurses station and sat down. She stated, "(Name of facility next door) came over and said there was someone in the parking lot looking for their car. I went outside. It was (name of Resident #108) and I easily redirected him back inside. I almost had a heart attack. There's always a transition period for a new person."</p> <p>An interview with the DON regarding whether, when, and for whom elopement risk assessments are completed was conducted on 9/27/12 at 1:23 p.m. She paused and indicated, "I'm coming up with a blank." She indicated admission assessments include: pain, bowel and bladder, dental, skin, dehydration, fall, and incontinence.</p>			

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	<p>She stated, "We do not do an elopement risk assessment on admission. It's not in our packet."</p> <p>During another interview with the DON on 9/27/12 at 2:20 p.m. she indicated elopement risk assessments are not done in the facility at all. She indicated the facility would know if a resident was at risk for elopement if they paced, wandered, and commented on wanting to leave. At this time, she reviewed Resident #108's emergency order for placement regarding wandering and indicated she was unaware of it. She indicated anyone on the dementia unit was an elopement risk. "We tell staff to make sure the door latches before walking away. We remind visitors. My understanding is he followed visitors out the door."</p> <p>The "Missing/Wandering Resident" policy was provided by the DON on 9/27/12 at 2:20 p.m. It indicated the purpose was "To locate the missing or wandering resident as soon as possible." The policy did not include any proactive measures to prevent elopement.</p> <p>An Immediate Jeopardy was identified on 9/27/12 at 2:00 p.m.</p>			

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	<p>The Immediate Jeopardy began on 9/19/12 when a resident was admitted to the facility with an order indicating "Rx: Emergency admit to skilled facility (lock unit) -dx: Dementia severe 290.0 (wandering)...". The Administrator and Director of Nursing were notified on 9/27/12 at 3:05 p.m. of the Immediate Jeopardy related to lack of supervision to prevent elopement. The Immediate Jeopardy was removed on 9/28/12 when through observations, interviews, and record reviews, it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>2. During the initial tour of the facility, on 9/19/12 at 12:10 p.m., the door to the bathroom/shower room across from room 10 A on the Heritage Haven/memory care unit, was unlocked and open. There was no staff in the vicinity of the</p>						

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	<p>bathroom/shower room. The following products were within reach and accessible: Derma Rite hand/body lotion, Derma Rite body wash/shampoo, Renson shaving cream, Dynarex shaving cream, and Dawn mist powder.</p> <p>In an interview with the DoN (Director of Nursing), on 9/19/12 at 1:45 p.m., she indicated the personal care products listed above should have not been in the bathroom/shower room.</p> <p>The following Material Safety Data Sheets (MSDS) were provided by the DoN on 9/20/12 at 11:35 a.m. The MSDS for Derma Rite hand/body lotion, dated 4/1/99, indicated the lotion was a health hazard, if ingested, and to induce vomiting, if swallowed. The Dawn mist powder MSDS, dated 11/15/10, indicated to be cautious of inhalation and to call a physician or Poison Control Center immediately, if ingested. The MSDS for Dynarex shaving cream, dated 7/10, indicated to avoid contact with eyes, because irritation to eyes may occur. The Freshscent Aerosol/Renson shaving cream MSDS, dated 3/12, indicated ingestion may cause nausea, vomiting, and diarrhea. The same MSDS also indicated the product was</p>			

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	<p>an aspiration hazard and inhalation may produce anesthetic effects and feeling of euphoria, while prolonged exposure can cause rapid breathing, headache, dizziness, unconsciousness, and death from asphyxiation depending on concentration and time of exposure.</p> <p>A list of 18 independently mobile residents, who could move throughout the Heritage Haven/memory care unit without physical assistance, was provided by the DoN, on 9/20/12 at 11:35 a.m. The list also included the BIMS (Brief Interview of Mental Status) scores for the independently mobile residents, residing in the Heritage Haven/memory care unit. The BIMS scores were as follows: Resident #63 used a walker-BIMS of 4 (indicative of severe cognitive impairment) Resident #109 used a walker-BIMS of 3 (indicative of severe cognitive impairment) Resident #97 used a cane-BIMS of 5 (indicative of severe cognitive impairment) Resident #41 used a wheelchair-BIMS of 5 Resident 54 used a wheelchair-BIMS of 4 Resident #60 used a walker-BIMS of</p>			

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4	<p>Resident #75 was up ad lib (no device)-BIMS of 5</p> <p>On 9/20/12 at 2:15 p.m., the DoN indicated 25 residents resided in the Heritage Haven/memory care unit.</p> <p>3.1-45(a)(1)</p>			

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F0334 SS=C	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p>			

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	<p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview the facility failed to provide residents and or resident's legal representatives with written education regarding benefits and potential side effects of the influenza vaccine. This had the potential to affect 90 of 90 residents who are offered immunizations. (Resident #40, Resident #53.)</p> <p>Findings include:</p> <p>A 'Record of TB test and Immunizations records', indicated Resident #40 received the Flu</p>	F0334	CDC education materials for Influenza Vaccinations were provided to residents 40, and 53, and or their legal representative. The education material was sent by mail to all resident legal representatives on 10/1/12. Alert and oriented residents were provided a copy of Influenza Vaccination education materials to review, with each signing an acknowledgment of receipt. On admission, residents and or legal representative will receive Influenza Vaccination educational materials to review. An acknowledgment of receipt with election for Influenza Vaccinations will be signed on	10/01/2012			

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	<p>vaccine on 10/08/2011.</p> <p>A 'Record of TB test and Immunizations records', indicated Resident #53 refused the Flu vaccine in 10/2011.</p> <p>Interview with DON on 9/27/12 at 12:56 p.m. indicated the facility obtains written consent for immunizations upon a resident's admission. Yearly thereafter they only get verbal consent, and then document either the resident received it or refused the immunization. The nurses provide verbal education at the time they offer the flu shots, but do not provide written documentation to give to the residents or the Power of Attorney.</p> <p>A Policy and Procedure for Influenza Vaccination of Residents provided by the Director of Nursing on 9/27/2012 at 12:30 pm indicated, "Obtain written, informed consent from resident; this should be included on admission. Document vaccination in the Medication Administration Record and in Nurses Notes."</p> <p>3.1-13(a)</p>		<p>admission. Annually, on or about September 1 st , CDC Influenza Vaccination material for current year will be provided to all residents and or legal representative. DON will maintain check list to ensure all residents and or legal representative has received the current year Influenza Vaccination material. The facility policy for Influenza Vaccination has been updated to reflect the updated process. This process is ongoing annually (September) and any issues identified will be corrected immediately, recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring.</p>		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on record review and observation the facility failed to ensure food was protected from potential contamination of foreign substances, specifically jewelry and nail polish, during food preparation. This deficient practice had the potential to affect 89 of 90 residents who eat in the facility.</p> <p>Findings include:</p> <p>Observation of the lunch meal tray line on 9/27/2012 at 11:20 am indicated Dietary Manager #1 was wearing hoop earrings not contained within her hair net, a nose stud, and hot pink nail polish on her nails. Dietary assistant #2 was wearing an eyebrow ring. Both Dietary Manager #1 and Dietary assistant #2 were placing food items onto the meal trays.</p> <p>An 'Employee Handbook' policy on uniforms, provided by the Admission</p>	F0371	<p>No residents are known to have been affected by this finding. Corrective action will address all residents with the potential of being affected by this finding. The dietary department policy for "Employee Cleanliness and Dress Code" has been amended to clearly prohibit facial piercing from being visible when on duty, ear rings that hang below ear, and nail polish when on duty (SEE ATTACHMENT #5). The department policy now better reflects the departmental expectations and is consistent with the employee handbook. Dietary managers have in-serviced department staff and reviewed the amended Employee Cleanliness and Dress Code policy with each. Dietary staff and managers will be expected to comply with this policy. Administrator will monitor overall dietary department compliance and dietary manager will monitor daily department compliance. Dietary manager(s) will complete daily the "Checklist For Employee Cleanliness and Dress Code" (attachment to ensure QA of the dietary staff</p>	10/04/2012			

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	<p>Coordinator on 9/27/2012 at 11:43 am, indicated, "Earrings will not dangle from the ears...Facial rings, such as nose, eyebrow, lip or tongue piercing are not permitted."</p> <p>An 'Employee Cleanliness' policy provided by Dietary Manager #1 on 9/27/2012 at 11:44 am indicated, "2. Fingernail polish and artificial fingernails are not permitted."</p> <p>3.1-21(i)(1)</p>		<p>preparing and serving meals. Any issues identified will be corrected immediately, recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring. This process will be monitored on an ongoing basis. Checklist for Employee Cleanliness and Dress Code will be maintained for 12 months period for review and QA evaluation for compliance.</p>		

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F0411 SS=D	<p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to recognize and address an oral condition for 1 of 3 residents reviewed who met the criteria for dental status and services. (Resident #42)</p> <p>Findings include:</p> <p>The clinical record for Resident #42 was reviewed on 9/25/12 at 1:00 p.m.</p> <p>The diagnoses for Resident #42 included, but were not limited to: Alzheimer's dementia.</p> <p>During an observation of Resident #42 on 9/21/12 at 11:00 a.m., a chipped tooth was observed on the bottom right side. The resident</p>	F0411	<p>Corrective action addresses resident 42 who was scheduled to be seen by onsite dental service however the scheduled service was canceled by the dental provider. The family for resident was contacted and approval was given for resident to be seen by community based dental service. The dental appointment was scheduled for 10/18/12 in which the dentist did fill the affected tooth. To identify any resident needing dental/oral care and services, the nursing assessment tool has been amended to include a comprehensive oral assessment. This tool will be completed by neighborhood (unit) nurse weekly and all residents have been assessed and evaluated using this tool. In-servicing was completed on October 10, 11, and 12 to</p>	10/18/2012			

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	<p>willingly pointed to the chipped tooth and indicated she chipped it the day before, on 9/20/12.</p> <p>During an interview with Family Member #5 on 9/21/12 at 11:30 a.m. regarding whether Resident #42 had any tooth problems, she indicated Resident #42 chipped her tooth the previous day, on 9/20/12.</p> <p>A 4/4/12 oral care plan, reviewed 6/27/12, indicated interventions were to observe and ask if any discomfort and to report concerns to M.D.</p> <p>No nurses notes could be found regarding Resident #42's chipped tooth.</p> <p>The 9/21/12 Nurses Weekly Summary completed by LPN #6 did not indicate Resident #42 had any loose or broken teeth.</p> <p>Review of the ADL (activities of daily living) book indicated oral care for Resident #42 was independent and assist on 9/20/12. There was no information for days since 9/20/12.</p> <p>During an interview with CNA #7 on 9/26/12 at 11:49 a.m., she indicated she hadn't noticed any concerns with Resident #42's oral condition and that</p>		<p>educate the nurses on the modified weekly assessment tool with emphasis on comprehensively assessing the dental and oral condition of the residents. In instances where an issue related to dental and oral status is identified, the nurse will initiate immediate interventions as necessary. The DON and or designee will monitor the completeness of the weekly nursing assessments through QA process in which the Nursing Assessments are reviewed by nursing administration weekly. Assessments collected will be compared with the current census by unit to ensure all residents have been assessed/evaluated. Indications of dental/oral issues, and any other issue reflected on the Nursing Assessment will be followed up by nursing admin to confirm intervention had been initiated by unit nurse in a timely manner. The systematic changes will be reviewed weekly X 4 weeks until fully compliant. Review will then be completed monthly X 3 months until fully complaint. The review will then be completed at 6 months to ensure ongoing compliance. Any issues identified will be corrected immediately, recorded on a QA tracking form and reviewed in the facility QA meetings for recommendations and continued need for monitoring.</p>		

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	<p>Resident #42 would tell her if she had any.</p> <p>During an interview with LPN #2 on 9/26/12 at 11:50 a.m., she indicated nothing was reported to her regarding Resident #42's oral condition and that the resident hadn't mentioned anything either.</p> <p>During an interview with the DON (Director of Nursing) on 9/26/12 at 12:03 p.m., she indicated her expectation when nurses filled out the Nurses Weekly Summary was for nurses to know a resident's oral status and to base that knowledge on the information contained in the admission assessment. She indicated the CNAs would have to inform if something happened, like a broken tooth. She indicated if the resident did their own oral care, the resident themselves would have to inform. She stated, "If they don't report it, we wouldn't know. No one is looking in mouths weekly. She indicated she would know of any oral concerns if the resident wasn't eating or if they verbalized chewing problems. She stated, "The girls know the residents down here and they pick up on any concerns."</p> <p>During another interview with LPN #2</p>			

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	<p>on 9/26/12 at 12:10 p.m., she indicated she just saw Resident #42 and would report it to dentist . She indicated, "It's going to have to come out. She didn't tell us and neither did (relationship of Family Member #5). It's most definitely broken." She indicated the broken tooth was the bottom right canine."</p> <p>3.1-24(a)(2)</p>			