

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00148284.</p> <p>Survey dates: April 30, May 1, 2, 5, and 7, 2014</p> <p>Facility number: 000307 Provider number: 155666 AIM number: 100285660</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN Carol Miller, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 48 Total: 48</p> <p>Census payor type: Medicare: 8 Medicaid: 37 Other: 3 Total: 48</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Plan of correction 2014 This plan of correction is prepared and executed because the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the state allegations. Wesley Healthcare maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare requests paper compliance for F242, F280, F371, and F465. These were found to be low severity. There was no actual citation of harm to any of the residents.</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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F000242 SS=D	<p>Quality review completed on May 9, 2014 by Randy Fry RN.</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.</p> <p>Based on interview and record review the facility failed to ensure 2 of 3 residents (Resident # 78 and Resident #90) reviewed for choices, were offered choices concerning how many showers or baths in a week they would prefer.</p> <p>Findings include:</p> <p>1. Resident #78 was interviewed on 5/1/14 at 9:16 A.M.. Resident #78 indicated he would prefer more than the two bathing opportunities he is offered every week. The resident indicated he has never been asked if he would like more bathing opportunities.</p> <p>Review of Resident #78's clinical record</p>	F000242	<p>F 242 483.15(b) Self-Determination- Right to make choices</p> <p>The facility does recognize the resident's right to choose activities, schedules and healthcare consistent with his or her interests, assessments and plans of care; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>1. Corrective action taken: Resident # 78 and # 90 were interviewed by the Activity Director regarding preferences for bathing and the number of bathing opportunities they would</p>	05/21/2014	

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	<p>was done on 5/7/14 at 11:30 A.M.. The Minimum Data Set (MDS) Assessment, completed on 2/26/14, section F, Preferences for Customary Routine and Activities, indicated it was very important to Resident #78 to choose between a tub bath, shower, bed bath, or sponge bath. The MDS did not indicate Resident #78 was offered a choice on how many bathing opportunities he received.</p> <p>Review of a Care Plan, dated 8/9/12, for Activities, indicated "I enjoy small group or independent activities. i prefer to speak with staff and other residents on an individual basis rather than group situations. I prefer to be in a quiet environment: I especially like to be out of my room in the evening hours." One of the approaches indicated "offer choice of shower or tub bath 2 x per week."</p>		<p>like per week. Their bathing preferences were implemented on May 14 2014</p> <p>1.All residents have the potential to be affected by the alleged deficient practice. 2.The following measures will be done to ensure the alleged deficient practice does not recur</p> <p>a) Facility wide interview of residents was done by the Activity Director regarding their bathing preferences and number of opportunities. The interview was completed on May 5 2014.</p> <p>b) The Activity Director or designee will interview residents during admission and quarterly to determine their preference for bathing and number of bathing opportunities.</p> <p>1.The facility has implemented a QA tool to audit interview of newly admitted residents to ensure that their bathing preferences and number of bathing opportunities are being implemented. The DNS or designee will randomly audit weekly x 4 weeks and monthly x 4. Results will be reviewed at the quarterly QA meetings for review. 2.Date corrections completed on: May 21 2014</p>		

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F000280 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 a care plan following a fall for 1 of 3 residents reviewed for accidents (Resident #24).</p> <p>Findings include:</p> <p>The record for Resident #24 was reviewed on 5/5/14 at 9:00 A.M. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side).</p> <p>A nursing note, dated 4/15/14 at 4:50 A.M., indicated the writer was called into the resident's room by a CNA. The</p>	F000280	<p>F280 483.20(d)(3) 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The facility does recognize the resident's right, unless judged incompetent or otherwise found to be incapacitated under the laws of the State to participate in planning care and treatment or change in care and treatment.</p> <p>The facility does develop a comprehensive care plan within 7 days after the completion of the</p>	05/21/2014

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	<p>resident was noted to be on the floor. The CNA indicated the resident was on a stand lift and the resident's left leg came out from position on the lift and then her left arm lost position in the lift sling and the resident fell to floor.</p> <p>A Physician's Order, dated 4/16/14, indicated PT (physical therapy) was to evaluate and treat Resident #24.</p> <p>A Physical Therapy Plan of care note, dated 4/16/14, indicated "Patient was previously able to transfer with stand up lift and currently using a hoyer lift (a lift with a sling used to transfer residents) for safety...."</p> <p>CNA #2 was interviewed on 5/5/2014 at 9:30 A.M. During the interview, CNA #2 indicated on 4/15/2014 she was transferring Resident #24 using a standing lift. CNA #2 indicated the resident's left leg slipped and she lost her grip and fell from the lift. CNA #2 indicated staff were to now use a Hoyer lift to transfer Resident #24 because she was not safe to transfer with a standing lift. CNA #2 further indicated the specific type of lift to use for each resident was indicated on the CNA assignment sheets.</p> <p>Occupational Therapist (OT) #3 was</p>		<p>comprehensive assessment, prepared by the interdisciplinary team</p> <p>1. Corrective action taken:</p> <p>Resident #24 was reassessed and care plan updated</p> <p>CNA sheet was updated to include being transferred with the hoyer lift.</p> <p>1. All residents with a change in status have the potential to be affected by this practice.</p> <p>2. The following measures will be done to ensure the alleged deficient practice does not recur</p> <p>a. During morning meetings with all department heads, any changes in resident's status will be discussed and changes will be made immediately to update both the care plan and CNA sheets.</p> <p>1. The facility has implemented a QA tool to audit care plans of resident's with change in condition. The audits will be done by the DNS or designee t weekly x 4weeks, then bi weekly x2 weeks, then quarterly with MDS schedule.</p> <p>2. Date corrections completed: May 21, 2014</p>		

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	<p>interviewed on 5/5/2014 at 9:45 A.M. During the interview, OT #3 indicated Resident #24 had been evaluated by therapy following her fall on 4/15/2014. OT #3 indicated Resident #24 was now to be transferred with a Hoyer lift for safety.</p> <p>An undated CNA assignment sheet was provided by the facility's DON (Director of Nursing) on 5/5/2014 at 10:00 A.M. The DON indicated the assignment sheet was current and up to date. The assignment sheet indicated a stand up lift was to be used to transfer Resident #24.</p> <p>A care plan for falls, dated 9/24/2013, and a care plan for ADL's (activities of daily living) dated 9/24/2013, were provided by the DON on 5/5/2014 at 10:00 A.M. The DON indicated both care plans were current and up to date. The care plan for falls indicated "dependent on staff for transfers with standing lift." The care plan for ADLs indicated "stand up lift for transfers."</p> <p>The facility DON was interviewed on 5/5/2014 at 10:30 A.M. During the interview, the DON indicated the CNA assignment sheet and the care plans should have been updated to indicate a Hoyer lift was now to be used to transfer Resident #24.</p>			

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F000371 SS=E	<p>A policy entitled "Care Plans, dated 4/18/2011, was provided by RN #5 on 5/7/2014 at 9:30 A.M. RN #5 indicated the policy was the facility's current policy. The policy indicated "Care plans are to be reviewed and updated quarterly with IDT (interdisciplinary team) meeting, and as needed by the ADON (Assistant Director of Nursing) or designee."</p> <p>3.1-35(d)2(B)</p> <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 Based on observation, interview, and record review, the facility failed to ensure 2 dietary staff had their hair entirely secured under hair nets, during 3 observations of the kitchen, potentially affecting 35 residents whose food was prepared in the kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen beginning on 4/30/14 at 9:37 a.m., the Dietary Manager was observed to be</p>	F000371	<p>F371 483.35(I) FOOD PROCURE, STORE, PREPARE/SERVE- SANITARY The facility does store, prepare, distribute and serve food under sanitary conditions 1. Corrective action taken: The dietary services manager was in serviced on proper use and placement of hairnets, by the registered dietitian. Dietary aide #4 was in serviced on proper use and placement of hairnets by the dietary services manager. 1. All residents whose food is prepared in the kitchen of the</p>	05/21/2014			

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	<p>wearing a hair net, however hair was noted to be hanging out about 2-3 inches from both sides and the back of her head. The lunch meal was observed at 11:30 a.m., on 4/30/14, and the Dietary Manager was again observed with hair hanging out on both sides and from the back of the hair net.</p> <p>At 11:27 a.m., on 5/2/14, during the lunch meal observation in the kitchen, Dietary aide #4 was observed to be wearing a hair net, but there were strands of hair hanging out from the front and one side of the hair net.</p> <p>The Dietary Manager was also observed to be wearing a hair net, but there was hair hanging out from one side of the hair net.</p> <p>At 11:30 a.m., on 5/2/14, the dietary manager was informed of staff hair not being entirely secured under the hair nets, and indicated she would get a copy of the facility policy for hair nets.</p> <p>The Dietary Manager provided the policy for "Food Safety and Sanitation" at 12:37 p.m., on 5/2/14.</p> <p>The policy was reviewed at 12:38 p.m., on 5/2/14 and indicated the following: "All staff are required to have their hair styled so that it does not touch the collar, and to wear clean aprons, clothes and shoes. Hair restraints are required and should cover all hair on the head."</p>		<p>facility have the potential to be affected by the alleged deficient practice</p> <p>2.The following measures will be done to ensure that the deficient practice does not recur</p> <p>a. The administrator will monitor the dietary services manager and dietary aide 2 times a week for 1 month to ensure proper use and placements of hairnets. b. All dietary staff will be in serviced on proper use and placement of hairnets, by the dietary services manager</p> <p>1.The facility has implemented a QA tool to audit proper use and placement of hairnets. The audit will be done by the dietary services manager/designee weekly x 3months. Results will be discussed in the quarterly QA meeting for review.</p> <p>2.Date corrections completed: May 21,2014</p>				

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F000465 SS=D	<p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations, and interviews, the facility failed to ensure two resident bathrooms were free from cracked and peeling grout around the sink, white tape wrapped around 3/4 of the length of the grab bar, and the gout around the base of the toilet was dark brown in color. (Rooms 306 and 205).</p> <p>Findings include:</p> <p>On 4/30/14 at 1:45 p.m. observed in room 306-A's bathroom there was tape wrapped around 3/4 of the length of the grab bar that was affixed to the wall right next to the resident's toilet.</p> <p>On 4/30/14 at 2:53 p.m. observed in room 205, occupied by 2 residents, the gout around the base of the toilet was dark brown in color and the grout around the sink was cracked and peeling away</p>	F000465	<p>F465 483.70(h) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT</p> <p>The facility does provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public</p> <p>1. Corrective action taken:</p> <p>Re: The bathroom connected to room 205 was repaired with a new toilet and grout on May 9, 2014. The grout around the sink was repaired.</p> <p>Re: The tape on the grab bar in the bathroom of room 306 was removed and the grab bar was cleaned.</p>	05/21/2014

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	<p>from the resident's wall.</p> <p>On 5/7/14 at 12:45 p.m. with the Administrator/Maintenance Director observations were made in the bathroom of room 306. There was white tape wrapped around 3/4 of the length of the grab bar that was affixed to the wall next to the toilet.</p> <p>The Administrator/Maintenance Director was interviewed and indicated he was not sure why the white tape was placed on the grab bar, who had placed the white tape on the grab bar, or how long the white tape had been on the grab bar.</p> <p>The next observations were in the bathroom of room 205. The grout around the base of the toilet was dark brown in color and the grout around the sink was cracked and peeling away from the wall.</p> <p>The Administrator/ Maintenance Director was interviewed and indicated the grout around the toilet was dirty and the grout around the sink was cracked and peeling.</p> <p>The Administrator/ Maintenance Director indicated he inspects the Resident's rooms on a regular basis and as needed, and also indicted if staff have an environmental issue they would put in a work order.</p> <p>3.1-19(f)</p>		<p>1.All residents have the potential to be affected by the alleged deficient practice.</p> <p>2.The following measures will be done to ensure the alleged deficient practice does not recur</p> <p>a. Maintenance staff will check all bathrooms to ensure there are no problems with the grout and no tape on grab bars; and make any necessary repairs by May 16, 2014.</p> <p>1.The facility has implemented a QA tool to randomly audit weekly x 3months. These audits will be done by maintenance director or designee. Results will be discussed in the quarterly QA meeting for review.</p> <p>2.Date corrections completed: May 21 2014</p> <p>.</p> <p>.</p>				

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