

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 28, 29, 30, & 31, 2015, January 4, 5, & 6, 2016.</p> <p>Facility number: 000537 Provider number: 155409 AIM number: 100267270</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census Payor Type: Medicare: 7 Medicaid: 46 Other: 4 Total: 57</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed on January 13, 2016.</p>	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility respectfully requests paper compliance for this citation.	
F 0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE			

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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Bldg. 00	<p>PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a care plan was reviewed and revised for a resident who developed a pressure ulcer (Resident #24) and for 2 residents with weight loss. (Residents #18 and #54).</p> <p>Findings include:</p> <p>1.) The closed clinical record of Resident #24 was reviewed on 1/4/16 at 2:05 p.m. Diagnoses for the resident included, but were not limited to pressure ulcer and wound infection.</p> <p>Resident #24 was admitted to the facility</p>	F 0279	F279 Develop Comprehensive Care Plans 1. Resident #24 no longer resides at the facility. The care plans of Resident #18 and Resident #54 have been reviewed and revised as necessary to promote weight gain or stabilize weight loss. 2. All residents identified with the potential for skin breakdown or actual skin breakdown have the potential to be affected. Once the potential for skin breakdown or actual skin breakdown has been identified and evaluated, an appropriate care plan will be developed to prevent breakdown or further breakdown, and to promote healing or prevent worsening of the area. All residents identified	01/30/2016

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	<p>on 7/23/15.</p> <p>A care plan dated 7/23/15 and current through 10/22/15, indicated the resident had a potential for skin breakdown. Interventions included a pressure reducing pad in wheelchair, staff to observe skin condition with each care interaction, weekly skin assessment to be completed, and providing a pressure reducing mattress on the bed.</p> <p>A nurse's note dated 8/14/15 at 2:05 p.m., indicated Resident #24 had an excoriated open area on his left gluteal fold measuring 3 centimeters (cm) x 2.5 cm x 0.5 cm.</p> <p>Another care plan, initiated on 8/16/15 and current through 10/22/15, indicated the resident had an actual skin breakdown, Stage III pressure ulcer. A Stage III pressure ulcer involves full thickness skin loss and involves damage to subcutaneous tissue.</p> <p>The goal was the resident's wound would reduce in size every week and have no further skin breakdown. This goal was not initiated until 9/3/15. Interventions included, but were not limited to, double food portions, low air loss mattress, treatments as ordered, vitamin supplements as ordered, wound</p>		<p>with significant weight loss have the potential to be affected. Once weight loss has been identified and evaluated, an appropriate care plan will be developed to promote weight gain or stabilize weight loss. This will include Registered Dietician intervention. The Director of Nursing or her Designee will monitor the weekly weight sheet as well as the weekly skin assessments at the weekly Skin and Weight Assessment Meeting. Any newly discovered skin issues from progress notes or weekly skin assessment or any weight losses will be reported to the weekday Continuous Quality Improvement Meeting. At that time the Director of Nursing or her Designee will ensure that all notifications, assessments, interventions, and care plan updates take place. This process will be ongoing. 3. The Interdisciplinary Team and nursing staff were educated on January 25th, 2016 on the importance of timely care planning and the timely implementation of interventions with both weight loss and pressure ulcers. Topics included skin assessments, skin breakdown prevention, what should be done if you identify a skin issue or weight loss, what constitutes a change of condition in regards to skin issues and weight loss, and care planning for skin issues and weight loss. The Interdisciplinary Team meets</p>	

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	<p>assessment routinely. The care plan indicated these interventions were not initiated until 9/3/15, 17 days after the pressure was identified.</p> <p>2.a.) A clinical record review for Resident #18 was completed on 12/30/15 at 3:39 p.m. Diagnoses included, but were not limited to, morbid obesity and lymphedema.</p> <p>A review of Resident #18's weight summary, indicated resident weighed 435.9 pounds on 11/26/15, and 399 pounds on 12/2/15 (36.9 pound weight loss in 6 days).</p> <p>A careplan dated 11/20/15, indicated Resident #18 was at risk for a significant weight loss. The careplan lacked documentation of revision after 12/2/15.</p> <p>Review of a Nutritional Risk Quarterly Review, effective date 12/16/15, signed date 12/18/15, indicated Resident #18 had a weight loss of 5-7.5% in 30 days. The summary of nutritional review indicated "...care plan updated, consult dietician as needed, continue to monitor...."</p> <p>A careplan dated 12/18/15 (16 days after documented weight decrease on 12/2/15), indicated Resident #18 had a significant</p>		<p>each weekday review new problems or concerns. New areas of skin breakdown will be addressed at that time. Any staff member who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. 4. The Interdisciplinary Team will meet to review all new problems or concerns with pressure ulcers or weight loss as evidenced by the Director of Nursing or her Designee monitoring. This will take place daily at the Continuous Quality Improvement meeting to ensure that all areas have been addressed in a timely manner. Results of the monitoring will be reviewed at the monthly Quality Assurance Committee. Any potential problems and necessary reeducation will be discussed. An Action Plan will be written by the committee to address any patterns and monitored weekly by the Administrator until resolved.</p> <p>5. January 30, 2016</p>	

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	<p>weight loss.</p> <p>A review of progress notes from 12/2/15 through 12/18/15, lacked documentation indicating the plan of care had been updated for Resident #18's significant weight loss.</p> <p>During an interview on 1/6/16 at 2:21 p.m., the DON indicated there was no documentation addressing the significant weight loss in Resident #18's clinical record from 12/2/15, until the Nutritional Risk Quarterly Review dated 12/16/15.</p> <p>2.b.) The clinical record of Resident #54 was reviewed on 12/30/15 at 3:23 p.m. Diagnoses for the resident included, but were not limited to, stroke, mild intellectual disabilities and major depressive disorder.</p> <p>Review of Resident #54's weights indicated on 11/3/15, he weight 238 pounds (lbs). On 12/2/15 he weighed 211.8 lbs. This is a significant weight loss of approximately 11% in 30 days.</p> <p>A care plan dated 8/18/13, and current through 3/2/16, indicated Resident #54 was at risk for significant weight loss and/or weight fluctuation related to general debility. The goal was, "Weight will remain stable." The significant</p>			

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	<p>weight loss was not addressed in the resident's care plan.</p> <p>On 12/31/15 at 11:00 a.m. the Director of Nursing (DON) provided a policy titled Weight Assessment and Intervention, dated 2010, and indicated it was the policy currently used by the facility. The policy indicated, "3. Any weight change of 5% or more since the previous weight assessment shall be retaken the next day to confirm....4. The Registered Dietitian will review the unit Weigh Record by the 15th of the month to follow individual weight trends. Negative trends will be evaluated by the treatment team to determine whether or not significant weight change has occurred...Individualized care plans shall address the following to whatever extent possible: identified cause of weight loss, goals and benchmarks for improvement. Time frames and parameters for monitoring and reassessment."</p> <p>In an interview on 1/6/16 at 2:23 p.m., with the DON, the Administrator, and the Registered Dietician, the DON indicated she enters all weights taken on the residents into the computer. Sometimes she doesn't get the weights entered for a week or more after they are done, but the date of the weights showing on the computer is the day the weights were</p>			

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F 0282 SS=E Bldg. 00	<p>actually done. The Registered Dietician (RD) was in the facility on 12/11/15 and a monthly weight report was printed for her to review. The RD did not address Resident #54's significant weight loss of 11% taken on 12/2/15. The Administrator indicated the DON had probably not yet entered Resident #54's weight of 211.8 taken on 12/2/15, into the computer, therefore it would not show on the report.</p> <p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure plans of care were followed for a resident who developed a pressure ulcer (Resident #24), a resident with physician call orders for blood glucose levels (Resident #8), and residents with contractures (Residents #40 and #37).</p> <p>Findings include:</p>	F 0282	<p>F282 Services by Qualified Person/Per Care Plan 1. Resident #24 no longer resides at the facility. The physician of Resident #8 is being notified if blood glucose levels are outside of call orders. Resident #37 and Resident #40 are receiving restorative services in regards to range of motion as indicated in their respective plans of care. 2. All residents have the potential to develop skin breakdown. All</p>	01/30/2016

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	<p>1. The closed clinical record of Resident #24 was reviewed on 1/4/16 at 2:05 p.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and wound infection.</p> <p>Resident #24 was admitted to the facility on 7/23/15.</p> <p>A care plan dated 7/23/15 and current through 10/22/15, indicated the resident had a potential for skin breakdown. Interventions included, but were not limited to, staff to observe skin condition with each care interaction and a weekly skin assessment to be completed.</p> <p>An admission Minimum Data Set assessment, dated 8/4/15, indicated the resident required extensive physical assistance of 2+ staff for bed mobility, toileting and personal hygiene, was totally dependent on staff for transferring, had functional limitation in range of motion on both sides of upper and lower extremities, and did not have a pressure ulcer.</p> <p>A nursing admission record with skin assessment, dated 7/23/15, indicated Resident #24 did not have a pressure ulcer.</p> <p>A Weekly Skin Sheet assessment, dated</p>		<p>residents have been assessed for risk factors and a plan of care to prevent skin breakdown has been developed based on the degree of risk or any current skin issues. All residents having call orders for blood glucose levels have the potential to be affected. The physician is made aware of blood glucose levels outside of call orders in a timely manner. All residents identified as requiring restorative services for range of motion have the potential to be affected. Care plans have been reviewed and residents requiring these services have been identified and care plans updated as necessary. 3. Licensed Nurses were educated regarding initial wound assessment and timely intervention on January 25th, 2016. Topics included skin assessments, skin breakdown prevention, what should be done if you identify a skin issue, what constitutes a change of condition in regards to skin issues, and care planning for skin issues. Skin assessments are completed upon admission and weekly. If skin breakdown is identified, evaluated, and determined to be a pressure area, an appropriate treatment plan will be developed to promote healing or prevent worsening of the area. A care plan will be developed by the Interdisciplinary Team and interventions will be reviewed, developed, and implemented in a timely fashion. Reevaluation of</p>	

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	<p>7/31/15, indicated Resident #24 did not have any open areas.</p> <p>The next reference to the resident's risk for developing a pressure ulcer was 8/14/15. A nurse's note timed at 2:05 p.m. indicated the resident had an excoriated open area on his left gluteal fold measuring 3 centimeters (cm) x 2.5 cm x 0.5 cm.</p> <p>The next skin assessment was done 8/20/15, which indicated Resident #24 had a Stage III pressure ulcer on his left ischium.</p> <p>On 1/4/16 at 5:34 p.m., the DON indicated she was not able to find any Weekly Skin Assessments done between 7/31/15 and 8/20/15.</p> <p>2. The clinical record of Resident #8 was reviewed on 12/30/15 at 4:36 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.</p> <p>A recapitulated physician's order for November, 2015, with an original order date of 9/14/15, indicated Resident #8 was to receive blood glucose monitoring checks 4 times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. The order indicated to call the physician if the blood glucose level was less than 70 or</p>		<p>pressure areas will occur weekly or more often if necessary. Licensed Nurses were educated regarding the need for physician notification of blood glucose levels falling outside of parameters on January 18th, 2016. Monitoring has been initiated to ensure that all values falling outside of parameters are reported to the physician timely. Certified Nursing Assistants and Restorative Aides were educated on January 20th, 2016 regarding completing both active and passive range of motion based on each resident's plan of care. Education included documentation of the provision of the service. Any staff member who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. 4. The Director of Nursing or her Designee will monitor the Blood Glucose Levels of residents to determine if appropriate physician notification has occurred daily for four weeks then twice weekly for two months. Monitoring will continue weekly for three months for a total of six months. Any concerns found will be addressed immediately. Results of the monitoring will be reported to the Quality Assurance Committee. Any potential problems and necessary reeducation or disciplinary action will be discussed. If necessary, an Action Plan will be written by the</p>	

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	<p>above 250.</p> <p>A review of Resident #8's Medication Administration Record (MAR), indicated the blood glucose level was above 250 on November 3, 11, and 23, 2015, for the 1600 hour blood glucose monitoring check. The MAR indicated the blood glucose level was above 250 on November 1, 2, 3, 6, 9, 11, 15, and 21, 2015, for the 2100 hour blood glucose monitoring check.</p> <p>A review of nursing progress notes for the month of November, 2015, lacked documentation indicating the physician was notified of the blood glucose level above 250 on those dates.</p> <p>A review of physician's orders for the month of November, 2015, lacked documentation indicating a new order was obtained related to a blood glucose level above 250 on those dates.</p> <p>A recapitulated physician's orders for December, 2015, with an original order date of 12/15/15, indicated Resident #8 was to receive blood glucose monitoring checks 4 times a day at 0600, 1100, 1600, and 2100. The order indicated to call the physician if the blood glucose level was less than 70 or above 250.</p>		<p>committee and monitored weekly by the Administrator until resolved. The Director of Nursing or her Designee will monitor routine weekly assessments and initial wound assessments for accuracy, completeness, and need for intervention daily for four weeks and then twice weekly for two months. Monitoring will continue once weekly for three months for a total of six months. Any concerns found will be addressed immediately. Results of the monitoring will be reported to the Quality Assurance Committee. Any potential problems and necessary reeducation or disciplinary action will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until resolved. The Director of Nursing or her Designee will monitor the documentation of active and passive range of motion by Certified Nursing Assistants and Restorative Aides daily for one month. The Restorative Nurse will randomly observe Certified Nursing Assistants and Restorative Aides providing services three times weekly for one month. Continued monitoring will occur four times weekly for two months and then weekly for three month for a total of six months. The results of monitoring will be reported monthly to the Quality Assurance</p>	

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	<p>A review of Resident #8's MAR, indicated the blood glucose level was above 250 on December 19, 20, and 26, 2015, for the 1600 hour blood glucose monitoring check. The MAR indicated the blood glucose level was above 250 on December 15, 19, and 20, 2015, for the 2100 hour blood glucose monitoring check.</p> <p>A review of nursing progress notes for the month of December, 2015, lacked documentation indicating the physician was notified of the blood glucose level above 250 on those dates.</p> <p>A review of physician's orders for the month of December, 2015, lacked documentation indicating a new order was obtained related to a blood glucose level above 250 on those dates.</p> <p>On 12/31/15 at 11:25 a.m., the Director of Nursing (DON) indicated the nurses are to notify the physician upon obtaining a blood glucose level that is above or below the number indicated on the physician's order. The DON indicated documentation of physician notification should be documented in a nursing progress note or included with a new order if one was obtained upon notifying the physician of the blood glucose level. A policy regarding blood glucose</p>		<p>Committee. Any potential problems and necessary reeducation or disciplinary action will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until resolved. 5. January 30, 2016</p>	

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	<p>monitoring and notifying physician of results was requested at this time.</p> <p>During an interview on 1/6/16 at 2:05 p.m., the DON indicated there was no documentation in the clinical record indicating notification of physician for blood glucose levels above 250 for November 1, 2, 3, 6, 9, 11, 15, 21, or 23, 2015, and December 15, 19, 20, or 26, 2015.</p> <p>No policy for blood glucose monitoring and notifying physician of results was provided by the survey exit on 1/6/16 at 4:40 p.m.</p> <p>3.a. The clinical record of Resident #37 was reviewed on 1/4/15 at 9:00 A.M. Diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>TriCare Rehab referral to nursing dated 9/16/2015, from PT (physical therapy) included orders for AROM (active range of motion) and PROM (passive range of motion). Recommendations, AROM of right upper extremity 20 reps 2 sets, all planes utilizing 2 pound weights. Wear left hand splint every day for 4 hours.</p> <p>Task List Report indicates, Nursing rehab: PROM 15-20 reps to left extremities daily.</p>			

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	<p>Nursing rehab: AROM 15-20 reps to right extremities daily with a 2 pound weight. Task Schedule: Everyday - shift 7:00 a.m. - 3:00 p.m.</p> <p>A care plan dated 12/30/2015 indicated, Resident #37 required a restorative program for AROM and PROM to restore or maintain their functional range of motion. Date initiated 9/30/2013. FOCUS: Requires a restorative program for PROM and AROM to restore or maintain their functional range of motion. GOAL: Resident #37 will complete 10-15 reps (replications) of AROM to right extremities daily through next review. Resident #37 will complete 10-15 reps of PROM to left extremities daily through next review. INTERVENTIONS: Administer the program per schedule, Encourage resident to complete 10-15 reps of AROM to right extremities, Do not move joints if the resident c/o (complains of) or shows sign of pain. Evaluate and revise program as needed, Notify nurse of any decline or improvement for further evaluation, possible therapy and or MD (medical doctor) notification. Provide assistance as needed.</p> <p>Restorative documentation indicated AROM and PROM was not done on</p>			

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	<p>10/06/2015, 10/10/2015, 10/11/2015, 10/15/2015, 10/20/2015, 10/24/2015, 10/29/2015, 10/31/2015, 11/01/2015, 11/02/2015, 11/03/2015, 11/07/2015, 11/8/2015, 11/09/2015, 11/10/2015, 11/11/2015, 11/12/2015, 11/14/2015, 11/15/2015, 11/17/2015, 11/21/2015, 11/22/2015, 11/24/15, 11/26/2015, 11/27/2015, 11/29/2015, 12/01/2015.</p> <p>3.b. The clinical record of Resident #40 was reviewed on 1/4/15 at 11:00 A.M. Diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>TriCare Rehab referral to nursing dated 4/21/2014, from PT (Physical Therapy) included orders for AROM (active range of motion), PROM (passive range of motion), and Orthotic/prosthetic.</p> <p>Recommendations, AROM of right shoulder 20 reps, all planes utilizing 2 pound weights. PROM right shoulder 15 reps, all planes. Wear left hand splint every day for 2 hours. Goals, To maintain strength, ROM (range of motion), activity tolerance for self feeding, manage contracture.</p> <p>Care Plan dated 12/30/2015 indicated, Resident #40 required a restorative program for PROM to restore or maintain their functional range of motion. Date</p>			

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	<p>initiated 9/29/2013.</p> <p>FOCUS: Requires a restorative program for PROM to restore or maintain their functional range of motion. All extremities.</p> <p>GOAL: Resident #40 will allow staff to complete 10-15 reps of PROM to all extremities daily through next review.</p> <p>INTERVENTIONS: Administer for the program per schedule, Do not move joints if the resident c/o or shows sign of pain. Evaluate and revise program as needed, Resident #40 will allow staff to complete 10-15 reps of PROM to all extremities, Notify nurse of any decline or improvement for further evaluation, possible therapy and or MD notification, Provide assistance as needed.</p> <p>Task List Report indicated, Nursing rehab: PROM 15-20 reps to all extremities daily. CNA (Certified Nursing Assistant) functional maintenance: Splint Left hand . Splint on after breakfast, off at lunch, on after lunch and off at dinner. off at night. Task Schedule: Everyday. Qshift (every shift). Day 7:00 a.m.- 3:00 p.m. Evening 3:00 p.m. - 11:00 p.m.</p> <p>Restorative documentation sheet indicated Resident #40 did not receive any PROM on the following dates: 09/28/2015, 09/29/2015, 10/02/2015,</p>			

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	<p>10/03/2015, 10/04/2015, 10/05/2015, 10/10/2015, 10/11/2015, 10/19/2015, 10/22/2015, 10/24/2015, 10/25/2015, 10/26/2015, 11/19/2015, 11/20/2015, 11/21/2015, 11/22/15, 11/27/2015, 11/30/2015, 12/5/15, 12/6/15, 12/11/15, 12/13/15, 12/14/15, 12/19/15, 12/20/15, 12/23/15, 12/25/15, 12/27/15, 12/28/15, 1/2/16, 1/3/16, 1/4/16.</p> <p>On 1/4/16 at 10:30 a.m., the Minimum Data Set (MDS) assessment coordinator indicated after reviewing the restorative flow sheets there were days range of motion had not been documented and if it was not documented, "it was not done." On the dates restorative aides are not there, the certified nursing assistants are supposed to follow the restorative program and document on the restorative program sheets. There was no other place this service would be documented.</p> <p>Restorative Aide (RA) #1, on January 6th at 9:30 a.m., indicated she was the restorative aide for Faith and Hope halls. Review of the restorative program documentation sheet indicated there were days active range of motion and passive range of motion, were not documented. RA #1 indicated CNA's are to provide the restorative services when she is not there, and then document on the restorative program sheet. If range of motion was</p>			

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	not documented then it was not done. An undated policy for "Restorative Nursing Programming" was provided by the MDS Coordinator as their current policy on 1/5/16 at 4:00 p.m. The policy indicated, "All Restorative Programs must have the following documentation available to validate the the program... the actual number of minutes per day spent in each restorative program for each resident needs to be documented during the look-back period for the MDS... -The documentation shows that the programs are ongoing and administered as planned even outside of the look-back period for the MDS." 3.1-35(g)(2)						
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from						

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	<p>developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure 2 residents who entered the facility without pressure ulcers did not develop a pressure ulcer, in that a resident did not receive timely skin assessments/interventions and developed a Stage III pressure ulcer on his left ischium (hip area) (Resident #24), a resident admitted with redness to her sacrum did not receive timely assessments and interventions and developed an open area on her coccyx (Resident #75), and a resident admitted with a Stage III pressure ulcer did not receive wound assessments according to her plan of care and facility policy (Resident #62) for 3 of 4 residents who met the criteria for review of pressure ulcers.</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident #24 was reviewed on 1/4/16 at 2:05 p.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and wound infection.</p> <p>Resident #24 was admitted to the facility on 7/23/15.</p> <p>A care plan dated 7/23/15 and current through 10/22/15, indicated the resident</p>	F 0314	<p>F314 Treatment Services to Prevent/Heal Pressure Ulcers</p> <p>1. Resident #24 and Resident #75 no longer reside at the facility. The care plan of Resident #62 has been reviewed and services to heal the pressure area are being provided.</p> <p>2. All residents have the potential to develop skin breakdown. All residents have been assessed for risk factors and a plan of care to prevent skin breakdown has been developed based on the degree of risk.</p> <p>3. Progress Notes and Weekly Skin Assessments will be reviewed daily to ensure that any identified skin issue is appropriately addressed and follow through developed per policy. Residents will be added to those reviewed by the Skin and Weight Assessment Team. Licensed Nurses were educated regarding initial wound assessment and timely intervention on January 25th, 2016. Topics included the Skin and Weight Assessment Team, when to complete skin assessments, what to do if a resident is at risk, what to do if a resident has actual skin breakdown, preventative measures and care planning, timely interventions and notifications, when skin breakdown is a change of condition, Minimum Data Sets and skin assessments, and Dietary and Registered Dietician notification. Skin assessments</p>	01/30/2016

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	<p>had a potential for skin breakdown. Interventions included a pressure reducing pad in wheelchair, staff to observe skin condition with each care interaction, weekly skin assessment to be completed, and providing a pressure reducing mattress on the bed. On 1/6/15 at 11:00 a.m., the Administrator indicated a pressure reducing mattress was the standard mattress used by the facility for all residents, unless they required a mattress providing additional pressure relief.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 8/4/15, indicated the resident required extensive physical assistance of 2+ staff for bed mobility, toileting and personal hygiene, was totally dependent on staff for transferring, had functional limitation in range of motion on both sides of upper and lower extremities, and did not have a pressure ulcer.</p> <p>A nursing admission record, dated 7/23/15, indicated he did not have a pressure ulcer.</p> <p>A nurse's note dated 7/23/15 at 10:30 p.m., indicated the resident said he needed an, "air bed," because he had one at home.</p>		<p>are completed weekly. If skin breakdown is identified, evaluated, and determined to be a pressure area, an appropriate treatment plan will be developed to promote healing or prevent worsening of the area. A care plan will be developed by the Interdisciplinary Team and interventions will be reviewed, developed, and implemented in a timely fashion. Reevaluation of pressure areas will occur weekly or more often if necessary. Orders will be obtained for all areas of skin issues and timely and appropriate notifications will be made. Any staff member who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. 4. The Director of Nursing or her Designee will monitor routine weekly assessments and initial wound assessments for accuracy, completeness, and need for intervention daily for four weeks and then twice weekly for two months. Monitoring will continue once weekly for three months for a total of six months. Results of the monitoring will be reported to the Quality Assurance Committee and any patterns identified. Any potential problems and necessary reeducation or disciplinary action will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until</p>	

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	<p>A nurse's note dated 7/24/15 at 3:23 p.m., indicated the resident again requested an air mattress.</p> <p>A nurses's note dated 7/24/15 at 1:53 a.m., indicated no open areas in the resident's skin were noted.</p> <p>A Weekly Skin Sheet assessment dated 7/31/15, indicated he did not have any open areas.</p> <p>The next reference to the resident's risk for developing a pressure ulcer was 8/14/15 (14 days later). A nurse's note dated 8/14/15 at 2:05 p.m., indicated the resident had an excoriated open area on his left gluteal fold measuring 3 centimeters (cm) x 2.5 cm x 0.5 cm.</p> <p>The resident's, "excoriated area," was not evaluated by a wound nurse until 8/20/15 at 12:03 p.m. (6 days after the initial open area was noted). A Wound 3.2 Weekly Skin Assessment dated 8/20/15, indicated the resident now had a Stage III pressure ulcer on his left ischium. A Stage III pressure ulcer involves full thickness skin loss and involves damage to subcutaneous tissue.</p> <p>On 1/4/16 at 4:45 p.m., the MDS (Minimum Data Set) coordinator indicated a low air loss mattress, as</p>		resolved. 5. January 30, 2016				

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	<p>indicated by his care plan, was not provided to Resident #24 until 9/3/15.</p> <p>2. The clinical record review for Resident #75 was completed on 12/31/15 at 1:54 p.m. Diagnoses included, but were not limited to, pressure ulcer and depressive disorder.</p> <p>a) A review of an admission assessment dated 7/29/15, indicated Resident #75 had redness to the sacral area. The sacrum is a bone formed from the fusion of spinal vertebra between the coccyx and lumbar regions.</p> <p>A nurses note dated 8/4/15 at 13:17, indicated "...New order for skin barrier to o/a [open area] on coccyx[...]" No further wound assessment documentation was found in the clinical record between 8/4/15 through 8/11/15, when Resident #75 discharged to hospital.</p> <p>An Admission/Re-admission Assessment dated 8/14/15, indicated resident had an open area to coccyx, measuring 5.0 centimeters long by 5.0 centimeters wide by 0.5 centimeters deep. No further wound assessment documentation was found in Resident #75's clinical record.</p> <p>On 12/31/15 at 10:04 a.m., the DON provided a policy titled, "Pressure Ulcer Assessment and Staging," dated 7/1/11,</p>			

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	<p>and indicated it was the current policy used by the facility. The policy indicated, "...When the Charge Nurse is aware of skin breakdown...Document site, stage, size, depth, drainage, color, odor, prevention and treatment response...Documentation of decubitus must occur upon identification and at lease once a week. Assessment must include: a) Characteristics, (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue)...."</p> <p>On 1/4/16 at 11:35 a.m., the DON indicated there was no other wound assessment documentation available in the clinical record for Resident #75.</p> <p>b) A dietary note dated 8/25/15 at 09:37, indicated Resident #75 was to receive cottage cheese and fortified pudding twice a day to aid in healing resident's wound.</p> <p>Point of Care meal consumptions documentation was reviewed for August and September, 2015. Documentation included date, meal time, and a number indicating the amount eaten (0 indicated 0-25% meal consumption, 1 indicated 26%-50% meal consumption, 2 indicated 51%-75% meal consumption, 3 indicated 76%-100% meal consumption).</p>			

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	<p>A dietary note dated 8/24/15, indicated Resident #75's average meal intake consumption is 50-75%.</p> <p>A review of facility meal intake documentation for September 1 - September 27, 2015, indicated Resident #75 consumed 26%-50% of 12 meals and 51%-75% of 24 meals.</p> <p>During an interview on 1/4/15 at 11:35 a.m., the DON indicated there is no separate documentation to monitor the consumption of cottage cheese and fortified pudding interventions in place to aid in wound healing. The DON indicated they are included in the overall meal consumption documentation.</p> <p>3. The clinical record review for Resident #62 was completed on 12/30/15 at 2:30 p.m. Diagnoses included, but were not limited to, unstageable pressure ulcer and neuromuscular dysfunction of bladder. Resident #62 admitted to the facility on 9/24/15.</p> <p>An assessment of Resident #62's skin, dated 9/24/15, indicated Resident #62 admitted to facility with a stage 3 pressure ulcer wound to right ischium.</p> <p>A review of Resident #62's clinical record, lacked documentation of right</p>			

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	<p>ischium wound assessments between 9/25/15 to 10/7/15, and 10/15 to 11/1/15.</p> <p>Weekly skin reports dated 10/5/15, 10/17/15, 10/31/15, indicated Resident #62 had a wound to right ischium, but lacked an assessment of the wound.</p> <p>A review of nursing progress notes from 9/25/15 through 11/2/15, lacked documentation of right ischium wound assessment.</p> <p>On 1/5/16 at 1:45 p.m., Resident #62's unstageable right ischium wound was observed to be consistent with wound clinic documentation.</p> <p>During an interview on 1/6/16 at 10:26 a.m., the Director of Nursing (DON) indicated there were no other wound assessments between 9/25/15 to 10/7/15 and 10/15-11/1/15, in the clinical record for Resident #62.</p> <p>On 12/31/15 at 10:04 a.m., the DON provided a policy titled, "Pressure Ulcer Assessment and Staging," dated 7/1/11, and indicated it was the current policy used by the facility. The policy indicated, "...Documentation of decubitus must occur upon identification and at least once a week. Assessment must include: a) Characteristics, (i.e. size, shape,</p>			

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F 0315 SS=D Bldg. 00	<p>depth, color, presence of granulation tissue, necrotic tissue)...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure urinary catheter drainage bags and tubing were maintained in a manner to prevent urinary tract infection for 3 of 3 residents observed (Residents #23, #69 and #62).</p> <p>Findings include:</p> <p>1. A clinical record review for Resident #23 was completed on 1/5/16 at 3:28 p.m. Diagnoses included, but were not limited to, hemiplegia and enlarged</p>	F 0315	<p>F315 No Catheter, Prevent UTI, Restore Bladder</p> <p>1. The catheter tubing and catheter drainage bags of Resident #23 and Resident #62 have been properly maintained in a manner to prevent urinary tract infection. Resident #69 was not identified on the sample list provided by surveyors.</p> <p>2. All residents with urinary catheters have the potential to be affected. These residents have had urinary drainage equipment</p>	01/30/2016

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	<p>prostate.</p> <p>A recapitulated physician's order for January, 2016, with an original order date of 12/23/15, indicated Resident #23 had a urinary catheter (a tube which drains urine from the bladder).</p> <p>On 12/28/15 at 11:16 a.m. and 2:50 p.m., Resident #23's indwelling catheter drainage bag and tubing were observed resting on the floor.</p> <p>On 12/29/15 at 9:29 a.m., Resident #23's catheter drainage bag was observed resting on the floor.</p> <p>On 12/30/15 at at 9:19 a.m., Resident #23's catheter tubing was observed resting on the floor.</p> <p>2. A clinical record review for Resident #69 was completed on 1/5/16 at 3:28 p.m. Diagnoses included, but were not limited to, pressure ulcer of sacral region and retention of urine.</p> <p>A recapitulated physician's order for January, 2016, with an original order date of 12/29/15, indicated Resident #69 had a urinary catheter.</p> <p>On 12/29/15 at 3:13 p.m., Resident #69's urinary catheter bag was observed resting</p>		<p>evaluated and replaced as necessary to ensure that they are maintained properly to prevent infection.</p> <p>3. All nursing staff were educated on January 20th, 2016 on Catheter Care to Prevent Infections. Topics included criteria for catheter care, the appropriate care and handling of catheter tubing, and the risk of infection related to catheter care. Catheter tubing and drainage bags will be monitored to assure that it is being maintained in a manner that assures best practices.</p> <p>Any staff member who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated.</p> <p>4. The Director of Nursing or her Designee will monitor catheter tubing and drainage bags five times weekly on various shifts for four weeks to ensure that it is maintained properly based on best practices. Monitoring will continued twice weekly for two months and then weekly for three months for a total of six months. Monitoring will occur randomly. Any concerns will be corrected as discovered. The results of monitoring will be reported to the Quality Assurance Committee. Any potential problems and necessary reeducation or disciplinary</p>	

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NAME OF PROVIDER OR SUPPLIER WATERS OF INDIANAPOLIS, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227			
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	<p>on the floor.</p> <p>3. A clinical record review for Resident #62 was completed on 1/6/2015 at 10:26 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and open wound of buttock.</p> <p>A recapitulated physician's order for January, 2016, with an original order date of 12/24/15, indicated Resident #62 had a urinary catheter.</p> <p>On 1/5/16 at 12:34 p.m., Resident #62's urinary catheter bag and tubing were observed resting on the floor.</p> <p>On 1/5/16 at 3:29 p.m., Resident #62's urinary catheter bag was observed resting on the floor.</p> <p>On 1/5/16 at 12:33 p.m. the Director of Nursing (DON) indicated it was not best practice to have any part of the catheter tubing or drainage bag touching the floor. An indwelling catheter care policy was requested at that time.</p> <p>On 1/5/16 at 3:27 p.m., the DON provided a guideline titled, "Indwelling Catheter Justification/Decision Diagram," revision date of 2/5/15, and indicated this was currently used by the facility. The guideline did not contain information</p>		<p>action will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until resolved.</p> <p>5. January 30, 2016</p>				

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F 0318 SS=D Bldg. 00	<p>regarding keeping the urinary catheter drainage system off of the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review, the facility failed to ensure residents with contractures received treatment and services as ordered by the physician to prevent further decrease in range of motion, for 2 of 3 residents reviewed for receiving treatment to prevent decrease in range of motion. (Residents #37 and #40)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #37 was reviewed on 1/4/15 at 9:00 A.M. Diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 9/30/15, indicated Resident #37 had impaired range of</p>	F 0318	F318 Increase/Prevent Decrease in Range of Motion 1. Resident #37 and Resident #40 are receiving restorative services in regarding to range of motion as indicated in their respective plans of care. 2. All residents identified as requiring restorative services for range of motion have the potential to be affected. Care plans have been reviewed and residents requiring these services have been identified. 3. Certified Nursing Assistants and Restorative Aides were educated on January 20th, 2016 regarding completing both active and passive range of motion based on each resident's Minimum Data Set and plan of care. Education included documentation of the provision of the service. Any staff member who fails to comply with the points of the inservice will be	01/30/2016

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	<p>motion on one side of both her lower and upper extremity.</p> <p>TriCare Rehab-Referral to Nursing, dated 9/2/2015--Current functional Status: orders include: Passive Range of Motion (PROM), Active Range of Motion (AROM), Splint/Brace, Transfer. (B) Bilateral LE (lower extremity) exercises with no wts (weights) on (L) Left lower Extremity (LE) and 2# wts on Right (R) LE. PROM (L) LE. AROM right (R) LE. Stand at parallel bar or rail in hallway for static stand balance. Recommendations include, Patient (PT) must wear AFO (splint) on Left LE when out of bed. Do not attempt to ambulate pt. due to high risk of falls. Ambulation: 0 feet, Transfer: Min assist with support of grab bar, Weight Bearing status: full, Precautions: unsafe to ambulate. TriCare Rehab referral to nursing dated 9/16/2015 from PT include orders for AROM and PROM.</p> <p>Recommendations, AROM exe of right upper extremity 20 reps 2 sets, all planes utilizing 2 pound weights. Wear left hand splint every day for 4 hours.</p> <p>Task List Report indicates, Nursing rehab: PROM 15-20 reps to left extremities daily. Nursing rehab: AROM 15-20 reps to right extremities daily with a 2 pound</p>		<p>further educated and/or progressively disciplined as indicated. 4. The DON or her Designee will monitor the documentation of active and passive range of motion by Certified Nursing Assistants and Restorative Aides daily for one month. The Restorative Nurse will randomly observe Certified Nursing Assistants and Restorative Aides providing services three times weekly for one month. Continued monitoring will occur four times weekly for two months and then weekly for three months for a total of six months. The results of monitoring will be reported monthly to the Quality Assurance Committee. Any patterns or potential problems and necessary reeducation or disciplinary action will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until resolved. 5. January 30, 2016</p>	

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	<p>weight. Task Schedule: Everyday. Qshift (every shift). Day 7:00 a.m. - 3:00 p.m.</p> <p>A Care Plan dated 9/30/15, current through 12/30/2015 indicated, Resident required a restorative program for AROM (active range of motion) and PROM (passive range of motion) to restore or maintain functional range of motion. FOCUS: Requires a restorative program for PROM and AROM to restore or maintain their functional range of motion. GOAL: Resident will complete 10-15 reps (replications) of AROM to right extremities daily through next review. Resident will complete 10-15 reps of PROM to left extremities daily through next review. INTERVENTIONS: Administer the program per schedule, Encourage resident to complete 10-15 reps of AROM to right extremities, Do not move joints if the resident c/o or shows sign of pain. Evaluate and revise program as needed, Notify nurse of any decline or improvement for further evaluation, possible therapy and or MD (medical doctor) notification. Provide assistance as needed.</p> <p>Restorative documentation indicated AROM and PROM was not done on 10/06/2015, 10/10/2015, 10/11/2015,</p>			

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	<p>10/15/2015, 10/20/2015, 10/24/2015, 10/29/2015, 10/31/2015, 11/01/2015, 11/02/2015, 11/03/2015, 11/07/2015, 11/8/2015, 11/09/2015, 11/10/2015, 11/11/2015, 11/12/2015, 11/14/2015, 11/15/2015, 11/17/2015, 11/21/2015, 11/22/2015, 11/24/15, 11/26/2015, 11/27/2015, 11/29/2015, 12/01/2015.</p> <p>2. The clinical record of Resident #40 was reviewed on 1/4/15 at 11:00 A.M. Diagnoses included, but were not limited to, dementia and muscle weakness.</p> <p>A quarterly MDS assessment dated 11/13/15, indicated Resident #40 had impaired range of motion on both sides of upper and lower extremities.</p> <p>A Care Plan initiated 9/29/13 and current through 12/30/2015, indicated, Resident requires a restorative program for PROM (passive range of motion) to restore or maintain their functional range of motion. FOCUS: Requires a restorative program for PROM to restore or maintain their functional range of motion. All extremities. GOAL: Resident #40 will allow staff to complete 10-15 reps of PROM to all extremities daily through next review. INTERVENTIONS: Administer the program per schedule, Do not move joints if the resident c/o or shows sign of</p>			

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	<p>pain. Evaluate and revise program as needed, Resident #40 will allow staff to complete 10-15 reps of PROM to all extremities, Notify nurse of any decline or improvement for further evaluation, possible therapy and or MD notification, Provide assistance as needed.</p> <p>TriCare Rehab-Referral to Nursing, dated 2/28/2014--Current functional Status: orders include: Active Range of Motion (AROM). (B) Bilateral LE exercises with no wts 20 reps x 2 sets in all planes.</p> <p>TriCare Rehab referral to nursing dated 4/21/2014 from PT include orders for AROM, PROM, and Orthotic/ prosthetic. Recommendations, AROM of right shoulder 20 reps, all planes utilizing 2 pound weights. PROM right shoulder 15 reps, all planes. Wear left hand splint every day for 2 hours. Goals, To maintain strength, ROM, activity tolerance for self feeding, manage contracture.</p> <p>Task List Report indicates, Nursing rehab: PROM 15-20 reps to all extremities daily. CNA (Certified Nursing Assistant) functional maintenance: Splint Left hand . Splint on after breakfast, off at lunch, on after lunch and off at dinner. off at night. Task Schedule: Everyday. Qshift. Day 7:00 a.m.- 3:00 p.m. Evening 3:00 p.m. -</p>			

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	<p>11:00 p.m.</p> <p>Restorative documentation sheet indicated Resident #40 did not receive any PROM on the following dates as: 09/28/2015, 09/29/2015, 10/02/2015, 10/03/2015, 10/04/2015, 10/05/2015, 10/10/2015, 10/11/2015, 10/19/2015, 10/22/2015, 10/24/2015, 10/25/2015, 10/26/2015, 11/19/2015, 11/20/2015, 11/21/2015, 11/22/15, 11/27/2015, 11/30/2015, 12/5/15, 12/6/15, 12/11/15, 12/13/15, 12/14/15, 12/19/15, 12/20/15, 12/23/15, 12/25/15, 12/27/15, 12/28/15, 1/2/16, 1/3/16, 1/4/16.</p> <p>On 1/4/16 at 10:30 a.m., the MDS (Minimum Data Set) Coordinator indicated after reviewing the restorative flow sheets there were days range of motion had not been documented and if it was not documented, "it was not done." On the dates restorative aides are not there, the CNAs are supposed to follow the restorative program and document on the restorative program sheets. There was no other place this service would be documented.</p> <p>Restorative Aide (RA) #1, on January 6th at 9:30 a.m., indicated she was the restorative aide for Faith and Hope halls. Review of the restorative program documentation sheet indicated there were</p>			

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F 0329 SS=D Bldg. 00	<p>days active range of motion and passive range of motion , were not documented. RA #1 indicated CNA's are to provide the restorative services when she is not there, and then document on the restorative program sheet. If range of motion was not documented then it was not done.</p> <p>An undated policy for "Restorative Nursing Programming" was provided by the MDS Coordinator as the current facility policy on 1/5/16 at 4:00 p.m. The policy indicated, "All Restorative Programs must have the following documentation available to validate the the program... the actual number of minutes per day spent in each restorative program for each resident needs to be documented during the look-back period for the MDS... -The documentation shows that the programs are ongoing and administered as planned even outside of the look-back period for the MDS."</p> <p>3.1-42(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive</p>			

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	<p>dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the cause of a resident's anxiety was evaluated and alternative interventions were considered prior to the administration of an anti-anxiety medication, for 1 of 5 residents who met the criteria for review of unnecessary medication use. (Resident #40)</p> <p>Findings include:</p> <p>The clinical record of Resident #40 was reviewed on 12/31/15 at 9:50 a.m. Diagnoses for the resident included, but were not limited to, depressive disorder, insomnia, and anxiety.</p>	F 0329	F329 Drug Regimen is Free From Unnecessary Drugs 1. The clinical record of Resident # 40 has been reviewed and a care plan has been developed with individualized interventions, including non-pharmacological, to address anxiety. 2. All residents receiving as needed antianxiety medication have the potential to be affected. All residents have been identified and care plans have been reviewed to assure that they have individualized interventions, including non-pharmacological, to address anxiety. 3. The Behavior Management Monitoring program was reviewed. Licensed Nurses were educated on January 25th, 2016 regarding identifying the cause and the use of behavioral	01/30/2016

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	<p>Resident #40 did not have a care plan for symptoms of anxiety.</p> <p>A recapitulated physician's order for December, 2015, with an original date of 6/24/15, indicated Resident #40 could receive lorazepam, 1.0 milligrams, every 6 hours, as needed, for anxiety. Lorazepam is a psychoactive medication given for anxiety.</p> <p>Medication Administration Records for December, 2015, indicated the resident received lorazepam on 12/7/15 at 8:02 p.m., 12/14/15 at 10:37 p.m., 12/15/15 at 10:27 p.m., 12/29/15 at 10:19 a.m., and 12/20/15 at 10:03 a.m.</p> <p>No documentation was found in the resident's record which indicated the causes of his anxiety had been evaluated or alternative interventions had been considered prior to the administration of the lorazepam.</p> <p>On 12/31/15 at 3:34 p.m., the Director of Nursing (DON) indicated she was not able to find any information regarding the causes of the resident's anxiety or alternative interventions considered or attempted during the month of December, 2015, when the as needed lorazepam was administered.</p>		<p>interventions prior to medication administration. Any staff member who fails to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. 4. The DON or her Designee will monitor the administration of antianxiety PRN medications five times weekly for four weeks, then twice weekly for two months, then once weekly for three months for a total of six months. Findings will be reported to the Quality Assurance Committee and any potential problems and necessary reeducation will be discussed. If necessary, an Action Plan will be written by the committee and monitored weekly by the Administrator until resolved. 5. January 30, 2016</p>	

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	<p>On 12/31/15 at 10:44 a.m., the DON provided a policy, dated 11/ 2010, titled, "Program Policy & Procedure," and indicated it was the policy currently used by the facility. The policy indicated, "...Alternative interventions will be attempted prior to the use of PRN [as needed] psychoactive medications."</p> <p>3.1-48(a)(4)</p>				