

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
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NAME OF PROVIDER OR SUPPLIER  CATHEDRAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 11, 12, 13, 14, 2016.</p> <p>Facility number: 000315 Provider number: 155720 AIM number: 100289030</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 3 Medicaid: 36 Other: 5 Total: 44</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on July 22, 2016.</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective August 13, 2016 to the annual licensure survey completed on July 14, 2016. The facility also request that our plan of correction be considered for paper review compliance. The facility would respectfully submit to you any compliance paper work needed.	
F 0155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE			

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><b>ADVANCE DIRECTIVES</b></p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</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 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. Based on observation, interview, and record review the facility failed to ensure resident preferences for advance directives were followed for 1 of 4 residents who met the criteria for review of choices. (Resident #51)</p> <p>Findings include:</p> <p>During an observation on 7/12/16 at 10:55 A.M., Resident #51 was observed sitting up in a recliner in the Floor 1 resident lounge in no apparent distress.</p> <p>The clinical record for Resident #51 was reviewed on 7/13/16 at 11:00 A.M. The diagnoses included, but was not limited to dementia, downs syndrome, sick sinus</p>	F 0155	<p><b>F155</b></p> <p><b>It is the practice of this facility to assure that resident's preferences are honored.</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Resident #51 physician order has been changed. The CNA assignment sheet has also been changed. The resident's preferences related to code status is being honored.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>All residents have been reviewed to assure that their residents' preferences have been honored and that all clinical documents correctly identify their preference related to</p>	08/13/2016

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	<p>syndrome. In the front cover of Resident #51 chart there was an index card with a bright green sticker indicating "FULL CODE".</p> <p>A document titled "INDIANA PHYSICIANS ORDERS SCOPE OF TREATMENT (POST) form dated 4/26/16, indicated Resident #51 was a DNR (Do Not Attempt Resuscitation). The document was signed by Resident #51 POA, and by the residents Medical Doctor on 4/29/16.</p> <p>The residents "Admission Assessment" dated 4/26/17 indicated Resident #51 was a "Full Code".</p> <p>The admission "PHYSICAN'S ORDERS" dated 4/26/16 indicated Resident #51 was a "FULL CODE".</p> <p>A document titled "STATE OF INDIANA OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER" dated 6/3/16 indicated Resident #51 was a DNR. The document was signed by Resident #51 POA on 6/3/16, and by the residents Medical Doctor on 6/17/16.</p> <p>The most recent signed "PHYSICAN'S ORDERS" dated 6/4/16 indicated Resident #51 was a "FULL CODE".</p>		<p>code status. No other issues have been identified.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>An in-service has been conducted for Social Services and Nurses related to honoring of resident code status preference. All new admissions or readmissions from hospital will be reviewed by the IDT to assure that the resident's identified preference related to code status is honored and reflected on all clinical documents.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that randomly reviews 5 residents to assure that their code status preference is honored and accurately reflected in the medical record. The Social Services Director, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b> August 13, 2016</p>				

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	<p>A CNA (Certified Nursing Assistant assignment sheet provided by the ADON (Assistant Director of Nursing) on 7/12/16 contained a red heart above resident #51's name. The key at the bottom of the document indicated "RED HEART = Full code".</p> <p>During an interview on 7/12/16 at 2:15 P.M., with the ADON. She indicated Resident the red hearts above resident's name on the form indicated they were a full code. She indicated it had been added so staff would have a quick reference guide to assist in an emergency.</p> <p>During an interview with the DON (Director of Nursing) on 7/13/16 at 11:00 A.M. She indicated the card and stickers were an "internal tool". She indicated she was unsure of the reason Resident #51 was listed as a full code as he had been a DNR since his admission.</p> <p>The clinical record for Resident #51 was again reviewed on 7/14/16 at 2:55 P.M. At that time the index card and sticker had been removed. The other documentation remained unchanged.</p> <p>During an interview with the DON on 7/14/16 at 3:55 P.M., she indicated she was unaware the physicians orders and</p>			

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F 0225 SS=D Bldg. 00	<p>the signed DNR orders and the CNA assignment sheets did not match. She indicated at that time all of the information should be updated when a code status is verified and/or changed.</p> <p>The DON provided a copy of a telephone order dated 7/14/16 at 3:45 P.M. The order included, but was not limited to "Clarification : DC [discontinue] Full Code Status Res [Resident] is a DNR".</p> <p>A policy for advance directives was requested but not provided.</p> <p>3.1-4(d)(e) 3.1-38(f)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>			

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	<p>abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure all allegations of abuse were, identified, thoroughly investigated and reported to the Administrator and Indiana State Department of Health (ISDH) for 2 of 3 allegation of abuse that met the criteria for review. (Resident #54, Resident #26)</p> <p>Findings include:</p> <p>1. Resident #54 was observed on 7/11/16 at 10:55 A.M., sitting up in a recliner in her room in no apparent distress.</p>	F 0225	<p><b>F225</b></p> <p><b>It is the practice of this facility to assure that allegations of abuse are reported to the administrator immediately, investigated, and reported to the appropriate agencies as identified per the regulation</b></p> <p><b><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></b></p> <p>Residents #54 and #26 have voiced no further issues.</p> <p><b><i>Other residents that have the potential to be affected have been identified by:</i></b></p> <p>Potentially all residents could be affected. Abuse allegations since</p>	08/13/2016

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	<p>During an interview on 7/11/16 at 10:57 A.M., Resident #54 indicated one morning a nurse had been verbally abusive to her. She indicated she had sent a CNA to get the nurse as she was not feeling well and her heart was "flipping" and she was "light headed". She indicated the nurse came into her room and "flew into her" and was yelling about how she was not the only resident, and about the facility staffing issues. Resident #54 indicated the nurse had then instructed her to turn on her call light and she would get to her when she could. She indicated she asked what she should do if she needed help and the nurse had instructed her to "call the Administrator". Resident #54 indicated the facility had taken care of the issue quickly and she did not want to cause any problems however, she did feel the incident was abuse.</p> <p>The Administrator provided the facilities reportable incidents for June and July on 7/11/16 at 12:15 P.M. The documentation lacked an allegation being reported by Resident #54.</p> <p>During an interview with the Administrator on 7/11/16 at 12:22 P.M., he indicated he did have a concern that had been reported by Resident #54 but he did not feel it was an allegation of abuse.</p>		<p>survey exit date have been reported, investigated, and appropriate agencies notified appropriately.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All staff has been in-serviced related to abuse and reporting mechanism and to assure a thorough understanding of the regulation including the reporting of abuse to the facility Administrator immediately to allow for proper investigation and to other appropriate agencies as required by the regulation.</p> <p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that will be utilized to review the proper following of the abuse policy including notification of administrator, investigation, and notification of the appropriate state agencies in a timely manner. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any identified issues will be immediately addressed as needed. The Quality Assurance Committee will review the tool at the</p>				

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	<p>A copy of the concerns were provided on 7/11/16 at 2:52 P.M. The documents included, but were not limited to the following:</p> <p>An untimed statement from the Resident #54 dated 7/6/16 included, but was not limited to, "I feel the nurse is trying to make a point to Administration that she needs help. I sent [name of CNA] to get help because I needed help. I wouldn't send someone if nothing was wrong. That is why I did not use the buzzer. The nurse was too busy she said to listen to the CNA's 'rattle'. I've go [sic] more Important [sic] things to do- Your no more Important than anyone else. I said I have just had heart surgery- she said I don't care about that I have others to take care of too. She felt she was telling her this to use her as a pawn to get more help. I told The therapist I had cardiac arrest- They should have let me go I was a pain in the but. Now I am OK. The Nurse also said 'I've got 19 residents, I'm to busy and too much stress!'"</p> <p>A untimed statement from RN #44 dated 7/6/16 included, but was not limited to, "Walked into pt room pt [patient] upset states I have waited for a nurse for 45 minutes. This nurse states you should never have to wait that long for help there are 3 other nurses in the building that can</p>		<p>scheduled meeting following the completion of the tool with recommendations as needed based on the outcomes of the tool</p> <p><b>The date the systemic changes will be completed:</b> August 13, 2016</p>	

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	<p>help if I cannot get to you. You should not have to wait more than 10 to 15 minutes for help. Everyone is treated the same. If you have chest pain et [and] someone else has nausea or vomiting. I would come to you first...She felt she was not as important or felt left out...Everyone he [sic] is treated the same I would be upset too if I waited 45 minutes on help..."</p> <p>The investigation contained interviews from other residents, no other staff interviews were provided.</p> <p>An untimed statement dated 7/6/16 included "Admin and DON met with [name of RN #44] regarding resident's concern. Discussed the concern, statement was taken and Admin. asked [RN #44] to go ahead and leave for the day. Later in the day, DON called [RN #44] and let her know that the concern investigation was complete and she was ok to return the following day.</p> <p>A "Corrective Action" form dated 7/11/16 indicated, RN #44 was issued a "verbal warning" for a "Customer Service Complaint" that occurred on 7/6/16.</p> <p>The clinical record for Resident# 54 was reviewed on 07/13/2016 9:30:13 AM.</p>			

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	<p>The diagnoses included, but were not limited to, hypothyroidism, hypertension, and heart valve replacement.</p> <p>An admission MDS (Minimum Data Set) assessment dated 7/7/16 indicated Resident #54 had a BIMS (Brief Interview for Mental Status) score of 15 indicating she was cognitively intact. The MDS further indicated Resident #54 experienced no behaviors, psychosis or mood disorders.</p> <p>An admission assessment dated 6/30/16 indicated resident was alert and oriented x 3, cognitive function intact , clear speech.</p> <p>The care plans included, but was not limited to, a care plan for the resident code status, short term stay at facility, activities, diet and anticoagulation medication and limited mobility related to a recent open heart surgery.</p> <p>During an interview with CNA #55 on 7/14/16 at 9:55 A.M., she indicated on 7/6/16 Resident #51 had reported to her that she felt RN #44 was rude to her and she made her feel like she was bothering the staff because of the way RN #44 had talked to her. CNA #55 indicated she reported the incident immediately to the charge nurse.</p>			

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	<p>During an interview with LPN #15 on 7/14/16 at 9:45 A.M., she indicated having an attitude with residents could be considered abuse and should be reported immediately.</p> <p>During an interview with LPN #25 with 7/14/16 at 11:40 A.M., she indicated an example of verbal and/or mental abuse would be telling a resident "I don't care" if reference to something they were concerned about. She further indicated any staff member yelling at a resident could also be considered abuse.</p> <p>2. Resident #26 was observed on ambulating in the hallway near the 2nd floor nurses desk on 7/11/16 at 12:40 P.M., Resident #26 was in no apparent distress.</p> <p>The clinical record for Resident #26 was reviewed on 7/13/16 at 1:55 P.M. The diagnoses included, but were not limited to Bipolar disorder, diabetes and hypertension.</p> <p>A Quarterly MDS dated 6/22/16 indicated Resident #26 had a BIMS score of 14 indicating he was cognitively intact. No mood disorder and/or behavioral conditions.</p>			

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	<p>The administrator provided the investigation into allegation #35 on 7/11/16 at 12:15 P.M. The report included the following:</p> <p>An untimed statement dated 6/17/16 from the ADON (Assistant Director of Nursing) included, but was not limited to, "At approximately 1245pm [sic] [Name of Resident # 26] came to my office door and stated 'Can I talk to you about something, please?' I said yes of course and [Resident] came into my office and stated 'I like [Activity Director] and everything, but I don't want her to be grouchy to me...[Resident] appeared very tearful when talking to us....'It's been for a couple of days' when asked if something happened today. [Resident] was asked to give us an example or tell us that she says to him and he said 'no, she is just grouchy with me and avoids me'...When [Resident] was asked how he felt about [Activity Director] being grouchy to him, he stated 'I feel bad'...[Resident] denied any physical contact...[Resident] then stated 'something really needs to be done about this before it gets worse'... [Regional Administrator] contacted by myself and notified us to report incident to ISDH and remove [Activity Director] from facility schedule pending investigation...notified [Activity</p>			

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	<p>Director] that there had been an allegation against her and I needed to ask her to leave the building pending investigation. [Activity director] was very visibly upset and stated 'I know this has to do with [Resident #26], doesn't it...I would never do anything, anyone that knows or family history knows that we are her to protect these people, that is just crazy'...[Activity Director] was notified to not return to the building until being notified...MD was notified by me, and family was notified...ISDH notified..."</p> <p>An untimed, undated statement from the DON included, "...on 6/15/16, I noticed...Activity Director walking down the hall...[Resident #26] something... [Activity Director] sighed and said 'what [name]'... [name of resident] then spoke back to [Activity Director] and she replied 'I don't know'. [Activity Director] seemed upset and short in her answer to [Resident]...A short time passed and [Activity Director] returned to her office with another resident. She was presently conversing with the other resident. She was pleasantly conversing with the other resident. [Resident] approached [Activity Director's] office door. At which time, [Activity Director] left her office and shut the door. [Resident] said something to [Activity Director] and she walked past him saying 'excuse me'."</p>			

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	<p>An untimed, undated statement from the ADON included, "On 6/15/16 I was standing in DON office having a conversation with [DON] when [Activity Director] walked down the hall to her office [Resident #26] walked down to her office shortly after. [Activity Director] then left her office and [Resident] was trying to talk to her and [Activity Director] huffed loudly and said 'What [name]?' [Resident] had said something that I could not make out and [Activity Director] replied 'I don't know.'...Activity Director appeared short and frustrated with [Resident] in that conversation. Shortly after, while I was still with DON having a conversation [Activity Director] went back to her office and [Name of 2nd resident] followed shortly behind. [Activity director] was overheard having a pleasant conversation with [2nd Resident] and offered him a snack. [Resident #26] wet to [Activity Director's] office again when [2nd Resident] and [Activity director] were in her office. [Activity Director] left her office with [2nd Resident] and shut the door with [Resident #26] standing in the hallway. [Resident #26] tried talking to [Activity Director] and [Activity Director] just said 'excuse me' and did not address [Resident #26].</p>			
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	<p>A untimed staff interview form dated 6/17/16 from LPN #14, included, but was not limited to, "1. Have you every witnessed another staff member being rude or intentionally avoiding a resident? 'yes-[Activity Director] brushed off [Resident #26] when he asked to go outside with her when she was taking another resident out. She said she didn't have time to take him'. "</p> <p>A untimed staff interview form dated 6/20/16 from HSK #15, included, but was not limited to, " 1. Have you every witnessed another staff member being rude or intentionally avoiding a resident? 'yes [Activity Director] was rude to [Resident #26] on Thursday -last week 6/16/16...She was very short with him-but I know she is very busy'. During the course of working here, have you observed any resident being treated inappropriately-either verbally, physically, mentally, or sexually? 'yes-6/16/16. See #1.'..."</p> <p>During an interview with the DON on 7/14/16 at 1:45 P.M., she indicated she had written a statement following the allegation of mistreatment by Resident #26. She indicated she had witnessed the former Activity Director on 7/15/16 be short with and purposely avoiding Resident #26. She indicated Resident #26</p>						

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	<p>really liked the Activity Director and would follow her around a lot and they felt she was becoming overwhelmed. She indicated she did not report the incident because she did not feel it was abuse and the HFA was on vacation at the time. She indicated they were continuously monitoring the former Activity Director for burnout for a while prior to the incident. She indicated staff knew to redirect Resident #26 whenever possible away from continuously following the former Activity Director. She indicated when Resident #26 had came to the ADON on 6/17/16 they notified the regional HFA (Health Facility Administrator) and she told them to immediately suspend the former Activity Director pending an investigation, and report the incident to the ISDH.</p> <p>During an interview with the facility Cook #66 on 6/14/16 at 2:33 P.M., they indicated they were regularly inserviced on the facility abuse prevention policy. Cook #66 indicated any and all witnessed, reported and suspected abuse situations were to be reported immediately to the HFA so they could be investigated. At that time, Cook #66 indicated that yelling at, ignoring and or being rude or telling a resident they didn't care could possibly be considered abuse under the facility policy and from the</p>			

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	<p>training they had received.</p> <p>During an interview with the HFA on 7/14/16 at 3:22 P.M., he indicated the facility had reported Incident #35 when it was reported by Resident #26. He indicated he was aware that staff had witnessed issues with the behavior of the former Activity Director towards Resident #26 in the days prior to reporting the incident however, it was determined what was witnessed was "poor customer service" and the facility choose to terminate the former Activity Director at that time.</p> <p>The facility policy titled, "Abuse Prevention" dated 7/11 included "All employees are required to attend our facilities's resident rights and abuse prevention program service training prior to having any resident contact. This will include reporting obligations of reasonable suspicions of crime against a resident. Our....abuse prevention in-service training programs consist of the following ....the facilities abuse prevention and reporting policies and procedures...What constitutes abuse, neglect....Stress reduction and burn-out...How and to whom incidents of mistreatment, neglect, and abuse should be reported...Our facility will not condone any form of resident abuse and</p>			

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	<p>will continually monitor our facilities's policies, procedures...to assist in preventing resident abuse....Our abuse prevention/intervention program may include, but is not necessarily limited to, the following: Conducting conflict resolution training classes for all staff..."Venting" sessions where staff can express frustrations with their job or working with difficult residents...Rotating staff working with difficult residents...Should an incident of suspected incident of resident abuse, neglect or injury of unknown source be reported, the administrator or designee, will appoint a member of management to investigate the alleged incident...The individual conducting the investigation will, at a minimum...Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident...Employees of this facility who have been accused of resident abuse will be suspended from duty until results of the investigation have been reviewed by the administrator...Allegations of abuse are to be reported to ISDH and local law enforcement immediately. The Administrator or designee will provide a written report of the result of all abuse investigations and appropriate action taken to the state survey and certification</p>			

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F 0226 SS=D Bldg. 00	<p>agency within 5 days....Verbal abuse is defied as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance... Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services...regardless of their age, ability to comprehend, or disability...A competed copy of the abuse report and written statements from witnesses, if any, must be provided to the Administrator within 24 hours of the occurrence...".</p> <p>3.1-13(g)(1) 3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to follow its abuse prevention and investigating</p>	F 0226	<p>F226 It is the practice ofthis facility to assure that the Administrator is notified immediately relatedto</p>	08/13/2016

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	<p>policy for 2 of 3 allegation of abuse that met the criteria for review. (Resident #54, Resident #26)</p> <p>Findings include:</p> <p>1. During an interview on 7/11/16 at 10:57 A.M., Resident #54 indicated one morning a nurse had been verbally abusive to her. She indicated she had sent a CNA to get the nurse as she was not feeling well and her heart was "flipping" and she was "light headed". She indicated the nurse came into her room and "flew into her" and was yelling about how she was not the only resident, and about the facility staffing issues. Resident #54 indicated the nurse had then instructed her to turn on her call light and she would get to her when she could. She indicated she asked what she should do if she needed help and the nurse had instructed her to "call the Administrator". Resident #54 indicated the facility had taken care of the issue quickly and she did not want to cause any problems however, she did feel the incident was abuse.</p> <p>The Administrator provided the facilities reportable incidents for June and July on 7/11/16 at 12:15 P.M. Documentation that an allegation of abuse had been reported by Resident #54 was lacking.</p>		<p><b>allegation of abuse, neglect, or misappropriation of property. The Administrator, or designee, is responsible for initiating and completing investigation. The Administrator is then responsible for notifying the appropriate agencies as required in a timely manner per the facility policy and the regulation and facility policy. The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>There have been no subsequent allegations of abuse by residents #54 or #26</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>There have been no incidents of abuse related to any additional residents. Potentially all residents could be affected and therefore there has been additional training on the abuse policy.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>All staff has been in-serviced on the policy related to abuse to assure a thorough understanding of the regulation including the immediate notification of the Administrator, protocol for investigation, and the reporting of allegations of abuse in a timely manner to the appropriate agencies.</p>				

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	<p>During an interview with the administrator on 7/11/16 at 12:22 P.M., he indicated he did have a concern that had been reported by Resident #54 but he did not feel it was an allegation of abuse.</p> <p>A copy of the concerns were provided on 7/11/16 at 2:52 P.M. The documents included, but were not limited to the following:</p> <p>An untimed statement from the Resident #54 dated 7/6/16 included, but was not limited to, "I feel the nurse is trying to make a point to Administration that she needs help. I sent [name of CNA] to get help because I needed help. I wouldn't send someone if nothing was wrong. That is why I did not use the buzzer. The nurse was too busy she said to listen to the CNA's 'rattle'. I've go [sic] more Important [sic] things to do- Your no more Important than anyone else. I said I have just had heart surgery- she said I don't care about that I have others to take care of too. She felt she was telling her this to use her as a pawn to get more help. I told The therapist I had cardiac arrest- They should have let me go I was a pain in the butt. Now I am OK. The Nurse also said 'I've got 19 residents, I'm to busy and too much stress'."</p> <p>A untimed statement from RN #44 dated</p>		<p><b>The corrective action taken to monitor performance to assure compliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated that will be utilized to review reportable events to assure that they are reported timely and investigated in accordance with the facility policy and the regulation. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on any negative outcomes of the tools.</p> <p><b>The date the systemic changes will be completed:</b> August 13, 2016</p>	

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	<p>7/6/16 included, but was not limited to, "Walked into pt room pt [patient] upset states I have waited for a nurse for 45 minutes. This nurse states you should never have to wait that long for help there are 3 other nurses in the building that can help if I cannot get to you. You should not have to wait more than 10 to 15 minutes for help. Everyone is treated the same. If you have chest pain et [and] someone else has nausea or vomiting. I would come to you first...She felt she was not as important or felt left out...Everyone he [sic] is treated the same I would be upset too if I waited 45 minutes on help..."</p> <p>The investigation contained interviews from other residents, no other staff interviews were provided.</p> <p>An untimed statement dated 7/6/16 included "Admin and DON met with [name of RN #44] regarding resident's concern. Discussed the concern, statement was taken and Admin. asked [RN #44] to go ahead and leave for the day. Later in the day, DON called [RN #44] and let her know that the concern investigation was complete and she was ok to return the following day.</p> <p>A "Corrective Action" form dated 7/11/16 indicated, RN #44 was issued a</p>						

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	<p>"verbal warning" for a "Customer Service Complaint" that occurred on 7/6/16.</p> <p>The clinical record for Resident# 54 was reviewed on 07/13/2016 9:30:13 AM. The diagnoses included, but were not limited to, hypothyroidism, hypertension, and heart valve replacement.</p> <p>An admission MDS (Minimum Data Set) assessment dated 7/7/16 indicated Resident #54 had a BIMS (Brief Interview for Mental Status) score of 15 indicating she was cognitively intact. The MDS further indicated Resident #54 experienced no behaviors, psychosis or mood disorders.</p> <p>An admission assessment dated 6/30/16 indicated resident was alert and oriented x 3, cognitive function intact , clear speech.</p> <p>The care plans included, but was not limited to, a care plan for the resident code status, short term stay at facility, activities, diet and anticoagulation medication and limited mobility related to a recent open heart surgery.</p> <p>During an interview with CNA #55 on 7/14/16 at 9:55 A.M., she indicated on 7/6/16 Resident #44 had reported to her</p>			

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	<p>that she felt RN #44 was rude to her and she made her feel like she was bothering the staff because of the way RN #44 had talked to her. CNA #55 indicated she reported the incident immediately.</p> <p>During an interview with LPN #15 on 7/14/16 at 9:45 A.M., she indicated having an attitude with residents could be considered abuse and should be reported immediately.</p> <p>During an interview with LPN #25 with 7/14/16 at 11:40 A.M., she indicated an example of verbal and/or mental abuse would be telling a resident "I don't care" if reference to something they were concerned about. She further indicated any staff member yelling at a resident could also be considered abuse.</p> <p>2. Resident #26 was observed ambulating in the hallway near the 2nd floor nurses desk on 7/11/16 at 12:40 P.M., Resident #26 appeared to be in no apparent distress.</p> <p>The clinical record for Resident #26 was reviewed on 7/13/16 at 1:55 P.M. The diagnoses included, but were not limited to Bipolar disorder, diabetes and hypertension.</p>			

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	<p>A Quarterly MDS dated 6/22/16 indicated Resident #26 had a BIMS score of 14 indicating he was cognitively intact. No mood disorder and/or behavioral conditions.</p> <p>The Administrator provided the investigation into allegation #35 on 7/11/16 at 12:15 P.M. The report included the following:</p> <p>An untimed statement dated 6/17/16 from the ADON (Assistant Director of Nursing) included, but was not limited to, "At approximately 1245pm [sic] [Name of Resident # 26] came to my office door and stated 'Can I talk to you about something, please?'" I said yes of course and [Resident] came into my office and stated 'I like [Activity Director] and everything, but I don't want her to be grouchy to me...[Resident] appeared very tearful when talking to us....'It's been for a couple of days' when asked if something happened today. [Resident] was asked to give us an example or tell us that she says to him and he said 'no, she is just grouchy with me and avoids me'...When [Resident] was asked how he felt about [Activity Director] being grouchy to him, he stated 'I feel bad'...[Resident] denied any physical contact...[Resident] then stated 'something really needs to be done about this before it gets worse'...</p>			

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	<p>[Regional Administrator] contacted by myself and notified us to report incident to ISDH and remove [Activity Director] from facility schedule pending investigation...notified [Activity Director] that there had been an allegation against her and I needed to ask her to leave the building pending investigation. [Activity director] was very visibly upset and stated 'I know this has to do with [Resident #26], doesn't it'...'I would never do anything, anyone that knows or family history knows that we are her to protect these people, that is just crazy'...[Activity Director] was notified to not return to the building until being notified...MD was notified by me, and family was notified...ISDH notified..."</p> <p>An untimed, undated statement from the DON included, "...on 6/15/16, I noticed...Activity Director walking down the hall...[Resident #26] something... [Activity Director] sighed and said 'what [name]'... [name of resident] then spoke back to [Activity Director] and she replied 'I don't know'. [Activity Director] seemed upset and short in her answer to [Resident]...A short time passed and [Activity Director] returned to her office with another resident. She was pleasantly conversing with the other resident. She was pleasantly conversing with the other resident. [Resident] approached</p>			

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	<p>[Activity Director's] office door. At which time, [Activity Director] left her office and shut the door. [Resident] said something to [Activity Director] and she walked past him saying 'excuse me'."</p> <p>An untimed, undated statement from the ADON included, "On 6/15/16 I was standing in DON office having a conversation with [DON] when [Activity Director] walked down the hall to her office [Resident #26] walked down to her office shortly after. [Activity Director] then left her office and [Resident] was trying to talk to her and [Activity Director] huffed loudly and said 'What [name]?' [Resident] had said something that I could not make out and [Activity Director] replied 'I don't know.'...Activity Director appeared short and frustrated with [Resident] in that conversation. Shortly after, while I was still with DON having a conversation [Activity Director] went back to her office and [Name of 2nd resident] followed shortly behind. [Activity director] was overheard having a pleasant conversation with [2nd Resident] and offered him a snack. [Resident #26] went to [Activity Director's] office again when [2nd Resident] and [Activity director] were in her office. [Activity Director] left her office with [2nd Resident] and shut the door with [Resident #26] standing in the</p>			

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	<p>hallway. [Resident #26] tried talking to [Activity Director] and [Activity Director] just said 'excuse me' and did not address [Resident #26].</p> <p>A untimed staff interview form dated 6/17/16 from LPN #14, included, but was not limited to, "1. Have you ever witnessed another staff member being rude or intentionally avoiding a resident? 'yes-[Activity Director] brushed off [Resident #26] when he asked to go outside with her when she was taking another resident out. She said she didn't have time to take him'. "</p> <p>A untimed staff interview form dated 6/20/16 from HSK #15, included, but was not limited to, " 1. Have you ever witnessed another staff member being rude or intentionally avoiding a resident? 'yes [Activity Director] was rude to [Resident #26] on Thursday -last week 6/16/16...She was very short with him-but I know she is very busy'. During the course of working here, have you observed any resident being treated inappropriately-either verbally, physically, mentally, or sexually? 'yes-6/16/16. See #1.'..."</p> <p>During an interview with the DON on 7/14/16 at 1:45 P.M., she indicated she had written a statement following the</p>			

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	<p>allegation of mistreatment by Resident #26. She indicated she had witnessed the former Activity Director on 7/15/16 be short with and purposely avoiding Resident #26. She indicated Resident #26 really liked the Activity Director and would follow her around a lot and they felt she was becoming overwhelmed. She indicated she did not report the incident because she did not feel it was abuse and the HFA was on vacation at the time. She indicated they were continuously monitoring the former Activity Director for burnout for a while prior to the incident. She indicated staff knew to redirect Resident #26 whenever possible away from continuously following the former Activity Director. She indicated when Resident #26 had came to the ADON on 6/17/16 they notified the regional HFA (Health Facility Administrator) and she told them to immediately suspend the former Activity Director pending an investigation, and report the incident to the ISDH.</p> <p>During an interview with the facility Cook #66 on 6/14/16 at 2:33 P.M., they indicated they were regularly inserviced on the facility abuse prevention policy. Cook #66 indicated any and all witnessed, reported and suspected abuse situations were to be reported immediately to the HFA so they could be</p>			

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	<p>investigated. At that time, Cook #66 indicated that yelling at, ignoring and or being rude or telling a resident they didn't care could possibly be considered abuse under the facility policy and from the training they had received.</p> <p>During an interview with the HFA on 7/14/16 at 3:22 P.M., he indicated the facility had reported Incident #35 when it was reported by Resident #26. He indicated he was aware that staff had witnessed issues with the behavior of the former Activity Director towards Resident #26 in the days prior to reporting the incident however, it was determined what was witnessed was "poor customer service" and the facility choose to terminate the former Activity Director at that time.</p> <p>The facility policy titled, "Abuse Prevention" dated 7/11 included "All employees are required to attend our facilities's resident rights and abuse prevention program service training prior to having any resident contact. This will include reporting obligations of reasonable suspicions of crime against a resident. Our....abuse prevention in-service training programs consist of the following ....the facilities abuse prevention and reporting policies and procedures...What constitutes abuse,</p>			

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	neglect....Stress reduction and burn-out...How and to whom incidents of mistreatment, neglect, and abuse should be reported...Our facility will not condone any form of resident abuse and will continually monitor our facilities's policies, procedures...to assist in preventing resident abuse....Our abuse prevention/intervention program may include, but is not necessarily limited to, the following: Conducting conflict resolution training classes for all staff...'Venting' sessions where staff can express frustrations with their job or working with difficult residents...Rotating staff working with difficult residents...Should an incident of suspected incident of resident abuse, neglect or injury of unknown source be reported, the administrator or designee, will appoint a member of management to investigate the alleged incident...The individual conducting the investigation will, at a minimum...Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident...Employees of this facility who have been accused of resident abuse will be suspended from duty until results of the investigation have been reviewed by the administrator...Allegations of abuse are to be reported to ISDH and local law			

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F 0318 SS=D Bldg. 00	<p>enforcement immediately. The administrator or designee will provide a written report of the result of all abuse investigations and appropriate action taken to the state survey and certification agency within 5 days....Verbal abuse is defied as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance... Mental abuse is defined as, but is not limited to, humiliation, harassment, threats of punishment, or withholding of treatment or services...regardless of their age, ability to comprehend, or disability...A competed copy of the abuse report and written statements from witnesses, if any, must be provided to the Administrator within 24 hours of the occurrence...".</p> <p>3.1-28(a)</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.</p>			

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	<p>Based on observation, interview, and record review, the facility failed to ensure restorative nursing services were provided for 2 of 3 residents who met the criteria for review of range of motion. (Resident #23, Resident #44)</p> <p>Findings include:</p> <p>1. Resident #23 was observed on 7/11/16 at 4:07 P.M. sitting in a recliner with a blanket covering the lower body. Resident #23 was observed, at that time, to have contractures of the bilateral hands. During an interview, at that time, Resident #23 indicated staff had not provided range of motion services in a long time.</p> <p>The clinical record of Resident #23 was reviewed on 7/12/16 at 2:30 P.M. The record indicated the diagnoses of Resident #23 included, but were not limited to, Parkinson's disease.</p> <p>The Annual MDS (Minimum Data Set) assessment dated 2/4/16 indicated Resident #23 experienced minimal cognitive impairment, required the extensive assistance of two staff for transfers, dressing, and toileting, experienced functional impairment to the bilateral upper and lower extremities, and received active and passive range of</p>	F 0318	<p><b>F318</b></p> <p><b>It is the practice of this facility to assure that residents identified with limited range of motion receive services to increase range of motion and/or prevent further decrease in range of motion.</b></p> <p><b>The correction action taken for those residents found to be affected by the deficient practice include:</b></p> <p>Residents #23 and #44 have been reviewed and are now receiving ROM in accordance with the plan of care and in accordance with previous therapy recommendations.</p> <p><b>Other residents that have the potential to be affected have been identified by:</b></p> <p>All residents have been reviewed to assure that if there were recommendations from therapy for restorative services that they are receiving the services as recommended.</p> <p><b>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</b></p> <p>The Therapy Department will be providing recommendations for restorative services. The recommendations will be given to the MDS Coordinator who is responsible for assuring that a plan is written and restorative services are initiated. The change in the system includes that the therapy will also be providing a copy of the recommendations to the DNS</p>	08/13/2016			

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	<p>motion services 7 of 7 days during the assessment period.</p> <p>The most recent Quarterly MDS assessment dated 5/4/16 indicated Resident #23 experienced no cognitive impairment, required the extensive assistance of two staff for dressing, and toileting, required the total assistance of two staff for transfers, experienced functional impairment to the bilateral upper and lower extremities, and received active range of motion services 7 of 7 days during the assessment period.</p> <p>The June 2016 Physician's Order Recap lacked any documentation to indicate Resident #23 should receive active or passive range of motion services.</p> <p>A Care Plan for, "impaired mobility...contractures of upper and lower extremities" dated 5/4/16 indicated interventions of:</p> <p>"Nurse to evaluate program periodically, Report to nurse if residents [sic] complains of pain, Staff to provide 15-20 reps daily to upper and lower extremities. [passive range of motion]"</p> <p>A CNA Assignment Sheet dated 7/9/16 provided by the ADON (Assistant</p>		<p>whowill review in the morning IDT meeting to assure that the plan is beingimplemented and restorative services initiated. The MDS Coordinator has been in-serviced related to the importance ofrestorative services in correlation with the plan of care based on thetherapist or nursing recommendations being implemented in a timely manner.</p> <p><b>The corrective action taken to monitor performance to assurecompliance through quality assurance is:</b></p> <p>A Performance Improvement Tool has been initiated thatrandomly reviews 5 residents for restorative recommendations and properprovision of services. The Director of Nursing, or designee, will complete thistool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will reviewthe tools at the scheduled meetings with recommendations as needed based on theoutcome of the tools.</p> <p><b>The date the systemic changes will be completed:</b> August 13, 2016</p>	

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	<p>Director of Nursing) on 7/12/16 at 9:00 A.M. lacked any documentation to indicate Resident #23 should receive range of motion services to the upper and lower extremities.</p> <p>During an interview on 7/12/16 at 9:05 A.M., the ADON indicated Resident #23 experienced contractures of the bilateral hands and received range of motion services.</p> <p>During an interview on 7/13/16 at 9:10 A.M., COTA [Certified Occupational Therapy Assistant) #3 indicated, Resident #23 was discharged from OT (Occupational Therapy) to the RNP (Restorative Nursing Program) on 5/6/15. COTA #3 further indicated Resident #23 was discharged from PT (Physical Therapy) to the RNP on 7/7/15.</p> <p>An Occupational Therapy Discharge Summary dated 5/6/15 indicated, "...Designed and implemented RNP...RNP initiated with caregivers focusing on BUE [bilateral upper extremity] strengthening..."</p> <p>An "Occupational Therapy Communication/In-service to Nursing" form dated 5/6/15 indicated, "...Patient has limited ROM [range of motion] of LUE [left upper extremity]...has</p>			

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	<p>functional ROM in RUE [right upper extremity]...should be encouraged to compelte [sic] ROM activites [sic] with no weight or resistance..."</p> <p>A Physical Therapy Plan of Care dated 7/7/15 indicated, "...Patient will d/c [discharge] to nursing staff full time with RNP in place..."</p> <p>A Restorative Nursing log dated 6/14/16 through 7/13/16 indicated Resident #23 received, "AROM [active range of motion services] 15-20 reps upper and lower extremities" for 15 minutes daily. The log lacked any documentation to indicate Resident #23 received passive range of motion services.</p> <p>An undated Restorative Nursing Program worksheet provided by the MDS Coordinator on 7/13/16 at 2:00 P.M. indicated Resident #23 should receive, "...AROM [active range of motion] 15-20 upper/lower exts [extremities], PROM [passive range of motion] 10 qd [every day] Bil [bilateral] upper ext [extremities]"</p> <p>During an interview on 7/13/16 at 9:15 A.M., LPN #6 indicated range of motion services were provided by the CNA's during routine care and further indicated, the daily CNA assignment identified</p>			

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	<p>which CNA was responsible to ensure restorative nursing care was provided and documented.</p> <p>The CNA assignment sheet for 7/13/16 was reviewed on 7/13/16 at 9:17 A.M. and indicated CNA #8 was responsible to ensure restorative nursing care was provided and documented.</p> <p>During an interview on 7/13/16 at 2:05 P.M. the MDS Coordinator indicated a revised Restorative Nursing Program worksheet had just been developed and provided the updated worksheet. The worksheet indicated Resident #23 should receive, "...AROM 15-20 upper/lower exts, PROM 10 qd Bil upper ext." The MDS Coordinator further indicated, at that time, Resident #23 experienced contractures of the bilateral elbows and demonstrated how flexion/extension range of motion exercises should be performed.</p> <p>During an interview on 7/14/16 at 11:30 A.M., the DON indicated she had reviewed the clinical record of Resident #23 and no documentation could be provided to indicate Resident #23 received active or passive range of motion services as recommended by OT or PT.</p>			

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	<p>2. On 7/11/16 at 12:15 P.M., Resident #44 was observed sitting at a table in the dining room. Resident #44 was observed, at that time, to have contractures of the bilateral hands and ankles.</p> <p>On 7/12/16 at 9:00 A.M. Resident #44 was observed lying in bed. Resident #44 was observed, at that time, to have contractures of the bilateral hands and ankles.</p> <p>The clinical record of Resident #44 was reviewed on 7/11/16 at 3:37 P.M. The record indicated Resident #44 was admitted to the facility on 3/24/16 with diagnoses including, but not limited to, quadriplegia (paralysis that results in the partial or total loss of use of all four limbs and torso), muscle spasms, and muscle weakness.</p> <p>The Admission MDS assessment dated 4/5/16 indicated Resident #44 experienced moderate cognitive impairment, required the extensive assistance of two staff for dressing and eating, experienced functional limitation of the bilateral upper and lower extremities, and did not receive restorative nursing services for range of motion.</p>			

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	<p>The July 2016 Physician's Order Recap lacked any documentation to indicate Resident #44 should receive active or passive range of motion services.</p> <p>During an interview on 7/12/16 at 9:15 A.M. the ADON indicated Resident #44 experienced contractures to the bilateral upper and lower extremities and received range of motion services.</p> <p>During an interview on 7/13/16 at 9:10 A.M. COTA #3 indicated, Resident #44 was discharged from OT to the RNP on 4/28/16. COTA #3 further indicated Resident #44 was discharged from PT to the RNP on 4/22/16.</p> <p>A Physical Therapy Discharge Summary dated 4/22/16 indicated, "...Contractures [sic]...recommendations...included initiation of and participation in RNP..." The form lacked any documentation related to providing range of motion services.</p> <p>A Physical Therapy Communication/In-service to Nursing form dated 4/22/16 indicated Resident #44 was discharged to the RNP [Restorative Nursing Program]. The form lacked any documentation related to providing range of motion services.</p>			

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	<p>An Occupational Therapy Discharge Summary dated 4/28/16 indicated, "...Recommendations discussed with patient and/or caregivers include initiation and follow through with RNP." The form lacked any documentation related to providing range of motion services.</p> <p>An Occupational Therapy Communication/In-service to Nursing form dated 4/28/16 indicated Resident #44 was discharged to the RNP [Restorative Nursing Program] with the following recommendations, "...patient should complete LUE [left upper extremity] ROM [range of motion] exercises in all planes shoulder flex [flexion]/exten [extension], elbow flex/exten, wrist pronation [turning downward]/supination [turning upward], wrist flex/exten, digit flex/exten, shoulder horizontal abd[abduction] [turning away from the body]/add [adduction] [turning towards the body] with restorative assistance...."</p> <p>The Plan of Care from 4/28/16 through 7/12/16 lacked any documentation to indicate a Restorative Nursing Program was implemented for Resident #44.</p> <p>The Nursing Progress notes from 4/22/16 through 7/4/16 lacked any documentation</p>			

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	<p>to indicate a Restorative Nursing Program was implemented for Resident #44.</p> <p>The CNA Assignment Sheet provided by the ADON on 7/12/16 at 9:30 A.M. lacked any documentation to indicate Resident #44 received range of motion services.</p> <p>An undated Restorative Nursing Program worksheet provided by the MDS Coordinator on 7/13/16 at 2:00 P.M. lacked any documentation to indicate Resident #44 received restorative nursing services.</p> <p>During an interview on 7/13/16 at 2:10 P.M., the MDS Coordinator indicated she was responsible for the Restorative Nursing Program. The MDS Coordinator then indicated, Resident #44 did not currently receive restorative nursing services because staff said Resident #44 experienced increased spasticity and pain, but no documentation could be provided to indicate Resident #44 experienced increased muscle spasticity or pain before 7/4/16. The MDS Coordinator then indicated, she was not aware Resident #44 had ever been referred to the restorative nursing program.</p> <p>During an interview on 7/13/16 at 9:20</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155720	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/14/2016
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NAME OF PROVIDER OR SUPPLIER  CATHEDRAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W 9TH ST JASPER, IN 47546
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	<p>A.M., CNA #8 indicated she did not know the restorative nursing plan of care for Resident #23 or Resident #44, did not know how to access the restorative nursing plan of care for Resident #23 or Resident #44, and did not know who was responsible to ensure restorative nursing care was completed and documented.</p> <p>During an interview on 7/14/16 at 2:30 P.M., the ADON indicated range of motion services should be provided by CNA's during routine daily care. The ADON then indicated, no further documentation could be provided to indicate Resident #23 or Resident #44 received range of motion services as recommended by OT/PT.</p> <p>The Policy and Procedure for Restorative Nursing provided by the DON (Director of Nursing) on 7/14/16 at 2:30 P.M. indicated, "...Range of Motion (Passive) -The extent to which, or the limits between [sic] which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body...Range of motion (Active)-exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record..."</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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