| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155636 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | X3) DATE SURVEY COMPLETED 05/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

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| F000000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey Dates: April 24, 25, 28, 29, 30, and May 1, 2014.<br><br>Facility number: 000241<br>Provider number: 155636<br>AIM number: 100291310<br><br>Survey Team:<br>Courtney Mujic, RN- TC<br>Beth Walsh, RN (April 24, 25, 28, May 1, 2014)<br>Karina Gates, Medical Surveyor<br>Tom Stauss, RN (April 24, 25, 28, 29, 30, 2014)<br><br>Census Bed Type:<br>SNF/NF: 103<br>Total: 103<br><br>Census Payor Type:<br>Medicare: 8<br>Medicaid: 83<br>Other: 12<br>Total: 103<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. | F000000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | Quality review completed on May 8, 2014 by Cheryl Fielden, RN. | | | |
| F000250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | F000250 | **F 250 Social Services** | 05/31/2014 |
| | Based on interview, and record review, the facility failed to ensure a legal guardian was arranged to coordinate facility services for 1 of 1 residents reviewed for social services and failed to ensure a PASSR Level II assessment was current for 1 of 1 residents reviewed for PASSR (Pre Admission Screening Determination). (Resident #94 & #96) | | It is the intent of this provider to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | |
| | Findings include: | | **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** | |
| | Resident #94's record was reviewed on 4/25/14 at 12:58 p.m. The resident's diagnoses included, but were not limited to, alcohol abuse, anemia, senile dementia, anxiety disorder, neuropathy. Resident #94 was admitted to the facility on 11/25/13. | | The corrective actions taken for Residents #94 & #96: #94 now has an appointed guardian and consents have been signed for Dental and Vision Services. Referrals to the Dentist and Optometrist have been made. Resident #96's Level II is current as of May 14, 2014. | |
| | An MDS (minimum data set) assessment dated 12/2/13, indicated Resident #94 was identified as having "... no natural | | | |

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| | teeth or tooth fragment(s)..." An MDS assessment dated 2/27/14, indicated Resident #94's vision was assessed as "impaired" and also indicated Resident #94 would benefit from corrective lenses.<br><br>During an interview with Social Services Assistant #1 on 4/28/14 at 1:50 p.m., she indicated Resident #94 does not wear dentures and does not wear glasses.<br><br>On 4/28/14 at 2:31 p.m., during an interview, the Social Services Director (SSD) indicated a "comprehensive admission assessment" indicated Resident #94 does not wear dentures or glasses. She indicated the resident has not had a dental evaluation since his admission to the facility. She also indicated residents identified with dental or vision problems would normally have a dental or vision evaluation within 4 months of admission, but she indicated the facility was having difficulty getting certain documentation signed by the resident's guardian. She indicated there was a change in lthe resident's legal guardian status sometime after the resident's admission to the facility which was also making it difficult to get necessary paperwork for "ancillary services" to be signed.<br><br>A physician's order, dated 11/25/13, | | **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents have the potential to being affected by the alleged deficient practice. A facility-wide audit has been conducted by SSD and those residents without a guardian or POA have been identified and referred to At Risk Elders. All residents requiring PASSR were also reviewed.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The systemic changes put into place to ensure this practice does not recur are: A Guardianship CQI tool and PASSR tracker has been put into place and will be reviewed by the ED monthly. All SS staff have been in-serviced by 5-30-14 by the MCF / Designee regarding the importance of following up on residents in pursuit of guardianship appointment. | |

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| | indicated Resident #94 "may be seen by Podiatrist, Dentist, Optometrist, Audiologist."<br><br>On 4/29/14 at 9:49 a.m., during an interview, the SSD indicated she is not aware of any optometry or dental services provided to Resident #94 She indicated a referral had not been made to a dentist or to an optometrist for Resident #94 since his 11/25/13 admission.<br><br>On 4/29/14 at 9:59 a.m., during an interview, the DNS (Director of Nursing Service) indicated the facility's system "broke down" in regards to following up on Resident #94's legal guardianship. She also indicated this led to a delay in getting necessary dental and vision care provided to Resident #94.<br><br>On 4/29/14 at 11:34 a.m., the SSD indicated the Social Services department should have followed up "within a day or so" of the court hearing to find out the status of Resident #94's guardianship hearing. She indicated the facility then could have had the guardian sign necessary documents to get dental and vision services provided to the resident as necessary. She indicated the "system did break down" in regards to getting necessary services provided to Resident #94. | | All SS staff will be in-serviced by 5-30-14 by MCF/Designee regarding importance of following up residents that require an annual Level II. Any new SS staff members will be in-serviced on both topics during orientation.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored via the Guardianship CQI tool and PASSR tracker weekly by SS staff as indicated and monthly by the SSD and then quarterly by the Memory Care Facilitator (MCF). Those residents who require annual Level II will be reviewed monthly by the SSD and quarterly by the MCF. The results of these audits will be reviewed by the CQI Committee members overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.<br><br>Compliance date: May 31, 2014 | |

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| | The facility provided copies of guardianship hearing court documents for Resident #94. The documents indicated Resident #94 was assigned a family member as a legal guardian on 3/5/14. | | | |
| F000279<br>SS=D | 483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>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.<br><br>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). | F000279 | **F 279 Develop Comprehensive Care Plans**<br><br>It is the intent of this provider to use the results of the assessment to develop, review and revise the resident's comprehensive care plan. | 05/31/2014 |
| | Based on observation, interview, and record review, the facility failed to ensure a dental care plan, an incontinence care plan, a vision care plan, and a Psychotropic Drug Use Care Plan, were created for 4 of 22 residents reviewed for care plans. (Resident #94 & #50) | | | |

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| | Findings include:<br><br>Resident #94's record was reviewed on 4/25/14 at 12:58 p.m. The resident's diagnoses included, but were not limited to, alcohol abuse, anemia, senile dementia, anxiety disorder, neuropathy.<br><br>1. An MDS assessment dated 12/2/13, indicated Resident #94 was identified as having "... no natural teeth or tooth fragment(s)..."<br><br>On 4/28/14 at 1:52 p.m., during an interview, Resident #94 indicated he had all his teeth pulled years ago, but would like to have dentures. He indicated not receiving any dental evaluation since his has resided at the facility.<br><br>On 4/30/14 at 1:38 p.m., during an interview, the DNS indicated a care plan should have been created for dental care or dental evaluation and treatment for Resident #94. She indicated no dental care plan in place for Resident #94.<br><br>2. An MDS assessment dated 12/2/13, indicated Resident #94 was "Always continent." A subsequent MDS assessment dated 1/22/14, indicated Resident<br>#94 was "Occasionally incontinent." | | **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>The corrective actions taken for Resident #94 are as follows: there are care plans in place addressing the resident's dental, incontinence and visual needs. For Resident #50, there is a care plan in place addressing psychotropic drug use.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents have the potential to be affected. A facility audit has been completed by the Interdisciplinary Team to ensure all residents who have incontinence, psychotropic medication usage, visual impairment and dental needs are care planned.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the** | |

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| | On 4/28/14 at 1:52 p.m., during an interview, Resident #94 indicated he is almost never incontinent of bowel and bladder. He indicated he takes himself to and from the bathroom for toileting purposes at all times of day.<br><br>Facility records indicated Resident #94 was incontinent on the following dates; 11/25/13, 12/11/13, 12/15/13, 12/16/13, 12/17/13, 12/20/13, 12/24/13, 12/27/13, 1/15/14, 1/16/14, 1/18/14, 1/19/14, 1/21/14, 2/24/14, 2/26/14, 2/28/14, 3/17/14, 3/22/14, 4/15/14 & 4/23/14.<br><br>On 4/29/14 at 12:53 p.m., the DNS indicated the facility should have created a care plan for Resident #94's occasional incontinence but had not prior to 4/28/14.<br><br>3. During an interview with the Social Services Assistant #1 on 4/28/14 at 1:50 p.m., she indicated Resident #94 does not wear glasses.<br><br>On 4/28/14 at 1:52 p.m., Resident #94 indicated he wore reading glasses when reading, but he didn't have them anymore. He indicated the glasses went missing sometime after his admission to the facility and he indicated the glasses had not been replaced by the facility. He indicated wanting reading glasses, because "it's hard to read without them." | | **alleged deficient practice does not recur**<br><br>The IDT members have been in-serviced by the RAI Specialist / Designee on the Care Plan Update process. Any new members will be in-serviced during orientation. Any new admissions and/or any residents with change in condition will have their medical record reviewed by the IDT to ensure appropriate care plans and interventions are in place.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored weekly by the IDT, using the Care Plan Update CQI tool weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. | |

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| | On 4/28/14 at 2:31 p.m., during an interview, the SSD indicated a "comprehensive admission assessment" indicated the resident does not have glasses. She indicated the resident has not had a vision evaluation since his admission to the facility. She also indicated residents identified with vision problems would have an assessment done within 4 months of admission.<br><br>An MDS assessment dated 2/27/14, indicated Resident #94's vision was assessed as "impaired."<br><br>On 4/30/14 at 1:38 p.m., during an interview, the DNS indicated a care plan should have been created for a visual deficit identified by assessment for Resident #94. She indicated no vision care plan in place for Resident #94. | | **Compliance date: May 31, 2014** | |
| F000280<br>SS=D | 483.20(d)(3), 483.10(k)(2)<br>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other | | | |

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| | appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br>Based on interview and record review, the facility failed to update fall care plans for 2 of 22 residents reviewed for care plans. (Resident #91 & #109)<br><br>Findings include:<br><br>1. An interview with LPN #5, on 4/25/2014 at 2:14 p.m., indicated Resident #91 had a fall on 4/20/2014.<br><br>Resident #91's clinical record was reviewed on 4/29/2014 at 9:15 a.m. Diagnoses included but were not limited to; Epilepsy, neuropathy, arthritis, and dementia.<br><br>A progress note, dated 4/20/2014 at 10:55 a.m., indicated, "Resident was found on floor in another resident's room, writer assessed...no injuries or bruises noted, fall f/u [follow up] with neurochecks and 15 minute checks implemented...will continue to monitor".<br><br>A progress note, dated 4/21/2014 at 10:56 a.m., indicated, "IDT (Interdisciplinary Team) review of | F000280 | **F 280 Care Plan Revision**<br><br>It is the intent of this provider to ensure residents have the right to participate in the care planning process and ensure the process if periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>The fall care plans have been updated for resident #91 and resident #109 to include the current interventions to prevent falls.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** | 05/31/2014 |

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| | unwitnessed fall which occurred on 4/20/2014 at 10:30 a.m. indicated, "...Will refer resident to therapy for evaluation."<br><br>A care plan, dated 12/01/2011, indicated, "Problem: Resident is at risk for fall due to: incontinence, poor cognition, medication regimen, walks looking downward, fatigue, impaired mobility, paces constantly, sits for brief periods, ataxia, seizure disorder. Approaches: Fall risk, dated 7/2/2013. Offer rests periods, dated 3/14/2012. Refer to therapy for screen, dated 2/23/2012. Call light in reach, dated 12/1/2011. Non skid footwear, dated 12/1/2011. Personal items in reach, dated 12/1/2011. Therapy screen as indicated, dated 12/1/2011."<br><br>An interview with the DNS on 4/29/2014 at 9:45 a.m., indicated after a resident experiences a fall, the IDT team meets to develop a new intervention. At this point, either the IDT team, or the unit manager, or the MDS nurse, will update the care plan to reflect the new intervention. She will look into why this care plan was not updated after the resident's most recent fall. | | All residents with new fall interventions have the potential for being affected. A facility audit has been conducted by the Interdisciplinary team and all residents care plans have been updated with the fall interventions.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The IDT members have been in-serviced by the RAI Specialist / Designee regarding the Care Plan Updating process. Care plans will be reviewed by the IDT after each fall event, and with quarterly review to ensure appropriate fall interventions are in place.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be | |

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| | | | monitored weekly by the IDT, using the Care Plan Updating CQI tool weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.<br><br>**Compliance date: May 31, 2014** | |
| F000282<br>SS=D | 483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>Based on interview and record review, the facility failed to obtain a lipid profile as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #10)<br><br>Findings inlcude:<br><br>The clinical record for Resident #10 was reviewed on 4/29/14 at 10:30 p.m. The diagnoses for Resident #10 included, but were not limited to, hyperlipidemia.<br><br>The April, 2014 Physician Orders for Resident #10 indicated, "Lipid Profile | F000282 | **F 282 Services by Qualified Person**<br><br>It is the intent of this provider to arrange for services to be provided by qualified persons in accordance with each resident's written plan of care.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** | 05/31/2014 |

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| | [DX (diagnosis): Hyperlipidemia...Once A Day on 4th Tue (Tuesday) of Apr (April), Oct (October); Lab" with a start date of 10/22/13.<br><br>The lab results for April, 2014 were reviewed, and no lipid profile results were found.<br><br>An interview was conducted with the DNS on 4/30/14 at 1:40 p.m., regarding whether a lipid profile was obtained for Resident #10 in April, 2014. She stated, "The lipid profile and the valproic acid was missed on 4/22 (4/22/14) with the rest of the labs. We are getting an order for them." A copy of the most recent lipid profile results obtained for Resident #10 was requested at this time.<br><br>On 4/30/14 at 2:12 p.m., the DNS provided a copy of the most recent lipid profile results for Resident #10. It was dated 10/22/13.<br><br>3.1-35(g)(2) | | The corrective actions taken for Resident #10 is that the lipid profile has been drawn.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents have the potential to be affected by this alleged deficient practice. All residents were reviewed for completion of lab orders by the Medical Records nurse and all labs have been obtained per MD order.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The Clinical Education Coordinator and DNSS / Designee will conduct an in-service with licensed nursing staff on lab procedures and lab tracking by 5-30-14. Labs will be tracked daily by the Medical Records nurse to ensure labs are drawn per | |

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| | 155636 | | 05/01/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HARRISON TERRACE | 1924 WELLESLEY BLVD<br>INDIANAPOLIS, IN 46219 |

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| | | | MD order. DNS / Designee will review lab tracking form bi-weekly to ensure compliance.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored via the Lab CQI tool monthly x 4 months, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.<br><br>**Compliance date: May 31, 2014** | |
| F000309<br>SS=D | 483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F000309 | | 05/31/2014 |

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| | Based on interview and record review, the facility failed to follow physician's orders regarding dialysis for 1 of 1 resident reviewed for dialysis. (Resident #6)<br><br>Findings include:<br><br>The clinical record for Resident #6 was reviewed on 4/30/14 at 2:00 p.m. The diagnoses for Resident #6 included, but were not limited to, end stage renal disease.<br><br>The April, 2014 Physician Orders for Resident #6 indicated, "Record blood pressure upon return from dialysis. Special Instructions: Check Blood Pressure on Tuesday, Thursday, and Saturday upon return from Dialysis Once A Day on Tue (Tuesday), Thu (Thursday), Sat (Saturday); 4:00 p.m." with a start date of 2/18/14.<br><br>The April, 2014 MAR (medication administration record) and April, 2014 Matrix Vitals Report indicated the blood pressure was not taken as ordered on 4/9/14, 4/15/14, and 4/19/14.<br><br>The April, 2014 Physicians Orders indicated, "Access Site: Left chest port-a-cath (catheter) Special Instructions: Check dressing site daily | | **F 309 Provide Services for Highest Well Being**<br><br>It is the intent of this provider for each resident to receive the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>Resident #6's blood pressures are being recorded on the MAR per the physician order. Her access site is assessed and documented in the MAR per the physician order.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents receiving dialysis services have the potential to be affected. An audit has been | |

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| | Once A Day; 6:00 a.m. - 6:00 p.m." with a start date of 2/18/14.<br><br>The April, 2014 MAR and April, 2014 progress notes did not indicate Resident #6's dressing site was checked daily as ordered on the following dates: 4/6/14, 4/7/14, 4/8/14, 4/10/14, 4/11/14, 4/13/14, 4/14/14, 4/15/14, 4/17/14, 4/19/14, 4/20/14, 4/22/14, 4/24/14, 4/25/14, 4/26/14, 4/27/14, and 4/28/14.<br><br>An interview was conducted with LPN #4, the nurse for Resident #6, on 5/1/14 at 10:40 a.m., regarding Resident #6 and the significance of obtaining her blood pressures and assessment of the dressing over her access site. She indicated, "We are supposed to get her blood pressure when she comes back. We document the blood pressure in the MAR. You can also put it (blood pressure reading) in Matrix. We get it to make sure her blood pressure is not too low. She's also on Coreg (high blood pressure medication), so we don't want to give it to her if her blood pressure is too low. I assess for bleeding, that she has no swelling or redness, or signs or symptoms of infection or trauma. We do it daily. Make sure it's nice, clean, and dry and intact."<br><br>An interview was conducted with the | | completed by the Medical Records nurse on residents who receive dialysis services to ensure physician orders are being followed.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The licensed nursing staff has been in-serviced by the CEC / Designee by 5-30-14 regarding the importance of recording blood pressures and assessing the access site on the MAR per the physician order. All new nurses will receive the training during their orientation. The unit managers will monitor the MAR / TARs daily to ensure documentation has occurred per the physician orders. Licensed staff found not to be following physician orders will receive additional education and / or progressive disciplinary action as needed.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** | |

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| | DNS on 4/30/14 at 3:28 p.m., regarding Resident #6's order for checking of the access site. She stated, "It looks like they (nursing staff) should be checking off on the MAR for check access site." Regarding the missing blood pressures, she stated, "I'm still missing 4/8 (4/8/14), 4/15 (4/15/14), and 4/19 (4/19/14)."<br><br>The 1/9/12 dialysis care plan, with a goal date of 7/24/14, indicated an approach was, "Assess rt (right) side porta-cath (catheter) access site daily for excessive bleeding, drainage, swelling, redness, warmth. Document findings, report abnormals to MD and dialysis."<br><br>The Dialysis Care policy was provided by the Executive Director on 5/1/14 at 9:45 a.m. It indicated, "4. An assessment of the resident's dialysis access site will be completed daily ....and recorded on the Medication Administration Record(MAR)...8. An assessment of the resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site including bruit and thrill (if applicable), drainage, and general condition. Documentation of the assessment will be recorded in EMR and dialysis flow sheet or MAR."<br><br>3.1-37(a) | | The corrective actions will be monitored via the Dialysis CQI tool weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.<br><br>**Compliance date: May 31, 2014** | |

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| F000313<br>SS=D | 483.25(b)<br>TREATMENT/DEVICES TO MAINTAIN HEARING/VISION<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br><br>Based on observation, interview, and record review, the facility failed to address a resident's decline in vision and failed to provide care for a resident's vision for 2 out of 3 residents reviewed of 36 who met the criteria for vision. (Resident #60 & #94)<br><br>Findings include:<br><br>1. The clinical record for Resident #60 was reviewed on 4/28/14 at 1:30 p.m. The diagnoses for Resident #60 included, but were not limited to, dementia.<br><br>The 2/19/14 Admission MDS (minimum data set) assessment for vision indicated | F000313 | **F313 Treatment/Devices to Maintain Hearing/Vision**<br><br>It is the intent of this provider to ensure residents receive proper treatment and assistive devices to maintain vision and hearing abilities.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>Resident #60 no longer resides in the | 05/31/2014 |

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| | Resident #60's ability to see in adequate light was adequate. It defined adequate vision as, "sees fine detail, such as regular print in newspapers/books." It indicated no corrective lenses were used.<br><br>The 2/24/14 14-day MDS assessment for vision indicated Resident #60's ability to see in adequate light was adequate, and no corrective lenses were used.<br><br>The 3/10/14 30-day MDS assessment indicated Resident #60's ability to see in adequate light was impaired. It defined impaired as "sees large print, but not regular print in newspapers/books." It indicated no corrective lenses were used.<br><br>Resident #60's care plans were reviewed, and no vision care plan was found.<br><br>The 3/12/14 progress note completed by SSA (Social Services Assistant) #1 indicated, "30 Day MDS completed on 3/10/14...." It did not reference Resident #60's vision decline. No where in the progress notes did it indicate Resident #60s family was informed of the decline in vision, including the 3/20/14 progress notes regarding her discharge home with her daughter.<br><br>On 4/28/14 at 2:30 p.m., an interview was conducted with SSA #1, who | | facility. The corrective action taken for resident #94 is he was provided with a pair of reading glasses.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents who are assessed to have “impaired” vision are at risk to be affected by this practice. A facility audit has been conducted by the SSD and all residents assessed to have “impaired” vision have been referred for vision services as needed.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>SS staff will be in-serviced by the MCF / Designee by 5-30-14 regarding the importance of completing the visual assessment and the policy and procedure for when a change in vision is detected. Any new SS staff will receive similar training during orientation. The | |

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| | completed Resident #60's 3/10/14 MDS vision assessment. She provided a copy of the vision tool used for Resident #60's 2/19/14, 2/24/14, and 3/10/14 MDS assessments. She pointed to line 2, and identified it as the line Resident #60 was able to read. Line 2 indicated, "Large print - 14 point type." She pointed to line 1, and identified it as the line Resident #60 was unable to read. Line 1 indicated, "Regular print in newspaper/books-10 point type." SSA #1 stated, "If they can read the middle (line 2) but not the top (line 1), it's impaired."<br><br>SSA #1 indicated she recognized the 3/10/14 decline in vision from the previous assessments. Regarding how the decline was addressed, whether an eye appointment was made, and whether family was notified of the vision decline, she indicated, "I just kind of let staff know. I don't know what nurse I told. I didn't care plan it. I normally would....She was only here short term. I didn't put her on the list (to see the ophthalmologist.) I didn't let the family know, but I will now, so she can go see the ophthalmologist." | | MDS Coordinator will review vision assessments to ensure any changes in vision are noted and care plans updated as needed.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored via the Hearing & Vision Services CQI tool weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed. | |
| F000329<br>SS=D | 483.25(l)<br>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive | | | |

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| | 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.<br><br>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. | | | |
| | Based on interview and record review, the facility failed to obtain a valproic acid level as ordered to adequately monitor a resident's use of divalproex for 1 of 5 residents reviewed for unnecessary medication. (Resident #10)<br><br>Findings include:<br><br>The clinical record for Resident #10 was reviewed on 4/29/14 at 10:30 p.m. The diagnoses for Resident #10 included, but were not limited to, schizophrenia.<br><br>The April, 2014 Physician Orders for Resident #10 indicated, "divalproex tablet extended release 24 hr; 250 mg" once daily at 5:00 p.m., with a start date | F000329 | **F 329 Drug Regimen is Free from Unnecessary Drugs**<br><br>It is the intent of the intent of the provider to ensure each resident's drug regimen is free from unnecessary drugs.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** | 05/31/2014 |

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| | of 10/26/10. It indicated, "Valproic Acid Level Special Instructions: Once a day on the 4th Tues (Tuesday) of Apr, July, Oct. and Jan." with a start date of 1/30/14.<br><br>The lab results for April, 2014 were reviewed, and no valproic acid level was found.<br><br>An interview was conducted with the DNS on 4/30/14 at 1:40 p.m., regarding whether a valproic acid level was obtained for Resident #10 in April, 2014. She stated, "The lipid profile and the valproic acid was missed on 4/22 (4/22/14) with the rest of the labs. We are getting an order for them. The valproic acid was in regards to her depakote (divalproex) usage." A copy of the most recent valproic acid level obtained for Resident #10 was requested at this time.<br><br>On 4/30/14 at 2:12 p.m., the DNS provided a copy of the most recent valproic acid level for Resident #10. It was dated 1/14/14.<br><br>Regarding the medication divalproex, the Lipincott Williams & Wilkins Nursing 2014 Drug Handbook indicated, "Monitor drug level. Therapeutic level is commonly considered to be 50 to 100 | | The corrective action taken for Resident #10 is that the valproic level has been drawn.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents have the potential to be affected by this alleged deficient practice. All residents were reviewed by Medical Records nurse for completion of lab orders and all labs have been obtained per MD order.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The CEC and DNSS / Designee will conduct an in-service with licensed nursing staff on lab procedures and lab tracking by 5-30-14. Any new nurses will receive the same in-service training during their orientation. Labs will be tracked daily by the Medical Records nurse to ensure labs are drawn per MD | |

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| | mcg/mL."<br><br>3.1-48(a)(3)<br>3.1-48(b)(2) | | order. DNS will review lab tracking form bi-monthly to ensure compliance.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored via the Lab CQI tool monthly x 4 months, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed.<br><br>**Compliance date: May 31, 2014** | |
| F000333<br>SS=D | 483.25(m)(2)<br>RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br>The facility must ensure that residents are free of any significant medication errors.<br>Based on observation, interview, and record review, the facility failed to ensure the correct dosage of a medication was administered for 1 of 11 residents | F000333 | **F 333 Residents Free of Significant Med Errors** | 05/31/2014 |

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| | observed during medication administration. (Resident #51)<br><br>Findings include:<br><br>An observation, on 4/30/2014 at 1:36 p.m., indicated LPN #5 removed one capsule from a package labeled, "Gabapentin 100mg", and placed the capsule into a clear medicine cup. LPN #5 was observed to then place the medicine cup into Resident #51 's hands. Resident #51 poured the medication into her mouth and drank water.<br><br>Resident #51's MD orders were reviewed at 2:10 p.m. and indicated, "12/3/2013: Neurontin (gabapentin) capsule; 100 mg; amt (amount): 200 mg; oral. Special instructions: Indication: neuropathy. TID-Three times a day; 09:00 am, 01:00 pm, 09:00 pm."<br><br>An interview with the DNS, on 4/30/2014 at 2:15 p.m., indicated she did not think there was any way to prove the correct dosage of medication was given.<br><br>An observation, on 4/30/2014 at 2:15 p.m., with the DNS, indicated Resident #51 had 5 full medication cards, each filled with 30 individual doses of 100mg Gabapentin capsules. There was 1 medication card filled with 24 medication | | **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>The corrective action taken for Resident #51 is that she has continued to receive the correct dose of all medications. The physician was notified immediately of the possibility of an insignificant med error, and indicated there would be no negative outcome, with no new order given for that dose.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents who receive medications have the potential to be affected by this alleged deficient practice. Licensed nursing staff will be in-serviced by the CEC or designee by 5-30-14 on the Five Rights of Medication Pass. Any new nurses will receive the same training during orientation. | |

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| | doses of 100mg Gabapentin capsules. The pharmacy delivery date on all the medication cards was 4/21/2014.<br><br>An interview with the DNS and the Nurse Consultant, on 4/30/3014 at 2:25 p.m., indicated they were unsure of the specific number of capsules delivered from pharmacy and did not think there was a way to reconcile the number of capsules given to the resident.<br><br>A progress note, dated 4/30/2014 at 3:09 p.m., indicated, "Resident #51. During 1 pm med pass observation, there is a possibility that the resident only received 1 capsule (100mg) of Neurontin instead of 2 capsules (200mg). Dr. was notified and stated, "either way, it would not result in any negative outcome for the resident, don't do anything different."...Charge nurse notified, will continue to monitor."<br><br>3.1-48(c)(2) | | **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>Licensed nursing staff will be inserviced by the CEC/Designee by 5-30-14 on 5 Rights of Medication Pass. This information will also be provided for new nurses during orientation. DNS / CEC / Consultant Pharmacist will continue to conduct medication pass audits using the Medication Skills Validation tool with licensed nursing staff by 5-30-14 and on-going.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The CEC / Designee will complete a medication pass skills validation tool for 3 nurses (at least one from each shift) weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan | |

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| | | | will be developed. | |
| F000406<br>SS=D | 483.45(a)<br>PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br><br>Based on observation, interview, and record review, the facility failed to provide the necessary therapy services to a resident in need of speech therapy for 1 of 4 residents reviewed for therapy. (Resident #43)<br><br>Findings include:<br><br>The clinical record for Resident #43 was reviewed on 4/29/14 at 2:00 p.m. The diagnoses for Resident #43 included, but were not limited to, dementia.<br><br>An interview was conducted with Resident #43 on 4/25/14 at 2:01 p.m. regarding whether he had any chewing or eating problems. He indicated, "It's hard for me to swallow. I had throat surgery. | F000406 | **F 406 Specialized Rehab Services**<br><br>It is the intent of this provider to provide the required physical, speech-language pathology, occupational therapy and mental health rehabilitative services.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>Resident #43 has received evaluation and appropriate services related to speech therapy; resident #43 had a barium swallow study that showed no | 05/31/2014 |

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| | I used to have bass in my voice. Now, I don't have any." Resident #43's voice had the tone of a high pitched whisper. He was slow to articulate his words. He tucked his chin to his chest several times throughout this conversation.<br><br>Another interview was conducted with Resident #43 on 4/29/14 at 2:22 p.m. He indicated, "When I swallow, it's hard for food to go down. I have to nod my head for the food to go down. It's been like that for about 3 years." Regarding whether he had any associated pain, he indicated, "It hurts me enough to stop me from talking....It hurts when I talk for a while. I pause and nod my head quite often. It's been 3 years since the surgery."<br><br>An interview was conducted with Unit Manager #1 regarding Resident #1's reported swallowing and speaking problems on 4/29/14 at 2:31 p.m. He indicated, "I've noticed the tone of his speech. I did notice once, while he was talking, that he put his head down....To my knowledge, he does not have swallowing problems. I've sat with him many times, and there's no signs or symptoms of any problems with eating...I've never noticed him pause or put his head down while talking to him. I'll talk to speech and have him referred." | | swallowing deficits.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents have the potential to be affected by this alleged deficient practice. Staff will be educated by the Clinical Education Coordinator / Designee by 5-30-14 regarding the communication form for reasons to refer to therapy. Any resident with chewing/swallowing problems will be referred to therapy for screening. Therapy services will continue to make observations at mealtimes for residents with potential therapy needs.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>The CEC / Designee will educate facility staff by 5-30-14 regarding the communication tool for reasons to refer to therapy. The CEC will also provide education to the Meal | |

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| | Unit Manager #1 looked in the computer too see if Resident #43 ever received speech therapy. He stated, "It looks like 7/23/12 was his last speech therapy, 5 times a week for 12 weeks. If everything (being said) is true, poor guy."<br><br>During review of Resident #43's care plans, no care plans were found to address an alteration in communication or swallowing difficulty.<br><br>An interview was conducted with SLP (Speech Language Pathologist) #3 on 5/1/14 at 11:03 a.m. He indicated, "We re-evaluated him yesterday for speech therapy. He has a diagnosis of dysphagia oropharyngeal phase. He never complained of anything swallowing related until yesterday. I went over a couple options with him. He said no to a barium swallowing study and no to a downgraded diet. They put him on hot charting for nursing. I educated him on aspiration risks and choking risks, sitting upright after he eats. He verbalized agreeement. I recommended a GI (gastrointestinal) consult. He was burping during his evaluation, a reflux type burp. I noted that too. The only way we would know he had swallowing problems would be for nursing to tell us. I think this diagnosis (dysphagia) is justifiable. He told the (title of person to | | Managers on how to utilize the NAR Mealtime Checklist. Any new staff will be in-serviced during their orientation. Therapy services will continue to make observations at mealtime for residents with potential therapy needs. All new residents and those with a significant change related to chewing/swallowing will be referred to speech therapy to ensure needs are met.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The Rehab Services Manager / Designee will interview ten residents regarding swallowing, coughing and choking during eating weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed. | |

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| | whom Resident #43 reported the swallowing and speaking problems) he developed a strategy where he tucks his chin. I asked him about that, and he admitted to it, but couldn't put a date to it. When I worked with him in 2012, he didn't tuck his chin or have any known swallowing problems. He has a closed stoma. He had a C1 fracture. I can't really tell anything without an instrumental eval (evaluation). I would have liked to get him to the hospital to look at it. I don't think the chin tuck is what he needs. I think when he eats a solid, he's trying to force the bolus back over. The big thing is having him take small bites, alternate liquids and solids, so he's not eating just solids and washing it down. I talked to him about his voice. He said that he has pain in his voice after talking for a while. He said he will stop talking throughout the day. We've given him a communication board, and we're going to train him to use it. I wrote a goal for that. I'd like him to be able to use it with 90% accuracy. He's going to need to follow some cues and develop some strategies."<br><br>The 4/30/14 Speech Therapy Plan of Care completed by SLP #3 indicated, "Patient referred for skilled ST (speech therapy) evaluation secondary to pt (patient) report of difficulty swallowing | | | |

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| | solids as well as vocal fatigue during the day, leading him to cease verbalizations. Patient has hx (history) of dementia and spinal cord injury to c1. Patient has a closed stoma which he references as being a reason for swallowing difficulty. Therapist directed trials (of) regular solids during breakfast and lunch. Patient utilized chin tuck during all presentations stating that it helped him to swallow. Patient displayed intermittent belching and delayed cough during lunch with noted mild delay initiating swallow which is likely secondary to pt preparing to tuck chin and force bolus over the base of tongue. No overt s/s (signs/symptoms) aspiration noted when consuming thin liquids. Patient presented options for instrumental evaluation, FEES and MBSS. Patient stated that he did not want to participate in either evaluation or be placed on mechanical soft diet for trial period. Will recommend possible GI consult secondary to presence of belching when eating, possible GERD (gastro esophageal reflux disease). Patient was provided with picture communication board for use when not utilizing voice. Patient instructed to use board when needs/wants should be identified to staff....Therapy Necessity: Therapy necessary for dysphagia management and alternative communication device training. Without therapy patient at risk | | | |

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| | for possible aspiration, decreased nutrition and decreased communication of wants and needs."<br><br>Another interview was conducted with Resident #6 on 5/1/14 at 11:53 a.m., regarding whether he'd ever mentioned his swallowing problems or pain while speaking to anyone. He stated, "I have told someone, but it doesn't do any good." He indicated he could not recall who he'd told.<br><br>Upon recommendation by the DNS an interview was conducted with CNA #2, on 5/1/14 at 11:50 a.m. CNA #2 indicated, "I have noticed he puts his head down while he talks during a long conversation, but not while he eats."<br><br>During a second interview with CNA #2 on 5/1/14 at 12:18 p.m., regarding whether she'd ever reported Resident #43 putting his head down during long conversations, she indicated, "I noticed him putting his head down, but I didn't report it, because I didn't think it was anything that needed to be reported."<br><br>3.1-23(a)(2) | | | |

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| F000411 SS=D | 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.<br><br>Based on observation, interview, and record review, the facility failed to provide for evaluation and treatment of a resident's dental services for 1 of 3 residents reviewed for dental services. (Resident #94)<br><br>Findings include:<br><br>Resident #94's record was reviewed on 4/25/14 at 12:58 p.m. The resident's diagnoses included, but were not limited to, alcohol abuse, anemia, senile dementia, anxiety disorder, neuropathy. | F000411 | **F 411 Dental Services**<br><br>It is the intent of the provider to assist residents in obtaining routine and 24-hour emergency dental care.<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?**<br><br>Resident #94 has been referred for | 05/31/2014 |

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| | An MDS (minimum data set) Assessment, dated 12/2/13, indicated Resident #94 was identified as having "... no natural teeth or tooth fragment(s)..."<br><br>During an interview with Social Services Assistant #1 on 4/28/14 at 1:50 p.m., she indicated Resident #94 does not wear dentures.<br><br>On 4/28/14 at 2:31 p.m., during an interview, the Social Services Director (SSD) indicated a "comprehensive admission assessment" indicated Resident #94 does not wear dentures. She indicated the resident has not had a dental evaluation during his time as a facility resident. She also indicated residents identified with dental problems would normally have a dental evaluation within 4 months of admission, but she indicated the facility was having difficulty getting certain documentation signed by Resident #94's guardian. She indicated there was a change in lthe resident's legal guardian status some time after the resident's admission to the facility which was also making it difficult to get necessary paperwork for "ancillary services" to be signed.<br><br>A physician's order, dated 11/25/13, indicated Resident #94 "may be seen by | | dental services.<br><br>**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**<br><br>All residents with dental needs have the potential to be affected by this alleged deficient practice. A facility audit has been conducted by SSD to ensure all residents who have dental needs have been referred for dental services as appropriate.<br><br>**What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur**<br><br>SS will obtain information regarding the need for dental services via the RAI Instrument. SS staff will be in-serviced by the MCF/Designee by 5-30-14 regarding the importance of acquiring the dental information from the assessment and pursuing notification of the dental provider. New SS staff will have similar training during orientation. All new residents and those with a significant | |

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| | Podiatrist, Dentist, Optometrist, Audiologist."<br><br>On 4/29/14 at 9:59 a.m., during an interview, the DNS indicated the facility's system"broke down" in regards to following up on Resident #94's legal guardianship. She also indicated this led to a delay in getting necessary dental care provided to Resident #94.<br><br>On 4/29/14 at 11:34 a.m., the SSD indicated the "system did break down" in regards to getting necessary dental services provided to Resident #94.<br><br>On 4/28/14 at 1:51 p.m., during an observation, Resident #94 revealed he was missing most or all of his teeth.<br><br>On 4/28/14 at 1:52 p.m., Resident #94 indicated he had all his teeth pulled years ago, but would like to have dentures. He indicated not receving any dental evaluation since his has resided at the facility.<br><br>A facility policy titled "Dental Services" indicated the following: "...The policy provides dental services to meet the oral health needs of each resident..." and "...The facility maintains an outside resource to provide dental services to meet the needs of each resident..." and | | change will be assessed for dental needs and will be referred as needed to the dental provider.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place**<br><br>The corrective actions will be monitored via the Dental Services CQI tool weekly x 4 weeks, bimonthly x 2 months and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed. | |

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| | "...The dentist of the resident's choice provides both routine and emergency dental service..." and "...Residents with lost, poorly fitting, or damaged dentures are promptly referred to the dentist..." and "...The facility will assist the residents in making dental appointments, arranging transportation to and from the dentist's office..."<br><br>3.1-24(a)<br>3.1-24(a)(3) | | | |