

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2014
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NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526
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F000000	<p>This visit was for the Investigation of Complaint Number IN00146141.</p> <p>Complaint Number IN00146141 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, and F315.</p> <p>Survey dates: April 29, and 30, 2014</p> <p>Facility number: 011150 Provider number: 155760 AIM number: 200831020</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: SNF: 26 SNF/NF: 33 Total: 59</p> <p>Census payor type: Medicare: 19 Medicaid: 15 Other: 25 Total: 59</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This is the requested Plan of Correction for the alleged deficiencies cited during Complaint Survey #IN00146141. The survey was conducted on April 29 and 30, 2014 for facility number 011150. This constitutes the written plan of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet the requirements established by state and federal law. The date effective of compliance is May 30, 2014. The Maples at Waterford Crossing Health Campus respectfully requests this Plan of Correction be submitted as desk review for compliance for the deficiencies cited.</p>	

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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F000282 SS=D	<p>Quality Review completed on May 8, 2014, by Brenda Meredith, R.N.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow physicians orders for 3 of 5 residents reviewed for following physician's orders in a sample of 5. (Resident #V, Resident #X, and Resident #Y)</p> <p>Findings include:</p> <p>1. Resident #V's record was reviewed 4-29-2014 at 1:17 PM. Resident #V's diagnoses included, but were not limited to, dementia, high blood pressure, and depression.</p> <p>A physician's order, dated 2-7-2014, indicated resident #V was to be transferred by Hoyer lift due to risk for injury to legs.</p> <p>A quarterly Minimum Data Set assessment, dated 2-26-2014, indicated Resident #V needed extensive assist of 2</p>	F000282	<p>1) Residents V, X, Y were not identified due to the confidentiality of the resident list related to the complaint survey. 2) All residents have the potential to be affected by this deficient practice. All current residents will have physicians orders reviewed for the last 30 days to ensure all physician orders were followed. 3) Licensed nurses will be re-inserviced on following the physician orders and ensuring the orders are followed. Five residents per day five times a week will be audited for accuracy of MD orders. The telephone order copies will go into the clinical care meeting book to be reviewed five times per week. The DHS (Director of Health Services) or designee will report findings to QAA monthly for six months. 4) QAA will monitor monthly for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for six months or</p>	05/30/2014

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	<p>persons to transfer.</p> <p>A care plan titled, ADL self care deficit, dated 9-8-2013, indicated Resident #V needed assistance for transfers, but did not indicated the extent of the assistance needed. Interventions included OT (Occupational Therapy), and PT (Physical Therapy) treatment, but did not indicate the extent of the assistance that was to be provided.</p> <p>A current care plan, dated 4-29-2014, provided by the Director of Nursing (DON), on 4-29-2014 at 4:10 PM, indicated Resident #V required assistance with transfers, but did not indicated the level of assistance required.</p> <p>A CRCA 24 hour report sheet (CNA assignment sheet) indicated Resident #V was to lay down after meals, but the sheet did not indicate how to assist with transfers.</p> <p>In an interview on 4-29-2014 at 1:59 PM, CNA #1 indicated Resident #V was a 2 person lift to transfer. CNA #1 further indicated she thought Resident #V should have been a Hoyer lift.</p> <p>In an interview on 4-29-2014 at 2:12 PM, CNA #2 indicated Resident #V was a 2 person lift to transfer on her 24 hour</p>		until 100% compliance is achieved.				

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	<p>report sheet. CNA #2 further indicated she often assisted another CNA to complete a 2 person lift transfer.</p> <p>In an observation on 4-29-2014 at 4:05 PM, CNA #4 and the DON transferred Resident #V safely utilizing a Hoyer lift.</p> <p>In an interview on 4-30-2014 at 10:10 AM, the DON indicated the facility had no policy regarding following physician orders, but it was understood, physician orders should be followed.</p> <p>2. On 4-29-2014 at 12:30 PM, Resident #V was observed sitting in the resident lounge in a high backed chair. Resident #V did not have leg separators in place.</p> <p>On 4-30-2014 at 10:15 AM, Resident #V was observed sitting up in a high backed wheelchair in the resident lounge. Resident #V did not have leg separators in place.</p> <p>OT notes, dated 3-5-2014, indicated under recommendation to have a leg separator in place.</p> <p>A current CRCA 24 hour sheet indicated Resident #V was to keep a foot buddy with feet separated while up in wheelchair.</p>						

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	<p>In an interview on 4-30-2014 at 10:12 AM, CNA #3 indicated she could not find the foot separator today.</p> <p>3. Resident #X's record was reviewed 4-29-2014 at 3:25 PM. Resident #X's diagnoses included, but was not limited to, dementia, high blood pressure, and Parkinson's disease.</p> <p>During an observation on 4-29-2014 at 4:15 PM, incontinent care was performed on Resident #X by CNA #5 and the DON. Protective skin barrier was not applied prior to placing a clean brief on Resident #X.</p> <p>A physician's order, dated 2-5-2014, indicated to apply skin barrier cream to Resident #X after each incontinent episode.</p> <p>During an interview on 4-29-2014 at 4:25 PM, CNA #5 indicated she did not know there was an order to apply the cream.</p> <p>4. Resident #Y's record was reviewed 4-30-2014 at 10:41 AM. Resident #Y's diagnoses included, but were not limited to, liver failure, stroke, and atrial fibrillation.</p> <p>A physician's order, dated 9-13-13, indicated Resident #Y's diet was to be</p>			

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	<p>Regular consistency with nectar thick liquids.</p> <p>On 4-29-2014 at 5:02 PM, Resident #Y was in the assisted dining area and was observed to have a thin carbonated beverage.</p> <p>In an interview on 4-29-2014 at 5:02 PM, the Assistant Director of Nursing (ADON) indicated Resident #Y was allowed to have carbonated beverages because Frazier Water Protocol permitted it and indicated carbonated beverages were the same as nectar thick liquids.</p> <p>During an interview on 4-30-02014 at 10:59 AM, the DON indicated there was no policy for the facility or company to utilize Frazier Water protocol.</p> <p>During an interview on 4-30-2014 at 11:15 AM, the Speech Therapist indicated there was research that indicated carbonated beverages did not need thickened and they did not need to be thickened. The Speech Therapist further indicated there was not a physician's order that indicated Resident #Y was allowed thin carbonated beverages, and further, there was no care plan to address the ability of Resident #Y to have thin carbonated beverages. The Speech therapist further indicated the</p>				

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F000315 SS=D	<p>facility and the corporation did not have a policy to address the use of thin carbonated beverages with a thickened liquids order.</p> <p>The facility did not to provide a copy of the research cited.</p> <p>This Federal citation relates to Complaint IN00146141.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to consistently assess urinary status for 2 of 3 residents reviewed for urinary assessment in a sample of 5. (Resident #V, and Resident #W)</p>	F000315	<p>1) Residents V and W were not identified due to the confidentiality of the resident list related to the compliant survey. 2) All current residents who are incontinent of bladder or who have experienced a UTI have the potential to be affected by this deficient practice. 3) Licensed nures will be</p>	05/30/2014			

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	<p>Findings include:</p> <p>1. Resident #V's record was reviewed 4-29-2014 at 1:17 PM. Resident #V's diagnoses included, but were not limited to, dementia, high blood pressure, and depression.</p> <p>An initial care plan, dated 9-8-2013, indicated Resident #V's bladder status was totally continent. Interventions included to wear an incontinent product.</p> <p>A Monthly Nursing Assessment and Data Collection, dated 2-19-2014, indicated Resident #V was always incontinent.</p> <p>A current care plan, dated 4-30-2014, indicated Resident #V was to be checked for incontinence and changed every 2 hours as needed, and to provide pericare after each incontinent episode.</p> <p>There was no three day voiding pattern available for review after the continence change was observed.</p> <p>During an interview on 4-30-2014 at 10:18 AM, the Director of Nursing (DON) indicated a three day voiding pattern had not been completed when the change was observed.</p> <p>A current policy titled, Bowel and</p>		<p>re-inserviced on urinary assessment and assessment of residents with urinary tract infections. All current residents will be assessed for urinary status. All residents with urinary tract infections diagnosis will be assessed for 72 hours or until the signs and symptoms are no longer present. DHS or designee will monitor residents with diagnosis of UTI to ensure licensed nurses continue to do ongoing assessments until UTI resolved. DHS or designee will monitor five residents per day five days per week for urinary status and/or UTI and ensure the assessments are completed. DHS or designee will report findings monthly to QAA for six months. 4) QAA will monitor monthly for any trends and make recommendations to the Plan of Correction as needed. QAA will monitor monthly for six months or until 100% compliance is achieved.</p>				

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	<p>Bladder Continence Programming, dated 10-07, provided by the DON on 4-30-14 at 10:56 AM indicated "5. Analyze assessments to determine resident's ability to participate in a continence program. If a toileting plan may be beneficial, initiate the Elimination record and schedule to record the resident's elimination pattern for a 3 day period."</p> <p>2. On 4-29-2014 at 12:30 PM, Resident #V was observed sitting in the resident lounge in a high backed chair. Resident #V did not have leg separators in place.</p> <p>A physician's order, dated 3-19-2014, indicated Resident #V was to receive Ampicillin (an antibiotic) 500 milligrams (mg) by mouth (po) three times daily (TID) for 10 days for UTI.</p> <p>A review of Resident #V's nurse's notes, dated 3-19-2014 through 3-29-2014, did not indicate if Resident #V was urinating adequately, if the urine was clear, the color of the urine, or if the urine had an odor.</p> <p>During an interview on 4-30-2014 at 10:18 AM, the DON indicated urinary assessment should have been completed daily while the resident was on the antibiotic.</p>			

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	<p>3. Resident #W's record was reviewed 4-30-14 at 9:44 AM. Resident #W's diagnoses included, but were not limited to, high blood pressure, diabetes, and depression.</p> <p>A physician's order, dated 4-16-2014, indicated Resident #W was to have a urinalysis with a culture and sensitivity (a lab test for urinary tract infection) if indicated.</p> <p>A urinalysis lab test, dated 4-16-2014, indicated Resident #W had a trace of bacteria, but no other abnormalities existed.</p> <p>A Nursing Admission Assessment and Data Collection Sheet, dated 3-13-14, indicated Resident #W's bladder status was always continent, and her urine was clear/ yellow.</p> <p>A review of Resident #W's Nurse's notes indicated the following: on 4-15-14, Resident #W seemed confused. The elimination section of the form was blank. On 4-16-14, Resident #W had no hallucinations, and her urine was clear yellow. There was no other indication of frequency, urgency, or urine odor. On 4-17-14, the notes indicated Resident #W's urine was yellow and clear, but there was no indication Resident #W had</p>						

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	<p>any frequency, urgency, or if the urine had an odor.</p> <p>There was no urinary assessment to indicate if Resident #W needed further testing.</p> <p>This Federal citation relates to Complaint IN00146141.</p> <p>3.1-41(a)(2)</p>			