

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/06/2012
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NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268
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F0000	<p>This visit was for the Investigation of Complaints IN00119776 and IN00120497.</p> <p>Complaint IN00119776 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F309.</p> <p>Complaint IN00120497 - Unsubstantiated due to lack of evidence.</p> <p>Survey Date: 12/06/12</p> <p>Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350</p> <p>Survey Team: Heather Lay, RN - TC Lori Brettnacher, RN</p> <p>Census Bed Type: SNF: 10 SNF/NF: 62 Total: 72</p> <p>Census Payor Type: Medicare: 10 Medicaid: 43 Other: 19 Total: 72</p>	F0000	<p>I have enclosed the Plan of Correction for the above-referenced facility in response to the Statement of Deficiencies. While this document is being submitted as confirmation of the facility's on-going efforts to comply with all statutory and regulatory requirements, it should not be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or findings, nor have we identified mitigating factors.</p> <p>This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a Post Survey Review on or after January 5, 2013.</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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	<p>Sample: 05</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/10/12 Cathy Emswiller RN</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop an individualized comprehensive plan of care related to safe transfer needs and pain management for a resident who was admitted for rehabilitation services related to left sided weakness and a history of left shoulder pain following a stroke. This deficient practice resulted in a staff member inappropriately transferring a resident that caused pain. This deficient practice affected 1 of 1 resident reviewed for complaints of pain with transfer in a sample of 5 residents reviewed. [Resident B]</p>	F0279	<p>F279 Develop Comprehensive Care Plans</p> <p>It is the practice of the provider to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The resident has been discharged from the facility.</p>	01/05/2013

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	<p>Findings include:</p> <p>On 12/6/12 at 10:30 A.M., the Executive Director provided a facility abuse investigation involving Resident B.</p> <p>On 12/6/12 at 10:45 A.M., the abuse investigation was reviewed and included, but was not limited to the following:</p> <p>A written statement from Therapy #1, dated 11/13/12 at 1:00 P.M., included, but was not limited to, "[Resident B] stated to [Therapy #1] that before 10:00 P.M. on 11/12/12, a staff person was helping her get out of bed to go to the bathroom. Before the transfer, [Resident B] stated that she told the staff person [CNA #2] that her left side was her stroke side. [Resident B] said that the [CNA #2] took hold of her by both arms at mid arm and lifted her up. [Resident B] stated that she immediately felt pain and cried out. She stated that her shoulder hurt until morning [11/13/12]. [Resident B] stated that the aides in general are rough and should be easier on residents..."</p> <p>A written statement from the Social Service Director, dated 11/13/12, no time, included, but was not limited to, "[Resident B] reported an allegation to [Therapy #1]. Social worker [Social</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>New admissions will be reviewed by the Interdisciplinary Team in the facility's morning meeting to verify that a care plan exists that addresses the safe transfer needs of the resident and addresses the pain management needs of the resident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Staff will be re-educated by the Director of Nursing or designee on the provider's policies regarding Safe Transfers of residents, Pain Evaluation and Pain Assessment, and Care Plans including interim care plans upon resident admission.</p> <p>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:</p> <p>An Interim Care Plan and Pain Assessment Quality Assurance</p>		

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	<p>Service Director] interviewed [Resident B] on 11/13/12 at 10:30 A.M. [in the therapy department]. [Resident B] stated that [CNA #2] pulled her left arm while getting her out of bed to take her to the restroom. [Resident B] stated that as soon as [CNA #2] pulled her arm she felt pain in her arm and the pain went down her leg. [Social Service Director] apologized about the incident that occurred and asked the resident how do you feel and the resident said fearful. [Resident B] previous [sic] indicated the same word fearful to [Therapy #1]..."</p> <p>A written statement from CNA #2, dated 11/13/12 at 2:30 P.M., included, but was not limited to, "At 8:00 P.M., [CNA #2] enters [sic] [Resident B's] room responding to her call light. It was time for resident's shower. Resident was in bed. Resident stated to staff that she needed to use the restroom before her shower. Resident was lying in bed. Staff put her shoes on her in bed. Resident positioned herself on the side of the bed. [CNA #2] held resident by both shoulders and positioned her in the sitting position. Resident used side rail to transfer to the wheel [sic]. [CNA #2] stated that the resident did not complain of pain. No other staff were present..."</p> <p>On 12/6/12 at 12:00 P.M., Resident B's</p>		<p>Performance Improvement audit tool will be completed 1 time weekly times 1 quarter, then 1 time bi-weekly for 1-month until the alleged deficient practice does not recur. The Interim Care Plan and Pain Assessment Quality Assurance Performance Improvement audit tools will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assurance Committee.</p>				

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	<p>closed record was reviewed. Diagnoses included, but were not limited to, chronic atrial fibrillation, hypertension, right frontal lobe infarction, right sided cerebral vascular accident [stroke], and left sided weakness.</p> <p>Resident B was admitted to the facility on 11/2/12 and discharged home on 11/15/12.</p> <p>An "Admission Evaluation Data" dated 11/2/12 at 3:40 P.M., included, but was not limited to, "Cognition: Oriented to: person, place, time... Alert... Pain Evaluation: Other: Left Shoulder... F/3 [frequently at a 3 on a 10 point scale]...</p> <p>An "Admission Evaluation Data" nurse's notes, dated 11/2/12 at 7:30 P.M., included, but was not limited to, "Around 3:40 P.M., resident [Resident B] arrived to the facility with family in wheelchair... admitted to hospital after resident had stroke... resident discharged to home from hospital... family brought to facility... resident alert and oriented x3 [person, place, and time] with left side weakness with stroke... [Resident B] complains of pain to left shoulder... tolerable at this time..."</p> <p>The "Interim Plan of Care" attached to the "Admission Evaluation Data" was blank.</p>			

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	<p>There was no documentation of care plans prior to 11/9/12 [admit date 11/2/12].</p> <p>The following care plans were dated 11/9/12:</p> <p>"ADL [Activities of Daily Living]/Functional: Resident requires extensive assist from staff: Goal: Resident will be clean, well groomed and well nourished every day with staff assist... Interventions: Be non-judgmental about resident's ADL abilities, serve diet as ordered and provide needed assistance, change clothes every day and PRN [as needed], oral care twice daily, encourage resident to comb own hair, encourage resident to wash own face and hands, praise all efforts and give time as needed, shower twice weekly and assist with bath daily, toileting/incontinent care as needed... Fall: Resident is at risk for fall/injury... Goal: Resident will have no falls or injury thru next review... Interventions: Keep MD and family informed, administer medications as ordered, monitor vital signs, as indicated, monitor labs/X-rays per order, observe for side effects of any drugs that can cause, as indicated: gait disturbance, orthostatic hypotension, weakness, sedation, fatigue, seizures, syncope, vertigo, provide environmental adaptations, as indicated, low platform bed, area to wander safely,</p>				

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	<p>provide/monitor use of adaptive devices, as indicated, wheelchair, reinforce safety awareness as indicated, lock brakes on bed, chair, etc, before transferring, appropriate footwear, PT/OT to evaluate and treat... Incontinence: Incontinent of bladder potential for skin breakdown... Goal: Skin will remain intact thru next review... Interventions: Check resident PRN for incontinence, provide hygiene PRN, weekly skin assessment, observe skin during care..., encourage diet/fluids..., observe urine for signs/symptoms or urinary tract infection..., obtain labs as ordered..., observe signs/symptoms of dehydration... Pressure: Increased potential for pressure ulcers due to resident requiring assist for bed mobility... Goal: skin will remain intact... Interventions: Observe skin..., encourage food..., observe for incontinence..., report to MD any alteration in skin..., assist with toileting..., pressure relieving device in bed..."</p> <p>There was no documentation of an individualized plan of care regarding Resident B's left sided weakness [specifically safe transfers related to weakness] or Resident B's left shoulder pain.</p> <p>The following care plan, dated 11/13/12, included, but was not limited to:</p>			

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	<p>"CVA: CVA with left sided hemiparesis [weakness] with a potential for ADL decline... Goals: Resident will maintain current ADL status with assistance to be provided by staff as needed and will be free of complications related to CVA through next review... Interventions: Staff will provide assistance as needed for all ADL needs, staff will encourage resident to participate in all ADL's to the best of the resident's ability, ADL tasks will be broken down into short simple steps, cues will be provided by staff as necessary, PT/OT per order, resident will be encouraged to participate in activities to help increase socialization, medications to be administered per orders, when assisting resident do not leave unattended but provide privacy..."</p> <p>There was no documentation related to Resident B's left sided weakness [safe transfers] or Resident B's left shoulder pain.</p> <p>On 12/6/12 at 1:30 P.M., in an interview with Unit Manager #3, she indicated that upon admission, the facility [nursing] should complete the section "Interim Plan of Care" on the "Admission Evaluation Data." That information would be used as each resident's care plan until the comprehensive care plan was completed</p>						

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	<p>by the MDS [Minimum Data Set] coordinator. She indicated she did not have an interim care plan for Resident B. In addition, she indicated there were no other care plans for Resident B.</p> <p>On 12/6/12 at 1:40 P.M., in an interview, the MDS coordinator indicated that the care plans are used to develop and update the CNA assignment sheets [used to care for residents]. She indicated that since care plans were not developed for Resident B until day 7, that the CNA taking care of Resident B would have been given report from the nurse on how to care for her. In regard to lack of a pain care plan or care plan regarding Resident B's left sided weakness, the MDS coordinator indicated the physical therapy department would have communicated how to adequately transfer the resident.</p> <p>On 12/6/12 at 2:00 P.M., all physical therapy training of staff regarding Resident B was requested.</p> <p>On 12/6/12 at 3:00 P.M., the Executive Director provided Resident B's physical therapy "Inpatient Daily/Weekly Progress Report" dated 11/5/12 through 11/15/12; however, was unable to provide written documentation of communication between the physical therapy department and the nursing department regarding safe</p>			

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	<p>transfers related to Resident B's left sided weakness.</p> <p>On 12/6/12 at 3:00 P.M., the Executive Director indicated that CNA #2 was trained on how to transfer Resident B after the above incident. He was unable to provide documentation of that training and indicated there was no training related to Resident B's transfers prior to the incident on 11/12/12.</p> <p>On 12/6/12 at 3:00 P.M., the Executive Director provided a "Safe Lifting and Movement of Residents" policy, dated 10/2009, and a "Care Plans-Comprehensive" policy, dated 10/2009.</p> <p>The "Safe Lifting...", policy included, but was not limited to, "Policy: In order to protect the safety and well being of staff and residents, and to promote quality care, this facility uses appropriate technique and devices to lift and move residents... Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents... Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting</p>						

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	<p>needs in the care plan. Such assessment shall include: Resident's preferences for assistance, resident's mobility, resident's size, weight-bearing ability, cognitive status, whether the resident is usually cooperative with staff, the resident's goals for rehabilitation, including restoring or maintaining functional abilities..."</p> <p>The "Care Plans..." policy, included, but was not limited to, "Policy: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident... Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident... develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain, Each resident's comprehensive care plan is designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and or functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitative program..."</p> <p>This federal tag relates to complaint number IN00119776.</p>				

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	3.1-35(b)(1)				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.</p> <p>Based on interview and record review, the facility failed to adequately assess and implement a comprehensive plan of care for a resident's pain and ensure pain was prevented, related to inappropriate transfer, during an assisted transfer. This deficient practice affected 1 of 1 resident reviewed for complaints of pain with transfer in a sample of 5 residents reviewed. [Resident B]</p> <p>Findings include:</p> <p>On 12/6/12 at 10:30 A.M., the Executive Director provided a facility abuse investigation involving Resident B.</p> <p>On 12/6/12 at 10:45 A.M., the abuse investigation was reviewed and included, but was not limited to the following:</p> <p>A written statement from Therapy #1, dated 11/13/12 at 1:00 P.M., included, but was not limited to, "[Resident B] stated to [Therapy #1] that before 10:00 P.M. on 11/12/12, a staff person was helping her</p>	F0309	<p>F309 Provide Care/Services For Highest Well Being</p> <p>It is the practice of the provider for each resident to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The resident has been discharged from the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>New admissions will be reviewed by the Interdisciplinary Team in the facility's morning meeting to verify that a care plan exists that addresses the safe transfer</p>	01/05/2013			

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	<p>get out of bed to go to the bathroom. Before the transfer, [Resident B] stated that she told the staff person [CNA #2] that her left side was her stroke side. [Resident B] said that the [CNA #2] took hold of her by both arms at mid arm and lifted her up. [Resident B] stated that she immediately felt pain and cried out. She stated that her shoulder hurt until morning [11/13/12]. [Resident B] stated that the aides in general are rough and should be easier on residents..."</p> <p>A written statement from the Social Service Director, dated 11/13/12, no time, included, but was not limited to, "[Resident B] reported an allegation to [Therapy #1]. Social worker [Social Service Director] interviewed [Resident B] on 11/13/12 at 10:30 A.M. [in the therapy department]. [Resident B] stated that [CNA #2] pulled her left arm while getting her out of bed to take her to the restroom. [Resident B] stated that as soon as [CNA #2] pulled her arm she felt pain in her arm and the pain went down her leg. [Social Service Director] apologized about the incident that occurred and asked the resident how do you feel and the resident said fearful. [Resident B] previous [sic] indicated the same word fearful to [Therapy #1]..."</p> <p>A written statement from CNA #2, dated</p>		<p>needs of the resident and addresses the pain management needs of the resident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Staff will be re-educated by the Director of Nursing or designee on the provider's policies regarding Safe Transfers of residents, Pain Evaluation and Pain Assessment, and Care Plans including interim care plans upon resident admission.</p> <p>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:</p> <p>An Interim Care Plan and Pain Assessment Quality Assurance Performance Improvement audit tool will be completed 1 time weekly times 1 quarter, then 1 time bi-weekly for 1-month until the alleged deficient practice does not recur. The Interim Care Plan and Pain Assessment Quality Assurance Performance Improvement audit tools will be reviewed in the monthly Quality Assurance Performance</p>		

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	<p>11/13/12 at 2:30 P.M., included, but was not limited to, "At 8:00 P.M., [CNA #2] enters [sic] [Resident B's] room responding to her call light. It was time for resident's shower. Resident was in bed. Resident stated to staff that she needed to use the restroom before her shower. Resident was lying in bed. Staff put her shoes on her in bed. Resident positioned herself on the side of the bed. [CNA #2] held resident by both shoulders and positioned her in the sitting position. Resident used side rail to transfer to the wheel [sic]. [CNA #2] stated that the resident did not complain of pain. No other staff were present..."</p> <p>On 12/6/12 at 12:00 P.M., Resident B's closed record was reviewed. Diagnoses included, but were not limited to, chronic atrial fibrillation, hypertension, right frontal lobe infarction, right sided cerebral vascular accident [stroke], and left sided weakness.</p> <p>Resident B was admitted to the facility on 11/2/12 and discharged home on 11/15/12.</p> <p>An "Admission Evaluation Data" dated 11/2/12 at 3:40 P.M., included, but was not limited to, "Cognition: Oriented to: person, place, time... Alert... Pain Evaluation: Other: Left Shoulder... F/3</p>		Improvement meeting by the Quality Assurance committee.	

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	<p>[frequently at a 3 on a 10 point scale]...</p> <p>An "Admission Evaluation Data" nurse's notes, dated 11/2/12 at 7:30 P.M., included, but was not limited to, "Around 3:40 P.M., resident [Resident B] arrived to the facility with family in wheelchair... admitted to hospital after resident had stroke... resident discharged to home from hospital... family brought to facility... resident alert and oriented x3 [person, place, and time] with left side weakness with stroke... [Resident B] complains of pain to left shoulder... tolerable at this time..."</p> <p>The "Interim Plan of Care" attached to the "Admission Evaluation Data" was blank. There was no documentation of care plans prior to 11/9/12 [admit date 11/2/12].</p> <p>The following care plans were dated 11/9/12:</p> <p>"ADL [Activities of Daily Living]/Functional: Resident requires extensive assist from staff. Goal: Resident will be clean, well groomed and well nourished every day with staff assist... Interventions: Be non-judgmental about resident's ADL abilities, serve diet as ordered and provide needed assistance, change clothes every day and PRN [as needed], oral care twice daily, encourage</p>						

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	<p>resident to comb own hair, encourage resident to wash own face and hands, praise all efforts and give time as needed, shower twice weekly and assist with bath daily, toileting/incontinent care as needed... Fall: Resident is at risk for fall/injury... Goal: Resident will have no falls or injury thru next review...</p> <p>Interventions: Keep MD and family informed, administer medications as ordered, monitor vital signs, as indicated, monitor labs/X-rays per order, observe for side effects of any drugs that can cause, as indicated: gait disturbance, orthostatic hypotension, weakness, sedation, fatigue, seizures, syncope, vertigo, provide environmental adaptations, as indicated, low platform bed, area to wander safely, provide/monitor use of adaptive devices, as indicated, wheelchair, reinforce safety awareness as indicated, lock brakes on bed, chair, etc, before transferring, appropriate footwear, PT/OT to evaluate and treat... Incontinence: Incontinent of bladder potential for skin breakdown... Goal: Skin will remain intact thru next review... Interventions: Check resident PRN for incontinence, provide hygiene PRN, weekly skin assessment, observe skin during care..., encourage diet/fluids..., observe urine for signs/symptoms or urinary tract infection..., obtain labs as ordered..., observe signs/symptoms of dehydration...</p>			

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	<p>Pressure: Increased potential for pressure ulcers due to resident requiring assist for bed mobility... Goal: skin will remain intact... Interventions: Observe skin..., encourage food..., observe for incontinence..., report to MD any alteration in skin..., assist with toileting..., pressure relieving device in bed..."</p> <p>There was no documentation of an individualized plan of care regarding Resident B's left sided weakness [specifically safe transfers related to weakness] or Resident B's left shoulder pain.</p> <p>A "Daily Skilled Nurse's Notes" dated 11/13/12 at 10:55 A.M., included, but was not limited to, "Resident complains of pain in left shoulder, MD notified. New order for x-ray left shoulder and arm... family notified..."</p> <p>A "Daily Skilled Nurse's Notes" dated 11/13/12 at 11:15 A.M., included, but was not limited to, "Left side flaccid, no complaints of pain, [Resident B] states was sore last night... no bruising, discoloration, edema, tenderness on palpation... they [CNA #2] were sitting me up and pulled on my arm..."</p> <p>A "MD Visit" dated 11/13/12, no time, included, but was not limited to, "Chief</p>			

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	<p>Complaint: [Resident B] reported that one of the CNAs [CNA #2] handled her left shoulder inappropriately and it caused left shoulder pain.... Patient does not request additional pain medications other than she [sic] gets now... Medical decision making: x-ray of left shoulder, continue current pain control..."</p> <p>A "Medication Record" dated 11/2/12 through 11/30/12, included, but was not limited to, "Acetaminophen 500 milligrams one by mouth as needed for pain... A dose was marked as given on 11/4/12 for complaints of discomfort... No other documentation was present for doses given..."</p> <p>A "Radiology Report" dated 11/13/12, no time, included, but was not limited to, "Conclusion: No evidence of acute fracture or dislocation of the left shoulder..."</p> <p>The following care plan, dated 11/13/12, included, but was not limited to:</p> <p>"CVA: CVA with left sided hemiparesis [weakness] with a potential for ADL decline... Goals: Resident will maintain current ADL status with assistance to be provided by staff as needed and will be free of complications related to CVA through next review... Interventions:</p>			

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	<p>Staff will provide assistance as needed for all ADL needs, staff will encourage resident to participate in all ADL's to the best of the resident's ability, ADL tasks will be broken down into short simple steps, cues will be provided by staff as necessary, PT/OT per order, resident will be encouraged to participate in activities to help increase socialization, medications to be administered per orders, when assisting resident do not leave unattended but provide privacy..."</p> <p>There was no documentation related to Resident B's left sided weakness [safe transfers] or Resident B's left shoulder pain.</p> <p>On 12/6/12 at 1:30 P.M., in an interview with Unit Manager #3, she indicated that upon admission, the facility[nursing] should complete the section "Interim Plan of Care"on the "Admission Evaluation Data." That information would be used as each resident's care plan until the comprehensive care plan was completed by the MDS [Minimum Data Set] coordinator. She indicated she did not have an interim care plan for Resident B. In addition, she indicated there were no other care plans for Resident B.</p> <p>On 12/6/12 at 1:40 P.M., in an interview, the MDS coordinator indicated that the</p>				

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	<p>care plans are used to develop and update the CNA assignment sheets [used to care for residents]. She indicated that since care plans were not developed for Resident B until day 7, that the CNA taking care of Resident B would have been given report from the nurse on how to care for her. In regard to lack of a pain care plan or care plan regarding Resident B's left sided weakness, the MDS coordinator indicated the physical therapy department would have communicated how to adequately transfer the resident.</p> <p>On 12/6/12 at 3:00 P.M., the Executive Director indicated that CNA #2 was trained on how to transfer Resident B after the above incident. He was unable to provide documentation of that training and indicated there was no training related to Resident B's transfers prior to the incident on 11/12/12.</p> <p>On 12/6/12 at 3:00 P.M., the Executive Director provided Resident B's physical therapy "Inpatient Daily/Weekly Progress Report" dated 11/5/12 through 11/15/12; however, was unable to provide written documentation of communication between the physical therapy department and the nursing department regarding safe transfers related to Resident B's left sided weakness.</p>			

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	<p>On 12/6/12 at 3:00 P.M., the Executive Director provided a "Safe Lifting and Movement of Residents" policy, dated 10/2009, and a "Care Plans-Comprehensive" policy, dated 10/2009.</p> <p>The "Safe Lifting...", policy included, but was not limited to, "Policy: In order to protect the safety and well being of staff and residents, and to promote quality care, this facility uses appropriate technique and devices to lift and move residents... Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents... Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident's preferences for assistance, resident's mobility, resident's size, weight-bearing ability, cognitive status, whether the resident is usually cooperative with staff, the resident's goals for rehabilitation, including restoring or maintaining functional abilities..."</p> <p>The "Care Plans...", policy, included, but was not limited to, "Policy: An individualized comprehensive care plan</p>			

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	<p>that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident... Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident... develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain, Each resident's comprehensive care plan is designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and or functional levels, enhance the optimal functioning of the resident by focusing on a rehabilitative program..."</p> <p>This federal tag relates to complaint number IN00119776.</p> <p>3.1-37(a)</p>				