

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/22/2012
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NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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F0000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey Date: March, 12, 13, 14, 15, 16, 17, and 22 , 2012</p> <p>Facility Number: 004268 Provider Number: 155735 AIM Number: 200504460</p> <p>Survey Team: Beth Walsh, R.N., TC Barbara Hughes, R.N. Courtney Mujic, R.N. Karina Gates, M.S. Lora Brettnacher, R.N.</p> <p>Census Bed Type SNF: 14 SNF/NF: 40 Residential : 32 Total: 86</p> <p>Census Payor Type Medicare: 12 Medicaid: 19 Other: 55 Total: 86</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p><b>Submission of this plan of correction does not constitute an admission by Ashford Place Health Campus of any wrong-doing or failure to comply with the Federal or State Regulations. Moreover, the allegations contained in this statement of deficiencies are not a true or accurate portrayal of the provision of nursing care or of the services of this facility. Ashford Place Health Campus submits this plan of correction in response to the allegations of noncompliance cited during the annual Recertification and State Licensure survey concluding on March 22, 2012. Please accept this plan of correction as the providers letter of credible allegation of compliance effective April 21, 2012. The Provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substancial compliance.</b></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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	Quality review completed 3/29/12 Cathy Emswiller RN			

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F0156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to ensure a Medicare beneficiary resident was notified of the potential liability amount for his non-covered stay in the facility. This affected 1 of 4 Medicare beneficiaries discharged in the past 6 months who were reviewed for appropriate liability and appeal notices. (Resident #48)</p> <p>Findings include:</p> <p>The Notice of Medicare Non-Coverage for Resident #48 was reviewed on 3/16/12 at 4:00 p.m. The notice indicated, "last covered day under MCRA (Medicare A) is on 1/11/12 and as of 1/12/12 will be private pay." The notice did not indicate the specific private pay rate.</p> <p>During interview with the Business</p>	F0156	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b> POA of resident #48 was notified of resident liability amount for non-covered Medicare stay within the facility. <b>Other residents having the potential to be affected by the same alleged deficient practice were identified and corrective action taken:</b> All residents receiving Medicare benefits for covered stays within the facility have the potential to be affect. <b>Measures put into place or systemic changes made to ensure the deficient practice does not recur:</b> ED or designee will re-educate the Social Services Director and Business Office Manager regarding the Notice of Medicare Non-Coverage. <b>The</b></p>	04/21/2012

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	<p>Manager on 3/16/12 at 4:08 p.m., she indicated neither the resident nor Resident #48's P. O. A. (Power of Attorney) was notified of the specific liability amount for non-covered stay.</p> <p>3.1-4(f)(3)</p>		<p><b>corrective action will be monitored to ensure the deficient practice does not recur:</b> The ED or designee review five discharges per week for sixty days, and then monthly thereafter to ensure the Medicare Non-Coverage Notice was provided to the resident or POA. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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F0172 SS=B	<p>483.10(j)(1)&amp;(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</p> <p>The resident has the right and the facility must provide immediate access to any resident by the following:</p> <p>Any representative of the Secretary;</p> <p>Any representative of the State;</p> <p>The resident's individual physician;</p> <p>The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);</p> <p>The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);</p> <p>The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);</p> <p>Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and</p> <p>Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.</p> <p>The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at</p>			

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	<p>any time.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Ombudsman information, including the telephone number, was visibly posted and accessible for 31 residents who utilized a wheel chair/geri-chair for mobility in the facility census of 54. (Resident #69)</p> <p>Findings include:</p> <p>During interview with Resident #69, a resident council member and wheel chair utilizer, on 3/15/12 at 2:30 p.m., she indicated she didn't know who the Ombudsman was or where to find the telephone number.</p> <p>During interview with the Activity Director on 3/16/12 at 11:30 a.m., she stated, "The Ombudsman's information is posted up front, I think."</p> <p>Upon observation of the front lobby area on 3/16/12 at 2:00 p.m., the Ombudsman information was posted in the hallway at 6 feet up from the floor, not within plain sight for residents who utilize a wheel chair/geri-chair for mobility.</p> <p>Review of the Resident Census and Condition Report provided by the Executive Director on 3/12/12 at 11:00 a.m. indicated 31 residents in the facility</p>			F0172	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b> Ombudsman information was relocated to be visibly accessible for residents who utilize a wheelchair/geri-chair for mobility. <b>Other residents having the potential to be affected by the same alleged deficient practice were identified and corrective action taken:</b> All residents utilizing a wheel chair/geri-chair for mobility have the potential to be affected. <b>Measures put into place or systemic changes made to ensure the deficient practice does not recur:</b> Residents will be provided information regarding the placement of the ombudsman information during resident first meetings and resident council. <b>The corrective action will be monitored to ensure the deficient practice does not recur:</b> The Executive Director (ED) or designee will interview five residents per week for thirty days, then five residents per month for five months to ensure the ombudsman information is visibly accessible to the residents utilizing wheel chairs/geri-chairs for mobility.</p>		04/21/2012

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	utilized a wheel chair/geri-chair for mobility.  3.1-8(b)(4)			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review, observation, and interview, the facility failed to notify the</p>	F0225	<b>Corrective actions accomplished for those residents found to have been</b>	04/21/2012

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	<p>charge staff or Administrator immediately, or immediately initiate an investigation of the potential causative factors of a bruise of unknown origin for 1 of 3 residents reviewed for skin conditions out of 7 residents who exceeded the threshold for skin conditions (non-pressure related). Resident #50</p> <p>Findings include:</p> <p>Resident #50's clinical record was reviewed on 3/16/2012 at 10:30 a.m. Diagnoses included, but were not limited to; renal urethral disease, dehydration, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylitis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this and history of subarachnoid hemorrhage.</p> <p>An observation on 3/12/2012 at 3:07 p.m., indicated Resident #50 had a bruise on the top of her right hand that was a light blue color and size of a half dollar.</p> <p>Review of the March 2012 monthly nursing assessments and nurse's notes indicated no evidence found relating to mention of or assessment of the right hand bruise. March 2012 labs were</p>		<p><b>affected by the alleged deficient practice:</b> Investigation of injury involving resident #50 was initiated, and Executive Director (ED) and Director of Health Services (DHS) were notified. <b>Other residents having the potential to be affected by the same alleged deficient practice were identified and corrective action taken:</b> Skin assessments were completed on current residents. Any new areas or bruises were of unknown origin were documented, and investigations initiated as indicated. <b>Measures put into place or systemic changes made to ensure the deficient practice does not recur:</b> Nursing staff will be re-educated regarding Accident and Incident Reporting Guidelines and Abuse and Neglect Procedural Guidelines, specific to prevention of incidents. <b>The corrective action will be monitored to ensure the deficient practice does not recur:</b> DHS or designee will audit Accident and Incident forms and Skin Impairment forms weekly for sixty days, and monthly thereafter for four months to ensure bruises or other injuries of unknown source have been investigated and documented. DHS or designee will randomly observe five resident's skin condition five times per week for sixty days, then monthly thereafter for four</p>				

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	<p>reviewed to check for possibility of a blood draw as a potential cause but none were found in the clinical record.</p> <p>An interview on 3/15/2012 at 10:00 a.m., with QMA #7 indicated she did not know when, where, or how the resident got a bruise on her right hand. She looked in the most current incident notes binder and said there was nothing listed regarding the bruise on resident # 50's bruise.</p> <p>An interview with CNA #6 on 3/15/2012 at 10:46 a.m., indicated she noticed the bruise was brand new one day and the Hospice nurse was here so she reported it to her. The hospice nurse told the CNA that the bruise wasn't new, it had been there for a couple of days. CNA #6 indicated this conversation occurred on her first day back after she had been off for awhile. She couldn't recall the date. The CNA did not indicate she notified the facility Administrator, Director of Nursing, or the facility Charge Nurse/Unit Manager.</p> <p>An interview with RN #8, (who was the unit manager), on 3/16/2012 at 12:05 p.m., indicated she was unaware of any bruise on Resident #50's hand. She indicated she would educate the CNA who reported it only to the hospice nurse because the CNA should have also</p>		<p>months to ensure injuries of unknown origin have been reported to the ED, and investigated. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>	

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	<p>reported it to the facility nurse as well. The facility nurse would then be expected to make an incident report and update their skin assessment sheets.</p> <p>This resulted in no investigation being initiated immediately to determine the potential causative factor of resident # 50's bruise.</p> <p>An abuse and neglect procedural guidelines policy provided by the Administrator on 3/22/2012 at 3:00 p.m., indicated, "i. Injuries of unknown source-means an injury that occurs when both of the following conditions are met: i. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury." Also, "c. Prevention 5. Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director and Director of Health Services." Also, "d. Identification iii. The shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. Immediately notify the Executive Director. If the Executive Director is absent they may appoint a designee. v. The Executive Director or</p>			

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	<p>designee must notify the resident(s)' physician(s) and family/responsible party.</p> <p>vi. Complete an Accident and Incident Report. Refer to the Accident and Incident Program regarding investigation procedures. vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated."</p> <p>3.1-28(c)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review, observation, and interview, the facility failed to implement and follow their policy and procedure to notify the charge staff or Administrator immediately, or immediately initiate an investigation of the potential causative factors of a bruise of unknown origin for 1 of 3 residents reviewed for skin conditions out of 7 residents who exceeded the threshold for skin conditions (non-pressure related). Resident #50</p> <p>Findings include:</p> <p>Resident #50's clinical record was reviewed on 3/16/2012 at 10:30 a.m. Diagnoses included, but were not limited to; renal urethral disease, dehydration, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylasis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this and history of subarachnoid hemorrhage.</p> <p>An observation on 3/12/2012 at 3:07</p>	F0226	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b> Investigation of injury involving resident #50 was initiated, and ED and DHS were notified. <b>Other residents having the potential to be affected by the same alleged deficient practice were identified and corrective action taken:</b> Skin assessments were completed on current residents. Any new areas or bruises of unknown origin were documented, and investigations initiated as indicated. <b>Measures put into place or systemic changes made to ensure the deficient practice does not recur:</b> Nursing staff will be re-educated regarding Accident and Incident Reporting Guidelines and Abuse and Neglect Procedural Guidelines, specific to prevention of incidents. <b>The corrective action will be monitored to ensure the deficient practice does not recur:</b> DHS or designee will audit Accident and Incident forms and Skin Impairment forms weekly for</p>	04/21/2012	

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	<p>p.m., indicated Resident #50 had a bruise on the top of her right hand that was a light blue color and size of a half dollar.</p> <p>Review of the March 2012 monthly nursing assessments and nurse's notes indicated no evidence found relating to mention of or assessment of the right hand bruise. March 2012 labs were reviewed to check for possibility of a blood draw as a potential cause but none were found in the clinical record.</p> <p>An interview on 3/15/2012 at 10:00 a.m., with QMA #7 indicated she did not know when, where, or how the resident got a bruise on her right hand. She looked in the most current incident notes binder and said there was nothing listed regarding the bruise on resident # 50's bruise.</p> <p>An interview with CNA #6 on 3/15/2012 at 10:46 a.m., indicated she noticed the bruise was brand new one day and the Hospice nurse was here so she reported it to her. The hospice nurse told the CNA that the bruise wasn't new, it had been there for a couple of days. CNA #6 indicated this conversation occurred on her first day back after she had been off for awhile. She couldn't recall the date. The CNA did not indicate she notified the facility Administrator, Director of</p>		<p>sixty days, and monthly thereafter for four months to ensure bruises or other injuries of unknown source have been investigated and documented. DHS or designee will randomly observe five resident's skin conditions five times per week for sixty days, then monthly thereafter for four months to ensure injuries of unknown origin have been reported to ED or DHS and investigated. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>				

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	<p>Nursing, or the facility Charge Nurse/Unit Manager.</p> <p>An interview with RN #8, (who was the unit manager), on 3/16/2012 at 12:05 p.m., indicated she was unaware of any bruise on Resident #50's hand. She indicated she would educate the CNA who reported it only to the hospice nurse because the CNA should have also reported it to the facility nurse as well. The facility nurse would then be expected to make an incident report and update their skin assessment sheets.</p> <p>This resulted in no investigation being initiated immediately to determine the potential causative factor of resident # 50's bruise.</p> <p>An abuse and neglect procedural guidelines policy provided by the Administrator on 3/22/2012 at 3:00 p.m., indicated, "i. Injuries of unknown source-means an injury that occurs when both of the following conditions are met: i. The source of the injury is not observed by any person or the source of the injury could not be explained by the resident AND ii. The injury is suspicious in nature because of the extent of the injury or the location of the injury." Also, "c. Prevention 5. Staff is required to report concerns, incidents and grievances</p>			

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	<p>immediately to your manager and/or Executive Director and Director of Health Services." Also, "d. Identification iii. The shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: iv. Immediately notify the Executive Director. If the Executive Director is absent they may appoint a designee. v. The Executive Director or designee must notify the resident(s)' physician(s) and family/responsible party. vi. Complete an Accident and Incident Report. Refer to the Accident and Incident Program regarding investigation procedures. vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated."</p> <p>3.1-28(a)</p>			

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to assist residents while eating and maintain dignity for 2 of 7 residents (residents' #39 and #57) eating in the Restorative Dining Room which resulted in residents' food ending up on their faces, hands, and clothing.</p> <p>Findings include:</p> <p>1. On 3/12/12 at 12:10 p.m. resident #39 was observed eating lunch with no assistance. She was served spaghetti and used her hands to pull up spaghetti with meatballs from the plate to her mouth with strings of spaghetti laying across her blanket on her lap. Spaghetti sauce was smeared on her face and hands as she tried to eat.</p> <p>On 3/12/12 at 12:37, 17 minutes after resident #39 was served her food, CNA #6 was observed removing the resident's food from the table in front of Resident #39 and returning with a new plate of spaghetti which she began feeding to this</p>	F0241	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #39 and #57 were observed in the restorative dining and noted to be assisted with feeding with no food noted to be on hands, face or clothing.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents who require assistance with feeding in the restorative dining room have the potential to be affected by this deficient practice. These stated residents were observed and noted to be assisted with feeding with no food noted to be on hands, face or clothing. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the standard of providing assistance to residents, as identified in their plan of care, while eating, which in turn will prevent food from ending up on hands/face/clothing and therefore</p>	04/21/2012			

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	<p>resident.</p> <p>The clinical record of resident # 39 was reviewed on 3/22/12 at 10:30 a.m. Resident # 39's diagnoses included, but were not limited to, cerebrovascular accident [stroke], vascular dementia, and neuropathy.</p> <p>Resident #39's Nutritional Care Plan dated 11/11 indicated this resident was on a mechanically altered diet related to a chewing problem and swallowing problem.</p> <p>Resident #39's care plan for Restorative Dining dated 12/14/11 indicated the resident had an inability to feed self and the interventions were to set up meal for resident, identify the food and beverage, and feed resident the meal while observing for signs and symptoms of coughing and aspiration.</p> <p>A dietary note dated 2/9/12 indicated this resident was to be served finger foods per hospice. A physician's recap diet order dated 3/1/12, indicated Resident #39 was to be served finger foods.</p> <p>2. An observation on 3/15/2012 from 12:10 p.m. to 1:20 p.m. of the lunch meal in the assisted dining room indicated Resident #57 was asleep for most of the</p>		<p>maintaining dignity. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will observe the Restorative Dining Room during all three meals five times per week for sixty days, then monthly thereafter for four months to ensure assistance while eating is provided to the residents, as it is identified in their plan of care to prevent food from ending up on the resident's hands/face/clothing and therefore maintaining dignity. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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	<p>meal with her piece of uneaten garlic bread in her hand the entire time. No staff were observed to provide assistance to the resident. Half of Resident #57's meal of spaghetti and meatballs was on her clothing protector or on the table next to the plate. At 1:16 p.m. CNA #9 asked the resident if she was done and took her plate away, but left her garlic bread in her hand while the resident went back to sleep in her chair.</p> <p>3.1-3(t)</p>			

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F0244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to act on grievances from resident council. This had the potential to affect 5 of 5 residents residing in the facility who attended resident council in November, 2011 and January, 2012. (Resident #67, 25, 38, 71, and 47)</p> <p>Findings include:</p> <p>The resident council minutes for November and December, 2011 and January, 2012, provided by the Activity Director on 3/14/12 at 12:00 p.m., were reviewed at this time. The November, 2011 minutes indicated Residents #67, 25 and 38 were in attendance, and January, 2012 minutes indicated Residents #71 and 47 were in attendance. The November, 2011 minutes included a concern regarding call lights not being answered, but no indication of the specific resident with the concern. The December, 2011 minutes did not include any response to this concern. The January, 2012 minutes included another concern with a call light</p>	F0244	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The resident council minutes for the last meeting will be reviewed. Each concern listed will have a documented response / resolution and those responses / resolutions will be presented at the next resident council meeting.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents who attend resident council have the potential to be affected by this alleged deficient practice. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> ED or designee will re-educate the Activity and Social Service team members on the standard of documented follow up to concerns identified in resident council and presenting the responses / resolutions to those concerns during the next resident council meeting, or sooner if</p>	04/21/2012			

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	<p>not being answered for 40 minutes, but no indication of the specific resident with the concern. There were no February, 2012 minutes to review for a response to this concern.</p> <p>During interview with the Activity Director on 3/16/12 at 11:30 a.m., she indicated she verbally took concerns from resident council to the appropriate department manager and they followed up with the resident. She had no verification of follow up on the concerns from the November, 2011 and January, 2012 council meetings.</p> <p>3.1-3(l)</p>		<p>necessary. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> ED or designee will review the minutes from each resident council meeting as well as the documents listing the concerns identified with the responses / resolutions noted. ED or deignee will also review the documented date the responses / resolutions were presented to the resident council. This review will be on going. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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F0248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review, observation, and interview, the facility failed to provide activities for 1 of 3 residents reviewed for activities out of 9 residents who exceeded the threshold for structured activities for cognitively impaired residents. Resident #50.</p> <p>Findings include:</p> <p>Resident #50's clinical record was reviewed on 3/16/2012 at 10:30 a.m. Diagnoses included, but were not limited to; renal urethral disease, dehydration, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylasis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this and history of subarachnoid hemorrhage.</p> <p>A work sheet entitled resident preference for customary routine and activities interview, dated 4/21/2011, indicated, while you are at the facility how</p>	F0248	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b> The careplan for Resident #50 was updated to include current activity preferences. <b>Other residents having the potential to be affected by the same alleged deficient practice were identified and corrective action taken:</b> Activity careplans for residents with a cognitive impairment were reviewed to ensure current activity preferences for structured activities were reflected. <b>Measures put into place or systemic changes made to ensure the deficient practice does not recur:</b> Activity staff will be re-educated by Executive Director or designee regarding completion of the resident preference sheets, and the Daily Participation Log. <b>The corrective action will be monitored to ensure the deficient practice does not recur:</b> The Activity Director or designee will audit the Daily</p>	04/21/2012	

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	<p>important is it to you.....and resident response was marked as very important to have; books, papers, and magazines to read, listen to music you like, animals such as pets around you, keep up with the news, to go out and get fresh air when the weather is good, participate in religious services or practices.</p> <p>An activities care plan, dated 8/24/2008 and most recent date updated 10/19/2011, indicated the resident interests as; "cards and games, trips/outings, music, entertainment. Interventions: Offer to assist/escort resident to activity functions, invite to scheduled activities, consider impact of medical problems on activity level, offer variety of activity types and locations."</p> <p>A 'resident first conference note,' dated 1/3/2012, indicated activities was checked marked as a topic being reviewed at the conference meeting. Comments indicated, "participates in group activities, comments; music/entertainment programs-pre-meal stretches, slow response, family visit very attentive."</p> <p>A Daily Participation Log provided by the A.D. (Activity Director) on 3/15/2012 at 2:40 p.m. indicated that the resident's activities for the month of February 2012 included; passive participation in</p>		<p>Participation Log five times per week for sixty days, then monthly for four months to ensure residents with a cognitive impairment have been provided with structured activities consistent with preferences. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>	

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	<p>TV/radio and kick ball/exercise/ROM [range of motion] on the 1st of the month. On the 14th she had active participation with peer/friend/family visits, on the 15th she had active participation in bird watching/pet therapy, and on the 16th she had passive participation in TV/radio and kick ball/exercise/ROM.</p> <p>Observations on 3/14/2012 at 9:40 a.m., indicated the resident was sleeping in bed with no television or music on in the room. At 2:11 p.m. Resident #50 was lying in bed with eyes open, looking at ceiling. Her room door was open and no television or music was on in room. At 2:45 p.m. the resident was asleep in bed.</p> <p>Observations on 3/15/2012 at 9:15 a.m. indicated the resident was sleeping in bed. No television or music was on in room. At 10:30 a.m. At this time, in the main dining room was a music program with a live musician and Resident #50 was not present. Later that day, at 1:50 p.m. and 3:00 p.m. the resident was in her room in bed with her eyes closed.</p> <p>Interview with the Activity Director on 3/14/2012 at 10:08 a.m. indicated, "This resident loves to come to music and entertainment activities, pet visits, she can do the balloon toss by lightly hitting it with the tips of her fingers. Family</p>			

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	<p>usually visit 3-4 times a week, two sons visit in the mornings and evenings, her friends come to visit frequently. She has her television on in her room most of the time. Hospice does her nails, when she gets her baths. She knows what's going on in the news, likes it on in the background for the noise. Its very uncomfortable for her to be in the geri chair on outings, on the bus. The bouncing on the back of the bus while she's in her geri chair is too hard for her. She went out to a baseball game last summer, but since has requested to not go out on any more outings. She had her son's wedding here last summer: hospice brought in special outfit and corsage, etc. for it. No music playing in her room for the most part, it seems that she just goes to the music entertainment, though occasionally she's had music on in her room. She'll go to the special music events about once a month or so, she prefers not to go to the church events. When we go and offer to bring her to activities it takes a little longer for her to respond yes or no and then if we do take her we keep her in the back in case she gets too uncomfortable. Over the holidays she went to all the music activities (1-2 a week,) right now those events aren't as frequent."</p> <p>An interview with QMA # 7 on 3/15/2012 at 10:03 a.m. indicated the resident "keeps</p>			

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	<p>her T.V. on in her room, but as far as activities goes she doesn't do much. She does perk up when her son comes to visit. Resident #50 usually gets up at 6:30 or 7:00 a.m. Usually all the restorative people need to get up by 7 a.m. because they eat in the assist dining room starting at 7 a.m. The CNA's take her to activities. She didn't go today because she was probably with Hospice today. But usually she will go to all the music programs, she doesn't go to any of the other things though."</p> <p>Interview with Activity Director on 3/15/2012 at 2:43 p.m. indicated Resident #50 "is not on a one-on-one program but she doesn't meet the criteria for the program. There is one other resident in the building who is on the one-on-one program. He doesn't meet the criteria for being on one-on-ones but he needs it because he has some behavior issues so the bus driver will occasionally go in and talk with him. The Activity Director indicated that the criteria for being placed on a one-on-one activity program is; if they have no visitors, no activity involvement or little activity involvement. Hospice is with Resident #50 3 times a week, so she's stimulated by the sounds of movement in her room and music on in her room. Passing mail to her usually takes 5 minutes, so that is stimulation.</p>			

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	<p>Her family comes once a week, she goes to the music programs once a month so she doesn't really meet the criteria." She also indicated there was some missing documentation on the activity log.</p> <p>3.1-33(a)</p>			

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F0279 SS=E	<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 record review, interview, and observation, the facility failed to develop comprehensive care plans for geri sleeves, and for catheter use for 2 of 36 residents reviewed for care plans. Resident's #29 and #15.</p> <p>Findings include:</p>	F0279	<p><b>Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:</b> Resident #29 care plan updated to include use of geri-sleeves. Resident #15 care plan developed for catheter use and includes interventions of catheter changes and catheter care. <b>Other residents having the potential to be affected by the same alleged deficient practice identified and corrective actions taken:</b> Care plans were reviewed for current residents with catheters and geri sleeve</p>	04/21/2012	

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	<p>1. The clinical record for Resident #29 was reviewed on 3/14/12 at 9:30 a.m. The diagnoses for Resident #29 included, but were not limited to: anemia, restless leg syndrome, hypertension, and arthritis.</p> <p>The March, 2012 physician's recapitulation orders indicated geri-sleeves to bilateral arms to be worn</p>		<p>use to ensure the care plan was in place and identified the use of geri-sleeves and interventions for catheter changes and catheter care. <b>Measures put into place to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the campus care plan team on the Interdisciplinary Team Care Plan Guidelines, and will re-educate Licensed Nurses on the Guidelines for Urinary Catheter Care, specific to item #23 stating to "change only for dislodgement and PRN". <b>Corrective action will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit five care plans per week for sixty days, then five care plans monthly thereafter for four months to ensure a comprehensive care plan is in place related to residents with catheter and geri sleeve use. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>	

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	<p>effective 10/1/10.</p> <p>Observations of Resident #29 wearing his geri-sleeves were made on 3/12/12 at 12:30 p.m., 3/13/12 at 10:00 a.m., and 3/14/12 at 9:40 a.m.</p> <p>The 2/19/12 skin integrity care plan did not address the use of geri-sleeves.</p> <p>2. The clinical record of resident # 15 was reviewed on 3/12/12 at 2:00 p.m. Diagnoses included, but are not limited to, acute UTI's [urinary tract infections], neurogenic bladder, chronic kidney disease and uropathy obstruction.</p> <p>On 3/12/12 at 2:00 p.m., Resident #15 was observed to have a catheter. The resident's clinical record lacked a care plan for the resident's catheter.</p> <p>A recapitulation of physician orders dated 3/1/12, reviewed on 3/16/12 at 2:30 p.m. for Resident #15 included an order for 'catheter change prn [as needed].'</p> <p>A review of records on 3/16/12 at 1:45 p.m. for Resident #15 indicated hospice orders were written on 3/15/12 requesting catheter care to be done 2 times a day in bed. There was no indication as to when the catheter was to be changed.</p> <p>RN #8 was interviewed on 3/16/12 at</p>			

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	<p>2:00 p.m. and indicated the facility changed the catheter when it was needed. She indicated this resident did have an order dated 1/23/12 for the catheter to be changed monthly, prior to a recent hospitalization, but he did not return from the hospital with that order. She said the resident was known to have frequent UTI's and the catheter clogged so they watched him closely. He also had penis irritation issues from the catheter. She said she thought their policy was to change catheters as needed.</p> <p>Review of the facility's most current policy on 3/16/12 at 2:30 p.m. titled "Guidelines for Urinary Catheter Care" did not list any provisions for changing resident catheters.</p> <p>3.1-35(a)</p>			

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F0280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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 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.</p> <p>Based on record review, interview, and observation, the facility failed to update comprehensive care plans for pain management, for use of an urinary catheter, falls, and for nutrition for 5 of 36 residents reviewed for care plans. Resident's #50, #29, #39, #47 and #49.</p> <p>Findings include:</p> <p>1. Resident #50's record was reviewed on 3/14/2012 at 11:00 a.m. Diagnoses included, but were not limited to; renal urethral disease, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylasis, mood</p>	F0280	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #50 pain care plan was updated and a pain assessment was completed. Resident #47's MD was contacted and order received to add neurogenic bladder as medical justification for catheter use and care plan was developed. Resident #49 nutrition care plan was updated to reflect the discontinuation of tube feedings. The RD was notified of the discontinuation of the tube feeding. Resident #39 care plan was updated to reflect the changes in the diet orders.</p>	04/21/2012			

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	<p>disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this and history of subarachnoid hemorrhage.</p> <p>Record review of a pain care plan, dated 4/21/2011 and most recent date updated 10/20/2011, indicated the resident had chronic pain AEB (as evidenced by) facial grimace, complaints of pain, R/T (related to) headache and right CVA. Goals: resident will state/demonstrate relief or reduction in pain within one hour after receiving interventions, resident will not experience a decline in overall function related to pain. Interventions; monitor and report to nurse signs and symptoms of pain, worsening pain, report changes in pain location/type/frequency/intensity to physician, provide comfort measures, repositioning. Administer, monitor effectiveness and for side effects from; routine, PRN pain medication. Invite, encourage, remind and escort to preferred activities consistent with the resident's interests as a diversion from pain. Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour or receiving the intervention.</p> <p>The plan of care had not been updated since 10/20/11, 5 months prior.</p>		<p>Resident #29 care plan was updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All resident comprehensive care plans were reviewed and updated for pain management, urinary catheter use and medical justification, nutrition diet orders, and anti-roll back brakes applied to wheelchairs. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the campus care plan team, including the RD, on the Interdisciplinary Team Care Plan Guidelines. DHS or designee will educate the Plant Operations team members regarding their responsibility to inspect anti-roll back brakes applied to wheelchairs on an on-going, weekly basis and to log completion of the inspections. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit five care plans per week for sixty days, then five care plans per week for</p>		

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	<p>The resident's current physician's orders included, but were not limited to, Hydrocodone/Apap 5/325 mg scheduled to be given every 8 hrs. routinely. Baclofen (a pain reducer) 10 mg give 1 tab by mouth every 12 hrs. Gabapentin/Neurontin (a muscle relaxer) 600 mg give 1 capsule orally 3 times a day. No as needed pain medications were ordered.</p> <p>The clinical record contained no pain assessments for Resident #50.</p> <p>An interview on 3/15/2012 at 9:33 a.m. with RN #8 indicated resident # 50 was on scheduled pain medication. She also had muscle relaxer's ordered. "Hospice handles all the pain medication orders. We give all the pain meds. We do not currently have copies of the Hospice records." RN #8 was working on getting the Hospice records right now for three residents but was having trouble because they [hospice] were reluctant to give the facility copies.</p> <p>An interview with CNA #6 on 3/15/2012 at 10:46 a.m. indicated she could tell when the resident was in pain because her face would change. "Either she'll turn white, or she'll have tears in her eyes, or she'll grimace. She can blink yes to you if you ask her if she's in pain but she can't</p>		<p>four months to ensure a comprehensive care plan is in place and has been updated to reflect current interventions in pain management, urinary catheter use and medical justification, anti-roll back brakes applied to wheelchairs, and nutrition diet orders. ED or designee will audit Plant Operations anti-roll back brake inspection logs weekly for sixty days, then monthly for four months to ensure completeness. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>				

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	<p>talk or tell you where the pain is located. When this happens, and it happens almost every day at least once, she will tell the nurse what she observed."</p> <p>An interview on 3/16/2012 at 3:10 p.m. with RN #8 indicated resident # 50's pain and pain meds were primarily monitored by Hospice. She indicated the facility charted by exception, so if there wasn't anything in the chart then she wasn't having any pain. If there was a problem, it would be written on a incident form and put in the IDT [interdisciplinary team] note section of her chart. We would immediately tell the Hospice nurse if there was an issue and then they would tell us what to do. "I can't recall her having any problems with pain recently and I see her every day."</p> <p>Review of a policy titled guidelines for pain assessment and management provided by the Director of Nurses on 3/16/2012 at 3:00 p.m. indicated, "2. Ongoing assessment will be documented on the Monthly Nursing Summary, and Skilled Nursing Assessment form if applicable. 3. Indicate a plan of care related to chronic, acute, or breakthrough pain. 4. If there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care</p>			

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	<p>plan update. a. assess the resident for a condition that would indicate that pain may be expected (injury, surgery, procedure). b. assess for behaviors that may be indicators of pain or activities that increase indicators of pain. 5. Educate the resident/family/care givers on the pain management interventions and importance of notifying staff of changes in pain status. 6. Implement the care plan approaches to assist with pain management. 7. Evaluate the effectiveness of pain management interventions and modify as indicated."</p> <p>2. Resident #47's record was reviewed on 3/14/2012 at 2:00 p.m. The resident's diagnoses included, but were not limited to, urinary retention.</p> <p>An Interview with RN #8 on 3/13/2012 at 11:39 a.m. indicated Resident #47 used an indwelling foley catheter due to urinary retention and the resident never officially received a diagnosis of neurogenic bladder.</p> <p>An incontinence care plan, dated 8/23/2011 and most recent date reviewed 11/21/2011, indicated the resident was incontinent of bowel and bladder, related to Neurogenic bladder, cognitive impairment. Goals: resident will be free of skin breakdown related to</p>			

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	<p>incontinence, be clean and dry. The clinical record did not contain a care plan relating to medical justification for the use of a urinary catheter. The care plans had not been updated since 11/21/11, 4 months prior.</p> <p>Review of the resident's nurses notes, dated 3/14/2012, indicated "f/c (foley catheter) changed without difficulty. Res [resident] tolerated well." Multiple foley catheter changes for the past 2 months were documented in the resident's nurses notes.</p> <p>During observation on 3/15/2012 at 1:55 p.m. of catheter care provided by CNA #1 and CNA #2, Resident #47 had a urinary catheter with a leg bag attached. During interview at that time, CNA #1 indicated the CNA's empty the bag a couple of times per shift. At night the resident wears a regular catheter bag so that it doesn't need to be emptied as often.</p> <p>Interview with the Director of Nurses on 3/15/2012 at 2:50 p.m. indicated she would look into why resident # 47 still had a catheter and when it was originally placed. She indicated she thought it was for neurogenic bladder.</p> <p>3. Resident #49's clinical record was reviewed on 3/13/2012 at 10:30 A.M. Resident #49 was admitted to the facility</p>			

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	<p>on 5/21/10 and had current diagnoses which included, but were not limited to, gastritis, history of partial gastrectomy, splenectomy, and neuropathy.</p> <p>The resident's record indicated prior to 2/9/2012 Resident #49 was provided nutrition through tube feedings along with honey thickened liquids and comfort foods. Resident #49 along with her family decided to sign a self determination of care request form dated 8/9/2011. This form indicated Resident #49 did not like the looks, flavor, or texture of a pureed diet or the honey thickened liquid. She requested pleasure foods, toast at breakfast, soup for lunch and dinner, and the tube feeding.</p> <p>A nurse's note dated 2/9/2012 timed 12:30 P.M. indicated Resident #49 wanted to stop the tube feedings. A physician's order dated 2/9/2012 indicated the tube feedings were to be stopped.</p> <p>A current physician's order dated 3/2/2012, indicated Resident #49's current diet order was pureed with honey thickened liquids, low salt, supplemental feedings, and regular water.</p> <p>A current care plan originally dated 8/5/2011 and last updated 1/25/12, indicated Resident #49 was to have a</p>			

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	<p>pureed diet, toast for breakfast, and soup for lunch and dinner.</p> <p>A nutrition care plan dated 1/4/2011 and last updated 1/12/2012, indicated Resident #49 had a potential for alteration in nutritional and/or fluid balance related to: a partial gastrectomy, less than 75% of oral intake, and the inability to take P.O. (oral)-requiring tube feedings. Interventions included: encourage oral intake, thickened liquids per physician order, and tube feedings per physician order. This care plan had not been updated to reflect the physician's order of 2/9/12 to stop the tube feedings.</p> <p>On 3/15/2012 at 10:20 A.M., Resident #49 was observed eating a regular texture cookie.</p> <p>During an interview on 3/15/2012 at 10:20 A.M., CNA #2 stated, ". . .she can eat and drink. She doesn't get tube feedings anymore. She gets regular food-toast at breakfast and soup everyday at lunch. I don't know what she gets for dinner. I am not here."</p> <p>During an observation of the noon meal on 3/13/2012, Resident #49 was observed to be served a cup of vegetable soup and a glass of water. Resident #49 ate all of the soup and drank some of the water.</p>			

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	<p>Everyone else in the dining room was served and assisted with their meals including another resident sitting at the table with Resident #49. At no time during this meal did anyone offer Resident #49 anything else to eat or drink. Resident #49 kept looking around the room picking up her empty cup of soup and attempting to get more out of it. When the staff at the table asked the other resident sitting with Resident #49 if she wanted dessert Resident #49 requested dessert. Dessert was brought to Resident #49 and she ate 100% of the dessert.</p> <p>During an interview on 3/14/2012 at 11:30 A.M., the Nurse Practitioner reviewing Resident #49's clinical record indicated she did not realize Resident #49 was not receiving the ordered honey thickened pureed diet.</p> <p>During an interview on 3/14/2012 at 11:50 A.M., The Dietician indicated she was new to the building and was not aware Resident #49 was not getting anything offered to her other than the comfort foods she requested when she was still getting the tube feedings. Resident #49's caloric/fluid intake requirements had not been reassessed since the tube feeding had been stopped and the care plan had not been updated.</p>			

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	<p>Review of the dietary notes indicated the last dietary entry was dated 1/13/12. This dietary note indicated Resident #49 was still getting tube feedings.</p> <p>During an interview on 3/15/12 at 2:20 P.M., the Director of Health Care Services indicated she was unable to provide documentation that Resident #49's plan of care had been revised since the tube feedings had been discontinued.</p> <p>4. On 3/12/12 at 12:10 p.m., resident #39 was observed eating lunch with no assistance. She was served spaghetti and used her hands to pull up spaghetti with meatballs from the plate to her mouth with strings of spaghetti laying across her blanket on her lap. Spaghetti sauce was smeared on her face as she tried to eat.</p> <p>On 3/12/12 at 12:37, 17 minutes after Resident #39 was served her meal, CNA #6 was observed removing food from this resident and then returned with a new plate of spaghetti. At that time she began feeding the food to the resident.</p> <p>The clinical record of resident # 39 was reviewed on 3/22/12 at 10:30 p.m. A care plan dated 12/14/11 indicated Resident #39 was unable to feed herself. Interventions included, but were not limited to, facility setting up meals, identifying food and beverage for resident</p>			

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	<p>and to feed resident the meal while observing for signs and symptoms of coughing and aspiration.</p> <p>A dietary note dated 2/9/12 indicated meals for Resident #39 were to be finger foods per hospice. A physician recapitulation of orders included, but were not limited to a diet order dated 3/1/12, which indicated Resident #39 was to have finger foods.</p> <p>Diagnoses of resident #39 included, but were not limited to, vascular dementia, neuropathy and cerebrovascular accident-stroke.</p> <p>A nutrition care plan dated 11/11 indicated Resident #39 was on a mechanically altered diet related to a chewing and swallowing problem.</p> <p>During record review on 3/22/12 at 10:35 a.m., a care plan dated 12/14/11 indicated Resident #39 was unable to feed herself. Interventions included, but were not limited to, facility setting up meals, identifying food and beverage for resident and to feed resident the meal while observing for signs and symptoms of coughing and aspiration. The plan of care had not been updated since 12/14/11, 3 months earlier and did not reflect the changes in the resident's diet orders.</p>			

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	<p>5. The clinical record for Resident #29 was reviewed on 3/14/12 at 9:30 a.m. The diagnoses for Resident #29 included, but were not limited to: anemia, restless leg syndrome, hypertension, and arthritis.</p> <p>The 2/19/12 fall care plan indicated the goal was "resident will have reduced risk of fall related injury by utilizing fall precautions." Interventions were as follows: provide/monitor use of adaptive devices: wheelchair, lock breaks on chair before transferring, and to check the function of anti-rollback brakes (on wheelchair). The care plan was not updated to reflect the frequency of checking the brakes, by whom the brakes would be checked, or who would be responsible for ensuring the brakes were actually checked.</p> <p>The Fall Circumstance, Assessment, and Intervention form indicated Resident #29 fell while toileting on 3/2/12. It indicated the root cause of the fall was anti-lock brakes in need of repair. It indicated the anti-lock brakes were repaired by Maintenance Staff #11.</p> <p>During interview about the above fall with Maintenance Staff #11 on 3/14/12 at 11:05 a.m., he indicated he was told Resident #29 had a slip and it had to do w/his anti-rollback brakes. He stated, "I</p>	F0280	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #50 pain care plan was updated and a pain assessment was completed. Resident #47's MD was contacted and order received to add neurogenic bladder as medical justification for catheter use and care plan was developed. Resident #49 nutrition care plan was updated to reflect the discontinuation of tube feedings. The RD was notified of the discontinuation of the tube feeding. Resident #39 care plan was updated to reflect the changes in the diet orders. Resident #29 care plan was updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All resident comprehensive care plans were reviewed and updated for pain management, urinary catheter use and medical justification, nutrition diet orders, and anti-roll back brakes applied to wheelchairs. <b>Measures put in place and systemic changes made to ensure the alleged</b></p>	04/21/2012

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	<p>repaired the anti-rollback brakes. The brakes were out of adjustment. The brakes were not locking tight enough when he would get out of it." He indicated the brakes on Resident #29's wheelchair were not regularly checked for proper function by maintenance, but would be inspected when told there was a problem. He indicated it had been at least a couple of months since maintenance had seen Resident #29's wheelchair prior to the repair made as a result of the 3/2/12 fall.</p> <p>During interview with the Maintenance Supervisor on 3/14/12 at 11:05 a.m., he indicated nursing staff was responsible for checking the brakes, not maintenance, and that therapy checked brakes too.</p> <p>During interview with Physical Therapist #13 on 3/14/12 at 11:25 a.m., she indicated therapy checked brakes on residents wheelchairs as needed, if it was brought to their attention there was a problem. She indicated Resident #29 stopped coming to therapy over 6 months ago, and since he wasn't coming to therapy, she supposed they had not inspected Resident #29's wheel chair brakes in the last 6 months.</p> <p>During interview with RN #14 on 3/16/12 at 9:35 a.m., she indicated she did not</p>		<p><b>deficient practice does not recur:</b> DHS or designee will re-educate the campus care plan team, including the RD, on the Interdisciplinary Team Care Plan Guidelines. DHS or designee will educate the Plant Operations team members regarding their responsibility to inspect anti-roll back brakes applied to wheelchairs on an on-going, weekly basis and to log completion of the inspections.<b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit five care plans per week for sixty days, then five care plans per week for four months to ensure a comprehensive care plan is in place and has been updated to reflect current interventions in pain management, urinary catheter use and medical justification, anti-roll back brakes applied to wheelchairs, and nutrition diet orders. ED or designee will audit Plant Operations anti-roll back brake inspection logs weekly for sixty days, then monthly for four months to ensure completeness. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>				

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	<p>know the monitoring system for proper wheelchair function and that nursing does not check wheelchair brakes regularly.</p> <p>During interview with Resident #29 on 3/14/12 at 2:40 p.m. about his fall on 3/2/12, he stated, "The chair went sideways during the fall. The brakes were on, but the chair still moved sideways."</p> <p>3.1-35(b)(1) 3.1-35(d)(2)B)</p>			

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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure services were provided in accordance with each resident's plan of care for 4 of 36 residents reviewed for the plan of care being followed in a total sample of 36 residents. (Residents #30, #29, #50, #49).</p> <p>Findings included:</p> <p>1. The clinical record of resident # 30 was reviewed on 3/15/12 at 9:41 a.m. Resident #30 was admitted to the facility on 5/04/05 and had current diagnoses which included, but were not limited to, chronic schizophrenia and depression.</p> <p>A care plan dated 2/14/2012 indicated Resident #30 had dementia related to a diagnoses of schizophrenia. Her decision making, recall, and memory were impaired. A goal listed for Resident #30 was for her to make routine decisions with cues/supervision and to remember self, family, and staff. The resident's plan of care did not identify the information provided as follows: during an interview on 3/15/2012 at 10:29 A.M., CNA #6</p>	F0282	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> In regards to resident #30, nursing staff was re-educated on residents need for assistance with oral hygiene and expectation for resident's teeth to be brushed every AM and PM, per plan of care. Nurses to document on MAR that brushing was completed every AM and PM, per MD order. Resident #49 potential for dehydration careplan was updated to reflect resident's physical restrictions and inability to access fluids without assistance. Nursing staff was re-educated on the expectation that fluids will be offered and assisted to this resident during care and at meal times. Resident #50 pain care plan was reviewed and updated to reflect current interventions and a pain assessment was completed. Resident #29 care plan was updated to reflect the frequency of checking the anti-roll back brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked. <b>Identification of other</b></p>	04/21/2012			

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	<p>indicated Resident #30 needed her toothbrush set up and cueing. If this was provided for her, Resident #30 would brush her own teeth for twenty minutes on top and twenty minutes on the bottom</p> <p>An annual MDS (minimum data set assessment) dated 2/14/2012 indicated Resident #30 required extensive physical assist of one person for personal hygiene including brushing her teeth.</p> <p>A care plan dated 2/19/12 indicated Resident #30 had an activities of daily living self care deficit. Resident #30 needed assistance and/or was dependent on staff for dressing, toilet use, personal hygiene, and bathing. Interventions included, but were not limited to, staff to assist with personal hygiene as needed including oral/dental care Assist of one or two cueing/prompting or hands-on-hand over hand needed.</p> <p>During a family interview on 3/12/2012 at 3:23 P.M., Resident #30's family member indicated Resident #30 was unable to make day to day choices so choices had to be made for her. Resident #30's overall oral care was neglected. This family member indicated she would be taking Resident #30 to the dentist this week.</p>		<p><b>residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected. Residents requiring assistance with oral hygiene will have an inspection of the oral cavity to ensure there are no oral health concerns. All residents with physical restrictions and/or inability to access fluids without assistance will have careplans reviewed and updated to reflect current physical limitations and/or restrictions. All residents having a careplan for pain management will be reviewed and updated to reflect assessment and interventions as indicated. All residents having anti-roll back brakes to the wheelchair will have care plans updated to include frequency of checking the brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will educate nursing staff on the guidelines for Oral Care and Hydration Management Interventions and Suggestions, as well as offering additional fluids, if no restrictions, to residents during care and at meal times and documenting as given. DHS or designee will re-educate</p>		

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	<p>Resident #30's family member stated, "I keep checking her mouth. Care is neglected. They say, 'We are too busy after meals.' The dentist is very upset with the care of teeth with (facility named). Her gargle is barely touched." On 3/14/2012 at 2:00 P.M. and 3:00 P.M. Resident # 30 was observed standing at the nurse's station with gauze in her mouth.</p> <p>A physician's order originally dated 10/13/05 and on current March rewrite orders indicated Resident #30's teeth were to be brushed twice a day-in the A.M. and at bedtime.</p> <p>During an interview on 3/15/2012 at 10:29 A.M., CNA #6 indicated Resident #30 needed her toothbrush set up and cueing. If this was provided for her, Resident #30 would brush her own teeth for twenty minutes on top and twenty minutes on the bottom.</p> <p>Review of February and March 2012 Medication Administration Records indicated Resident #30 did not have her teeth brushed at bed time during this time.</p> <p>During an interview on 3/16/2012 at 12:00 P.M., the Director of Health Services indicated she was unable to</p>		<p>the campus care plan team on the Interdisciplinary Team Care Plan Guidelines. DHS or designee will re-educate licensed nurses on the following: Pain Assessment and Management Guidelines, specific to assessment of changes in pain, education to family/caregivers on pain management interventions, and evaluation of effectiveness of interventions. DHS or designee will re-educate the Plant Operations team members on guidelines for their responsibility to inspect anti-roll back brakes applied to wheelchairs on an on-going weekly basis and to log inspections. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will conduct visual observation on day and evening shift of oral care provided by nursing staff and inspect residents oral cavity of five residents per week for sixty days, then monthly for four months to ensure oral hygiene is being provided per care plan. DHS or designee will observe five residents during resident care and at meal times per week for sixty days, then monthly thereafter to ensure additional fluids are being offered to residents with physical restrictions and that have the inability to access fluids on their own. DHS or designee will audit five care plans per week for</p>		

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	<p>provide documentation or an explanation which explained why Resident #30 had not had her teeth brushed at bedtime every evening as ordered by the physician.</p> <p>During an interview on 3/16/12 at 2:00 P.M., the dental assistant from Resident #30's dentist office indicated Resident #30 had tooth number twenty nine removed this week because tooth decay had reached the nerve.</p> <p>2. Resident #49's clinical record was reviewed on 3/13/2012 at 10:30 A.M. Resident #49 was admitted to the facility on 5/21/10 and had current diagnoses which included, but were not limited to, gastritis, history of partial gastrectomy, splenectomy, and neuropathy.</p> <p>On 3/13/12 at 9:51 A.M., Resident #49 was observed to have contractures of both arms, both hands, and all fingers on both hands. Resident #49 was observed in a chair in her room with a water pitcher and stack of plastic cups on the bedside table across the room out of her reach.</p> <p>During an interview on 3/13/2012 at 9:51 A.M., Resident #49 replied no when asked if she got the fluids she wanted between meals.</p> <p>A minimum data set assessment (MDS)</p>		<p>sixty days, then five care plans per week for four months to ensure a comprehensive care plan is in place, that has been updated to reflect the current status of the resident's physical restrictions and/or inability to access fluids without assistance, as well as status updates in pain management. DHS or designee will audit five medical records per week for sixty days, then monthly thereafter to ensure pain assessments have been completed. ED or designee will audit Plant Operations adaptive equipment inspection logs weekly for sixty days, then monthly for four months to ensure completeness. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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	<p>completed on 1/24/2012 indicated Resident #49 was able to answer questions properly and required extensive assist of two persons for bed mobility and transfers. Resident #49 did not walk and required one person physical assist for eating. Resident #49 had limitation in range of motion on both sides both upper and lower.</p> <p>A care plan dated 8/5/2011 and most recently updated on 1/25/12 reviewed on 3/14/12 at 2:07 P.M. indicated Resident #49 had an activities of daily living (ADL) self deficit and needed assistance or was dependent with bed mobility transfer, walking, locomotion, dressing, eating, toilet use, and personal hygiene.</p> <p>A care plan dated 8/5/2011 and last updated on 1/25/12 indicated Resident #49 was at risk for dehydration and fresh water was to be provided at her bedside. The plan of care had not been updated to address the resident's physical restrictions or inability to access fluids on her own.</p> <p>Resident #49 was observed in her room either in bed or in a high back reclined wheel chair with a large pitcher of water out of reach on the following dates: 3/13/2012 at 9:51 A.M., 3/14/12 at 9:30 A.M., 10:00 A.M., 2:21 P.M. 3:30 P.M., 3/15/2012 at 8:45 A.M., 10:00 A.M.,</p>			

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	<p>10:20 A.M., 2:50 P.M., 3/16/2012 at 9:30 A.M., 10:30 A.M., 2:58 P.M.</p> <p>On 3/15/2012 at 10:20 A.M. two CNAs (Certified Nursing Assistants) were observed to enter Resident #49's room. Resident #49 was transferred to bed. During the care CNA #2 stated, "She can drink and eat on her own. She can't use her left hand as well as her right but she can eat and drink. She doesn't get tube feedings anymore. She gets regular food-toast at breakfast and soup everyday at lunch. I don't know what she gets for dinner. I am not here." Once care was provided both, CNAs told Resident #49 they would see her at lunch. The resident was not offered fluids at this time. The pitcher of water and plastic cups remained on the bedside table in a high position out of reach of resident #49.</p> <p>During an interview on 3/15/12 at 2:20 P.M. the Director of Health Care Services indicated Resident #49 could not lift a pitcher of water but could drink out of a cup if it was close to her. She drinks her soup out of a cup with handles at lunch. The Director of Health Care Services indicated the staff should offer Resident #49 fluids when they are in her room and when they make rounds.</p> <p>During an observation of the noon meal</p>			

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	<p>on 3/13/2012 and 3/14/2012, Resident #49 was observed drinking her soup out of a cup with handles without assistance from staff.</p> <p>3. Resident #50's clinical record was reviewed on 3/14/2012 at 11:00 a.m. Diagnoses included, but were not limited to; renal urethral disease, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylasis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this and history of subarachnoid hemorrhage.</p> <p>Record review of a pain care plan, dated 4/21/2011 and most recent date updated 10/20/2011, 5 months prior, indicated "chronic pain AEB (as evidenced by) facial grimace, complaints of pain, R/T (related to) headache and right CVA (cerebrovascular accident/stroke). Goals: resident will state/demonstrate relief or reduction in pain within one hour after receiving interventions, resident will not experience a decline in overall function related to pain. Interventions; monitor and report to nurse signs and symptoms of pain, worsening pain, report changes in pain location/type/frequency/intensity to physician, provide comfort measures, repositioning. Administer, monitor effectiveness and for side effects from;</p>			

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NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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	<p>routine, PRN (as needed) pain medication. Invite, encourage, remind and escort to preferred activities consistent with the resident's interests as a diversion from pain. Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour or receiving the intervention."</p> <p>The resident's current physician orders indicated Hydrocodone/Apap 5/325 mg scheduled to be given every 8 hrs. routinely. Baclofen (a pain reducer) 10 mg give 1 tab by mouth every 12 hrs. Gabapentin/Neurontin (a muscle relaxer) 600 mg give 1 capsule orally 3 times a day. No as needed pain meds ordered.</p> <p>No pain assessments could be found for Resident #50 nor had the resident's plan of care been updated to reflect the pain observed by the facility CNA as follows: An interview with CNA #6 on 3/15/2012 at 10:46 a.m. indicated she can tell when the resident is in pain because her face will change. "Either she'll turn white, or she'll have tears in her eyes, or she'll grimace. She can blink yes to you if you ask her if she's in pain but she can't talk or tell you where the pain is located. When this happens, and it happens almost every day at least once, she will tell the nurse what she observed."</p>			

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	<p>An interview on 3/15/2012 at 9:33 a.m. with RN #8 indicated that resident is on scheduled pain medication, she also has muscle relaxer's ordered. "Hospice handles all the pain medication orders. We give all the pain meds. We do not currently have copies of the Hospice records." RN #8 is working on getting the Hospice records right now for three residents but is having trouble because they are reluctant to give the facility copies.</p> <p>An interview on 3/16/2012 at 3:10 p.m. with RN #8 indicated resident's pain and pain meds are primarily monitored by Hospice. We chart by exception, so if there isn't anything in the chart then she isn't having any pain. If there was a problem, it would be written on a incident form and put in the IDT note section of her chart. We would immediately tell the Hospice nurse if there was an issue and then they would tell us what to do. "I can't recall her having any problems with pain recently and I see her every day."</p> <p>Review of a policy entitled guidelines for pain assessment and management provided by the Director of Nurses on 3/16/2012 at 3:00 p.m. indicated, "2. Ongoing assessment will be documented on the Monthly Nursing Summary, and Skilled Nursing Assessment form if</p>			

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	<p>applicable. 3. Indicate a plan of care related to chronic, acute, or breakthrough pain. 4. If there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care plan update. a. assess the resident for a condition that would indicate that pain may be expected (injury, surgery, procedure). b. assess for behaviors that may be indicators of pain or activities that increase indicators of pain. 5. Educate the resident/family/care givers on the pain management interventions and importance of notifying staff of changes in pain status. 6. Implement the care plan approaches to assist with pain management. 7. Evaluate the effectiveness of pain management interventions and modify as indicated."</p> <p>4. The clinical record for Resident #29 was reviewed on 3/14/12 at 9:30 a.m. The diagnoses for Resident #29 included, but were not limited to: anemia, restless leg syndrome, hypertension, and arthritis.</p> <p>The 2/19/12 fall care plan indicated the goal was "resident will have reduced risk of fall related injury by utilizing fall precautions." Interventions were as follows: provide/monitor use of adaptive devices: wheelchair, lock breaks on chair before transferring, and to check the</p>			

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	<p>function of anti-roll back brakes (on wheelchair). The care plan did not reflect the frequency of checking the brakes, by whom the brakes would be checked, or who would be responsible for ensuring the brakes were actually checked.</p> <p>The Fall Circumstance, Assessment, and Intervention form indicated Resident #29 fell while toileting on 3/2/12. It indicated the root cause of the fall was anti-lock brakes in need of repair. It indicated the anti-lock brakes were repaired by Maintenance Staff #11.</p> <p>During interview about the above fall with Maintenance Staff #11 on 3/14/12 at 11:05 a.m., he indicated he was told Resident #29 had a slip and it had to do with his anti-rollback brakes. He stated, "I repaired the anti-rollback brakes. The brakes were out of adjustment. The brakes were not locking tight enough when he would get out of it." He indicated the brakes on Resident #29's wheelchair were not regularly checked for proper function by maintenance, but would be inspected when told there was a problem. He indicated it had been at least a couple of months since maintenance had seen Resident #29's wheelchair prior to the repair made as a result of the 3/2/12 fall.</p>			

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	<p>During interview with the Maintenance Supervisor on 3/14/12 at 11:05 a.m., he indicated nursing staff was responsible for checking the brakes, not maintenance, and that therapy checked brakes too.</p> <p>During interview with Physical Therapist #13 on 3/14/12 at 11:25 a.m., she indicated therapy checked brakes on residents wheelchairs as needed, if it was brought to their attention that there was a problem. She indicated Resident #29 stopped coming to therapy over 6 months ago, and since he wasn't coming to therapy, she supposed they had not inspected Resident #29's wheelchair brakes in the last 6 months.</p> <p>During interview with RN #14 on 3/16/12 at 9:35 A.M., she indicated she did not know the monitoring system for proper wheelchair function and that nursing does not check wheelchair brakes regularly.</p> <p>During interview with Resident #29 on 3/14/12 at 2:40 p.m. about his fall on 3/2/12, he stated, "The chair went sideways during the fall. The brakes were on, but the chair still moved sideways."</p> <p>3.1-35(g)(2)</p>			

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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 observation, interview, and record review the facility failed to ensure two resident's skin was properly assessed for bruises and failed to monitor a resident's pain and effectiveness of pain interventions for 2 of 40 residents reviewed for quality care. (Resident #29 and 50)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #29 was reviewed on 3/14/12 at 9:30 a.m.</p> <p>The diagnoses for Resident #29 included, but were not limited to: anemia, restless leg syndrome, hypertension, and arthritis .</p> <p>The 2/19/12 care plan for potential alteration in skin integrity indicated an intervention was to assess/record changes in skin status.</p> <p>During observation of Resident #29 on 3/12/12 at 3:00 p.m., a large, purple bruise about half the size of a dollar bill</p>	F0309	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #29 skin was assessed and any new areas documented. Resident #50 pain care plan was updated and assessment completed.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Skin assessments were completed on current residents. Any new areas of impairment were assessed and documented. All resident with pain care plans will be reviewed and updated to reflect changes as indicated, and pain assessments were reviewed to ensure completeness. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will be re-educated nursing staff regarding Accident and Incident Reporting Guidelines. Licensed Nurses will be re-educated</p>	04/21/2012			

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	<p>was observed on the left wrist extending onto the hand of Resident #29.</p> <p>Review of the weekly skin assessment on the March, 2012 MAR (medication administration record) indicated no areas on 3/6/12, 3/9/12, and 3/13/12.</p> <p>During interview at 11:00 a.m. on 3/15/12 with LPN #5, she indicated she was unaware of a dark purple area on his left wrist/hand area. She stated, "He doesn't tell us when he has a new area. The evening nurse (LPN #15) does his weekly skin assessments."</p> <p>During interview with LPN #15 and LPN #5 at 2:15 p.m. on 3/15/12, LPN #15 indicated he did the skin assessment on 3/13/12 and didn't notice anything on Resident #29's left wrist/hand. At this time, LPN #5 indicated Resident #29 did, in fact, have 2 bruises on the left wrist/hand area, one measuring 1.5 inches x (by) 4 inches on his left hand and one measuring 1.8 inches x 1.3 inches on his left wrist.</p>		<p>regarding skin assessments, and completion of the Skin Impairment Circumstance, Assessment, and Intervention. DHS or designee will re-educate the campus care plan team on the Interdisciplinary Team Care plan Guidelines. DHS or designee will re-educate licensed nurses on the Pain Assessment and Management Guideline, specific to assessment and completion of the forms, assessing for changes in pain, evaluation of the effectiveness of the interventions, as well as providing education to the family/caregivers regarding pain management interventions and importance of notifying staff of any changes in pain that have been observed. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit Accident and Incident forms and Skin Impairment Forms weekly for sixty days, and monthly thereafter for four months to ensure any new areas of skin impairment were assessed and documented. DHS or designee will randomly observe five resident's skin condition five times per week for sixty days, then monthly thereafter for four months to ensure any new areas of skin impairment have been assessed and documented. DHS or designee will audit five medical records per week for sixty days,</p>		

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	<p>2. Resident #50's clinical record was reviewed on 3/14/2012 at 11:00 a.m. Diagnoses included but were not limited to; renal urethral disease, hypothyroid, transient ischemic attack (mini stroke), joint pain, spinal stenosis, spondylasis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this, history of subarachnoid hemorrhage.</p> <p>Record review of a pain care plan, dated 4/21/2011 and most recent date updated 10/20/2011, indicated chronic pain AEB (as evidenced by) facial grimace, complaints of pain, R/T (related to) headache and right CVA. Goals: resident will state/demonstrate relief or reduction in pain within one hour after receiving interventions, resident will not experience a decline in overall function related to pain. Interventions; monitor and report to nurse signs and symptoms of pain, worsening pain, report changes in pain</p>		then monthly thereafter to ensure pain assessments have been completed and that pain care plans have been updated to reflect any changes. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.	

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	<p>location/type/frequency/intensity to physician, provide comfort measures, repositioning. Administer, monitor effectiveness and for side effects from; routine, PRN pain medication. Invite, encourage, remind and escort to preferred activities consistent with the resident's interests as a diversion from pain. Notify the resident's physician if they do not state/demonstrate relief or reduction of pain after one hour or receiving the intervention.</p> <p>MD orders indicated Hydrocodone/Apap 5/325 mg scheduled to be given every 8 hrs. routinely. Baclofen (a pain reducer) 10 mg give 1 tab by mouth every 12 hrs. Gabapentin/Neurontin (a muscle relaxer) 600 mg give 1 capsule orally 3 times a day. No as needed pain meds ordered.</p> <p>Record review indicated no pain assessments could be found for Resident #50 in her chart or in resident incident binder.</p> <p>An interview on 3/15/2012 at 9:33 a.m. with RN #8 indicated that resident is on scheduled pain medication, she also has muscle relaxer's ordered. "Hospice handles all the pain medication orders. We give all the pain meds. We do not currently have copies of the Hospice records." RN #8 is working on getting the</p>			

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	<p>Hospice records right now for three residents but is having trouble because they are reluctant to give the facility copies.</p> <p>An interview with CNA #6 on 3/15/2012 at 10:46 a.m. indicated she can tell when the resident is in pain because her face will change. "Either she'll turn white, or she'll have tears in her eyes, or she'll grimace. She can blink yes to you if you ask her if she's in pain but she can't talk or tell you where the pain is located. When this happens, and it happens almost every day at least once, she will tell the nurse what she observed."</p> <p>An interview on 3/16/2012 at 3:10 p.m. with RN #8 indicated resident's pain and pain meds are primarily monitored by Hospice. We chart by exception, so if there isn't anything in the chart then she isn't having any pain. If there was a problem, it would be written on a incident form and put in the IDT note section of her chart. We would immediately tell the Hospice nurse if there was an issue and then they would tell us what to do. "I can't recall her having any problems with pain recently and I see her every day."</p> <p>Review of a policy titled guidelines for pain assessment and management provided by the Director of Nurses on</p>				

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	<p>3/16/2012 at 3:00 p.m. indicated, "2. Ongoing assessment will be documented on the Monthly Nursing Summary, and Skilled Nursing Assessment form if applicable. 3. Indicate a plan of care related to chronic, acute, or breakthrough pain. 4. If there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care plan update. a. assess the resident for a condition that would indicate that pain may be expected (injury, surgery, procedure). b. assess for behaviors that may be indicators of pain or activities that increase indicators of pain. 5. Educate the resident/family/care givers on the pain management interventions and importance of notifying staff of changes in pain status. 6. Implement the care plan approaches to assist with pain management. 7. Evaluate the effectiveness of pain management interventions and modify as indicated."</p> <p>3.1-37(a)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good oral hygiene for 1 of 5 residents reviewed for activities of daily living being provided in a total sample of 36 residents. (Resident #30)</p> <p>Findings include:</p> <p>Resident #30 was admitted on 5/04/05 and had current diagnoses which included but were not limited to chronic schizophrenia and depression.</p> <p>Resident #30's clinical record was reviewed on 3/15/2012 at 9:41 A.M. A care plan dated 2/14/2012 indicated Resident #30 had dementia related to a diagnoses of schizophrenia. Her decision making, recall, and memory were impaired. A goal listed for Resident #30 was for her to make routine decisions with cues/supervision and to remember self, family, and staff.</p>	F0312	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> In regards to resident #30, nursing staff was re-educated on the resident's need for assistance with oral hygiene and the expectation for resident's teeth to be brushed every AM and PM, per plan of care. Nurses were re-educated to document on MAR that brushing was completed every AM and PM, per MD order.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Completed inspection of oral cavity of all residents requiring assistance with oral hygiene to ensure no oral health concerns were present.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will educate nursing staff on expectations of assisting residents with oral hygiene in the AM and PM, documenting that</p>	04/21/2012			

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	<p>An annual MDS (minimum data set assessment) dated 2/14/2012 indicated Resident #30 required extensive physical assist of one person for personal hygiene including brushing her teeth.</p> <p>A care plan dated 2/19/12 indicated Resident #30 had an activities of daily living self care deficit. Resident #30 needed assistance and/or was dependent on staff for dressing, toilet use, personal hygiene, and bathing. Interventions included staff to assist with personal hygiene as needed including oral/dental care. Assist of one or two cueing/prompting or hands-on-hand over hand needed.</p> <p>During a family interview on 3/12/2012 at 3:23 P.M., Resident #30's family member indicated Resident #30 was unable to make day to day choices so choices had to be made for her. Resident #30's overall oral care was neglected. This family member indicated she would be taking Resident #30 to the dentist this week. Resident #30's family member stated, "I keep checking her mouth. Care is neglected. They say, 'We are too busy after meals.' The dentist is very upset with the care of teeth with (facility named). Her gargle is barely touched."</p>		<p>oral hygiene was completed, and the level of assistance provided to the resident. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will observe oral hygiene provided to five residents per week for sixty days , then monthly for four months to ensure assistance with oral hygiene was provided per the careplan. DHS or designee will randomly inspect the oral cavity of five residents requiring assistance with oral hygiene to ensure oral hygiene has been provided, and no dental concerns are present. These random inspections will occur five times per week for sixty days, and monthly for four months.</p> <p>The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>				

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	<p>On 3/14/2012 at 2:00 P.M. and 3:00 P.M. Resident # 30 was observed standing at the nurse's station with gauze in her mouth.</p> <p>A physician's order originally dated 10/13/05 and on current March rewrite orders indicated Resident #30's teeth were to be brushed twice a day-in the A.M. and at bedtime.</p> <p>During an interview on 3/15/2012 at 10:29 A.M., CNA (certified nursing assistant) #6 indicated Resident #30 needed her toothbrush set up and cueing. If this was provided for her Resident #30 would brush her own teeth for twenty minutes on top and twenty minutes on the bottom.</p> <p>Review of February and March 2012 Medication Administration Records indicated Resident #30 did not have her teeth brushed at bed time during this time.</p> <p>During an interview on 3/16/2012 at 12:00 P.M., the Director of Health Services indicated she was unable to provide documentation or an explanation which explained why Resident #30 had not had her teeth brushed at bed time every evening as ordered by the physician.</p> <p>During an interview on 3/16/12 at 2:00</p>						

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	<p>P.M., the dental assistant from Resident #30's dentist office indicated Resident #30 had tooth number twenty nine removed this week because tooth decay had reached the nerve.</p> <p>3.1-38(a)(3)(C)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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 record review, observation, and interview the facility failed to provide medical justification for the use of a urinary catheter for 1 of 3 residents reviewed for catheter use who exceeded the threshold for unjustified use of a catheter. Resident #50.</p> <p>Findings include:</p> <p>Resident #50's clinical record was reviewed on 3/14/2012 at 11:00 a.m. Diagnoses included but were not limited to; renal urethral disease, dehydration, transient ischemic attack (mini stroke), spinal stenosis, spondylitis, mood disorder and dementia, history of extensive cerebrovascular accident (stroke) with marked neurologic debility secondary to this.</p> <p>Interview with RN #8 on 3/13/2012 at</p>	F0315	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #50 MD order received for diagnosis of urinary retention as medical justification for catheter use.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents with urinary catheter will be reviewed to ensure medical justification for catheter use is in place.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate licensed nurses and hospices nurses on requirement for obtaining medical justification from the resident's MD for the</p>	04/21/2012	

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	<p>11:26 a.m. indicated that the resident has a regular foley catheter in place. "I've tried to get it discharged but hospice wants to keep it, she had a now healed pressure ulcer there."</p> <p>MD orders reviewed on 3/14/2012 at 11:00 a.m. indicated the following; dated 8/14/2011, for "catheter care every shift." Dated 8/17/2011, to "change foley catheter every 4 weeks w/ 16 FR, 30 mL Balloon foley cath due to urinary retention". Dated 11/21/2011, "resident to have leg bag catheter on during day per family request."</p> <p>A 12/9/2011 Nurse Practitioner visit note indicated "a chronic problem of urinary retention as; well controlled, continue foley cath with cath care q (every) shift."</p> <p>Lab results indicated that Resident #50's most recent Urinalysis, dated 2/28/2012, indicated resident had a UTI, bacteria is Augmentin sensitive. A 3/1/2012 MD order for Augmentin 875 mg po (by mouth) BID (twice daily) times 10 days.</p> <p>Observation of foley catheter care on 3/16/2012 at 1:40 p.m. with CNA #10 and CNA #2 present. No skin concerns noted at catheter site. Both CNA's indicated that they document catheter care each shift.</p>		<p>use of urinary catheters. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit the medical records of three residents per week for sixty days, and then monthly thereafter for four months to ensure documentation of medical justification is in place for the use of urinary catheters. DHS or designee will review all new urinary catheter orders on an ongoing basis to ensure documentation of medical justification is in place for the utilization of the catheter.</p> <p>The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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	<p>Interview with CNA #6 on 3/15/2012 at 10:46 a.m. indicated the only thing she is allowed to do with the catheter is to wash around it. If she noticed any problems with it kinking, or not draining right or anything out of the usual she would tell the nurse that she was working with that day.</p> <p>Interview with DON on 3/15/2012 at 2:50 p.m. indicated she would look into why resident still had catheter, she thinks its for comfort.</p> <p>Hospice notes, dated 10/11/2011 indicated, "Discussed whether to keep catheter in d/t continued skin issues et original retention issues et son is in agreement to keep catheter in for comfort, retention problems." Hospice note, dated 3/22/2011, indicated, "Expressed concern that pt's urine incontinence will contribute to area not healing well. Was able to get pt awake long enough that she agreed to placement of catheter after explaining reasoning. #16 Fr catheter place without any problems with 500 mL urine returned."</p> <p>Interview with the Director of Nurses on 3/16/2012 at 2:05 p.m. indicated Resident #50's foley was last changed by the hospice nurse on 2/28/2012 due to</p>			

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	<p>occlusion, and she so happened at that time to have a UTI.</p> <p>Facility nurses notes, dated 3/14/2012, indicated "f/c (foley catheter) changed without difficulty. Resident tolerated well."</p> <p>3.1-41(a)(2)</p>				

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure safety precautions were taken during a Hoyer (mechanical lift) transfer of a resident and the facility also failed to ensure the anti-roll brakes on resident's wheelchair were properly maintained, in a sample of 36 observed for accidents and supervision (Resident # 39 and #29).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #39 was reviewed on 3/14/11 at 1:30 p.m.</p> <p>The diagnoses for Resident #39 included, but were not limited to: vascular dementia, neuropathy, breast cancer, and hypertension.</p> <p>During a Hoyer transfer lift observation of Resident #39, with CNA #1 and CNA #2, on 3/15/12 at 9:34 a.m., the resident was transferred from their wheelchair to their bed. During the transfer, the wheelchair wheels were not locked when the resident was lifted out of the wheelchair.</p>	F0323	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> In regards to resident #39, nursing staff was re-educated on the safety requirement of locking the resident's wheelchair brakes prior to transferring from a wheelchair with the use of a mechanical lift. Resident #29 care plan was updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents who require the use of mechanical lifts for transfer from the wheelchair have the potential to be affected by the same alleged deficient practice. The careplans of those residents having anti-roll back brakes on the wheelchairs were updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked,</p>	04/21/2012			

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	<p>In an interview with CNA #1 and CNA #2, on 3/15/12 at 9:40 a.m., CNA #1 indicated that the wheelchair brakes are supposed to be locked during a Hoyer transfer of a resident. Also, during the same interview, CNA #2 confirmed that the wheelchair brakes were not locked during the transfer.</p> <p>In an interview with the DoN (Director of Nursing), on 3/15 at 2:45 p.m., she indicated that the wheelchair brakes are supposed to be locked during a Hoyer transfer of a resident.</p>		<p>and who would be responsible for ensuring the brakes were actually checked. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the safety requirement of locking the resident's wheelchair brakes prior to transferring from the wheelchair utilizing a mechanical lift. DHS or designee will educate the Plant Operations team members regarding their responsibility to inspect anti-roll back brakes applied to wheelchairs on an on-going, weekly basis and to log the completion of the inspections. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will observe transfers utilizing a mechanical lift to transfer a resident from a wheelchair. These observations will include five staff members per week for sixty days, and then monthly for four months to ensure wheelchair brakes are locked prior to transferring the resident. ED or designee will audit the anti-roll back brakes inspection logs weekly for sixty days, then monthly for four months to ensure completeness. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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	<p>2. The clinical record for Resident #29 was reviewed on 3/14/12 at 9:30 a.m.</p> <p>The diagnoses for Resident #29 included, but were not limited to: anemia, restless leg syndrome, hypertension, and arthritis .</p> <p>The 2/14/12 quarterly MDS (minimum data set) assessment indicated the following: transfer - limited assist/one person, toilet use - limited assist/one person, walking - not steady/only able to stabilize with human assistance, turning around - activity did not occur, moving on and off toilet - not steady but able to stabilize without human assistance, falls since last assessment (on 11/15/11) - 2 with injury.</p> <p>The 2/14/12 and 1/31/12 safety assessments indicated Resident #29 had no history of falls and did not require assistance to transfer.</p> <p>During interview with RN #14 on 3/16/12 at 9:35 a.m., she indicated the 2/14/12 and 1/31/12 safety assessments were not correct assessments regarding history of falls or assistance to transfer.</p> <p>The 2/19/12 fall care plan indicated the goal was "resident will have reduced risk of fall related injury by utilizing fall</p>	F0323	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> In regards to resident #39, nursing staff was re-educated on the safety requirement of locking the resident's wheelchair brakes prior to transferring from a wheelchair with the use of a mechanical lift. Resident #29 care plan was updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents who require the use of mechanical lifts for transfer from the wheelchair have the potential to be affected by the same alleged deficient practice. The careplans of those residents having anti-roll back brakes on the wheelchairs were updated to reflect the frequency of checking the anti-rollback brakes, by whom the brakes would be checked, and who would be responsible for ensuring the brakes were actually checked. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the</p>	04/21/2012			

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	<p>precautions." Interventions were as follows: provide/monitor use of adaptive devices: wheelchair, lock breaks on chair before transferring, and to check the function of anti-rollback brakes (on wheelchair). The care plan did not address the frequency of checking the brakes, by whom the brakes would be checked, or who would be responsible for ensuring brakes were actually checked.</p> <p>The Fall Circumstance, Assessment, and Intervention form indicated Resident #29 fell while toileting on 3/2/12. It indicated the root cause of the fall was anti-lock brakes in need of repair. It indicated the anti-lock brakes were repaired by Maintenance Staff #11.</p> <p>During interview about the above fall with Maintenance Staff #11 on 3/14/12 at 11:05 a.m., he indicated he was told Resident #29 had a slip and it had to do with his anti-rollback brakes. He stated, "I repaired the anti-rollback brakes. The brakes were out of adjustment. The brakes were not locking tight enough when he would get out of it." He indicated the brakes on Resident #29's wheelchair were not regularly checked for proper function by maintenance, but would be inspected when told there was a problem. He indicated it had been at least a couple of months since maintenance</p>		<p>nursing staff on the safety requirement of locking the resident's wheelchair brakes prior to transferring from the wheelchair utilizing a mechanical lift. DHS or designee will educate the Plant Operations team members regarding their responsibility to inspect anti-roll back brakes applied to wheelchairs on an on-going, weekly basis and to log the completion of the inspections. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will observe transfers utilizing a mechanical lift to transfer a resident from a wheelchair. These observations will include five staff members per week for sixty days, and then monthly for four months to ensure wheelchair brakes are locked prior to transferring the resident. ED or designee will audit the anti-roll back brakes inspection logs weekly for sixty days, then monthly for four months to ensure completeness. The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>				

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	<p>saw Resident #29's wheelchair prior to the repair made as a result of the 3/2/12 fall.</p> <p>During interview with the Maintenance Supervisor on 3/14/12 at 11:05 a.m., he indicated nursing staff was responsible for checking the brakes, not maintenance, and that therapy checked brakes too.</p> <p>During interview with Physical Therapist #13 on 3/14/12 at 11:25 a.m., she indicated therapy checked brakes on residents wheelchairs as needed, if it was brought to their attention that there was a problem. She indicated Resident #29 stopped coming to therapy over 6 months ago, and since he wasn't coming to therapy, she supposed they had not inspected Resident #29's wheelchair brakes in the last 6 months.</p> <p>During interview with RN #14 on 3/16/12 at 9:35 a.m., she indicated she did not know the monitoring system for proper wheelchair function and that nursing did not check wheelchair brakes regularly.</p> <p>During interview with Resident #29 on 3/14/12 at 2:40 p.m. about his fall on 3/2/12, he stated, "The chair went sideways during the fall. The brakes were on, but the chair still moved sideways."</p> <p>3.1-45(a)(1)</p>			

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview, and clinical record review, the facility failed to ensure each resident was evaluated for appropriate fluid intake to maintain proper hydration for 1 of 1 residents reviewed for adequate hydration in a total sample of 36 residents. (Resident #49)</p> <p>Findings include:</p> <p>Resident #49's clinical record was reviewed on 3/13/2012 at 10:30 A.M. Resident #49 was admitted on 5/21/10 and had current diagnoses which included but were not limited to gastritis, history of partial gastrectomy, splenectomy, and neuropathy.</p> <p>Prior to 2/9/2012 Resident #49 was provided nutrition through tube feedings along with honey thickened liquids and comfort foods. Resident #49 along with her family decided to sign a self determination of care request form dated 8/9/2011. This form indicated Resident #49 did not like the looks, flavor, or texture of a pureed diet or the honey thickened liquid. She requested pleasure foods, toast at breakfast, soup for lunch</p>	F0327	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> The registered dietician (RD) was notified of the discontinuation of the tube feeding and re-assessment of appropriate fluid intake was documented for resident #49.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee re-educated the nurse managers to provide written notification to the RD regarding residents with changes or potential changes in fluid intake, i.e. discontinuation of a tube feeding. RD was also re-educated on the requirement to evaluate appropriate fluid intake on residents with changes or potential changes in fluid intake to maintain proper</p>	04/21/2012			

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	<p>and dinner, and the tube feedings.</p> <p>A nurse's note dated 2/9/2012 timed 12:30 P.M. indicated Resident #49 wanted to stop the tube feedings. A physician's order dated 2/9/2012 indicated the tube feedings were to be stopped.</p> <p>A current physician's order dated 3/2/2012, indicated Resident #49's current diet order was pureed with honey thickened liquids, low salt, supplemental feedings, and regular water.</p> <p>A current care plan originally dated 8/5/2011 and last updated 1/25/12, indicated Resident #49 was to have a pureed diet, toast for breakfast, and soup for lunch and dinner.</p> <p>A nutrition care plan dated 1/4/2011 and last updated 1/12/2012, indicated Resident #49 had a potential for alteration in nutritional and/or fluid balance related to a partial gastrectomy, less than 75% of oral intake, and the inability to take P.O. (oral)-requiring tube feedings. Interventions included encourage oral intake, thickened liquids per physician order, and tube feedings per physician order.</p> <p>On 3/13/12 at 9:51 A.M. Resident #49 was observed to have contractures of both</p>		<p>hydration. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> DHS or designee will audit notifications to the RD regarding residents with changes or potential changes in fluid intake on a weekly and on going basis to ensure appropriate residents are identified for review. In addition, DHS or designee will audit five RD assessments per week for sixty days, then monthly for four months to ensure documentation is in place to reflect the evaluation of fluid intake to maintain proper hydration.</p> <p>The audits will be presented to the monthly Quality Assurance Committee for six months for further recommendations.</p>		

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	<p>arms, both hands, and all fingers on both hands. Resident #49 was observed in a chair in her room with a water pitcher and stack of plastic cups on the bedside table across the room out of her reach.</p> <p>During an interview on 3/13/2012 at 9:51 A.M., Resident #49 replied no when asked if she got the fluids she wanted between meals.</p> <p>A minimum data set assessment (MDS) completed on 1/24/2012 indicated Resident #49 was able to answer questions properly and required extensive assist of two persons for bed mobility and transfers. Resident #49 did not walk and required one person physical assist for eating. Resident #49 had limitation in range of motion on both sides both upper and lower.</p> <p>A care plan dated 8/5/2011 and most recently updated on 1/25/12 reviewed on 3/14/12 at 2:07 P.M. indicated Resident #49 had an activities of daily living (ADL) self deficit and needed assistance or was dependent with bed mobility transfer, walking, locomotion, dressing, eating, toilet use, and personal hygiene.</p> <p>A care plan dated 8/5/2011 and last updated on 1/25/12 indicated Resident #49 was at risk for dehydration and fresh</p>			

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	<p>water was to be provided at her bedside.</p> <p>Resident #49 was observed in her room either in bed or in a high back reclined wheel chair with a large pitcher of water out of reach on the following dates: 3/13/2012 at 9:51 A.M., 3/14/12 at 9:30 A.M., 10:00 A.M., 2:21 P.M. 3:30 P.M., 3/15/2012 at 8:45 A.M., 10:00 A.M., 10:20 A.M., 2:50 P.M., 3/16/2012 at 9:30 A.M., 10:30 A.M., 2:58 P.M.</p> <p>On 3/15/2012 at 10:20 A.M. two CNAs (certified nursing assistants) were observed to enter Resident #49's room. Resident #49 was transferred to bed. During the care CNA #2 stated, "She can drink and eat on her own. She can't use her left hand as well as her right but she can eat and drink. She doesn't get tube feedings anymore. She gets regular food-toast at breakfast and soup everyday at lunch. I don't know what she gets for dinner. I am not here." Once care was provided both CNAs told Resident #49 they would see her at lunch. The resident was not offered fluids at this time. The pitcher of water and plastic cups remained on the bedside table in a high position out of reach of resident #49.</p> <p>During an interview on 3/15/12 at 2:20 P.M. the Director of Health Care Services indicated Resident #49 could not lift a</p>			

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	<p>pitcher of water but could drink out of a cup if it was close to her. She drinks her soup out of a cup with handles at lunch. The Director of Health Care Services indicated the staff should be offering Resident #49 fluids when they are in her room and when they make rounds.</p> <p>During an observation at the noon meal on 3/13/2012 and 3/14/2012, Resident #49 was observed drinking her soup out of a cup with handles without assistance from staff.</p> <p>During an interview on 3/14/2012 at 11:30 A.M., The nurse practitioner reviewing Resident #49's chart indicated she did not realize Resident #49 was not receiving the honey thickened pureed diet that was ordered.</p> <p>During an interview on 3/14/2012 at 11:50 A.M., The dietician indicated she was new to the building and was not aware Resident #49 was not getting anything offered to her other than the comfort foods she requested when she was still getting the tube feedings. Resident #49's caloric/fluid intake requirements had not been reassessed since the tube feeding had been stopped.</p> <p>Review of the dietary notes indicated the last entry was dated 1/13/12 and indicated</p>			

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	<p>Resident #49 was still receiving nutrition/fluids through the tube.</p> <p>During an interview on 3/15/12 at 2:20 P.M. the Director of Health Care Services indicated she was unable to provide documentation that Resident #49's fluid requirements had been reevaluated since the tube feedings had been discontinued.</p> <p>3.1-46(b)</p>			