

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2015
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 18, 19, 20, 21, and 24, 2015</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 9 Medicaid: 60 Other: 13 Total: 82</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0241 SS=E Bldg. 00	<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</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment which promoted self-esteem and ensured the dignity for 5 of 6 residents (who shared a common bathroom with another resident's room) by providing privacy. The facility also failed to ensure residents were treated in a dignified manner during care and in the dining room. (Resident #25, Resident #33, Resident #55, Resident #74, Resident #76)</p> <p>Findings include:</p> <p>1. During an interview on 8/19/15 at 8:45 A.M., Resident #25 indicated she and her friend had requested to be roommates and that they had moved into their current room 7/7/15. Resident #25 said, "The man next door uses the same bathroom as we do and they say he doesn't know what he is doing, but he does it every day. He did it this morning. He came in to my room and opened the bathroom door! I was just getting up to pull my pants up and I told him to get out and he wouldn't." Resident #25 indicated a person should have privacy in the bathroom. They just keep telling us he doesn't know what he is doing. Resident</p>	F 0241	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F241</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident 25, 74 and 60 affected by the alleged deficient practice have been moved rooms that do not share bathrooms with each other. · Resident 76, 33, and 55 affected by the alleged deficient practice have been identified by the interdisciplinary team and are no longer affected. 	09/23/2015			

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	<p>#25 further indicated that this morning she had told the CNA that Resident #60 entered her room and bathroom, but indicated she did not know if the CNA told the nurse. Resident #25 indicated she was afraid of him.</p> <p>During an interview on 8/20/15 at 10:30 A.M., Resident #74 (Resident #25's roommate) indicated Resident #60 entered their room yesterday and they told him to get out. Resident #74 said, "He finally left, but he came back to the door and made mean faces at us. The other morning he just came right in the room and opened the bathroom door while she (Resident #25) was on the commode. It's not right. We have told all kinds of people here, CNA's and nurses. Nothing gets done. It happens every day. He knows what he is doing. When he gets mad he has given me the finger before."</p> <p>The clinical record of Resident #25 was reviewed on 8/20/15 at 11:30 A.M. The record indicated the diagnoses of Resident #25 included, but were not limited to, anxiety, depression, Diabetes and a history of fractured pelvis.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 3/30/15 indicated Resident #25 experienced no cognitive</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. DNS/Social services/Designee will monitor resident needs and concerns regarding roommate and co-roommates that share restrooms daily. ·DNS/Social services/Designee will not allow individuals of opposite genders to share restrooms unless care planned upon request. ED/SS/Designee to audit all rooms to identify concerns regarding shared bathrooms and initiate move per room move policy. ·ED/Designee will monitor grievances, resident council minutes, and QIS surveys for any concerns relating to cell phone use, roommates, and dignity concerns and provide immediate follow up next business day. <p>What measures will be put into place or what systemic changes you will make to ensure that the</p>		

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	<p>impairment.</p> <p>During an interview on 8/20/15 at 10:53 A.M., CNA #10 indicated she frequently had worked on the hall where Resident #25 and Resident #74 resided. CNA #10 indicated that both Resident #25 and Resident #74 have had problems with Resident #60 and they complained about him all the time. CNA #10 said, "We have told them, but I don't think they understood, he didn't know what he was doing." CNA #10 was made aware of the incident that occurred on the morning of 8/19/15 where Resident #60 went into the residents' room and into their bathroom while it was occupied by Resident # 25. CNA #10 said, "That is a real dignity issue." CNA #10 said, "That is just the way Resident #60 is. He didn't mean anything by it."</p> <p>During an interview on 8/21/15 at 12:04 P.M., OTR (Occupational Therapy R) indicated she was aware of the problems between Resident #25 and Resident #74 who shared a bathroom with Resident #60. OTR indicated she had advised Resident #25 to speak louder when Resident #60 knocked on the bathroom door because Resident #60 was hard of hearing. OTR indicated she had been working with Resident #60, but he had discharged from therapy recently. OTR</p>		<p>deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on dignity, roommates/preferences, and resident rights has been provided to all staff by ED/DNS/Designee by September 15, 2015. ·ED/DNS/nurse manager/designee will daily identify any resident grievances and provide proper follow up and resolve grievance. ·ED/DNS/nurse manager/designee will conduct daily audits on grievance forms, roommate/room preferences, observations regarding cell phone use and dignity. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/ Designee will daily utilize dignity and cell phone CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. 				

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	<p>indicated she had not been notified about the current events on the morning of 8/19/15.</p> <p>During an interview on 8/21/15 7:41 A.M., the Nurse Consultant was made aware of Resident #25's and Resident #74's concerns with the lack of privacy in their bathroom. CN indicated it was a concern.2. During a meal observation in the Cottage dining room on 8/18/15 at 12:12 P.M., Resident #76 was observed to hit the top of the dining room table in a loud and repetitive manner. LPN # 10 was observed, at that time, to talk to Resident #76, until the loud hitting of the table stopped. LPN #10 was then observed to travel through the dining room and Resident #76 was then observed to resume hitting the top of the table again. LPN #10 then stated to Resident #91, "...didn't work for long, it never does..."</p> <p>During an interview on 8/24/15 at 4:15 P.M., the HFA (Health Facilities Administrator) indicated no specific policy could be provided related to dining dignity, but it was the usual facility policy to treat all residents with dignity. 3. The resident council minutes were reviewed on 8/21/15 at 11:00 A.M., comments included but were not limited to:</p>		<p>Compliance date: September 23, 2015</p>				

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	<p>April 27, 2015 "...Residents had some concerns with staff being on their cell phones while giving care..." The facility indicated it would be holding an in-service on 4/28/15.</p> <p>May 18, 2015 "...Concerns with staff using cell phones..." The facility response was to educate certified nursing assistants regarding cell phone use while on duty.</p> <p>July 30, 2015, "...Staff on cell phones, somebody needs to come in in [sic] the evenings..." The facility response was to educate staff regarding cell phone use.</p> <p>On 8/21/15 at 11:45 A.M., Resident #33 was observed sitting on the side of his bed. Resident #33 indicated he attended resident council meeting. Resident #33 indicated staff still would use cell phones in the rooms while giving care. He further indicated he felt this was disrespectful.</p> <p>The clinical record for Resident #33 was reviewed on 8/24/15 at 11:10 A.M. The MDS (Minimum Data Set assessment) dated 6/28/15 indicated Resident #33 had a BIMS (Brief Interview for Mental Status) of 15 indicating he is cognitively intact. The MDS further indicated</p>			

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F 0242 SS=D Bldg. 00	<p>Resident #33 experienced no behaviors.</p> <p>During an interview on 8/24/15 with Resident #55 she indicated she required assistance to complete her ADL care. She indicated staff would often use cellular phones in rooms while assisting with care and it made her feel rushed, and uneasy.</p> <p>The clinical record for Resident #55 was reviewed on 8/24/15 at 11:30 A.M. An MDS assessment dated 5/15/15 indicated Resident #55 had a BIMS score of 15 indicating she was cognitively intact and had no behavioral concerns.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observations, interview, and record review the facility failed to honor residents bathing preferences for 2 of 3 residents reviewed for choices. (Resident</p>	F 0242	conclusion set forth in the statement of deficiencies, or of any violation of regulation.	09/23/2015	

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	<p>#15, Resident #49)</p> <p>Findings include:</p> <p>1. On 8/20/15 at 8:37 A.M., Resident #15 was observed sitting in a wheelchair in the 300/400 lounge in no apparent distress.</p> <p>During an interview on 8/19/15 at 9:05 A.M., the Power of Attorney (POA) for Resident #15 indicated he felt Resident #15 was not getting her two scheduled showers or needed more showers.</p> <p>The clinical record for Resident #15 was reviewed on 8/20/15 at 9:02 A.M. The diagnoses included hypertension and bi polar disorder.</p> <p>A shower schedule for the 300/400 halls was provided on 8/24/15 at 11:00 A.M., by LPN #10. The schedule indicated Resident #15's showers was scheduled on Wednesday and Saturdays evening shift.</p> <p>The care plans included, but were not limited to, a care plan for self care deficit initiated 5/30/12. The interventions included, but were not limited to, "...Staff to assist with ADL's [Activities of Daily Living]..." initiated 7/9/14, and offer shower two days per week with partial in between and as needed initiated 5/30/12.</p>		<p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F242</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident 15 and 49 affected by the alleged deficient practice have been identified by interdisciplinary team and have been reviewed regarding shower preferences and nursing staff have been educated regarding their preferences. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will review shower sheets daily and identified if one is missed or if resident is 				

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	<p>An ADL report for Resident #15 for 7/26/15 through 8/24/15 was reviewed on 8/24/15 at 11:00 A.M., it included:</p> <p>The week of 7/26/15 through 8/1/15 no showers were documented.</p> <p>The week of 8/2/15 through 8/8/15 no showers were documented.</p> <p>The week of 8/16/15 through 8/22/15 1 shower was documented. The ADL documentation indicated Resident #15 had missed 5 of 8 scheduled showers.</p> <p>During an interview on 8/21/15 with CNA #3, she indicated if a resident were to refuse a shower nurses would be notified so they could document the refusal and to then reattempt to give the shower later.</p> <p>During an interview 8/24/15 at 3:00 P.M., the Healthcare Facility Administrator (HFA) indicated the facility did not have any further documentation to indicate Resident #15 had received or refused the scheduled showers.</p> <p>2. During a random observation on 8/20/15 at 3:30 P.M., a loud screaming</p>		<p>refusing showers and proper documentation will be provided next business day.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on shower preferences and right to make choices has been provided to all nurses and CNAs by ED/DNS/Designee by September 15, 2015. ·DNS/UM/ designee will conduct daily audits on shower sheets to identify missing shower sheets or refusals. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/ Designee will daily utilize shower CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported 	

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	<p>was overheard on the 300 hall. LPN (Licensed Practical Nurse) #10 indicated it was Resident #49, "she always does that during her showers."</p> <p>Resident #49 was observed on 8/20/15 at 3:40 P.M., sitting in a wheelchair. Resident #49 was visibly upset.</p> <p>The clinical record for Resident #49 was reviewed on 8/21/15 at 9:00 A.M., the diagnoses include but were not limited to, schizoaffective disorder, Alzheimer's disease, and psychosis.</p> <p>A shower schedule for the 300/400 halls was provided on 8/24/15 at 11:00 A.M., by LPN #10. The schedule indicated Resident #49's showers was scheduled on Monday and Thursday evening shift.</p> <p>The care plans were reviewed and included, but were not limited to, a care plan for resistance of care initiated 3/6/14. The interventions included, but were not limited to ...Leave alone and re-approach care... ..Aproch [sic] calmly and communicate care needed and to be provided... ..Ensure comfortable before and during care..." initiated 3/6/14.</p> <p>During an interview with CNA #13 on 8/24/15 at 2:50 P.M., she indicated Resident #49 continuously yelled out</p>		<p>in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: September 23, 2015</p>	

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F 0250 SS=D Bldg. 00	<p>during showers. CNA #13 indicated she was unaware of the interventions for Resident #49's behaviors.</p> <p>During an interview with the Administrator on 8/24/15 at 3:00 P.M., she indicated Resident #49 was afraid of water and would yell out during bathing. She further indicated no documentation could be provided that an alternative bathing method had been attempted.</p> <p>3.1-3(u)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident exhibiting behaviors receive comprehensive monitoring by social services and had a care plan developed for behavior management for 1 of 3 residents who met the criteria for review of social services. (Resident #60)</p> <p>Findings include:</p>	F 0250	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post</p>	09/23/2015

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	<p>On 8/19/15 at 8:45 A.M., Resident #60 was observed in bed with his eyes closed in no distress.</p> <p>During an interview on 8/19/15 at 8:45 A.M., Resident #25 said, "The man next door uses the same bathroom as we do and they say he doesn't know what he is doing, but he does it every day. He did it this morning. He came in to my room and opened the bathroom door! I was just getting up to pull my pants up and I told him to get out and he wouldn't." Resident #25 indicated a person should have privacy in the bathroom. "They just keep telling us he doesn't know what he is doing." Resident #25 further indicated that this morning she had reported to the CNA that Resident #60 entered her room and bathroom, but indicated she did not know if the CNA told the nurse. Resident #25 indicated she was afraid of him.</p> <p>During an interview on 8/20/15 at 10:30 A.M., Resident #74 (Resident #25's roommate) indicated Resident #60 entered their room yesterday and they told him to get out. Resident #74 said, "He finally left, but he came back to the door and made mean faces at us. The other morning he just came right in the room and opened the bathroom door while she (Resident #25) was on the</p>		<p>Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F250</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident 25, 75, and 60 have been moved rooms to no longer share bathrooms. ·Residents 25, 75, 60 affected by the alleged deficient practice have been identified by the interdisciplinary team have been provided rooms that satisfies resident's preferences and no long share bathrooms. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will review daily grievances, progress notes identifying social service concerns regarding possible behaviors. 	

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	<p>commode. It's not right. We have told all kinds of people here, CNAs and nurses. Nothing gets done. It happens every day. He knows what he is doing. When he gets mad he has given me the finger before."</p> <p>The clinical record of Resident #60 was reviewed on 8/20/15 at 11:30 A.M. The record indicated Resident #60 was admitted on 3/15/12 with diagnoses including, but not limited to, diabetes, hypertension, and cerebral vascular accident.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 4/29/15 indicated Resident #60 experienced severe cognitive impairment, experienced no mood impairments, and no behaviors.</p> <p>Resident #60's clinical record lacked documentation of behavior monitoring and a care plan to address Resident #60's behaviors.</p> <p>During an interview on 8/20/15 at 10:53 A.M., CNA #10 indicated she frequently had worked on the hall where Resident #25 and Resident #74 resided. CNA #10 indicated that both Resident #25 and Resident #74 have had problems with Resident #60 and they complained about him all the time. CNA #10 said, "We</p>		<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on behavior management, room preferences, and roommate concerns has been provided to all staff by ED/DNS/Designee by September 15, 2015. ·DNS/ED/nurse manager/designee will conduct daily audits on progress notes to identify potential social service concerns and grievances. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/ Designee will daily utilize behavior management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 	

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	<p>have told them, but I don't think they understood, he didn't know what he was doing." CNA #10 was made aware of the incident that occurred on the morning of 8/19/15 where Resident #60 went into the residents' room and into their bathroom while it was occupied by Resident #25. CNA #10 said, "That is just the way Resident #60 is. He didn't mean anything by it."</p> <p>The Resident Progress Notes dated 7/14/15 at 12:56 P.M., read as follows: "Resident having difficulty locating room and bathroom. Co-resident report resident enters their room frequently looking for his. Therapy notified."</p> <p>During an interview on 8/21/15 at 12:04 P.M., OT #1 (Occupational Therapy) indicated she was aware of the problems between Resident #25 and Resident #74 who shared a bathroom with Resident #60. OT indicated she had advised Resident #25 to speak louder when Resident #60 knocked on the bathroom door because Resident #60 was hard of hearing. OT indicated she had been working with Resident #60, but he had discharged from therapy recently. OT indicated she had not been notified about the current events on the morning of 8/19/15.</p>		<p>months.</p> <p>Compliance date: September 23, 2015</p>				

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	<p>During an interview on 8/24/15 at 10:17 A.M., the SSD (Social Service Director) indicated Resident #60 had not experience any behaviors. The SSD was made aware that Resident #25 and Resident #74 indicated Resident #60 had bothered them every day since they had moved into their room and that when Resident #60 would become angry, he came to the door and gave them "the finger" and made mean faces at them. Resident #25 indicated she was afraid of Resident #60.</p> <p>The SSD indicated, at that time, she was unaware of the incidents and had no idea of the frequency with which these behaviors had occurred. The SSD said, "I run a report every morning to see what has happen and if it is not documented by the nurses then I don't know about it."</p> <p>The SSD further indicated, Resident #60's behaviors needed to be documented, a behavior care plan with interventions needed to be initiated, and a psychological evaluation needed to be completed.</p> <p>The policy and procedure "Behavior Management Policy" was provided by the Nurse Consultant on 8/20/15 at 4:20 P.M., and it read as follows: "...It is the policy...to provide behavior interventions for residents with problematic or distressing behavior...Care plans should</p>			

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F 0282 SS=D Bldg. 00	<p>be initiated for any behavioral issue that affects, or has the potential to affect the resident or other residents...When a behavior occurs, the staff communicates to the nurse what behavior occurred. the nurse records it on the monitoring form..."</p> <p>The position description for "Social Service Director" was provided by the Administrator on 8/24/15 at 3:53 P.M., and read as follows: "...Assess each resident's psychosocial needs and developed a plan of care...Collaborates with other departments, physicians, consultants...to improve quality of services and to resolve problems."</p> <p>3.1-34(a)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an ankle brace and Ted (compression hose) hose were applied daily according to the physician's order for 1 of 6</p>	F 0282	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	09/23/2015	

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	<p>residents who met the criteria for review of accidents. (Resident #81)</p> <p>Findings include:</p> <p>During an observation on 8/20/15 at 10:18 A.M., CNA #5 removed Resident #81's blankets and uncovered his/her feet. Resident #81 did not have Ted hose or an ankle brace on his/ her left foot. At that time, CNA #5 indicated she was unsure if Resident #81 needed an ankle brace or not. CNA #5 indicated she had not worked the 400 hall very often.</p> <p>The clinical record of Resident #81 was reviewed on 8/19/15 at 3:21 P.M. The record indicated Resident #81 was admitted on 1/14/15 and had experienced a fall on 7/27/15 at 12:10 P.M., which resulted in an avulsion fracture to the left ankle. The diagnoses of Resident #81 included, but were not limited to, schizophrenia with delusional disorder.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 6/13/15, indicated Resident #81 experienced mild cognitive impairment, no behaviors, no rejection of care, required the extensive assist of two staff for transfers.</p> <p>A physician's order dated 8/11/15 read as follows: "Ted hose to LLE [lower left</p>		<p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F282</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·Residents 81 affected by the alleged deficient practice have been identified by the interdisciplinary team have been provided ankle brace and ted hose per physician order.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will review physician orders daily and ensure nursing staff is aware of any changes</p>	

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	<p>extremities] (knee high) x [times] 4 weeks during the day aso [sic] ankle brace to L [left] ankle x 4 weeks during the day."</p> <p>A "Resident Progress Note" dated 8/18/15 at 12:15 P.M., read as follows: "resident c/o [complains of] pain this evening ...ted [sic] hose not on this evening went [sic] I performed TX [treatment] and neither was the brace to L [left] ankle..."</p> <p>During an interview on 8/20/15 at 10:25 A.M., LPN #10 indicated Resident #81 was supposed to wear Ted hose and an ankle brace to stabilize his/her foot. LPN #10 indicated the Ted hose and the ankle brace should be applied in the morning and removed at night. At that time, LPN #10 was made aware Resident #10 was not wearing the Ted hose and the ankle brace. LPN #10 indicated the night shift was supposed to ensure Resident #10 had them on in the morning.</p> <p>The Policy and Procedure for Physicians Orders was requested on 8/24/15 at 3:30 P.M. but was not provided.</p> <p>3.1-35 (g)(2)</p>		<p>and that physician orders are being followed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Education on following physician orders has been provided to all staff by ED/DNS/Designee by September 15, 2015.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/ Designee will daily utilize Physician order CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p>				

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F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 received the required assistance with oral care for 1 of 1 resident who met the criteria for review of oral care. (Resident #77)</p> <p>Findings include:</p> <p>On 8/18/15 at 12:10 P.M., Resident #77 was observed to have a strong pervasive mouth odor and a large amount of debris on the lower front teeth.</p> <p>On 8/19/15 at 3:00 P.M., Resident #77 was observed to have a strong pervasive mouth odor and a large amount of debris on the lower front teeth.</p> <p>On 8/20/15 at 9:38 A.M., Resident #77 was observed to have a strong pervasive mouth odor and a large amount of debris on the lower front teeth.</p>			F 0312	<p>Compliance date: September 23, 2015</p> <p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F312</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident 77 affected by the alleged deficient practice have been</p>		09/23/2015

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	<p>The clinical record of Resident #77 was reviewed on 8/20/15 at 9:51 A.M. The record indicated the diagnoses of Resident #77 included, but were not limited to, dementia.</p> <p>The most recent annual MDS (Minimum Data Set) assessment indicated Resident #77 experienced severe cognitive impairment, had no history of rejecting care, and required the extensive assist of one staff for oral care.</p> <p>A Plan of Care dated 8/17/15 for "ADL (Activities of Daily Living) Functional ...Self Care Deficit..." included, but was not limited to, an intervention of "...provide oral care at least two times daily..."</p> <p>A Plan of Care dated 8/17/15 for "ADL Functional...Requires assistance...for ADL care..." included, but was not limited to, an intervention of, "...AM (morning) cares (sic) including....oral care...PM (evening) cares (sic) including...oral care..."</p> <p>The CNA ADL Point of Care report dated 8/20/15 indicated Resident #77 received oral care on 8/18/15 at 10:30 A.M. and 6:53 P.M. and 8/19/15 at 2:18 P.M. and 6:54 P.M. The report further</p>		<p>identified by the interdisciplinary team and has been provided oral care and hot charting opened to monitor oral care.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will review daily ADL documentation regarding oral care.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Education on oral care has been provided to all staff by ED/DNS/ Designee by September 15, 2015. ·DNS/ nurse manager/designee will conduct daily audits on ADL entries to ensure oral care is provided.</p> <p>How the corrective action(s) will be monitored to ensure the</p>	

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F 0323 SS=G Bldg. 00	<p>indicated no oral care had been provided as of 8/20/15 at 10:15 P.M.</p> <p>During an interview on 8/20/15 at 10:00 A.M. CNA #5 indicated she had not provided oral care to Resident #77 and further indicated, at that time, oral care should have been provided by night shift staff.</p> <p>During an interview on 8/20/15 at 10:08 A.M., UM (Unit manager) #5 indicated Resident #77 had strong pervasive mouth odor, a large amount of debris on the lower teeth, and needed to be provided oral care.</p> <p>During an interview on 8/20/15 at 4:20 P.M., the Nurse Consultant indicated no specific policy for oral care could be provided, but presented a "...Skills Validation-CNA...Procedure Steps" The Skills Validation indicated, "...7. Assist resident with oral hygiene..."</p> <p>3/1-38(a)(3)(c)</p> <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</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/ Designee will daily utilize oral care CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: September 23, 2015</p>		

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	<p>receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and effective interventions to prevent accidents and injuries were provided for 5 of 6 residents reviewed for accidents. This deficient practice resulted in Resident #107 experiencing a subarachnoid hemorrhage and requiring hospitalization. (Resident #53, Resident #81, Resident #100, Resident #107, Resident #105,)</p> <p>Findings include:</p> <p>1. During an interview on 8/19/15 at 3:42 P.M., LPN #30 indicated Resident #107 had fallen twice on 8/12/15, at 5:50 A.M., and again at 8:30 A.M. LPN #30 indicated Resident #107 had received a laceration above the left eye and had been sent to the hospital on 8/14/15. Resident #107 had a diagnosis of subarachnoid hemorrhage and was in the ICU [Intensive Care Unit].</p> <p>During an observation on 8/19/15 at 12:15 P.M., Resident #107 was sitting in a dining room chair at the table. Resident #107 was eating lunch and was observed to have a large amount of bruising on the left side of her face.</p>	F 0323	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F-323</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> -Resident 107 and resident 81 have been identified by IDT has addressed falls and provided a fall IDT review and updated care plans. · Resident 53 has been discharged · Resident 100 has been discharged · Resident 105 has been discharged 	09/23/2015			

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	<p>The clinical record of Resident #107 was reviewed on 8/19/15 at 3:21 P.M. The record indicated Resident #107 was admitted on 8/5/15. The diagnoses of Resident #107 included, but were not limited to, dementia with behaviors, chronic pain, Alzheimer's disease, obsessive compulsive disorder.</p> <p>A Care Plan "Resident is at risk for fall..." was initiated on 8/5/15 and it read as follows: "...clean et [and] clutter free pathways with adequate lighting...call light within reach...personal items in reach..."</p> <p>A resident profile used to guide staff with care for Resident #107 was provided on 8/18/15 at 3:52 P.M. by the Director of Nursing. "The Profile Care Plan Approaches" read as follows: "...8/12/15 1 assist with transfers...Pad alarm to all surfaces...Resident to sit in eye view of nurses station at meals..."</p> <p>Fall #1</p> <p>A "Safety Events -- ...Fall Event" report indicated Resident #107 experienced an unwitnessed fall on 8/12/15 at 5:50 A.M. Resident #107 was found face down on the floor in her room. Resident #107's blood pressure was documented at the</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · Entire facility audit conducted by the DNS/designee on September 23, 2015 on all falls for the past 30 days to ensure the Fall Management Program was followed and an intervention to prevent further accidents/injuries was in place. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · In-service on Fall Management and staffing completed for all staff on or before 9/23/15 by ED/DNS/Designee · DNS/Designee will conduct rounds every shift to ensure fall interventions are in place per the plan of care. · DNS/Nurse Manager/Designee will daily identify noted falls and will investigate fall and root cause, develop an IDT 	

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	<p>time of the fall as 74/55.</p> <p>An IDT (interdisciplinary team) note dated 8/12/15 at 10:12 A.M. read as follows: "...review of unwitnessed fall that occurred on 8/12/15 at 5:50 am [sic]... ..Alarm was sounding and Res [Resident] was found face down on floor near doorway of room...Res did hit her head...Res on an anticoagulant [blood thinner]...Laceration noted to left eyebrow and skin tear to right hand...Roommate bedside table near doorway...MD [physician] decreased Cardizem [medication used to lower blood pressure]...root cause of fall loss of balance. New intervention: Bedside table moved away from door...Res noted to have low b/p [blood pressure] upon assessment after fall..."</p> <p>Fall #2</p> <p>A "Safety Events ...Fall Event" report indicated Resident #107 experienced an unwitnessed fall on 8/12/15 at 8:30 A.M. Resident #107 was found in the dining room, lying on the floor, on her right side.</p> <p>An IDT [interdisciplinary team] note dated 8/13/15 at 10:12 A.M. read as follows: "...review of unwitnessed fall that occurred on 8/12/15 at 8:30 am -</p>		<p>review note of fall, providing proper documentation noting what interventions were put in place to prevent further accidents/ injuries and update the plan of care</p> <p>How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> To ensure compliance the DNS/Designee will daily utilize staffing and fall management CQI tool weekly times 2 weeks, then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. <p>Compliance date: September 23, 2015</p>		

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	<p>resident was sitting in dining room chair at dining room table prior to fall - had finished eating breakfast --resident stated she was trying to stand and feet got tangled and fell - resident was found lying on her left side...Resident did hit her head...laceration to right ear noted...Resident is on an anti-coagulant...Root cause of fall - resident states feet tangled - however resident was observed trying to lean over and spit in trash can once sitting back in chair after fall - IDT feels resident possibly was trying to spit when fall occurred - and recent low blood pressure contributing to causing loss f [sic] balance..."</p> <p>A Progress Note dated 8/12/15 at 5:01 P.M. read as follows: "MDS completed for the 5 day, BIMS [Brief Interview for Mental Status] score of 3 [indicating severe impaired cognition]."</p> <p>A Care Plan "Resident is at risk for fall..." was initiated on 8/5/15 and revised on 8/12/15 and it read as follows: "1 assist with transfers...pad alarm to all surfaces...resident to sit in eye view of nurses station at meals...clean et [and] clutter free pathways with adequate lighting"</p> <p>A "Discharge/Appointment/Transfer"</p>			

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	<p>report dated 8/14/15 3:45 P.M. indicated Resident #107 was transferred to the emergency room by ambulance due to a change in cognition.</p> <p>A "...Hospital Transfer Report" dated 8/14/15 read as follows: "...Patient fell two days ago and hit head...patient has been having pain to her posterior head." Resident #107 was admitted to the ICU with traumatic injury from a fall. The admitting diagnosis was intracranial hemorrhage.</p> <p>2. On 8/19/15 at 9:31 A.M., Resident #81 was observed in bed and his/her call light was hanging over the drawer pull on the night stand. Resident #81 was leaning over the side of the bed, stretching towards the call light, but was unable to reach it. At that time, NA #2 (Nursing Assistant) was observed in the doorway and was made aware Resident #81 could not reach his/her call light. NA #2 said, "We are not supposed to let him/her have it. It is not to be clipped to her because she is schizophrenic and she just twists it around."</p> <p>During an interview on 8/19/15 at 10:30 A.M., LPN #32 indicated that on 7/27/15, Resident #81 had elevated his/her bed to the high position and then fell from the bed while trying to get up, which resulted</p>			

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	<p>in an avulsion fracture to her left foot. LPN #32 further indicated staff was to keep the bed in low position and tape the remote under the bed so Resident #81 would not be able to elevate the bed again.</p> <p>On 8/19/15 at 1:37 P.M., Resident #81 was observed lying in bed with the bed elevated. The bed remote and the call light were lying on the floor next to the bed and the bedside table was pushed to the right side of the bed. At that time, CNA #10 was walking down 400 hall and was made aware Resident #81's bed was elevated. Upon entering the room, CNA #10 indicated dietary should have lowered her bed to the lowest position after her lunch tray was taken away.</p> <p>A resident profile used to guide staff with care for Resident #81 was provided on 8/18/15 at 3:52 P.M. by the Director of Nursing. "The Profile Care Plan Approaches" read as follows: "...3/16/15 Bed in lowest position..." Resident #81's profile lacked documentation the call light should be within reach.</p> <p>The clinical record of Resident #81 was reviewed on 8/19/15 at 3:21 P.M. The record indicated Resident #81 was admitted on 1/14/15 and had experienced 6 falls on the following dates: 2/1/15 at</p>			

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	<p>9:27 A.M., 3/13/15 at 10:44 A.M., 4/18/15 at 11:45 A.M., 4/24/15 at 8:30 P.M., 7/27/15 at 12:10 P.M., 8/18/15 at 2:05 A.M., one of which resulted in an avulsion fracture to the left ankle. The diagnoses of Resident #81 included, but were not limited to, schizophrenia with delusional disorder.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 6/13/15, indicated Resident #81 experienced mild cognitive impairment, no behaviors, no rejection of care, required the extensive assist of two staff for transfers.</p> <p>A Care Plan for "Resident is at risk for fall..." was initiated on 1/14/15 and read as follows: "03/16/2015...Bed in lowest position...01/14/2015...Call light in reach...07/27/2015...Remote out of reach of resident...Mats to floor on bilateral sides of bed..."</p> <p>An "Admission Assessment" dated 1/14/15 indicated Resident #81 was at a high risk to fall due to his/her previous history of falls and needed the extensive assistance of 2 staff and a Hoyer Lift for transfers.</p> <p>A Progress Note dated 7/27/15 at 12:06 P.M. read as follows: "Resident was found on floor in room. Resident raised</p>			

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	<p>bed to elevated position and was trying to get up when resident fell...Resident then complained of pain to left hip...Resident sent to ER [emergency room] for Eval [evaluation] and treatment."</p> <p>A Progress Note dated 7/28/15 at 10:00 A.M. read as follows: "IDT review of unwitnessed fall that occurred on 7/27/15 at 12:10 [pm.... ER reported that res [resident] had an avulsion FX [fracture] to left ankle/foot. Res is non-weight bearing to LLE [lower left extremity]..."</p> <p>Fall #1</p> <p>A "Safety Events ...Fall Event" report indicated Resident #81 experienced an unwitnessed fall on 7/27/15 at 12:10 P.M. Resident #81 had raised the bed to the elevated position and was trying to get up when the fall occurred. Resident #81 indicated post fall pain in left hip and was sent to the Emergency Room for evaluation. The emergency room reported indicated Resident #81 had experienced an avulsion fracture to left ankle/foot.</p> <p>Fall #2</p> <p>A "Safety Events -- ASC Fall Event" report indicated Resident #81 experienced an unwitnessed fall on</p>			

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	<p>8/18/15 at 2:05 A.M. Resident #81 was heard yelling, "help me", and was found on the mat on the floor next to the bed. Resident #81 indicated he/she was trying to remove his/her depends and rolled out of bed.</p> <p>The policy and procedure "Fall Management Program" was provided by the Corporate Nurse on 8/20/15 at 1:30 P.M., and it read as follows: "...4. Resident specific care requirements will be communicated to the assigned caregivers utilizing resident profile or CNA assignment sheet."</p> <p>During an interview on 7/24/15 at 4:00 P.M., the Nurse Consultant was made aware of the observations on 8/19/15 concerning the call light, which was not within reach, and that the bed was left elevated without staff in the room, and indicated it was a concern.</p> <p>3. During an observation on 8/20/15 at 10:20 A.M., Resident #105 was observed sitting in a wheelchair trying to enter another resident's room.</p> <p>The clinical record of Resident #105 was reviewed on 8/21/15 at 2:45 P.M. The record indicated Resident #105 was admitted on 6/26/15 and the diagnoses of Resident #107 included, but were not</p>				

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	<p>limited to, Alzheimer's disease, hypertension.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 7/3/15 indicated Resident #105 experienced severe cognitive impairment, required the extensive assist of two staff for transfers, and was frequently incontinent.</p> <p>A Care Plan for "Resident is at risk for fall..." was initiated on 6/26/15 and it read as follows: "call light within reach...up ad lib [up at liberty]...personal items in reach..." The care plan for falls was updated on 7/8/15 and it read as follows: "...1 assist with transfers..." The care plan for falls was updated on 7/23/15 and it read as follows: "...resident not to sit in rocking chair...2 assist with transfers..."</p> <p>A PT (Physical Therapy)- Therapy progress note dated 7/3/15 for Resident #105 was provided by PTA #3 and the progress note indicated the following: "...The patient is able to safely turn corners and change directions unsupported with CG [contact guard assist] to stand by assist (close enough to reach patient if assist needed).</p> <p>Fall #1</p>			

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	<p>A "Safety Events... Fall Event" report indicated Resident #105 experienced an unwitnessed fall on 7/7/15 at 8:56 P.M. Resident #105 was found lying flat on his/her back. Resident #105 had a laceration to the back of his/her head.</p> <p>An IDT (interdisciplinary team) note dated 7/7/15 at 8:56 P.M. read as follows: "...review of unwitnessed fall that occurred on 8/12/15 at 5:56 PM. Res was sitting in chair in TV lounge prior to fall... Res was found lying on back on floor. Nurse noted cut to back of head upon assessment...res c/o pain to head...Resident stated she stumbled and fell...Resident was sent out to ER...Resident returned from ER with...3 staples to the back of head."</p> <p>Fall #2</p> <p>A "Safety Events...Fall Event" report indicated Resident #105 experienced a witnessed fall on 7/23/15 at 5:08 P.M. Resident #105 was to be transferred from a rocking chair in the lounge area to the dining room. While attempting to stand up from the rocker with the assistance of 1 staff person, Resident #105 lost his/her footing and fell to the floor on her left side.</p> <p>An IDT note dated 7/24/15 at 2:33 P.M.</p>			

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	<p>read as follows: "...review of witnessed fall that occurred on 7/23/15 at 5:08 PM. Res was being assisted with 1 assist and gait belt to transfer from rocking lounge chair and lost footing while attempting to stand up. Res was lying on left side...Elbow noted to be slightly red..."</p> <p>Fall #3</p> <p>A "Safety Events ...Fall Event" report indicated Resident #105 experienced an unwitnessed fall on 8/9/15 at 1:52 P.M. Resident #105 was in the TV room and got up from her wheelchair and fell on her right side. Resident was incontinent at the time of the fall. Interventions put into place: toilet every 2 hours.</p> <p>An IDT (interdisciplinary team) note dated 8/10/15 at 9:54 P.M. read as follows: "...review of unwitnessed fall that occurred on 8/9/15 at 1:58 PM. Res was sitting in w/c in tv room prior to fall. Res was found laying on her right side...Res was incontinent at time of fall...immediate intervention: Toilet every 2 hours..."</p> <p>During an interview on 8/24/15 at 12:40 P.M., PTA #3 [Physical Therapy Assistant] indicated Resident #105 was evaluated by physical therapy on 6/29/15 and at that time Resident #105 needed</p>			

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	<p>cues for safety and contact guard assist when walking. Resident #105 needed standby assistance of 1 staff when standing up from a sitting position. Resident #105 needed to have someone with him/her when going to bed or bathroom.</p> <p>4. During a random observation on 8/18/15 at 12:45 P.M., Resident #100 was observed to have a large bruise to the left side of his face.</p> <p>The clinical record for Resident #100 was reviewed on 8/20/15 at 9:35 A.M., diagnoses include, but are not limited to, chronic kidney disease stage 3, and dementia. The clinical record indicated Resident #100 was admitted as a 2 assist for transfers, on 7/16/15.</p> <p>An MDS assessment dated 7/23/15 indicated Resident #100 BIMS (Brief Interview for Mental Status) score was 3 indicating he was significantly cognitively impaired, and required extensive assistance of 2 for transfers, bed mobility and extensive assistance of 1 for ambulation.</p> <p>The care plans were reviewed and included, but were not limited to, at risk or wandering initiated 7/27/15 interventions included, but not limited to toilet every 2 hours and PM, encourage</p>			

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	<p>resident to engage in activities of choice, offer food and during, pull tab alarm. toileting program (8/1/15), pad alarm to all sitting surfaces (8/4/15)</p> <p>A care plan for falls was initiated 7/16/15, the interventions included, but were not limited to, therapy screen, personal items in reach, pad alarm to bed, non skid footwear, clutter free pathways, call light in reach and 2 assist for transfers, initiated 7/16/16.</p> <p>Fall #1 A fall event report dated 8/4/15 at 3:16 P.M., indicated Resident #100 was found laying face down on floor in the T.V. room of the Cottage (secured dementia care unit).</p> <p>A nurse ' s note dated 8/4/15 at 3:21 P.M., included "nurse heard resident yelling out and noted resident had fallen out of w/c [wheel chair] onto the floor. resident had a cut to this forehead and skin tear to right elbow. Resident noted to be very lethargic et [and] pupils very pin point."</p> <p>The immediate intervention following return from the hospital was to replace the personal (pull tab) alarm with a pressure pad alarm.</p>			

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	<p>Fall #2 A fall event report dated 8/8/15 at 9:40 A.M., indicated Resident #100 had been sitting in a recliner in the Cottage T.V room and was found lying on his left side. Resident #100 was observed to have a hematoma to his left forehead. The document continued to include "Resident or witness statement of how fall occurred... .. Resident was restless and moving around and caused recliner to tip forward causing resident to slide to the floor."The immediate intervention was to remove Resident #100 from the recliner.</p> <p>Fall #3 A fall event report dated 8/15/15 at 2:20 P.M., indicated Resident #100 was witnessed ambulating in the 300/400 T.V. room, prior to staff being able to reach Resident #100 he sat on the footboard of another resident's chair and fell to the floor in a seated position. The document continued to include "Describe resident appearance at time of fall... ..clip alarm not attached to shirt..." The immediate intervention was to remove the personal (pull tab) alarm and put a pressure pad alarm.</p> <p>During an interview with the Nurse Consultant on 8/21/15 at 10:02 A.M., she indicated:</p>			

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	<p>Resident #100's admission transfer orders were to be up with 1 assistance and a walker, a pressure alarm to bed and non skid footwear.</p> <p>Fall #1 had occurred on 8/4/15 at 3:16 P.M., in the Cottage T.V room, she indicated the fall was unwitnessed and Resident #100 had suffered a laceration that required sutures to his forehead and skin tears. She indicted the intervention added was to take off the pull tab alarm and place a pressure pad alarm to alert staff when attempting to rise.</p> <p>Fall #2 had occurred on 8/8/15 at 9:40 A.M., she indicated Resident #100 had tipped the recliner he was sitting in over and received a hematoma to the left forehead. She indicated the interventions were to remove Resident #100 from the recliner and to not elevate Resident #100's feet when in a recliner.</p> <p>Fall #3 had occurred on 8/15/15 at 2:20 P.M., she indicated Resident #100's personal alarm had come unattached from his shirt and he was seen ambulating in the 300 hall T.V. room. She indicated staff attempted to get to resident but he sat on another residents foot rests and fell off onto the floor with no injuries. The intervention put into place was to remove the personal alarm and place Resident #100 on a pressure</p>			

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	<p>alarm pad.</p> <p>5. During a random observation on 8/19/15 at 10:56 A.M., Resident #53 was observed to be sitting on the side of the bed. The alarm was heard to be sounding briefly. The resident was observed attempting to remove the pad alarm from under his body and the alarm went on and off for approximately 2 minutes. Staff were observed to be standing at the nurses' station not responding to the alarm until notified by the surveyor.</p> <p>On 8/19/15 at 9:59 A.M., Resident #53's clinical record was reviewed. Resident #53 had been admitted to the facility on 7/16/15. His diagnoses included, but were not limited to, lung cancer, congestive heart failure, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>His admission physician orders of 7/16/15 included the order for hospice.</p> <p>His admission Minimum Data Set assessment dated 7/2/15, indicated, a cognitive summary score of 9 (moderate cognitive impairment), and extensive assistance of 2 or more staff for bed mobility and transfers.</p> <p>The assessment indicated extensive assistance of 1 staff was needed for walking in the room and the corridor.</p>			

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	<p>A care plan dated 7/16/15, addressed the problem of at risk for falls. Interventions included, but were not limited to, call light and personal items in reach, gripper socks while in bed, and clutter free pathways. An admission assessment dated 7/16/15, indicated no falls in the past 6 months.</p> <p>The following falls were reviewed with the Nurse Consultant on 8/21/15 at 10:45 A.M.:</p> <p>Fall Event documentation on 7/17/15 at 12:00 A.M., indicated a witnessed fall had occurred. "...Res. [resident] stated was 'getting up to plug in phone.'..." The position of the resident after the fall was "...lying on L. [left] side on floor between bed et wall..." The documentation indicated Resident #53 had been wearing "... t-shirt only. Bare feet..." The location of the fall was "in between bed et [and] w[with]/window, parallel w/bed, head toward ft [foot] of bed..." "...S/T [skin tear] to LFA [left forearm] near elbow, 4.0 x 2.0 cm [centimeter], lg. [large] amt. [amount] of bleeding, cleansed et [and] applied 3 steri-strips, covered w [with] / telfa et secured w/ kerlix. Bruise surrounding S/T covering L [left] elbow et LFA, 16.5 x 5.0 cm dk [dark] purple. Dk purple bruise to above</p>			

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	<p>webbing of L thumb/index finger, 1.0 x 1.5 cm. Dk purple bruise to L outer wrist 3.0 x 1.5 cm. Pinkish purple bruise to R [right] of coccyx, 3.0 x 0.9 cm. Bottom of L gr. [great] toe T shaped dk brown area..."</p> <p>A progress note dated 7/17/15 at 3:41 A.M., indicated, "Resting quietly in bed at this time. Ext.[extensive] assist w [with]/ ADL's [activities of daily living]. Transfer post -fall w/3 assist. PRN [when needed] Ativan [antianxiety medication] et [and] Roxanol [pain medication] req [requested] et given for anxiety et back pain prior to fall, unrelieved by repositioning, fluids et distraction. Both PRN Ativan et Roxanol eff. [effective]. No new pain noted from fall. S/T [skin tear] to LFA [left forearm] near elbow, numerous bruises to LUE [left upper extremity] et sm. [small] one to L [left] of coccyx. ROM [range of motion] WNL [within normal limits]. Fall witnessed by this nurse. Education provided to call for assist, pressure alarm placed, res. [resident] voiced understanding. Will cont. [continue to observe]."</p> <p>A IDT [Interdisciplinary Team] review of witnessed fall that occurred on 7/17/15 at 12 A.M., indicated, " Resident was in bed prior to fall..." "... Res [resident] was</p>			

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	<p>incontinent at time of fall... .. Nurse states she was walking by room and witnessed fall but was unable to reach res in time to prevent fall. No environmental factors noted. Immediate intervention was pad alarm on bed and education to use call light for assistance. IDT feels root cause of fall is resident's increased weakness and new environment. New intervention of gripper socks donned per staff at night as well as room modification to ensure cell phone charger within resident's reach..."</p> <p>A progress note dated 8/5/15 at 6:37 A.M., indicated a 2nd fall had occurred. The documentation indicated, " Resident was on 100 hall by marketing room waiting for 'nurse' to get there. Resident stood up out of wheelchair. When resident was asked to sit back down resident's wheelchair moved away from him due to wheels not being locked. Full assessment done. No complaints of pain or discomfort voiced at this time..."</p> <p>On 8/21/15 at 10:45 A.M., during interview with the Nurse Consultant, she indicated Resident #53 had resided in same room on the 400 hall since admission to the facility on 7/16/15. The Nurse Consultant indicated Resident #53 after first admitted utilized a w/c. The Nurse Consultant was made aware at the</p>				

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	<p>time of the 8/5/15 fall Resident #53 was on another unit of the facility at 6:37 A.M., and concern of adequate supervision being provided to prevent falls. The fall documentation (8/5/15) was reviewed with the Nurse Consultant at that time. The Nurse Consultant was made aware that documentation was lacking of an intervention being initiated after the 8/5/15 fall. Documentation was also lacking also lacking that an IDT (interdisciplinary team) review of the 8/5/15 fall. Nurse Consultant agreed documentation was lacking of an intervention initiated after the 8/5/15 fall and of an Interdisciplinary team review note of the fall.</p> <p>A 3rd fall (witnessed fall) occurred on 8/19/15 at 5:05 A.M. The Event documentation indicated the resident "...stood up from bed et [and] sat down on floor..." At time of fall, "...T-shirt brief et gripper socks worn. Resident had taken O 2 [oxygen] off..."</p> <p>A progress note dated 8/19/15 at 6:40 A.M., indicated, "This nurse was entering resident's room to answer call light, noted resident standing up from bed ET [and] sat on floor. Alert, oriented to self only, confused speech nonsensical. AROM [active range of motion] to all extremities. Resident had taken O2</p>			

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	<p>[oxygen] cannula off, assisted to put O2 back on. No c/o [complaints] discomfort. Resident was not incontinent. Was wearing gripper socks. Assisted to stand by 2 staff with the use of gait belt et [and] transferred back to bed without difficulty. Was cooperative with care. Noted skin tear 1 cm length R [right] medial wrist, skin tear R posterior upper arm 3 cm length et scattered small abrasions L [left] posterior upper arm, sure site applied to areas after cleansed. Skin edges well approximated. Dr [physician's name] notified of fall et injuries. Bed pad alarm placed under resident's shoulders."</p> <p>An IDT (Interdisciplinary team) note dated 8/19/15 at 5:19 P.M., indicated, "... Root cause-IDT feels resident was possibly getting up due to confusion, restlessness and anxiety from removing O2 [oxygen] -replaced-resident is non compliant with keeping O2 on- resident offered mask and declined, resident also with decline in medical condition due to lung cancer dx [diagnosis]-Resident assessed for injury and placed back in bed-ensuring pad alarm under shoulders. New intervention- will offer resident to get up in broda chair when restless..."</p> <p>During interview with the Nurse Consultant on 8/21/15 at 10:45 A.M., the Nurse Consultant was made aware</p>			

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	<p>documentation was lacking of the alarm sounding before the 8/19/15 witnessed fall and that the bed pad alarm had to be repositioned. The care plan intervention to put the pad alarm under the resident's shoulders had been initiated on 7/17/15 before the 8/19/15 fall. The intervention of a Broda chair and foot rest had also been initiated on the care plan on 8/17/15 before the 8/19/15 fall.</p> <p>A Fall Event documented a witnessed fall on 8/21/15 at 5:57 P.M. Documentation indicated Resident #53 had been in bed and then observed sitting on buttocks on mat beside bed. Documentation indicated Resident #53 was wearing pants, shirt and socks.</p> <p>A progress note dated 8/21/15 at 6:09 P.M., indicated, " res [resident] slid out of bed onto floor on mat. This nurse couldn't reach res in time. No injuries noted from fall. Res denies pain and discomfort. Res incont [incontinent] at the time..."</p> <p>A late entry note on 8/24/15 at 8:31 A.M., indicated, "Resident found on floor by nursing staff. No injury noted by this nurse upon placing resident back into bed. New intervention applied, wedge support to support resident while in bed."</p>			

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	<p>Another Fall Event documented a unwitnessed fall on 8/22/15 at 6:05 A.M. The documentation indicated, prior to the fall the resident had been awakened to take medications. The resident was found beside air bed "...sitting with BLE [bilateral lower extremities] bent to left side under him. Hands/arms holding his upper torso up with bedrail..."</p> <p>On 8/24/15 at 12:52 P.M., Nurse Consultant was interviewed regarding the falls of 8/21/15 and 8/22/15. The Nurse Consultant was made aware of documentation lacking of the pad alarm sounding regarding the 8/21/15 and 8/22/15 falls. The RN Consultant indicated at that time, a wedge cushion had been initiated after the 8/21/15 fall. The Nurse Consultant indicated after the 8/22/15 fall a mattress was placed beside the bed and Resident #53's bed was positioned against the wall. The Nurse Consultant indicated Hospice staff had come to the facility for medication evaluation regarding the medication, Ativan after the 8/22/15 fall. The Nurse Consultant indicated hospice staff was going to sit with the resident 1:1 after the 8/22/15 fall. The Nurse Consultant was made aware at that time of the problem of a lack of adequate supervision being provided to prevent falls for Resident #53.</p>			

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F 0353 SS=E Bldg. 00	<p>The facility policy entitled, "Fall Management Program (last revision 2/2015) was received and reviewed on 8/20/15. The policy included but was not limited to, "...Post fall 4. A fall event will be initiated as soon as the resident has been assessed and cared for. The report must be completed in full in order to identify possible root causes of the fall and provide immediate interventions. 5. All falls will be discussed by the interdisciplinary team at the 1st IDT [Interdisciplinary] meeting after the fall to determine root cause and other possible interventions to prevent future falls. The fall event will be reviewed by the team. IDT note will be written..."</p> <p>3.1-45(a)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to</p>			

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	<p>provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff was available to prevent falls for 5 of 5 residents on 2 of 4 units who met the criteria for review of falls, and provide care and assistance for 4 of 15 residents interviewed, and 1 of 3 families interviewed who indicated staff was frequently insufficient, and 4 of 6 resident council minutes reviewed which indicated staff was lacking. (Resident #105, Resident #53, Resident #105, Resident #81, Resident #100, 400 unit, Cottage unit)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #105 was reviewed on 8/21/15 at 2:45 P.M. The record indicated Resident #105 was admitted on 6/26/15 and the diagnoses of Resident #107 included, but were not limited to, Alzheimer's disease, hypertension.</p>	F 0353	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F353</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents affected by the alleged deficient practice have been identified by the interdisciplinary</p>	09/23/2015

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	<p>Resident #105 experienced the following falls:</p> <p>Fall #1, An unwitnessed fall in the TV lounge of the Cottage unit on 7/7/15 at 8:56 P.M.</p> <p>Fall #2 A fall during an assisted transfer on 7/23/15 at 5:08 P.M.</p> <p>Fall #3 An unwitnessed fall in the 400 unit T.V. lounge on 8/9/15 at 1:52 P.M.</p> <p>2. On 8/19/15 at 9:59 A.M., Resident #53's clinical record was reviewed. Resident #53 had been admitted to the facility on 7/16/15. His diagnoses included, but were not limited to, lung cancer, congestive heart failure, chronic obstructive pulmonary disease, and muscle weakness.</p> <p>Resident #53 experienced the following falls:</p> <p>Fall #1 A witnessed fall in his/her room on the 400 unit on 7/17/15 at 12:00 A.M.</p> <p>Fall #2 A witnessed fall on the 100 hall (Resident # 53 resided on the 400).</p> <p>Fall #3 A witnessed fall in his/her room on the 400 unit on 8/19/15 at 5:05 A.M.</p> <p>Fall #4 An unwitnessed fall in his/her room on the 400 unit on 8/21/15 at 5:57 P.M.</p> <p>Fall #5 A witnessed fall in his/her room on the 400 unit on 8/22/15 at 6:05 A.M.</p> <p>3. The clinical record for Resident #100 was reviewed on 8/20/15 at 9:35 A.M.,</p>		<p>team and has addressed falls and provided a fall IDT review.</p> <p>·Resident 105 and 53 have been discharged.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will review staffing daily and monitor breaks to ensure floor coverage.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Education on staffing and fall management has been provided to all staff by ED/DNS/Designee by September 23, 2015.</p> <p>·DNS/nurse manager/designee will daily identify noted falls and will investigate fall and root cause of fall and develop an IDT review note of fall and provide proper documentation noting interventions, plan of care, and future preventions.</p>				

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	<p>diagnoses include, but are not limited to, chronic kidney disease stage 3, and dementia. The clinical record indicated Resident #100 was admitted as a 2 assist for transfers, on 7/16/15.</p> <p>Resident #100 experienced the following falls:</p> <p>Fall #1 An unwitnessed fall in the TV lounge on the Cottage unit on 8/4/15 at 3:16 P.M.</p> <p>Fall #2 A witnessed fall in the TV lounge on the Cottage unit on 8/8/15 at 9:40 A.M.</p> <p>Fall #3 A witnessed fall in the 400 unit T.V. lounge on 8/15/15 at 2:20 P.M.</p> <p>4. The clinical record of Resident #81 was reviewed on 8/19/15 at 3:21 P.M. The record indicated Resident #81 was admitted on 1/14/15 and had experienced 6 falls on the following dates: 2/1/15 at 9:27 A.M., 3/13/15 at 10:44 A.M., 4/18/15 at 11:45 A.M., 4/24/15 at 8:30 P.M., 7/27/15 at 12:10 P.M., 8/18/15 at 2:05 A.M., one of which resulted in an avulsion fracture to the left ankle. The diagnoses of Resident #81 included, but were not limited to, schizophrenia with delusional disorder.</p> <p>Resident #81 experienced an unwitnessed fall in the 400 unit hallway on 7/27/15 at 12:10 P.M., and an unwitnessed fall in his/her room on the 400 unit on 8/18/15 at 2:05 A.M.</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/ Designee will daily utilize staffing and fall management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: September 23, 2015</p>	

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	<p>5. The clinical record of Resident #107 was reviewed on 8/19/15 at 3:21 P.M. The record indicated Resident #107 was admitted on 8/5/15. The diagnoses of Resident #107 included, but were not limited to, dementia with behaviors, chronic pain, Alzheimer's disease, obsessive compulsive disorder. Resident #107 experienced 2 unwitnessed falls on 8/12/15 while residing on the Cottage unit. The first fall occurred on 8/12/15 at 5:50 A.M., in his/her room and the second was an unwitnessed fall in the dining room of the Cottage unit on 8/12/15 at 8:30 A.M. Resident #107 was hospitalized with a subarachnoid hemorrhage as a result of the falls.</p> <p>6. During a confidential interview on 8/18/15 at 2:00 P.M., Resident #500 indicated staff was not sufficient for him/her to get care and assistance without having to wait a long time.</p> <p>During a confidential interview on 8/18/15 at 11:24 A.M., Resident #501 indicated staff was not sufficient during meal times. Resident #501 further indicated he/she was afraid to call for help because staff is so busy.</p> <p>During a confidential interview on</p>			

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	<p>8/19/15 at 9:01 A.M., Resident #502 indicated he/she had to wait up to 30 minutes for staff assistance on all shifts.</p> <p>During a confidential interview on 8/19/15 at 11:33 A.M., Resident #503 indicated he/she had experienced incontinence because it takes staff a long time to answer the call light. Resident #503 further indicated, at that time, staff would enter the room, turn off call light, exit the room, and not return.</p> <p>During a confidential interview on 8/18/15 at 3:41 P.M., Resident #504 indicated he/she usually had to wait 30-45 minutes for staff assistance.</p> <p>During a confidential interview on 8/18/15 at 3:29 P.M., Family Member #600 indicated staffing was routinely lacking to provide care and supervision to the residents.</p> <p>7. The Resident Council Minutes were reviewed on 8/21/15 at 11:00 A.M., as follows:</p> <p>The 2/2/15 Resident Council Minutes indicated, "...Resident (sic) agreed it took the CNA's up to (sic) half hour to answer lights...a few times the CNA's would walk into room and shut off the call light without satisfying need of resident..."</p>			

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	<p>The 3/18/15 Resident Council Minutes indicated, "...call lights are not getting answered in a timely manner...resident medications are not getting passed timely..."</p> <p>The 6/30/15 Resident Council Minutes indicated, "...staff taking too long to answer call lights on 300 and 400 halls..."</p> <p>The 7/29/15 Resident Council Minutes indicated, "...resident noticed...no one is answering call light to shower room restroom when a resident turns on light for help..."</p> <p>8. The Point of Care Acuity Reports dated 7/17/15 through 8/24/15 provided by the Nurse Consultant on 8/24/15 at 2:30 P.M. indicated the following:</p> <p>400 unit- 29 residents Need assist of two staff for bed mobility: 17 Need assist of two staff for transfers: 16 Need assist of two staff for toileting: 18</p> <p>Cottage unit- 23 residents Need assist of two staff for bed mobility: 7 Need assist of two staff for transfers: 6 Need assist of two staff for toileting: 6</p>			

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	<p>During an interview on 8/20/15 at 10:15 A.M., the UM (Unit Manager) #5 indicated 22 of 23 residents on the Cottage unit experienced cognitive impairment,</p> <p>8. During an interview on 8/24/15 at 10:50 A.M., the Staffing Coordinator provided an "as-worked" nursing schedule from July 17-August 24, 2015. The staffing schedule indicated the facility routinely staffed 1 nurse/1 CNA on the Cottage unit and the 400 unit for the night shift, 1 nurse/2 CNA's on the Cottage unit and the 400 unit for the evening shift, and 1 nurse/2 CNA's on the Cottage unit and the 400 unit for the day shift. During an interview, at that time, the Staffing Coordinator indicated the facility experienced frequent staff call-ins.</p> <p>During an interview on 8/24/15 at 2:31 P.M., the Nurse Consultant indicated all residents currently residing in the facility were considered at risk to experience a fall, staff should be sufficient to supervise, and no specific policy for staffing could be provided, but it should be the usual practice of the facility to provide sufficient staff to ensure adequate supervision, care, and assistance.</p>				

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	<p>During a random observation on 8/24/15 at 3:10 P.M., LPN #5 was observed at the 400 unit nursing station with LPN #10 and RN #5.</p> <p>During a random observation on 8/24/15 at 3:15 P.M., the CEC (Clinical Education Coordinator) was observed on the Cottage unit and indicated he was working as a CNA on the unit. The CEC further indicated LPN #5 had left the unit to perform clerical duties, but was the nurse in charge, and CNA #5 was in the common bathroom assisting other residents. The CEC was observed from 3:16 P.M. through 3:25 P.M. standing at the nursing station with his back to 7 residents sitting TV lounge area.</p> <p>During a random observation on 8/24/15 at 3:34 P.M., LPN #10, LPN #5, and RN #5 were observed coming through the back service hall towards the 400 unit.</p> <p>During an interview on 8/24/15 at 4:45 P.M., the HFA (Health Facilities Administrator) indicated she did not know why the nurses would be in the back service hall because it only contained an outside exit door.</p> <p>3.1-17(a) 3.1-17(b)</p>						

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F 0431 SS=E Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F 0431	The creation and submission of this	09/23/2015

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	<p>a scheduled IV drug was stored and secured in a separate locked device for 2 of 3 medication rooms observed. (300-400 medication room and secured unit medication room)</p> <p>Findings include:</p> <p>On 8/24/15 at 11:00 A.M., the medication room on the secured unit was randomly toured with LPN #20. The medication refrigerator contained a metal narcotic box that was not locked. LPN # 20 indicated at that time the narcotic box should be locked. The unlocked narcotic box included, but was not limited to, a blue plastic bag that contained 6 unopened 1 ml (milliliter) injectable vials of 2 mg (milligrams)/ml (milliliter) of Lorazepam (Ativan-antianxiety medication) for Resident #107. Another blue plastic bag contained for Resident #107, 8 unopened 1 ml injectable vials of Lorazepam 2 mg/ml. The narcotic box also contained a blue plastic bag with 10 unopened injectable vials of Lorazepam 2 mg/ml for Resident #10. On 8/24/15 at 11:20 A.M., LPN # 20 indicated she had locked the narcotic box</p> <p>On 8/24/15 at 4:10 P.M., the medication room on the 300/400 hall was randomly toured with LPN #10. The medication refrigerator contained an unlocked</p>		<p>Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on September 23, 2015.</p> <p>F431</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·No residents were affected by alleged deficient practice.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to</p>	

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	<p>narcotic box. LPN #10 indicated at that time the narcotic box should be locked. The unlocked narcotic box included, but was not limited to, a blue plastic bag containing 7 unopened injectable vials of Lorazepam 2 mg/ml for Resident #28, a blue plastic bag containing 4 unopened injectable Lorazepam 2 mg/ml vials for Resident #9, and a blue plastic bag containing 2 unopened injectable vials of Lorazepam 2 mg/ml for Resident #19. The unlocked narcotic box also contained a blue plastic bag with an opened bottle of Lorazepam Intensol 2 mg/ml sublingual (under the tongue) solution for Resident #11.</p> <p>A facility policy from the Pharmakon Long Term Care Pharmacy Policy and Procedure Manual (revision 7/2011) p. 51 was reviewed on 8/24/15 at 4:40 P.M. The policy included, but was not limited to, "... 7.04 SCHEDULED II, III, IV and V MEDICATIONS: Schedule II, III, IV and V medications must be kept in a separately locked drawer or cabinet designated for that purpose..."</p> <p>On 8/24/15 at 4:45 P.M., the Nurse Consultant was made aware of the above injectable Lorazepam vials for Residents: #9, #19, #28 and #10, and Lorazepam sublingual solution for Resident #11 had been unlocked in narcotic boxes on the</p>		<p>be affected by the alleged deficient practice. DNS/UM/Designee will monitor daily to ensure that all medication rooms and medications are properly secured at all times of the day.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on proper medication storage has been provided to all staff by CEC/DNS/SSD/Designee by September 23, 2015. ·DNS/ nurse manager/designee will daily audit medication rooms, medication carts, and lock boxes. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/ Designee will daily utilize drug storage CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be 				

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	secured unit and the 300-400 medication rooms. No further information was provided. 3.1-25(n)		developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. Compliance date: September 23, 2015		