

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155481	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2016
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NAME OF PROVIDER OR SUPPLIER ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00192721.</p> <p>Complaint IN00192721-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: February 11, 12 and 15, 2016</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Census bed type: SNF: 14 SNF/NF: 80 Residential: 30 Total: 124</p> <p>Census payor type: Medicare: 27 Medicaid: 49 Other: 18 Total: 94</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Arbor Trace requests papercompliance review for the two alleged deficiencies. This plan of correction is to serve as Arbor Trace's credibleallegation of compliance. Submission of this plan of correction does not constitute anadmission by Arbor Trace or its management company that the allegationscontained in the survey report is a true and accurate portrayal of theprovision of nursing care and other services in this facility. Nor doesthis submission constitute an agreement or admission of the survey allegations.</p>	
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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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F 0282 SS=D Bldg. 00	<p>Quality review completed by 30576 on February 19, 2016</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure physician's orders for daily dressing changes to a resident's recent surgical site were conducted as ordered for 1 of 3 residents reviewed for treatments as ordered in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 2-11-16 at 12:01 p.m. It indicated his diagnoses included, but were not limited to, right below the knee amputation (January, 2016), diabetes, peripheral neuropathy and end-stage renal disease with dialysis. It indicated he had a physician's order, dated 1-15-16, to change the dressing to his right below the knee amputation stump every other day with xeroform nonstick dressing, then wrap with Kerlix (roll gauze) and secure with an Ace wrap (type of elastic roll bandage).change the This order was</p>	F 0282	<p>F282 483.20(k)(3)(ii)SERVICES BY QUALIFIEDPERSONS/PER CARE PLAN I. Resident #B careplan was reviewed for accuracy during the survey. II. All residents receiving dialysis services have the potential to beaffected. Current residents receiving dialysis will have their dressingtreatments and med administration times audited and changed if needed so theyare centered around their dialysis treatment times. This will be done to ensure all treatmentsare completed as ordered. III. Education will be provided to all licensed nursing staff regardingscheduleing medications and treatments around dialysis times. The systemicchange includes upon admission of dialysis patients their doctor's orders willbe checked by nursing administration to ensure their skin care treatments andmed administration times are</p>	03/04/2016

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	<p>discontinued on 1-22-16 and to begin to change the dressing to his right below the knee amputation stump with an ABD pad (type of large absorbent dressing), then wrap with Kerlix and secure with an Ace wrap daily.</p> <p>Review of Resident #B's electronic Medication Administration Record (eMAR) indicated the initial order, dated 1-15-16, for dressing changes every other day, was conducted as ordered. The second order, which began on 1-22-16, indicated the daily dressing changes were conducted on 1-23-16, 1-24-16, 1-27-16, 1-29-16, 1-31-16, 2-2-16, 2-6-16, 2-7-16, 2-8-16, 2-9-16, 2-10-16 and 2-12-16. On 1-25-16, 1-26-16, 1-28-16, 1-30-16, 2-4-16, 2-5-16 and 2-11-16, a notation indicated the resident was unavailable and was indicated the daily dressing change was not conducted. On 2-3-16, it indicated the dressing change was not conducted as the resident was unavailable due to being out to an appointment. This indicated 8 of 21 ordered dressing changes were not conducted as ordered. It indicated LPN #3 had documented 7 of the 8 times in which the eMAR indicated the resident was unavailable.</p> <p>In an interview with Resident #B on 2-12-16, he indicated he was aware of his stump dressings not being done for at</p>		<p>established around their dialysis treatment. This will be done to ensure they are completed as ordered.</p> <p>IV. The Director of Nursing or designee will audit all new orders for residents receiving dialysis daily including weekends to determine the scheduled times do not conflict with the dialysis schedule. This audit will be completed for 5 residents per week for 180 days, then five residents per month for an additional 180 days to total 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 3/4/2016</p>		

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	<p>least one to two days at a time.</p> <p>In an interview with LPN #3 on 2-11-16 at 11:16 a.m., she indicated on 1-30-16, she had been unable to conduct the stump dressing as the resident was out to dialysis. She did not indicate if she made the next shift of the need to conduct the daily dressing change. She indicated on Resident #B's dialysis days, he is usually out of the facility from around 10:00 a.m., and returns around 4:30 p.m. or 5:00 p.m. She indicated on that date, as to the present, the stump dressing was to be conducted on a daily basis.</p> <p>In an interview with the Unit Manager of the hall on which Resident #B's resided on 2-15-16 at 9:40 a.m., she indicated she recalled speaking to Resident #B's spouse in regards to his other dressings, but not about the stump dressing. She indicated her expectations are, "That for any treatment or care that does not get done, the nurse on duty should pass that information on in report and the next shift will get it done. Like in [name of Resident #B]'s case, if the day shift can't do his dressing changes because he's out to dialysis or an appointment, they need to tell the next shift. With the eMAR, [one] can go in and amend it to show it was done, or just put it in the nurse's notes."</p>			

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F 0323 SS=D Bldg. 00	<p>This Federal tag relates to Complaint IN00192721.</p> <p>3.1-35(g)(2)</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 receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure staff provided supervision during a shower and did not leave the resident unattended for over 30 minutes in the shower for 1 of 3 residents reviewed for bathing and hygiene in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>During an interview with Resident #B on 2-12-16 at 9:27 a.m., he indicated that on a weekend morning, several weeks previously, one of the facility's CNA's assisted him into the shower, on a shower chair, around 9:15 a.m. He indicated he was left unattended after being assisted into the shower until nearly 11:00 a.m.. He indicated, "Not sure what happened. They may have sent the CNA to go do something else and forgot me [being in</p>	F 0323	<p>F323 483.25(h) FREE OFACCIDENT/HAZARDS/SUPERVISION/DEVICES I. Resident B was not injured concerning the alleged deficientpractice. The two staff members directlyinvolved with his shower that day was given education specific to not leavingdependent residents alone during their showers. The alleged incident was identified prior to the complaint survey andthe teaching occurred at that time. II. All residents who wish to shower independently have the potential to beaffected. Therapy will assess all residents upon admission, quarterly and withsignificant changes to determine if they are able to be independent withshowering. If resident is identified as being independent</p>	03/04/2016

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	<p>the shower.]" He indicated, "I finally opened the shower curtain and started yelling for help and they finally showed up [to provide assistance]... While waiting for help, [I] was much more PO'd [angry] than scared." He indicated there are no call lights available in the showers, just by the toilet.</p> <p>In an interview with CNA #1 on 2-12-16 at 10:30 a.m., she indicated she had worked with Resident #B on the weekend of 1-30-16 and 1-31-16. She described the resident as being alert and oriented to person, place and time. She indicated he required assistance of one to two persons with ADL's (activities of daily living) and required assistance with bathing/showering to wash his back and below the waist.</p> <p>CNA #1 indicated on 1-31-16, around 11:00 a.m., she asked CNA #2 if she would help her complete her care assignment by assisting Resident #B getting him "set up" and into the shower, then she (CNA #1) would go back and help the resident complete his shower and his morning care. "That's where the misunderstanding began, I should have clarified. I thought she would let me know when she got him into the shower, because I thought he could get started on his upper body. What happened was she</p>		<p>and their desire isto be left alone in the shower they will receive a bell to ring in case of anemergency. All dependent residents willnot be left alone in the shower. III. Education will be provided to all nursing staff regarding residents whoshower independently and assuring they have a bell available if they showeralone. The systemic change includes assessment of all residents upon admisionsto determine independent or dependent status for showers. Dependentsresidents will not be left alone. Independent residents will be given a bell to ring in case of anemergency. IV. The DON/Designee will audit 100% of new residents for shower preferencesand safety daily including weekends. This audit will be ongoing. Resultsof audit will be reported to the QA Committee monthly to assist with additionalrecommendations if necessary.</p> <p>COMPLIANCE DATE: 3/4/2016</p>				

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	<p>had gotten him on the toilet and then came out [of the resident's room] to chart [at the nurse's station.] She told me he was on the toilet. Right after, I saw his [call] light come on and saw her go to answer it. I hadn't heard anymore from her until around 12:15 p.m. I just assumed she just stayed in there to help him with his shower. That's what you get for assuming. Before I started helping with lunch, around 11:30 a.m. or 11:45 a.m., [name of LPN #3], came and told me that [name of Resident #B] had told her he had been in the shower for 45 minutes and water had turned cold. By the time I went to check on him, I helped dry him off and dress him. [Name of LPN #3] had heard him yell for help...I apologized and apologized to him. [He] kept telling me it was okay, but you could tell he was upset...We are not supposed to ever leave a resident alone in the shower."</p> <p>In an interview with CNA #2 on 2-11-16 at 12:07 p.m., she indicated CNA #1 "asked me if I would help to start [name of Resident #B]'s shower and she would finish [his care.] [I] went in helped him onto the toilet from his wheelchair [requiring] extensive assistance, [because he] had only one leg. Had already put him onto the shower chair to toilet to make it easier for him. He did not want</p>			

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	<p>me to stay in the bathroom with him, so [I] went out to the desk to do charting. [Name of CNA #1] asked if he was in the shower. Told her, 'No, still on the toilet,' but would put him in the shower for her. Told her he'd let her know when he was ready and pull the call light. She said okay." She indicated when she saw Resident #B's call light on, she returned to assist him into the shower. She indicated, "He told me I could go ahead and leave. I asked him if he was okay and he said 'Yes.' He seemed very comfortable with the situation. Have no idea what happened after that. Went back to the nurse's station to finish charting. [Then,] looked up and saw a call light on the private hall and went to answer it." CNA #2 described Resident #B as very alert and oriented and capable of using the call light. CNA #2 was unable to identify the time of this event, except it occurred after breakfast and before lunch.</p> <p>In an interview with LPN #3 on 2-11-16 at 11:16 a.m., she indicated on 1-31-16, between 10:45 a.m. and 11:15 a.m., she had been aware that CNA #1 had requested the assistance of CNA #2 to complete her assignment by helping Resident #B with his shower. She indicated around that time, she observed CNA #2 at the desk completing some</p>			

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	<p>charting. She indicated she was not informed by CNA #2 that Resident #B was in the shower. She indicated at some point after this, she was in the hallway near Resident #B's room and speaking to a therapy staff member when they heard Resident #B yell for help. She indicated the room door and the bathroom door was closed. She indicated she found Resident #B in the shower, on a shower chair, with the water still running and the water was cold. She indicated the resident told her he had been in the shower for at least 45 minutes. She indicated the therapy staff member remained with the resident while she obtained blankets and towels to dry him off. She indicated CNA #1 assisted her in drying him off and moving him from the shower chair and into his wheelchair. She indicated Resident #B, "Initially was upset, but calmed down. LPN indicated she reported the event to her immediate supervisor, the Unit Manager of the private hall on 1-31-16, who in turn notified the Director of Nursing on the following day.</p> <p>Resident #B's clinical record was reviewed on 2-11-16 at 12:01 p.m. It indicated his diagnoses included, but were not limited to, right below the knee amputation (January, 2016), diabetes, peripheral neuropathy and end-stage renal</p>			

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	<p>disease with dialysis. His re-admission Minimum Data Set assessment, dated 1-19-16, indicated he required extensive assistance of two persons with transfers, could ambulate with extensive assistance of one person, required the use of a wheelchair for mobility and required extensive assistance of two persons for bathing/showering. An aide assignment sheet was provided by the Executive Director on 2-11-16 at 2:45 p.m. The Executive Director indicated this aide assignment sheet was the current one utilized by the facility for Resident #B. It indicated Resident #B required the assistance of two persons for transfers, used a wheelchair for mobility, is scheduled for showers twice weekly on Wednesdays and Sundays on the day shift, and requires extensive assistance with bathing, dressing and grooming.</p> <p>On 2-12-16 at 11:30 a.m., the Executive Director provided a procedure entitled, "Procedure #32: Shower/Shampoo." This procedure was indicated to be currently utilized by the facility. This policy indicated, "Never take your eyes off the resident or turn your back to the resident while in the shower."</p> <p>This Federal tag relates to Complaint IN00192721.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/29/2016

FORM APPROVED

OMB NO. 0938-0391

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	3.1-45(a)(2)				