

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155338	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2013
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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00122582 and IN00122854.</p> <p>Complaint IN00122582 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F223, F225, F226, F279, F282, F309, F323, and F353.</p> <p>Complaint IN00122854 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226, F309, F323, and F353.</p> <p>Survey Dates: February 7, 8, 12, 13, 14, 15, and 18, 2013.</p> <p>Facility Number: 000231 Provider Number: 155338 AIM Number: 100267900</p> <p>Survey Team: Heather Lay, RN - TC Lori Brettnacher, RN</p> <p>Census Bed Type: SNF: 31 SNF/NF: 75 Total: 106</p>	F000000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.</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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	<p>Census Payor Type: Medicare: 13 Medicaid: 60 Other: 33 Total: 106</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 02/25/2013 by Brenda Nunan, RN.</p>				

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F000157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to notify a physician of a significant change in condition to a resident which had the potential for requiring physician intervention when</p>	F000157	It is the practice of Manor Care Prestwick to contact a patient's physician and Family when the patient has an accident involving injury and has the potential for requiring physician intervention	03/20/2013	

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	<p>a resident had an abnormal blood pressure (Resident B) and when a resident needed pain management and had abnormal respirations (Resident C). The facility also failed to notify a family member when there was a significant change in condition (Resident C). This deficient practice affected 2 of 35 residents reviewed for physician/family notification.</p> <p>Findings:</p> <p>1. Resident C's record was reviewed on 2/14/2013 at 2:37 P.M. Resident C was admitted to the facility on 12/17/2012, from an acute care hospital and had diagnoses, which included but were not limited to, urinary tract infection, muscle weakness, chronic anemia, senile dementia, peripheral vascular disease, depressive disorder, uncontrolled diabetes type 2, atrial fibrillation, hypertension, urinary obstruction, chronic kidney disease, and gangrene symptoms. Resident C's son was the Power of Attorney and the primary contact.</p> <p>Review of a discharge summary (not dated) from the acute care hospital from which Resident C was admitted, indicated, Resident C's physicians had had conversations with Resident</p>		<p>and when a patient has a significant change in physical, mental, or psychosocial status. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident B and Resident C no longer resides at the facility. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Newly admitted residents who have the potential for requiring physician intervention and current residents with a significant change in condition are at risk to be affected. Nursing staff will notify physician and family immediately when there is a significant change in the resident's physical, mental, or psychosocial status and or if upon admission there is a potential for requiring physician intervention or need to alter treatment significantly. This notification will be documented in the progress note. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Licensed nursing staff has been in-serviced on criteria for notification of physician/family when there is a change in the resident's condition and that immediate notification to</p>		

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	<p>C's son regarding his end stage debility and possible diagnoses of dementia. This record indicated, "...the patient's son was adamant that the patient be tried on some type of alternative alimention... Dr. [named] and the patient's son came up with a plan of putting in a PICC [peripheral inserted central catheter] line and trying TPN [total parental nutrition] for two weeks. If this does not succeed in increasing his functional status they will consider possible hospice versus other forms of alimention at that point...."</p> <p>A document, dated 12/23/2012 and titled, "State of Indiana, Out of Hospital Do Not Resuscitate Declaration and Order", indicated Resident C's son gave a verbal consent to change his fathers status to DNR [do not resuscitate]. This form indicated, "... I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain...."</p>		<p>physician and family when a resident has a significant change in physical, mental, or psychosocial status. <b>How the corrective action will be monitored to ensure the deficient practice does not re occur?</b> A QAA monitoring tool will be completed by ADNS or designee on change of condition status. ADNS or designee will monitor for resident's change in condition status daily through clinical rounding with licensed nurses, on current residents and any new admission from previous day, and include a review of the nursing progress notes to assure identified condition changes are communicated to physician and family and are documented in the clinical record. Acute condition changes are discussed during the morning interdisciplinary clinical meeting and Director of Care Delivery is responsible to assure follow through. Monitoring will be completed weekly times six weeks and then monthly times 3 months. The results will be reviewed by QAA committee weekly. After that point, the QA Committee will make a recommendation for frequency of continued monitoring. ADDENDUMMonitoring will be completed weekly times six weeks and then monthly times 6 months</p>		

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	<p>A social service note, dated 12/24/2012, indicated, "Spoke with Resident's son [named] regarding hospice. [Nurse named], Nurse Weekend Manger had discussed hospice benefits with them over the weekend. I explained that hospice comes into the building to provide care on top of services that we already provide and is a good support for the family also. Resident has expressed to family that he wanted to die at home. The family is looking at all options right now. [Son named] had talked with hospice today but no decision have been currently...They would like to take him home but have things to get ready at home first. He stated that hospice may only be for a few days and then home but they haven't decided yet. I stated that I would follow up with him on Wednesday when I was back in the office." Orders were obtained to have the patient evaluated by hospice.</p> <p>A document, dated 12/23/2013 and titled, "Manor Care Health Services Fax Cover Sheet", indicated, a hospice company was faxed with a request to contact Resident C's son on 12/24/2012 to discuss hospice.</p> <p>An untrimmed nurse's note, dated 12/17/2012, indicated, "Resident</p>				

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	<p>arrived at facility accompanied by 2 paramedics. Resident was transferred to bed in Rm [room].... Resident noted to be contracted into fetal position, moans and cries out in pain if attempts to straighten limbs are made. Resident has multiple open areas as detailed on skin assessment. Skin is warm and dry. Resident is lethargic alert to self. Vitals signs are stable. Respirations even, non labored..." The record including the MAR [Medication Administration Record] lacked documentation Resident C was administered pain medicine on this date.</p> <p>Resident C's admission physician's orders, dated 12/17/2012, indicated Resident C was to have a daily numeric pain score. These physician's orders indicated an order for acetaminophen 325 milligrams 2 by mouth every 6 hours as needed for pain. A telephone order, dated 2/20/2012, indicated, Tylenol 325 milligrams 2 tablets by mouth were to be given (scheduled) twice a day for generalized pain.</p> <p>A care plan initiated on 12/17/2012, indicated, Resident C had generalized pain as evidenced by verbal and non-verbal signs and</p>						

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	<p>symptoms related to contractures, arthritis, and pressure points/ulcers. The goal was for pain or analgesia to not affect participation in activities of choice or daily care. Interventions listed to meet this goal included: 1) Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. 2) Administer pain medication per physician orders 3) Encourage/Assist to reposition frequently to a position of comfort 4) Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.</p> <p>An untimed document, dated 12/18/2012 and titled, "Pain Assessment in Advanced Dementia (PAINAD) Scale", indicated, "...the PAINAD scale was used for patients who could not verbally communicate about their pain. The PAINAD scale evaluates the realms of breathing, independent of vocalization; negative vocalizations; facial expression; body language; and consolability. The observations are converted to a numeric 0-10 scale. Observe the patient for five minutes before scoring the behaviors."</p> <p>A nurse's note, dated</p>						

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	<p>12/18/2012-7:11 A.M., indicated Resident C had no signs of pain. The MAR, indicated at 8:00 A.M., his pain score was 8 out of 10.</p> <p>The next nurse's note, dated 12/18/2012-10:49 P.M., indicated, "...pt [patient] moans with touch..." The record did not have documentation of a pain assessment or the physician being notified of the ineffectiveness of the ordered pain medication.</p> <p>A nurse's note, dated 12/18/2012-1:26 P.M., indicated, "Resident verbalized understanding of care being provided but would yell out and draw [sic] in with repositioning and care."</p> <p>An occupational therapy note, dated 12/18/2012-untimed, indicated, Resident C had an increase in expressions of pain.</p> <p>A nurse's note, dated 12/20/12-3:21 P.M., indicated, "...Pt [patient] has several necrotic areas on feet and toes. Dressings and treatments completed on bilateral feet, toes and on buttocks. Pt says "ouch" anytime he is being moved or repositioned. Takes his meds crushed in apple sauce...." Resident C's record lacked</p>						

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	<p>documentation of a pain assessment, evaluation of the effectiveness of the ordered pain medication, or notification to the physician regarding Resident C's increased pain interfering with his daily care.</p> <p>A nurse's note, dated 12/22/2012-11:38 P.M., indicated, "Res. [resident] refused all oral meds[medications] this PM. Cursed at nursing staff when repositioned... Bed bath completed and lotions applied to skin. Res. continues to moan out in pain and curse when moved in bed...." The record lacked documentation a physician was notified of the his current pain status and the ineffectiveness of the ordered pain medication.</p> <p>A nurse's note, dated 12/23/2012-1:59 P.M., indicated, "...pt [patient] laying in bed in fetal position, staff attempted to reposition several times...any time pt is touched for care or repositioning pt yells out, becoming very combative, pt unable to make needs or wants clear to staff, pt currently laying in bed with call light in reach." The record lacked documentation of a pain assessment or documentation the physician was informed of the resident's current pain level and possible need to change or</p>			

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	<p>increase his pain medication.</p> <p>The December MAR indicated, on 12/23/2012, staff attempted to give Tylenol to Resident C but he was unable to swallow any medication. The record lacked documentation of a physician being notified of Resident C's inability to swallow medication or a request for pain medication to be delivered in a route other than oral.</p> <p>A physical therapy note, dated 12/24/2012-untimed, indicated, "...pt [patient] is non-responsive and been sleeping all time. Pt is completely dependent for bed mob. [mobility]. Unable to perform functional transfers R [related to] L/E [lower extremity] contracture... Not alert or oriented at all. Pt also c/o [complains] generalized pain. Pt has dr's [doctors] for possible hospice eval. [evaluation]. Not appropriate for skilled PT [physical therapy] at this date." The record lacked documentation of the physician being notified that Resident C could not complete therapy because of pain.</p> <p>An occupational therapy note, dated 12/24/2013, indicated, "...movement of any sort appears uncomfortable as indicated by grimacing and moaning...." This note further</p>				

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	<p>indicated Resident C had expressions of pain with touch or movement. The record lacked documentation the physician was notified Resident C could not complete therapy because of pain.</p> <p>A nurse's note, dated 12/24/2012-11:18 A.M., indicated, "...staff state resident "yells out and moans" whenever care is provided. He has orders for scheduled pain med [medicine] however resident has been refusing all meds po [oral] meds at this time..." The record lacked documentation of a pain assessment, pain medication being administered, or the physician being notified of the patients increased pain.</p> <p>A physician's telephone order, dated 12/24/2012-untimed, indicated, Resident C may have the Tylenol given rectally instead of orally. The MAR indicated Resident C was administered Tylenol 650 Milligrams rectally on 12/24/2013 at 8:00 P.M. (Eight hours after staff reported patients yelling and moaning.) A pain assessment or an evaluation of the effectiveness of the pain medication was not completed.</p> <p>A nurse's note, dated 12/26/2013-2:15 P.M., indicated,</p>				

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	<p>"Res. [resident] blood sugar was 534 at 11 am. Writer called and spoke with NP [Nurse Practitioner] and was told to give 18 units. Writer also spoke to NP about res pain, as he cries out when repositioned. Tylenol was D/C'd [discontinued] and a new order for Roxanol (a stronger pain medication) was given. Writer gave one does..."</p> <p>The MAR indicated Roxanol was administered one time on 12/26/2012 at 1:30 P.M.</p> <p>Resident C died on 12/27/2012. The record lacked documentation of care or assessments of Resident C after the above nurse's note, dated 12/26/2012- 2:15 P.M.</p> <p>During an interview, on 2/18/2013 at 9:30 A.M., the Administrator indicated there was not further documentation on Resident C after 12/26/2012 at 2:15 P.M. The Administrator was asked about the details surrounding the residents death and he indicated he was looking into it.</p> <p>The DON [Director of Nursing] obtained a statement on 2/18/2013 at 9:50 A.M., from the nurse who cared for Resident C on 12/27/2012. LPN #17 indicated in this statement, "I went in after report around 6:30-6:45</p>			

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	<p>A.M. and checked him. He was having periods of apnea then. I went in to check on him between 8-8:30 A.M. and he was already gone. Listened to his chest no heart beat or respirations. Went and got [nurse named]. She listened to him and verified no heart rate or respirations. I called the son to notify him. Son just said thanks for letting me know. Then I notified the NP [named] in facility."</p> <p>During an interview, 2/18/2013 at 5:10 P.M., the DON was asked to provide documentation Resident C's family and physician were notified when the nurse noted the change in his breathing, for any assessments of pain and/or follow up assessment on the elevated blood sugar reported in the last nurse's note. Policies were requested for: doctor notification, significant change, pain evaluation and management, and TPN/IV [Total parental nutrition/intra-venous] assessments. The DON indicated Resident C was not a hospice patient and indicated the physician should have been notified regarding Resident C's change in condition. The DON stated, "That's a good question," when queried regarding why the record lacked documentation of follow up regarding unrelieved pain and an elevated blood sugar.</p>						

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	<p>During the exit conference, 2/18/2013 at 7:00 P.M., the Administrator and DON indicated no further documentation was available.</p> <p>2. Resident B's record was reviewed on 2/8/2013 at 2:08 P.M. Resident B was admitted to the facility on 12/14/2012. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, history of bladder cancer, osteoporosis and Alzheimer's disease. Resident B was a DNR (do not resuscitate) but was not a hospice patient.</p> <p>A nurse's admission note, dated 12/14/2012-10:24 P.M., indicated, Resident B was brought to the facility late in the evening. She was very scared and called out please help me repeatedly. The family indicated to the staff the resident had eaten poorly in the few days prior to admission to the facility. Her vitals were taken. This note indicated, "...Her blood pressure was very low on admission 79/50." The record lacked documentation a physician was notified of this low blood pressure.</p> <p>A nurse's note, dated 12/15/2012-7:04 A.M., indicated Resident B refused to have her vitals</p>			

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NAME OF PROVIDER OR SUPPLIER  MANORCARE HEALTH SERVICES - PRESTWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 445 S CR 525 E AVON, IN 46123
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	<p>taken. A nurse's note, dated 12/15/2012-13:14, indicated, she continued to refuse to have her vitals taken. The record lacked documentation which indicated the physician was notified of the resident's refusals to allow monitoring of vital signs following the low blood pressure on admission.</p> <p>A nurse's note, dated 12/15/2012-5:39 P.M., indicated, the physician was called regarding the resident's behaviors of yelling and calling out all night. An anti-anxiety medication was ordered for three days until the physician could evaluate her.</p> <p>A nurse's note, dated 12/15/2012-9:40 P.M., indicated, Resident B was yelling out and hitting the staff. The record indicated Resident B's family was called and indicated the family informed facility staff that the resident had not eaten and barely drank anything during the four days prior to admission to the facility. The nurse's note indicted the resident continued the nutrition and hydration routine. The record lacked documentation which indicated the physician was notified of the resident's nutrition/hydration status.</p>			

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	<p>A nurse's note, dated 12/16/2012-4:20 A.M., indicated, "Aide came to nurse to report pt [patient] did not seem "right". On arriving in pt room, noticed labored respirations and groaning coming from pt. Vital signs obtained -O2 [oxygen level]-80%, HR [heart rate] 54, RR [respirations]-24, BP [blood pressure]-unable to obtain. Applied supplemental oxygen 4L[liters] O2-94%, RR-16, HR-68 still unable to obtain BP. Pt only responded to sternal rub by groaning. Lung sounds clear...Dr office notified of pt. status. Family notified."</p> <p>A nurse's note, dated 12/16/2012-5:55 A.M., indicated, "Pt [patient] family member came to get nurse to discuss further care options for pt. Pt husband wanted to see wife before discussing further options with family. Nurse escorted family to pt room. Upon going to pt side of room pt did not have visible respiration. On assessing pt no audible heart sounds. Went to get another nurse to verify no audible heart sounds..."</p> <p>During an interview, on 2/15/2013 at 3:00 P.M., the Administrator was asked if a physician had been notified of Resident B's admission blood pressure "being very low". He</p>			

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	<p>indicated he would check into it.</p> <p>During an interview ,on 2/18/2013 at 9:30 A.M., the Administrator indicated, the nurse could not remember if she notified the physician of the blood pressure and the record did not have documentation the physician was notified.</p> <p>This federal tag is related to Complaint IN00122582.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview, and record review, the facility failed to ensure residents were free from sexual abuse for 1 of 35 residents reviewed (Resident D).</p> <p>Findings:</p> <p>Resident D's record was reviewed on 2/14/2012 at 9:37 A.M. Resident D was admitted to the facility on 12/12/12. He had current diagnoses which included, but were not limited to, muscle weakness, anxiety, and a stroke. He was alert and oriented.</p> <p>Review of a nurse's note, dated 2/6/2012-2:26 P.M., indicated, "...reported a concern to writer that occurred several days ago in therapy. Resident stated another resident [Resident I's initials given] reached out and touched his right thigh and also made inappropriate gestures toward him. Reported this concern to social services. Unclear exactly when</p>	F000223	<p>It is the practice of Manor Care Prestwick to ensure residents are free from verbal, sexual, physical, and mental abuse <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident D and Resident I both continue to reside in the facility and neither have had a change of condition. Resident I was moved to a private room and is now sitting at a different table in the dining room. A one to one education was conducted with the Director of Social Services to re-educate on the correct reporting procedures, appropriate interventions and incidents that would be considered an abuse allegation, required reporting and protecting other residents while investigating allegations of abuse. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents that reside at this facility are at</p>	03/20/2013	

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	<p>it happened."</p> <p>During an interview, on 2/15/2013 at 10:00 A.M., The Social Service Director (SSD) indicated she was notified of an allegation of Resident I touching Resident D's thigh and an inappropriate hand gesture. The SSD indicated another nurse heard Resident D call Resident I a derogatory name. The SSD indicated she did not inform the Administrator of the allegations of abuse since she did not consider the actions to be abuse. The SSD indicated she had conversation with Resident I regarding the incident and indicated the resident did not deny or acknowledge touching Resident D's thigh or making inappropriate hand gestures. The SSD was asked to provide documentation of any interventions implemented to prevent potential sexual abuse.</p> <p>During an interview, on 2/18/2013 at 8:27 A.M., Resident D stated, "He still sits with us. That's why I quit going down to the dining room for awhile. He is a [derogatory name]. I told him never to touch me again...He still sits at my table at dinner. He doesn't mess with me any more."</p> <p>Resident I's chart was reviewed on</p>		<p>risk to be affected. Residents were interviewed to determine if anyone else had concerns and no new concerns were noted. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The facility staff was re-educated on abuse and the correct reporting procedures and appropriate interventions. The Director of Activities or designee will incorporate asking residents during the monthly Resident Council if they feel safe. Any issues noted will be immediately reported to the facility Administrator or designee to address any concerns. Additionally, abuse training of staff will be conducted on a quarterly basis. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Social Services or Designee will interview 5 residents a week for 6 weeks to validate they feel safe and free from abuse in the facility. Any concerns will be immediately reported to the facility administrator to be addressed. Additionally, the Social Service Director or Designee will report outcomes to the QA committee on a weekly basis. The Director of Activities or Designee will report findings of the Resident Council Meeting to the Quality Assurance Committee.</p>		

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	<p>2/18/13 at 3:10 P.M. The record indicated, Resident I had a history of sexually inappropriate behavior towards other residents and had a preference for men.</p> <p>Review of the facility's current abuse policy, provided by the Administrator on 2/25/2013 at 2:00 P.M., indicated, "...Definitions:..." "Verbal Abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within hearing distance, regardless of their age, ability to comprehend or disability. "Sexual Abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault... Procedures for reporting-...The administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...Protect...Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and abuse prevention coordinator...Patient protection actions include immediately removing the patient from contact with alleged abuser during the investigation...</p>		<p>ADDENDUMS Social Services or Designee will interview 5 residents a week for 6 weeks then monthly for 6 months to validate they feel safe and free from abuse in the facility.</p>				

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	<p>Reporting-The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures..."</p> <p>This federal tag is related to complaint IN00122582.</p> <p>3.1-27(a)</p>			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	It is the practice of Manor Care	03/20/2013			

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	<p>review, the facility failed to immediately report to the administrator of the facility and to other officials in accordance with State laws an allegation of abuse for 1 of 3 allegations of abuse incidents reviewed (Resident D).</p> <p>Findings:</p> <p>Resident D's record was reviewed on 2/14/2013 at 9:37 A.M. Resident D was admitted to the facility on 12/12/12. He had current diagnoses which included, but were not limited to, muscle weakness, anxiety, and a stroke. He was alert and oriented.</p> <p>Review of a nurse's note, dated 2/6/2012-2:26 P.M., indicated, "...reported a concern to writer that occurred several days ago in therapy. Resident stated another resident [Resident I's initials given] reached out and touched his right thigh and also made inappropriate gestures toward him. Reported this concern to social services. Unclear exactly when it happened."</p> <p>During an interview, on 2/15/2013 at 10:00 A.M., The Social Service Director (SSD) indicated she was notified of an allegation of Resident I touching Resident D's thigh and an</p>		<p>Prestwick to report and investigate all allegations of abuse <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> This incident was reported to the ISDH and fully investigated. A one to one education was conducted with the Director of Social Services to re-educate on the correct reporting procedures, appropriate interventions and incidents that would be considered an abuse allegation, required reporting and protecting other residents while investigating allegations of abuse. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents that reside at this facility are at risk to be affected. Residents were interviewed to determine if there were other concerns and no new concerns were noted. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The facility staff was re-educated on abuse and the correct reporting procedures that include reporting of any allegation of abuse immediately to the Abuse Coordinator. Director of Activities or Designee, through the use of a brief questionnaire will, on an ongoing basis ask if</p>		

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	<p>inappropriate hand gesture. The SSD indicated another nurse heard Resident D call Resident I a derogatory name. The SSD indicated she did not inform the Administrator of the allegations of abuse since she did not consider the actions to be abuse. The SSD indicated she had conversation with Resident I regarding the incident and indicated the resident did not deny or acknowledge touching Resident D's thigh or making inappropriate hand gestures. The SSD was asked to provide documentation of any interventions implemented to prevent potential sexual abuse. Documentation was not provided of interventions being implemented.</p> <p>During an interview, on 2/18/2013 at 8:27 A.M., Resident D stated, "He still sits with us. That's why I quit going down to the dining room for awhile. He is a [derogatory name]. I told him never to touch me again...He still sits at my table at dinner. He doesn't mess with me any more."</p> <p>Resident I's chart was reviewed on 2/18/13 at 3:10 P.M. The record indicated, Resident I had a history of sexually inappropriate behavior towards other residents and had a preference for men.</p>		<p>residents feel safe during the monthly Resident Council Meeting and immediately report to the facility administrator or designee any concerns to be addressed immediately. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Social Services or Designee to interview 5 residents a week for 6 weeks to validate they feel safe in the facility. Any concerns will be immediately reported to the facility administrator to be addressed. QAA committee will validate staff's learning of Abuse procedures through the use of a questionnaire that will be administered weekly to staff of random departments x 15 staff members per week for 6 weeks. This learning validation will be reported weekly to the QA committee and recommendation for frequency of continued monitoring. After that point, the QA Committee will make a recommendation for frequency of continued monitoring or reeducation. ADDENDUMQAA committee will validate staff's learning of Abuse procedures through the use of a questionnaire that will be administered weekly to staff of random departments x 15 staff members per week for 6 weeks then monthly for 6 months.</p>				

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	<p>Review of the facility's current abuse policy, provided by the Administrator on 2/25/2013 at 2:00 P.M., indicated, "...Definitions..." "Verbal Abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within hearing distance, regardless of their age, ability to comprehend or disability. "Sexual Abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault... Procedures for reporting-...The administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...Protect...Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and abuse prevention coordinator...Patient protection actions include immediately removing the patient from contact with alleged abuser during the investigation... Reporting-The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident</p>			
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	<p>property are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures..." The Administrator indicated at this time this incident was not reported because he had not been made aware of it.</p> <p>This federal tag is related to Complaint(s) IN00122582 and IN00122854.</p> <p>3.1-28(b)(2)</p>				

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review the facility failed to implement written policies and procedures to prohibit the abuse for 1 of 35 residents reviewed for abuse (Resident D).</p> <p>Findings:</p> <p>Resident D's record was reviewed on 2/14/2013 at 9:37 A.M. Resident D was admitted to the facility on 12/12/12. He had current diagnoses which included, but were not limited to, muscle weakness, anxiety, and a stroke. He was alert and oriented.</p> <p>Review of a nurse's note, dated 2/6/2012-2:26 P.M., indicated, "...reported a concern to writer that occurred several days ago in therapy. Resident stated another resident [Resident I's initials given] reached out and touched his right thigh and also made inappropriate gestures toward him. Reported this concern to social services. Unclear exactly when it happened."</p>	F000226	<p>It is the practice of Manor Care Prestwick to develop and implement policies and procedures that prohibit abuse <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> This incident was reported to the ISDH and fully investigated. Resident D and Resident I both continue to reside in the facility and neither have had a change of condition. A one to one education was conducted with the Director of Social Services to re-educate on the correct reporting procedures, appropriate interventions and incidents that would be considered an abuse allegation, require reporting and protecting other residents while investigating allegations of abuse. Resident I was moved to a private room and now sits at a different table in the dining room <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents that reside in the facility are at risk to be affected. Residents</p>	03/20/2013			

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	<p>During an interview, on 2/15/2013 at 10:00 A.M., The Social Service Director (SSD) indicated she was notified of an allegation of Resident I touching Resident D's thigh and an inappropriate hand gesture. The SSD indicated another nurse heard Resident D call Resident I a derogatory name. The SSD indicated she did not inform the Administrator of the allegations of abuse since she did not consider the actions to be abuse. The SSD indicated she had conversation with Resident I regarding the incident and indicated the resident did not deny or acknowledge touching Resident D's thigh or making inappropriate hand gestures. The SSD was asked to provide documentation of any interventions implemented to prevent potential sexual abuse. Documentation was not provided of interventions being implemented.</p> <p>During an interview, on 2/18/2013 at 8:27 A.M., Resident D stated, "He still sits with us. That's why I quit going down to the dining room for awhile. He is a [derogatory name]. I told him never to touch me again...He still sits at my table at dinner. He doesn't mess with me any more."</p> <p>Resident I's chart was reviewed on</p>		<p>were interviewed to determine if there are other concerns and no new concerns were noted. Director of Activities or Designee, through the use of a brief questionnaire will, on an ongoing basis ask if residents feel safe during the monthly Resident Council Meeting and immediately report to the facility administrator or designee any concerns to be addressed immediately. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The facility staff was re-educated on abuse and the correct reporting procedures and appropriate interventions. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Social Services or Designee to interview 5 residents a week for 6 weeks to validate they feel safe in the facility. Any concerns will be immediately reported to the facility administrator to be addressed. QAA committee will validate staff's learning of Abuse procedures through the use of a questionnaire that will be administered weekly to staff of random departments x 15 staff members per week for 6 weeks. This learning validation will be reported weekly to the QA committee and recommendation for frequency of continued monitoring or reeducation. After</p>		

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	<p>2/18/13 at 3:10 P.M. The record indicated, Resident I had a history of sexually inappropriate behavior towards other residents and had a preference for men.</p> <p>Review of the facility's current abuse policy, provided by the Administrator on 2/25/2013 at 2:00 P.M., indicated, "...Definitions:..." "Verbal Abuse" is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within hearing distance, regardless of their age, ability to comprehend or disability. "Sexual Abuse" includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault... Procedures for reporting-...The administrator is responsible for the investigating, reporting and coordinating of the investigation process of any alleged or suspected abuse regardless of the source of the concern...Protect...Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and abuse prevention coordinator...Patient protection actions include immediately removing the patient from contact with alleged abuser during the investigation...</p>		<p>that point, the QA Committee will make a recommendation for frequency of continued monitoring. ADDENDUMQAA committee will validate staff's learning of Abuse procedures through the use of a questionnaire that will be administered weekly to staff of random departments x 15 staff members per week for 6 weeks then monthly for 6 months.</p>		

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	<p>Reporting-The center must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures..." The Administrator indicated at this time this incident was not reported because he had not been made aware of it.</p> <p>This federal tag is related to Complaint(s) IN00122582 and IN00122854.</p> <p>2.2-28(a)</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to respond to a resident's request for assistance in a timely manner [Resident #197]. In addition, the facility failed to maintain a dependent resident's privacy of body while in bed. This deficient practice affected 2 of 4 residents reviewed for dignity [Residents #197 and #27].</p> <p>Findings include:</p> <p>1. On 2/7/13 at 3:22 P.M., in an interview, Resident #197 indicated that staff took a long time to answer his call light when he needed assistance to get back to bed.</p> <p>On 2/7/13 at 3:35 P.M., in an interview, Resident #197 indicated he needed help back to bed from his wheelchair. At that time, he activated his call light for assistance. After five minutes of waiting, Resident #197 started yelling in his room that he needed help transferring back to bed. There was no staff observed near</p>	F000241	<p>It is the practice of Manor Care Prestwick to act in a manner that promotes dignity and respect for residents while providing care to/for residents <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident # 197 was assisted at the time of survey and now assistance is provided timely. Resident #27 was covered to preserve his dignity. LPN #11 is no longer employed at this facility. LPN #12 was provided a one to one re-education on Resident Dignity/Right to Privacy. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Other residents dependent on staff for assistance for transfer and basic ADL care are at risk. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The facility staff has been educated on Residents Right to Dignity and Privacy and</p>	03/20/2013			

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	<p>Resident #197's room.</p> <p>On 2/7/13 at 3:40 P.M., in an interview, Licensed Practical Nurse [LPN] #11 indicated he was not the nurse taking care of Resident #197. At that time, LPN#11 was informed that Resident #197 required assistance and was yelling for help. LPN #11 responded that he needed to finish his narcotic count. The LPN did not respond to Resident #197's yelling out and request for help and continued the task of counting narcotics.</p> <p>On 2/7/13 at 3:47 P.M., 12 minutes after Resident #197 activated his call light, LPN #1 and Certified Nursing Assistant [CNA] #3 were observed assisting Resident #197 to bed.</p> <p>2. On 2/8/13 from 11:25 A.M. to 12:00 P.M., Resident #27 was observed in his room in bed from the hallway. Resident #27 was observed uncovered, wearing an incontinent brief. During the observation, Licensed Practical Nurse [LPN] #12 was observed passing Resident #27's room on two occasions while Resident #27's incontinent brief was exposed.</p> <p>On 2/13/13 at 2:35 P.M., Resident</p>		<p>accommodating their needs in a timely manner. The IDT has been directed to immediately step in and correct any problem they observe. Call light response time audits have been implemented and are occurring daily, including the weekend by the IDT during the day shift and ADNS has designated a nurse on the afternoon and night shift to complete the audits for those corresponding shifts daily, including the weekend. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Observation of resident dignity and privacy has been included on the routine daily rounds made by Department Managers and ADNS has designated a lead nurse on the afternoon and night shift to complete dignity and privacy daily rounds daily, including the weekends. Audits will be summarized and reported to weekly QAA meeting. After 6 weeks the QA Team will make a recommendation on the continuation of the monitoring schedule. The call light response time audit outcomes will be reported to the ADNS daily for immediate problem resolution. Director of Nursing will track/trend daily, and as above report to QAA weekly. ADDENDUMMonitoring will occur daily for 6 weeks then monthly for 6 months.</p>		

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	<p>#27's record was reviewed. Diagnoses included, but were not limited to, head injury, hand contracture, dysphagia, and osteoarthritis.</p> <p>An activities of daily living [ADL] care plan, dated 1/9/13, included, but was not limited to, "ADL self care deficit as evidence by total assist needed to complete ADL tasks related to physical and cognitive deficits secondary to traumatic brain injury... Will be clean, dressed, and well groomed daily to promote dignity and psychosocial well being..."</p> <p>On 2/18/13 at 11:30 A.M., in an interview, the Administrator indicated he was aware of the incident regarding Resident #197. He indicated staff were being inserviced on answering call lights in a timely manner. In addition, the Administrator indicated that Resident #27 removed his coverings; however, he indicated staff needed to maintain Resident #27's privacy as he was dependent on staff.</p> <p>3.1-3(t)</p>				

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F000242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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 observation, interview, and record review, the facility failed to ensure residents were able to make choices about bathing. This deficient practice effected 3 of 35 residents reviewed for choices (Resident #42, Resident #141, and Resident #171).</p> <p>Findings:</p> <p>1. Resident #42's record was reviewed on 2/14/2013 at 12:06 P.M. She was admitted to the facility on 9/23/2011. She had current diagnoses which included, but were not limited to, uterine cancer, cellulitis/abscess, hypertension, anxiety, depression, and morbid obesity.</p> <p>During an interview on 2/7/2013 at 2:53 P.M., Resident #42 indicated the showers were not designed for bariatric patients. She indicated would like to take showers but she could not because they did not have a</p>	F000242	<p>It is the practice of this facility to ensure residents are able to make choices about bathing</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> An appropriate shower chair was provided enabling resident # 42 to receive showers. Resident # 141 was re-interviewed to determine her choices for showers and her shower schedule was revised to honor her choices. Resident #171 was interviewed to determine her choices for showers and her shower schedule was revised to honor her choices. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents who reside in the facility are at risk and have the potential to be affected. We will continue to provide care for residents in a manner and in an environment that maintains respect for their</p>	03/20/2013			

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	<p>bariatric chair for her to sit on. She indicated she was only offered bed baths because her wheel chair did not fit in the showe area.</p> <p>Review of the last full minimum data set assessment tool (MDS,) dated 9/23/11, indicated, it was very important for Resident #42 to choose the type of bath she preferred.</p> <p>A current care plan, dated 11/21/2012, indicated Resident #42 had an activity of daily living (ADL) self care deficit as evidenced by requiring extensive assistance related to disease process: morbid obesity, chronic pain, and physical limitations. A goal for Resident #42 included she would receive the assistance necessary to meet her ADL needs and would maintain her existing ADL self performance. She would be clean, dressed, and well groomed daily to promote dignity and psychosocial well being. Interventions to meet this goal included: assist with bathe/shower as needed, assist with daily hygiene grooming, dressing, oral care, and eating. As needed use of assistive/adaptive equipment.</p> <p>During an interview, on 2/15/2013 at 2:13 P.M., the Administrator indicated</p>		<p>choices/preferences for ADL care. Each resident will be interviewed to assure their preferences/choices for shower routines have been identified and scheduled according to their preference/choice. In addition we will have an ongoing process to assure we have current choices identified. During quarterly care plan meetings social services will inquire if there are any changes in identified preferences/choices and assure choices are being honored. This will be documented in the care conference note.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Facility staff was re-educated on honoring a resident's right to make choices. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Department Managers, including nursing leadership, will interview a total of 20 residents a week for 6 weeks to validate their choices are accommodated and honored. The ADNS/ Designee will track the responses. Any problems noted will be addressed and the findings of the interviews will be reported to the QA committee weekly. The QA committee will make recommendations based on the findings for the continuation of the audits.</p>		

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	<p>he didn't realize she did not have a bariatric shower chair."</p> <p>Bathing records for the last three months were reviewed (December 2012, January 2013, and February 2013). These records indicated, Resident #43 had only been offered the choice of a bed bath.</p> <p>2. On 2/8/13 at 9:38 A.M., in an interview, Resident #141 indicated she did not choose how many showers or the days she received a shower [Resident #141 indicated she did not receive a tub bath]. Resident #141 indicated the facility set certain days for her shower and on those set days she had missed a shower related to the facility being short staffed with aides.</p> <p>On 2/18/13 at 2:00 P.M., the Director of Nursing [DoN] provided Resident #141's shower documentation.</p> <p>An "Interventions/Task for December 2012 through February 2013," included, but was not limited to, "Shower/Bath: Every day shift except shower days... Shower/Bath: Monday and Thursday days..."</p>		<p>ADDENDUM Department Managers, including nursing leadership, will interview a total of 20 residents a week for 6 weeks then monthly for 6 months to validate their choices are accommodated and honored.</p>				

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	<p>Resident #141 did not receive a bath, shower, or bed bath on the following days: 12/13/12, 12/27/12, 1/3/13, 1/14/13, 1/24/13, 1/28/13, 2/4/13, 2/7/13, and 2/14/13.</p> <p>There was no documentation of a shower being given on a non-scheduled shower/bath day for the months of December 2012 through February 18, 2013.</p> <p>3. On 2/8/13 at 10:00 A.M., in an interview, Resident #171 indicated she did not choose how many times a week she took a shower [Resident #171 indicated she did not receive a tub bath]. She indicated the facility chose her shower days and if she refused a shower on her scheduled day she was not allowed to receive one on a different day. Resident #171 indicated the aides told her she could not receive a shower on non-scheduled days.</p> <p>On 2/18/13 at 2:00 P.M., the DoN provided Resident #171's shower documentation.</p> <p>An "Intervention/Task for December 2012 through February 2013," included, but was not limited to, "Shower/Bath: Wednesday/Saturday evenings... Bed bath every day</p>						

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	<p>shift..."</p> <p>Resident #171 did not receive a bath, shower, or bed bath on the following days: 12/5/12, 12/8/12, 12/26/12, 1/19/13, 1/23/13, 1/26/13, and 2/2/13.</p> <p>There was no documentation of a shower being given on a non-scheduled shower/bath day for the months of December 2012 through February 18, 2013.</p> <p>On 2/18/12 at 9:15 A.M., the DoN indicated that if a resident did not receive his or her scheduled shower or bath, the resident should have been offered a shower or bath the next day, not just a bed bath.</p> <p>On 2/18/13 at 10:52 A.M., Certified Nursing Assistant [CNA] #14 indicated if a resident did not receive a shower on his or her scheduled day, she would try to fit it in her schedule the next day. She would give a bed bath if there was not enough time to give a resident a shower.</p> <p>3.1-3(u)(1)</p>				

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interview, and record review, the facility failed to ensure accommodations were made for a patient to be able to take showers for 1 of 35 residents reviewed for accommodations of needs (Resident #42)</p> <p>Findings:</p> <p>1. Resident #42's record was reviewed on 2/14/2013 at 12:06 P.M. She was admitted to the facility on 9/23/2011. She had current diagnoses which included, but were not limited to, uterine cancer, cellulitis/abscess, hypertension, anxiety, depression, and morbid obesity.</p> <p>During an interview on 2/7/2013 at 2:53 P.M., Resident #42 indicated the showers were not designed for bariatric patients. She indicated would like to take showers but she could not because they did not have a bariatric chair for her to sit on. She</p>	F000246	<p>It is the practice of Manor Care Prestwick to provide our residents with reasonable accommodations of individual needs and preferences. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident #42 was provided an appropriate shower chair and arrangements made to provide her showers when desired per her choice. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents in facility were evaluated to assure they have necessary equipment in place to assure they have access to showers per their preferences. Needs were assessed by the IDT to determine any other resident with the same/similar equipment needs. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The nursing staff was re-educated on</p>	03/20/2013			

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	<p>indicated she was only offered bed baths because her wheel chair did not fit in the showe area.</p> <p>Review of the last full minimum data set assessment tool (MDS,) dated 9/23/11, indicated, it was very important for Resident #42 to choose the type of bath she preferred.</p> <p>A current care plan, dated 11/21/2012, indicated Resident #42 had an activity of daily living (ADL) self care deficit as evidenced by requiring extensive assistance related to disease process: morbid obesity, chronic pain, and physical limitations. A goal for Resident #42 included she would receive the assistance necessary to meet her ADL needs and would maintain her existing ADL self performance. She would be clean, dressed, and well groomed daily to promote dignity and psychosocial well being. Interventions to meet this goal included: assist with bathe/shower as needed, assist with daily hygiene grooming, dressing, oral care, and eating. As needed use of assistive/adaptive equipment.</p> <p>During an interview, on 2/15/2013 at 2:13 P.M., the Administrator indicated he didn't realize she did not have a</p>		<p>accommodating all individualized needs and choices of each resident. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> Department Managers, including nursing leadership, will interview a total of 20 residents a week for 6 weeks to validate their choices are accommodated and honored. The ADNS/ Designee will track the responses. Any problems noted will be addressed and the findings of the interviews will be reported to the QA committee weekly. The QA committee will make recommendations based on the findings for the continuation of the audits. ADDENDUM Department Managers, including nursing leadership, will interview a total of 20 residents a week for 6 weeks then monthly for 6 months to validate their choices are accommodated and honored.</p>		

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	<p>bariatric shower chair."</p> <p>Bathing records for the last three months were reviewed (December 2012, January 2013, and February 2013). These records indicated, Resident #43 had only been offered the choice of a bed bath.</p> <p>3.1-3(v)(1)</p>			

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review, and interview the facility failed to ensure a hospice resident had a comprehensive care plan which indicated specific goals and interventions collaborating the care between the facility and the contracted hospice company (Resident E), a care plan was developed to meet resident needs (Resident B), and a care plan was developed which included appropriate interventions for fall preventions (Resident F). This deficient practice affected 3 of 35 residents reviewed</p>	F000279	It is the practice of Manor Care Prestwick to develop comprehensive care plans addressing the individualized needs of each resident. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The care plan for Resident E was revised and now specifies who will be providing daily care in collaboration with Hospice care providers. The fall risk factors for Resident F were reviewed and appropriate interventions have been implemented. Resident B no	03/20/2013	

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	<p>for care plans.</p> <p>Findings:</p> <p>1. Resident E's record was reviewed on 2/13/2013 at 2:19 P.M. She was admitted to the facility on 1/17/2011. She had diagnoses which included, but were not limited to, dementia, dysphagia, oropharngal phase, constipation, hypothyroidism, hypertension, neuralgia-trigeminal, depressive disorder, and Alzheimer's disease. She was receiving hospice services.</p> <p>During an interview, on 2/18/2013 at 2:40 P.M., CNA (Certified Nursing Assistant) #20 and LPN (Licensed Practical Nurse) #21, were asked what days hospice provided care for Resident E. They both indicated, hospice had different schedules and it varied. When asked how they knew who was providing the showers/baths care for the day they indicated they did not know it by heart, nothing was written, and it varied. At this time LPN #21 indicated, the hospice nurse was in the facility and should be consulted to gain information regarding coordination of care between the facility and hospice.</p> <p>During an interview, on 2/18/2012 at 2:48 P.M., The hospice nurse stated,</p>		<p>longer resides at the facility. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents on Hospice, residents that have been admitted within the last 30 days and residents with falls in the last 30 days have been reviewed to validate comprehensive care plans are in place and updated to address the resident's most immediate care needs. IDT will validate on an ongoing basis through the daily clinical meeting that changes, updates to theses resident's care plans are initiated with appropriate interventions. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The staff has been re-educated on the development of comprehensive care plans and the benefit / need of coordinating care with outside agencies, such as Hospice. The DCD's, (Director of Care Delivery), have been re-educated on the process of care plan development and implementation based on new orders or changes of condition. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> IDT will review new admissions daily during the morning clinical meeting for 6</p>		

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	<p>"It should be easy. We document when we come."</p> <p>Resident E's care plan dated 1/21/13, failed to specify who would be providing daily care in collaboration with the hospice care team.</p> <p>2. Resident B's record was reviewed on 2/8/2013 at 2:08 P.M. Resident B was admitted to the facility on 12/14/2012. Diagnoses included, but were not limited to: atrial fibrillation, hypertension, history of bladder cancer, osteoporosis and Alzheimer's disease.</p> <p>A nurse's admission note, dated 12/14/2012-10:24 P.M., indicated, Resident B was arrived at the facility late in the evening. She was very scared and repeatedly called out,"help me please". The family informed facility staff she had been eating poorly the last few days. This note further indicated, ..."Her blood pressure was very low on admission 79/50."</p> <p>A nurse's note, dated 12/15/2012-7:04 A.M., indicated, Resident B refused to have her vitals taken. A nurse's note, dated 12/15/2012-13:14, indicated she continued to refuse to let staff take</p>		<p>weeks to discuss the care plan needs of each resident and to validate that care plans are initiated at the time of admission. Random selections of 3 residents being served by Hospice will be chosen weekly for 6 weeks to validate the care plans are current and there is documentation of the collaborative effort to provide care. The fall care plan will be reviewed by IDT of each resident who fall to assure new interventions address root cause of the fall each day in the morning clinical meeting times 6 weeks. The Director of Nursing/Designee will track compliance weekly times six weeks and report to the weekly QA meeting and, based on the outcomes, the QA committee will determine the need for continued monitoring past 6 weeks and recommend a schedule for monitoring. ADDENDUM All monitoring of this tag will move to monthly for 6 months after the initial 6 weeks</p>				

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	<p>her vitals.</p> <p>A nurse's note, dated 12/15/2012-5:39 P.M., indicated, the physician was called regarding the resident's behaviors of yelling and calling out all night. An anti-anxiety medication was ordered for three days until the physician could evaluate her.</p> <p>A nurse's note, dated 12/15/2012-9:40 P.M., indicated Resident B was yelling out and hitting the staff. The family was called and they informed the staff she had not eaten for about four days at home and barely drank anything. This note indicated since admission she had continued the same routine.</p> <p>A nurse's note, dated 12/16/2012-4:20 A.M., indicated, "Aide came to nurse to report pt [patient] did not seem "right". On arriving in pt room, noticed labored respirations and groaning coming from pt. Vital signs obtained -02[oxygen level]-80%, HR [heart rate] 54, RR [respirations]-24, BP [blood pressure]-unable to obtain. Applied supplemental oxygen 4L[Liters] 02-94%, RR-16, HR-68 still unable to obtain BP. Pt only responded to sternal rub by groaning.</p>						

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	<p>Lung sounds clear...Dr office notified of pt. status. Family notified."</p> <p>A nurse's note, dated 12/16/2012-5:55 A.M., indicated, "Pt [patient] family member came to get nurse to discuss further care options for pt. Pt husband wanted to see wife before discussing further options with family. Nurse escorted family to pt room. Upon going to pt side of room pt did not have visible respiration. On assessing pt no audible heart sounds. Went to get another nurse to verify no audible heart sounds..."</p> <p>During an interview, on 2/15/2013 at 3:00 P.M., the Administrator was asked to provide a copy of Resident B's care plans.</p> <p>During an interview, on 2/18/2013 at 9:30 A.M., the Administrator indicated there were no care plans for this resident.</p> <p>3. On 2/13/13 at 3:10 P.M., Resident F's record was reviewed. Diagnoses included, but were not limited to, difficulty walking, muscle weakness, dementia, venous insufficiency, sleep apnea, diabetes mellitus, cellulitis of leg, benign prostate hypertrophy, and</p>						

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	<p>coronary artery disease.</p> <p>A "Patient Admission/Re-Admission" assessment, dated 10/15/12 at 11:03 P.M., included but was not limited to, "Fall Risk: [marked] Unsteady gait, Appliances/device in use [wheelchair], Underlying health conditions that may predispose patient to falls [dementia, cellulitis of leg, heart disease with diuretic use]..."</p> <p>A fall care plan, dated 10/15/12, included, but was not limited to, "At risk for falls due to impaired balance/poor coordination, unsteady gait/noncompliant with asking for assistance... Minimize risk of injury related to falls... Administer medication per physician's order [10/15/12], Encourage transfer and change positions slowly [10/15/12], Provide assist to transfer and ambulate as needed [10/15/12], Reinforce need to call for assistance [10/15/12]..."</p> <p>An admission MDS [Minimum Data Screening] assessment, dated 10/22/12, indicated Resident F had cognitive impairment with a BIMS [Brief Interview Mental Status] score of 7, required extensive assistance of 1 staff member for transfers, required limited assistance of 1 staff member</p>			

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	<p>to walk in his room, and required limited assistance of 1 staff member for toileting. In addition, Resident F was assessed as occasionally incontinent of his bladder.</p> <p>A fall assessment [after a fall], dated 10/27/12 at 2:04 P.M., included, but was not limited to, "Resident [F] was found laying on floor between bed, wheelchair brakes were locked, call light was not on, resident was barefooted... states that his wheelchair slid out from underneath him... root cause poor safety awareness related to lack of footwear... [Interventions] Non-skid socks were immediately applied, educated on using call light..."</p> <p>A "Nurse's Progress Notes" dated 10/29/12 at 1:35 P.M., included, but was not limited to, "Resident [F] still exhibiting poor safety awareness... not utilizing call light for staff assistance... resident [Resident F] is still ambulating in room using wheelchair as assistive device and furniture walking... Resident [F] and wife acknowledged education... they both require reinforcement and encouragement for compliance..."</p> <p>A "Nurse's Progress Notes" dated 11/24/12 at 7:24 A.M., included, but</p>				

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	<p>was not limited to, "At 5:00 A.M., resident [Resident F] was found by staff sitting on bottom [buttocks] on floor in front of wheelchair... immediate intervention initiated to maintain an environment free of hazard and debris..."</p> <p>A "Nurse's Progress Notes" dated 12/13/12 at 7:07 A.M., included, but was not limited to, "Wife of resident [Resident F] came to door and stated her husband needed help... was laying on floor between the two beds attempting to get up... skin tear on left elbow 6 centimeters in length... family notified and requested an alarm... new intervention is to report development of pain, bruises, or change in mental status..."</p> <p>There was no documentation in the care plan of alarm implementation for Resident F. In addition, the facility failed to implement new fall interventions to address Resident F's non-compliance with self-transferring. Resident F had a well documented history of noncompliance with transfer assist.</p> <p>A "Nurse's Progress Notes" dated 12/13/12 at 4:33 P.M., included, but was not limited to, "Resident [F] fell in bathroom this was witnessed by head</p>						

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	<p>of housekeeping... resident [Resident F] has always been non-compliant with transfers refuses to ask for help... New intervention anti roll back brakes... educated on need to wait for assistance..."</p> <p>A "Nurse's Progress Notes" dated 12/13/12 at 9:54 P.M., included, but was not limited to, "Resident [F] has transferred self in and out of wheel chair several times this shift..."</p> <p>There was no documentation in Resident F's care plan regarding implementation of new fall interventions. Resident F had 2 falls on 12/13/12 and was observed by staff to transfer without assistance throughout the evening of 12/13/12. However, the facility failed to address alternative fall interventions related to Resident F's continued noncompliance with transfers.</p> <p>A "Nurse's Progress Notes" dated 12/14/12 at 5:37 P.M., included, but was not limited to, "Resident [F] was found on the floor by an aide on his left side and wife was trying to help him up... has a laceration on his forehead and left arm... sent to [Local Hospital] emergency room..."</p> <p>An Acute Care Transfer assessment,</p>						

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	<p>dated 12/14/12 at 2:00 P.M., included, but was not limited to, "Unplanned transfer... Reason for transfer: Patient fell in his room and has a large puncture laceration on his forehead and a small laceration on his left wrist..."</p> <p>A "[Local Hospital] Discharge Instructions" dated 12/14/12 at 6:28 P.M., included, but was not limited to, "Final Diagnosis: Facial laceration [Resident F received 4 sutures to his forehead]..."</p> <p>The facility's failure to address alternative fall interventions resulted in harm to Resident F.</p> <p>On 2/14/13 at 2:00 P.M., Resident F was observed in his room sitting in his wheelchair with his call light on the floor. Resident F was required to call for assistance before transferring and had a history of falling.</p> <p>On 2/18/13 at 2:44 P.M., in an interview, the Director of Nursing [DoN] indicated Resident F required a lot of supervision from admission in October, 2012 through December, 2012. She indicated staff needed to keep close watch of him because he would transfer without assistance. She indicated the main cause of his</p>						

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	<p>falls was related to unassisted transfers in the bathroom or related to his need to toilet. The DoN indicated the facility was an alarm free facility, therefore, the use of alarms was not implemented as requested by Resident F's family. The DoN indicated his falls have decreased as a result of the implementing every 2 hour toileting [added to care plan on 1/25/13].</p> <p>This federal tag is related to Complaint IN00122582.</p> <p>3.1-35(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident's plan of care was followed. This deficient practice affected 2 of 35 sampled residents whose plan of care was reviewed [Residents G and H].</p> <p>Findings include:</p> <p>1. On 2/12/13 at 11:12 A.M., in an interview, Resident G's wife indicated she visits her husband daily around 2:30 P.M. and she had concerns regarding an incident [on 2/11/13 at 2:30 P.M.] when Certified Nursing Assistant [CNA] #15 [who worked the 6:00 A.M. to 2:00 P.M. shift on 2/11/13] left her husband [Resident G] wet after transferring him from his wheelchair to the bed. She indicated she made the staff aware of her concerns.</p> <p>On 2/14/13 at 10:20 A.M., Resident G's record was reviewed. Diagnoses included, but were not limited to, dementia, esophageal reflux, dysphagia, hypertension, and history</p>	F000282	<p>It is the practice of Manor Care Prestwick to follow the residents' plan of care <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident G was checked and provided assistance as soon as the situation was brought to the attention of the staff. The physician of Resident H was contacted, in addition to the family of Resident H, to make notification of the medication error. C.N.A #15 was provided a one to one re-education. LPN #20 is no longer employed here. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents going out for Dialysis and those dependent for incontinence care would be at risk. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The Nursing staff was re-educated on following the plan of care related to incontinence care. Licensed Nurses have been re-educated</p>	03/20/2013	

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	<p>of pneumonia.</p> <p>An Activities of Daily Living [ADL] care plan, dated 12/6/12, included, but was not limited to, "ADL self care deficit as evidenced by declined cognitive functions related to middle stage dementia, cva[cerebral vascular accident] with left hemiparesis [weakness or paralysis]... will receive assistance necessary to meet adl needs... assist to bather shower as needed, assist with daily hygiene, grooming, dressing, oral care, and eating as needed, check for incontinence frequently and provide incontinent care as needed, transfer with mechanical sling lift..."</p> <p>On 2/15/13 at 3:40 P.M., in an interview, Licensed Practical Nurse [LPN] #17 indicated on 2/11/13, her evening aide, CNA #18 informed her that Resident G was left wet [urine soaked brief] by the day aide, CNA #15 and Resident G's wife was not happy about the situation. LPN #17 indicated that her CNA [#18] provided the necessary incontinent care for Resident G.</p> <p>On 2/18/13 at 11:00 A.M., the DoN indicated she was aware Resident G was found wet on the second shift [2:00 P.M. to 10:00 P.M.] shift and</p>		<p>on the shift to shift report process and importance of medications for dialysis residents being adjusted around their dialysis times as ordered. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> The Director of Nursing/designee to conduct random rounds 3 times a week, to include days, evening, nights and weekend to validate incontinence care is being provided as care planned. The Director of Nursing/Designee to monitor medication pass of residents with orders for hemodialysis to assure those medications that have been adjusted around their dialysis times are administered as ordered. This monitoring will occur 3 times a week for 6 weeks. The Director of Nursing/Designee will track compliance weekly times six weeks and report to the weekly QA meeting and, based on the outcomes, the QA committee will determine the need for continued monitoring past 6 weeks and recommend a schedule for monitoring ADDENDUMThe Director of Nursing/Designee to monitor medication pass of residents with orders for hemodialysis to assure those medications that have been adjusted around their dialysis times are administered as ordered. This monitoring will</p>		

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	<p>that a proper shift change was not conducted before CNA #15 left the floor. She indicated that if a proper shift change would have been completed, Resident G would not have been left wet or incontinent.</p> <p>2. On 2/14/13 at 10:00 A.M., Resident H's record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, weakness, depression, atrial fibrillation, and diabetes mellitus.</p> <p>A "Physician's Orders" dated 11/29/12, included, but was not limited to, "May give A.M. [prior to dialysis at 6:00 A.M.] medications on return from Dialysis..."</p> <p>A "Medication Administration Record" dated 2/1/13, indicated the following medications were not given upon return from dialysis: 2/5/13 and 2/14/13: Acetaminophen [pain medication] 1000 mg [milligrams] [twice daily at 8 A.M. and 8 P.M.], Amiodarone [antiarryhythmic] HCL 200 mg [once daily at 8 A.M.], Aspirin 81 mg [once daily at 8 A.M.], Calcium Acetate 667 mg [once daily with breakfast at 8 A.M.], Seroquel [anti-psychotic] 50 mg [twice daily at 8 A.M. and 8 P.M.], Pantoprazole [proton pump inhibitor, used for reflux]</p>		<p>occur 3 times a week for 6 weeks then monthly for 6 months. The Director of Nursing/Designee will track compliance weekly times 6 weeks then monthly for 6 months and report to the weekly QA meeting and, based on the outcomes, the QA committee will determine the need for continued monitoring and recommend a schedule for monitoring</p>	

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	<p>Sod Dr 40 mg [once daily at 8 A.M.], and Miralax [stool softener] [once daily at 8 A.M.].</p> <p>On 2/15/13 at 11:00 A.M., in an interview, Licensed Practical Nurse [LPN] #19 indicated Resident H returned to the facility around 11:15 A.M. on dialysis days and she was aware she was supposed to give her morning medications upon return.</p> <p>On 2/15/13 at 11:10 A.M., in an interview, LPN #20 indicated she did not give Resident H her morning medications on 2/14/13 because she didn't see the order and she was a float nurse.</p> <p>This federal tag is related to Complaint IN00122582.</p> <p>3.1-35(g)(2)</p>				

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F000309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview the facility failed to provide the necessary services to ensure a resident with pain was evaluated and provided proper pain management interventions (Resident C). This deficient practice affected 1 of 3 residents reviewed for death/dying.</p> <p>Findings:</p> <p>Resident C's record was reviewed on 2/14/2013 at 2:37 P.M. Resident C was admitted to the facility on 12/17/2012, from an acute care hospital, and had diagnoses which included urinary tract infection, muscle weakness, chronic anemia, senile dementia, peripheral vascular disease, depressive disorder, uncontrolled diabetes type 2, atrial fibrillation, hypertension, urinary obstruction, chronic kidney disease, and gangrene symptoms. Resident C's son was his Power of Attorney and the primary contact.</p>	F000309	<p>It is the practice of Manor Care Prestwick to provide all residents with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident C no longer resides at the facility. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents who are experiencing pain and or have the potential for pain are at risk. Newly admitted residents will be evaluated for presence and or recent history of pain. Appropriate pain management interventions will be initiated. Current residents whose pain scores are above their stated goal will be re-evaluated to assure pain interventions are appropriate for managing their pain. <b>What measures will be put into place or what systemic changes will</b></p>	03/20/2013	

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	<p>Review of an undated discharge summary, from the acute care hospital from which Resident C was admitted, indicated, Resident C's hospital physicians had had conversations with his son regarding his end stage debility and possible diagnoses of dementia. This record indicated, "...the patient's son was adamant that the patient be tried on some type of alternative alimentation... Dr. [named] and the patient's son came up with a plan of putting in a PICC [peripherally inserted central catheter] line and trying TPN [total parental nutrition] for two weeks. If this does not succeed in increasing his functional status they will consider possible hospice versus other form of alimentation at that point...."</p> <p>A document dated, 12/23/2012 and titled, "State of Indiana, Out of Hospital Do Not Resuscitate Declaration and Order", indicated Resident C's son gave a verbal consent to change his fathers status to DNR [do not resuscitate]. This form indicated, "I declare: My attending physician has certified that I am a qualified person, meaning that I have a terminal condition a medical condition such that, if I suffer cardiac</p>		<p><b>be made to ensure that the deficient practice does not reoccur?</b> Licensed nursing staffs were in-serviced on Pain Management Guidelines including an approach that uses the nursing process framework to assess, plan, implement and evaluate pain management. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> A QAA monitoring tool will be completed by the ADNS/designee on Pain Management. ADNS/designee will monitor new admits daily; those with pain will monitored to assure they are evaluated at the time of admission and appropriate pain management interventions are in place. ADNS/designee will also monitor daily those residents experiencing pain to assure pain is evaluated, appropriate pain management interventions are in place and meeting the needs of the resident to assure resident maintains the highest practicable physical, mental, and psychosocial well-being. Monitoring will be completed weekly times six weeks and then monthly times 3 months. The results will be reviewed by QAA committee weekly. After that point, the QA Committee will make a recommendation for frequency of continued monitoring. ADDENDUMMonitoring will be completed weekly times six</p>		

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	<p>or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death. I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain...."</p> <p>A social service note, dated 12/24/2012, indicated, "Spoke with Resident's son [named] regarding hospice. [Nurse named], Nurse Weekend Manger had discussed hospice benefits with them over the weekend. I explained that hospice comes into the building to provide care on top of services that we already provide and is a good support for the family also. Resident has expressed to family that he wanted to die at home. The family is looking at all options right now. [Son named] had talked with hospice today but no decision have been currently...They would like to take him home but have things to get ready at home first. He stated that hospice may only be for a</p>		<p>weeks and then monthly times 6 months. The results will be reviewed by QAA committee weekly. After that point, the QA Committee will make a recommendation for frequency of continued monitoring.</p>				

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	<p>few days and then home but they haven't decided yet. I stated that I would follow up with him on Wednesday when I was back in the office." Orders were obtained to have the patient evaluated by hospice.</p> <p>A document, dated 12/23/2013, and titled, "Manor Care Health Services Fax Cover Sheet", indicated, a hospice company was faxed with a request to contact Resident C's son on 12/24/2012 to discuss hospice.</p> <p>An untrimmed nurse's note, dated 12/17/2012 indicated, "Resident arrived at facility accompanied by 2 paramedics. Resident was transferred to bed in Rm [room].... Resident noted to be contracted into fetal position, moans and cries out in pain if attempts to straighten limbs are made. Resident has multiple open areas as detailed on skin assessment. Skin is warm and dry. Resident is lethargic alert to self. Vitals signs are stable. Respirations even, non labored..." The record including the MAR [Medication Administration Record] lacked documentation Resident C was administered pain medicine on this date.</p> <p>Resident C's admission physician's</p>				

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	<p>orders, dated 12/17/2012, indicated, Resident C was to have a daily numeric pain score. These physician's orders indicated an order for acetaminophen 325 milligrams 2 by mouth every 6 hours as needed for pain. A physician's order, dated 12/20/2012, indicated scheduled Tylenol 325 milligrams 2 tablets were to be given by mouth twice a day for generalized pain.</p> <p>A care plan initiated on 12/17/2012, indicated, Resident C had generalized pain as evidenced by verbal and non-verbal signs and symptoms related to contractures, arthritis, and pressure points/ulcers. The goal was for pain or analgesia to not affect participation in activities of choice or daily care. Interventions listed to meet this goal included: 1) Report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. 2) Administer pain medication per physician orders 3) Encourage/Assist to reposition frequently to a position of comfort 4) Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective.</p> <p>A untimed document, dated</p>			

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	<p>12/18/2012, and titled, "Pain Assessment in Advanced Dementia (PAINAD) Scale", indicated, "...the PAINAD scale was used for patients who could not verbally communicate about their pain. The PAINAD scale evaluates the realms of breathing, independent of vocalization; negative vocalizations; facial expression; body language; and consolability. The observations are converted to a numeric 0-10 scale. Observe the patient for five minutes before scoring the behaviors."</p> <p>A nurse's note, dated 12/18/2012-7:11 A.M., indicated, Resident C had no signs of pain. The MAR [Medication Administration Record] indicated, at 8:00 A.M., his pain score was 8 out of 10. He was not given pain medication at this time.</p> <p>The next nurse's note, dated 12/18/2012-10:49 P.M., indicated, ..."pt [patient] moans with touch..." The record did not have documentation of a pain assessment being completed or pain medication being administered.</p> <p>A nurse's note, dated 12/18/2012-1:26 P.M., indicated, Resident C verbalized understanding of care being provided but would yell</p>			

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	<p>out and drawl in with repositioning and care.</p> <p>An occupational therapy note, dated 12/18/2012-untimed, indicated Resident C had an increase in expressions of pain.</p> <p>The December MAR indicated, on 12/19/2012 at 8:00 A.M., Resident C was assessed to have a pain score of 2 out of 10. The record lacked documentation pain medication was administered at that time.</p> <p>A nurse's noted, dated 12/20/12-3:21 P.M., indicated, "...Pt [patient] has several necrotic areas on feet and toes. Dressings and treatments completed on Bilateral feet, toes and on buttocks. Pt says "ouch" anytime he is being moved or repositioned. Takes his meds crushed in apple sauce...." Resident #18's record lacked documentation of a pain assessment. The MAR (medication administration record) indicated Tylenol was given at 8 P.M. The record lacked documentation of the effectiveness of the pain medication.</p> <p>The December MAR indicated, on 12/21/2012, Resident C was administered Tylenol at 8:00 A.M. for pain of 4 out of 10. The record</p>						

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	<p>lacked documentation of the effectiveness of the pain medication.</p> <p>A nurse's note, dated 12/22/2012-11:38 P.M., indicated, "Res. [resident] refused all oral meds [medications] this PM. Cursed at nursing staff when repositioned....Bed bath completed and lotions applied to skin. Res. continues to moan out in pain and curse when moved in bed..." The record lacked documentation of a pain assessment, the administration of ordered pain medications, or the physician being notified of the his pain interfering with care.</p> <p>A nurse's note, dated 12/23/2012-1:59 P.M., indicated, "...pt [patient] laying in bed in fetal position, staff attempted to reposition several times...any time pt is touched for care or repositioning pt yells out, becoming very combative, pt unable to make needs or wants clear to staff, pt currently laying in bed with call light in reach." The record lacked documentation of a pain assessment at this time or the administration of ordered pain medications.</p> <p>The December MAR indicated, on 12/23/2013, staff attempted to give Tylenol to resident C but he was unable to swallow any medication.</p>			

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	<p>The record lacked documentation of a physician being notified of Resident C's inability to swallow medication or a request for pain medication to be delivered in a route other than oral.</p> <p>The MAR for 12/24/2012, indicated Resident #18's daily pain score was zero.</p> <p>A physical therapy note, dated 12/24/2012, indicated, "...Pt is non-responsive and been sleeping all time. Pt [patient] is completely dependent for bed mob. [mobility]. Unable to perform functional transfers R [related to] L/E [lower extremity] contracture... Not alert or oriented at all. Pt also c/o [complains] generalized pain. Pt has dr's [doctors] for possible hospice eval. [evaluation]. Not appropriate for skilled PT [physical therapy] at this date."</p> <p>An occupational therapy note, dated 12/24/2013, indicated, "...movement of any sort appears uncomfortable as indicated by grimacing and moaning...." This note further indicated Resident #18 had expressions of pain with touch or movement.</p> <p>A nurse's note, dated</p>						

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	<p>12/24/2012-11:18, indicated, "...staff state resident "yells out and moans" whenever care is provided. He has orders for scheduled pain med [medicine] however resident has been refusing all meds po [oral] meds at this time..." The record lacked documentation of a pain assessment at this time or of pain medication being administered on this date.</p> <p>A physician's telephone order, dated 12/24/2012-untimed, indicated, Resident C may have the Tylenol given rectally instead of orally. The MAR indicated Resident C was administered Tylenol 650 Milligrams rectally on 12/24/2013 at 8:00 P.M. The record lacked documentation of a pain assessment or the effectiveness of the pain medication.</p> <p>The MAR indicated, on 12/25/2012 at 8:00 P.M., Resident C was administered the Tylenol suppository for pain as ordered. The record lacked documentation of a pain assessment or the effectiveness of the pain medication given.</p> <p>The next nursing note, dated 12/26/2013-2:15 P.M., indicated, "Res. [resident] blood sugar was 534 at 11 am. Writer called and spoke with NP [nurse practitioner] and was</p>			

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	<p>told to give 18 units. Writer also spoke to NP about res pain, as he cries out when repositioned. Tylenol was D/C'd [discontinued] and a new order for Roxanol (a stronger pain medication) was given. Writer gave one does. Writer called and spoke with son, updating him on the condition of his father and informing him of the new orders for pain meds. Son stated that even though we have been unable to give meds due to res inability to swallow, he would like for us to continue to try to give him his meds." The MAR indicated Roxanol was administered one time on 12/26/2012 at 1:30 P.M. The record lacked documentation of the effectiveness of the pain medication that was administered.</p> <p>Resident C died on 12/27/2012. The record lacked documentation of care and assessments for Resident C after the above nurse's note, dated 12/26/2012 at 2:15 P.M.</p> <p>During an interview, on 2/18/2013 at 9:30 A.M., the Administrator indicated there was not any further documentation on Resident C after 12/26/2012 at 2:15 P.M. The Administrator was asked about the details surrounding the residents death and he indicated he was</p>			

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	<p>looking into it.</p> <p>The DON [Director of Nursing] called the nurse's who cared for Resident C his last day in the facility. The gave statements regarding the care provided. A statement from LPN #15, obtained on 12/18/2013 at 4:50 P.M., indicated she worked on 12/26/2012 from 2 PM to 10 PM. LPN [Licensed Practical Nurse] #15 indicated, "I only had him that one time. I know that he wasn't swallowing his meds, but I know that wasn't new, he wasn't taking his meds. [nurse named], got new orders for Roxanol on her shift. He had TPN running. Nothing changed on my shift. I started Roxanol on my shift. No apnea or mottling noted. He was asleep the whole shift. I sent [staff named] to give him mouth care. Basically what I did for him that night was comfort care. Kept him clean, gave him mouth care, turned him, he wasn't eating or drinking, comfort meds, TPN was running."</p> <p>A statement, obtained from LPN #16 on 2/18/2013 at 3:50 P.M., indicated, she was asked how the resident was during the night shift. She replied, "Fine." She was asked if she took his 6 A.M. Blood sugar. She replied, "Yes." She was asked to tell her</p>			
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	<p>assessment of him when she was in the room taking his blood sugar. She replied, "He was laying on his right side, 02 was on, TPN was running. I said his name. He opened his eyes. I checked his blood sugar. I think it was like 132 or in the 130s. It was normal. I didn't have to give him insulin. After I got done checking his blood sugar the CNA's (certified nursing assistants) stated he seemed more comfortable and they were going in there to check him. She was asked if she noticed any apnea or mottling and she replied, "no apnea, no mottling, he seemed normal." She was asked if she remembered anything else. She replied, "No not right now."</p> <p>A statement, obtained from LPN #17 on 2/18/2013-9:50 A.M., indicated, she worked 12/27/2012-6-2 P.M.. LPN #17 indicated, "I went in after report around 6:30-6:45 A.M. and checked him. He was having periods of apnea then. I went in to check on him between 8-8:30 A.M. and he was already gone. Listened to his chest no heart beat or respirations. Went and got [nurse named]. She listened to him and verified no heart rate or respirations. I called the son to notify him. Son just said thanks for letting me know. Then I notified the NP</p>			

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	<p>[named] in facility."</p> <p>During the interview, on 2/18/2013 at 5:10 P.M., the DON was asked to provide information which included, but not limited to, pain assessments, assessments of the effectiveness of the ordered pain medication, and physician notification of Resident C's inability to have care due to his pain. Policies for pain management and assessment were requested. I asked her why there wasn't any documentation regarding a follow-up on Resident #18's pain and she replied, "That's a good question."</p> <p>Review of Resident C's controlled substance record, indicated, LPN #17 administered one dose of Roxanol on 12/26/2012 at 1:30 P.M. The rest of the medication was destroyed when Resident C died.</p> <p>During the exit conference, on 2/18/2013 at 7:00 P.M., the Administrator and the DON indicated they did not have any further information to provided at that time.</p> <p>This federal tag relates to Complaint(s) IN00122582 and IN00122854</p> <p>3.1-37(a)</p>				

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F000323 SS=G	<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 record review, interview, and observation, the facility failed to implement appropriate fall interventions to prevent injury of a cognitively impaired resident who was identified as a high fall risk on admission. This deficient practice affected 1 of 3 residents reviewed for accidents out of 35 sampled residents [Resident F].</p> <p>Findings include:</p> <p>On 2/13/13 at 3:10 P.M., Resident F's record was reviewed. Diagnoses included, but were not limited to, difficulty walking, muscle weakness, dementia, venous insufficiency, sleep apnea, diabetes mellitus, cellulitis of leg, benign prostate hypertrophy, and coronary artery disease.</p> <p>A "Patient Admission/Re-Admission" assessment, dated 10/15/12 at 11:03 P.M., included but was not limited to, "Fall Risk: [marked] Unsteady gait, Appliances/device in use [wheelchair], Underlying health conditions that may</p>	F000323	<p>It is the practice of Manor Care Prestwick to provide a resident environment that remains as free of accident as is possible. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident F received a fall risk and functional status evaluation. Fall interventions are in place that have been deemed appropriate to address current fall risk and functional factors to aid in preventing injuries related to falls. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Current residents will receive a fall assessment to be completed by nursing management. Residents determined to be a fall-risk will have fall interventions reviewed and changes implemented as needed. New admissions will have a fall assessment and interventions implemented as necessary upon admission. The Director of Care Delivery/designee updates the resident kardex used by direct</p>	03/20/2013

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	<p>predispose patient to falls [dementia, cellulitis of leg, heart disease with diuretic use]..."</p> <p>A fall care plan, dated 10/15/12, included, but was not limited to, "At risk for falls due to impaired balance/poor coordination, unsteady gait/noncompliant with asking for assistance... Minimize risk of injury related to falls... Administer medication per physician's order [10/15/12], Encourage transfer and change positions slowly [10/15/12], Provide assist to transfer and ambulate as needed [10/15/12], Reinforce need to call for assistance [10/15/12]..."</p> <p>An admission MDS [Minimum Data Screening] assessment, dated 10/22/12, indicated Resident F had cognitive impairment with a BIMS [Brief Interview Mental Status] score of 7, required extensive assistance of 1 staff member for transfers, required limited assistance of 1 staff member to walk in his room, and required limited assistance of 1 staff member for toileting. In addition, Resident F was assessed as occasionally incontinent of his bladder.</p> <p>A fall assessment [after a fall], dated 10/27/12 at 2:04 P.M., included, but</p>		<p>care staff with new/changes in fall interventions and completes a bedside validation. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b>Licensed nursing staff have been in-serviced on post fall evaluation, implementation of fall interventions, and updating the plan of care. The Director of Care Delivery/designee validates that care plans and the resident kardex used by direct care staff with new/changes in fall interventions are updated. Then they are to complete a bedside validation to ensure interventions are in place as care planned. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> A QAA monitoring tool will be completed by ADNS/designee on post fall evaluation, and intervention implementation in patients with current fall. Monitoring will be completed weekly times six weeks and then monthly times 3 months. The results will be reviewed by QAA committee weekly. After that point, the QA Committee will make a recommendation for frequency of continued monitoring. ADDENDUM A QAA monitoring tool will be completed by ADNS/designee on post fall evaluation, and intervention implementation in patients with</p>				

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	<p>was not limited to, "Resident [F] was found laying on floor between bed, wheelchair brakes were locked, call light was not on, resident was barefooted... states that his wheelchair slid out from underneath him... root cause poor safety awareness related to lack of footwear... [Interventions] Non-skid socks were immediately applied, educated on using call light..."</p> <p>A "Nurse's Progress Notes" dated 10/29/12 at 1:35 P.M., included, but was not limited to, "Resident [F] still exhibiting poor safety awareness... not utilizing call light for staff assistance... resident [Resident F] is still ambulating in room using wheelchair as assistive device and furniture walking... Resident [F] and wife acknowledged education... they both require reinforcement and encouragement for compliance..."</p> <p>A "Nurse's Progress Notes" dated 11/24/12 at 7:24 A.M., included, but was not limited to, "At 5:00 A.M., resident [Resident F] was found by staff sitting on bottom [buttocks] on floor in front of wheelchair... immediate intervention initiated to maintain an environment free of hazard and debris..."</p>		<p>current fall. Monitoring will be completed weekly times six weeks and then monthly times 6 months. The results will be reviewed by QAA committee weekly. After that point, the QA Committee will make a recommendation for frequency of continued monitoring.</p>	

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	<p>A "Nurse's Progress Notes" dated 12/13/12 at 7:07 A.M., included, but was not limited to, "Wife of resident [Resident F] came to door and stated her husband needed help... was laying on floor between the two beds attempting to get up... skin tear on left elbow 6 centimeters in length... family notified and requested an alarm... new intervention is to report development of pain, bruises, or change in mental status..."</p> <p>There was no documentation in the care plan of an alarm being implemented for Resident F.</p> <p>A "Nurse's Progress Notes" dated 12/13/12 at 4:33 P.M., included, but was not limited to, "Resident [F] fell in bathroom this was witnessed by head of housekeeping... resident [Resident F] has always been non-compliant with transfers refuses to ask for help... New intervention anti roll back brakes... educated on need to wait for assistance..."</p> <p>A "Nurse's Progress Notes" dated 12/13/12 at 9:54 P.M., included, but was not limited to, "Resident [F] has transferred self in and out of wheel chair several times this shift..."</p> <p>There was no documentation in the</p>			

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	<p>care plan of new fall interventions implemented related to Resident F's continued non-compliance with using call light for assistance with transfers.</p> <p>A "Nurse's Progress Notes" dated 12/14/12 at 5:37 P.M., included, but was not limited to, "Resident [F] was found on the floor by an aide on his left side and wife was trying to help him up... has a laceration on his forehead and left arm... sent to [Local Hospital] emergency room..."</p> <p>An Acute Care Transfer assessment, dated 12/14/12 at 2:00 P.M., included, but was not limited to, "Unplanned transfer... Reason for transfer: Patient fell in his room and has a large puncture laceration on his forehead and a small laceration on his left wrist..."</p> <p>A "[Local Hospital] Discharge Instructions" dated 12/14/12 at 6:28 P.M., included, but was not limited to, "Final Diagnosis: Facial laceration [Resident F received 4 sutures to his forehead]..."</p> <p>On 2/14/13 at 2:00 P.M., Resident F was observed in his room sitting in his wheelchair with his call light on the floor. At that time, in an interview [Resident F was alert and oriented to</p>						

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	<p>person and place], Resident F indicated he could reach his call light if needed.</p> <p>On 2/18/13 at 2:44 P.M., in an interview, the Director of Nursing [DoN] indicated Resident F required a lot of supervision from admission in October, 2012 through December, 2012. She indicated staff needed to keep close watch of him because he would transfer without assistance. She indicated the main cause of his falls was related to unassisted transfers in the bathroom or related to his need to toilet. The DoN indicated the facility was an alarm free facility, therefore, the use of alarms was not implemented as requested by Resident F's family. The DoN indicated his falls have decreased as a result of the implementing every 2 hour toileting [added to care plan on 1/25/13].</p> <p>This federal tag is related to Complaints IN00122582 and IN00122854.</p> <p>3.1-45(a)(2)</p>				

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F000353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>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 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 nursing staff [Certified Nursing Assistants, Registered Nurses, and Licensed Practical Nurses] were available to meet the daily needs of the residents. This deficient practice affected 1 of 35 residents reviewed for choices and 23 of 23 residents who dined in the South unit dining area.</p> <p>Findings include:</p>	F000353	It is the practice of ManorCare Prestwick to have sufficient staff to provide needed care to residents <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The staffing pattern in the building was adjusted to provide coverage for the two staff members that called off work. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents residing in the	03/20/2013	

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	<p>1. On 2/8/13 at 9:38 A.M., in an interview, Resident #141 indicated she did not choose how many showers or the days she received a shower [Resident #141 indicated she did not receive a tub bath]. Resident #141 indicated the facility set certain days for her shower and on those set days she had missed a shower related to the facility being short staffed with aides.</p> <p>On 2/18/13 at 2:00 P.M., the Director of Nursing [DoN] provided Resident #141's shower documentation.</p> <p>An "Interventions/Task for December 2012 through February 2013," included, but was not limited to, "Shower/Bath: Every day shift except shower days... Shower/Bath: Monday and Thursday days..."</p> <p>Resident #141 did not receive a bath, shower, or bed bath on the following days: 12/13/12, 12/27/12, 1/3/13, 1/14/13, 1/24/13, 1/28/13, 2/4/13, 2/7/13, and 2/14/13.</p> <p>There was no documentation of a shower being given on a non-scheduled shower/bath day for the months of December 2012 through February 18, 2013.</p>		<p>facility would be at risk. We will continue to provide quality care to our residents. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> A staffing meeting will be held daily to determine appropriate staffing needs and validate coverage is in place. The Staffing Coordinator will turn in daily staffing sheet to the Director of Nursing for review. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> The Director of Nursing/Designee will report the trends identified through analysis of the daily staffing sheet to the QA Committee on a weekly basis for 6 weeks. The QA Committee will make a recommendation for continued monitoring based on the information provided. <b>ADDENDUM</b>The Director of Nursing/Designee will report the trends identified through analysis of the daily staffing sheet to the QA Committee on a weekly basis for 6 weeks then monthly for 6 months.</p>		

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	<p>On 2/8/13 at 9:38 A.M., in an interview, Resident #141 indicated she did not choose how many showers or the days she received a shower [Resident #141 indicated she did not receive a tub bath]. Resident #141 indicated the facility set certain days for her shower and on those set days she had missed a shower related to the facility being short staffed with aides.</p> <p>On 2/18/13 at 2:00 P.M., the Director of Nursing [DoN] provided Resident #141's shower documentation.</p> <p>An "Interventions/Task for December 2012 through February 2013," included, but was not limited to, "Shower/Bath: Every day shift except shower days... Shower/Bath: Monday and Thursday days..."</p> <p>Resident #141 did not receive a bath, shower, or bed bath on the following days: 12/13/12, 12/27/12, 1/3/13, 1/14/13, 1/24/13, 1/28/13, 2/4/13, 2/7/13, and 2/14/13.</p> <p>There was no documentation of a shower being given on a non-scheduled shower/bath day for the months of December 2012 through February 18, 2013.</p>			

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	<p>On 2/18/12 at 9:15 A.M., the DoN indicated that if a resident did not receive his or her scheduled shower or bath, the resident should have been offered a shower or bath the next day, not just a bed bath.</p> <p>On 2/18/13 at 10:52 A.M., Certified Nursing Assistant [CNA] #14 indicated if a resident did not receive a shower on his or her scheduled day, she would try to fit it in her schedule the next day. She would give a bed bath if there was not enough time to give a resident a shower.</p> <p>2. During observations on 2/18/13, residents residing on the South unit were observed leaving the dining area between 8:07 A.M. through 9:00 A.M. without eating breakfast. Licensed Practical Nurse [LPN #30] informed the residents there was not sufficient staff to monitor the meal in the main dining area. LPN #30 indicated breakfast would be served in residents' rooms.</p> <p>In regard to the incident that involved residents on the South unit and breakfast, in an interview on 2/18/13 at 10:37 A.M., the Administrator indicated the DoN should have been notified before staff made the</p>				

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	<p>decision to not serve breakfast in the main dining room. He indicated one nurse and one aide had called off work for the day shift [6:00 A.M. to 2:00 P.M.] on 2/18/13. Therefore, there were not enough staff available to supervise the residents on the South unit while in the main dining room.</p> <p>Further, the Administrator indicated residents have had to eat in their rooms on other dates related to unavailable staff; however, he could not provide the exact dates. He indicated the Director of Nursing had a system in place; however, the Quality Assurance Committee did not have a plan of correction for the problem.</p> <p>Review of as worked schedules for 2/18/2013 indicated, on the South Unit there were two floor nurses, one nurse director, and two CNAs from 6-9:A.M. The unit lacked one nurse and one aide.</p> <p>This federal tag is related to Complaints IN00122582 and IN00122854.</p> <p>3.1-17(a)</p>						

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to accurately document the assessment of a resident's dialysis access site. This deficient practice affected 1 of 1 resident reviewed who received dialysis out of 35 sampled residents [Resident H].</p> <p>Findings include:</p> <p>On 2/8/13 at 3:00 P.M., Resident H indicated she received dialysis. She indicated her access sites in both arms [left and right fistulas] were clotted. She indicated her neck port [right subclavian catheter] was used for dialysis.</p> <p>On 2/14/13 at 10:00 A.M., Resident H's record was reviewed. Diagnoses</p>	F000514	<p>It is the practice of ManorCare Prestwick to have complete accurate and accessible records. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The Medication Administration Record was reviewed and revised for Resident H. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents who have orders for hemodialysis have been assessed, including the presence and type of dialysis access. The physician orders and medication administration records of residents with dialysis access sites were reviewed to validate the it matches the order and is accurately transcribed. <b>What</b></p>	03/20/2013	

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	<p>included, but were not limited to, end stage renal disease, weakness, depression, atrial fibrillation, and diabetes mellitus.</p> <p>A care plan, dated 12/21/12, included, but was not limited to, "Renal insufficiencies related to chronic renal failure, presence of new fistula [clotted] in right upper arm and old fistula in left upper arm with right subclavian catheter utilized at this time... no complications related to dialysis devices or treatment... adm [administer] med's [medications] per physician orders, check access site for lack of thrill/bruit [no longer present related to being clotted], evidence of infection, swelling, or excessive bleeding per facility guidelines..., confer with physician and or dialysis treatment center regarding changes in med adm times..., coordinate dialysis care with dialysis treatment center, dialysis 3 times..."</p> <p>A "Physician's Orders" dated 2/1/13, included, but was not limited to, "Check dialysis port every shift..."</p> <p>A "Medication Administration Record" dated 2/1/13, included, but was not limited to, "Check dialysis port right AV [arteriovenous] shunt every shift</p>		<p><b>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The nursing staff was re-educated on the proper protocols for checking dialysis access sites. The nursing staff was also re-educated on the proper procedure to document inspection of the of dialysis sites.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> The Director of Nursing / Designee will audit the Medication Administration Records of residents with dialysis access sites for validity and accuracy of documentation one time a week for 6 weeks and report audit findings to the QA Committee on a weekly basis. The QA committee will make recommendations based on the reported findings on the continuation of the audits.</p> <p>ADDENDUMThe Director of Nursing / Designee will audit the Medication Administration Records of residents with dialysis access sites for validity and accuracy of documentation one time a week for 6 weeks then monthly for 6 months and report audit findings to the QA Committee.</p>				

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	<p>for bruit and thrill..." The Medication Administration Record indicated presence of a bruit and thrill [Resident H did not have an AV shunt or functioning fistual] from 2/1/13 through 2/18/13.</p> <p>On 2/15/13 at 11:00 A.M., in an interview, Licensed Practical Nurse [LPN] #19 indicated Resident H did not have an AV shunt. She indicated she was aware Resident H had 2 clotted fistulas [one in each arm] and she indicated the access site she checked each shift was her right neck port [subclavian port]. She indicated she was aware the order to check Resident H's dialysis port and the medication administration record was documented incorrectly.</p> <p>On 2/18/13 at 3:00 P.M., in an interview, the Director of Nursing [DoN] indicated Resident H's fistulas were clotted and the site that should be checked daily was her right subclavian port.</p> <p>3.1-50(a)(2)</p>				

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify non-compliance of sufficient staffing related to answering call lights timely and supervision in a dining area through the quality assurance protocol.</p> <p>Findings include:</p> <p>On 2/15/13 at 3:00 P.M., Resident council minutes were reviewed for the</p>	F000520	It is the practice of Manor Care Prestwick to identify issues and develop proactive plans to correct them through the Quality Assurance Committee. <b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The staffing pattern in the building was adjusted to provide coverage for the two staff members that called off work ensuring the residents received the care needed. <b>How other</b>	03/20/2013	

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	<p>months of December, 2012, January, 2010, and February, 2013. There were documented issues related to excessive wait times for assistance [call lights not being answered efficiently].</p> <p>During observations on 2/18/13, residents residing on the South unit were observed leaving the dining area between 8:07 A.M. through 9:00 A.M. without eating breakfast. Licensed Practical Nurse [LPN] #30 informed the residents there was not sufficient staff to monitor the meal in the main dining area. LPN #30 indicated breakfast would be served in residents' rooms.</p> <p>The Resident Council minutes were reviewed as a result of numerous interviews with residents regarding their complaints with excessive wait times for assistance from staff [call lights not being answered efficiently].</p> <p>On 2/18/13 at 10:37 A.M., in an interview, the Administrator indicated the facility's Quality Assurance Committee meets daily in the morning and afternoon as well as monthly with the Medical Director and quarterly with the Consultant Pharmacist. At that time, the Administrator indicated he was aware of the general concern</p>		<p><b>residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents that reside in this facility are at risk to be affected by this practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> The facility leadership team has been re-educated by the Quality Assurance Consultant to ensure the entire team understands the intent and processes of the Quality Assurance Committee. The QA committee has reviewed the staffing patterns for the building and implemented a daily staffing meeting to ensure staffing coverage is addressed in a timely manner. Additionally, the committee reviewed call light response times and has implemented a plan to address the issue. The department managers, including nursing leadership, will conduct a total of 20 call light response time audits a week for 6 weeks and the Director of Nursing/Designee will report audit findings to the Quality Assurance Committee. The QA committee will make recommendations on the continuation of the audits based on the audit results. <b>How the corrective action will be monitored to ensure the</b></p>		

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	<p>regarding call lights not being answered promptly; however, was not aware it was a large concern. Therefore, a plan of correction was not implemented through the Quality Assurance Committee .</p> <p>He further indicated that the unit managers dealt with the issue of call lights with the individual resident to resolve the problem. However, he indicated a process will be placed to monitor the wait times for all residents who use their call light or need staff assistance.</p> <p>In regard to the incident that involved residents on the South unit and breakfast, the Administrator indicated the DoN should have been notified before staff made the decision to not serve breakfast in the main dining room. He indicated one nurse and one aide had called off work for the day shift [6:00 A.M. to 2:00 P.M.] on 2/18/13. Therefore, there were not enough staff available to supervise the residents on the South unit while in the main dining room.</p> <p>Further, the Administrator indicated residents have had to eat in their rooms on other dates related to unavailable staff; however, he could not provide the exact dates. He</p>		<p><b>deficient practice does not reoccur?</b> The Regional Director of Operations will monitor compliance of the QAA process and outcomes monthly to ensure that sustained substantial compliance is achieved. QAA committee will monitor until such time it is deemed that the facility is in substantial compliance. The facility will continue to conduct scheduled Quality Assurance Meetings: identified findings will be reviewed by the Administrator. The process will include completing audit tools to identify issues with respect to which quality assessment and assurance activities are recommended then develop and implement appropriate plans of action to correct identified quality deficiencies. The action plan will be revised as indicated when reviewed at subsequent quality assurance meetings.</p> <p>ADDENDUMThe Regional Director of Operations will monitor compliance of the QAA process and outcomes monthly for 6 months to ensure that sustained substantial compliance is achieved.</p>		

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	indicated the Director of Nursing had a system in place; however, the Quality Assurance Committee did not have a plan of correction for the problem.  3.1-52(b)(2)				