

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2015
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 9, 10, 13, 14, 15, and 16, 2015</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 26 Medicaid: 41 Other: 7 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the July 16, 2015 Recertification and State licensure Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on July 30, 2015 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly Ready Executive Director</p>	
F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the</p>			

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

TITLE

(X6) DATE

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

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	<p>resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's Minimum Data Set (MDS) assessment was accurate related to functional limitations and range of motion for 3 of 3 residents who were reviewed for range of motion of the 9 residents who met the criteria for range of motion. (Residents #24, #56, and #85)</p> <p>Findings include:</p>	F 0278	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: On 7/14/15, the MDS assessments for residents #24, #56, and #85 were corrected to reflect accurate coding related to functional limitations and range of motion. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will</p>	08/15/2015	

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	<p>1. On 7/09/15 at 12:31 p.m., Resident #56 was observed sitting in a Broda chair. At that time, both of the resident's hands were closed and clenched in the shape of a fist. The resident had hand carrots (an anti-contracture device) in both hands.</p> <p>The record for Resident #56 was reviewed on 7/13/15 at 10:09 a.m. The resident's diagnoses included, but were not limited to, stiffness of joint involving ankle and foot, abnormal posture, contracture of multiple sites, and muscle weakness.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 6/22/15 indicated the resident had short term and long term memory problems and was severely impaired for decision making. The resident was coded as having no impairment for functional limitation in range of motion to upper extremities and lower extremities.</p> <p>The updated and current plan of care dated 6/2015 indicated the resident was at risk for impaired skin integrity related to range of motion limitations to hands.</p> <p>An Occupational Therapy Progress note dated 4/2/15 indicated the resident was</p>		<p>be taken: A full audit of MDS assessments for current residents' with contractures to ensure accurate coding related to functional limitation and range of motion will be completed on or before 8/15/15 by the facilities' new MDS Coordinator and/or designee. Any identified issues will be immediately corrected to accurately reflect current resident status on or before 8/15/15.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A new MDSCoordinator was hired on 6/22/15 with orientation and education provided by the Clinical Reimbursement Corporate Consultant in regard to the Resident Assessment Instrument (RAI). The Corporate Consultant will continue to be a resource for the new MDS Coordinator and provide ongoing education related to the RAI program at the facility.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Interdisciplinary team members will audit MDS assessments during the weekly care plan meeting for 6 months on a minimum of 5 residents to ensure accurate coding is completed on the MDS assessment. Any issues will be immediately addressed and all results will be discussed and system components will be</p>				

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	<p>being seen for orthotic management and training 5 times a week for 2 weeks. An assessment indicated the resident was noted with bilateral flexor contractures of the digits. The resident demonstrated bilateral hand contractures of digits.</p> <p>Interview with the MDS Coordinator on 7/14/15 at 12:57 p.m., indicated the functional impairment for range of motion was coded incorrectly for the resident's upper extremities.</p> <p>2. On 7/09/15 at 12:26 p.m., Resident #85 was observed sitting in her wheelchair in her room. At that time, the resident's left hand was closed in the shape of a fist. There was no splint noted in the hand.</p> <p>The record for Resident #85 was reviewed on 7/14/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia affecting non dominant side, muscle weakness, muscle wasting and disuse atrophy, difficulty walking, and history of fall.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/10/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact and alert and oriented. The resident's functional ability</p>		<p>reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>and range of motion indicated she had no impairment on right or left upper and lower extremities.</p> <p>The current and updated plan of care dated 4/2015 indicated the problem of "I am unable to complete Activities of Daily Living (ADLS) due to my recent stroke and impaired mobility." The Nursing approaches were to use half lap tray and pommel cushion in wheelchair to support left hemiplegia arm and increased upright posture. Apply a left upper extremity resting pan orthosis at all times and remove for hygiene.</p> <p>A Restorative Nursing assessment dated 4/28/15 indicated the resident had impairment to the left side upper extremity and left side lower extremity.</p> <p>Interview with the MDS Coordinator on 7/14/15 at 12:57 p.m., indicated the functional impairment for range of motion was coded incorrectly for the resident's upper extremities.</p> <p>3. On 7/9/15 at 10:00 a.m., Resident #24 was observed in her room. Her left hand was observed to be contracted. Her left middle finger, ring finger, and pinky finger were observed to be contracted. Interview with the resident at the time indicated she could not open her hand.</p>			

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F 0282 SS=D Bldg. 00	<p>The record for resident #24 was reviewed on 7/14/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, heart failure and dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 6/24/15 indicated the resident's BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident's functional status had no impairment.</p> <p>Interview with the MDS Coordinator on 7/14/15 at 3:31 p.m., indicated the resident was not assessed appropriately related to her left hand impairment/contracture and she would adjust the MDS related to the resident's impairment to her left hand.</p> <p>3.1-31(g)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure the resident's care plan was followed related</p>	F 0282	What corrective action(s) will be accomplished for those residents found to have been	08/15/2015

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	<p>to the timeliness of completing Braden Scale assessments and monitoring bruising for 2 of 2 residents reviewed for pressure sores and for 1 of 3 residents reviewed for non pressure sores. (Residents #46, #50, &, #56)</p> <p>Findings include:</p> <p>1. The record for Resident #50 was reviewed on 7/13/15 at 9:01 a.m. The resident's diagnoses included, decubitus ulcer and heel pressure ulcer.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 6/10/15 indicated the resident had long term and short memory problems and was severely impaired for decision making. The resident had 1 stage 4 pressure sore, and 1 unstageable pressure sore with the most severe sore at a stage 4 with eschar (necrotic) tissue.</p> <p>The current plan of care updated 6/2015 indicated the resident was at risk for pressure ulcers and had one Stage 4 pressure ulcer to the sacrum and one Unstageable pressure ulcer to the left heel. The Nursing approaches were to complete a Braden Scale assessment quarterly and as needed.</p> <p>The last documented Braden Scale assessment was dated 3/10/15 and the</p>		<p>affected by the deficient practice: A Braden Scale assessment was completed for both residents: #50 and #56 with no new issues identified. The observed bruises to resident#46's left forearm and left elbow will be monitored until healed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit of Braden Scale assessments was completed on 7/27/15 by nursing administration to ensure assessments are updated according to residents' plan of care. Full facility skin audit will be completed by nursing administration on or before 8/15/15 to ensure any identified bruises have proper documentation and follow up as per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: A new MDSCoordinator was hired on 6/22/15 with orientation and education provided by theClinical Reimbursement Corporate Consultant in regard to Resident Assessment Instrument (RAI). The Corporate Consultant will continue to be a resource for the new MDS Coordinator and provide ongoing education related to the RAI program at the facility. Education will also be provided to</p>	

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	<p>resident's score was a 13 indicating she was a moderate risk for developing pressure ulcers.</p> <p>Interview with the MDS Coordinator on 7/14/15 at 1:08 p.m., indicated a new Braden Scale assessment had not been completed quarterly as per the care plan.</p> <p>2. The record for Resident #56 was reviewed on 7/13/15 at 10:09 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer Stage 4.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 6/22/15 indicated the resident had short term and long term memory problems and was severely impaired for decision making. The resident had a Stage 4 pressure ulcer with granulation tissue.</p> <p>The current and updated plan of care dated 6/2015 indicated the resident had an alteration in skin integrity related to a Stage 4 pressure ulcer on the sacrum. The Nursing approaches were to complete a Braden Scale Risk assessment quarterly and as needed.</p> <p>The last documented Braden Scale assessment was dated 1/20/15 which indicated the resident was a moderate risk for pressure ulcers.</p>		<p>licensed nurses by the DON and/or designee by 8/15/15 related to identification of bruises and prompt notification to ensure proper documentation and follow up per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Interdisciplinary Team Members will audit MDS assessments during the weekly care plan meeting for 6 months on a minimum of 5 residents to ensure accurate coding is completed on the MDS, along with MDS assessments being completed timely as per RAI guidelines. Nursing administration will perform a weekly audit for 6 months on a minimum of 10 residents to ensure weekly skin checks are completed with proper documentation and follow up as per facility policy. Validation of this audit will occur via visual inspection of the resident. Any issues will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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	<p>Interview with the MDS Coordinator on 7/14/15 at 1:08 p.m., indicated a new Braden Scale assessment had not been completed quarterly as per the care plan.</p> <p>3. On 7/10/15 at 8:46 a.m., Resident #46 was observed in his room lying in bed. The resident was observed with purple bruising to his left forearm and left elbow.</p> <p>The record for Resident #46 was reviewed on 7/13/15 at 8:39 a.m. The resident's diagnoses included, but were not limited to, falls, and diabetes.</p> <p>Review of the current care plan dated 6/18/15 indicated the resident had bruising to his left upper extremity. The interventions included, but were not limited to: complete weekly skin assessments and inspect skin during bathing, especially over bony prominences.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 6/11/15 indicated a Brief Interview for Mental Status (BIMS) of 15 indicating the resident was alert and oriented. The resident needed extensive assist with bed mobility, transfers, and dressing with a one person physical.</p>			

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F 0309 SS=D Bldg. 00	<p>Review of the Weekly Skin Integrity Data Collection sheets dated 6/18/15 through 6/30/15 indicated all the resident's bruising was resolved on 6/30/15.</p> <p>Review of the Non-pressure Skin Condition Records for July 2015 indicated no evidence of documentation related to the resident's bruising to his left forearm and elbow.</p> <p>Interview and observation with the Wound Nurse on 7/13/15 at 9:51 a.m., indicated the resident had bruising to the top of his left forearm and elbow. Continued interview at the Wound Nurse indicated the resident would have his skin checked on that day during his shower.</p> <p>Review of the Non-pressure Skin Condition Records dated 7/13/15 indicated the resident had bruising to his left forearm near the elbow measuring 3 x 3.5 centimeters (cm), left forearm 0.5 x 0.5 cm, and left forearm 0.5 x 0.5 cm.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>			

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	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to the documentation and assessment of bruises for 1 of 3 residents reviewed for non-pressure related skin conditions of the 4 residents who met the criteria for non- pressure related skin conditions. (Resident #46)</p> <p>Findings include:</p> <p>On 7/10/15 at 8:46 a.m., Resident #46 was observed in his room lying in bed. The resident was observed with purple bruising to his left forearm and left elbow.</p> <p>On 7/13/2015 at 8:34 a.m., Resident #46 was observed in his room alert and oriented. Interview at the time indicated he was aware of the bruising to his left forearm and left elbow, however, he did not know how they occurred.</p> <p>The record for Resident #46 was reviewed on 7/13/15 at 8:39 a.m. The</p>	F 0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The observed bruises to resident #46's left forearm and left elbow will be monitored until healed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility skin audit will be completed by nursing administration on or before 8/15/15 to ensure any identified bruises have proper documentation and follow up per facility policy. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education will also be provided to licensed nurses by the DON and/or designee by 8/15/15 related to identification of bruises and prompt notification to ensure proper documentation and follow up per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing administration will</p>	08/15/2015

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	<p>resident's diagnoses included, but were not limited to, falls, and diabetes.</p> <p>Review of the current care plan dated 6/18/15 indicated the resident had bruising to his left upper extremity. The interventions included, but were not limited to: complete weekly skin assessments and inspect skin during bathing, especially over bony prominences.</p> <p>Review of the quarterly Minimum Data Set assessment (MDS) dated 6/11/15 indicated a Brief Interview for Mental Status (BIMS) of 15 indicating the resident was alert and oriented. The resident needed extensive assist with bed mobility, transfers, and dressing with a one person physical.</p> <p>Review of the Weekly Skin Integrity Data Collection sheets dated 6/18/15 through 6/30/15 indicated all the resident's bruising was resolved on 6/30/15.</p> <p>Review of the Non-pressure Skin Condition Records for July 2015 indicated no evidence of documentation related to the resident's bruising to his left forearm and elbow.</p> <p>Interview and observation with the</p>		<p>perform a weekly audit for 6 months on a minimum of 10 residents to ensure weekly skin checks are completed, along with proper documentation and follow up as per facility policy. Validation of this audit will occur via visual inspection of the resident. Any issues will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F 0312 SS=D Bldg. 00	<p>Wound Nurse on 7/13/15 at 9:51 a.m., indicated the resident had bruising to the top of his left forearm and elbow. Continued interview at the Wound Nurse indicated the resident would have his skin checked on that day during his shower.</p> <p>Review of the Non-pressure Skin Condition Records dated 7/13/15 indicated the resident had bruising to his left forearm near the elbow measuring 3 x 3.5 centimeters (cm), left forearm 0.5 x 0.5 cm, and left forearm 0.5 x 0.5 cm.</p> <p>Interview with the Regional Nurse on 7/13/15 at 11:33 a.m., indicated the facility did not have a policy related to non-pressure skin conditions. Continued interview with Regional Nurse indicated bruising should be monitored weekly and if there were any new concerns they should be documented on the resident's shower bi-weekly sheets once identified during their shower and nursing should document the new skin condition on Non-pressure Skin Condition Record.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out</p>			

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	<p>activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a dependent resident who was unable to complete their Activities of Daily Living (ADLS) related to personal hygiene were were assisted with ADLS for 1 of 3 residents reviewed for ADLS of the 5 who met the criteria for ADLS. (Resident #85)</p> <p>Finding includes:</p> <p>1. On 7/09/15 at 11:18 a.m., Resident #85 was observed sitting in her wheelchair in her room. At that time, the resident's left hand was closed in the shape of a fist. The resident's fingernails were long and touching the palm of her hand. She indicated at that time, she could not move her left hand to cut her nails and they were in need of being trimmed.</p> <p>On 7/10/15 at 9:30 a.m., the resident was observed sitting in a wheelchair. At that time, the resident's left hand was closed in the shape of a fist. The resident's fingernails were long and touching the palm of her hand.</p> <p>On 7/13/15 at 8:54 a.m., the resident was</p>	F 0312	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Facility staff provided nail care to resident #85 on 7/13/15 with routine nail care ongoing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A full facility audit will be completed on 7/31/15 by department managers to identify any residents in need of nail care. Care will be rendered when deemed necessary. In addition, nail care needs are routinely addressed on shower days. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff Development Coordinator to provide education to nursing staff by 8/15/15 with respect to the ongoing inspection of nails to ensure they are neat, clean, and trimmed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Weekly random audits will be completed by facility department managers for the next 6months on various shifts to</p>	08/15/2015

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	<p>observed in bed waiting on breakfast. The resident's left hand was closed in the shape of a fist and her fingernails were long and touching her skin. .</p> <p>On 7/13/15 at 2:02 p.m., the resident was observed in bed. Her left hand was closed and her fingernails remained long and touching her skin.</p> <p>On 7/13/15 at 3:03 p.m., The South Unit Manager performed a skin assessment for the resident. At that time, she observed the resident's fingernails to the left hand. She indicated the resident was alert and oriented and tells us when she wants her nails done, however, the left hand fingernails were in need of being trimmed because they were long and touching her skin. The South Unit Manager further indicated due to the resident's limited range of motion of her left hand, the fingernails should be kept shorter.</p> <p>The record for Resident #85 was reviewed on 7/14/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia affecting non dominant side, muscle weakness, muscle wasting and disuse atrophy, difficulty walking, and history of fall.</p> <p>The Quarterly Minimum Data Set (MDS)</p>		<p>observe a minimum of 5 residents to ensure appropriate nail care is provided to residents. Any issues identified will be immediately brought to nursing staff's attention for resolution and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F 0318 SS=D Bldg. 00	<p>assessment dated 4/10/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact, alert, and oriented. The resident needed extensive assist with one person physical assist with personal hygiene.</p> <p>The current and updated plan of care dated 4/2015 indicated the problem of "I am unable to complete Activities of Daily Living (ADLS) due to my recent stroke and impaired mobility." The Nursing approaches were to use half lap tray and pommel cushion in wheelchair to support left hemiplegia arm and increased upright posture. Apply a left upper extremity resting pan orthosis at all times and remove for hygiene.</p> <p>3.1-38(a)(3)(E)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and</p>	F 0318	What corrective action(s) will be accomplished for those	08/15/2015

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	<p>interview, the facility failed to ensure a resident with a contracture received the necessary treatment and services to prevent decline related to providing passive range of motion and splint application for 1 of 3 residents reviewed for range of motion of the 9 who met the criteria for range of motion. (Resident #85)</p> <p>Finding includes:</p> <p>1. On 7/09/15 at 12:26 p.m., Resident #85 was observed sitting in her wheelchair in her room. At that time, the resident's left hand was closed in the shape of a fist. There was no splint noted in the hand.</p> <p>On 7/10/15 at 9:30 a.m. the resident was observed sitting in a wheelchair. At that time, the resident's left hand was closed in the shape of a fist. There was no splint noted in the hand.</p> <p>On 7/13/15 at 8:54 a.m., the resident was observed in bed waiting on breakfast. The resident's left hand was closed in the shape of a fist and there was no brace or splint noted in the hand.</p> <p>On 7/13/15 at 11:45 a.m., the resident was observed in her wheelchair. At that time she was observed wearing a sling</p>		<p>residents found to have been affected by the deficient practice: On 7/14/15 resident #85 was evaluated by therapy with physician order to treat for left sided positioning devices to support the resident's flaccid left upper extremity. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full audit of current residents' will be completed on or before 8/15/15 by nursing administration to ensure residents with contractures receive the necessary treatment and services to prevent decline related to providing passive range of motion and splint application. Any identified issues will be referred to therapy for further evaluation and treatment. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Effective 7/24/15, the MDS Coordinator has assumed oversight of the Restorative program at the facility with orientation and education provided by the Clinical Reimbursement Corporate Consultant in relation to the Restorative program's policy and procedures, staff competencies, and use of restorative forms for documentation. The Corporate Consultant will continue to be a</p>				

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	<p>around her left arm, however, there was nothing in her left hand which remained closed.</p> <p>On 7/14/15 at 9:09 a.m., and 12:30 p.m., the resident was observed in bed. At those times her left hand was closed and in the shape of a fist. There was no splint device in her hand.</p> <p>The record for Resident #85 was reviewed on 7/14/15 at 9:00 a.m. The resident's diagnoses included, but were not limited to, hemiplegia affecting non dominant side, muscle weakness, muscle wasting and disuse atrophy, difficulty walking, and history of fall.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 4/10/15 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact and alert and oriented. The resident's functional ability and range of motion indicated she had no impairment on right or left upper and lower extremities.</p> <p>The current and updated plan of care dated 4/2015 indicated the problem of "I am unable to complete Activities of Daily Living (ADLS) due to my recent stroke and impaired mobility." The Nursing approaches were to use half lap tray and</p>		<p>resource for the MDS Coordinator and provide education for the Restorative program and program oversight as needed.</p> <p>MDS Coordinator will complete staff competencies to the Restorative CNAs related to range of motion on or before 8/15/15. In addition, education will be provided by the MDS Coordinator on or before 8/15/15 to Restorative nursing staff (CNAs and Restorative Nurse) related to the Restorative program's policy and procedures along with proper documentation and necessary forms.</p> <p>Education will be provided by the DON and/or designee to the nursing staff on or before 8/15/15 in regards to following residents' plan of care and care directives in relation to applying orthotic devices. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A weekly Restorative meeting has been implemented and will be ongoing with the Restorative nursing staff to review residents both on caseload as well as any other residents identified as having a potential for decline to ensure residents receive the necessary treatment and services to prevent decline. Any issues identified will be referred to the therapy department for further evaluation and treatment if deemed necessary. Nursing administration will review the weekly Restorative</p>				

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	<p>pommel cushion in wheelchair to support left hemiplegia arm and increased upright posture. Apply a left upper extremity resting pan orthosis at all times and remove for hygiene.</p> <p>Physician Orders dated 8/29/13 and on the current 7/2015 recap indicated the resident was to wear hemi cuff to the Left Upper Extremity (LUE) while up in wheelchair per OT (Occupational Orders). Another Physician Order dated 2/20/14 and on the current recap indicated the resident was to wear LUE resting pan orthosis at all times and to be removed for hygiene.</p> <p>A 5/20/15 Physician Order indicated Restorative Nursing level II up to 7 days active range of motion to Right Upper and Right Lower Extremities (RUE) (RLE). Active range of motion to Left Lower Extremity (LLE). There were no Restorative Orders for any type of range of motion to the left hand.</p> <p>A Restorative Nursing assessment dated 4/28/15 indicated the resident had impairment to the left side upper extremity and left side lower extremity.</p> <p>The Restorative Administration Record for the month of 7/2015 indicated the resident was supposed to receive active</p>		<p>meeting minutes/notes to ensure appropriate residents are reviewed and necessary orders, treatment administration record, plan of care, and care directives are updated as needed.</p> <p>Weekly random audits will be completed by facility department managers for the next 6 months on various shifts to observe a minimum of 5 residents to validate care directives are followed to ensure splinting devices are applied as per residents' plan of care. Any issues will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>range of motion to RUE/RLE 20 reps times 2 and active range of motion LLE. Continued review of the Restorative Administration record indicated the resident had refused all the exercises on 7/3, 7/4, 7/7, 7/10, and 7/13/15. The rest of the record was blank and incomplete.</p> <p>Interview with Restorative CNA #1 on 7/15/15 at 1:15 p.m., indicated she works full time. She indicated there were always two restorative CNAs that work at the same time. The CNA indicated the resident refuses a lot of her restorative therapy. She indicated they were currently only working with resident's right side and both of her legs. She indicated they do not do anything with her left hand and she was not aware of any splint the resident was supposed to wear. The Restorative CNA further indicated the incomplete or blanks on the Restorative record indicated she was unable to get to the resident on that day or she was pulled to the floor to work as a regular CNA.</p> <p>Interview with the Restorative Nurse on 7/14/15 at 9:52 a.m., indicated she had just taken over the Restorative Nursing at the facility. She further indicated she had not had a chance to asses Resident #85 and was unaware of any contracture to the left hand. The Restorative Nurse</p>			

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	<p>indicated if the documentation on the Restorative Record was blank, than the Restorative CNAS were pulled to the floor and the therapy was not completed.</p> <p>Continued interview with the Restorative Nurse on 7/14/15 at 10:42 a.m., indicated she had just assessed the resident for a contracture and concluded she had some limitations to the left hand. She indicated she was able to open the resident's left hand without meeting resistance and was going to have Occupational Therapy screen the resident.</p> <p>An Occupational Therapy (TO) screen dated 7/14/15 indicated under the comments: "Patient has received OT numerous times at facility, when not in therapy wears left upper extremity shoulder orthosis and left upper extremity resting splint." The Functional Screen indicated "will review left sided splinting/positioning devices. May potentially benefit from skilled therapy intervention to address deficits. Will pursue eval and treatment orders for OT."</p> <p>Interview with the Restorative Nurse on 7/14/15 at 2:43 p.m., indicated the CNAS were putting on the wrong orthotic device. She indicated the resident was supposed to wear a pan splint to the left hand, and the CNAS were not applying</p>			

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F 0329 SS=D Bldg. 00	<p>the correct splint to the resident. She further indicated the pan splint was just now applied to her left hand.</p> <p>3.1-42(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure each resident's medication regimen was free from unnecessary drugs related to documentation and monitoring of a resident's insulin for 1 of 5 residents</p>	F 0329	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident#46 receives ongoing monitoring for insulin use as per physician orders.</p>	08/15/2015	

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	<p>reviewed for unnecessary medications. (Resident #46)</p> <p>Finding includes:</p> <p>The record for Resident #46 was reviewed on 7/13/15 at 8:39 a.m. The resident's diagnoses included, but were not limited to, falls, and diabetes.</p> <p>Review of the 6/2015 Medication Administration Record (MAR) indicated accuchecks (bid) twice daily at 6:00 a.m. and 4 p.m. alternating with 11:00 a.m. and 9:00 p.m. It further indicated sliding scale Novolin coverage. The coverage order was rewritten on 6/12/15 which read accuchecks bid with alternate times with sliding scale coverage (Novolin) as follows:</p> <p>0-149=0 units 150-200=4 units 201-250=6 units 251-300=8 units 301-400=10 units</p> <p>Continued review of the 6/2015 MAR indicated:</p> <p>6/7/15 at - no accucheck or insulin coverage as ordered at 6:00 a.m. 6/4/15 - no accucheck or insulin coverage as ordered at 11:00 a.m. 6/6/15 at - no accucheck or insulin coverage ordered at 11:00 a.m.</p>		<p>Resident's plan of care was reviewed with staff and education provided related to importance of documentation of insulin use and monitoring. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Full facility audit was completed by nursing administration related to those residents requiring glucose monitoring and administration of insulin. No other issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education will be provided to licensed nurses by the DON and/or designee by 8/15/15 in regard to documentation and monitoring of insulin use related to blood sugar sliding scale orders. Use of a new sliding scale insulin record will be implemented 8/1/15. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing administration to perform weekly audits of a minimum of 5 residents requiring use of sliding scale insulin for the next 6 months to ensure proper monitoring and documentation of insulin use as per current physician order. Any issues identified will be immediately</p>		

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	<p>6/10/15 - no accucheck or insulin coverage as ordered at 11:00 a.m.</p> <p>6/5/15 - no evidence of documentation for insulin coverage for a blood glucose of 307 at 4:00 p.m.</p> <p>6/7/15 - no evidence of documentation of an accucheck or insulin coverage at 4:00 p.m.</p> <p>6/11/15 - no evidence of documentation of an accucheck or insulin coverage at 4:00 p.m.</p> <p>6/4/15 - no evidence of documentation of an accucheck or insulin coverage at 9 p.m.</p> <p>6/6/15 - no evidence of documentation of an accucheck or insulin coverage at 9:00 p.m.</p> <p>6/9/15 - no evidence of documentation for insulin coverage for a blood glucose of 253 at 9:00 p.m.</p> <p>6/10/15 - accucheck or insulin coverage as ordered at 9:00 p.m.</p> <p>Interview with the Regional Nurse on 7/13/15 at 2:15 p.m. with the DON (Director of Nursing) and Regional Nurse indicated the concern was identified by the facility and the order was rewritten on 6/12/15.</p> <p>3.1-48(a)(3)</p>		addressed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.		

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F 0332 SS=D Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% was maintained for 1 of 5 residents observed during medication pass. Two errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 7%. (Resident #120)</p> <p>Finding includes:</p> <p>On 7/15/15 at 9:14 a.m., RN #1 was observed administering medications to Resident #120. The RN was observed dispensing one Sodium Bicarbonate 650 milligrams (mg) tablet into a medication cup with the resident's other medications. She then placed one Potassium Bicarbonate effervescent 25 Milliequivalents (meq) tablet into a plastic drinking cup containing approximately 4 ounces of water, and stirred the contents. An observation at the time of the medication packets indicated Sodium Bicarbonate 650 mg give two tablets and Potassium Bicarbonate Effervescent 25 meq give two tablets.</p>	F 0332	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The physician and appropriate responsible party were made aware of the medication errors for resident #120. No new orders were received per the physician. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Per review of current resident medication administration records and interviews with RN #1 and LPN #1, no other residents were affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education was immediately provided to RN #1 related to administration of ordered medications by DON. Education for licensed nursing staff will be completed by 8/15/15 on the five rights of medication administration by the Staff Development Coordinator and/or designee. MedicationAdministration</p>	08/15/2015			

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F 0371 SS=D Bldg. 00	<p>Physician's Orders indicated, but were not limited to, Sodium Bicarbonate 1300 milligrams (mg) and Potassium Bicarbonate Effervescent 50 milliequivalents (meq).</p> <p>Interview with RN#1 on 7/15/15 at 9:40 a.m., indicated she should have administered two 650 Mg Sodium Bicarbonate tablets to the resident.</p> <p>Interview with LPN #1 on 7/16/15 at 8:13 a.m., the Potassium tables were packaged in 25 meq quantities and the RN should have administered two tablets during medication pass on 7/15/14 at 9:14 a.m.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was stored under sanitary conditions</p>	F 0371	<p>Competencies will be completed with each licensed nurse and one QMA by 8/15/15. This return demonstration will be observed by nursing administration and the consultant pharmacy nurse. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing administration to randomly observe 2 nurses weekly for the next 6 months on medication administration pass. These audits will be conducted on various shifts and education immediately provided as deemed necessary. All audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</p>	08/15/2015	

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	<p>related undated resident food in the pantry for 1 of 2 Units. (The North Unit)</p> <p>Finding includes:</p> <p>Observation on 7/13/15 at 11:45 a.m. in the North Unit Nourishment room in the refrigerator the following was observed:</p> <p>a. There was a bag of McDonalds food and a Styrofoam container of food for a resident. Both food items were not dated.</p> <p>b. There were two other Styrofoam containers of food for 2 other residents. Both containers were not dated.</p> <p>Review of the facility policy titled "Nourishment Storage Areas" on 7/13/15 at 1:45 p.m., which was provided by the Dietary Food Manager and identified as current, indicated "food is covered, labeled, and dated appropriately."</p> <p>Interview with the Dietary Food Manager on 7/13/15 at 1:25 p.m., indicated any type of food that was stored in the refrigerator in the Nourishment Pantry, should be dated.</p> <p>3.1-21(i)(3)</p>		<p>practice: All undated food and containers were removed from the North Unit Nourishment room's refrigerator and discarded. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: No other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education for both dietary and nursing staff will be completed by the Staff Development Coordinator and/or designee by 8/15/15 related to labeling food items and storage of leftover food to ensure residents' food is stored under sanitary conditions as per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Unit Managers to perform random audits of the nourishment refrigerators a minimum of 5 times weekly on various shifts and various days for the next 6 months. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>	

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F 0431 SS=D Bldg. 00	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure the Emergency Drug Kit (EDK) box was locked for 1 of 2 medication rooms. (The North Unit)</p>	F 0431	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The emergency drug</p>	08/15/2015	

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	<p>Finding includes:</p> <p>Observation on 7/13/15 at 2:25 p.m. in the North Unit medication room the EDK box was opened and unlocked and the clasp was not fastened. There was no slip of paper in the clear plastic cover to indicate when the EDK box was opened.</p> <p>Interview with the Director of Nursing (DoN) at the time, indicated the EDK was opened on the weekend and a new EDK box was to be delivered to the facility on Monday.</p> <p>Interview with the DoN and the facility Nurse Consultant on 7/13/15 at 3:08 p.m., indicated the EDK box should have been locked after being opened.</p> <p>3.1-25(b)</p>		<p>box was immediately locked upon identification as per facility policy. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: No other residents were affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education for licensed nursing staff will be completed by the Staff Development Coordinator and/or designee by 8/15/15 related to keeping medications needed for emergency care properly secured in the emergency drug box as per facility policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Nursing Unit Managers to perform random audits of each nursing unit's emergency drug boxes a minimum of 5 times weekly on various shifts and various days for the next 6 months to ensure medications needed for emergency care are properly secure. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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F 0465 SS=B Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the resident's environment was clean and in good repair related to marred and scuffed walls, rusted bolts, loose heat registers and gouged walls for 2 of 2 Units. (The North and South Units)</p> <p>Findings include:</p> <p>During the Environmental Tour on 7/13/15 at 1:28 p.m., with the Housekeeping and Maintenance Supervisors, the following was observed:</p> <p>The North Hall</p> <p>a. There were holes in the wall beneath the grab bar located next to the bathroom in Room 218. One resident resided in this room.</p> <p>b. Behind the head of bed two in Room 223, the heat register cover was loose and pulling away from the unit. The wall next to bed two was scratched and marred. Two residents resided in this room.</p>	F 0465	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The hole in the wall beneath the grab bar located next to the bathroom in room 218 has been repaired. The heat register cover was secured to the register behind the head of bed in room 223, along with the scratches and marred areas on wall next to bed repaired. The bolts located at the base of the toilet in room 111 were replaced. The baseboard was replaced behind bed two in room 112, along with repairs made to the lower half of wall behind bed two and behind chair.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Environmental rounds have been completed by maintenance department and plan has been put in place to address identified issues and/or items to be replaced. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Re-education will be provided by</p>	08/15/2015
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	<p>The South Unit</p> <p>a. The bolts located at the base of the toilet in Room 111 were exposed and rusty in appearance.</p> <p>b. The lower half of the wall behind the head of bed two in Room 112 was gouged and marred. The base of the wall behind the chair was also gouged and marred. The base board was peeling behind the head of bed two. Two residents resided in this room.</p> <p>Interview with the Housekeeping and Maintenance Supervisors at the time, indicated the above areas were in need of repair.</p> <p>3.1-19(f)</p>		<p>the ED and/or designee by 8/15/15 to the Maintenance staff in regards to keeping the resident's environment clean and in good repair relating to marred and scuffed walls, rusted bolts, loose heat registers and gouged walls. The Maintenance Director will include identified areas in the current preventive maintenance program and conduct routine resident room rounds according to the facility protocol. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Department managers to conduct resident room observation 5 times weekly and will report any maintenance related issues to the maintenance department upon identification of any concerns. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>	