

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/13/2013
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00137401, IN00138427, and IN00139562.</p> <p>Complaint IN00137401-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00138427-Federal/state deficiencies related to the allegations are cited at F309 and F312.</p> <p>Complaint IN00139562-Federal/state deficiency related to the allegations are cited at F312.</p> <p>Survey dates: December 8, 9, 10, 11, 12, &amp; 13, 2013</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Heather Tuttle, R.N. T.C. Lara Richards, R.N. Cynthia Stramel, R.N. Yolanda Love, R.N.</p> <p>Census bed type: SNF/NF: 119</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. The facility requests a desk review for paper with all citations related to this survey.</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><b>Total: 119</b></p> <p>Census payor type: Medicare: 29 Medicaid: 67 Other: 23 Total: 119</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 19, 2013, by Janelyn Kulik, RN.</p>				

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F000157 SS=D	<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 promptly notify a resident's family member of a wound clinic office visit for 1 of 1 resident's reviewed for notification of</p>	F000157	F 157 Notification of ChangesWe respectfully request a desk review for paper compliance for this citation.1) Resident C had her appointment cancelled and was seen by a Wound MD at the	01/12/2014

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	<p>change of the 1 resident who met the criteria for notification of change. (Resident #C)</p> <p>Findings include:</p> <p>Interview on 12/09/2013 at 11:55 a.m., with Resident #C's daughter indicated she was not promptly notified that her mom had a wound clinic office visit back in November 2013. She further indicated the wound clinic ended up canceling the appointment because the resident had no family member there and no services were provided.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation, acute osteomyelitis, high blood pressure, dementia without behaviors, and decubitus ulcer.</p> <p>Review of the Resident Appointment sheet (no date noted) indicated the resident was to see the wound Physician at the wound clinic at the local hospital on 11/15/13. The resident was to be transported by ambulance. Further review of the Resident Appointment sheet indicated</p>		<p>facility with her daughter's permission) 2) Audit of all appointments currently scheduled to ensure family notification. 3) In-servicing licenses nurses and medical records manager/designee on notification of resident's family members of appointments. All residents with appointments scheduled outside of the facility will have appointments given to medical records manager/designee for appropriate follow-up. The Medical Records manager/designee will schedule the appointment, arrange for transportation and forward all information to the unit manager for notification of family. The unit manager/designee will be responsible to maintain compliance which includes family notification. An appointment log will be maintained to monitor compliance and will be reviewed 3 times per week by the DNS/designee for compliance. 4) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>		

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	<p>family notification was not completed and left blank. The appointment was again confirmed on 11/11/13 with the transportation company.</p> <p>Review of Nurses Notes dated 11/15/13 at 3:34 p.m., indicated patient went to the wound clinic the nurse called and stated family had to be present, family was informed and unable to be with resident. The patient was brought back to the facility.</p> <p>Interview with the Wound Nurse on 12/10/13 at 1:40 p.m., indicated the Medical Records person made all the appointments for the nurses. She further indicated she would not be the person to notify the family, that was the nurse's responsibility.</p> <p>Interview with Medical Records on 12/10/13 at 2:20 p.m., indicated she makes appointments for new admissions. She indicated she makes the appointment and confirms it with the transportation company and then gives it to the nurses. The Medical Records person indicated it was the nurses responsibility to notify the family.</p> <p>Interview on 12/11/13 at 10:30 a.m., with LPN #2 indicated she usually</p>			

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	<p>works weekend and fills in during the weekday. She indicated she was aware the Medical Records person makes the new admission appointments for them only. The LPN also assumed she notified the resident's family at that time as well.</p> <p>Interview with LPN #1 on 12/11/13 at 10:30 a.m., indicated she was aware Medical Records made appointments for new admissions, and indicated after they were made she places the paper in a book on the unit. She further indicated she could see how the resident's family may not get notified, if no staff Nurse checks the book.</p> <p>3.1-5(a)(3)</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, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to being dressed institutional style such as wearing a hospital gown for 1 of 3 residents reviewed for dignity of the 10 residents who met the criteria for dignity. (Resident #C)</p> <p>Findings include:</p> <p>On 12/08/2013 from 10:13 a.m. until 12:55 p.m., Resident #C was observed in bed and dressed in a hospital gown.</p> <p>On 12/9/13 at 8:45 a.m., 1:15 p.m., and 3:00 p.m., Resident #C was observed in bed in her room dressed in a hospital gown.</p> <p>On 12/10/13 at 8:20 a.m. and 9:50 a.m., Resident #C was observed in bed, wearing a hospital gown.</p> <p>On 12/10/13 at 11:40 a.m., after the resident just had her pressure ulcer</p>	F000241	<p>F 241 Dignity and Respect of Individuality We respectfully request a desk review for paper compliance for this citation. 1) Resident C is being dressed appropriately. 2) All care plans are noted with resident's preference of clothing, if applicable. 3) In-servicing of nursing staff on maintaining resident's dignity related to clothing. 5 residents will be interviewed per week and Angel Rounds will be completed 2 times per week to ensure residents are dressed as they prefer. 4) Results of these audits and interview results will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>	01/12/2014

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	<p>treatment, the Wound Nurse and CNA #9 were observed to change the resident's hospital gown and placed a new hospital gown on her.</p> <p>12/10/13 at 2:13 p.m., the resident's daughter had came into the facility to play bingo with her mother. At that time, the resident was still in bed dressed in the hospital gown.</p> <p>Interview with the resident's daughter on 12/09/2013 at 11:40 a.m., indicated the resident was always dressed in a hospital gown, it was left to chance if she got dressed.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation, acute osteomyelitis, atrial fibrillation, anemia, high blood pressure, esophageal reflux, congestive heart failure, hypoglycemia, dementia without behaviors, and mood disorders.</p> <p>Review of the Admission 6/20/13 Minimum Data Set (MDS) assessment indicated the resident's Brief Interview for Mental Status</p>				

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	<p>(BIMS) was a 7. The resident had indicated it was somewhat important for her to decide what clothes to wear.</p> <p>Review of the current plan care dated 9/2013 indicated there was no care plan for the resident wanting to wear a hospital gown during the day.</p> <p>Review of the CNA assignment sheet indicated there was no information indicating the resident prefers to wear a hospital gown.</p> <p>Interview with the CNA #4 on 12/11/13 at 9:55 a.m., indicated she does not know why the resident always wears a hospital gown.</p> <p>Interview with the West Unit Manager on 12/11/13 at 10:40 a.m., indicated the CNAs were to get the resident dressed in their clothes rather than wearing a hospital gown unless the resident preferred that.</p> <p>3.1-3(t)</p>				

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to assist a resident to activities of their choice for 1 of 1 residents reviewed for activities of the 1 resident who met the criteria for activities. (Resident #C)</p> <p>Findings include:</p> <p>On 12/08/2013 at 10:13 a.m. and 12:55 p.m., Resident #C was observed in bed dressed a hospital gown. There was no radio or television on at those times.</p> <p>On 12/9/13 at 8:50 a.m., the resident was observed in bed. There was no television or radio on in the room.</p> <p>Interview with the resident's daughter on 12/9/13 at 11:35 a.m., indicated she had a communication problem with staff. She indicated she had told the staff the night before to have her mom up and ready to play bingo the next day by 2:00 p.m. She indicated</p>	F000248	F 248 Activities Meet Interests/Needs of Each Resident We respectfully request a desk review for paper compliance for this citation. 1) Resident C has visual/auditory stimulation with TV and/or Radio when in bed. Her Care Plan indicates that she should be up in her chair for Bingo and Mass. 2) All resident's care plans will be reviewed by Activity Director/designee for accuracy regarding Activities. 3) In-servicing of nursing staff and activity personnel on assisting residents to the activities of their choice. Social Services/Designee will interview 5 residents weekly to note compliance with activities. 4) Results of these interviews will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting	01/12/2014	

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	<p>it was a pretty big ordeal to get her up and therefore, if they had not gotten her up and out of bed by 2:00 p.m., bingo was usually over by the time they got there.</p> <p>On 12/10/13 at 2:13 p.m., the resident's daughter came into the facility to play bingo with her mother. At that time, her mother was still in bed and bingo was on the activity calendar to start at 2:15 p.m. At 2:25 p.m., the resident was finally up and dressed and placed into the wheelchair. Her daughter then pushed her mom down to the main dining room to attend bingo.</p> <p>Interview with the resident's daughter at that time, indicated she came early today to take her mom to bingo. She indicated her mom used to love going to bingo and enjoys it.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation, acute osteomyelitis, atrial fibrillation, anemia, high blood pressure, esophageal reflux, congestive heart failure, hypoglycemia, dementia without behaviors, and mood</p>				

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	<p>disorders.</p> <p>Review of the CNA assignment sheet indicated the resident was to be up in a wheelchair. There was no special information regarding getting the resident up for bingo on Tuesdays by 2:00 p.m.</p> <p>Review of the Admission 6/20/13 Minimum Data Set (MDS) assessment indicated the resident's Brief Interview for Mental Status (BIMS) score was a 7. The resident indicated it was somewhat important to have books, and the newspaper. It was not very important to listen to music and it was very important to keep up with the news. It was somewhat important to do things with groups and very important to participate in religious services. The resident needed extensive assist with 2 person physical assist for bed mobility, transfers, and locomotion on and off the unit.</p> <p>Review of the current plan of care dated 9/10/13 indicated the resident had expressed interest in attending mass. Her strengths were: like to read, and watch TV. Family requested name be placed on the mass list, family was supportive. The facility staff approaches were to have</p>				

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	<p>activity staff place an activity calendar in her room for reference, and assist her to and from activities.</p> <p>Review of an Activity Progress note completed on 12/10/13 indicated the resident watches TV in her room and was read to. She accepts pet visits and her family visits weekly. She plays bingo as she feels up to.</p> <p>Review the activity attendance record indicated the resident attended bingo on 11/12/13 and 11/19/13 for the month of November 2013. She had only attended bingo on 12/10/13 in the month of December.</p> <p>Interview with the Activity Director on 12/11/13 at 11:10 a.m., indicated the resident usually arrives about 15 minutes late for bingo. She indicated the resident was not there on time when bingo started at 2:15 p.m. She further indicated she does not know why the resident had not attended all the bingos in November and the first week of December. She further indicated she was aware her daughter does come in on Tuesdays and plays bingo with her.</p> <p>Interview with CNA #4 on 12/11/13 at 10:10 a.m., indicated she was unaware the resident was supposed</p>						

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	to be up for bingo on Tuesdays.  3.1-33(a)				

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F000279 SS=D	<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 observation, record review and interview, the facility failed to ensure a care plan was initiated related to contractures and Restorative range of motion (rom) therapies for 1 of 3 residents reviewed for range of motion of the 7 who met the criteria for range of motion. (Resident #F)</p> <p>Findings include:  On 12/9/13 at 11:46 a.m., Resident #F was observed in her room in a wheelchair. At that time, she was</p>	F000279	<p>F 279 Develop Comprehensive Care Plans We respectfully request a desk review for paper compliance for this citation.1) Resident F has been re-assessed and treated by OT for Contracture needs. She has been discharged from OT and placed on a Restorative Splint Management/PROM Program. 2) Care plans will be reviewed and/or initiated for all residents with splints by the DNS/designee. 3) Training /In-servicing provided to Restorative Nurse on initiation and review of Splint/ROM Care plans. Residents with limited ROM who</p>	01/12/2014	

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	<p>noted to have a contracture to her right hand with no splinting device in place.</p> <p>On 12/10/13 at 10:21 a.m., Resident #F was observed in her room in a wheelchair sleeping, no splinting device was noted to her right hand at that time.</p> <p>On 12/11/13 at 9:00 a.m., Resident #F was observed in the hallway seated in a wheelchair outside of the shower room, no splinting device was noted to her right hand at that time.</p> <p>The record for Resident #F was reviewed on 12/10/13 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depressive disorder, hemiplegia, hypertension, and CVA (cardiovascular accident).</p> <p>A Physician's Order dated 10/15/13 indicated the resident was to be discharged from Occupational Therapy services and begin Restorative nursing care.</p> <p>Review of the Restorative Nursing Care Referral form dated 10/9/13 indicated the resident was to receive passive range of motion (prom) beginning 10/11/13 to her left upper</p>		<p>need therapy intervention will be logged weekly by the Therapy Manager/designee. DNS/designee will ensure care plans are updated as recommended weekly.4) The Therapy &amp; nursing logs will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>				

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	<p>extremity. Passively range all joints, range the shoulder joint forward away from the body as tolerated for 10-15 sets for 3 months. Resident was also to begin a splint/brace assistance program.</p> <p>Review of the current plan of care indicated no evidence of documentation related to the resident's right hand contracture or passive rom therapies.</p> <p>Interview with the Director of Nursing (DoN) on 12/13/13 at 12:31 p.m., indicated a care plan related to the resident's right hand contracture and prom therapies should have been initiated.</p> <p>3.1-35(a)</p>			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's comprehensive plan of care was updated and reflective of the resident related to range of motion for 1 of 3 residents reviewed for range of motion of the 7 residents who met the criteria for range of motion. (Resident #104)</p> <p>Findings include:</p> <p>On 12/8/13 at 10:30 a.m., Resident #104 was observed to be sitting up in a wheelchair in her room. At that time, there was no anticontracture</p>	F000280	F 280 Care Plan RevisionWe respectfully request a desk review for paper compliance for this citation.1) Resident 104 is currently receiving OT for splint evaluation. 2) Care plans will be reviewed and/or initiated for all residents with splints by the DNS/designee. 3) Training /In-servicing provided to Restorative Nurse on initiation and review of Splint/ROM Care plans. Residents needing therapy intervention will be logged weekly by the Therapy Manager/designee. DNS/designee will ensure care plans are updated as recommended weekly.4) The Therapy and nursing logs will be	01/12/2014			

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	<p>device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward. The resident's left hand was closed but her fingers were not bent inward.</p> <p>On 12/8/13 at 12:45 p.m. the resident was observed sitting in her wheelchair. There was no anticontracture device noted in either one of her hands. The resident's right hand was noted to be closed with her fingers bent inward.</p> <p>On 12/9/13 at 8:00 a.m., the resident was observed sitting in a wheelchair. At that time, there was no anticontracture device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward.</p> <p>On 12/9/13 at 10:50 a.m., the resident was observed sitting in a wheelchair. At that time, there was a blue carrot (soft anticontracture device) noted in her right hand. The carrot was only half in her hand and the other half was sticking out of her hand.</p> <p>On 12/10/13 at 11:20 a.m., and 2:00 p.m., the resident was observed sitting up in a wheelchair in her room.</p>		<p>reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>				

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	<p>Her right hand was closed like a fist and there was a blue carrot noted in her hand. One fourth of the carrot was noted in her hand, while 3/4 of the carrot was sticking out of her hand.</p> <p>On 12/11/13 at 8:20 a.m., the resident was observed sitting in her wheelchair in dining room eating breakfast. The blue carrot was observed half in and half out of her right hand. Her hand was closed like a fist.</p> <p>On 12/11/13 at 10:00 a.m., and 11:44 a.m., the resident was observed in a wheelchair by the Nurse's station. Only 1/4 of the blue carrot was in her hand, the other 3/4 was sticking out of her hand and not in all the way.</p> <p>12/12/13 at 9:10 a.m., the resident was observed sitting in a wheelchair outside of the beauty shop. The blue carrot was noted in her right hand. At that time, CNA #7 the restorative CNA, was standing by her. Interview with CNA #7 at the time, indicated she only applies the blue carrot into her right hand. She indicated she does not provide range of motion to either one her hands. The CNA indicated the resident could not open her right hand at all by herself and</p>			

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	<p>needed some assistance opening her left hand. The CNA indicated she could not move her fingers by herself also.</p> <p>Interview on 12/12/13 at 9:55 a.m., with CNA #6 who was taking care of the resident, indicated she has taken care of the resident before. She then indicated she got the resident up out of bed today and provided morning care. She indicated she did not perform passive range of motion on her either one of her hands, due to the resident complained of pain. The CNA indicated she cleaned her right hand and when she tried to open her hand, the resident complained of pain. She indicated the resident was not able to open her right hand at all and only could open her left hand partially. The CNA indicated there was no place to document in the resident's clinical record any type of range of motion for her and if she had complaints of pain. She indicated because the resident had complained of pain there was no way to tell if the resident was receiving range of motion to her hands everyday.</p> <p>The record for resident #104 was reviewed on 12/11/13 at 1:52 p.m. The resident's diagnoses included, but were not limited to, high blood</p>			

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	<p>pressure, morbid obesity, and paranoid state.</p> <p>Review of Physician Orders with the original date of 4/24/12 and on the current 12/2013 recap indicated right hand splint to be worn during the day when up in wheelchair, off for meals and at night.</p> <p>Review of the 12/3/13 quarterly Minimum Data Set (MDS) assessment indicated the resident had functional impairment on one side to the upper extremity.</p> <p>Review of the updated plan of care dated 12/9/13 indicated resident requires active range of motion to keep physical function from declining. The Nursing approaches were to not force or move past the point of pain, provide gentle active range of motion with the resident's help before donning right hand air splint 10 reps times 3 sets 6-7 days per week as tolerated by the resident.</p> <p>Interview with the Director of Nursing on 12/12/13 at 10:55 a.m., indicated the resident's plan of care was not up to date and did not reflect the resident's current status.</p> <p>3.1-35(d)(2)(B)</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 observation, record review and interview, the facility failed to ensure sliding scale insulin coverage was administered as ordered for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure treatments to pressure ulcers were completed as ordered for 1 of 3 residents reviewed for pressure ulcers of the 4 residents who met the criteria for pressure ulcers as well as ensure bathing and hair washing was completed based on the plan of care for 1 of 4 residents reviewed for activities of daily living (ADL's) of the 8 residents who met the criteria for ADL's. (Residents #B, #C, and #36)</p> <p>Findings include:</p> <p>1. The record for Resident #36 was reviewed on 12/12/13 at 9:21 a.m. The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus.</p> <p>Review of readmission orders dated 11/20/13, indicated the resident was to receive Accuchecks (a test to</p>	F000282	<p>F 282 Services by Qualified Personnel We respectfully request a desk review for paper compliance for this citation.1) Medication Variance report for resident 36 was completed which included Physician notification. Resident C had her wounds immediately dressed per physicians orders and follow-up report of variance completed including physician notification. Resident B had her hair shampooed immediately.2) All residents with a preference for bed bathing will be interviewed regarding preference for hair care and an updated list will be completed for all residents that have hair done in the Beauty Shop. C.N.A. Care sheets, POC task documentation and Care Plans will be updated appropriately. Wound Treatment audit will be completed for all residents with wounds by the Wound Nurse/designee. ADNS/designee will complete Diabetic Review for all diabetic residents with sliding scale coverage and/or blood sugar monitoring orders. 3) Licensed nurses will be re-educated on diabetic/blood sugar/insulin needs of residents including</p>	01/12/2014			

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	<p>monitor the resident's blood sugar) three times a day.</p> <p>The resident was to receive the following Humalog (a type of insulin) sliding scale insulin coverage based on her Accucheck results:</p> <p>150-200=0 units 201-250=1 unit 251-300=2 units 301-350=3 units 351-400=4 units 401-450=6 units Call MD if below 70 or above 450</p> <p>Review of the 11/2013 Diabetic monitoring flow sheet, indicated the following:</p> <p>11/1/13 there was no blood sugar documented at 4:00 p.m.</p> <p>Review of the 10/2013 Diabetic monitoring flow sheet, indicated the following:</p> <p>10/10/13 at 11:00 a.m. blood sugar 301. There was no documentation of insulin being given. 10/22/13 at 7:00 a.m. blood sugar 226. There was no documentation of insulin being given. 10/22/13 at 4:00 p.m. blood sugar 247. There was no documentation of</p>		<p>documentation and notifications as well as administering treatments as ordered and protocol when a treatment is not competed as ordered. Nursing staff will be in-serviced on shower documentation, C.N.A. Care sheets and POC tasks regarding hair care. Angel check sheets will be completed 2 x/week for observation of proper grooming. An ADL audit will be completed 3x/week for 5 residents by the Unit Manager/designee for hair and nail care and shower documentation. Resident interviews to be completed for 5 residents weekly by Social Services. The Unit Manager/designee will audit 5 diabetic residents for accuracy 2 times weekly using Diabetic Review Audit form. The wound nurse/designee will complete wound treatment audit 3 x/ week on three residents for compliance4) Results of these audits/interviews will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>		

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	<p>insulin being given. 10/25/13 at 4:00 p.m., there was no documentation of the 4:00 p.m. blood sugar. 10/26/13 at 11:00 a.m. blood sugar was 245. The resident received 2 units of insulin rather than 1 unit of insulin.</p> <p>Review of the plan of care dated 6/10/13 and reviewed on 12/3/13, indicated the Resident had the diagnosis of diabetes mellitus. The interventions included, but were not limited to, diabetes medication as ordered by doctor.</p> <p>Interview with the Director of Nursing (DoN) on 12/12/13 at 2:01 p.m., indicated there was no documentation related to the missing blood sugars and insulin doses. She also indicated the resident did receive the wrong dose of insulin and a medication variance form was to be completed.</p> <p>2. On 12/10/13 at 10:56 a.m., the Wound Nurse was observed performing the treatment to Resident #C's pressure sores. At that time, there was a bandage observed to the resident's coccyx, lower mid back, left stump, right lateral foot, and right ankle all dated 12/9/13 with the initials</p>				

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	<p>of LK on them. The Wound Nurse indicated the nurse LK had worked during the day shift yesterday, and the above bandages had not been changed since then. The Wound Nurse further indicated the treatment for the resident's pressure sores was to be done two times a day.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation, acute osteomyelitis, atrial fibrillation, anemia, high blood pressure, protein calorie malnutrition, esophageal reflux, congestive heart failure, hypoglycemia, dementia without behaviors, peripheral vascular disease, and decubitus ulcers.</p> <p>Review of the current plan of care dated 9/13/13 indicated stage 4 pressure ulcer to coccyx, stage 3 to right ankle and mid back and stage 4 to right foot. The Nursing approaches were to administer treatments as ordered.</p> <p>Review of Physician Orders dated 12/7/13 indicated right ankle: cleanse with wound cleanser apply Betadine cover with dry dressing twice a day,</p>			

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	<p>12/7/13 left stump: cleanse with wound cleanser apply Betadine cover with dry dressing twice a day, 12/7/13 coccyx: cleanse with wound cleanser apply Betadine and cover with dry dressing twice a day, 12/7/13 mid back: cleanse with wound cleanser apply Betadine and cover with dry dressing twice a day.</p> <p>Interview with the West Unit Manager on 12/10/13 at 12:07 p.m., indicated the nurse who worked on the 2-10 shift yesterday should have changed the resident's pressure ulcer dressing as ordered by the Physician.</p> <p>3. On 12/9/13 at 8:35 a.m., Resident #B was observed in her bed. Her hair appeared unwashed and uncombed. The resident indicated her head was itching and that it had not been washed since she had been at the facility.</p> <p>The record for the resident was reviewed on 12/10/13 at 8:22 a.m. The resident was admitted to the facility on 10/16/13. The Minimum Data Set admission assessment dated 10/23/13 indicated a diagnoses of osteoporosis and joint disorder. The resident's BIMS (Brief Interview for Mental Status) score was 15, which indicated no cognitive</p>						

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	<p>impairment. For functional status, she required extensive assistance for bed mobility, transfers and personal hygiene.</p> <p>A care plan dated 11/4/13 indicated the problem of self care deficit related to arthritis and limited mobility. Approaches included to encourage the resident to participate in ADL's (Activities of Daily Living) and that the resident preferred a bed bath. Review of the showering schedule indicated the resident was to be bathed on Tuesday and Friday evenings.</p> <p>On 12/11/13 at 9:05 a.m., the resident was observed in her room. Her hair appeared unwashed and uncombed. CNA #1 was present in the room at that time and indicated she was going to wash the resident's hair later that day. The CNA indicated she did not normally work on that unit, so she had not washed the resident's hair before. At 2:00 p.m., the resident indicated her hair had not been washed, and they were going to wash it tomorrow.</p> <p>Interview with CNA #2 and CNA #3 on 12/11/13 at 2:15 p.m. indicated residents were to have their hair washed on their schedule shower</p>						

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	<p>days. The CNAs indicated they had never washed Resident #B's hair.</p> <p>Interview with the Director of Nursing on 12/11/13 at 2:40 p.m., she indicated the resident should have had her hair washed at least one time a week.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <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 the necessary care and services were provided related to monitoring and assessing bruises for 3 of 4 residents reviewed for skin conditions non-pressure related. (Residents #D, #F, and #G)</p> <p>Findings include:</p> <p>1. On 12/9/13 at 10:46 a.m., Resident #D was observed with reddish/purple bruises to her right knuckle and right middle finger.</p> <p>On 12/10/13 at 1:56 p.m., the resident was observed with bluish/purple bruises to her right forearm and right middle finger.</p> <p>The record for Resident #D was reviewed on 12/10/13 at 1:40 p.m. The resident's diagnoses included, but were not limited to, dementia without behavior disturbance and chronic ischemic heart disease.</p>	F000309	<p>F 309 Provide Care/Services for highest well-being We respectfully request a desk review for paper compliance for this citation. 1) Resident D has had a complete skin assessment with all unusual areas documented. All notifications were completed per policy. Event Report completed. Resident G received a complete skin assessment with all unusual areas documented. Physician notification completed with orders received as indicated. Family notification completed. Event Report completed. Resident F received a total skin assessment with all unusual areas documented. Physician and family notification completed. Event Report completed. 2) All residents have the potential to be affected by this practice. A complete skin assessment of all residents will be completed. Any unusual areas will be documented with appropriate notifications. 3) Licensed nurses and CNAs will be in-serviced on skin assessments, documentation and</p>	01/12/2014	

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	<p>Review of the Treatment book on 12/10/13 at 2:00 p.m., indicated there were no non-pressure skin sheets related to the resident's bruises.</p> <p>Review of the 12/3/13 Weekly skin assessment, indicated the resident had no new skin issues.</p> <p>The Weekly skin assessment dated 12/10/13, indicated the resident had no skin issues.</p> <p>On 12/11/13, LPN #2 was shown the bruises on the resident's right forearm and middle finger. The LPN indicated that she was not aware of these bruises. She indicated that she would notify the family and Physician and initiate non-pressure skin condition reports for the resident's bruises.</p> <p>Review of the Weekly non-pressure skin condition report initiated on 12/11/13, indicated the following:</p> <p>-right middle finger #2 1.9 centimeters (cm) x 1 cm dark purple</p> <p>-right middle finger #1 no measurements dark purple</p> <p>-right forearm 3 cm x 1.9 cm dark purple</p>		<p>notification. All residents will have weekly skin assessments as scheduled and shower skin assessments completed. Any unusual areas will be reported to the charge nurse if noted or at any other time. Proper documentation in record, event report and notification will be completed. The unit manager/designee will audit 5 shower sheets 2 times per week. Any deficiency will be corrected immediately with counseling as indicated. Non-pressure audits will be completed 2 x weekly for 5 residents by the Unit Manager/designee.4) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>		

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	<p>Physician orders dated 12/11/13 indicated, monitor discoloration to right mid finger #1 daily, monitor bruise to right mid finger distal daily, and monitor bruise to right forearm daily until healed.</p> <p>Interview with the Director of Nursing on 12/12/13 at 9:35 a.m., indicated that she talked with the nurse who had completed the skin assessment for the resident on 12/10/13, she indicated that she had not looked at the resident's skin but had coded the skin assessment as "no new areas."</p> <p>2. On 12/8/13 at 11:25 a.m., Resident #G was observed in his bed. He had two wounds on his right foot; a lightly scabbed great toe and a heavily scabbed second toe. The skin surrounding the scabbed area was yellowish. His third toe had been amputated. There were no dressings on his toes.</p> <p>The resident's record was reviewed on 12/10/13 at 8:54 a.m. The resident was initially admitted on 11/15/13. He was discharged to an acute care facility on 11/21/13 and</p>				

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	<p>re-admitted to the facility on 12/6/13. A Minimum Data Set admission assessment had not yet been completed since his return. Admitting diagnoses included, but were not limited to, dementia, organic psychosis, type 2 Diabetes and left hip fracture.</p> <p>An Initial Skin Assessment dated 12/6/13 indicated the resident's skin was, "...normal, supple and free from open areas". The Weekly Skin Assessment dated 12/6/13 also indicated there were no skin issues.</p> <p>On 12/10/13 at 11:50 a.m. another observation was made of the resident with the Unit Manager. There were scabbed areas on the resident's great toe and second toe on his right foot, and the surrounding skin was yellowish. There was also a large purple area on the left side of his abdomen. Interview with the Unit Manager at that time indicated the resident was not receiving treatment to his toes. She indicated during his previous admission on 11/15/13, he had been receiving wound treatment to his toes. She further indicated the wounds should have been identified on the initial skin assessment when he was readmitted on 12/6/13. She indicated she would do a skin</p>						

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	<p>assessment at that time.</p> <p>The policy Pressure Ulcer/ Non-Pressure Ulcer Assessment dated 8/31/12, indicated the rationale for weekly ulcer assessment was, "...to determine the progress of healing, the presence of possible complications (e.g., signs of increasing ulceration or soft tissue infection)..."</p> <p>3. On 12/9/13 at 11:46 a.m., Resident #F was observed in her room in a wheelchair. At that time, she was noted to have multiple areas with red/purplish bruising to her bilateral arms near her elbows.</p> <p>On 12/10/13 at 10:21 a.m., Resident #F was observed in her room in a wheelchair sleeping. At that time, she was noted to have multiple areas with red/purplish bruising to her bilateral arms near her elbows.</p> <p>On 12/11/13 at 9:00 a.m., Resident #F was observed in the hallway seated in a wheelchair outside of the shower room. At that time, she was noted to have multiple areas with red/purplish bruising to her bilateral arms near her elbows.</p>				

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	<p>The record for Resident #F was reviewed on 12/10/13 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depressive disorder, hemiplegia, hypertension, and CVA (cardiovascular accident).</p> <p>Review of the Treatment Assessment Record (TAR) dated 12/13 indicated no evidence of documentation related to bilateral arm bruising.</p> <p>Review of the West Shower Sheets indicated no documentation of bruises during the weekly shower skin checks.</p> <p>Interview with CNA #10 on 12/11/13 at 10:30 a.m., indicated no bruising was noted to the resident's bilateral arms during her morning shower on that date.</p> <p>Interview with LPN #1 on 12/11/13 at 10:40 a.m., indicated she was unaware of any new bruising to the resident's bilateral arms. At that time she was asked to assess the resident. During her assessment of the resident's bilateral arms she indicated the resident had three areas of discoloration to her right arm near the elbow and four small red bruises on her left arm near her elbow. She</p>			

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	<p>also indicated at that time, there had been no documentation of bruising to the resident's bilateral arms.</p> <p>This Federal tag relates to Complaint IN00138427.</p> <p>3.1-37(a)</p>						

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F000310 SS=D	<p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received Restorative Therapy as recommended from Occupational Therapy related to passive range of motion and splint application for 2 of 3 residents reviewed for Range of Motion of the 7 residents who met the criteria for Range of Motion. (Resident #F and #104)</p> <p>Findings include:</p> <p>1. On 12/8/13 at 10:30 a.m., Resident #104 was observed to be sitting up in a wheelchair in her room. At that time, there was no anticontracture device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward. The resident's left hand was closed but her fingers were not bent inward.</p>	F000310	F 310 ADLS do not decline unless unavoidableWe respectfully request a desk review for paper compliance for this citation. 1) Resident #104 is currently receiving OT for splint evaluation. Resident F is on a Restorative Splint Management Program and PROM program for splinting of right hand and range of motion to right hand 2) All residents with contractures have the potential to be affected by this practice. All residents will be assessed for stiffness/rigidity. Any residents noted with impairment in ROM will be referred to therapy for further evaluation. Residents as appropriate will be put in therapy. Post completion of therapy, Restorative Program will be initiated as applicable and therapy will educate the restorative nurse on the follow-up care including ROM/splinting as indicated.3) Restorative Nurse and CNAs to be in-serviced on the process of initiating, providing care,	01/12/2014			

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	<p>On 12/8/13 at 12:45 p.m. the resident was observed sitting in her wheelchair. There was no anticontracture device noted in either one of her hands. The resident's right hand was noted to be closed with her fingers bent inward.</p> <p>On 12/9/13 at 8:00 a.m., the resident was observed sitting in a wheelchair. At that time, there was no anticontracture device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward.</p> <p>On 12/9/13 at 10:50 a.m., the resident was observed sitting in a wheelchair. At that time, there was a blue carrot (soft anticontracture device) noted in her right hand. The carrot was only half in her hand and the other half was sticking out of her hand.</p> <p>On 12/10/13 at 11:20 a.m., and 2:00 p.m., the resident was observed sitting up in a wheelchair in her room. Her right hand was closed like a fist and there was a blue carrot noted in her hand. One fourth of the carrot was noted in her hand, while 3/4 of the carrot was sticking out of her hand.</p>		<p>documenting and care planning Splint Management and ROM Restorative Programs. Nursing staff will be re-educated on noting any stiffness to charge nurse. The charge nurse must properly document and notify therapy to screen and evaluate as indicated. Nursing splint audit will be completed weekly by Restorative Nurse/designee. Therapy splint audit to be completed 3 times weekly by Therapy Director/designee. 4) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>				

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	<p>On 12/11/13 at 8:20 a.m., the resident was observed sitting in her wheelchair in dining room eating breakfast. The blue carrot was observed half in and half out of her right hand. Her hand was closed like a fist.</p> <p>On 12/11/13 at 10:00 a.m., and 11:44 a.m., the resident was observed in a wheelchair by the Nurse's station. Only 1/4 of the blue carrot was in her hand, the other 3/4 was sticking out of her hand and not in all the way.</p> <p>12/12/13 at 9:10 a.m., the resident was observed sitting in a wheelchair outside of the beauty shop. The blue carrot was noted in her right hand. At that time, CNA #7 the Restorative CNA, was standing by her. Interview with CNA #7 at the time, indicated she only applies the blue carrot into her right hand. She indicated she does not provide range of motion to either one her hands. The CNA indicated the resident could not open her right hand at all by herself and needed some assistance opening her left hand. The CNA indicated she could not move her fingers by herself also.</p> <p>Interview on 12/12/13 at 9:55 a.m.,</p>			

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	<p>with CNA #6 who was taking care of the resident, indicated she has taken care of the resident before. She then indicated she got the resident up out of bed today and provided morning care. She indicated she did not perform passive range of motion on her either one of her hands, due to the resident complained of pain. The CNA indicated she cleaned her right hand and when she tried to open her hand, the resident complained of pain. She indicated the resident was not able to open her right hand at all and only could open her left hand partially. The CNA indicated there was no place to document in the resident's clinical record any type of range of motion for her and if she had complaints of pain. She indicated because the resident had complained of pain there was no way to tell if the resident was receiving range of motion to her hands everyday.</p> <p>The record for resident #104 was reviewed on 12/11/13 at 1:52 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, morbid obesity, and paranoid state.</p> <p>Review of Physician Orders with the original date of 4/24/12 and on the current 12/2013 recap indicated right</p>			

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	<p>hand splint to be worn during the day when up in wheelchair, off for meals and at night.</p> <p>Review of the 12/3/13 quarterly Minimum Data Set (MDS) assessment indicated the resident had functional impairment on one side to the upper extremity.</p> <p>Review of the updated plan of care dated 12/9/13 indicated resident requires active range of motion to keep physical function from declining. The Nursing approaches were to not force or move past the point of pain, provide gentle active range of motion with the resident's help before donning right hand air splint 10 reps times 3 sets 6-7 days per week as tolerated by the resident.</p> <p>Review of an Occupational Therapy evaluation indicated per nursing referral dated 8/23/13 resident has increased contractures on both hands and noncompliance with splint wearing. Resident has complaints of pain to both hands.</p> <p>Review of an Occupational Therapy (OT) discharge summary dated 9/30/13 indicated skilled OT services were provided for passive range of motion to bilateral upper extremities</p>						

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	<p>to decrease edema. Therapeutic activities provided to increase activity tolerance and find gross motor to utilize utensils for self feeding. Patient has met highest goal in OT. Awaiting for splints. Patient reached maximum level of rehabilitation. Patient to be rescreened/evaluated after delivery of splint for contracture management. Patient/caregiver training provided: range of motion exercises, self feeding skills. Discharge recommendations FMP/Restorative Aide for passive range of motion with splint/brace application.</p> <p>Review of the clinical record indicated there was no evidence of any Restorative Progress Notes for the months of 10/13, 11/13 and 12/13 for the resident. There was no Restorative Assessment completed or any type of Restorative Therapy Progress Note for the resident.</p> <p>Review of the CNA task assignments indicated there was no documentation to indicate if the resident was receiving Restorative Therapy.</p> <p>Interview with the Director of Nursing on 12/12/13 at 10:55 a.m., indicated the facility has been without a Restorative Nurse since the middle of</p>			

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	<p>October 2013 and she has been trying to keep up with it. She further indicated if the resident was discharged from Occupational Therapy with recommendations for Restorative Therapy and passive range of motion there should have been an assessment and plan of care for the services.</p> <p>2. On 12/9/13 at 11:46 a.m., Resident #F was observed in her room in a wheelchair. At that time, she was noted to have a contracture to her right hand with no splinting device in place.</p> <p>On 12/10/13 at 10:21 a.m., Resident #F was observed in her room in a wheelchair sleeping, no splinting device was noted to her right hand at that time.</p> <p>On 12/11/13 at 9:00 a.m., Resident #F was observed in the hallway seated in a wheelchair outside of the shower room, no splinting device was noted to her right hand at that time.</p> <p>The record for Resident #F was reviewed on 12/10/13 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depressive disorder,</p>				

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	<p>hemiplegia, hypertension, and cva (cardiovascular accident).</p> <p>A Physician's Order dated 10/15/13 indicated the resident was to be discharged from Occupational Therapy services and begin Restorative nursing care.</p> <p>Review of the Nursing Progress Notes dated 10/15/13 indicated a new order, discharge resident from Occupational Therapy to Restorative Program.</p> <p>Review of the Restorative Nursing Care Referral form dated 10/9/13 indicated the resident was to receive passive range of motion (prom) beginning 10/11/13 to her left upper extremity. Passively range all joints, range the shoulder joint forward away from the body as tolerated for 10-15 sets for 3 months. Resident was also to begin a splint/brace assistance program.</p> <p>Review of the Treatment Assessment Record (TAR) indicated no evidence of documentation related to splinting of the resident's right hand or Restorative nursing care.</p> <p>There was no evidence of documentation of a plan of care</p>				

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	<p>related to prom for the resident's bilateral upper extremities or splinting of the resident's right hand.</p> <p>There was no evidence of daily documentation completed to ensure the resident was receiving the prom or splinting of the resident's right hand.</p> <p>Interview with the Restorative Aide on 12/10/13 at 2:33 p.m., indicated the resident was not receiving Restorative services at this time and had not received Restorative services since her discharge from Occupational Therapy services dated 10/12/13.</p> <p>Interview with CNA #11 on 12/12/13 at 9:31 a.m., indicated she had not performed any splinting or prom exercises for the resident. A following interview with CNA #12 also indicated she had not performed any splinting or prom exercises for the resident.</p> <p>Interview with CNA #10 on 12/12/13 at 9:46 a.m., indicated there was no evidence of documentation of splinting or prom exercises for the resident on the CNA care card dated 12/12/13.</p> <p>Interview with the Occupational</p>						

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	<p>Therapist on 12/12/13 at 2:50 p.m., indicated the resident should have begun receiving Restorative services on 10/11/13. She also indicated she provided an in-service to all shifts on 10/10/13 which demonstrated how to properly splint the resident's right hand and proper prom technique.</p> <p>3.1-38(a)(2)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure 3 of 4 residents reviewed for activities of daily living of the 8 residents who met the criteria for activities of daily living received the necessary services to maintain good grooming and personal hygiene related to bathing, oral care, nail care and hair washing. (Residents #B, #C, and #E)</p> <p>Findings include:</p> <p>1. Interview with Resident #E on 12/9/13 at 11:28 a.m., indicated that recently she had been receiving a shower once a week rather than twice a week.</p> <p>The record for Resident #E was reviewed on 12/10/13 at 1:32 p.m. The resident's diagnoses included, but were not limited to, difficulty walking and muscle weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated</p>	F000312	F312 ADL Care provided for Dependent ResidentsWe respectfully request a desk review for paper compliance for this citation. 1) Resident E has received her showers as scheduled. Resident C received immediate oral care. Resident B had her hair washed immediately.2) All residents who require assistance with ADL's have the potential to not receive care as directed. An ADL audit will be completed for all residents for validation of oral care, nail care and showers. 3) Nursing staff will be in-serviced on showers and routine ADL care including documentation in POC and shower sheets for ADL care. Angel check sheets will be completed 2 x/week for observation of proper grooming. An ADL audit will be completed 3x/week for 5 residents by the Unit Manager/designee for hair and nail care and shower documentation. Resident interviews will be completed on 5 residents weekly by Social Services. 4)Results of these audits/interviews will be reviewed at least monthly x 6 months in the facility's Performance	01/12/2014			

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	<p>9/17/13, indicated the resident required extensive assist with bathing.</p> <p>Review of the shower schedule for the West Unit, on 12/12/13 at 9:36 a.m., indicated the resident was to receive her showers on the 2-10 shift on Tuesday and Friday.</p> <p>Review of the shower sheets for the month of November 2013, indicated the resident received a shower on 11/19 and 11/29/13.</p> <p>Interview with the Director of Nursing (DoN) on 12/12/13 at 1:15 p.m., indicated there was nothing logged in the computer to indicate if the resident had received a shower between 11/19 through 11/29/13. She did indicate skin sheets were completed on 11/19/13.</p> <p>2. Interview with Resident #C's daughter on 12/09/2013 at 11:40 a.m., indicated she did not think her mother's teeth were being brushed everyday. She indicated her mom has real teeth and she has asked several times to ensure her teeth were being brushed, however, many times she comes in and the resident has food in her teeth and along her gums. She indicated she usually comes in everyday around 5:00 p.m.</p>		Improvement Committee meeting				

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	<p>On 12/09/2013 at 1:09 p.m., Resident #C was observed in bed. At that time, there was a significant odor from the resident's mouth. The resident's teeth had food debris in them and along the gum line and were black in color. Further observation indicated the resident's fingernails were long and dirty with a dirt noted underneath them.</p> <p>On 12/10/13 at 8:20 a.m., 9:50 a.m., and 11:00 a.m., the resident was observed in bed. The resident's teeth were discolored brown/black and had a large amount of food debris noted in them. Her fingernails were long and dirty.</p> <p>On 12/11/13 at 9:55 a.m., the resident was observed in bed. There were two CNAs observed at the bedside CNA #4 and CNA #5. Both CNAs were performing Activities of Daily (ADL) care for the resident. CNA #4 was clipping the resident's fingernails. CNA #4 indicated nail care was done as needed. Both CNAs were informed at that time, the resident's nails had been long and dirty since 12/8/13. CNA #4 then finished cutting her nails and started to pack up the dirty linens to leave the room. At that time, both CNAs were asked if oral care had been</p>				

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	<p>completed. Both CNAs indicated they had not completed oral care for the resident. The resident then opened her mouth, so the CNAs could see the large amount of food debris noted in her mouth around her teeth and gums. CNA #5 then left the room to get some toothettes for the resident to brush her teeth. CNA #4 then placed the toothette into the resident's mouth and rubbed it gently over her teeth using toothpaste. At that time, when she removed the toothette, there was a large amount of food particles that came out of her mouth.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation, acute osteomyelitis, atrial fibrillation, anemia, high blood pressure, esophageal reflux, congestive heart failure, hypoglycemia, dementia without behaviors, and mood disorders.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 9/17/13 indicated the resident was impaired for decision making. The resident had no behaviors, or hallucinations. The resident was total</p>						

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	<p>assistance with dressing, bathing, and personal hygiene with one person physical assist. The resident had no broken or loose fitting dentures, no mouth or facial pain or difficulty with chewing.</p> <p>Review of the current plan of care dated 9/13/13 indicated Resident name has an ADL self care performance deficit related to left below the knee amputation and need for total assistance with ADLs. The Nursing approaches were to praise for effort and encourage to call for assist.</p> <p>Review of the care plan conference summary sheet dated 9/13/13 indicated summary of care plan conference discussion: "teeth brushing needs to happen on more regular basis." "How often does she bathe?"</p> <p>Review of the CNA assignment sheet indicated there was no information regarding the resident needing her teeth brushed more often or that she wanted a complete bed bath on her shower days.</p> <p>Review of the weekly shower information indicated the resident received a full bed bath on 11/4, 11/7.</p>				

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	<p>11/11, 11/15, 11/17, 11/21, 11/25, and 11/28/13. The resident had received a full bed bath on 12/5 and 12/9/13.</p> <p>There was no evidence of any documentation in Nursing Progress Notes of the resident being offered a shower and refusing to take one. There was no indication the resident refused her showers on those days and was given a bed bath instead.</p> <p>Interview with the West Unit Manager on 12/12/13 at 10:44 a.m., indicated the resident's teeth were to be brushed everyday after meals. She further indicated the resident was to have her nails trimmed and cleaned as needed and there was no reason the resident could not take a shower.</p> <p>3. On 12/9/13 at 8:35 a.m., Resident #B was observed in her bed. Her hair appeared unwashed and uncombed. The resident indicated her head was itching and that it had not been washed since she had been at the facility.</p> <p>The record for the resident was reviewed on 12/10/13 at 8:22 a.m.</p>						

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	<p>The resident was admitted to the facility on 10/16/13. The Minimum Data Set admission assessment dated 10/23/13 indicated diagnoses of osteoporosis and joint disorder. The resident's BIMS (Brief Interview for Mental Status) score was 15, which indicated no cognitive impairment. For functional status, she required extensive assistance for bed mobility, transfers and personal hygiene.</p> <p>A care plan dated 11/4/13 indicated the problem of self care deficit related to arthritis and limited mobility. Approaches included to encourage the resident to participate in ADL's (Activities of Daily Living) and that the resident preferred a bed bath. Review of the showering schedule indicated the resident was to be bathed on Tuesday and Friday evenings.</p> <p>On 12/11/13 at 9:05 a.m., the resident was observed in her room. Her hair appeared unwashed and uncombed. CNA #1 was present in the room at that time and indicated she was going to wash the resident's hair later that day. The CNA indicated she did not normally work on that unit, so she had not washed the resident's hair before. At 2:00</p>						

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	<p>p.m., the resident indicated her hair had not been washed, and they were going to wash it tomorrow.</p> <p>Interview with CNA #2 and CNA #3 on 12/11/13 at 2:15 p.m. indicated residents were to have their hair washed on their schedule shower days. The CNAs indicated they had never washed Resident #B's hair.</p> <p>Interview with the Director of Nursing on 12/11/13 at 2:40 p.m., she indicated the resident should have had her hair washed at least one time a week.</p> <p>This Federal tag relates to Complaints IN00138427 and IN00139562.</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(C) 3.1-38(a)(3)(E)</p>				

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the necessary treatment and services to prevent further breakdown related to treatment changes for 1 of 3 residents reviewed for pressure ulcers of the 8 residents who met the criteria for pressure ulcers. (Resident #C)</p> <p>Findings include:</p> <p>On 12/10/13 at 10:56 a.m., the Wound Nurse was observed performing the treatment to the resident's pressure sores. At that time, there were bandages observed to the resident's coccyx, lower mid back, left stump, right lateral foot, and right ankle all dated 12/9/13 with the initials of LK on them. The Wound Nurse indicated the nurse LK had</p>	F000314	F314 Treatment to Prevent/Heal Pressure Ulcers We respectfully request a desk review for paper compliance for this citation.1) Resident C had all dressings changed immediately. Event Report completed. 2) All residents with wounds have the potential for this deficient practice to occur.Wound Treatment audit will be completed for all residents with wounds by the Wound Nurse/designee. 3) Licensed nurses will be re-educated on administering treatments as ordered and protocol when a treatment is not competed as ordered. The wound nurse/designee will complete wound treatment audit 3x/ per week on three residents for compliance. Any deficiencies will be corrected immediately and documented with an event report which includes Physician and family notification per policy.4) Results of these audits will be	01/12/2014			

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	<p>worked during the day shift yesterday, and the above bandages had not been changed since then. The Wound Nurse further indicated the treatment for the resident's pressure sores was to be done two times a day. At that time, there was a large amount of dried bloody drainage observed on the pad underneath the resident. There were large amounts of drainage observed on all the old gauze sponges after the Wound Nurse had removed them. The pressure ulcers were then measured by the Wound Nurse as followed: right ankle: 4 centimeters (cm) by 3 cm by .2 with 20% slough and 80% granulation. Right lateral foot: 2 cm by 1.9 cm by 0.2 cm with 90% slough and 10% granulation. Right heel: 7 cm by 6 cm with 100% eschar. Left stump: 2 cm by 3 cm by .7 cm with 50% slough and 50% granulation. Coccyx: 8 cm by 9 cm by 3.5 cm with undermining of 2 cm at 12:00 o'clock. Lower mid back: 3.5 cm by 3.8 cm by .5 cm with 30% slough and 70% granulation.</p> <p>The record for Resident #C was reviewed on 12/10/13 at 8:51 a.m. The resident was admitted to the facility on 6/13/13. The resident's diagnoses included, but were not limited to, below knee amputation,</p>		<p>reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>				

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	<p>acute osteomyelitis, atrial fibrillation, anemia, high blood pressure, protein calorie malnutrition, esophageal reflux, congestive heart failure, hypoglycemia, dementia without behaviors, peripheral vascular disease, and decubitus ulcers.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 9/17/13 indicated the resident was impaired for decision making. The resident was a two person physical with extensive assistance with bed mobility and transfers. The resident was at risk for developing pressure sores with the highest pressure ulcer coded at a stage IV. The stage IV pressure ulcer was also noted with necrotic tissue.</p> <p>Review of the current plan of care dated 9/13/13 indicated stage IV pressure ulcer to coccyx, stage III to right ankle and mid back and stage IV to right foot. The Nursing approaches were to administer treatments as ordered.</p> <p>Review of Physician Orders dated 12/7/13 indicated right ankle: cleanse with wound cleanser apply Betadine cover with dry dressing twice a day, 12/7/13 left stump: cleanse with wound cleanser apply Betadine cover</p>						

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	<p>with dry dressing twice a day, 12/7/13 coccyx: cleanse with wound cleanser apply Betadine and cover with dry dressing twice a day, 12/7/13 mid back: cleanse with wound cleanser apply Betadine and cover with dry dressing twice a day.</p> <p>Review of the weekly measurements on last weekly pressure sore sheet dated 12/4/13 indicated the left stump was stage IV and measured 1.6 cm by 1.6 cm by .2 cm. The right heel was unstageable and measured 6.5 cm by 6 cm. The right mid foot measured 2 cm by 2 cm and was unstageable. The mid back was a stage IV and measured 3 cm by 3 cm by 1.5 cm. The right ankle was a stage IV and measured 3 cm by 2 cm by .3 cm and the coccyx was a stage IV and measured 8.5 cm by 8.5 cm by 3 cm.</p> <p>Interview with the Wound Nurse on 12/10/13 at 11:50 a.m., indicated the treatment was to be done two times a day as ordered by the Physician</p> <p>3.1-40(a)</p>				

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F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>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 interview, the facility failed to ensure each resident received range of motion services related to passive range of motion and splint application for 2 of 3 residents reviewed for Range of Motion of the 7 residents who met the criteria for Range of Motion. (Resident #F and #104)</p> <p>Findings include:</p> <p>1. On 12/8/13 at 10:30 a.m., Resident #104 was observed to be sitting up in a wheelchair in her room. At that time, there was no anticontracture device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward. The resident's left hand was closed but her fingers were not bent inward.</p> <p>On 12/8/13 at 12:45 p.m. the resident was observed sitting in her wheelchair. There was no anticontracture device noted in either</p>	F000318	F318 Increase/prevent decrease in ROMWe respectfully request a desk review for paper compliance for this citation.1) Resident #104 is currently receiving OT for splint evaluation. Resident F is on a Restorative Splint Management Program and PROM program for splinting of right hand and range of motion to right hand 2) All residents with contractures have the potential to be affected by this practice. All residents will be assessed for stiffness/rigidity. Any residents noted with impairment in ROM will be referred to therapy for further evaluation. Residents as appropriate will be put in therapy. Post completion of therapy, Restorative Program will be initiated as applicable and therapy will educate the restorative nurse on the follow-up care including ROM/splinting as indicated.3) Restorative Nurse and CNAs to be in-serviced on the process of initiating, providing care, documenting and care planning Splint Management and ROM Restorative Programs. Nursing staff will be re-educated on noting	01/12/2014	

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	<p>one of her hands. The resident's right hand was noted to be closed with her fingers bent inward.</p> <p>On 12/9/13 at 8:00 a.m., the resident was observed sitting in a wheelchair. At that time, there was no anticontracture device in either one of her hands. The resident's right hand was noted to be closed, with her fingers bent inward.</p> <p>On 12/9/13 at 10:50 a.m., the resident was observed sitting in a wheelchair. At that time, there was a blue carrot (soft anticontracture device) noted in her right hand. The carrot was only half in her hand and the other half was sticking out of her hand.</p> <p>On 12/10/13 at 11:20 a.m., and 2:00 p.m., the resident was observed sitting up in a wheelchair in her room. Her right hand was closed like a fist and there was a blue carrot noted in her hand. One fourth of the carrot was noted in her hand, while 3/4 of the carrot was sticking out of her hand.</p> <p>On 12/11/13 at 8:20 a.m., the resident was observed sitting in her wheelchair in dining room eating breakfast. The blue carrot was</p>		<p>any stiffness to charge nurse. The charge nurse must properly document and notify therapy to screen and evaluate as indicated. Nursing splint audit will be completed weekly by Restorative Nurse/designee. Therapy splint audit to be completed 3 times weekly by Therapy Director/designee. 4) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>		

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	<p>observed half in and half out of her right hand. Her hand was closed like a fist.</p> <p>On 12/11/13 at 10:00 a.m., and 11:44 a.m., the resident was observed in a wheelchair by the Nurse's station. Only 1/4 of the blue carrot was in her hand, the other 3/4 was sticking out of her hand and not in all the way.</p> <p>12/12/13 at 9:10 a.m., the resident was observed sitting in a wheelchair outside of the beauty shop. The blue carrot was noted in her right hand. At that time, CNA #7 the Restorative CNA, was standing by her. Interview with CNA #7 at the time, indicated she only applies the blue carrot into her right hand. She indicated she does not provide range of motion to either one her hands. The CNA indicated the resident could not open her right hand at all by herself and needed some assistance opening her left hand. The CNA indicated she could not move her fingers by herself also.</p> <p>Interview on 12/12/13 at 9:55 a.m., with CNA #6 who was taking care of the resident, indicated she has taken care of the resident before. She then indicated she got the resident up out of bed today and provided morning</p>						

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	<p>care. She indicated she did not perform passive range of motion on her either one of her hands, due to the resident complained of pain. The CNA indicated she cleaned her right hand and when she tried to open her hand, the resident complained of pain. She indicated the resident was not able to open her right hand at all and only could open her left hand partially. The CNA indicated there was no place to document in the resident's clinical record any type of range of motion for her and if she had complaints of pain. She indicated because the resident had complained of pain there was no way to tell if the resident was receiving range of motion to her hands everyday. The CNA further indicated she was unaware the resident was to wear any type of splints or anticontracture devices to either hand.</p> <p>The record for resident #104 was reviewed on 12/11/13 at 1:52 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, morbid obesity, and paranoid state.</p> <p>Review of Physician Orders with the original date of 4/24/12 and on the current 12/2013 recap indicated right hand splint to be worn during the day</p>			

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	<p>when up in wheelchair, off for meals and at night.</p> <p>Review of the patient nursing evaluation functional impairment and range of motion assessment dated 11/2013 indicated there was no impairment to upper extremities (shoulder, elbow, wrist, hand) and no impairment to lower extremities (hip, knee, ankle, foot).</p> <p>Review of the 12/3/13 quarterly Minimum Data Set (MDS) assessment indicated the resident had functional impairment on one side to the upper extremity.</p> <p>Review of the updated plan of care dated 12/9/13 indicated resident requires active range of motion to keep physical function from declining. The Nursing approaches were to not force or move past the point of pain, provide gentle active range of motion with the resident's help before donning right hand air splint 10 reps times 3 sets 6-7 days per week as tolerated by the resident.</p> <p>Review of an Occupational Therapy evaluation indicated per nursing referral dated 8/23/13 resident has increased contractures on both hands and noncompliance with splint</p>						

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	<p>wearing. Resident has complaints of pain to both hands.</p> <p>Review of an Occupational Therapy (OT) discharge summary dated 9/30/13 indicated skilled OT services were provided for passive range of motion to bilateral upper extremities to decrease edema. Therapeutic activities provided to increase activity tolerance and find gross motor to utilize utensils for self feeding. Patient has met highest goal in OT. Awaiting for splints. Patient reached maximum level of rehabilitation. Patient to be rescreened/evaluated after delivery of splint for contracture management. Patient/caregiver training provided: range of motion exercises, self feeding skills. Discharge recommendations FMP/Restorative Aide for passive range of motion with splint/brace application.</p> <p>Review of the clinical record indicated there was no evidence of any Restorative Progress Notes for the months of 10/13, 11/13 and 12/13 for the resident. There was no Restorative Assessment completed or any type of Restorative Therapy Progress Note for the resident.</p> <p>Review of the CNA task assignments</p>						

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	<p>indicated there was no documentation to indicate if the resident was receiving Restorative Therapy. Further review of the CNA task assignments indicated there was no documentation to indicate if the resident was receiving passive range of motion everyday or if the resident refused or had pain.</p> <p>Interview with the Director of Nursing on 12/12/13 at 10:55 a.m., indicated the facility has been without a restorative nurse since the middle of October 2013 and she has been trying to keep up with it. She further indicated if the resident was discharged from Occupational Therapy with recommendations for Restorative Therapy and passive range of motion then there should be an assessment and plan of care. She further indicated the functional limitation assessment was inaccurate and the care plan was not updated to reflect the resident. She indicated the carrot was put in place because they could not find the resident's hand splint.</p> <p>Interview with the Rehab Director 12/12/13 at 4:00 p.m., indicated she spoke to the Occupational Therapist who indicated he had ordered the splints for the resident's hands,</p>			

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	<p>however, they have not come in yet.</p> <p>Interview with the CNA/Central Supply supervisor on 12/13/13 at 10:20 a.m., indicated she had ordered splints on 9/30/13 about four pairs, however, she had no idea who she was ordering for. She then indicated she was given notice by one of the supply companies the resident's splint was on backorder. She then let therapy know they were on backorder, however, she still did not know whose splints were backordered. She further indicated when the splints were delivered to the facility she just delivered them to the therapy department and they passed them out to the residents.</p> <p><b>Interview with the Director of Rehab on 12/13/13 at 10:30 a.m., indicated the resident's hand splints were still on backorder and not available from the supply company.</b></p> <p>2. On 12/9/13 at 11:46 a.m., Resident #F was observed in her room in a wheelchair. At that time, she was noted to have a contracture to her right hand with no splinting device in place. Her fingers were curled into the palm of her hand.</p> <p>On 12/10/13 at 10:21 a.m., Resident</p>						

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	<p>#F was observed in her room in a wheelchair sleeping, no splinting device was noted to her right hand at that time. Her fingers were curled into the palm of her hand.</p> <p>On 12/11/13 at 9:00 a.m., Resident #F was observed in the hallway seated in a wheelchair outside of the shower room, no splinting device was noted to her right hand at that time. Her fingers were curled into the palm of her hand.</p> <p>The record for Resident #F was reviewed on 12/10/13 at 11:00 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, depressive disorder, hemiplegia, hypertension, and CVA (cardiovascular accident).</p> <p>A Physician's Order dated 10/15/13 indicated the resident was to be discharged from Occupational Therapy services and begin Restorative nursing care.</p> <p>Review of the Nursing Progress Notes dated 10/15/13 indicated a new order, discharge resident from Occupational Therapy to Restorative Program.</p> <p>Review of the Restorative Nursing</p>			

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	<p>Care Referral form dated 10/9/13 indicated the resident was to receive passive range of motion (prom) beginning 10/11/13 to her left upper extremity. Passively range all joints, range the shoulder joint forward away from the body as tolerated for 10-15 sets for 3 months. Resident was to also to begin a splint/brace assistance program.</p> <p>There was no evidence of documentation of a plan of care related to prom for the resident's bilateral upper extremities.</p> <p>There was no evidence of daily documentation completed to ensure the resident was receiving the prom.</p> <p>Interview with the Restorative Aide on 12/10/13 at 2:33 p.m., indicated the resident was not receiving Restorative services at this time and had not received Restorative services since her discharge from Occupational Therapy services dated 10/12/13.</p> <p>Interview with CNA #11 on 12/12/13 at 9:31 a.m., indicated she had not performed any splinting or prom exercises for the resident. A following interview with CNA #12 staff indicated she had not performed any splinting or prom exercises for the resident.</p>			

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	<p>Interview with CNA #10 on 12/12/13 at 9:46 a.m., indicated there was no evidence of documentation of splinting or prom exercises for the resident on the CNA care card dated 12/12/13.</p> <p>Interview with the Occupational Therapist on 12/12/13 at 2:50 p.m., indicated the resident should have began receiving Restorative services on 10/11/13. She also indicated she provided an in-service to all shifts on 10/10/13 which demonstrated how to properly splint the resident's right hand and proper prom technique.</p> <p>3.1-42(a)(2)</p>			
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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 sliding scale insulin coverage was administered as ordered and blood sugars were monitored as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident #36)</p> <p>Findings include:</p> <p>The record for Resident #36 was reviewed on 12/12/13 at 9:21 a.m.</p>	F000329	<p>F329 Unnecessary Drugs</p> <p>We respectfully request a desk review for paper compliance for this citation. 1) Medication Variance report for resident 36 was completed which included Physician notification. 2) All diabetic orders have been reviewed for accuracy. ADNS/designee will complete Diabetic Review for all diabetic residents with sliding scale coverage and/or blood sugar monitoring orders. 3) Licensed nurses will be re-educated on diabetic/blood sugar/insulin needs</p>	01/12/2014			

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	<p>The resident's diagnoses included, but were not limited to, insulin dependent diabetes mellitus.</p> <p>Review of readmission orders dated 11/20/13, indicated the resident was to receive Accuchecks (a test to monitor the resident's blood sugar) three times a day.</p> <p>The resident was to receive the following Humalog (a type of insulin) sliding scale insulin coverage based on her Accucheck results:</p> <p>150-200=0 units 201-250=1 unit 251-300=2 units 301-350=3 units 351-400=4 units 401-450=6 units Call MD if below 70 or above 450</p> <p>Review of the 11/2013 Diabetic monitoring flow sheet, indicated the following:</p> <p>11/1/13 there was no blood sugar documented at 4:00 p.m.</p> <p>Review of the 10/2013 Diabetic monitoring flow sheet, indicated the following:</p> <p>10/10/13 at 11:00 a.m. blood sugar</p>		<p>of residents including documentation and notifications. The Unit Manager/designee will audit 5 diabetic residents for accuracy 2 times weekly. A log of audits will be maintained.4) ) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>				

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	<p>301. There was no documentation of insulin being given. 10/22/13 at 7:00 a.m. blood sugar 226. There was no documentation of insulin being given. 10/22/13 at 4:00 p.m. blood sugar 247. There was no documentation of insulin being given. 10/25/13 at 4:00 p.m., there was no documentation of the 4:00 p.m. blood sugar. 10/26/13 at 11:00 a.m. blood sugar was 245. The resident received 2 units of insulin rather than 1 unit of insulin.</p> <p>Review of the plan of care dated 6/10/13 and reviewed on 12/3/13, indicated the Resident had the diagnosis of diabetes mellitus. The interventions included, but were not limited to, diabetes medication as ordered by doctor.</p> <p>Interview with the Director of Nursing (DoN) on 12/12/13 at 2:01 p.m., indicated there was no documentation related to the missing blood sugars and insulin doses. She also indicated the resident did receive the wrong dose of insulin and a medication variance form was to be completed.</p> <p>3.1-48(a)(3)</p>						

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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	F441 Infection ControlWe respectfully request a desk review	01/12/2014			

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	<p>ensure an infection control program was maintained related to soiled gloves and linen on the floor as well as wash basins on the floor and not covered for 1 of 3 units throughout the facility. (The West Unit)</p> <p>Findings include:</p> <p>1. On 12/8/13 at 9:25 a.m., a soiled towel was observed on the floor by the bathroom door in Room 107.</p> <p>Interview with the Director of Nursing on 12/13/13 at 1:25 p.m., indicated linen should not be left on the floor.</p> <p>2. On 12/8/13 at 9:26 a.m., soiled gloves were observed on the floor in Room #108.</p> <p>Interview with the Director of Nursing on 12/13/13 at 1:25 p.m., indicated the gloves should have been put in the trash can.</p> <p>3. On 12/9/13 at 8:50 a.m., an unwrapped plastic bath basin was observed on the bathroom floor of Room 108. Two residents resided in the room .</p>		<p>for paper compliance for this citation.1) Soiled towel removed from floor in bathroom of 107, soiled gloves were discarded in room 108, bath basin discarded from room 108, bath basin discarded from bathroom of room 129, bath basin in room 134 were discarded.2) An infection control with linen, used gloves and equipment audit will be completed by the Executive Director/designee for compliance 3) All nursing staff and assigned "Angel" staff will be in-serviced regarding infection control with linen, used gloves and equipment. Infection control rounds will be completed 2 times per week on 5 residents by four angles using the Angel Care Rounds check sheet. Any deficiencies will be corrected immediately and counseling as indicated. The housekeeping manager/designee and Executive Director/designee will tour one unit weekly alternating units. All deficiencies will be corrected immediately with counseling as indicated.4) Results of these audits will be reviewed at least monthly x 6 months in the facility's Performance Improvement Committee meeting</p>		

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	<p>4. On 12/9/13 at 12:11 p.m., an unwrapped plastic bath basin was observed on the bathroom floor of Room 129. On 12/12/13 at 11:15 a.m., there was an unwrapped plastic basin on the bathroom floor. Two residents resided in the room.</p> <p>5. On 12/9/13 at 1:08 p.m., an unwrapped plastic bath basin was on the bathroom floor in Room 134. On 12/12/13 at 11:15 p.m., there were 2 unwrapped plastic basins on the bathroom floor. Two residents resided in the room.</p> <p>Interview with the Unit Manager on 12/12/13 at 11:20 a.m., she indicated the basins should not be stored on the bathroom floor.</p> <p>The policy titled Bed Bath, dated 4/28/13 and identified as current, was received from the Director of Nursing on 12/12/13 at 2:00 p.m. The policy indicated, "...27. Empty bath basin, rinse and wipe with a 10% bleach wipe and store. Store in a bag apart from other personal care items."</p> <p>3.1-18(a) 3.1-19(g)(1)</p>				

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F000520 SS=D	<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 record review and interview, the facility failed to ensure the systemic plan of action of identified issues through the facility's Quality Assurance Program such as Restorative Therapy, non pressure areas and Activities of Daily Living related to the lack of assessments, range of motion, splint application and showers were maintained after the correction date.</p>	F000520	F 520 Quality Assessments and Assurance MeetingWe respectfully request a desk review for paper compliance for this citation.1) Action plans have been created/updated for showers, splinting/ROM, &non-pressure skin assessment. A Performance Improvement Committee meeting was held in the month of December, in which these action plans were reviewed.2) All action plans have been reviewed through the Performance Improvement	01/12/2014

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	<p>Findings include:</p> <p>Interview with the Administrator on 12/13/13 at 9:51 a.m., indicated the facility's Quality Assurance Committee meets every month and consists of herself, the Director of Nursing, Social Service, Dietary, Activities, and Nursing as well as the Medical Director. The Administrator indicated at the time, Activities of Daily related to showers had been identified in the Quality Assurance process. She further indicated the facility had identified non pressure skin issues such as monitoring and assessing new bruises as well through the Quality Assurance protocol.</p> <p>Interview with the Director of Nursing at that time, indicated they identified the problem of showers not being completed timely and twice a week on July 22, 2013. She then immediately put a plan into place and added shower CNAs on each unit. She was then monitoring showers to see if they were done. In mid October 2013, there was an increase of grievances from families and residents indicating their showers were not being done. She then removed the shower CNAs from the units and gave that task back to the floor CNAs. Her overall</p>		<p>Committee.3) Department heads inserviced on initiating and updating action plans per policy. The Executive Director will audit action plans monthly.4) Audit results will provided to QA for review monthly for three months then quarterly unless QAA notes otherwise. Any changes in plan will be implemented as recommended. The medical director is an active member of the committee and will participate in program recommendations.</p>		

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	<p>completion date was 10/28/13. She further indicated she saw a big improvement and showers were being done. The Director of Nursing indicated her plan to follow up and audit was to have the p.m. Supervisor audit the showers, however she had just asked her to do that about two weeks ago and this had not been being done.</p> <p>Further interview with the Director of Nursing at that time, indicated they had discussed and put a plan of action into place for non pressure sores such as bruises on September 9, 2013. The plan of action consisted to continue to use paper instead of all documentation in the computer. Also the unit managers were going to start auditing sheets to make sure each resident had non pressure ulcer sheets when there was bruising. She also implemented that every unit was doing the same thing for documentation of the bruising. She indicated the facility has a QIS mock survey every quarter and non pressure ulcers such as bruising were identified as not being assessed or documented.</p> <p>Continued interview with the Director of Nursing at that time, indicated the facility's Restorative Nurse had quit in</p>			

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	<p>mid October 2013. She indicated she tried to keep up with the Restorative Therapy, but did get behind. She indicated the problems developed in the month of November 2013 when they lost a Restorative CNA as well. The facility now only has one Restorative CNA and was designed to have 2 and 1/2 CNAs to do Restorative therapy. The Director of Nursing was aware of the issues for Restorative Therapy but was going to bring Restorative therapy to the December meeting this month.</p> <p>3.1-52(b)(2)</p>				