

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to a Recertification and State Licensure Survey completed on 4-28-14. This included the PSR to the Investigation of Complaint #IN00145950 completed on 4-28-14.</p> <p>Complaint #IN00145950 - Not Corrected</p> <p>Survey dates: June 10, 11, 12, & 13, 2014</p> <p>Facility number: 000034 Provider number: 155086 AIM number: 100274880</p> <p>Survey Team: Debora Kammeyer, RN-TC Sharon Ewing, RN Lora Swanson, RN (6/10, 6/11, 6/12, 2014) Julie Wagoner, RN</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 11 Medicaid: 50 Other: 9 Total: 70</p>	F000000	<p>Survey Event ID: WODB21 Exit date: 06.26.14 Please consider this Plan of Correction as the facility credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents, and it is submitted solely as a requirement of the provisions of Federal and State law. If there are any further questions or concerns, please feel free to contact me at 574-295-0096. Respectfully, Tara Trevino, LPN, HFA, BS</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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F000248 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality Review completed on June 21, 2014, by Brenda Meredith, R.N.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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 ensure residents were provided with opportunities to participate in activities for 2 of 12 residents on the Dementia Unit. (Resident #44 and Resident #21)</p> <p>Findings include:</p> <p>1. On 6-10-14 at 1:45 P.M., Resident #44 was observed in his room, sitting in a recliner, with his eyes closed and his head down.</p> <p>On 6-11-14 at 9:15 A.M., the resident was observed in his room sitting in a recliner.</p>	F000248	F248 I. R44 and R21 have been reassessed for activity preferences and abilities. II. All Residents on unit will be reassessed for activity preferences and abilities. III. The Activity Calendar for the unit will be reviewed by Regional Director of Clinical Operations and will be revised to include more structured activities. A life enrichment aide position will be created and individual will be hired to assist with activity programming. C.N.A. set sheets will be updated to include Resident preferences and activity plans. All activities and nursing staff will be educated on Resident activity preferences, assistance needed to activities and independent activities for Residents on the unit. IV. The	07/13/2014			

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	<p>On 6-11-14 from 10:00 A.M. to 10:40 A.M., Resident #44 was observed sitting in a chair in the hallway near the nurses station, his head was down and his eyes were closed. The resident never spoke to the residents around him, nor did anyone speak to him during that time frame. The Activity Director was located in her office with the door open. Occasionally a resident was observed to enter her office to talk with her.</p> <p>The clinical record of Resident #44 was reviewed on 6-11-14 at 10:03 A.M. The resident's diagnoses included but were not limited to: Alzheimer's dementia, hypertension, depression, vascular dementia with delusions including sexual inappropriateness, organic psychosis, chronic kidney disease and frontal lobe syndrome.</p> <p>A quarterly Progress Note/Activities, dated 4-14-14, indicated the resident was "...oor [out of room] qd [everyday] for meals and engages with peers. res [resident] actively participates in independent, normalization activities with expressed interest in trivia, movies/tv watching, napping, socializing on a daily basis...res indicates satisfaction with current socialization et [and] stimulation pursuits...." The resident's BIMS (Brief Interview Mental Status)</p>		<p>Administrator or designee will audit the provision and participation of activities on the unit weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Administrator will report audit findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved.</p> <p>Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/residents once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>	

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	<p>score was 3 which indicated severe cognitive impairment.</p> <p>The careplan related to activity, revised on 2-28-14, indicated the resident had a diagnosis of dementia and needed opportunities for socialization and stimulation. The resident at times declines participation in group programming and prefers trivia, movies/TV watching, napping, food-related socialization with peers. The interventions included, but were not limited to: honor his preferences and choices, inform resident of activities of assessed interests and assist/direct as needed, and offer socialization opportunities with peers of similar interests/capacities.</p> <p>During an interview, on 6-11-14 at 11:55 A.M., RN #1 indicated the Dementia Unit did not have an activity calendar, only a Specialized Events Sheet which was posted on the bulletin board at nurses station. The form indicated one event was scheduled on 6-11-14 at 2:00 P.M. "Blueberry Pie." RN #1 indicated some of the residents throughout the facility had made pies yesterday and today the residents could eat the pies that were made.</p> <p>On 6-11-14 at 12:07 P.M., a review of an</p>						

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	<p>email regarding a routine careplan meeting, dated 4-17-14, from the resident's daughter, indicated she had a few questions "...Does my Dad get to spend some time outside when the weather is nice? He loves being outdoors... Is he engaging in activities?...." An email, dated 4-24-14, to daughter indicated "...he does enjoy activities and actively participates in mindful minutes, socializing with other residents, cooking/tasting activities, trivia and exercise group...."</p> <p>On 6-11-14 at 1:58 P.M., an activity "Blueberry Pie" was announced for the facility, however the Activity Director for the unit was not available and no other staff member invited or assisted the residents to the activity, which was off the unit. There was approximately 5 to 6 residents out of 12 residents on the dementia unit, standing, wandering or sitting on a bench near the Activity Directors office and Nurses Station. Another announcement was made indicating the last call for blueberry pie activity in the main activity center. The Activity Director for the unit was observed to be in the Administrator's Office. The Activity Director for the dementia unit was approached while she was off the unit and inquired about who and when she would be taking resident's</p>						

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	<p>to the Blueberry Pie activity. The Activity Director had no answer. When inquired about Resident #44's activity preferences and careplan update, she explained she had completed an audit and all resident's on the Dementia Unit had been reviewed and updated as needed. She further indicated the resident's care plan was current and did not need a revision of the plan.</p> <p>On 6-12-14 at 9:20 A.M., Resident #44 was observed sitting in his room on a recliner, his eyes were open looking around the room. No TV was on in the room.</p> <p>On 6-12-14 at 10:15 A.M., Resident #44 was observed sitting in his room in a recliner, with his head down and eyes closed.</p> <p>2. During the environmental tour on 6-11-14 at 10:15 A.M., Resident #21 was observed standing near the nurse's station asking for someone to take her to bingo. RN #1 indicated there was no one to take her off the dementia unit to attend the bingo activity.</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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F000272 SS=D	<p>3.1-33(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;</p>				

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	<p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>Based on record review and interviews, the facility failed to ensure bladder incontinence was thoroughly assessed for 1 of 3 residents reviewed for incontinence. (Resident #36)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #36 was reviewed on 06/10/14 at 2:30 P.M. Resident #36 was admitted to the facility on 01/31/14, with diagnoses, including but were not limited to: paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle, muscular wasting and disuse atrophy, and Parkinson' disease.</p> <p>Review of the quarterly MDS (minimum data set) assessment, completed on 05/14/14, indicated the resident was always incontinent of her bladder and frequently incontinent of her bowels.</p> <p>Interview with the MDS coordinator, RN #26 on 06/10/14 at 3:00 P.M., indicated</p>	F000272	<p>F272 I. R36 has been reassessed for toileting needs and plan developed based on assessment. R36's care plan and C.N.A. set sheet have been updated to provide adequate direction to staff. II. All incontinent Residents will be reassessed for toileting needs and individualized toileting plans will be developed based on assessments. Care plans and C.N.A. set sheets will be updated to provide adequate guidance to staff. III. Directed Inservice will be provided on 7/1/14 that will include but will not be limited to education for all nursing staff regarding the facility's policy and procedures regarding comprehensive bladder incontinence assessments. An audit tool will be drafted to assure comprehensive assessments are completed according to facility policy. IV. The Regional Director of Clinical Operations will audit the comprehensive assessments for bladder incontinence weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months</p>	07/13/2014

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	<p>she was still updating the care plans. She reviewed the audit forms and indicated Resident #36 had last had her bowel and bladder incontinence assessed on 04/03/14, prior to the previous survey. She presented the same assessment form utilized during the annual survey, stated the resident had "functional" incontinence though she had forgotten to mark it on the assessment form, and after searching in her office indicated the resident was on a restorative scheduled toileting plan. She did have a copy of the plan of correction in her office but just kept referring to the facility patterning form, with the identified types of incontinence, and the summary. The summary for Resident #36 indicated the following: "[resident's name] is always incontinent of both bladder and bowel. She is currently on therapy caseload and has been ambulating in therapy. She is agreeable to start a scheduled toileting program when she finishes therapy and is put on a RNP [restorative nursing program] for walking." There was no updated bladder assessment form. There was no assessment of any medications, disease processes, or signs of urinary tract infections documented as assessed. There was also 2 to 8 hour gaps in the 3 day voiding patterning form documentation. There was no documentation of the assessment</p>		<p>or until 100% compliance is achieved. Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>				

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F000282 SS=E	<p>information which led the MDS coordinator to determine the resident's incontinence was caused by functional issues or what those issues were.</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-31(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interviews, the facility failed to ensure toileting, and/or pressure relief care plans were followed for 3 of 3 residents</p>	F000282	F282 I. An order has been obtained for R36 to receive PT and OT eval for transfer and wheelchair positioning. R36's skin has been assessed and	07/13/2014			

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	<p>reviewed for incontinence needs (Resident #36, Resident #44 and Resident 75), and 1 of 4 residents reviewed for pressure ulcers (Resident #36). In addition, the facility failed to follow a physician's order regarding the need to obtain a chest X-ray for 1 of 3 residents reviewed for pressure ulcers. (Resident #26)</p> <p>Findings include:</p> <p>1. On 6/10/14 at 2:20 P.M., Resident #36 was observed lying in her bed on her back. The resident was dressed in a gown, brief, and was lying on two quilted bed pads on top of the mattress and underneath the resident's bottom. In addition, there was a folded quilted bed pad and a pillow noted in the resident's wheelchair. Interview with the resident indicated she was now being taken into the bathroom sometimes. She indicated she also was trying not to stay up in the wheelchair as long as she used to sit. She indicated she still had sores on her bottom but they were putting "cream" on them. She indicated she was also being offered to toilet more frequently. She indicated she had gotten up around 7:30 A.M. and had been offered to go to the bathroom in the morning. She indicated she was laid down around 12:30 P.M.</p>		<p>appropriate treatment measures are in place. A pressure relieving cushion was provided for R36's wheelchair. R36's care plan and C.N.A. set sheet were updated to reflect interventions. C.N.A.'s 20, 21, 23, and 24 will receive 1:1 education regarding the provision of pericare. R44 and R74 have been assessed for toileting needs and a plans have been developed based on assessment. R44 and R75's care plan and C.N.A. set sheet have been updated to provide adequate direction to staff. Chest x-ray was completed for R26. II. All Residents will be reassessed for skin risk and the presence of pressure relieving devices. All incontinent Residents will be reassessed for toileting needs and individualized toileting plans will be developed based on assessments. Care plans and C.N.A. set sheets will be updated to provide adequate guidance to staff. All Residents will be reviewed for outstanding lab orders and any outstanding lab orders will be obtained. III. Directed Inservice will be provided on 7/1/14 that will include but will not be limited to education for all nursing staff regarding the facility's policy and procedures regarding the following of care plans for pressure relief and toileting plans as well as education regarding following of physician's orders including but not limited to labs and tracking of labs. An audit tool</p>				

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	<p>On 06/11/14, the following was observed and interviews were conducted:</p> <ul style="list-style-type: none"> - At 8:10 A.M., Resident #36 was observed in dining room at table in a wheelchair waiting on breakfast to be served. Resident 336 was dressed, sitting on quilted bed pad over a pillow in her wheelchair. Resident #36 indicated she gotten up around 7:00 A.M. this morning and was not taken to the bathroom, just washed up and assisted to transfer into her wheelchair. She indicated there were more residents as the building is "full" and that meant less time for aides to help her. She indicated some staff take her to the bathroom and others do not take her. - Resident #36 remained in the dining room until 8:50 A.M., when she was pushed from dining room to the hallway just outside of the dining room by a nursing staff member. She was noted to start reading a book. - Resident #36 remained in her wheelchair in the hallway from 8:50 A.M. to 9:50 A.M., and stayed in her wheelchair in the hallway reading her book and visiting with other residents. -At 9:50 A.M. the Restorative CNA #20, pushed her from the hallway into the dining room for an exercise activity. She remained in the dining room and 		<p>will be drafted to assure pressure relieving devices are properly placed, that toileting plans are being followed and that labs are obtained as prescribed. IV. The Regional Director of Clinical Operations will audit the placement of pressure relieving devices, provision of toileting plans and obtainment and tracking of labs weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved.</p> <p>Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/ residents once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>	

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	<p>participated in Restorative exercises until 10:10 A.M.</p> <p>- At 10:10 A.M., Resident #36 was noted to have been taken to her room and assisted to sit on the toilet by CNA #21 and the Restorative aide, CNA #20. Resident #36 was noted to be able to stand briefly. Interview with CNA #20 indicated the resident was continent of both bowel and bladder during the toileting. She indicated the resident's brief did get wet just as they were transferring her to the toilet because as soon as she stood she started urinating. CNA #20 indicated Resident #26 had requested to be taken to the toilet during the Restorative exercises and had to wait until the exercise activity was completed before CNA #20 could assist her to the toilet.</p> <p>- At 10:23 A.M., Resident #36 was taken by CNA #21 back to the main dining room for a Bingo activity. She remained in the dining room playing Bingo from 10:23 A.M. - 11:15 A.M. At 11:15 A.M., she was pushed from one dining room table to another. Resident #36 indicated the table she was pushed to was her "spot" for lunch.</p> <p>- Resident #36 was noted to remain in the dining room, at a dining table from 11:15</p>						

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	<p>A.M. - 12:15 P.M. when she was served her noon meal.</p> <p>- At 12:50 P.M., Resident #36 was noted to be in her wheelchair in her room, watching television. She indicated she had just returned to her room and had not been toileted yet. She indicated she was going to stay up for the 2:00 P.M. scheduled activity of pie and coffee chat.</p> <p>- Resident #36 remained in her wheelchair in her room, watching television and reading from 12:50 P.M. - 1:50 P.M. She was not toileted during the hour she was in her room. At 1:50 P.M. she was pushed across the hall to the activity room for the pie and coffee activity.</p> <p>- She remained in the activity room from 1:50 P.M. - 2:20 P.M., when she was pushed back to her room by the Activity Director. The resident immediately activated her call light.</p> <p>- At 2:30 P.M., Resident #36's call light was answered by LPN #22. Resident #36 requested to be laid down and LPN #22 indicated she would inform Resident #36's aide.</p> <p>- At 2:35 P.M., CNA #23 and #21 assisted Resident #36, to use her walker</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>and transfer into her bed. Resident #36's incontinent brief was wet. Resident #36 was transferred without providing any incontinence care. The resident was noted to be instructed to lay in her bed on top of two stacked incontinence pads. Resident #36 had requested her brief and outside pants removed. The brief and pants were bagged separately. The resident was not offered any toileting opportunity and was not given incontinence care.</p> <p>On 06/12/14 the following was observed and interviews were conducted:</p> <ul style="list-style-type: none"> - At 8:20 A.M., Resident #36 was noted in the dining room, in her wheelchair, eating her breakfast. AT 8:43 A.M., she was taken to the hallway by the dining room entrance and parked in her wheelchair by a nursing staff member. - From 8:43 A.M. to 9:32 A.M., Resident #36 sat in her wheelchair, in the hallway, talking to other residents. - At 9:32 A.M., she was taken by CNA #24 from the hallway directly back into the dining room to be ready for exercises activity. - Resident #36 remained in the dining room, participating in the exercises 			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>activity from 9:32 A.M. to 10:13 A.M.</p> <p>- At 10:13 A.M., the Activity Director pushed her from the dining room to the activity room. The Activity Director then put on a movie for the resident at her request.</p> <p>- Resident #36 remained in the activity room from 10:13 A.M. to 11:45 A.M., watching a movie At approximately 10:30 A.M., CNA #24 was noted to enter the activity room and spoke briefly with Resident #36.</p> <p>- At 11:45 A.M., Resident #36 was pushed to the dining room from the activity room. The resident indicated she did not trust the particular aide assigned to care for her. She indicated the CNA would not listen to her, had offered to toilet her but she had refused because she did not want the aide to care for her. She indicated the aide today had pulled the incontinence brief too tight and it was cutting in one her privates because it was too tight. She indicated there was no restorative aide today because the Restorative aide, CNA #20 was on vacation.</p> <p>- Resident #36 remained in the dining room from 11:45 A.M. through 12:00 P.M.</p>						

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>- At 1:10 P.M., Resident #36 was noted to be in her room, in her wheelchair, watching television. She indicated the aide, CNA #24, was coming back after she was done picking up trays and was going to assist her.</p> <p>- At 1:30 P.M., Resident #36 had been transferred to her bed by CNA #24. Her outside pants and soaked incontinence brief were noted at the end of the bed. A new brief had been placed on the resident and the resident was placed on two stacked incontinence pads in her bed. The resident smelled like urine. Interview with CNA #24 indicated she had not toileted the resident but she had offered "a few times" during the day. She said sometimes she checked with the resident every "hour or two" but said she thought the resident was to be toileted "every 2 hours." She did not have any washcloths or soap noted and did not provide peri care and Resident #36 did not request to be cleaned.</p> <p>During an interview on 06/12/14 at 1:45 P.M., CNA #24 indicated she had asked Resident #36 about toileting when she was in the activity room watching the movie and the resident said she was dry and refused to be toileted at that time. She indicated after lunch she asked her</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>again and the resident indicated she would wait until after the CNA was done picking up lunch trays from the hallway. CNA #24 again indicated she was aware of the resident's toileting plan and scheduled toileting times.</p> <p>The clinical record for Resident #36 was reviewed on 06/10/14 at 2:30 P.M. Resident #36 was admitted to the facility on 01/31/14, with diagnoses, including but not limited to: paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle, muscular wasting and disuse atrophy, and Parkinson' disease.</p> <p>Review of the quarterly MDS (minimum data set) assessment, completed on 05/14/14, indicated the resident was always incontinent of her bladder and frequently incontinent of her bowels and had "moisture related skin damage."</p> <p>Interview with the MDS coordinator, RN #26 on 06/10/14 at 3:00 P.M., indicated she was still updating the care plans.</p> <p>The care plan, related to activities of daily living, initiated on 09/27/12 and reviewed as current, on 05/19/14, indicated the resident required</p>						

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	<p>mechanical aid Hoyer lift for transfers and one staff participation with personal hygiene, oral care and dressing needs. The care plan related to incontinence, initiated on 05/22/13, revised on 02/18/14, and reviewed on 05/19/14, indicated the following: "[Resident's name] is functionally incontinent. She wears adult briefs, as a dignity measure to help promote normalcy of appearance in care of incontinence in public. She is at risk for UTI [urinary tract infection]and alteration in skin integrity r/t [related to] use of adult briefs. - Interventions: Apply adult briefs when out of bed. Check and change every 2 hours and prn [as needed]. Remove adult brief when in bed, Assist [resident's name] with peri care and handwashing, document on ADL grid any continence or incontinence, if [resident's name] is unable to stand in the bathroom then obtain the bedside commode form the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished, know that [resident's name] has really painful arthritis to her knees and has difficulty with standing for any length of time, observed/document for s/sx [signs and symptoms] UTI [Urinary tract Infection]: pain, burning, blood tinged urine, cloudiness..., offer assistance for toileting upon rising, before and after</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>meals, at hs [bed time], and prn [as needed], praise for all efforts."</p> <p>Interview with the MDS coordinator, RN #26 on 06/10/14 at 3:00 P.M., indicated she was still updating the care plans. There was no explanation as to why a thorough bladder incontinence assessment had not been completed for Resident #36.</p> <p>A restorative toileting plan was located in the ADL (activities of daily living) book located at the nurse's station. Review of the form, on 06/13/14 at 10:00 A.M., indicated the form had been initiated on 06/01/14. The form indicated the resident was to be assisted to the bathroom upon arising, before and after meals, before bedtime, and at 2:00 A.M., and as needed. The documentation section of the form indicated "involved extremity, frequency, and repetition" were to be documented. However, of the 12 days completed in June 2014, there was no documentation for 7 of the days for the day or evening shift. In addition, interview with the Restorative Aide, CNA #20, on 06/11/14 at 1:45 P.M. indicated she just documented the time it took to toilet Resident #36. She indicated there was no place on the form to document if the resident had been continent of her bladder or bowels, the</p>						

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	<p>time she had been toileted, or the number of times in a shift she had been toileted. She indicated she had charted 15 minutes for the time of the toileting opportunity which had been observed on 06/11/14 around 10:15 A.M. Of the 22 shifts which had actually documented on the restorative toileting plan, anywhere from 15 - 25 minutes was documented. It was unclear if the form meant only once a shift was the resident offered her restorative toileting program.</p> <p>A care plan related to an alteration in skin integrity, initiated on 04/24/14, and reviewed on 05/19/14, indicated the resident had an area to the right upper inner thigh, and redness underneath breast and abdominal folds. The interventions were "skin issues will be measured weekly noting size, color, drainage, and odor and ordered treatments - apply zinc oxide [skin protectant] to right upper inner thigh area bid until healed, nystatin powder tid [three times a day] bilateral breast and abd [abdominal] fold bid [twice a day] until healed then change to prn [as needed] for redness."</p> <p>A care plan for "Resident with skin breakdown to right upper inner thigh; redness under abdominal folds," reviewed on 05/19/14, included the</p>			

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	<p>following interventions: " treatment as ordered to abdominal fold and right upper inner thigh, and pt [physical therapy] eval [evaluation] for w/c [wheelchair] cushion/positioning."</p> <p>A care plan related to the resident's potential for impaired skin r/t (related to)disease process, limited mobility, requires help with ADLS (Activities of Daily Living). Has history of edema to lower extremity and status dermatitis, reviewed on 05/19/14, included the following interventions: " the resident requires pressure reducing device on bed, administer medications as ordered, Monitor/document for side effects and effectiveness, administer treatments as ordered and monitor for effectiveness, and follow facility policies/protocols for the preventions/treatment of skin breakdown."</p> <p>A physician's order, dated 04/24/14, indicated "apply zinc oxide [skin protectant] to right inner thigh open area bid [twice daily] until healed."</p> <p>A physician's order, dated 05/29/14, included "Zinc Oxide - apply topically to buttocks q [every] shift and prn [as needed]...Nystatin [antifungal medication] - apply below bilateral breasts et [and] abdominal folds prn</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
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	<p>bid...."</p> <p>Discharge occupational therapy progress and discharge summary, dated 04/09/14, indicated the resident was able to safely perform all toileting task utilizing grab bars requiring minimal assist. There was no note the resident was assessed for pressure reduction or seating issues in her wheelchair.</p> <p>During an interview on 6/12/14 at 8:20 A.M., the Physical Therapist, Employee #28 indicated she had not evaluated the resident for wheelchair positioning or pressure relief because that fell under the occupational therapy side.</p> <p>During an interview on 6/11/14 at 8:30 A.M., the Occupational Therapist, Employee #27, indicated she had not evaluated Resident #36 for pressure relief or a wheelchair pressure relief cushion. She indicated "a few weeks ago she had asked her [Resident #36] where the cushion she had before [on a prior admission] was and the resident indicated she preferred to sit on a pillow and did not wish to have a cushion." Employee #27, indicated the resident had a pressure relief cushion on a prior admission and when she discharged to another facility it went with her but did not return when she was readmitted to this facility. She</p>				

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	<p>indicated she had not given an in-service to staff regarding pressure relief techniques but said the staff "knew" all about that and "knew" not to double up the incontinence pads underneath the resident. She indicated the resident herself probably did that. There was no documentation provided by Employee #27 regarding the cushion or the resident's refusal of a cushion.</p> <p>During an interview on 6/12/14 at 2:30 P.M., Resident #36 indicated she was not offered another pressure relief cushion. She indicated she did tell Employee #27 she was comfortable sitting on the pillow in her wheelchair but the conversation did not involve the possibility of a new pressure relief cushion. She indicated the previous pressure relief cushion, which had been lost when she was at another facility, was a donut style cushion and was not comfortable.</p> <p>Interview with the Physical Therapist, Employee #28, on 06/12/14 at 8:20 A.M., indicated she had not evaluated the resident for wheelchair positioning or pressure relief because that fell under the occupational therapy side.</p> <p>2. The clinical record of Resident #44 was reviewed on 6-11-14 at 10:03 A.M. The resident's diagnoses included but</p>						

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	<p>were not limited to: Alzheimer's dementia, hypertension, depression, vascular dementia with delusions including sexual inappropriateness, organic psychosis, chronic kidney disease and frontal lobe syndrome.</p> <p>A review of the careplan, dated 1-30-14, indicated the resident had a history of urinating on the floor. The interventions included but were not limited to: consider triggers and/or patterns when he was urinating in public, inform doctor as needed for increased incontinence, inquire throughout the day to see if he needs toileted, offer assistance with toileting routinely such as upon rising, between meals, before bed and prn. Another careplan, revised on 4-22-14, indicated resident was ADL (Activities of Daily Living) Self Care Performance Deficit related to dementia. The interventions included but were not limited to "...toilet use: resident needs one assist with Toileting and is on the CNA [Certified Nursing Assistant] Scheduled Toileting Program...."</p> <p>Another careplan, revised on 4-22-14, titled "Scheduled Toileting Program" indicated resident was functionally incontinent and unable to reach toilet in timely manner related to cognitive deficits. Interventions included but were not limited to: offer assistance with</p>			

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	<p>toileting upon rising, before and after meals, at bedtime and as needed, and RNP (Restorative Nurse Program) to reassess scheduled toileting program progress monthly.</p> <p>On 6-11-14 at 9:30 A.M., the ADL grid for June 2014 indicated the CNA's were to document each shift how many times the resident had been continent or incontinent during each shift. The following documentation was recorded on the grid for June:</p> <p>Day 1- night shift was blank, day shift was blank and evening shift indicated resident was continent 3x (times).</p> <p>Day 2- night shift continent 3x, day shift continent 2x, and evening shift continent 3x.</p> <p>Day 3- night shift continent 2x, day shift incontinent 3x, and evening shift incontinent 1x.</p> <p>Day 4- night shift continent 1x, day shift continent 3x, and evening shift left blank.</p> <p>Day 5- night shift continent 1x, day shift continent 3x, and evening shift continent 1x.</p> <p>Day 6- night shift continent, day shift incontinent 1x, and evening shift left blank.</p> <p>Day 7- night shift continent 3x, day shift left blank and evening shift left blank.</p> <p>Day 8- night shift continent 2x, day shift left blank and evening shift left blank.</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>Day 9- night shift continent 3x, day shift left blank and evening shift continent 3x. Day 10- night shift continent 2x, days shift continent and evening shift left blank.</p> <p>During an interview on 6-11-14 at 11:27 A.M., RN #1 indicated the resident doesn't wear a brief during the day but may wear at night. She further indicated the resident was mostly continent.</p> <p>During an interview on 6-11-14 at 11:57 A.M., CNA #4 indicated she gave the resident a shower this morning. She indicated the resident had dry underwear on prior to his shower and a "pull up" brief was placed after his shower, in case he had an accident.</p> <p>On 6-11-14 at 12:10 P.M. a review of the "CNA Assignment Sheet" indicated the resident was "...continent, incontinent at times...."</p> <p>During an interview on 6-11-14 at 3:10 P.M., the MDS Coordinator indicated the resident was no longer on the restorative program. A form titled "Restorative Program Plan and Summary," dated 5-27-14, was provided by the MDS Coordinator. The form indicated the resident was refusing to participate in the scheduled toileting program and was</p>						

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	<p>discharged from the plan. She was unaware the careplan for the resident indicated he was still being assessed by the restorative nurse program.</p> <p>During an interview on 6-12-14 at 9:50 A.M., CNA#4 indicated her Assignment Sheet stated the resident was continent and incontinent at times, and at times used a brief. However, use of a brief/pull up was not indicated on her assignment sheet for Resident #44 She further indicated the brief was used incase he had an incontinent episode. When asked about the use of the brief per the careplan, she wasn't sure what the careplan said about brief usage for the resident. She indicated she was to document on the ADL grid if the resident was incontinent or continent, she did not included in her documentation if the resident was in a brief or not.</p> <p>6-13-14 at 8:45 A.M., Resident #44 was sitting in his room and had a brief on.</p> <p>3. On 6-10-14 at 2:22 P.M. a review of the clinical record for Resident #75 was conducted. The record indicated the resident was admitted on 5-23-14. The resident's diagnoses included, but were not limited to: weakness, gastroenteritis, pneumonia, hypertension, hypothyroidism, history of stroke.</p>			

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	<p>The Admission Nursing Assessment, dated 5-23-14, indicated the resident was incontinent of bowel and bladder. The Nursing Notes indicated nurses document daily resident was incontinent of bowel and bladder.</p> <p>The careplan, dated 6-2-14, indicated the resident was incontinent of bladder and used adult briefs to help promote normalcy of appearance in case of incontinence in public. This placed him at risk for UTI (urinary tract infection) or alteration in skin integrity related use of adult briefs. The interventions included, but were not limited to: apply brief when out of bed or as needed, check and change every 2 hours and as needed, remove brief when in bed, encourage fluids to promote voiding, and notify MD (medical doctor) of signs and symptoms of UTI. Another careplan dated 6-2-14 indicated the resident had an ADL (Activities of Daily Living) Self Care Performance Deficit related to activity intolerance, impaired balance, weakness, pneumonia and gastroenteritis. The goal indicated the resident would improve in his current level of function in bed mobility, transfers, toilet use and personal hygiene. The interventions included but were not limited to: Toilet Use: "...requires one staff participation to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>use the toilet...."</p> <p>A review of the Restorative care plan indicated the resident had functional incontinence and was unable to reach the toilet in a timely manner related to malaise and fatigue. The careplan goal indicated the resident would have at least 2 continent episodes daily. The interventions included but were not limited to: assist to bathroom upon rising, before meals, after meals, before bedtime, at 2:00 A.M. and as needed, document any continence and incontinence episodes on the ADL grid, RNP (restorative nursing program) team to reassess scheduled toileting program progress.</p> <p>On 6-10-14 at 2:50 P.M., an Intake and Output Record, dated 5-23-14 thru 5-27-14, indicated the resident had 2-3 wet briefs per shift. The resident was placed on a 3 day bowel and bladder assessment, which indicated the following: -5/30/14 Large Urinary Incontinence at 7:00 A.M., 1:00 P.M. & 7:00 P.M., Urinated in toilet at 9:00 A.M. and 1:00 P.M., Small Urinary Incontinence at 3:00 P.M., Resident Dry at 5:00 P.M. & 9:00 P.M., and N/A 11:00 A.M. Remaining times during the day left blank -5/31/14 Large Urinary Incontinence at</p>						

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>7:00 A.M., Urinated in toilet at 9:00 A.M. and noon, and Small Urinary Incontinence at 2:00 P.M. The remaining times during the day were left blank.</p> <p>-6/1/14 Large Urinary Incontinence at 5:00 P.M., Urinated in toilet at 9:00 A.M., noon, 2:00 P.M. and 8:00 P.M., and Small Urinary Incontinence at 7:00 A.M. and 5:00 P.M. The remaining times during the day were left blank.</p> <p>-A summary of the 3 day recordings indicated the resident was "frequently incontinent" of bladder and "does not always ask for assist with toileting". The resident will begin a trial of a scheduled toileting program. The resident had a diagnosis of malaise, fatigue and lack of coordination. He was not on a diuretic.</p> <p>On 6-11-14 at 9:41 A.M., Resident 75's room was observed to have a toilet riser on the toilet seat and a urinal was observed hooked over plumbing pipes in the restroom.</p> <p>On 6-11-14 at 11:45 A.M., Resident #75 was observed to be sitting at a table in the skilled dining room, waiting for lunch to be served. The resident indicated he had been taken to the dining room by the therapist. He further indicated he had a brief on and had not been taken to the restroom all morning.</p>			

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	<p>During an interview on 6-11-14 at 3:10 P.M. the MDS (Minimum Data Set assessment) Coordinator indicated the resident was on a restorative care plan. She explained the resident's restorative plan recorded the minutes a caregiver spent with the resident each shift, implementing the care plan. She indicated "only the minutes" were recorded. When asked what time represented, she indicated it could be any of the items listed in the plan.</p> <p>During an interview on 6-12-14 at 10:05 A.M., CNA #5 reviewed her CNA Assignment Sheet and indicated Resident #75 was incontinent. When asked if resident was on a restorative plan regarding the incontinence she referred to the ADL binder before answering. CNA #5 further indicated the Restorative Charting indicated the minutes represented the amount of time it took to take the resident to the restroom. When asked why only 15 minutes was recorded each shift she indicated she took the resident to the restroom once a shift because he wore a brief.</p> <p>On 6-13-14 at 9:10 the resident was observed eating his breakfast in his room. The resident indicated he had not been assisted to the restroom before his breakfast arrived. He further indicated he</p>				

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	<p>had a brief on and if he had an accident he was "covered."</p> <p>On 6-13-14 at 9:15 A.M., a review of a Policy and Procedure titled "Assessing the Resident with Incontinence" dated 8/2009, indicated on paged 37, "...Programs That Are Dependant on Staff Involvement and Assistance - Prompted Voiding - Prompted Voiding is a behavioral technique for use with dependent or more cognitively impaired residents...Prompted voiding has three components: 1. Regular monitoring with encouragement to report continence status. 2. Prompting to toilet on a scheduled basis. 3. Praise and positive feedback when the resident is continent and attempts to toilet. To ensure success, these methods require training, motivation and continued effect by resident and caregivers. Habit Training/Scheduled Voiding - Habit training/Scheduled Voiding is a behavioral technique that calls for scheduling toileting at regular intervals on a planned basis to match the resident's voiding habits. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges. Habit training includes timed voiding with the interval based on the resident's usual voiding schedule or pattern. Scheduled voiding is timed</p>			

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	<p>voiding - usually every three to four hours while awake. Candidates for Habit Training/Scheduled Voiding are residents who cannot self-toilet...."</p> <p>4. On 6/12/14 at 11:30 A.M., the clinical record for Resident #26 was reviewed. Resident 26's diagnoses included, but were not limited to: diabetes mellitus type II, peripheral vascular disease, hyperlipidemia, obesity and coronary artery disease.</p> <p>A physician's telephone order, dated 6/9/14, indicated but was not limited to the following: "...Obtain chest x-ray - fax results to [name of local wound clinic]...." Further review of the clinical record lacked documentation to indicate the order for the chest x-ray had been completed.</p> <p>A nurse's note, dated 6/9/14 at 1:30 P.M., indicated "...Returned from wound clinic-n/o [new order] obtain chest x-ray return to clinic in 1 week...."</p> <p>A careplan, dated 2/28/14, indicated but was not limited to the following: "...Problem Alteration In Skin Integrity R/T [related to] Unstageable [full tissue loss in which the base of the ulcer is covered by slough and/or eschar in the ulcer base] to R [right] outer heel.</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
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	<p>Intervention: Tx [treatment] as ordered by wound clinic...."</p> <p>During an interview on 6/12/14 at 1:17 P.M., the Assistant Director of Nursing was conducted. The Assistant Director of Nursing indicated the chest x-ray ordered on 6/9/14 had not been completed.</p> <p>During an interview on 6/12/14 at 1:57 P.M., Resident #26 indicated he had not recently had a chest x-ray.</p> <p>During an interview on 6/12/14 at 2:30 P.M., the Director of Nursing indicated her expectation was when a physician's order was taken, it is recorded, double checked on night shift and then the order was considered done (completed).</p> <p>On 6/12/14 at 3:30 P.M., a policy provided by the Administrator titled Medication Orders, was reviewed. The policy indicated but was not limited to the following: "... Addendum: The night shift nurse will verify all new physicians orders in the past 24 hours daily by comparing the written telephone order to the Medication Administration Record (MAR) or Treatment Administration Record (TAR). The night nurse will signify verification by initialing the telephone order. All discrepancies will be corrected and require Nursing</p>				

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F000314 SS=D	<p>Administration notification...."</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p> <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 the care plans related to pressure relief were followed for 1 of 4 residents reviewed for pressure ulcers. (Resident #36)</p> <p>Finding includes:</p> <p>On 6/10/14 at 2:20 P.M., Resident #36 was observed lying in her bed on her back. The resident was dressed in a gown, brief, and was lying on two quilted</p>	F000314	F314 I. An OT eval has been ordered for R36 and a pressure relieving cushion has been provided for wheelchair. A skin assessment has been completed for R36 and appropriate treatment is being rendered. R36's care plan and C.N.A. set sheet has been updated to provide adequate guidance to staff. II. All Residents will be reassessed for skin risk and the presence of pressure relieving devices. Care plans and C.N.A. set sheets will be updated to	07/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
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	<p>bed pads on top of the mattress and underneath the resident's bottom. In addition, there was a folded quilted bed pad and a pillow noted in the resident's wheelchair. Interview with the resident indicated she was now being taken into the bathroom sometimes. She indicated she also was trying not to stay up in the wheelchair as long as she used to sit. She indicated she still had sores on her bottom but they were putting "cream" on them. She indicated she was also being offered to toilet more frequently. She indicated she had gotten up around 7:30 A.M. and had been offered to go to the bathroom in the morning. She indicated she was laid down around 12:30 P.M.</p> <p>On 06/11/14, the following was observed and interviews were conducted: - At 8:10 A.M., Resident #36 was observed in dining room at table in a wheelchair waiting on breakfast to be served. Resident 336 was dressed, sitting on quilted bed pad over a pillow in her wheelchair. Resident #36 indicated she gotten up around 7:00 A.M. this morning and was not taken to the bathroom, just washed up and assisted to transfer into her wheelchair. She indicated there were more residents as the building is "full" and that meant less time for aides to help her. She indicated some staff take her to the bathroom and others do not take her.</p>		<p>provide adequate guidance to staff. III. A Directed Inservice will be provided on 7/1/14 that will include but will not be limited to education for all nursing staff regarding the following of facility policies and procedures regarding following of care plans for pressure relief. An audit tool will be drafted to assure pressure relieving devices are in place according to the Resident's care plan. IV. The Regional Director of Clinical Operations will audit the placement of pressure relieving devices weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/ residents once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>				

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>- Resident #36 remained in the dining room until 8:50 A.M., when she was pushed from dining room to the hallway just outside of the dining room by a nursing staff member. She was noted to start reading a book.</p> <p>- Resident #36 remained in her wheelchair in the hallway from 8:50 A.M. to 9:50 A.M., and stayed in her wheelchair in the hallway reading her book and visiting with other residents.</p> <p>-At 9:50 A.M. the Restorative CNA #20, pushed her from the hallway into the dining room for an exercise activity. She remained in the dining room and participated in Restorative exercises until 10:10 A.M.</p> <p>- At 10:10 A.M., Resident #36 was noted to have been taken to her room and assisted to sit on the toilet by CNA #21 and the Restorative aide, CNA #20. Resident #36 was noted to be able to stand briefly. Interview with CNA #20 indicated the resident was continent of both bowel and bladder during the toileting. She indicated the resident's brief did get wet just as they were transferring her to the toilet because as soon as she stood she started urinating. CNA #20 indicated Resident #26 had</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>requested to be taken to the toilet during the Restorative exercises and had to wait until the exercise activity was completed before CNA #20 could assist her to the toilet.</p> <p>- At 10:23 A.M., Resident #36 was taken by CNA #21 back to the main dining room for a Bingo activity. She remained in the dining room playing Bingo from 10:23 A.M. - 11:15 A.M. At 11:15 A.M., she was pushed from one dining room table to another. Resident #36 indicated the table she was pushed to was her "spot" for lunch.</p> <p>- Resident #36 was noted to remain in the dining room, at a dining table from 11:15 A.M. - 12:15 P.M. when she was served her noon meal.</p> <p>- At 12:50 P.M., Resident #36 was noted to be in her wheelchair in her room, watching television. She indicated she had just returned to her room and had not been toileted yet. She indicated she was going to stay up for the 2:00 P.M. scheduled activity of pie and coffee chat.</p> <p>- Resident #36 remained in her wheelchair in her room, watching television and reading from 12:50 P.M. - 1:50 P.M. She was not toileted during the hour she was in her room. At 1:50</p>			

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	<p>P.M. she was pushed across the hall to the activity room for the pie and coffee activity.</p> <p>- She remained in the activity room from 1:50 P.M. - 2:20 P.M., when she was pushed back to her room by the Activity Director. The resident immediately activated her call light.</p> <p>- At 2:30 P.M., Resident #36's call light was answered by LPN #22. Resident #36 requested to be laid down and LPN #22 indicated she would inform Resident #36's aide.</p> <p>- At 2:35 P.M., CNA #23 and #21 assisted Resident #36, to use her walker and transfer into her bed. Resident #36's incontinent brief was wet. Resident #36 was transferred without providing any incontinence care. The resident was noted to be instructed to lay in her bed on top of two stacked incontinence pads. Resident #36 had requested her brief and outside pants removed. The brief and pants were bagged separately. The resident was not offered any toileting opportunity and was not given incontinence care.</p> <p>On 06/12/14 the following was observed and interviews were conducted:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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	<p>- At 8:20 A.M., Resident #36 was noted in the dining room, in her wheelchair, eating her breakfast. AT 8:43 A.M., she was taken to the hallway by the dining room entrance and parked in her wheelchair by a nursing staff member.</p> <p>- From 8:43 A.M. to 9:32 A.M., Resident #36 sat in her wheelchair, in the hallway, talking to other residents.</p> <p>- At 9:32 A.M., she was taken by CNA #24 from the hallway directly back into the dining room to be ready for exercises activity.</p> <p>- Resident #36 remained in the dining room, participating in the exercises activity from 9:32 A.M. to 10:13 A.M.</p> <p>- At 10:13 A.M., the Activity Director pushed her from the dining room to the activity room. The Activity Director then put on a movie for the resident at her request.</p> <p>- Resident #36 remained in the activity room from 10:13 A.M. to 11:45 A.M., watching a movie At approximately 10:30 A.M., CNA #24 was noted to enter the activity room and spoke briefly with Resident #36.</p> <p>- At 11:45 A.M., Resident #36 was</p>			

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	<p>pushed to the dining room from the activity room. The resident indicated she did not trust the particular aide assigned to care for her. She indicated the CNA would not listen to her, had offered to toilet her but she had refused because she did not want the aide to care for her. She indicated the aide today had pulled the incontinence brief too tight and it was cutting in one her privates because it was too tight. She indicated there was no restorative aide today because the Restorative aide, CNA #20 was on vacation.</p> <p>- Resident #36 remained in the dining room from 11:45 A.M. through 12:00 P.M.</p> <p>- At 1:10 P.M., Resident #36 was noted to be in her room, in her wheelchair, watching television. She indicated the aide, CNA #24, was coming back after she was done picking up trays and was going to assist her.</p> <p>- At 1:30 P.M., Resident #36 had been transferred to her bed by CNA #24. Her outside pants and soaked incontinence brief were noted at the end of the bed. A new brief had been placed on the resident and the resident was placed on two stacked incontinence pads in her bed. The resident smelled like urine. Interview</p>			

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	<p>with CNA #24 indicated she had not toileted the resident but she had offered "a few times" during the day. She said sometimes she checked with the resident every "hour or two" but said she thought the resident was to be toileted "every 2 hours." She did not have any washcloths or soap noted and did not provide peri care and Resident #36 did not request to be cleaned.</p> <p>During an interview on 06/12/14 at 1:45 P.M., CNA #24 indicated she had asked Resident #36 about toileting when she was in the activity room watching the movie and the resident said she was dry and refused to be toileted at that time. She indicated after lunch she asked her again and the resident indicated she would wait until after the CNA was done picking up lunch trays from the hallway. CNA #24 again indicated she was aware of the resident's toileting plan and scheduled toileting times.</p> <p>The skin for Resident #36 was observed with RN #25 on 06/12/14 at 2:10 P.M. RN #25 was noted to wash her hands, donn gloves, and put zinc oxide cream (skin protectant) on the resident's buttocks area and her posterior thighs. A healing flattened quarter sized superficial open area was noted on the posterior right upper thigh. The resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>complained of pain in the front upper right thigh area. A new linear open area was noted. The area was approximately 1 1/2 inches in length. After measuring the area the nurse put zinc oxide on the area. She did not cleanse the resident's skin prior to putting cream on the resident's open area. The nurse did change her gloves and washed her hands, however, the resident's skin was not cleansed. RN #25 indicated the staff could utilize two bed pads but they were not to be on top of each other with the resident on top of them. She made no effort to correct the bed pads underneath the resident.</p> <p>The clinical record for Resident #36 was reviewed on 06/10/14 at 2:30 P.M. Resident #36 was admitted to the facility on 01/31/14, with diagnoses, including but not limited to: paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle, muscular wasting and disuse atrophy, and Parkinson' disease.</p> <p>Review of the quarterly MDS (minimum data set) assessment, completed on 05/14/14, indicated the resident was always incontinent of her bladder and frequently incontinent of her bowels and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>had "moisture related skin damage." The MDS indicated the resident did not have any pressure ulcers.</p> <p>A care plan related to an alteration in skin integrity, initiated on 04/24/14, and reviewed on 05/19/14, indicated the resident had an area to the right upper inner thigh, and redness underneath breast and abdominal folds. The interventions were "skin issues will be measured weekly noting size, color, drainage, and odor and ordered treatments - apply zinc oxide to right upper inner thigh area bid until healed, nystatin powder tid [three times a day] bilateral breast and abd [abdominal] fold bid [twice a day] until healed then change to prn for redness."</p> <p>A care plan for "Resident with skin breakdown to right upper inner thigh; redness under abdominal folds," reviewed on 05/19/14, included the following interventions: " treatment as ordered to abdominal fold and right upper inner thigh, and pt [physical therapy] eval [evaluation] for w/c [wheelchair] cushion/positioning."</p> <p>A care plan related to the resident's potential for impaired skin r/t disease process, limited mobility, requires help with ADLS. Has history of edema to</p>						

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	<p>lower extremity and status dermatitis, reviewed on 05/19/14, included the following interventions: " the resident requires pressure reducing device on bed, administer medications as ordered, Monitor/document for side effects and effectiveness, administer treatments as ordered and monitor for effectiveness, and follow facility policies/protocols for the preventions/treatment of skin breakdown."</p> <p>A physician's order, dated 04/24/14, indicated "apply zinc oxide [skin protectant] to right inner thigh open area bid [twice daily] until healed."</p> <p>A physician's order, dated 05/29/14, included "Zinc Oxide - apply topically to buttocks q [every] shift and prn [as needed]...Nystatin [antifungal medication] - apply below bilateral breasts et [and] abdominal folds prn bid..."</p> <p>During an interview on 6/11/14 at 8:30 A.M., the Occupational Therapist, Employee #27, indicated she had not evaluated Resident #36 for pressure relief or a wheelchair pressure relief cushion. She indicated "a few weeks ago she had asked her [Resident #36] where the cushion she had before [on a prior admission] was and the resident indicated</p>			

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	<p>she preferred to sit on a pillow and did not wish to have a cushion." Employee #27, indicated the resident had a pressure relief cushion on a prior admission and when she discharged to another facility it went with her but did not return when she was readmitted to this facility. She indicated she had not given an in-service to staff regarding pressure relief techniques but said the staff "knew" all about that and "knew" not to double up the incontinence pads underneath the resident. She indicated the resident herself probably did that. There was no documentation provided by Employee #27 regarding the cushion or the resident's refusal of a cushion.</p> <p>During an interview on 6/12/14 at 8:20 A.M., the Physical Therapist, Employee #28 indicated she had not evaluated the resident for wheelchair positioning or pressure relief because that fell under the occupational therapy side.</p> <p>During an interview on 6/12/14 at 2:30 P.M., Resident #36 indicated she was not offered another pressure relief cushion. She indicated she did tell Employee #27 she was comfortable sitting on the pillow in her wheelchair but the conversation did not involve the possibility of a new pressure relief cushion. She indicated the previous pressure relief cushion, which</p>			

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F000315 SS=D	<p>had been lost when she was at another facility, was a donut style cushion and was not comfortable.</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interviews, the facility failed to ensure 2</p>	F000315	F315 I. R36 and R75 have been reassessed for toileting needs and toileting plans developed	07/13/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
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	<p>of 3 residents reviewed for incontinence had thorough bladder incontinence assessments and received consistent toileting assistance as per their plan of care to prevent urinary tract infections and to restore as much bladder function as was possible. (Resident #36 and Resident #75)</p> <p>Findings include:</p> <p>1. On 6/10/14 at 2:20 P.M., Resident #36 was observed lying in her bed on her back. The resident was dressed in a gown, brief, and was lying on two quilted bed pads on top of the mattress and underneath the resident's bottom. In addition, there was a folded quilted bed pad and a pillow noted in the resident's wheelchair. Interview with the resident indicated she was now being taken into the bathroom sometimes. She indicated she also was trying not to stay up in the wheelchair as long as she used to sit. She indicated she still had sores on her bottom but they were putting "cream" on them. She indicated she was also being offered to toilet more frequently. She indicated she had gotten up around 7:30 A.M. and had been offered to go to the bathroom in the morning. She indicated she was laid down around 12:30 P.M.</p> <p>On 06/11/14 the following was observed</p>		<p>based on assessment. R36 and R75's care plan and C.N.A. set sheet have been updated to provide adequate direction to staff. R36 and R75 have been assessed for s/s urinary tract infection with no signs present. II. All incontinent Residents will be reassessed for incontinent care and toileting needs and individualized plans will be developed based on assessments. Care plans and C.N.A. set sheets will be updated to provide adequate guidance to staff. III. Directed Inservice will be provided on 7/1/14 that will include but will not be limited to education for all nursing staff regarding the facility's policy and procedures regarding the following of care plans to for incontinence care and/or toileting plans. An audit tool will be drafted to assure pericare is provided and toileting plans are followed according to facility policy. IV. The Regional Director of Clinical Operations will audit the provision of pericare and toileting plans weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/residents once per</p>				

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	<p>and interviews were conducted.</p> <ul style="list-style-type: none"> - At 8:10 A.M., Resident #36 was observed in dining room at table in a wheelchair waiting on breakfast to be served. The resident was dressed, sitting on quilted bed pad over a pillow in her wheelchair.. Resident #36 indicated she gotten up around 7:00 A.M. this morning and was not taken to the bathroom, just washed up and assisted to transfer into her wheelchair. She indicated there were more residents as the building is "full" and that meant less time for aides to help her. She indicated some staff take her to the bathroom and others do not take her. - Resident #36 remained in the dining room until 8:50 A.M., when she was pushed from dining room to the hallway just outside of the dining room by a nursing staff member. She was noted to start reading a book. - Resident #36 remained in her wheelchair in the hallway from 8:50 A.M. to 9:50 A.M., and stayed in her wheelchair in the hallway reading her book and visiting with other residents. - At 9:50 A.M. the Restorative CNA #20, pushed her from the hallway into the dining room for an exercises activity. She remained in the dining room and participated in Restorative exercises until 		<p>quarter and review through QA to prevent the recurrence of these deficiencies.</p>	

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	<p>10:10 A.M.</p> <p>- At 10:10 A.M., she was noted to have been taken to her room and assisted to sit on the toilet by CNA #21 and the Restorative aide, CNA #20. Resident #36 was noted to be able to stand briefly. Interview with CNA #20 indicated the resident was continent of both bowel and bladder during the toileting. She indicated the resident's brief did get wet just as they were transferring her to the toilet because as soon as she stood she started urinating. CNA #20 indicated Resident #26 had requested to be taken to the toilet during the Restorative exercises and had to wait until the exercise activity was completed before CNA #20 could assist her to the toilet.</p> <p>- At 10:23 A.M., Resident #36 was taken by CNA #21 back to the main dining room for a Bingo activity. She remained in the dining room playing Bingo from 10:23 A.M. - 11:15 A.M. At 11:15 A.M., she was pushed from one dining room table to another. Resident #36 indicated the table she was pushed to was her "spot" for lunch. Resident #36 was noted to remain in the dining room, at a dining table from 11:15 A.M. - 12:15 P.M. when she was served her noon meal.</p> <p>- At 12:50 P.M., Resident #36 was noted</p>						

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	<p>to be in her wheelchair in her room, watching television. She indicated she had just returned to her room and had not been toileted yet. She indicated she was going to stay up for the 2:00 P.M. scheduled activity of pie and coffee chat.</p> <p>- Resident #36 remained in her wheelchair in her room, watching television and reading from 12:50 P.M. - 1:50 P.M. She was not toileted during the hour she was in her room. At 1:50 P.M. she was pushed across the hall to the activity room for the pie and coffee activity.</p> <p>- She remained in the activity room from 1:50 P.M. - 2:20 P.M., when she was pushed back to her room by the Activity Director. The resident immediately activated her call light.</p> <p>- At 2:30 P.M., Resident #36's call light was answered by LPN #22. Resident #36 requested to be laid down and LPN #22 indicated she would inform Resident #36's aide.</p> <p>- At 2:35 P.M., CNA #23 and #21 assisted Resident #36, to use her walker and transfer into her bed. Resident #36's incontinent brief was wet. Resident #36 was transferred without providing any incontinence care. The resident was</p>			

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	<p>noted to be instructed to lay in her bed on top of two stacked incontinence pads. Resident #36 had requested her brief and outside pants removed. The brief and pants were bagged separately. The resident was not offered any toileting opportunity and was not given incontinence care.</p> <p>On 06/12/14 the following was observed and interviews were conducted:</p> <ul style="list-style-type: none"> - At 8:20 A.M., Resident #36 was noted in dining room, in her wheelchair, eating her breakfast. AT 8:43 A.M., she was taken to hallway by dining room entrance and parked in her wheelchair by a nursing staff member. - From 8:43 A.M. to 9:32 A.M., Resident #36 sat in her wheelchair, in the hallway, talking to other residents. - At 9:32 A.M., she was taken by CNA #24 from the hallway directly back into the dining room to be ready for exercises activity. - Resident #36 remained in the dining room, participating in the exercises activity from 9:32 A.M. to 10:13 A.M. - At 10:13 A.M., the Activity Director pushed her from the dining room to the 			

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	<p>activity room. The Activity Director then put on a movie for the resident at her request.</p> <p>- Resident #36 remained in the activity room from 10:13 A.M. to 11:45 A.M., watching a movie At approximately 10:30 A.M., CNA #24 was noted to enter the activity room and spoke briefly with Resident #36.</p> <p>- At 11:45 A.M., Resident #36 was pushed to the dining room from the activity room. The resident indicated she did not trust the particular aide assigned to care for her. She indicated the CNA would not listen to her, had offered to toilet her but she had refused because she did not want the aide to care for her. She indicated the aide today had pulled the incontinence brief too tight and it was cutting in one her privates because it was too tight. She indicated there was no restorative aide today because the Restorative aide, CNA #20 was on vacation.</p> <p>- Resident #36 remained in the dining room from 11:45 A.M. through 12:00 P.M.,</p> <p>- At 1:10 PM., CNA #36 was noted to be in her room, in her wheelchair, watching television. She indicated the aide, CNA</p>						

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	<p>#24, was coming back after she was done picking up trays, and was going to assist her.</p> <p>- At 1:30 P.M. Resident #36 had been transferred to her bed by CNA #24. Her outside pants and soaked incontinence brief were noted at the end of the bed. A new brief had been placed on the resident and the resident was placed on two stacked incontinence pads in her bed. The resident smelled like urine. Interview with CNA #24 indicated she had not toileted the resident but she had offered "a few times" during the day. She said sometimes she checked with the resident every "hour or two" but said she thought the resident was to be toileted "every 2 hours." She did not have any washcloths or soap noted and did not provide peri care. and Resident #36 did not request to be cleaned.</p> <p>During an interview on 06/12/14 at 1:45 P.M., CNA #24 indicated she had asked Resident #36 about toileting when she was in the activity room watching the movie and the resident said she was dry and refused to be toileted at that time. She indicated after lunch she asked her again and the resident indicated she would wait until after the CNA was done picking up lunch trays from the hallway. CNA #24 again indicated she was aware</p>						

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	<p>of the resident's toileting plan and scheduled toileting times.</p> <p>The skin for Resident #36 was observed with RN #25 on 06/12/14 at 2:10 P.M. RN #25 was noted to wash her hands, donn gloves, and put zinc oxide cream (protectant skin cream) on the resident's buttocks area and her posterior thighs. A healing flattened quarter sized superficial open area was noted on the posterior right upper thigh. The resident complained of pain in the front upper right thigh area. A new linear open area was noted. The area was approximately 1 1/2 inches in length. After measuring the area the nurse put zinc oxide on the area. She did not cleanse the resident's skin prior to putting cream on the resident's open area. The nurse did change her gloves and washed her hands, however, the resident's skin was not cleansed. RN #25 indicated the staff could utilize two bed pads but they were not to be on top of each other with the resident on top of them. She made no effort to correct the bed pads underneath the resident.</p> <p>The clinical record for Resident #36 was reviewed on 06/10/14 at 2:30 P.M. Resident #36 was admitted to the facility on 01/31/14, with diagnoses, including but not limited to: paralysis agitans,</p>			

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	<p>diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle, muscular wasting and disuse atrophy, and Parkinson' disease.</p> <p>Review of the quarterly MDS (minimum data set) assessment, completed on 05/14/14, indicated the resident was always incontinent of her bladder and frequently incontinent of her bowels.</p> <p>Interview with the MDS coordinator, RN #26 on 06/10/14 at 3:00 P.M., indicated she was still updating the care plans. She reviewed the audit forms and indicated Resident #36 had last had her bowel and bladder incontinence assessed on 04/03/14, prior to the previous survey. She presented the same assessment form utilized during the annual survey, stated the resident had "functional" incontinence though she had forgotten to mark it on the assessment form, and after searching in her office indicated the resident was on a restorative scheduled toileting plan. She did have a copy of the plan of correction in her office but just kept referring to the facility patterning form, with the identified types of incontinence, and the summary. The summary for Resident #36 indicated the following: "[resident's name] is always</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>incontinent of both bladder and bowel. She is currently on therapy caseload and has been ambulating in therapy. She is agreeable to start a scheduled toileting program when she finishes therapy and is put on a RNP [restorative nursing program] for walking." There was no assessment of any medications, disease processes, or signs of urinary tract infections documented as assessed. There were 2 - 8 hour gaps in the 3 day voiding patterning form documentation. There was no documentation of the assessment information which led the MDS coordinator to determine the resident's incontinence was caused by functional issues or what those issues were.</p> <p>The occupational therapy progress and discharge summary, dated 04/09/14, indicated the resident was able to safely perform all toileting tasks, utilizing grab bars requiring minimal assist. .</p> <p>The care plan, related to activities of daily living, initiated on 09/27/12 and reviewed as current on 05/19/14, indicated the resident required mechanical aid Hoyer lift for transfers and one staff participation with personal hygiene and oral care and dressing needs. The care plan related to incontinence, initiated on 05/22/13, revised on 02/18/4,</p>			

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	and reviewed on 05/19/14, indicated the following: "[Resident's name] is functionally incontinent. She wears adult briefs, as a dignity measure to help promote normalcy of appearance in care of incontinence in public. She is at risk for UTI [Urinary Tract Infection] and alteration in skin integrity r/t [related to] use of adult briefs. - Interventions: Apply adult briefs when out of bed. Check and change every 2 hours and prn [as needed]. Remove adult brief when in bed, Assist [resident's name] with peri care and handwashing, document on ADL [Activity of Daily Living] grid any continence or incontinence, if [resident's name] is unable to stand in the bathroom then obtain the bedside commode from the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished, know that [resident's name] has really painful arthritis to her knees and has difficulty with standing for any length of time, observed/document for s/sx [signs and symptoms] UTI: pain, burring, blood tinged urine, cloudiness..., offer assistance for toileting upon rising, before and after meals, at hs [bed time], and prn [as needed], praise for all efforts." RN #26 indicated she was still updating the care plans. There was no explanation as to why a thorough bladder incontinence assessment had not been			

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	<p>completed for Resident #26.</p> <p>A restorative toileting plan was located in the ADL book located at the nurse's station. Review of the form, on 06/13/14 at 10:00 A.M., indicated the form had been initiated on 06/01/14. The form indicated the resident was to be assisted to the bathroom upon arising, before and after meals, before bedtime, and at 2:00 A.M., and as needed. The documentation section of the form indicated "involved extremity, frequency, and repetition" were to be documented. However, of the 12 days completed in June 2014, there was no documentation for 7 of the days for the day or evening shift. In addition, interview with the Restorative Aide, CNA #20, on 06/11/14 at 1:45 P.M. indicated she just documented the time it took to toilet Resident #36. She indicated there was no place on the form to document if the resident had been continent of her bladder or bowels, the time she had been toileted, or the number of times in a shift she had been toileted. She indicated she had charted 15 minutes for the time of the toileting opportunity which had been observed on 06/11/14 around 10:15 A.M. Of the 22 shifts which had actually documented on the restorative toileting plan, anywhere from 15 - 25 minutes was documented. It was unclear if the form it meant only once a</p>			
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>shift was the resident offered her restorative toileting program.</p> <p>2. On 6-10-14 at 2:22 P.M., a review of the clinical record for Resident #75 was conducted. The record indicated the resident was admitted on 5-23-14. The resident's diagnoses included, but were not limited to: weakness, gastroenteritis, pneumonia, hypertension, hypothyroidism, history of of stroke.</p> <p>The Admission Nursing Assessment, dated 5-23-14, indicated the resident was incontinent of bowel and bladder.</p> <p>The Nursing Notes indicated nurses document daily resident was incontinent of bowel and bladder.</p> <p>The careplan, dated 6-2-14, indicated the resident was incontinent of bladder and used adult briefs to help promote normalcy of appearance in case of incontinence in public. This places him at risk for UTI or alteration in skin integrity related to use of adult briefs. Interventions included but were not limited to: apply brief when out of bed or as needed, check and change every 2 hours and as needed, remove brief when in bed, encourage fluids to promote</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>voiding, and notify MD (medical doctor) of signs and symptoms of UTI. Another careplan dated 6-2-14 indicated the resident had an ADL Self Care Performance Deficit related to activity intolerance, impaired balance, weakness, pneumonia and gastroenteritis. The goal indicated the resident would improve in his current level of function in bed mobility, transfers, toilet use and personal hygiene. The interventions included but were not limited to: Toilet Use: "...requires one staff participation to use the toilet...." A review of the Restorative care plan indicated the resident had functional incontinence and was unable to reach the toilet in a timely manner related to malaise and fatigue. The careplan goal indicated the resident would have at least 2 continent episodes daily. The interventions included but were not limited to: assist to bathroom upon rising, before meals, after meals, before bedtime, at 2:00 A.M. and as needed, document any continence and incontinence episodes on the ADL grid, RNP (Restorative Nursing Program) team to reassess scheduled toileting program progress.</p> <p>On 6-10-14 at 2:50 P.M., an Intake and Output Record, dated 5-23-14 thru 5-27-14, indicated the resident had 2-3 wet briefs per shift. Resident was place</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>on a 3 day bowel and bladder assessment, which indicated the following:</p> <p>-5/30/14 Large Urinary Incontinence at 7:00 A.M., 1:00 P.M. & 7:00 P.M., Urinated in toilet at 9:00 A.M. and 1:00 P.M., Small Urinary Incontinence at 3:00 P.M., Resident Dry at 5:00 P.M. & 9:00 P.M., and N/A 11:00 A.M. Remaining times during the day left blank</p> <p>-5/31/14 Large Urinary Incontinence at 7:00 A.M., Urinated in toilet at 9:00 A.M. and noon, and Small Urinary Incontinence at 2:00 P.M. The remaining times during the day were left blank.</p> <p>-6/1/14 Large Urinary Incontinence at 5:00 P.M., Urinated in toilet at 9:00 A.M., noon, 2:00 P.M. and 8:00 P.M., and Small Urinary Incontinence at 7:00 A.M. and 5:00 P.M. The remaining times during the day were left blank.</p> <p>-A summary of the 3 day recordings indicated the resident was "frequently incontinent" of bladder and "does not always ask for assist with toileting". The resident will begin a trial of a scheduled toileting program. The resident has a diagnosis of malaise, fatigue and lack of coordination. He was not on a diuretic.</p> <p>On 6-11-14 at 9:41 A.M., the resident's room was observed to have a toilet riser on the toilet seat and a urinal was observed hooked over plumbing pipes in the restroom.</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>On 6-11-14 at 11:45 A.M., the resident was observed to be sitting at a table in the skilled dining room, waiting on lunch to be served. The resident indicated he had been taken to the dining room by the therapist. He further indicated he had a brief on and had not been taken to the restroom all morning.</p> <p>During an interview on 6-11-14 at 3:10 A.M., the MDS Coordinator indicated the resident was on a restorative care plan. When asked what the plan entailed she explained the resident's restorative plan recorded the minutes a caregiver spent with the resident, each shift, implementing the care plan. When asked where the care was documented on, she indicated "only the minutes" are recorded. When asked what time represented she indicated it could be any of the items listed in the plan.</p> <p>During an interview on 6-1-14 at 10:05 A.M., CNA #5's Assignment Sheet indicate the resident was incontinent. When asked if resident was on a restorative plan regarding the incontinence she referred to the ADL binder before answering. CNA #5 further indicated the Restorative Charting indicated the minutes represent the amount of time it took to assist the</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
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	<p>resident to the restroom. When asked why only 15 minutes was recorded each shift she indicated she took the resident to the restroom once a shift because he wore a brief.</p> <p>On 6-13-14 at 9:10 the resident was observed eating his breakfast in his room. The resident indicated he had not been assisted to the restroom before his breakfast arrived. He further indicated he had a brief on and if he had an accident he was "covered."</p> <p>On 6-13-14 at 9:15 A.M., a review of a Policy and Procedure titled "Assessing the Resident with Incontinence" dated 8/2009, indicated on paged 37, "...Programs That Are Dependant on Staff Involvement and Assistance - Prompted Voiding - Prompted Voiding is a behavioral technique for use with dependent or more cognitively impaired residents...Prompted voiding has three components: 1. Regular monitoring with encouragement to report continence status. 2. Prompting to toilet on a scheduled basis. 3. Praise and positive feedback when the resident is continent and attempts to toilet. To ensure success, these methods require training, motivation and continued effect by resident and caregivers. Habit Training/Scheduled Voiding - Habit</p>				

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>training/Scheduled Voiding is a behavioral technique that calls for scheduling toileting at regular intervals on a planned basis to match the resident's voiding habits. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges. Habit training includes timed voiding with the interval based on the resident's usual voiding schedule or pattern. Scheduled voiding is timed voiding - usually every three to four hours while awake. Candidates for Habit Training/Scheduled Voiding are residents who cannot self-toilet..." Another policy titled "Continence Assessment" undated indicated "...2. The Bowel and Bladder monitoring record will be completed for 72 consecutive hours. 3. The continence care plan will be based on the resident's comprehensive assessment including but not limited to the Bowel and Bladder Monitoring record...."</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-41(a)(2)</p>						

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure the resident environment was free of hazards and hazardous chemicals, related to a disposable razor blade and shaving cream left at the handwashing sink in a shared restroom. (Room 113) This had the potential to affect 2 of 22 residents residing on Unit 1. In addition, personal care products were left at the handwashing sinks on the dementia unit. (Room 402, 404, 405, 407, 408, 409 and 410) This had the potential to affect 11 of 17 residents residing on the dementia unit.</p> <p>B. Based on observation, interview and record review, the facility failed to ensure fall interventions and physical therapy recommendations were followed to reduce the risk of an accident for 2 of 3 residents reviewed for falls. (Resident #91 and Resident #41)</p>	F000323	<p>F323 I. Identified razor and personal care items were removed for sinks and resident access. Bed alarm was placed on R91 and R91's care plan and C.N.A. set sheet were updated to provide adequate guidance to staff. Anti-rollbacks were placed on R41's chair. R41's care plan and C.N.A. set sheet were updated to provide adequate guidance to staff. R37 was assisted inside and will not be permitted to sit outside in courtyard unattended. II. Environmental inspection for entire facility was completed to identify any sharps or personal care items present in resident access areas. All identified items removed and secured from resident access. All Residents will be reassessed for fall risk and interventions. Care plans and C.N.A. set sheets will be updated to provide adequate guidance to staff. III. The facility's policy was changed to prohibit Residents from Alzheimer Unit to sit outside in courtyard unattended. Directed</p>	07/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>C. Based on observation, interview and record review, the facility failed to ensure the safety of a resident residing on the dementia unit, related to leaving her unattended in a courtyard for 25 minutes. (Resident #37)</p> <p>Findings include:</p> <p>A. On 6/10/14 from 10:15 A.M. to 11:30 A.M., an initial tour was conducted of the facility, in addition a follow up tour was conducted on 6/11/14 from 10:15 A.M. to 10:30 A.M. with the Assistant Director of Nursing, during which the following was observed:</p> <p>Unit 1:</p> <p>On 6-10-14 at 10:45 A.M., an observation of Room 113 indicated one disposable razor and one can of shaving cream both items were unmarked and at the handwashing sink in a shared bathroom.</p> <p>Unit 4: (Dementia Unit)</p> <p>On 6-10-14 at 10:50 A.M., an observation of Room 402 indicated one bottle of shampoo/body wash unmarked, one bottle of white rain shampoo unmarked, one bottle of perineal cleanser unmarked, two tubes of toothpaste</p>		<p>inservice training will be completed for all staff including but not limited to ensuring the facility's policy and procedures are followed to assure environment is free from hazards, all fall interventions and physical therapy recommendations are followed and Residents receive adequate supervision. An audit tool was developed to assure sharps and personal care items are not accessible by Residents, that fall interventions are in place and are being followed, that physical therapy recommendations are followed and that no Resident residing on Alzheimer's unit is permitted to sit outside without supervision. IV. The Regional Director of Clinical Operations will audit to assure sharps and personal care items are not accessible by Residents, that fall interventions are in place and are being followed, that physical therapy recommendations are followed and that no Resident residing on Alzheimer's unit is permitted to sit outside without supervision weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. Addendum: Following the achievement of 100% compliance, the facility will</p>				

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--	---

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	<p>unmarked and one toothbrush unmarked. All items were on the handwashing sink of a shared room.</p> <p>At 10:55 A.M., an observation of Room 404 indicated one bottle of shampoo/body wash unmarked at the handwashing sink.</p> <p>At 11:00 A.M., an observation of Room 405 indicated one tube of toothpaste unmarked, one bottle of shampoo/body wash unmarked and one toothbrush unmarked. All items were on the handwashing sink of a shared room.</p> <p>At 11:05 A.M., an observation of Room 407 indicated one bottle of shampoo/body wash unmarked at the handwashing sink.</p> <p>At 11:10 A.M., an observation of Room 408 indicated one bottle of shampoo/body wash unmarked and one health liquid body wash unmarked at the handwashing sink.</p> <p>At 11:10 A.M., an observation of Room 409 indicated one tube of fresh mint toothpaste unmarked at the handwashing sink of a shared room.</p> <p>At 11:15 A.M., an observation of Room 410 indicated one deodorant unmarked,</p>		<p>continue to audit a sample of residents/ rooms once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>	

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>one toothpaste unmarked, one bar soap complete handwashing soap unmarked. one pre-electric shave liquid with a caution label that indicated: flammable keep out of reach of children and one toothbrush unmarked. All items were at the handwashing sink of a shared room.</p> <p>At 11:20 A.M., an observation of Room 412 indicated 2 bottles of shampoo/body wash unmarked at the handwashing sink of a shared room.</p> <p>On 6/11/14 at 10:05 A.M., an interview with the ADON (Assistant Director of Nursing) indicated when the resident care products are not in use they should be stored in their own containers. For the dementia unit resident's, their items should be stored in containers in the shower room. The ADON further indicated the problem on the dementia unit was some resident's brought their care items into the room to wash up and then left them at the sink.</p> <p>On 6/11/14 at 11:30 A.M., review of the current policy, titled "Proper Storage of Personal Hygiene Equipment", received from the Administrator, indicated "...In the memory care unit...2. All other personal hygiene items are to be stored in the shower room in individually labeled containers. 3. When a resident is</p>			

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	<p>participating in/or receiving personal care, the items may be taken to the resident for use, but must be returned to the shower room when finished...In the remaining areas of the facility: 1. Resident may keep personal care items in the drawers in their room...3. Residents may not keep safety razors in their room. 4. Residents may not store personal care items in the bathrooms unless in a private room..."</p> <p>B.1. On 6/10/14 at 2:30 P.M., a review of the clinical record for Resident #91 was conducted. The record indicated the resident was admitted to the facility on 5/30/14. The resident's diagnoses included, but were not limited to: Gerstmann-Straussler-Scheinker Syndrome (GSS - a neurogenerative disease), ataxia, abnormal movement disorder, dementia with behavioral disturbances, depressive disorder and anxiety.</p> <p>An admission fall risk assessment, dated 5/30/14, indicated the resident was disoriented to person,place and time, had a history of 1-2 falls in the past 3 months, was chair bound and required assist with elimination. Under the predisposing disease question, a zero was entered indicating the resident did not have a predisposing disease. The resident has a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>diagnosis of Gerstmann-Straussler-Scheinker Syndrome, which was a neurodegenerative disease. The total score was 8 on the fall assessment, a score of 10 or more represented a high risk for falls.</p> <p>A nurses note, dated 6/2/14 at 6:40 A.M., indicated "...Resident found laying on floor beside bed states she was trying to get in her w/c [wheelchair]...."</p> <p>A "Fall Scene Investigation Report," dated 6/2/14, indicated "...Resident stated she was trying to get out of bed and lost balance and fell to floor...What appears to be the root cause of the fall? Resident attempting to transfer self without assistance and has an unsteady gait and weakness r/t [related to] a progressive disease process: GSS Syndrome...initial interventions to prevent future falls: Bed alarm applied to bed...."</p> <p>A physician's order, dated 6/2/14, indicated "Apply bed alarm to bed-check placement and function q [every] shift."</p> <p>A fall risk assessment, dated 6/2/14, indicated a zero was marked under the predisposing disease category and that the resident's total score was an 8, a score of 10 or more represents a high risk for</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>falls.</p> <p>An interdisciplinary team progress note, dated 6/3/14, indicated "...On 6/2/14 @ [at] 6:40 A.M. resident attempting to transfer self without assistance and has unsteady gait and weakness r/t progressive disease process: GSS Syndrome and fell to floor (from bed)...Resident has a dx [diagnosis] of Gerstmann-Straussler-Scheinker Syndrome causing mental and physical decline. Care plan reviewed and updated to include bed alarm...."</p> <p>On 6/10/14 at 3:00 P.M., review of a care plan, initiated on 6/1/14 and revised on 6/2/14, indicated the problem: At risk for physical injury from falls related to: fall risk score of 8, unsteady ambulation, dementia, recent falls, use of high risk medication. Interventions included but were not limited to, assist of 1 for transfers, bed alarm (6/2/14).</p> <p>On 6/10/14 at 3:20 P.M., an observation of Resident #91 indicated the resident was awake and alert sitting up in her wheelchair, the resident was observed to have involuntary movements of her upper extremities. The resident indicated she had fallen recently and that a bed alarm had not been placed on her bed. Observation of the resident's bed</p>						

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>indicated no bed alarm was in place.</p> <p>On 6/11/14 at 8:40 A.M., an observation of the resident's bed indicated there was no bedding on the bed and no bed alarm was in place.</p> <p>On 6/11/14 at 8:49 A.M., an interview with LPN #21 indicated the resident should have a bed alarm in place because she had fallen recently. The nurse verified that there was not a bed alarm in place and that she would place one on the bed immediately.</p> <p>On 6/11/14 at 10:00 A.M., review of the current policy titled "Fall Prevention and Assessment" received from the Administrator, indicated "...Assessment and Recognition: 1. As part of the initial assessment, the facility will help identify individuals with a history of falls and risk factors for subsequent falling...c. While many falls are isolated individual incidents, a significant proportion occur among a few residents/patients. Those individuals may have a treatable medical disorder or functional disturbance as the underlying cause...Treatment /Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.</p>						

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	<p>2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation...Monitoring and follow up: 2. The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling...."</p> <p>B.2. On 6/12/14 at 9:10 A.M., a review of the clinical record for Resident #41 was conducted. The record indicated the resident was admitted to the facility on 3/27/12. The resident's diagnoses included, but were not limited to: Alzheimer's disease, hyperlipidemia, organic sleep disorder, rheumatic aortic stenosis, open angle glaucoma and lack of coordination.</p> <p>On 6/12/14 at 9:15 A.M., an observation of Resident #41 indicated the resident was awake and alert propelling herself down the hallway in her wheelchair, a chair alarm was in place and no anti-roll backs was observed on the wheelchair.</p> <p>An admission fall risk assessment, dated 3/27/12, indicated a total score of 10. A score of 10 or more represents a high risk for falls.</p>			

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	<p>A nurse note, dated 4/21/14 at 7:30 P.M., indicated "...Resident found sitting on the floor in hallway. No apparent injuries. Alarm not sounding as resident had taken blouse off and alarm was still attached to blouse...."</p> <p>A "Fall Scene Investigation Report," dated 4/21/14, indicated the time of fall was at 7:30 P.M. the resident was found sitting on buttocks on the floor in the hallway with the wheelchair next to the resident. Resident ate supper in the d/r (dining room), propelling self in w/c throughout unit, resident attempts to grab rails on wall and stand up without assistance. Additional Care Plan: PT (Physical Therapy)screening with recommendations.</p> <p>A fall risk assessment, dated 4/21/14, indicated a total score of 10. A score of 10 or more represents a high risk for falls.</p> <p>An interdisciplinary team progress note, dated 4/22/14, indicated "...On 4/21/14 at 7:30 P.M. resident up in w/c [wheelchair] propelling self throughout unit. Resident is unaware of safety and physical limitation...Continue with current safety interventions. PT screening with recommendations...."</p>			

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	<p>A rehab screen, dated 4/22/14, indicated "...Pt [Patient] may benefit from anti-roll backs on w/c...."</p> <p>On 6/12/14 at 11:34 A.M., an interview with Employee #22 indicated when physical or occupational therapy make recommendations for resident's that are a fall risk it was discussed in the stand up meeting every morning. For this particular resident, anti-roll backs were recommended for the wheelchair. Employee #22 further indicated that it would be the responsibility of the Maintenance man to get the anti-roll backs and place them on the wheelchair, she was unsure after the recommendation was given what happened after that.</p> <p>On 6/12/14 at 12:00 P.M., review of a care plan, initiated on 3/11/14 and revised on 4/22/14, indicated the problem: (Resident's name) will occasionally try to get out of bed on her own and is not steady enough to transfer herself. She has rolled out of bed on occasion. She needs her bed in the low position at all times. Interventions included but were not limited to, PT screening with recommendations.</p> <p>On 6/12/14 at 12:15 P.M., an interview with the Assistant Director of Nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514		
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	<p>(ADON) indicated that the anti-roll backs were never attempted on the resident and the information was not documented anywhere. The ADON further indicated she knew the resident very well and when her movements were restricted in any way she became very agitated and that was why the anti-roll backs were never even attempted.</p> <p>C.1. On 6/12/14 at 1:50 P.M., Resident #37, who resides in the dementia unit was observed in the outdoor courtyard area and left unattended until she was brought back inside by a staff member at 2:15 P.M. At 1:50 P.M., LPN #23 took Resident #37 in her wheelchair to the outdoor courtyard area and then the LPN left. No other resident's or staff members were present. At 2:00 P.M., a CNA (name unknown) came and checked on the resident, the resident indicated she was fine, the CNA then left the courtyard. At 2:05 P.M. LPN #23 came and checked on the resident and then left the courtyard area. At 2:15 P.M. the resident was brought back inside by the CNA (name unknown).</p> <p>On 6/12/14 at 2:15 P.M., a review of the clinical record for Resident #37 was conducted. The record indicated the resident was admitted to the facility of 5/2/14. The resident's diagnoses included,</p>				

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	<p>but were not limited to: fracture to the neck of the femur, schizophrenia, mood disorder, hypertension, lack of coordination and hypoglycemia.</p> <p>An admission fall risk assessment, dated 5/2/14, indicated the resident was a fall risk with a total score of 13. A score of 10 or more represents a high risk for falls.</p> <p>An admission fall risk assessment, dated 6/7/14, indicated the resident was not a fall risk with a total score of 6. The section indicating history of falls was marked with a zero indicating the resident had not had any falls in the past 3 months even though the resident had a documented fall on 4/11/14. The section indicating predisposing diseases was marked with a zero even though the resident sustained a fracture in January 2014.</p> <p>On 6/12/14 at 2:30 P.M., review of a care plan, initiated on 1/13/14 and reviewed on 5/19/14, indicated the problem: (Resident's name) has a hip fracture r/t fall at hospital. She may be at risk for future falls. Interventions included but were not limited to, "...anticipate and meet needs...and respond promptly to all requests for assistance...."</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F000353 SS=F	<p>On 6/12/14 at 2:35 P.M., an interview with the Director of Nursing indicated her expectation of staff would be that no resident would be left unattended in the courtyard especially a resident that was a fall risk who resided on the dementia unit.</p> <p>This deficiency was cited on 4/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other</p>			

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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>A. Based on observation, record review, and interviews, the facility failed to provide adequate staffing to meet the toileting needs of 1 of 3 residents reviewed for incontinence. (Resident #36)</p> <p>B. Based on record review and interviews, the facility failed to provide adequate nursing staff to answer call lights timely, meet the needs of a dying resident and provide showers as scheduled for 5 of 6 alert and oriented Residents. (Residents #10, #14, #35, #90, and #92)</p> <p>Findings include:</p> <p>A.1. Resident #36 was observed, on 06/10/14 at 2:20 P.M., lying in her bed on her back. The resident was dressed in a gown, brief, and was lying on two quilted bed pads stacked on top of the mattress and underneath the resident's bottom. In addition, there was a folded quilted bed pad and a pillow noted in the resident's wheelchair. Interview with the resident indicated she was now being taken into the bathroom sometimes. She</p>	F000353	<p>F353</p> <p>1. The Administrator will oversee nursing staff schedule beginning 6/30/14. An employee was designated to complete interviews and hiring process on 6/30/14. Nurse and C.N.A. advertisement were in place on careerbuilder and facility website as of 6/30/14, as well as local newspapers. These advertisements will continue until needed staff are hired and have completed orientation. Minimum and maximum staffing patterns were established on 6/30/14. R36 has been reassessed for toileting needs and a toileting plan has been established based on assessment. R36's care plan and C.N.A. set sheet have been updated to provide adequate guidance for staff. R10, 14, 90 and 92 have received showers. R35 has passed away.</p> <p>2. Resident care and supervision needs were identified through care plan review and staffing patterns were reviewed on 6/30/14. Minimum and maximum staffing patterns were established on 6/30/14. An employee was designated to complete interviews and hiring process on 6/30/14. Nurse and C.N.A. advertisement were in</p>	07/13/2014			

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	<p>indicated she also was trying not to stay up in the wheelchair as long as she used to sit. She indicated she still had sores on her bottom but they were putting "cream" on them. She indicated she was also being offered to toilet more frequently. She indicated she had gotten up around 7:30 A.M. and had been offered to go to the bathroom in the morning. She indicated she was laid down around 12:30 P.M.</p> <p>On 06/11/14, the following was observed and interviews were conducted:</p> <ul style="list-style-type: none"> - At 8:10 A.M., Resident #36 was observed in the dining room at a table, in her wheelchair waiting on breakfast to be served. The resident was dressed, sitting on quilted bed pad over a pillow in her wheelchair. Resident #36 indicated she gotten up around 7:00 A.M. this morning and was not taken to the bathroom, just washed up and assisted to transfer into her wheelchair. She indicated there were more residents as the building is "full" and that meant less time for aides to help her. She indicated some staff take her to the bathroom and others do not take her. - Resident #36 remained in the dining room until 8:50 A.M., when she was pushed from dining room to the hallway just outside of the dining room by a nursing staff member. She was noted to 		<p>place on careerbuilder and facility website as off 6/30/14, as well as local newspapers. These advertisements will continue until needed staff are hired and have completed orientation.</p> <ol style="list-style-type: none"> 1. <ol style="list-style-type: none"> 1.Administrator to oversee nursing staff schedule as of 6/30/14. 2.Employee was designated to hiring and orientation on 6/30/14. 3.Staffing patterns were reviewed and schedule was revised to increase staffing and supervision in the following manner – <ol style="list-style-type: none"> i. C.N.A.s: Minimum: 6 on Days, 5 on Eves, 4 on Nocs Maximum: 7 on Days, 1 restorative, 6 on Eves , 4 on Nocs 1.Nurse and C.N.A. advertisement to continue on careerbuilder, facility website and in local newspapers. 2.Life Enrichment aide position added and to be hired on Alzheimer's unit. 3.A bonus program will be implemented for those staff who pick up open shifts and will continue until necessary staff have been hired. 4.A schedule will be developed for facility administration to provide assistance with non-direct care i.e. meal tray pass, rounding for call lights, passing ice water, etc...to continue until necessary staff have been hired. 				

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	<p>start reading a book.</p> <p>- Resident #36 remained in her wheelchair in the hallway from 8:50 A.M. to 9:50 A.M., in the hallway reading her book and visiting with other residents.</p> <p>- At 9:50 A.M. the Restorative CNA #20, pushed her from the hallway into the dining room for an exercise activity. She remained in the dining room and participated in Restorative exercises until 10:10 A.M.</p> <p>- At 10:10 A.M., she was noted to have been taken to her room and assisted to sit on the toilet by CNA #29 and the Restorative aide, CNA #20. Resident #36 was noted to be able to stand briefly. Interview with CNA #20 indicated the resident was continent of both bowel and bladder during the toileting. She indicated the resident's brief did get wet just as they were transferring her to the toilet because as soon as she stood she started urinating. CNA #20 indicated Resident #26 had requested to be taken to the toilet during the Restorative exercises and had to wait until the exercise activity was completed before CNA #20 could assist her to the toilet.</p> <p>- At 10:23 A.M., Resident #36 was taken</p>		<p>1.</p> <p>1.The Social Services Director or designee will conduct Resident and Staff interviews to identify any ongoing concerns related to staffing. These audits will include staff members on each shift and will be conducted weekly for 8 weeks, monthly for two months or until 100% compliance is achieved. Identified concerns will be shared with Administrator immediately for resolution.</p> <p>i. The Social Services Director will report audit findings to QA weekly for 8 weeks, monthly for 2 months or until 100% compliance is achieved and quarterly thereafter.</p> <p>1.The Administrator will review staffing patterns daily to assure staffing does not fall below minimum staffing requirements as determined. If staffing does fall below minimum numbers, despite hiring and bonus program, the Administrator will immediately notify the Regional Director of Operations for additional support and guidance.</p> <p>2.The Regional Director of Clinical Operations will audit the provision of toileting plans, call light response and shower provision weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved.</p> <p>i. The Regional Director of Clinical Operations will report audit findings to QA weekly for 8 weeks and monthly for 2 months</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2014
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	<p>by CNA #29 back to the main dining room for a Bingo activity. She remained in the dining room playing Bingo from 10:23 A.M. - 11:15 A.M. At 11:15 A.M., she was pushed from one dining room table to another. Resident #36 indicated the table she was pushed to was her "spot" for lunch.</p> <p>- Resident #36 was noted to remain in the dining room, at a dining table from 11:15 A.M. - 12:15 P.M. when she was served her noon meal.</p> <p>- At 12:50 P.M., Resident #36 was noted to be in her wheelchair in her room, watching television. She indicated she had just returned to her room and had not been toileted yet. She indicated she was going to stay up for the 2:00 P.M. scheduled activity of pie and coffee chat.</p> <p>- Resident #36 remained in her wheelchair in her room, watching television and reading from 12:50 P.M. - 1:50 P.M. She was not toileted during the hour she was in her room. At 1:50 P.M. she was pushed across the hall to the activity room for the pie and coffee activity.</p> <p>- She remained in the activity room from 1:50 P.M. - 2:20 P.M., when she was pushed back to her room by the Activity</p>		<p>or until 100% compliance is achieved.</p> <p>Addendum: Newly hired staff will be trained during their orientation using the corrected policies and procedures to ensure that they have the knowledge to care for residents and maintain the environment so that these deficiencies do not recur.</p> <p>Addendum: Following the achievement of 100% compliance, the facility will continue to audit once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/13/2014	
NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514			
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	<p>Director. The resident immediately activated her call light.</p> <p>- At 2:30 P.M., Resident #36's call light was answered by LPN #30. Resident #36 requested to be laid down and LPN #30 indicated she would inform Resident #36's aide.</p> <p>- At 2:35 P.M., CNA #31 and #29 assisted Resident #36, to use her walker and transfer into her bed. Resident #36's incontinent brief was wet. Resident #36 was transferred without providing any incontinence care. The resident was noted to be instructed to lay in her bed on top of two stacked incontinence pads. Resident #36 had requested her brief and outside pants removed. The brief and pants were bagged separately. The resident was not offered any toileting opportunity and was not given incontinence care.</p> <p>On 06/12/14, the following was observed and interviews were conducted:</p> <p>- At 8:20 A.M., Resident #36 was noted in the dining room, in her wheelchair, eating her breakfast. At 8:43 A.M., she was taken to the hallway by the dining room entrance and parked in her wheelchair by a nursing staff member.</p>						

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	<p>- From 8:43 A.M. to 9:32 A.M., Resident #36 sat in her wheelchair, in the hallway, talking to other residents. At 9:32 A.M., she was taken by CNA #24 from the hallway directly back into the dining room to be ready for exercises activity.</p> <p>- Resident #36 remained in the dining room, participating in the exercises activity from 9:32 A.M. to 10:13 A.M.. At 10:13 A.M., the Activity Director pushed her from the dining room to the activity room. The Activity Director then put on a movie for the resident at her request.</p> <p>- Resident #36 remained in the activity room from 10:13 A.M. to 11:45 A.M., watching a movie At approximately 10:30 A.M., CNA #24 was noted to enter the activity room and spoke briefly with Resident #36.</p> <p>- At 11:45 A.M., Resident #36 was pushed to the dining room from the activity room. The resident indicated she did not trust the particular aide assigned to care for her. She indicated the CNA would not listen to her, had offered to toilet her but she had refused because she did not want the aide to care for her. She indicated the aide today had pulled the incontinence brief too tight and it was</p>			

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	<p>cutting in on her "privates" because it was too tight. She indicated there was no restorative aide today because the Restorative aide, CNA #20 was on vacation.</p> <p>- Resident #36 remained in the dining room from 11:45 A.M. through 12:00 P.M.</p> <p>- At 1:10 PM., Resident #36 was in her wheelchair, watching television. She indicated the aide, CNA #24, was coming back after she was done picking up trays, and was going to assist her.</p> <p>- At 1:30 P.M. Resident #36 had been transferred to her bed by CNA #24. Her outside pants and soaked incontinence brief were noted at the end of the bed. A new brief was placed on the resident and the resident was placed on two stacked incontinence pads in her bed.. The resident smelled like urine. Interview with CNA #24 indicated she had not toileted the resident but she had offered "a few times" during the day. She said sometimes she checked with the resident every "hour or two" but said she thought the resident was to be toileted "every 2 hours." She did not have any washcloths or soap noted and did not provide peri care and Resident #36 did not request to be cleaned.</p>				

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	<p>During an interview on 6/12/14 at 1:45 P.M., CNA #24 indicated she had asked Resident #36 about toileting when she was in the activity room watching the movie and the resident said she was dry and refused to be toileted at that time. She indicated after lunch she asked her again and the resident indicated she would wait until after the CNA was done picking up lunch trays from the hallway. CNA #24 again indicated she was aware of the resident's toileting plan and scheduled toileting times.</p> <p>The clinical record for Resident #36 was reviewed on 06/10/14 at 2:30 P.M. Resident #36 was admitted to the facility on 01/31/14, with diagnoses, including but not limited to: paralysis agitans, diabetes, osteoarthritis, hypertension, lack of coordination, osteoporosis, depressive disorder, morbid obesity, edema, disorder of muscle, muscular wasting and disuse atrophy, and Parkinson' disease.</p> <p>Review of the quarterly MDS (minimum data set) assessment, completed on 05/14/14, indicated the resident was always incontinent of her bladder and frequently incontinent of her bowels and had "moisture related skin damage."</p>			

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	<p>The care plan, related to activities of daily living, initiated on 09/27/12 and reviewed as current , on 05/19/14, indicated the resident required mechanical aid Hoyer lift for transfers and one staff participation with personal hygiene and oral care and dressing needs. The care plan related to incontinence, initiated on 05/22/13, revised on 02/18/4, and reviewed on 05/19/14, indicated the following: "[Resident's name] is functionally incontinent. She wears adult briefs, as a dignity measure to help promote normalcy of appearance in care of incontinence in public...Interventions: Apply adult briefs when out of bed. Check and change every 2 hours and prn [as needed]. Remove adult brief when in bed, Assist [resident's name] with peri care and handwashing, document on ADL grid any continence or incontinence, if [resident's name] is unable to stand in the bathroom then obtain the bedside commode form the shower room next door, allow her to use that, then clean and return the bedside commode to the shower room when finished, know that [resident's name] has really painful arthritis to her knees and has difficulty with standing for any length of time..., offer assistance for toileting upon rising, before and after meals, at hs [bed time], and prn, praise for all efforts."</p>			

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	<p>A restorative toileting plan was located in the ADL (activities of daily living) book located at the nurse's station. Review of the form, on 06/13/14 at 10:00 A.M., indicated the form had been initiated on 06/01/14. The form indicated the resident was to be assisted to the bathroom upon arising, before and after meals, before bedtime, and at 2:00 A.M., and as needed.</p> <p>B.1. Interview on 06/12/14 at 9:13 A.M. with Resident #92, indicated she had been at the facility for about three weeks. She indicated she had to wait too long for call lights to be answered sometimes. She indicated she took herself to the bathroom when staff did not come, but indicated she was not supposed to be taking herself to the bathroom.</p> <p>B.2. Interview on 06/11/14 at 1:20 P.M. with Resident #10 indicated the staffing had gotten worse (since the annual survey completed on 04/28/14). He indicated they had lost 6 staff in one week, 4 had quit and 2 were fired and one more was fired last week. He indicated they had gotten more residents and the facility was almost full which made the wait time increased for the rest of the residents. He just laughed sarcastically when queried regarding showers.</p>				

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	<p>Interview on 06/12/14 at 10:15 A.M. with Resident #90 indicated the facility was "short of staff". He indicated he had to wait long times routinely to get his call light answered. He indicated he did not always get his scheduled showers. He indicated only one time had he refused because he did not trust the person who was supposed to give him his showers. He indicated he did not always get his showers and he was told he should not have to remind staff of the need to give him a shower.</p> <p>Interview, on 06/12/14 at 11:25 A.M., with Resident #14, indicated there was not enough staff. She indicated last evening at 9:00 P.M., she and her roommate had to wait over 45 minutes to get the call light even answered. She also indicated she did not always receive her scheduled showers. She indicated one missed shower was because 2 CNA's were sent home due to an abuse investigations/allegations and so the dementia unit CNA was sent over to unit 1 and 2 and she said she was not going to do any showers.</p> <p>A form, presented by the Director of Nursing, on 06/13/14 at 11:00 A.M. indicated there were 43 residents total on unit 1 and 2, 10 of whom required a 1 person assist for toileting needs, 5 who</p>						

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	<p>required a 2 person transfer assist for toileting needs, 9 who required a mechanical lift for transfers, 16 who required a one person assist for transfers, 3 who required a two person assist for transfers, 9 who required every two hours incontinence checks, 9 of whom required restorative toileting assistance. Unit 3 had 11 residents, 4 of whom required a mechanical lift for transfers, 2 of which required a two person transfer assistants, and 3 of whom required a one person transfer assistance, 3 who required a one person assistance for toileting, 3 of whom required a two person assistance for toileting, and one resident who required every two hour incontinence checks. There were 17 residents on the secured dementia unit. Two whom required a two person transfer, 4 who required a one person transfer, 5 of whom needed one person assistance for toileting, 2 who required a 2 person assistance for toileting, and two resident who required every 2 hour incontinence checks. All 17 residents required one person staff assistance for dressing, hygiene, and grooming needs.</p> <p>On 6/13/14 at 9:30 A.M., an interview was conducted with the Administrator, Corporate Nurse Consultant, RN #29, the Director of Nursing and the MDS Coordinator, RN #26. The Administrator</p>			

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--	---	--	---

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	<p>indicated staff levels were determined to need 3 nursing assistants on Unit 1 and Unit 2 for the day and evening shifts, and 3 nursing assistants for the whole building for the night shifts. The Administrator indicated while the facility was advertising for new staff, and had hired a few new staff, they had not yet been able to staff per the appropriate staffing levels. While the sufficient nursing staff levels had not been able to be scheduled on a consistent basis, the facility had increased their resident census by 12 residents with no plans on how to supply sufficient nursing staff until they were able to hire a sufficient number of staff. The QA (Quality Assurance) committee indicated the Director of Nursing, Assistant Director of Nursing, and the Medical Records staff, who was a CNA, had been working the floor but did not reflect their hours on the day to day schedule.</p> <p>In addition, when queried regarding the staff levels for the Alzheimer's dementia unit, the Administrator indicated there were times when only one staff member was scheduled to work on the dementia unit. She indicated if the staff member was assisting a resident in a bathroom or room with the door closed, there would be no one on the unit during those times to supervise the rest of the residents.</p>			

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	<p>There was no QA plan to increase supervision on the dementia unit.</p> <p>The Administrator indicated the Corporation had been advised of the staff issues and was assisting the resident with advertising and recruitment of staff, however, there was no plan on how to provide nursing staffing.</p> <p>Review of the staffing patterns as worked form 5/30/14 through 6/13/14 indicated only 2 of 14 days and only one shift had 3 CNA's scheduled for the 100/200 Unit combined. There was never 3 CNA's scheduled for the 100 and 200 unit combined on any evening shift. In addition, it was noted several staff worked double shifts. In addition, at times, one staff member, either a nurse or an aide, had left an hour earlier than the shift ended.</p> <p>B. 3. During an interview on 6-11-14 at 9:14 A.M., RN #1 indicated she had noticed an increase of CNA's working on 1st and 2nd shift for hallways 100 and 200. She further indicated unit 100 & 200 used to have 2 CNA's now they are suppose to have 3.</p> <p>During an interview on 6-11-14 at 9:47 A.M., LPN #2 indicated the census has gone up, especially in her unit (skilled</p>						

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	<p>unit) all rooms are filled. She had one CNA to assist her on the unit with 12 residents, with 4 residents required a Hoyer to be transferred. She further indicated the 100 and 200 hallways now have 3 CNA's on 1st shift and 2nd shift. The LPN did not think they were sending CNA's home early, now that the census had increased.</p> <p>On 6-11-14 at 11:15 A.M. the posted Census and Nurse Staffing form for the facility, indicated day shift had 1 RN (Registered Nurse), 3 LPN's (Licensed Practical Nurse), and 4 CNA's (Certified Nursing Assistant), evening shift had 1 RN, 3 LPN's and 4 CNA's and night shift had 1 RN, 1 LPN and 3 CNA's. The census was 70 residents.</p> <p>During an interview on 6-11-14 at 4:40 P.M., LPN #3 indicated the 100-200 hallways were presently staff with herself, another LPN, with 2 CNA's. LPN#3 further indicated the census had increased and by tomorrow all the rooms would be filled on both hallways.</p> <p>During an interview on 6-11-14 at 5:07 P.M., the brother-in-law for Resident #35 indicated the resident was actively dying. The resident's mouth was open and oxygen was being delivered by a nasal canula to the resident. The resident was</p>			

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F000441 SS=D	<p>moist and extremities a dusky blue, cool to touch and mottled. The family member indicated no staff member had been in the room since noon. No one had offered to provide care such as moisten lips, or check her brief.</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-17(a)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>			

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	<p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 and interviews, the facility failed to ensure 3 of 3 staff observed providing care of 1 of 3 residents observed for incontinence needs, changed their gloves appropriately and/or provided peri care. (Resident #36)</p> <p>Finding includes:</p> <p>On 06/11/14 at 2:35 P.M., CNA #23 and CNA #21, were observed while transferring Resident #36 from her wheelchair into bed, utilizing the resident's walker. Both CNA's wore gloves during the transfer. The resident's incontinent brief was wet. The resident was noted to be positioned in bed on top of two stacked incontinence pads. Their was no peri care given, even though the resident's incontinence brief was noted to</p>	F000441	F441 I. R36 was provided with pericare and is receiving pericare following each incontinent episode. C.N.A.'s 23 and 21 were provided with 1:1 education regarding the provision of pericare including changing of gloves. II. All Residents with urinary incontinence were identified and will be considered at risk. III. A Directed Inservice will be provided on 7/1/14 that will include but will not be limited to education for all nursing staff regarding the following of facility policies and procedures regarding the provision of pericare and the changing of gloves. An audit tool will be drafted to assure pericare is provided and gloves are changed according to facility policy. IV. The Regional Director of Clinical Operations will audit pericare including changing of gloves weekly for 8 weeks and	07/13/2014

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	<p>be heavily saturated with urine. The resident requested not to have a new brief or outside pants placed on her. The brief was rolled up and placed in a bag by CNA #23. CNA #23 then proceeded, without changing her gloves, to pull up the top sheet, fold up a blanket at the foot of the bed, and hand the bed control and call light to the resident with her contaminated soiled gloves.</p> <p>On 06/12/14 at 1:30 P.M., Resident #36 had been transferred to bed by CNA #24. The resident's outside pants and soaked incontinence brief were noted at the end of the bed. A new brief had been placed on the resident and the resident was placed on two stacked incontinence pads in her bed. The resident smelled like urine. CNA #24 did not have any washcloths, soap or skin cleanser, or any supplies to provide peri care for Resident #36. Interview with Resident #36 indicated she was not given any peri care from CNA #24.</p> <p>This deficiency was cited on 4-28-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-18(b)(1)</p>		<p>monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/ residents once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>				

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a clean environment related to a strong urine odor in a resident bathroom and a dried brown substance on a wall heater and a picture in a resident room. This had the potential to affect 2 of 22 residents residing on Unit 1.</p> <p>Findings include:</p> <p>On 6/10/14 from 10:15 A.M. to 11:30 A.M., an initial tour was conducted of the facility, during which the following was observed:</p> <p>Unit 1:</p> <p>At 10:45 A.M., the shared restroom for Room 113 had a very strong urine odor. The heater that was attached to the wall under the window had a brown dried substance smeared across the grates. A framed picture that was leaned up against the heater also had a brown dried substance smeared across the top of the</p>	F000465	<p>F465 I. Room 113 was deep cleaned including but not limited to the bathroom, the framed picture and the heater. II. Environmental rounds will be completed throughout the entire facility to identify any other areas that require cleaning. III. The housekeeping staff will be reeducated on proper room cleaning. An audit tool will be created to assure proper cleaning of Resident rooms and bathrooms. IV. The Administrator will audit Resident rooms and bathrooms weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Administrator will report findings to QA weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved.</p> <p>Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of resident rooms once per quarter and review through QA to prevent the recurrence of these deficiencies.</p>	07/13/2014

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	<p>frame.</p> <p>On 6/11/14 from 10:15 A.M. to 10:50 A.M., an environmental tour was conducted with the Maintenance Director, during which the following was observed:</p> <p>Unit 1:</p> <p>At 10:30 A.M., the shared restroom for Room 113 had a very strong urine odor. The heater that was attached to the wall under the window had a brown dried substance smeared across the grates. A framed picture that was leaned up against the heater also had a brown dried substance smeared across the top of the frame.</p> <p>During an interview on 6/11/14 at 10:35 A.M., the Maintenance Director indicated that the urine odor was very strong and it was difficult to stay in the bathroom for any length of time due to the odor. The Maintenance Director further indicated that the dried brown substance on the heater and the picture looked like feces.</p> <p>This deficiency was cited on 4/28/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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F000520 SS=F	<p>3.1-19(f)</p> <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 observation, record reviews, and interviews, the facility failed to ensure the Quality Assurance Committee implemented and/or assured the effectiveness of their plan of correction to correct identified deficiencies. This potentially affected all residents in the facility.</p>	F000520	<p>F520 I. Refer to plan of correction for F248, F272, F282, F314, F315, F323, F353, F465. The documentation supporting the corrective actions for all identified Residents shall be maintained and reviewed by QA with oversight of Regional Director of Clinical Operations. II. Refer to plan of correction for F248, F272, F282, F314, F315,</p>	07/13/2014			

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	<p>Finding includes:</p> <p>During the annual Recertification and State Licensure survey, completed on 04/28/14, deficiencies were cited related to providing activities, following care plans, assessment of bladder incontinence and providing incontinence care, providing care to prevent pressure ulcers, fall prevention and accident/supervision issues, insufficient nursing staffing, nurse staff posting issues, hypnotic monitoring issues and infection control issues.</p> <p>During the post survey revisit, conducted on 06/10/14 - 06/13/14, the following issues were noted to still be apparent and were not corrected: activities, following care plans, assessment of bladder incontinence and providing incontinence care, providing care to prevent pressure ulcers, fall prevention and accident/supervision issues, insufficient nursing staffing, environmental issues, and infection control issues.</p> <p>Interview with the Administrator, Corporate Nurse Consultant, RN #29, the Director of Nursing, and the MDS Coordinator, RN #26, on 06/13/14 at 9:30 A.M., indicated the following information regarding the specific plans of correction:</p>		<p>F323, F353, F465. The documentation supporting the identification of Residents at risk and corrective action shall be maintained and reviewed by QA with oversight of Regional Director of Clinical Operations. III. The facility's QA policy was reviewed and found to be appropriate. All staff, including but not limited to Administrator and department managers, will be educated on the purpose of quality assurance to identify and correct quality deficiencies. A QA meeting template will be created specific to the findings of this survey to assure this facility implements and assures the efficacy of this plan of correction. IV. The Regional Director of Clinical Operations will be present at QA meetings weekly for 8 weeks and monthly for 2 months or until 100% compliance is achieved. The Regional Director of Clinical Operations will provide oversight, guidance and support to assure those actions stated in the plan of correction are completed.</p> <p>Addendum: Following the achievement of 100% compliance, the facility will continue to audit a sample of charts/ residents once per quarter and review through monthly QA to prevent the recurrence of these deficiencies.</p>				

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	<p>ACTIVITIES: Although activity staff were responsible for reassessing residents related to activity needs and updating the care plans, the Administrator was not aware of the lack of follow up and corrective action. In addition, although the plan of correction was discussed in the Quality Assurance (QA) weekly meetings, there were no problems identified related to this issue. There was no specific person assigned to monitor the corrective action progress for activities.</p> <p>In addition, there was a newly identified activity issue during the survey regarding a lack of activities provided to residents on the secured dementia unit. The Administrator indicated the Quality Assurance committee had recognized the issue and were "looking into " hiring a second person on the dementia unit to provide both activities and nursing assistance care.</p> <p>ASSESSMENTS: The MDS coordinator was responsible to ensure thorough bladder incontinence assessments were completed for the identified residents and all pertinent residents. The comprehensive aspects of the assessment were to be documented and assessed in the "Summary" section of the assessment form. The Quality Assurance committee</p>				

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	<p>was not aware there were problems completing the assessments timely. The only identified problems were with incomplete voiding patterning information and the MDS coordinator was following up with specific nursing assistants regarding this issue.</p> <p>NOT FOLLOWING CARE PLANS: The MDS coordinator was responsible for updating care plans and ensuring the updated information was added to the nursing assistant assignment forms. The MDS coordinator and the Director of Nursing were to complete the audits for this deficient area. There were no issues identified during the QA process for this issue except some assignment sheets which were updated when an issue was identified during the audits. The Director of Nursing indicated all nursing staff had attended the in-service regarding following incontinence and pressure relief care plans and she did not indicate any issues with her audits.</p> <p>PRESSURE ULCER RELIEF: The Assistant Director of Nursing was responsible to complete positioning audits. There was only one time a concern was noted on an audit regarding a resident who had refused care. There had been no skin care issues noted. The QA committee did not indicate they were</p>						

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	<p>aware of the issues regarding the lack of therapy follow through with obtaining adequate pressure relief for Resident #36.</p> <p>INCONTINENCE ASSESSMENTS AND FOLLOWING TOILETING PLANS/CARE: This issue had the same QA follow up as Assessments and Following Care plans</p> <p>ACCIDENT HAZARDS AND SUPERVISION: The Medical Records nursing staff member was responsible for monitoring personal care items and/or razors left accessible to residents. The Quality Assurance Committee was made aware of continued issues and when items were noted out in resident rooms and/or bathrooms, they were properly secured and nursing staff re-inserviced.</p> <p>The Assistant Director of Nursing was responsible for monitoring the fall assessments, care plans, and follow up regarding falls. The QA committee was not aware of any issues regarding this issue.</p> <p>In addition, a new issue regarding staff leaving a resident from the dementia resident, who had a history of falls, unsupervised in a courtyard area was brought to their attention. Interview with the Administrator indicated the resident</p>			

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	<p>should have been supervised while in the courtyard.</p> <p>SUFFICIENT NURSE STAFFING: Interview with the Administrator indicated staff levels were determined to need 3 nursing assistants on Unit 1 and Unit 2 for the day and evening shifts, and 3 nursing assistants for the whole building for the night shifts. The Administrator indicated while the facility was advertising for new staff, and had hired a few new staff, they had not yet been able to staff per the appropriate staffing levels. While the sufficient nursing staff levels had not been able to be scheduled on a consistent basis, the facility had increased their resident census by 12 residents with no plans on how to supply sufficient nursing staff until they were able to hire a sufficient number of staff. The QA committee indicated the Director of Nursing, Assistant Director of Nursing, and the Medical Records staff, who was a CNA, had been working the floor but did not reflect their hours on the day to day schedule.</p> <p>In addition, when queried regarding the staff levels for the Alzheimer's dementia unit, the Administrator indicated there were times when only one staff member was scheduled to work on the dementia</p>				

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	<p>unit. She indicated if the staff member was assisting a resident in a bathroom or room with the door closed, there would be no one on the unit during those times to supervise the rest of the residents. There was no QA plan to increase supervision on the dementia unit.</p> <p>The Administrator indicated the Corporation had been advised of the staff issues and was assisting the resident with advertising and recruitment of staff, however, there was no plan on how to provide nursing staffing.</p> <p>ENVIRONMENT: The housekeeping supervisor was responsible for ensuring the environmental concerns were adequately addressed . The Administrator indicated she had also checked on some of the Environmental follow up. She indicated it recently had become apparent that the deep cleaning of the odorous bathrooms did not sufficiently address the odor issues. She indicated there were now plans to replace the tiles. In addition, a new maintenance supervisor had recently been hired and prior to his hire and the departure of the former maintenance supervisor, she had personally inspected the cited issues and made a list of items for the new maintenance supervisor. It was unclear why the odor issues and insufficient</p>				

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	<p>corrective action was not apparent until "recently."</p> <p>The Administrator indicated even though there were multiple environmental issues cited on the annual survey and the facility had a time without a maintenance supervisor, there had been no corporate staff member in the building to ensure the repairs were made timely for the identified issues.</p> <p>3.1-52(b)(2)</p>			