

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00194194.</p> <p>Complaint IN00194194 - Unsubstantiated due to lack of evidence</p> <p>Survey dates: February 25, 26, and 29, 2016. March 1,2, and 3, 2016</p> <p>Facility number: 000009 Provider number: 155022 AIM number: 100274760</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 6 Medicaid: 46 Other: 14 Total: 66</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3-1.</p> <p>Quality review completed 3/7/16 by</p>	F 0000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0242 SS=D Bldg. 00	<p>29479.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to honor resident choices in regard to drinking water temperature (Resident #30), bathing preferences, and bed and wake times (Resident #73). This affected 2 of 3 residents reviewed for choices.</p> <p>Findings include:</p> <p>1. During an interview, on 2/25/16 at 1:21 p.m., Resident #30 indicated he doesn't receive the fluids he would like between meals, that what he gets is warm water.</p> <p>Resident #30's record was reviewed on 3/01/2016 at 9:10 a.m. Current physician's orders, dated 3/1/16 through 3/31/16, indicated diagnoses that</p>	F 0242	<p>F 242 Self-determination – Right to make choices It is the practice of the community to ensure the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care. Resident #30 plan of care has been updated and resident is receiving requested fluids between meals and fresh ice water every shift. Resident #73 has been interviewed by social services and has determined that she prefers to sleep in until late morning and to stay up late at night. The community will honor her preference and will serve her meal(s) in accordance to her sleep/awake schedule and as requested. Resident #73 plan of care has been updated to reflect this. Resident#73 has been interviewed by Social Services and has determined that she</p>	04/02/2016

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	<p>included, but were not limited to, dementia with depression, anxiety, inappropriate behaviors, high blood pressure, high blood fats, diabetes, coronary artery disease, insomnia, gastroesophageal reflux disorder, chronic obstructive pulmonary disease, difficulty swallowing water, chronic pain, delirium, psychotic disorder with delusions, and bipolar disorder.</p> <p>A quarterly MDS, dated 11/23/15, indicated Resident #30 was moderately impaired in cognitive skills for daily decision making, required supervision and set up for eating, had no impairment in range of motion, and had no chewing or swallowing problems.</p> <p>During an observation, on 3/02/2016 at 10:21 a.m., Resident #30 was lying in bed, had a nearly empty orange juice glass and empty water glass on his over bed table, and an almost empty pitcher on his over bed table that had no ice in it.</p> <p>On 3/03/2016 at 12:34 p.m., Resident #30 was seated in his wheelchair in his room. His water pitcher was observed on his over bed table and was empty with no ice or water in it.</p> <p>During an interview, on 3/3/16, at 3:00 p.m., the Director of Nursing indicated</p>		<p>prefers to have her shower every other day and PRN. The community will honor her preference and provide her showers on her preferred scheduled. Resident #73 plan of care has been updated to reflect this. All residents have the potential to be affected by this practice, no other residents were identified. All residents will be interviewed regarding their care and routine preferences. All care plans will reflect their current preferences. (Attachment 1) Staff will be in-serviced on honoring residents' preferences and maintaining fresh ice water at the bedside. Social Services or designee will audit all resident's preferences upon admission, quarterly, and PRN and update plan of care accordingly. (Attachment 2) Nursing services or designee will monitor the availability of water and fluids per the resident's preference each shift utilizing the Bedside per Resident's Preference QA tool. (Attachment 3). This tool will be reviewed weekly x 3 months then monthly x 3 months. All audit tool swill be reviewed by the Quality Assurance committee and any recommendations will be followed.</p>				

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	<p>the Charge Nurse monitors that the residents receive fresh ice water, and the residents are supposed to receive fresh ice water once a shift.</p> <p>A policy and procedure for "Hydration of Residents", with a last review date of 8/8/11, indicated "Purpose: To ensure that all residents are assessed for dehydration risk and encouraged to consume enough fluids to maintain adequate hydration. Policy: All residents will be assessed regularly for risk of dehydration. Hydration will be maintained by provision of fluids through meal service, juice and/or water given with administration of medication, replenishing water pitchers on each tour of duty and offering juice or water throughout the day...."</p> <p>2. Review of Resident #73's record on 3/1/16 at 1:10 p.m., indicated her diagnoses included, but were not limited to Osteoarthritis, depression, hypertension, confusion, vitamin D deficiency, muscle spasm, restless leg syndrome and dementia with depressive features.</p> <p>Resident #73's quarterly Minimum Data Set assessment dated 10/9/15, indicated, "Brief interview for Mental</p>			

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	<p>Status...severely impaired, Preferences for Customary Routine and Activities... Interview for Daily Preferences... how important is it for you to choose between a tub bath, shower, bed bath, or sponge bath? Somewhat important, ... how important is it to you to choose your own bedtime? Very important...."</p> <p>Review of a progress note dated 12/19/15 at 12:33 p.m., indicated, "Resident refused to get up for breakfast or lunch after multiple tries and much encouragement. States, "I don't want to." Denies pain/discomfort. Encouraged by 3 staff members but refused."</p> <p>A progress note dated 12/22/15 at 2:24 p.m., indicated, "Resident #73 refused to get up for breakfast, just wanted to sleep. Much encouragement for noon meal, did get up and ate 100% of food served. Yelling at staff when awakened, reminded need to eat."</p> <p>Review of a progress note dated 12/23/15 at 10:15 a.m., indicated, "refused to get out of bed for breakfast. Stated she didn't feel well. Did come down on her own around 20 minutes later and she has remained up since"...</p> <p>Review of a progress note dated 12/24/15 at 10:50 a.m., indicated Resident #73</p>			

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	<p>"refused to get up for breakfast after much encouragement. Became very upset with staff, yelling out, I told you I'm not getting up. Nurse Practitioner informed of increased episodes of refusing to get up and of refusing meals."</p> <p>A progress note dated 12/25/15 at 12:17 a.m., indicated, "Resident up watching TV till 12 a.m. then went to bed, no complaints of voiced."</p> <p>Review of progress note dated 12/25/15 at 1:27 p.m., indicated, "Staff informed writer neighbor had been up late last night, neighbor refused breakfast and lunch this shift, stated, "just don't want to go eat, don't want to get up."</p> <p>A progress note dated 1/8/16 at 12:00 a.m., indicated, "up in room cleaning at this time, no complaints of voiced."</p> <p>Review of progress note dated 1/8/16 at 10:33 a.m., indicated, "Resident refused breakfast this am, just not hungry. Voices no complaints of pain/discomfort."</p> <p>A progress note dated 1/9/16 at 3:00 p.m., indicated "Neighbor refused breakfast and noon meals" and stated, "I don't want to get up."</p> <p>Review of progress note dated 1/21/16 at</p>			

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	<p>12:36 p.m., indicated Resident #73 "refused breakfast this morning after much encouragement, did not get up and ate 100% of lunch"...</p> <p>A progress note dated 1/22/16 at 10:11 a.m., indicated Resident #73 "refused to get up for breakfast after much encouragement. Yelling at staff, "I don't want to get up," will offer food later"...</p> <p>Review of a progress note dated 1/23/16 at 2:07 p.m., indicated "Neighbor refused breakfast meal, stated she didn't want to get up."</p> <p>A progress note dated 1/28/16 at 10:55 a.m., indicated Resident #73 " did get up for breakfast, needed much encouragement."</p> <p>Weekly Nursing Assessment dated 2/19/16 indicated ... Comments and vital signs: Lee is alert to self, confused to time and place. Assist with ADLs. Frequently refuses breakfast. Encouraged to walk, non-compliant.</p> <p>Weekly Nursing Assessment dated 2/24/16 indicated ...Comments and vital signs: 128/76, 74, 18. Resident is one who doesn't like to be woken up in the morning. Will get up during the night. Was a night shift worker. Is resting</p>			

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	<p>quietly this night, thus far.</p> <p>Interview with Resident #73 on 2/25/16 at 2:12 p.m., indicated "I like to come to breakfast, but sometimes at night I can't sleep, so then I want to sleep in and the staff won't let me. It happened this morning, I was up and down 5-6 times last night and I was tired this morning and they said I have to come and eat breakfast. Breakfast is a little bit after 7:00 a.m."</p> <p>Review of shower sheet documentation indicated in January Resident #73 received a shower on the 6th,13th,16th, 20th and 30th. For February she received a shower on the 3rd, 6th,10th,13th,17th, 20th, 24th, 27th and 29th.</p> <p>Review of Care plan for Activities of Daily Living (ADL) indicated Focus: Resident #73 is fairly independent with ADL care. Needs primarily set up/ supervision most times. On occasion needs more assist. Date initiated 1/21/16. Goal: Resident will need no more than set up/ supervision at least 5 days a week through next review.</p> <p>Interventions: Assist with care to the extent needed on days Resident is unable to perform care without assist.</p> <p>Assist with showers/bathing.</p> <p>Ensure Resident has items needed to</p>			
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	<p>complete ADL tasks: toothbrush, toothpaste, washcloths, towels, soap. Set up/ supervise as needed with ADL care.</p> <p>Interview with Resident #73 on 2/25/16 at 2:16 p.m. indicated "I only get one shower a week, I would like to have one every day but that is not going to happen. I have told staff I would like to have more and they say they can only do what they can do."</p> <p>Interview on 3/3/16 at 1:10 p.m., with LPN #2 indicated "Resident gets showers twice a week unless care planned otherwise. No, I was not aware Resident #73 wanted more showers."</p> <p>3/3/16 at 1:20 p.m., interview with Resident #73 indicated "I would like more showers, every other day would be good."</p> <p>Interview with DON and Administrator on 3/3/16 at 3:00 p.m. indicated "How does the facility assess and know residents personal preferences for time to get up, go to bed and receive showers? The CNA on admission should be asking the residents their preferences."</p> <p>3.1-3(u)(1)(3)</p>			

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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record review and interview the facility failed to ensure a resident's wheelchair, and wheelchair pad were clean and free of odor for 1 of 35 residents reviewed for a accommodation of needs (Resident #30).</p> <p>Finding includes:</p> <p>Resident #30's record was reviewed on 3/01/2016 at 9:10 a.m. Current physician's orders, dated 3/1/16 through 3/31/16, indicated diagnoses that included, but were not limited to, dementia with depression, anxiety, inappropriate behaviors, high blood pressure, high blood fats, diabetes, coronary artery disease, insomnia, gastroesophageal reflux disorder, chronic obstructive pulmonary disease, difficulty</p>	F 0246	<p>F 246 Reasonable accommodation of needs/preferences It is the practice of this community to ensure the residents have the right to reside and receive service sin the community with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Resident #30 wheelchair has been cleaned and is on a routine cleaning schedule. All residents have the potential to be affected by this practice, no other residents were identified. All wheelchairs will be cleaned per the new wheelchair cleaning schedule. (Attachment 4) The staff responsible for cleaning wheelchairs have been educated on the wheelchair cleaning schedule and process. Administrator or designee will audit 5 wheelchairs a week times</p>	04/02/2016

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	<p>swallowing water, chronic pain, delirium, psychotic disorder with delusions, and bipolar disorder.</p> <p>A quarterly MDS (minimum data set) assessment, dated 11/23/15, indicated Resident #30 was moderately impaired in cognitive skills for daily decision making, required extensive assist of one for toileting and personal hygiene, one person physical assist for bathing, used a wheelchair, and was frequently incontinent of urine.</p> <p>On 3/02/2016 at 10:21 a.m. Resident #30 was observed lying in bed. The pad on his wheelchair was soiled, had a urine odor, and the wheelchair seat was soiled under the pad. Resident #30 indicated he can't remember "that far back" to when his chair was last cleaned.</p> <p>On 3/03/2016 at 12:34 p.m., Resident #30 was seated in his wheelchair in his room. The wheelchair cushion had a urine odor, was soiled, and the wheelchair seat beneath the cushion was covered with white scattered crumbs. LPN #5 indicated the wheelchairs have a cleaning schedule and she didn't know when it was cleaned, the night shift usually does the cleaning.</p>		<p>4 weeks, then 4 wheelchairs a week times 4 weeks, then 3 wheelchairs a week times 4 weeks, then 2 wheelchairs a week times for weeks, then 1 wheelchair a week times 4 weeks, then prn. (Attachment 5) All audit tools will be reviewed by the Quality Assurance Committee and any recommendations will be followed.</p>		

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F 0272 SS=D Bldg. 00	<p>During an interview, on 3/03/2016 at 10:34 a.m., the Director of Nursing (DoN) indicated there is no policy for cleaning wheelchairs, the wheelchairs have a schedule and the CNA's and nurses help clean them.</p> <p>On 3/3/16 at 3:00 p.m., the DoN indicated nursing staff clean the resident's equipment and chairs at night once a week unless it needs to be cleaned more often.</p> <p>3.1-19(v)(1)</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;</p>			

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	<p>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; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure a resident had a quarterly dehydration risk assessment for 2 of 2 residents reviewed for assessments (Residents #30 and #55).</p> <p>Findings include:</p> <p>1. Resident #30's record was reviewed on 3/01/2016 at 9:10 a.m. Current physician's orders, dated 3/1/16 through 3/31/16, indicated diagnoses that included, but were not limited to, dementia with depression, anxiety, inappropriate behaviors, high blood pressure, high blood fats, diabetes, coronary artery disease, insomnia,</p>	F 0272	<p>F 272 Comprehensive Assessments It is the practice of this community to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The hydration and fall risk assessment policy and procedures have been reviewed and updated. Resident #30 and resident #55 have new hydration and fall risk assessments completed. All residents have the potential to be affected by this practice, no other residents were identified. All residents have a current hydration screen and fall risk assessment completed. All residents will have hydration</p>	04/02/2016

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	<p>gastroesophageal reflux disorder, chronic obstructive pulmonary disease, difficulty swallowing water, chronic pain, delirium, psychotic disorder with delusions, and bipolar disorder.</p> <p>Resident #30's diet orders indicated a regular diet with no concentrated sweets, 8 ounces of chocolate milk with meals when requested, he was on a planned weight loss program by his request due to a body mass index of obese, and to offer 120 milliliters of fluid with each med pass.</p> <p>A quarterly MDS, dated 11/23/15, indicated Resident #30 was moderately impaired in cognitive skills for daily decision making, required supervision and set up for eating, had no impairment in range of motion, and had no chewing or swallowing problems.</p> <p>Review of the most recent "Dehydration Risk Screener" dated 9/24/15, in the electronic records, indicated the assessment was blank. There were no other dehydration screens or assessments in the electronic records.</p> <p>A care plan, last revised on 12/7/16, indicated a focus for: "[Resident #30] has an ADL (activities of daily living) self-care w (with) \performance deficit r/t</p>		<p>screen completed on admission, annually, and with significant change. All residents will have a fall assessment completed upon admission, annually, with each fall, and with significant changes in condition in accordance with the RAI guidelines. All licensed nursing staff will be in-serviced on the revised Hydration Policy (Attachment 6) and revised Fall Risk Assessment. (Attachment 7) The DON or designee will audit all new admissions, annuals, and significant changes weekly times 3 months then monthly times 3 months. (Attachment 8). All audit tools will be reviewed by the Quality Assurance Committee and any recommendations will be followed.</p>	

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	<p>(related to) dementia with behaviors. Goal: [Resident #30] will maintain current level of function in ADL care through the review date. Interventions: Eating: [Resident #30] requires set up and supervision at meal times in the dining room but extensive asst. (assistance) of 1 for fluid intake at HS (bedtime)...."</p> <p>A dietary quarterly assessment note, dated 2/29/16, indicated: "Neighbor feeds self in room or Blue River Bistro, participates in buffet, may have choc [chocolate] milk when requested at meals. Usually requests 2-8 oz (ounces) OJ w (with) /meals, but still would like to be asked what he would like to drink. Requests 1 c. (cup) scrambled eggs, 4 bacon, 2 sausage & 1 toast w/SF (with sugar free) jelly, also requests bologna w/mayo frequently at L&D (lunch and dinner)...would like to lose wt (weight), family provides snacks in room & [Resident #30] refuses meals frequently. Daily estimated fluid needs are 3600 cc's (cubic centimeters). Offered/encouraged 2160 cc's w/meals daily from dietary...."</p> <p>During an interview, on 3/03/2016 at 2:00 p.m., the Administrator indicated when they tried to print the "Dehydration Risk Screener" dated 9/24/15, it was blank. The Administrator indicated they</p>			

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	<p>had completed a "Dehydration Risk Screener" yesterday, on 3/2/16.</p> <p>The Administrator provided a "Dehydration Nursing Assessment", dated 5/2/15, on 3/3/16 at 2:12 p.m. and indicated it was the assessment done prior to the one on 9/24/16 that had not been completed.</p> <p>During an interview, on 3/3/16, at 3:00 p.m., the Director of Nursing indicated there is no other assessment that addresses hydration status beside the dehydration risk assessment.</p> <p>A policy and procedure for "Hydration of Residents", with a last review date of 8/8/11, was provided by the Director of Nurses on 3/3/16 at 10:36 a.m., and indicated: "Purpose: To ensure that all residents are assessed for dehydration risk and encouraged to consume enough fluids to maintain adequate hydration. Policy: All residents will be assessed regularly for risk of dehydration. Hydration will be maintained by provision of fluids through meal service, juice and/or water given with administration of medication, replenishing water pitchers on each tour of duty and offering juice or water throughout the day. Procedure...Personnel completing the</p>			

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F 0279 SS=D Bldg. 00	<p>MDS assessment are responsible for evaluating dehydration/over hydration risk and care planning accordingly...Dehydration assessment to be done quarterly and PRN (as needed)..."</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>			

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	<p>mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to revise a plan of care with interventions to manage new onset of pain for 1 of 3 residents reviewed for care plans for pain management (Resident #53).</p> <p>Findings include:</p> <p>Interview with Resident #53 on 2/25/16 at 1:53 p.m., indicated he was experiencing unrelieved pain in his right foot and ankle. The resident indicated the facility had given him pain medicine for the pain, but sometimes it did not relieve the pain.</p> <p>During observation on 2/29/16 at 1:00 p.m., Resident #53 had an ace wrap around his right ankle/foot.</p> <p>Review of the record of Resident #53 on 3/1/16 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, joint contractures, anemia, hypertension, Depression, vascular dementia, insomnia, anxiety,osteoarthritis, schizoaffetive</p>	F 0279	<p>F 279 Comprehensive Care Plans It is the practice of this community to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. Care Planning Policy and Procedure has been reviewed. Resident #53 plan of care for pain management has been revised. Resident #53 pain is managed to an acceptable level. All residents have the potential to be affected by this practice, no other residents were identified. All residents' care plans will be audited to ensure current interventions are in place. Care plans will be audited utilizing the Pain Audit Too(Attachment 9),upon admission. Ongoing audits will be completed every 2 weeks for 2 months then monthly times 6 months, then PRN. All recommendations will be reviewed by the QA Committee and will be followed Licensed nursing staff will be in-serviced on policy and procedure for developing and revising comprehensive care plans. (Attachment 9)</p>	04/02/2016

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	<p>disorder and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #53, dated 1/6/16, indicated he was able to make himself understood and had the ability to understands others, the resident requires extensive assistance of two people to transfer, walk in room- did not occur, The resident had not experienced pain in the last 5 days</p> <p>Progress note dated 2/9/16 at 3:51 p.m., "complaints of right ankle pain, mild swelling noted", Nurse Practitioner (NP) to evaluate, "no orders at this time." Electronically Signed by LPN #1.</p> <p>The pain careplan for Resident #53 had a revision, date of 10/23/15, there were no interventions on the care plan related to pain of his right foot or swelling.</p> <p>Interview and observation with Resident #53 on 3/2/16 at 10:36 a.m., indicated he did not feel good today as his right foot was hurting him. He said it had been hurting for days and it hurt bad, the resident indicated "it has been a living hell". He indicated his entire right foot was painful. The resident indicated he could not put any weight on it. The resident had on an ace bandage on his</p>			

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F 0309 SS=G	<p>right foot. He indicated he would like to know what was going on and he was suppose to have an x-ray.</p> <p>Interview with the Director Of Nursing (DON) on 3/2/16 at 12:40 p.m., indicated she was unable to find a plan of care for Resident #53's new onset of right foot pain and swelling.</p> <p>The care planning policy provided by the DON on 3/3/16 at 4:20 p.m., indicated a health care plan meeting are scheduled routinely and after a significant change to enable staff, family and the residents to develop an interdisciplinary plan that would allow the resident to reach his/her highest level of mental, physical, spiritual and psychological well-being. The careplan will be measurable, time framed goals are written for each problem/need. The documentation of a care plan must be done as follows: "update care plan weekly when changes" and with significant change.</p> <p>3.1-35(b)(1)</p>			
	483.25 PROVIDE CARE/SERVICES FOR			

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Bldg. 00	<p>HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to evaluate a new onset of pain resulting in delayed diagnosis of a fractured ankle and failed to monitor, treat, and evaluate efficacy of pain interventions resulting in the resident screaming out and verbalizing extreme pain during a dressing change for 1 of 3 residents reviewed for unrelieved pain (Resident #53).</p> <p>Finding includes:</p> <p>Resident #53 indicated he had been experiencing unrelieved pain in his right foot and ankle on 2/25/16 at 1:53 p.m.. The resident indicated the facility had given him pain medicine for the pain, but sometimes it did not relieve the pain.</p> <p>In an interview with the Wound Nurse on 2/29/16 at 1:02 p.m., indicated Resident #53 had a pressure ulcer on his right ankle. The Wound Nurse indicated she had changed his dressing on this day. The Wound Nurse indicated the resident had a</p>	F 0309	<p>F 309 Provide care/services for highest well being It is the practice of this community to ensure each resident receives and the community provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Pain, Assessment of Policy and Procedure was reviewed and updated. Resident #53 plan of care for pain management has been revised. On 03/03/16 resident #53 pain medication was changed per nurse practitioner order. Resident #53 pain is managed to an acceptable level. All residents have the potential to be affected by this practice, no other residents were identified. Effectiveness of pain medication will be assessed after each PRN medication administration and daily for routine pain medication as determined by interdisciplinary team. A new Assessment of Pain Policy has been put in Place. All licensed nursing staff will be in-serviced on this policy and procedure. (Attachment 11) All</p>	04/02/2016

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	<p>"little bit of pain" during the dressing change. The Wound Nurse indicated "no usually he isn't given pain medication prior to the dressing change." Review of the Medication Administration Record indicated on 2/29/16, Resident #53 was not given pain medication prior to the dressing change.</p> <p>On 3/1/16 at 2:45 p.m., LPN #1 was providing wound care to Resident #53's pressure ulcer on his right ankle and lateral outer aspect of his right foot. Resident #53 screamed in pain during the dressing change. The resident's entire right foot was moderately swollen. The resident indicated on pain scale from 1-10 his pain was above a 10 (the worst pain possible). The resident indicated he was unable to stand on his right foot at all. The resident had facial grimacing and wincing during the dressing change on his right foot. LPN #1 indicated she had been aware of the resident's right foot pain for a "week or so". She indicated she was a float nurse and when she started investigating the resident's pain today, she became aware he had not had an x-ray so requested an x-ray to be done. LPN #1 indicated she was getting off work, but would tell the oncoming nurse to give the resident pain medicine.</p> <p>Review of the record of Resident #53 on</p>		<p>residents on pain management will be audited utilizing the Pain Audit Tool upon admission , (Attachment 9). Ongoing audits will be completed every 2 weeks for 2 months then monthly times 6 months, then PRN. All recommendations will be reviewed by the QA Committee and will be followed</p>	

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	<p>3/1/16 at 2:15 p.m., indicated the resident's diagnoses included, but were not limited to, joint contractures, anemia, hypertension, Depression, vascular dementia, insomnia, anxiety, osteoarthritis, schizoaffetive disorder and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>The pain careplan for Resident #53 had a revision, date of 10/23/15, there were no interventions on the care plan related to pain of his right foot.</p> <p>The record of Resident #53 indicated the last pain assessment completed was, dated 12/31/15, with a report of no pain.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #53, dated 1/6/16, indicated he was able to make himself understood and had the ability to understands others and had not experienced pain in the last 5 days</p> <p>Progress note dated, 2/9/16 at 3:51 p.m., indicated "complaints of right ankle pain, mild swelling noted", Nurse Practitioner (NP) to evaluate, "no orders at this time." Electronically Signed by LPN #1.</p> <p>The Physician order for Resident #53, dated 2/9/16 (no time), indicated the resident was ordered tramadol 50 mg one</p>			

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	<p>tab by mouth every 12 hours for 14 days for right ankle pain and apply ace wrap to right lower extremity from toes up to ankle and remove at bedtime.</p> <p>The NP progress note for Resident #53, dated 2/11/16, indicated the resident had right ankle swelling with pain. The note indicated the resident complained of right ankle pain which was also swollen. The note indicated the resident reported "It really hurts right now when you touch it". The resident has an open area to the ankle with a treatment in place.</p> <p>Review of the Medication Administration Record (MAR) for Resident #53, dated February 2016, indicated the resident did not receive his first dose of tramadol was 2/10/16 at 8:00 p.m. The resident received the ordered routine tramadol 50 milligrams two times a day from 2/10/16 to 2/27/16. The MAR indicated Tylenol 500 milligrams two tabs as needed (prn) was given on 2/26/15 at 12 a.m. and 2/26/16 at 4:00 a.m. for "foot pain" The MAR indicated on the comment section that the Tylenol was no help.</p> <p>The progress note for Resident #53, dated 2/29/16 at 9:48 p.m., indicated the resident continued with right ankle pain, was holding his leg up on sit to stand lift and would not bear weight. The note</p>			

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	<p>indicated an x-ray had not been ordered and one was to be requested and "will refer to therapy for further transfer assessment." Electronically Signed by LPN #1.</p> <p>The NP progress note for Resident #53, dated 3/1/16 (no time), indicated they were asked by the Medical Doctor (MD) to see the resident who complained of having right ankle pain and swelling. The note indicated the resident reported no improvement and experienced pain when palpated or with range of motion.</p> <p>The NP wrote an order for Resident #53, dated 3/1/16, for an of X-ray of right ankle two views, schedule tramadol HCL 50 mg one tab BID (twice daily) for 30 days. Weight Bearing As Tolerated (WBAT) to Right lower extremity.</p> <p>Review of Resident #53's Medication Record Administration (MAR) for March 2016, indicated the resident did not receive pain medication (Tramadol 50 milligrams) on 3/1/16 at 8:00 p.m., which was 4 hours and 15 minutes after he expressed a pain level greater than 10.</p> <p>The progress note for Resident #53, dated 3/2/16 at 3:10 p.m., indicated the resident was ordered an orthopedic consult, non-weight bearing of the right leg and</p>			

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	<p>hoyer (mechanical lift) lift for all transfers.</p> <p>On 3/2/16 at 10:36 a.m., Resident #53 indicated he did not feel good and his right foot was hurting him. He said it had been hurting for days. The resident indicated "it has been a living h---". He indicated his entire right foot was painful. and he could not put any weight on it. The resident had on an ace bandage on his right foot. He indicated he would like to know what was going on and he was suppose to have an x-ray.</p> <p>Interview with LPN #2 on 3/2/15 at 11:06 a.m., indicated she gave Resident #53 his PRN tramadol at 11:00 a.m. for complaints of right foot pain and the resident had indicated it was a 10 on 1-10 pain scale.</p> <p>On 3/2/16 at 11:08 a.m., CNA #3 and CNA #4 transferred Resident #53 from his wheelchair to the bed, using a stand up mechanical lift. The resident was trying to keep weight off his right foot during the transfer, with only the tips of his toes on the right touching the lift. The resident had moaning and facial grimacing during the transfer. CNA #1 and CNA #2 indicated the resident had been experiencing pain with his right foot "for awhile now".</p>			

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	<p>In an interview on 3/2/16 at 12:40 p.m. the Director Of Nursing (DON) indicated Resident #53 had not had a pain assessment since 12/31/15. The DON indicated the nurse caring for Resident #53 should of completed a pain assessment after the new on set of right foot pain on 2/9/16. The DON indicated the resident did not receive any pain medication on 3/1/16 until 8:00 p.m. The DON indicated the nurses communicate from shift to shift about pain during a verbal report. The DON indicated she was unable to find documentation of monitoring for the effectiveness of the pain medication (tramadol) ordered on 2/9/16 for the resident's right foot pain.</p> <p>The Radiology report for Resident #53, dated 3/2/16, indicated and x-ray was completed of the right ankle and indicated a fracture involving the distal fibula (bone between the knee and ankle) with mild displacement.</p> <p>The pain policy provided by the Director Of Nursing (DON) on 3/2/16 at 11:40 a.m., the purpose was "to identify those resident who utilize frequent PRN or routine medications for pain control and evaluate efficacy thereof." The policy was "each resident shall be assessed for presence of complaint of pain and/or lack</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F 0431 SS=D Bldg. 00	<p>of pain relief following currently ordered pain medication administration." "If ineffective relief is noted, a pain assessment shall be completed in an effort to assess location, frequency, etc and notify the physician accordingly to ensure currently ordered pain medication is evaluated and revised as necessary." "If a resident verbalizes pain, unaffected by the currently ordered pain medication, and/or exhibits non-verbal communication that pain is present, the resident shall be identified and reviewed per pain assessment to ensure said pain symptoms are evaluated and communicated to the attending physician." "Any change in condition affecting pain and/or medication shall be evaluated by the Interdisciplinary team during careplan review and notification made to the physician." "The plan of care for the individual resident shall be reviewed to ensure pain management is addressed accordingly."</p> <p>3.1-37(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who</p>			

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	<p>establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to secure medications in a medication room from unauthorized persons for 1 of 3 medication room observations.</p> <p>Findings include:</p>	F 0431	F 431 Drugrecords, label/store drug & biological It is the practice of this community to ensure only authorized personnel are in medication storage rooms, any unauthorized personnel will be accompanied by an authorized person. Medication Storage in the Facility policy from Pharmacy Policy & Procedure manual was	04/03/2016

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	<p>On 3/01/2016 at 11:28 a.m., Housekeeper #7 was observed leaving the medication room on station 4, with a housekeeping cart and mop, and no nurse had been observed in the medication room with him.</p> <p>On 3/01/2016 at 11:30 a.m., the following was observed with RN #8: several boxes of Resident #86's medications sat on the right side of the counter. RN #8 indicated the medications were to be sent back to the pharmacy. The medications included, but were not limited to, Zoloft (antidepressant) 50 milligrams (mg), 6 pills; Zyprexa (antipsychotic) 2.5 mg, 27 pills; Lasix (diuretic) 80 mg, 2 boxes of numerous pills, and included multiple pills of Singulair (asthma medication), Cozaar (blood pressure medication), Feosol (iron supplement), Coumadin (blood thinner), Protonix (stomach medication), Colace (stool softener), and several bagged medications of other discharged residents that were also being sent back to the pharmacy. In an unlocked cabinet above the counter, multiple bottles of Milk of Magnesia, bottles of cough medicine, Tylenol, respiratory treatment vials, and glycerin suppositories. On a shelve unit, on the right side wall, were items that included</p>		<p>reviewed. This community will ensure that drugs and biological are stored in locked compartments and permit only authorized personnel to have access. Housekeeper #7 has been issued a Teaching Form. The community has the potential to be affected by this practice. All staff will be educated on Medication Storage in the Facility Policy. (Attachment 12) This system will be under continuous observation. Policy and Procedure will be strictly enforced.</p>	

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	<p>insulin syringes.</p> <p>On 3/01/2016 at 12:38 p.m., Housekeeper #7 indicated the nurse lets him in and he is only in there a few minutes to empty trash, sweep and mop and no one usually stays in the medication room with him.</p> <p>During an interview, on 3/03/2016 at 10:34 a.m., the Director of Nursing indicated there is no policy for who is allowed in the medication room, they let the housekeepers in there to clean, otherwise the nurse should be present; the nurse doesn't stay with them while they are cleaning, and it hasn't been a problem.</p> <p>During an interview, on 3/3/16 at 3:00 p.m., the Director of Nursing indicated who is allowed to be in the medication room without supervision; Pharmacy and housekeeping is allowed to go in and clean.</p> <p>3.1-25(m)</p>			