STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN 47720

(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
F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: February 11, 12, 13, 14, 18, 19, 20, 21, 2013. Facility Number:000442 Provider Number: 155621 AIM Number: 100266510 Survey Team: Barbara Fowler RN, TC Diane Hancock RN Amy Wininger RN 2/11/13 - 2/14/13, 2/19/13 - 2/21/13 Census Bed Type: SNF: 25 SNF/NF: 51 Total: 76 Census Payor Type: Medicare: 13 Medicaid: 37 Other: 26 Total: 76 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review was completed on February 27, 2013 by Jodi Meyer, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F0156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the			

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	individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.			
	Based on record review, interview, and observation, the facility failed to post documentation for notifying the State Department of Health, in that the procedure nor telephone numbers were readily accessible for 1 of 4 nursing units. (Harmony unit) Findings include: 1. Resident #16's record was reviewed on 2/19/13 at 8:30 a.m. The MDS [Minimum Data Set] assessment indicated the resident had a BIMS [Brief Interview for Mental Status] assessment rating of 14 out of 15, indicating the resident had minimal cognitive impairment. Resident #16 was interviewed on 2/19/13 at 3:00 p.m. Resident #16	F0156	F - 156 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #16 has been provided the procedure and the phone number for notifying the Indiana State Department of Health. In addition the facility has posted the procedure for notification and the Indiana State Department of Health phone number on each nursing unit including the Harmony Unit. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected. The facility has posted the procedure for notification and the phone number for the Indiana State Department of Health on each unit. In addition each resident was provided a copy of the Indiana State Department of	03/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/21/2013
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	indicated she had been a resident at the facility for eight years and had been appointed Resident Council President on 2/19/13. During the interview, Resident #16 indicated she did not really know how to contact the State Department of Health to file a grievance and did not know where the telephone number was located to the State Department of Health. She indicated she thought it was outside of the nurse's station on the Harmony unit but she was not sure. She indicated the AD [Activities Director] went over the resident right's at every resident council meeting but she did not recall the AD notifying the residents on how to contact the State Department of Health. 2. Observation of the area outside of the nurse's station on the Harmony unit on 2/19/13 at 3:13 p.m., indicated no documentation for contacting the State Department of Health was available. 3. Interview with LPN #1 on 2/19/13 at 3:15 p.m., indicated the telephone number for the State Department of Health was located behind the nurse's station on the Harmony unit and was listed on their report sheets. Interview with the DoN [Director of		Health notification procedure and phone number. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that the facility will continue to provide Indiana State Department of Health notification information and phone number to each resident upon admission. In addition this information will be reviewed at each resident council meeting as a reminder to the residents. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality Assurance audit tool has been developed and implemented to ensure that this information remains posted on each unit and through interviews of random residents to ensure their knowledge of this information. The tool will be completed by the Social Service Director and/or her designee weekly for four weeks, then monthly for three months, then quarterly for three quarters. The outcome of this audit will be reviewed at the facility's Quality Assurance meetings to determine if additional interventions are warranted. **Performance Improvement Tool F – 156 & F - 167 DIRECTIONS:** Through observations of the facility answer the questions below. Place a "Y" for yes or an "N" for No. Review the outcomes for possible additional action or	

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	Nursing] on 2/19/13 at 3:20 p.m., indicated he thought the State Department of Health's telephone number was posted on the "Resident Rights" document, dated August 1997, which was encased and posted across from the nurse's station on the Harmony unit. He was unable to locate it on the unit and indicated he was going to post the telephone number to the State Department of Health with the "Resident Rights" sign on the Harmony unit as soon as possible. Interview with the ADM [Administrator] on 2/20/13 at 10:46 a.m., indicated the document regarding how to contact the State Department of Health was encased and located on the South unit outside of the DoN's office. She indicated this was the only location for the document. 3.1-4(j)(3)(A)		interventions. **INDICATOR LOCATIONS COMMENTS** **Stocker 1 Stocker 2 Harmony South** 1. Upon observation of the unit there is a posting on information including phone number on how to contact the Indiana State Department of Health. 2. Upon observation of the unit the results of the most recent facility survey are readily available to all residents and visitors. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	

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F0167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. Based on record review, interview, and observation, the facility failed to provide the results from the most recent State survey of the facility readily available in that the results were not readily available for 3 of 4 nursing units. (Harmony unit, Stocker 1 unit, Stocker 2 unit) Findings include: 1. Resident #16's record was reviewed on 2/19/13 at 8:30 a.m. The the MDS [Minimum Data Set] assessment indicated the resident had a BIMS [Basic Interview for Mental Status] assessment rating of 14 out of 15, indicating the resident had minimal cognitive impairment. Resident #16 was interviewed on 2/19/13 at 3:00 p.m. Resident #16 indicated she had been a resident at	F0167	F – 167 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #16 has been advised of the location of the survey postings on each unit. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected. The facility has posted the most recent survey results in a binder on each of the facility's nurses' stations. The posting of survey results has also been discussed at the resident council meeting as a reminder to the residents of the location of this information. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that the administrator has been assigned the responsibility to ensure that the most recent survey results are posted on each nursing unit and that any up-dates	03/23/2013

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	the facility for eight years and had been appointed Resident Council President on 2/19/13. During the interview, Resident #16 indicated she thought the most recent survey results were posted on each unit. The resident indicated the survey results were possibly located across from the nurse's station on the Harmony unit. 2. Observation of the Harmony unit on 2/29/13 at 3:10 p.m., indicated the survey results were not located on the Harmony unit. 3. Observation of the Stocker 1 and Stocker 2 units on 2/19/13 at 3: 30 p.m., indicated the survey results were not located on either unit. 4. Interview with LPN #1 on 2/19/13 at 3:15 p.m., indicated the survey was located outside of the DoN's [Director of Nursing] office which was located on the South unit. The South unit was accessible for the residents by elevator from the Harmony unit. The Stocker 1 unit and Stocker 2 unit are actually in a separate building connected by a long hall. Interview of the DoN on 2/19/13 at 3:20 p.m., indicated the most recent survey results were located in a		on survey information are posted in those binders in a timely manner following any survey visit. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance audit tool has been developed and implemented to ensure that the most recent survey results are posted on each nursing unit. This tool will be completed by the Administrator and/or her designee. The tool will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. **Performance Improvement Tool F – 156 & F - 167 DIRECTIONS:** Through observations of the facility answer the questions below. Place a "Y" for yes or an "N" for No. Review the outcomes for possible additional action or interventions. **INDICATOR** **LOCATIONS** **COMMENTS** **Stocker 1 Stocker 2 Harmony South** 1. Upon observation of the unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013
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	binder outside of the business office on the South unit. The DoN indicated the results had only been located in one location "since he started working here." The DoN indicated he would be posting the results of the most recent survey for the Stocker units as soon as possible. He indicated the residents from the Harmony unit were able to access the South unit by elevator and that the residents were always able to get to the business office. 3.1-3(b)(1)		there is a posting on information including phone number on how to contact the Indiana State Department of Health. 2. Upon observation of the unit the results of the most recent facility survey are readily available to all residents and visitors. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	

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F0205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.			
	Based on interview and record review, the facility failed to ensure written information was given to a family member regarding the duration of the bed hold policy, for 1 of 1 resident reviewed for transfer/discharge, in the sample of 1 who exceeded the threshold. (Resident #112) Finding includes: On 2/12/13 at 10:38 a.m., the family member of Resident #112 was interviewed. He indicated the	F0205	F – 205 The corrective action taken for those residents found to be affected by the deficient practice is that the responsible party for the resident identified as resident #112 has been provided a copy of the facility's bed hold policy with an explanation of the facility's practice in providing this information upon transfer to a hospital or while on therapeutic leave from the facility. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents and their responsible parties are being provided a copy	03/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013
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	resident had been transferred to the hospital for a fracture and for pneumonia in the past several months. He indicated no one informed him of the bed hold policy or the policy permitting her to return to the facility. Resident #112's clinical record was reviewed on 2/20/13 at 10:45 a.m. The record indicated the resident transferred to the hospital on 5/7/12 after a fall. The record included a copy of the Transfer/Discharge Notice and Bed Hold Policy. There was no documentation the notice was provided to the family/Power of Attorney. The transfer form sent with the resident included a place to document providing the notice to the resident or sending with the transfer form, and giving to the family/legal representative. This area of the transfer form was not completed. Nurses' notes also did not indicate the notice was given to the family. On 2/20/13 at 11:00 a.m., RN #1 was interviewed. She indicated when a resident transferred to the hospital, they filled out and sent a transfer record and sent a copy of the bed hold policy and transfer/discharge notice with the resident. When queried about the family receiving a		of the Notice of Transfer/Discharge each time the residents are transferred to a hospital or while on therapeutic leave from the facility. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has developed and implemented a policy whereby a copy of the Notice of Discharge/Transfer form will be sent with each resident at the time of discharge/transfer. The medical records director is then responsible for mailing a copy of this form to the responsible party. The medical records director is also responsible for logging this information on a Notice of Discharge/Transfer log as to whom the notice was mailed to and the date that it was mailed. A mandatory in-service was conducted for all licensed nurses, QMAs and medical records staff on the facility's new policy related to the completion and distribution of the Notice of Discharge/Transfer form. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance tool has been developed and implemented to audit the completion and distribution of the Notice of Discharge/Transfer form in accordance with facility policy. This tool will be completed by the Administrator and/or her	

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	notice, she indicated no one had ever asked that and she would have to ask. At 11:05 a.m., she indicated she had asked the Director of Nursing and Consultant nurse and they indicated if the resident was adjudicated incompetent, they would give a copy to the guardian. The Policy and Procedure for Notice of Transfer or Discharge, dated 4/2/12, was provided by the Medical Records Clerk on 2/20/13 at 11:55 a.m. The policy and procedure indicated the facility would complete the State required Notice of Transfer or Discharge form when a resident was transferred or discharged. The procedure indicated the form would be completed by the nurse at the time of transfer/discharge. "A copy of the completed form will be given to the resident and/or responsible party." "The nurse will also indicate on the facility transfer form what documents are being sent with the resident at the time of the transfer/discharge." 3.1-12(a)(25)(B)		designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this audit tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. **Performance Improvement Tool F - 205** **DIRECTIONS:** Through observation and review of the clinical record and medical records documentation answer the questions below. Place a "Y" for Yes or an "N" for No. Review the outcomes to determine if additional action is warranted. **INDICATOR** **PATIENTS** **COMMENTS** **1 2 3 4 5 6 7 8** 1. Upon review of the clinical record there is documentation to support that the Notice of Transfer/Discharge form including the facility bed hold information was provided to the resident at the time of transfer. 2. Upon review of the medical records Notice of Transfer/Discharge Log there is documentation to support that the resident's responsible party was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
			provided a copy of the Notice of Transfer/Discharge form including the facility bed hold information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720	

(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
F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure dignity was promoted in the dining room and in the resident's room, in that, a radio was loudly playing a news/talk show with foul language, CNA's were observed calling out across the dining room to residents, and staff were feeding residents while standing over them for 6 of 16 residents in 1 of 5 dining room during the observation of dining, and a sign was posted above the resident's bed indicating personal care for 1 of 40 resident's rooms observed. (Resident #14, Resident #81, Resident #97, Resident #82, Resident # 8, Resident #10, resident # 33) Findings include: 1. During a meal observation in Dining Room #1 on 02/14/13, at 8:30 a.m., the radio was observed to be on and loudly playing a news/talk show from a local country station with foul	F0241	F – 241 The corrective action taken for those residents found to be affected by the deficient practice is that the dining room identified as dining room #1 has the radio station tuned to soothing music at a soft non- offensive sound level. The staff members assisting the residents at mealtime are conversing with the residents quietly and on a personal level. All nursing staff members are seated while feeding resident who require assistance. Residents identified as residents # 14, 81, 97, 82, 8 and 33 are enjoying their meals in a pleasant dining room setting with a quiet peaceful environment. The resident identified as resident #10 has had the hospice signage removed from above the bed. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All of the facility dining rooms are free of any loud offensive music. The staff in each dining room converse with the residents in a quiet and personal manner and	03/23/2013

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	language during breakfast. 2. During a meal observation in Dining Room #1 on 02/14/13, at 8:40 a.m., CNA #1 was observed assisting Resident #14 with breakfast. At that time, CNA #1 was observed to call out loudly to Resident #81 and stated, "...are you going to eat?" CNA #1 was then observed to call out loudly to Resident #97 and stated, "...aren't you going to drink your juice?" 3. During a meal observation in Dining Room #1 on 02/14/13, at 8:45 a.m., CNA #2 was observed assisting Resident #82 with breakfast. At that time, CNA #2 was observed to call out repeatedly and with a loud voice to Resident #81 and stated, "...wake up!" CNA #2 was then observed to call out repeatedly and with a loud to Resident #8 and stated, "...wake up!" 4. During a meal observation in Dining Room #1 on 02/14/13, at 11:57 a.m., CNA #2 was observed standing over Resident #33 while feeding. 5. During a meal observation in Dining Room #1 on At 12:00 p.m. LPN #1 was observed standing over Resident #14 while feeding.		are seated while feeding/assisting the residents. A housewide audit was completed of all residents' rooms to ensure no signage was posted related to the residents' personal care. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all nursing staff on Dining Room Atmosphere and Service. The nurses and QMAs were instructed on their responsibility to monitor the dining rooms to ensure the environment enhances each resident's dignity and respect in full recognition of their individuality. In addition each Hospice organization was notified via facility letter as it relates to the facility's practice of posting personal care information in the residents' room. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance audit tool has been developed and implemented to monitor the dining room environment as it relates to the residents' dignity and respect. The tool also includes the monitoring of personal care information in residents' room. This tool will be completed by the Social Service Director and/or her designee. The tool will be completed weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome	

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	The Dining Room #1 Seating Chart provided by the DoN [Director of Nursing] on 02/21/12 at 9:10 a.m., indicated Resident #14 was seated at Table #1, Resident #81 was seated at Table #3, Resident #97 was seated at Table #5, resident #82 was seated at Table #2, and Resident #8 was seated at Table #4. During an interview on 02/21/13 at 9:11 a.m., the DoN indicated there was no policy related to dining atmosphere but, the radio should have been playing music softly in the background during the mealtime, dining room staff should not be loudly calling out to residents, and staff should be seated next to residents when assisting with meals. An In-service planned to be presented by the DoN: Dining Room Atmosphere & Service provided by the DoN on 02/21/13 at 11:37 a.m. indicated, "...3. Radio can be on a low station, (appropriate radio station for our age group of residents)...4. We DO NOT shout across room to give encouragement for our resident to eat their meal...5. We DO NOT stand up and feed resident,..."		of this audit will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. **Performance Improvement Tool F - 241** **DIRECTIONS:** Through observation of the dining area during meal service answer the questions below. Place a "Y" for yes or an "N" for no. Review the outcome to determine if additional action is warranted. **INDICATOR** **DINING ROOM LOCATION** **COMMENTS** **Stocker 1 Stocker 2 Harmony South** 1. Upon observation of the dining area the radio is playing appropriate music at a low level to enhance the dining experience. 2. Upon observation of the nursing staff they are conversing with the residents on a personal level with no calling out to residents from across the dining area. 3. Upon observation of the nursing staff they are seated while feeding and/or assisting the residents with their meal.	

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	6. On 2/11/13 at 2:43 p.m., a sign was observed in Resident #10's room above the bed. The sign indicated a specific Hospice Agency would visit the resident on Tuesday for a bed bath or shower, on Wednesday for TLC [tender loving care] and nail care, and on Thursday for a bed bath or shower. On 2/20/13 at 10:07 a.m., a Hospice		4. The dining room presents a very warm and homelike atmosphere during meal service. **DIRECTIONS:** Through observation of the residents' rooms answer the questions below. Place a "Y" for yes or an "N" for no. Review the outcomes to determine if additional action is warranted. **INDICATOR RESIDENT ROOM NUMBER COMMENTS** 1. Upon observation of the resident's room there is no signage related to any information on the personal care of the resident. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	

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	Agency Aide was interviewed. She indicated they put the sign on the wall to communicate with CNAs what day they would be there and what they would do for the resident. She indicated they asked the nurse first. No indication they asked the resident or family. On 2/20/13 at 10:20 a.m., RN #1 indicated some agencies put their signs in closets, or at the nurses' station so staff knew when they were coming. She indicated she would have them put the sign in the closet. 3.1-3(t)			

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F0279 SS=D	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. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on observation, interview, and record review, the facility failed to ensure a care plan was developed for 1 of 3 residents who met the the criteria for review of range of motion, and for 1 of 10 residents reviewed for unnecessary medications, in that, a care plan was not developed for splints/range of motion and/or a care plan was not developed for insomnia prior to starting an antianxiety/antipsychotic medication. (Resident #26, Resident #117)	F0279	F – 279 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #26 now has a care plan in place to address the need for range of motion. The resident identified as resident #117 now has a care plan to address the identified behaviors and insomnia. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by the same deficient practice. A housewide review of	03/23/2013

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	Finding includes: 1. The clinical record of Resident #26 was reviewed on 02/14/13 at 10:02 a.m. The record indicated the diagnoses included, but was not limited to, arthritis. On 02/11/13 at 11:20 a.m., Resident #26 was observed lying in bed with the left hand to be lying on the mattress in a contracted position. Resident #26 was observed not to have a splint on the left hand. A PT-Therapist Progress & Discharge Summary dated 12/13/12 indicated "...Patient/Caregiver training: Patient has restorative program in place..." A Restorative progress note dated 12/28/12 indicated Resident #26 "...discharged from therapy. Restorative screened and will turn over to nursing for ROM..." The February 2013 Physician's Order Recap included, but was not limited to, orders for "...May attend Restorative Nursing..." The Comprehensive Plan of Care dated 01/09/13 lacked a plan of care for Restorative Nursing or Range of Motion.		all residents' care plans has been completed to ensure that all of the residents' individual needs have been addressed based on the comprehensive assessment of the resident. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all licensed nurses on the development and implementation of care plans based on the outcomes of the individual resident assessments. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance tool has been developed and implemented for the review of the resident's care plans to ensure that all identified needs have been addressed. This tool will be completed by the MDS coordinator and/or his designee weekly for four weeks, then monthly for three months and the quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted. **Performance Improvement Tool F – 279 & F - 318 DIRECTIONS:** Upon review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" if the question does not apply to that resident. Review the outcomes to	

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	During an interview on 02/12/13 at 9:09 a.m., LPN #1 indicated Resident #26 had a contracture to the left hand, did not use a splint, and did not receive restorative or range of motion services. During an interview on 02/19/13 at 2:00 p.m., Restorative Aide #1 indicated Resident #26 had not been receiving Restorative Services and was not on the current Restorative caseload. During an interview on 02/19/13 at 2:46 p.m., the DoN [Director of Nursing] indicated, Resident #26 had been referred by PT [Physical Therapy] for Restorative Services and had not received restorative services due to an oversight.		determine if additional action is warranted. **INDICATOR** **PATIENTS** **COMMENTS** **1 2 3 4 5 6 7 8** 1. Based on the resident's most recent assessments, the resident's care plans are appropriate to meet the current needs of the resident. 2. Upon review of the care plans they include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs. 3. Upon review of the care plans they contain appropriate interventions to meet the resident's current needs. 4. Upon review of the care plan there is a care plan in place to address any limitations in mobility, such as range of motion to any affected joint and/or splint usage. 5. Upon observation of the resident, the resident is receiving the necessary range of motion services in accordance with the plan of care. 6. Upon review of the clinical record there is documentation to	

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NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN 47720	

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			support that the resident is receiving range of motion in accordance with the plan of care. 7. Upon review of the care plan there is a care plan in place to address any identified behaviors. 8. Upon review of the care plan there is a care plan in place to address the use of any psychotropic medication as well as a supportive diagnosis for the medical justification for the use of this medication. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	
	2. Resident #117's clinical record was reviewed on 2/14/13 at 3:35 p.m. The resident's medications included, but were not limited to, the following: Risperdal [anti-psychotic medication] 0.25 mg [milligrams] by gastrostomy tube [g-tube] twice a day Namenda [used for treatment of Alzheimer's] 10 mg by g-tube twice a day ABH [Ativan-antianxiety], Benedryl [antihistamine], Haldol [antipsychotic] gel apply topically at bedtime and may repeat one time for insomnia [no later than 2 a.m.]			

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	The resident's record was reviewed again on 2/20/13 at 9:44 a.m. Diagnoses included, but were not limited to, iron deficiency anemia, cardiomyopathy, pneumonia, history of fall, and chronic atrial fibrillation. Review of hospital history and physicals from 1/10/13 and 12/15/12 failed to indicate any psychological diagnoses. A medication/diagnosis list in the record indicated the reason for the Risperdal [antipsychotic] was for a mood disorder [organic affective]. Interview with LPN #1 on 2/19/13 at 2:40 P.M., indicated the resident was having a lot of problems sleeping at night and Ativan [antianxiety] wasn't working. She indicated the resident was very loud, hollering out and was very dissatisfied. She was afraid people were going to kill her and was getting no rest. Nurses' notes, dated 1/28/13 [no time] indicated, "Faxed Dr. [name] with request for ABH apply topically at bedtime and may repeat one time for insomnia..." The record failed to include care plans for insomnia or the behaviors of yelling out. The care plan for			

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	psychotropic drug use did not include the use of the ABH gel. 3.1-35(a) 3.1-35(b)(1)			

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F0282 SS=G	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, interview, and record review, the facility failed to ensure care was provided according to the plan of care for 1 of 3 residents reviewed in a sample of 3 who met the criteria for review of pressure ulcers, the resident developed a pressure ulcer which worsened when care was not provided. (Resident #26) Findings include: The CNA Assignment Sheet provided by LPN #1 on 02/11/13 at 9:50 a.m., indicated Resident #26 was to be turned and repositioned every hour. On 02/11/13 at 11:09 a.m., Resident #26 was observed lying in bed on the right side. During an interview at that time, LPN #1 indicated the WCN [Wound Care Nurse] would be assessing Resident #26 related to a wound on the coccyx. LPN #1 further indicated at that time, the key to healing the pressure wounds was pressure relief. The coccyx wound was observed at that time, to have full thickness tissue loss with slough	F0282	F – 282 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #26 is receiving care and services in accordance with their plan of care to meet the resident's individual needs. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents are now receiving care and services in accordance with their individualized plan of care. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all nursing staff on the importance of providing care and services for each resident in accordance with the plan of care based on the resident's individualized needs. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality Assurance tool has been developed and implemented to monitor the care and services provided for the resident in	03/23/2013

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	present. During an interview on 02/11/13 at 11:10 a.m., the WCN indicated, the wound on the coccyx was a Stage 3 pressure wound with slough and measured 2.8 X 1.5 X unable to determine with 0.1 [centimeter] cm bridging. During an interview on 02/12/13 at 9:05 a.m., LPN #1 indicated Resident #26 had a facility acquired pressure wound on the coccyx. LPN #1 further indicated at that time, the wound had been discovered on 01/31/13 as a Stage 2 wound that measured 1.8 X 0.3 X 0.2 and had progressed to a Stage 3 wound on 02/11/13. Resident #26 was observed on 02/12/13 at 8:45 a.m. lying in bed, positioned to the right side. Resident #26 was observed on 02/12/13 at 9:45 a.m. lying in bed, positioned to right side. Resident #26 was observed on 02/12/13 at 10:45 a.m., lying in bed, positioned to the right side. Resident #26 was observed on 02/12/13 at 11:15 a.m., lying in bed, positioned to the right side.		accordance with the residents' plan of care. This tool will be completed by the Director of Nursing and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted. **Performance Improvement Tool F – 282 & F - 314** **DIRECTIONS:** Upon observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" if the question does not apply to that resident. Review the outcomes to determine if additional action is warranted. **INDICATOR** **PATIENTS** **COMMENTS** **1 2 3 4 5 6 7 8** 1. Upon observation of the nursing staff providing direct care to the resident the resident is receiving the necessary care and services in accordance with their plan of care. 2. Upon observation of the resident who is at high risk for pressure ulcers or who currently has a pressure ulcer the resident	

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	Resident #26 was observed on 02/12/13 at 11:30 a.m., being transferred by CNA #1 and CNA #2 from the bed to the wheelchair. During an interview at that time, CNA #2 indicated Resident #26 was to be turned and repositioned every 2 [two] hours. CNA #2 further indicated at that time, Resident #26 had not been repositioned since being laid down at 8:45 a.m. (total of 2.75 hours) Resident #26 was observed on 02/14/13 at 8:30 a.m., sitting in a wheelchair in Dining Room #1. Resident #26 was then observed on 02/14/13 at 9:25 a.m., being transported in the wheelchair from the dining room to the common lounge. At 9:29 a.m., CNA #1 was observed transporting Resident #26 from the common lounge to the resident's room. During an interview at that time, the Maintenance staff #1 indicated work was in progress in the resident's room and CNA #1 would have to wait to transfer Resident #26 to bed. CNA #2 was then observed to place the resident in the hallway outside of the room. Resident #26 was observed at that time, to not be repositioned in the wheelchair. Resident #26 was observed on 02/14/13 at 9:59 a.m., to be lying in		is being turned and repositioned in accordance with their plan of care. 3. Upon review of the CNA assignment sheet it reflects the current needs of the resident in accordance with their plan of care as it relates to turning and repositioning. 4. Upon observation of the resident all interventions are in place in accordance with the plan of care in the prevention/treatment of pressure wounds. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/21/2013
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	bed positioned on the right side. During an interview at that time, CNA #2 indicated Resident #26 had just been transferred to bed. CNA #1 further indicated at that time, Resident #26 had been transferred into the wheelchair at 7:30 a.m. that morning. (total of 2.5 hours) Resident #26 was observed on 02/14/13 at 11:30 a.m., to be transferred from the bed to the wheelchair. During an interview at that time, CNA #2 indicated Resident #26 had not been repositioned while in bed. (total of 1.5 hours) The clinical record of Resident #26 was reviewed on 02/14/13 at 10:02 a.m. The record indicated the diagnoses of Resident #26 included, but were not limited to, anemia and arthritis. A Physician's Telephone Order dated 02/09/13, included, but was not limited to, and order for, "...turn and reposition every 1 [one] hour..." An Avoidability Evaluation of Pressure Ulcer from the attending physician dated 02/12/13, indicated, "Pressure ulcer is Unavoidable due to the following factors: Chronic bowel incontinence...resident			

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	refuses nutrition...significant weight loss..Summary:...pressure Ulcer is Unavoidable...". The evaluation lacked any documentation related to Resident #26 refusing care or preventative interventions. The Nurses' Admission Record dated 10/28/12, indicated Resident #26 had been admitted from an acute care hospital with no pressure wound on the coccyx. The most recent Pressure Ulcer Risk Assessment dated 10/29/12, indicated Resident #26 was a high risk for pressure. A Wound Care Skin Integrity Evaluation dated 02/11/13, indicated Resident #26 had a facility acquired Stage #3 wound to the coccyx which measured 2.8 X 0.5 X 0.2 and included but, was not limited to, an intervention of, "...Turn schedule is q [every] 1 [one] hour at this time." The most recent Quarterly MDS [Minimum Data Set Assessment] dated 12/14/12, indicated Resident #26 experienced moderate cognitive impairment and required extensive assist of two staff for bed mobility. The care plan dated 01/31/13, for			

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	Stage 2 on coccyx included, but was not limited to, "...turn and reposition every two hours..." The Skin Management Program Policy and Procedure provided by MR #1 on 02/20/13 at 1:00 p.m., indicated,"...It is our policy that if an alteration does occur that the resident receives care and services to promote healing..." 3.1-35(g)(2)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. Based on observation, interview, and record review the facility failed to ensure care was provided as ordered, for 1 of 3 residents reviewed in a sample of 3 who met the criteria for review of pressure ulcers in that, a resident who was admitted without a pressure ulcer, developed a pressure ulcer, and the ulcer deteriorated to a Stage 3 wound. (Resident #26) Finding includes: The CNA Assignment Sheet provided by LPN #1 on 02/11/13 at 9:50 a.m., indicated Resident #26 was to be turned and repositioned every hour. On 02/11/13 at 11:09 a.m., Resident #26 was observed lying in bed on the right side. During an interview at that	F0314	F – 314 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #26 is receiving care and services in accordance with their plan of care to meet the resident's individual needs in the treatment and prevention of pressure wounds. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents are now receiving care and services in accordance with their individualized plan of care in the prevention and treatment of pressure wounds. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was conducted for all nursing staff on the facility policy and procedures in the prevention and treatment of pressure wounds. An emphasis	03/23/2013

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	time, LPN #1 indicated the WCN [Wound Care Nurse] would be assessing Resident #26 related to a wound on the coccyx. LPN #1 further indicated at that time, the key to healing the pressure wounds was pressure relief. The coccyx wound was observed at that time, to have full thickness tissue loss with slough present. During an interview on 02/11/13 at 11:10 a.m., the WCN indicated, the wound on the coccyx was a Stage 3 pressure wound with slough and measured 2.8 X 1.5 X unable to determine with 0.1 [centimeter] cm bridging. During an interview on 02/12/13 at 9:05 a.m., LPN #1 indicated Resident #26 had a facility acquired pressure wound on the coccyx. LPN #1 further indicated at that time, the wound had been discovered on 01/31/13 as a Stage 2 wound that measured 1.8 X 0.3 X 0.2 and had progressed to a Stage 3 wound on 02/11/13. Resident #26 was observed on 02/12/13 at 8:45 a.m. lying in bed, positioned to the right side. Resident #26 was observed on 02/12/13 at 9:45 a.m. lying in bed,		was also placed on the importance of turning and repositioning in accordance with the resident's individualized plan of care. In addition the facility has established a weekly wound meeting to review all pressure wounds. The purpose of this weekly meeting is to review the progress in the healing of this wound and to ensure all appropriate treatments/interventions are in place to meet the residents' needs. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that a Quality Assurance tool has been developed and implemented to monitor the prevention and treatment of pressure wounds in accordance with the residents' plan of care. This tool will be completed by the Director of Nursing and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. **Performance Improvement Tool F – 282 & F - 314 DIRECTIONS:** Upon observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" if the question does not	

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	positioned to right side. Resident #26 was observed on 02/12/13 at 10:45 a.m., lying in bed, positioned to the right side. Resident #26 was observed on 02/12/13 at 11:15 a.m., lying in bed, positioned to the right side. Resident #26 was observed on 02/12/13 at 11:30 a.m., being transferred by CNA #1 and CNA #2 from the bed to the wheelchair. During an interview at that time, CNA #2 indicated Resident #26 was to be turned and repositioned every 2 [two] hours. CNA #2 further indicated, at that time, Resident #26 had not been repositioned since being laid down at 8:45 a.m. (total of 2.75 hours) Resident #26 was observed on 02/14/13 at 8:30 a.m., sitting in a wheelchair in Dining Room #1. Resident #26 was then observed on 02/14/13 at 9:25 a.m., to be transported in the wheelchair from the dining room to the common lounge. At 9:29 a.m., CNA #1 was observed transporting Resident #26 from the common lounge to the resident's room. During an interview at that time, the Maintenance staff #1 indicated work was in progress in the		apply to that resident. Review the outcomes to determine if additional action is warranted. **INDICATOR** **PATIENTS** **COMMENTS** **1 2 3 4 5 6 7 8** 1. Upon observation of the nursing staff providing direct care to the resident the resident is receiving the necessary care and services in accordance with their plan of care. 2. Upon observation of the resident who is at high risk for pressure ulcers or who currently has a pressure ulcer the resident is being turned and repositioned in accordance with their plan of care. 3. Upon review of the CNA assignment sheet it reflects the current needs of the resident in accordance with their plan of care as it relates to turning and repositioning. 4. Upon observation of the resident all interventions are in place in accordance with the plan of care in the prevention/treatment of pressure wounds. _____ _____ _____	

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	resident's room and CNA #1 would have to wait to transfer Resident #26 to bed. CNA #2 was then observed to place the resident in the hallway outside of the room. Resident #26 was observed at that time, to not be repositioned in the wheelchair. Resident #26 was observed on 02/14/13 at 9:59 a.m., to be lying in bed positioned on the right side. During an interview at that time, CNA #2 indicated Resident #26 had just been transferred to bed. CNA #1 further indicated at that time, Resident #26 had been transferred into the wheelchair at 7:30 a.m. that morning. (total of 2.5 hours) Resident #26 was observed on 02/14/13 at 11:30 a.m., to be transferred from the bed to the wheelchair. During an interview at that time, CNA #2 indicated Resident #26 had not been repositioned while in bed. (total of 1.5 hours) The clinical record of Resident #26 was reviewed on 02/14/13 at 10:02 a.m. The record indicated the diagnoses of Resident #26 included, but were not limited to, anemia and arthritis. A Physician's Telephone Order dated 02/09/13, included, but was not		**SIGNATURE OF ASSESSOR DATE**	

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	limited to, and order for, "...turn and reposition every 1 [one] hour..." An Avoidability Evaluation of Pressure Ulcer from the attending physician dated 02/12/13, indicated, "Pressure ulcer is Unavoidable due to the following factors: Chronic bowel incontinence...resident refuses nutrition...significant weight loss..Summary:...pressure Ulcer is Unavoidable...". The evaluation lacked any documentation related to Resident #26 refusing care or preventative interventions. The Nurses' Admission Record dated 10/28/12, indicated Resident #26 had been admitted from an acute care hospital with no pressure wound on the coccyx. The most recent Pressure Ulcer Risk Assessment dated 10/29/12, indicated Resident #26 was a high risk for pressure. A Wound Care Skin Integrity Evaluation dated 02/11/13, indicated Resident #26 had a facility acquired Stage #3 wound to the coccyx which measured 2.8 X 0.5 X 0.2 and included but, was not limited to, an intervention of, "...Turn schedule is q [every] 1 [one] hour at this time."			

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	The most recent Quarterly MDS [Minimum Data Set Assessment dated 12/14/12, indicated Resident #26 experienced moderate cognitive impairment and required extensive assist of two staff for bed mobility. The care plan dated 01/31/13, for Stage 2 on coccyx included, but was not limited to, "...turn and reposition every two hours..." The Skin Management Program Policy and Procedure provided by MR #1 on 02/20/13 at 1:00 p.m., indicated,"...It is our policy that if an alteration does occur that the resident receives care and services to promote healing..." 3.1-40(a)(1)			

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F0318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure a resident with a contracture received range of motion services as ordered for 1 of 3 residents who met the criteria. (Resident #26) Finding includes: The clinical record of Resident #26 was reviewed on 02/14/13 at 10:02 a.m. The record indicated the diagnoses included, but was not limited to, arthritis. On 02/11/13 at 11:20 a.m., Resident #26 lying in bed with the left hand to be lying on the mattress in a contracted position. Resident #26 was observed not to have a splint on the left hand. The most recent quarterly MDS (Minimum Data Set Assessment) dated 12/14/12, indicated, "...ROM: Resident has impairment to the upper extremity..."	F0318	F – 318 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #26 is now receiving range of motion in accordance with their plan of care. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all resident have the potential to be affected by the same deficient practice. A housewide audit was completed on all residents to determine if there were any other residents who had the need for range of motion. Any identified residents were placed on the appropriate range of motion program to meet their individualized needs. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that an in-service was conducted for all nursing staff on assessing the residents' range of motion needs and the implementation of appropriate range of motion programs to meet those needs. The staff was directed to report	03/23/2013

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	A PT-Therapist Progress & Discharge Summary dated 12/13/12, indicated "...Patient/Caregiver training: Patient has restorative program in place..." A Restorative progress note dated 12/28/12, indicated Resident #26 "...discharged from therapy. Restorative screened and will turn over to nursing for ROM..." The February 2013 Physician's Order Recap included, but was not limited to, orders for "...May attend Restorative Nursing..." The Comprehensive Plan of Care dated 01/09/13, lacked a plan of care for Restorative Nursing or Range of Motion. The CNA Assignment Sheet provided by LPN #1 on 02/11/13 at 9:50 a.m., lacked any documentation related to Resident #26 receiving Restorative Nursing or Range of Motion services. During an interview on 02/12/13 at 9:09 a.m., LPN #1 indicated Resident #26 had a contracture to the left hand, did not use a splint, and did not receive restorative or range of motion services.		any change in a residents' range of motion immediately to the charge nurse for further assessment and development of the appropriate plan of care. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance tool was developed and implemented to monitor the care and services of residents with limited range of motion to ensure they receive the necessary range of motion services to meet their individualized needs. This tool will be completed by the Restorative Nurse weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted. **Performance Improvement Tool F – 279 & F - 318 DIRECTIONS:** Upon review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" if the question does not apply to that resident. Review the outcomes to determine if additional action is warranted. **INDICATOR** **PATIENTS**	

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	The ADL [Activities of Daily Living] Record from December 2012 through February 2013 were reviewed and indicated Resident #26 had received no services for range of motion. During an interview on 02/19/13 at 2:00 p.m., Restorative Aide #1 indicated Resident #26 was had not been receiving Restorative Services and was not on the current Restorative caseload. During an interview on 02/19/13 at 2:46 p.m., the DoN [Director of Nursing] indicated, Resident #26 had been referred by PT [Physical Therapy] for Restorative Services and had not received restorative services due to an oversight. 3.1-42(a)(2)		**COMMENTS** **1 2 3 4 5 6 7 8** 1. Based on the resident's most recent assessments, the resident's care plans are appropriate to meet the current needs of the resident. 2. Upon review of the care plans they include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs. 3. Upon review of the care plans they contain appropriate interventions to meet the resident's current needs. 4. Upon review of the care plan there is a care plan in place to address any limitations in mobility, such as range of motion to any affected joint and/or splint usage. 5. Upon observation of the resident, the resident is receiving the necessary range of motion services in accordance with the plan of care. 6. Upon review of the clinical record there is documentation to support that the resident is receiving range of motion in accordance with the plan of care. 7. Upon review of the care plan there is a care plan in place to address any identified behaviors.	

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			8. Upon review of the care plan there is a care plan in place to address the use of any psychotropic medication as well as a supportive diagnosis for the medical justification for the use of this medication. **SIGNATURE OF ASSESSOR DATE**	

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PINE HAVEN HEALTH AND REHABILITATION CENTER	3400 STOCKER DR EVANSVILLE, IN 47720

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure 1 of 10 residents reviewed for unnecessary medications was free of unnecessary medications, in that an order for a combination anti-anxiety/antipsychotic medication was obtained for Insomnia with no clear indications for use. (Resident # 117) Finding includes:	F0329	F – 329 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #117 no longer has an order for the anti-anxiety/antipsychotic medication for insomnia. The resident does have a care plan to address the problem of insomnia with non-chemical interventions in place. The care plan for psychotropic drug use has been revised to include non-chemical interventions. *The corrective action taken for the other*	03/23/2013

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	Resident #117's clinical record was reviewed on 2/14/13 at 3:35 p.m. The resident's physician's orders included, but were not limited to, the following: Risperdal [anti-psychotic medication] 0.25 mg [milligrams] by gastrostomy tube [g-tube] twice a day Namenda [used for treatment of Alzheimer's] 10 mg by g-tube twice a day ABH [Ativan -antianxiety], Benedryl [antihistimine], Haldol [antipsychotic] gel apply topically at bedtime and may repeat one time for insomnia [no later than 2 a.m.] The record was reviewed again on 2/20/13 at 9:44 a.m. The record indicated the resident was admitted to the facility on 12/21/12, with diagnoses including, but not limited to, iron deficiency anemia, cardiomyopathy, pneumonia, chronic atrial fibrillation, and history of a fall. A Medication/Diagnosis list indicated the reason for the Risperdal was a mood disorder [organic affective]. Review of hospital histories and physicals, dated 12/15/12 and 1/10/13, indicated the resident had no psychiatric diagnoses. Physician's orders, dated 2/15/13, indicated the Risperdal was decreased to 0.25 mg daily on that		*residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all residents' medication orders was conducted to ensure that any resident receiving an antipsychotic drug had a documented supportive diagnosis to treat a specific condition. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service for all licensed nurses has been conducted on the facility's policy as it relates to unnecessary drugs. The in-service included a focus on the need for supportive documentation related to the specific condition and diagnosis that must be documented in the clinical record along with the non-chemical interventions that have been attempted prior to obtaining an order for any psychotropic medication. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance tool has been developed and implemented to monitor the use of psychotropic medications. The tool is to monitor for supportive documentation of the specific condition that is being treated including diagnosis. The tool will also monitor the documentation of the non-chemical interventions	

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	date. Nurses notes included, but were not limited to, the following: "1/28/2013 09:22 *Health Status Note Note Text: Discussed with res [resident] how she was sleeping at night and how she was feeling. Res c/o [complaint of] dizziness all the time. This nurse asked if it was worse when sitting up or laying down. Res states it is all the time. Discussed with res talking with Dr. [name of Doctor] and requesting Antivert and something to help her sleep at night and possibly obtaining some labs. Res stated I would rather not take any other medicines. Discussed routine meds with her, reasons why she was taking it and when she took it. Res voiced understanding. 1/28/2013 04:31 *Health Status Note Note Text: Pt requested to get up in her chair. Explained it was 430 AM. Pt replied she didn't care. CNA Assisted her in getting up into chair. Tube flushed with no difficulty. Pt watching TV in room. 1/28/2013 03:31 *Health Status Note Note Text: Pt upset about her nose being stuffed up. "How does that just HAPPEN???!!" Inserted Saline into each nostril. Pt continued to yell		that have been attempted prior to the use of the psychotropic medication. This tool will be completed by the Director of Nursing and/or his designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. **Performance Improvement Tool F - 329** **DIRECTIONS:** Upon observation and review of the clinical record answer the questions below. Place a "Y" for Yes or an "N" for No. Place an "N/A" if the question does not apply to that resident. Review the outcomes to determine if additional action is warranted. **INDICATOR** **PATIENTS** **COMMENTS** **1 2 3 4 5 6 7 8** 1. Upon review of the clinical record there are supportive diagnoses for the use of all medications currently ordered for the resident. 2. Upon review of the clinical record there are non-chemical interventions in place which are to be utilized prior to the	

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	about her congestion. Ativan applied to wrists, for anxiety. v 1/27/2013 13:00 *Health Status Note Note Text: res with no increase in anxiety noted so far this shift. pleasant and cooperative with care. denies any c/o's at this time. 1/27/2013 05:07 *Health Status Note Note Text: Res. up and down. stated couldn't swallow. given mouth swabs. c/o anxiousness. c/o insomnia. ativan intensol given topically. effective in relaxing res. 1/26/2013 22:06 *Health Status Note Note Text: no increase in anxiety noted so far this week. 1/26/2013 12:46 *Health Status Note Note Text: no anxiety noted so far this shift. 1/25/2013 11:55 *Health Status Note Note Text: No anxiety noted this shift. Up in w/c at this time. No c/o voiced, no negative statements voiced. 1/25/2013 09:38 *Health Status Note Note Text: Res resting in bed with eyes closed @ present. Jevity 1.2 infusing per peg tube via pump without difficulty. Placement confirmed and PEG flushes well.		administration of any prn psychotropic medications. 3. Upon review of the clinical record there is documentation to support that non-chemical interventions were attempted prior to the administration of any prn psychotropic medication. 4. Upon review of the clinical record there is documentation to support that a specific condition exists which has not responded to non-chemical interventions prior to requesting an order for the treatment of this condition. _____ _____ _____ **SIGNATURE OF ASSESSOR DATE**	

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	1/25/2013 06:49 *Health Status Note Note Text: Pt continues to complain of being nervous. Ativan gel applied to wrist. [1/25/2013 05:52 *Health Status Note Note Text: Pt continues to feel "nervous" about "drying out" Offered to assist in getting some mouth wash to swish in her mouth, or brush her teeth. Pt declined to do either , just asked for more glycerine swabs. 1/25/2013 00:43 *Health Status Note Note Text: Pt requesting something to moisten her throat. Offer made to brush teeth and let her swish mouthwash around her mouth, pt declined. Pt stated "I'm too nervous for all that just get me some more of those lemon swabs" Lemon swabs offered and pt stated" these won't work for long" 1/24/2013 19:42 *Health Status Note Note Text: Res up in w/c watching tv. Jevity infusing via peg tube @45cc an hour. Peg placement verified via A/A [air auscultation]. Flushes well. Res very anxious this tour has required 1:1 and reassurance and TLC [tender loving care]. Res refused to allow staff to change her clothes for bed and refused to allow staff to help with			

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	oral care. BS [bowel sounds] x 4 MOM [milk of magnesia, laxative] given per tube. 1/24/2013 14:33 *Health Status Note Note Text: No anxiety noted this shift. Res up in w/c and watching t.v. in her room. 1/24/2013 11:26 *Health Status Note Note Text: No increase in anxiety noted this shift. Jevity 1.2 infusing at 45cc per hour via pump. Res tolerating feeding well. Res has attended therapy today." Nurses's notes, dated 1/28/13 [no time], indicated the following: "Faxed Dr. [name] with request for ABH [Ativan [antianxiety], Benedryl [antihistimine], Haldol [antipsychotic] [1-25-1, one milligram, 25 milligrams, 1 milligram] apply topically at bedtime and may repeat one time for insomnia (no later than 2 a.m.)" LPN #1 indicated, during interview on 2/19/13 at 2:40 p.m., the resident was having a lot of problems sleeping at night and the Ativan wasn't working. She indicated she would get very loud, hollering out that they weren't doing anything for her; it was really disturbing the resident. She was afraid people were going to kill her			

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	and was getting no rest. There was no indication the facility attempted alternatives to the use of psychoactive medications for sleep and there was no care plan for insomnia. The current care plans for psychotropic drug use and mood state issues, dated 1/2/13, failed to indicate alternatives to use prior to administering or obtaining orders for medications. 3.1-48(a)(4)			

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F0332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.			
	Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 10 residents observed during medication pass, in that medications were not given before or after meals as ordered/recommended, and medications were not diluted with ordered amount of water. Three [3] medication errors were observed during 53 opportunities for error. This resulted in an error rate of 5.66 %. (Residents #108, #28, #56) Findings include: 1. On 2/14/13 at 8:24 a.m., LPN #2 was observed administering medications to Resident #108. She administered Miralax [laxative] one cap full in a small blue plastic cup full of water. She indicated during interview, at that time, the cup held 120 cubic centimeters [ccs] of water [4 ounces]. Resident #108's clinical record was reviewed on 2/14/13 at 9:05 a.m. The resident's current physician's orders signed on 2/7/13 included, but were not limited to, the	F0332	F – 332 The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as #108, 28 and 56 are now receiving their medications at the correct time according to the manufacturer guidelines and their medications are being dissolved in the proper amount of liquid as ordered. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by the same deficient practice. A housewide medication review has been conducted to ensure that each resident is receiving their medications in accordance with the manufacturer guidelines and physician's orders. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses and QMAs on the following of the manufacturer guidelines and physician's orders on medication administration. *The corrective action taken to monitor to assure performance to assure compliance through quality*	03/23/2013

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	order for Miralax Gm [grams] 17 one capful in 8 ounces of water daily. 2. On 2/18/13 at 11:32 a.m., QMA [Qualified Medication Aide] #1 was observed administering medications to Resident #56. She administered Ativan [antianxiety medication] 0.5 mg [milligrams] one tablet by mouth at that time. The resident had not received her lunch tray. Review of the resident's clinical record, on 2/19/13 at 9:45 a.m., indicated the Ativan was ordered to be given three times a day "after meals." The orders were signed by the physician on 1/22/13. 3. On 2/19/13 at 9:23 a.m., QMA #1 was observed to administer medications to Resident #28. The medications included, but were not limited to, Omeprazole [proton pump inhibitor to reduce acid in stomach] 20 mg by mouth. The resident had received breakfast an hour or so previously the QMA indicated. The 2010 Nursing Spectrum Drug Handbook, reviewed on 2/19/13 at 9:50 a.m., indicated medication should be given "30 to 60 minutes before a meal, preferably in morning." Resident #28's clinical record was		*assurance is* the consultant pharmacist will review the scheduled medication administration times during his monthly review of each resident's medication regimen to ensure the manufacturer guidelines and physician's orders are being followed. This audit will be conducted by the consultant pharmacist monthly and will be an on-going process. In addition the pharmacy will conduct a random medication administration review monthly for the next three months and then quarterly thereafter to ensure that all medications are being administered in accordance with the manufacturer guidelines and physician's orders. The findings of these reports will be reviewed at the facility's Quality Assurance meeting to determine if any additional action is warranted.	

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	reviewed for medications on 2/19/13 at 9:45 a.m. The record included, but was not limited to, an order for Omeprazole 20 mg to be given daily, signed on 2/8/13. 3.1-25(b)(9) 3.1-48(c)(1)			