STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155291		04/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 13, 14, 15, 18, 19, 20, 21, and 22, 2016 Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census bed type: SNF/NF: 108 Total: 108 Census payor type: Medicare: 9 Medicaid: 79 Other: 20 Total: 108 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation of regulation.This provider respectfully requests that the2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance	
F 0223 SS=D Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse,			

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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	corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was not verbally abused when the roommate used disparaging and derogatory language within hearing distance for 1 of 3 residents reviewed for allegations of abuse (Resident #100). Finding includes: During an interview on 4/15/16 at 2:33 p.m., Resident #100's husband indicated his wife's roommate had been verbally abusive. He indicated his wife was in the bed furthest from the door and he and his son had to pass by her roommate to get to her side of the room. He indicated one evening when he and his son entered his wife's room Resident #80 became upset when they walked in front of her TV. He indicated she "used some really bad language" directed towards his wife, his son, and him. He stated, "...she was very abusive and used very bad language my wife wasn't use to." He further indicated he reported it to the nurse and had requested his wife be moved to another room.	F 0223	Eagle Valley Meadows respectfully requests additional evidentiaryinformation be considered to reduce or delete F 323 from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · At no point did Resident #100's husband make an allegation of abusetoward his wife to the facility staff. · Resident#100 was provided a room change upon request of the husband at the time of theinitial incident. There have been nofurther issues between Resident #100, Resident #80, and Resident #100's family. · Aninvestigation was immediately initiated and an initial report sent to ISDH uponnotification by ISDH surveyor of the abuse allegation. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential	05/20/2016

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	Resident #100's record was reviewed on 4/15/16 at 2:50 p.m. A Minimum Data Set (MDS) assessment, dated 3/9/16, indicated Resident #100 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15, had intact hearing, and could understand others. Resident #80's record was reviewed on 4/15/16 at 3:00 p.m. A MDS, dated 3/8/16 indicated Resident #80 had a BIMS score of 15 out of 15. A Social Service progress note, dated 1/26/16, indicated on 1/19/16 at 4:04 p.m., Resident #100 had been moved to another room in the facility because Resident #80 was not a compatible roommate for her. During an interview on 4/20/16 at 11:00 a.m., with the Administrator and Director of Nursing (DON) present, the Administrator indicated he could not remember the exact date however, the incident with Resident #100's roommate occurred over a weekend within the last few months. He indicated he was informed Resident #100's husband reported his wife's roommate had "cursed him out" in his wife's room. He further indicated he had not reported and/or investigated it per the facility's abuse		to be affected. · IDT will complete an abuse questionnaire and QIS interview questionspertaining to roommates for all alert and oriented residents. IDT will complete abuse questionnaire and QISinterview questions with responsible parties for all cognitively impairedresidents. Interviews will be completedby May 13, 2016. Any allegation orindication of possible abuse will be immediately reported and investigationinitiated. Any concerns with resident safety will be addressed immediatelyin the plan of care and the physician. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · Allnursing staff will be re-educated on the facility's Abuse Prohibition policy(Which includes the definition and reporting of verbal abuse) and the Reportingof Unusual Occurrences Policy. · Re-educationwill be conducted by Clinical Education Coordinator or designee and completedby May 14, 2016. · TheExecutive Director and Director of Nursing Services will be contactedimmediately upon any allegation of potential abuse. **How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?**	

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	policy because even though Resident #100 was in the room it was not directed towards her. He indicated the room change was made per his request. He further indicated he had not considered it "abuse" or "potential for abuse." During an interview on 4/21/16 at 10:00 a.m., the DON indicated Resident #100's husband initially reported the concern to Licensed Practical Nurse (LPN) #20. During an interview on 4/21/2016 at 2:59 p.m., LPN #20 indicated while in Resident #80 and #100's room administering medications, Resident #80 complained about Resident #100's visitors and the lack of privacy in her room. She indicated, approximately a hour after Resident #80 had complained, Resident #100's husband informed her he wanted his wife moved to another room because Resident #80 "yelled at him." She further indicated she immediately reported the concern to the Director of Nursing and to Customer Care Representative #21. During an interview on 4/21/16 at 3:30 p.m., Customer Care Representative #21 indicated she was notified by a nurse Resident #100's husband had reported his wife's roommate had talked "bad" to them and wanted his wife to be moved to		· SS/designeewill be responsible for the completion of the Resident to Resident Altercationsand Abuse CQI tools weekly times 4weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The Executive Director willcomplete the Abuse Prohibition and Investigation CQI Audit Tool upon any reportof alleged abuse. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If thresholdof 95% is not achieved, an action plan will be developed.	

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	another room. She indicated she immediately interviewed Resident #100's husband at which time he informed her he and his son had walked in front of Resident #80's TV to get to his wife's side of the room when Resident #80 started "talking bad to him." She indicated Resident #100's husband was "very humble" and would not repeat the exact language. She indicated she informed the Administrator and arranged for the room change. Customer Care Representative #21 further indicated even though it occurred in the presence of Resident #100 "at the time" she had not considered it abuse because it was directed towards a family and not a resident. An Abuse Prohibition, Reporting, and Investigation Policy an procedure identified as current by the Administrator on 4/20/16 at 11:05, indicated, "...It is the policy of American Senior Communities to protect residents from abuse including...verbal abuse...definition of abuse-Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish...This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental, or psychosocial well			

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	being...Verbal Abuse--or, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident...or scolding and/or speaking to them in harsh voice tones....Resident to Resident Abuse: Policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained if abuse is identified or suspected. Procedure: If resident to resident abuse is identified or there is suspicion of resident - to-resident abuse, the following guidelines will be followed...The staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintain..." 3.1-27(a)(1) 3.1-27(b)			
F 0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

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Bldg. 00	ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on interview and record review, the facility failed to ensure an allegation	F 0225	Eagle Valley Meadows respectfully requests additional evidentiaryinformation be	05/20/2016

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	of verbal abuse was immediately reported to Administrator and the State agency and thoroughly investigated for 1 of 3 residents reviewed for allegations of abuse (Resident #100). Finding includes: During an interview on 4/15/16 at 2:33 p.m., Resident #100's husband indicated his wife's roommate had been verbally abusive. He indicated his wife was in the bed furthest from the door and he and his son had to pass by her roommate to get to her side of the room. He indicated one evening when he and his son entered his wife's room Resident #80 became upset when they walked in front of her TV. He indicated she "used some really bad language" directed towards his wife, his son, and him. He stated, "...she was very abusive and used very bad language my wife wasn't use to." He further indicated he reported it to the nurse and had requested his wife be moved to another room. Resident #100's record was reviewed on 4/15/16 at 2:50 p.m. A Minimum Data Set (MDS) assessment, dated 3/9/16, indicated Resident #100 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of 15, had intact hearing, and could		considered to reduce or delete F 225 from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · At no point did Resident #100's husband make an allegation of abusetoward his wife to the facility staff. · Resident#100 was provided a room change upon request of the husband at the time of theinitial incident. There have been nofurther issues between Resident #100, Resident #80, and Resident #100's family. · Aninvestigation was immediately initiated and an initial report sent to ISDH uponnotification by ISDH surveyor of the abuse allegation. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential to be affected. · IDT will complete an abuse questionnaire and QIS interview questionspertaining to roommates for all alert and oriented residents. IDT will complete abuse questionnaire and QISinterview questions with responsible parties for all	

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	understand others. Resident #80's record was reviewed on 4/15/16 at 3:00 p.m. A MDS, dated 3/8/16 indicated Resident #80 had a BIMS score of 15 out of 15. A Social Service progress note, dated 1/26/16, indicated on 1/19/16 at 4:04 p.m., Resident #100 had been moved to another room in the facility because Resident #80 was not a compatible roommate for her. During an interview on 4/20/16 at 11:00 a.m., with the Administrator and Director of Nursing (DON) present, the Administrator indicated he could not remember the exact date however, the incident with Resident #100's roommate occurred over a weekend within the last few months. He indicated he was informed Resident #100's husband reported his wife's roommate had "cursed him out" in his wife's room. He further indicated he had not reported and/or investigated it per the facility's abuse policy because even though Resident #100 was in the room it was not directed towards her. He indicated the room change was made per his request. He further indicated he had not considered it "abuse" or "potential for abuse."		cognitively impairedresidents. Interviews will be completedby May 13, 2016. Any allegation orindication of possible abuse will be immediately reported and investigationinitiated. Any concerns with resident safety will be addressed immediatelyin the plan of care and the physician. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · Allnursing staff will be re-educated on the facility's Abuse Prohibition policy(Which includes the definition and reporting of verbal abuse) and the Reportingof Unusual Occurrences Policy. · Re-educationwill be conducted by Clinical Education Coordinator or designee and completedby May 14, 2016. · TheExecutive Director and Director of Nursing Services will be contactedimmediately upon any allegation of potential abuse. **How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?** · SS/designeewill be responsible for the completion of the Resident to Resident Altercationsand Abuse CQI tools weekly times 4weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is maintained for 2	

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	During an interview on 4/21/16 at 10:00 a.m., the DON indicated Resident #100's husband initially reported the concern to Licensed Practical Nurse (LPN) #20. During an interview on 4/21/2016 at 2:59 p.m., LPN #20 indicated while in Resident #80 and #100's room administering medications, Resident #80 complained about Resident #100's visitors and the lack of privacy in her room. She indicated approximately a hour after Resident #80 had complained, Resident #100's husband informed her he wanted his wife moved to another room because Resident #80 "yelled at him." She further indicated she immediately reported the concern to the Director of Nursing and to Customer Care Representative #21. During an interview on 4/21/16 at 3:30 p.m., Customer Care Representative #21 indicated she was notified by a nurse Resident #100's husband had reported his wife's roommate had talked "bad" to them and wanted his wife to be moved to another room. She indicated she immediately interviewed Resident #100's husband at which time he informed her he and his son had walked in front of Resident #80's TV to get to his wife's side of the room when Resident #80 started "talking bad to him." She		consecutivequarters. The Executive Director willcomplete the Abuse Prohibition and Investigation CQI Audit Tool upon any reportof alleged abuse. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If thresholdof 95% is not achieved, an action plan will be developed.	

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	indicated Resident #100's husband was "very humble" and would not repeat the exact language. She indicated she informed the Administrator and arranged for the room change. Customer Care Representative #21 further indicated even though it occurred in the presence of Resident #100 "at the time" she had not considered it abuse because it was directed towards a family and not a resident. An Abuse Prohibition, Reporting, and Investigation Policy an procedure identified as current by the Administrator on 4/20/16 at 11:05, indicated, "...It is the policy of American Senior Communities to protect residents from abuse including...verbal abuse...definition of abuse-Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish...This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental, or psychosocial well being...Verbal Abuse--or, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to:			

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	threats of harm, saying things to frighten a resident...or scolding and/or speaking to them in harsh voice tones....Resident to Resident Abuse: Policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained if abuse is identified or suspected. Procedure: If resident to resident abuse is identified or there is suspicion of resident - to-resident abuse, the following guidelines will be followed...The staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintain..." 3.1-28(d)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their	F 0226	Eagle Valley Meadows respectfully requests additional	05/20/2016

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	policies and procedures to immediately report to the Administrator and State agency and thoroughly investigate verbal abuse allegations for 1 of 3 residents reviewed for allegations of abuse (Resident #100). Finding includes: During an interview on 4/15/16 at 2:33 p.m., Resident #100's husband indicated his wife's roommate had been verbally abusive. He indicated his wife was in the bed furthest from the door and he and his son had to pass by her roommate to get to her side of the room. He indicated one evening when he and his son entered his wife's room Resident #80 became upset when they walked in front of her TV. He indicated she "used some really bad language" directed towards his wife, his son, and him. He stated, "...she was very abusive and used very bad language my wife wasn't use to." He further indicated he reported it to the nurse and had requested his wife be moved to another room. Resident #100's record was reviewed on 4/15/16 at 2:50 p.m. A Minimum Data Set (MDS) assessment, dated 3/9/16, indicated Resident #100 was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 out of		evidentiaryinformation be considered to reduce or delete F 226 from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · At no point did Resident #100's husband make an allegation of abusetoward his wife to the facility staff. · Resident#100 was provided a room change upon request of the husband at the time of theinitial incident. There have been nofurther issues between Resident #100, Resident #80, and Resident #100's family. · Aninvestigation was immediately initiated and an initial report sent to ISDH uponnotification by ISDH surveyor of the abuse allegation. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential to be affected. · IDT will complete an abuse questionnaire and QIS interview questionspertaining to roommates for all alert and oriented residents. IDT will complete abuse questionnaire and QISinterview questions with	

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	15, had intact hearing, and could understand others. Resident #80's record was reviewed on 4/15/16 at 3:00 p.m. A MDS, dated 3/8/16 indicated Resident #80 had a BIMS score of 15 out of 15. A Social Service progress note, dated 1/26/16, indicated on 1/19/16 at 4:04 p.m., Resident #100 had been moved to another room in the facility because Resident #80 was not a compatible roommate for her. During an interview on 4/20/16 at 11:00 a.m., with the Administrator and Director of Nursing (DON) present, the Administrator indicated he could not remember the exact date however, the incident with Resident #100's roommate occurred over a weekend within the last few months. He indicated he was informed Resident #100's husband reported his wife's roommate had "cursed him out" in his wife's room. He further indicated he had not reported and/or investigated it per the facility's abuse policy because even though Resident #100 was in the room it was not directed towards her. He indicated the room change was made per his request. He further indicated he had not considered it "abuse" or "potential for abuse."		responsible parties for all cognitively impairedresidents. Interviews will be completedby May 13, 2016. Any allegation orindication of possible abuse will be immediately reported and investigationinitiated. Any concerns with resident safety will be addressed immediatelyin the plan of care and the physician. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · Allnursing staff will be re-educated on the facility's Abuse Prohibition policy(Which includes the definition and reporting of verbal abuse) and the Reportingof Unusual Occurrences Policy. · Re-educationwill be conducted by Clinical Education Coordinator or designee and completedby May 14, 2016. · TheExecutive Director and Director of Nursing Services will be contactedimmediately upon any allegation of potential abuse. **How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?** · SS/designeewill be responsible for the completion of the Resident to Resident Altercationsand Abuse CQI tools weekly times 4weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is	

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	During an interview on 4/21/16 at 10:00 a.m., the DON indicated Resident #100's husband initially reported the concern to Licensed Practical Nurse (LPN) #20. During an interview on 4/21/2016 at 2:59 p.m., LPN #20 indicated while in Resident #80 and #100's room administering medications, Resident #80 complained about Resident #100's visitors and the lack of privacy in her room. She indicated approximately a hour after Resident #80 had complained, Resident #100's husband informed her he wanted his wife moved to another room because Resident #80 "yelled at him." She further indicated she immediately reported the concern to the Director of Nursing and to Customer Care Representative #21. During an interview on 4/21/16 at 3:30 p.m., Customer Care Representative #21 indicated she was notified by a nurse Resident #100's husband had reported his wife's roommate had talked "bad" to them and wanted his wife to be moved to another room. She indicated she immediately interviewed Resident #100's husband at which time he informed her he and his son had walked in front of Resident #80's TV to get to his wife's side of the room when Resident #80		maintained for 2 consecutivequarters. The Executive Director willcomplete the Abuse Prohibition and Investigation CQI Audit Tool upon any reportof alleged abuse. The results of theseaudits will be reviewed by the CQI committee overseen by the ED. If thresholdof 95% is not achieved, an action plan will be developed.	

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	started "talking bad to him." She indicated Resident #100's husband was "very humble" and would not repeat the exact language. She indicated she informed the Administrator and arranged for the room change. Customer Care Representative #21 further indicated even though it occurred in the presence of Resident #100 "at the time" she had not considered it abuse because it was directed towards a family and not a resident. An Abuse Prohibition, Reporting, and Investigation Policy an procedure identified as current by the Administrator on 4/20/16 at 11:05, indicated, "...It is the policy of American Senior Communities to protect residents from abuse including...verbal abuse...definition of abuse-Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish...This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental, or psychosocial well being...Verbal Abuse--or, written, or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing, regardless of their age, ability to comprehend, or disability. Examples			

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	would include, but are not limited to: threats of harm, saying things to frighten a resident...or scolding and/or speaking to them in harsh voice tones....Resident to Resident Abuse: Policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained if abuse is identified or suspected. Procedure: If resident to resident abuse is identified or there is suspicion of resident - to-resident abuse, the following guidelines will be followed...The staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintain..." 3.1-28(a) 3.1-28 (d)			
F 0241 SS=D Bldg. 00	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, record review, and interview, the facility failed to ensure	F 0241	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the**	05/20/2016

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	dignity was maintained when examinations, care, and health issues were provided or discussed in common areas and when staff did not ensure a resident who removed clothing was not visible to persons passing the room for 3 of 3 residents reviewed for dignity (Resident #31, #101, and #93). Findings include: 1a. During an observation on 4/18/16 at 12:16 p.m., Resident #31 was observed seated at the dining room table with two other residents. Nurse Practitioner (NP) #22 was observed using a stethoscope to assess Resident #31's lungs and abdomen. NP #22 was overheard discussing Resident #31's medical concerns regarding "swelling," "abdominal pain," and "sugar intake." A male resident at the table was overheard interjecting information to NP #22 regarding Resident #31's sugar intake. Resident #31's record was reviewed on 4/18/16 at 1:51 p.m. A Minimum Data Set (MDS) assessment, dated 2/2/16, indicated Resident #31 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15. During an interview on 4/18/16 at 12:20 p.m., with the Director of Nursing		**deficient practice?—** · NP #22 was immediately re-educated regarding conducting residentassessments within common areas. · Resident #31 hasbeen monitored for indications of negative psychosocial effects from the citedincidents. Resident #31 has continuedher normal daily routine and shows no adverse effects. · Resident 101'scare plan has been updated to reflect his common occurrences of undressing. Privacywas provided to Resident 101 by pulling his privacy curtain. Resident #101 has been monitored forindications of negative psychosocial effects from the cited incidents. Resident #101 has continued his normal dailyroutine and shows no adverse effects. · LPN #17 wasimmediately re-educated regarding resident privacy and the proper location formedication administration. · Resident #93 has been monitored forindications of negative psychosocial effects from the cited incidents. Resident #93 has continued her normal dailyroutine and shows no adverse effects. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential	

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	(DON)present, NP #22 indicated she did not usually examine residents in the lunch room. The DON indicated all care had to be done in private. During an interview on 4/18/16 at 1:45 p.m., Resident #31 indicated she preferred to be examined in private and not during lunch with other residents around. She further indicated she was not offered the option of going somewhere private prior to NP #22 examining her in the dining room during the noon meal. 1b. During an observation, on 4/14/16 at 9:49 a.m., Resident #31 was sitting in her wheelchair in her room without clothing and fully exposed and viewable from the hall. The door to her room was open and the privacy curtains were open. She was in full view of her roommate, Resident #81. A Certified Nurses Assistant (CNA) came in the room and asked why she was undressed, Resident #31 indicated her gown was wet. The CNA closed the curtain and the door and went to get a new gown. During an observation, on 4/19/2016 at 10:32 a.m., Resident #31 was observed naked while sitting on the toilet in her bathroom, the doors' to her room and bathroom were open. Her empty wheelchair was observed from the		to be affected. · All alert and oriented residents will be interviewed utilizing theprivacy section of the QIS interview to ensure privacy is being provided. Staff will interview the responsible paritiesof all cognitively impaired residents utilizing the privacy section of the QISinterview to ensure dignity and privacy is provided to all residents. Any concerns noted will be immediatelyaddressed and proper action plans put in place. Interviews will be completed by May 20, 2016. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · All Medical Practioners providing care within the facility will bere-educated regarding resident's privacy and dignity. Education will be provided by ClinicalEducation Coordinator or designee and will be completed by May 13, 20016. · All staff will be re-educated on providingresidents privacy and dignity at all times, including medicationadministration. Education will beprovided by Clinical Education Coordinator or designee and will be completed byMay 14, 2016. **How the corrective action(s) will**	

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	hallway, and Resident #31 was viewable after taking 2 steps into the room from the doorway. Resident #31 indicated someone went to get her some pants. Resident #31's chart was reviewed on 4/18/2016 at 2:43 p.m. Diagnoses included, but were not limited to, depressive episodes, brief psychotic disorder, muscle weakness, schizophrenia, mild intellectual disabilities, unspecified dementia without behavioral disturbance. A Minimum Data Set (MDS) assessment, dated 2/2/16, indicated she had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, had moderate cognitive impairment, and no behaviors were identified. During an interview, on 4/14/16 at 9:49 a.m., Resident #81 indicated she had observed Resident #31 naked in the room on multiple occasions. During an interview, on 4/21/2016 at 10:12 a.m., CNA #19 indicated Resident #31 was usually very modest. She further indicated Resident #31 can undress herself and when she was toileting she undressed. During an interview, on 4/21/2016 at 10:14 a.m., CNA #13 indicated Resident #31 would undress in bed while she was		**be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?** · Directorof Nursing or designee will be responsible for the completion of theDignity/Privacy CQI tools weekly times 4 weeks, bi-monthly times 2 months,monthly times 4 and then quarterly to encompass all shifts until continuedcompliance is maintained for 2 consecutive quarters. The Executive Director will complete theAbuse Prohibition and Investigation CQI Audit Tool upon any report of allegedabuse. The results of these audits willbe reviewed by the CQI committee overseen by the ED. If threshold of 95% is notachieved, an action plan will be developed.	

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	sleeping. During an interview, on 4/21/2016 at 10:12 a.m., the Director of Nursing Services (DNS) indicated Resident #31was usually very modest and it was not like her to be exposed. 2. During a continued observation, on 4/13/2016 from 11:15 a.m. to 11:41 a.m., Resident #101 was observed in his room with the door open sitting in his wheel chair with his pants down by his knees, He had a shirt and an incontinence brief on. Licensed Practical Nurse (LPN) #20 walked past the room, and did not assist Resident 31 with his privacy. During a continued observation on 4/15/2016 from 11:10 a.m. to 11:36 a.m., the door to Resident #101's room was wide open, Resident #101 was without clothes, he had an open brief held over his genitalia. Certified Occupational Therapy Assistant (COTA) #24, LPN #20, and LPN #22 walked by the room, looked in and did not provide him with privacy or offer to help dress him. A female visitor also walked by at this time and looked in the room as well. At 11:36 a.m. CNA #23 shut the door to Resident #101's room. Resident #101's chart was reviewed on			

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	4/18/2016 at 3:43 p.m. Diagnosis included, but were not limited to CVA (cerebrovascular accident). A Minimum Data Set (MDS) assessment, dated 2/26/15, indicated he had a Brief Interview for Mental (BIMS) of 5 out of 15, had severe cognitive impairment, and was identified as frequently incontinent of bladder and bowel. He was identified to have feelings of depression, feeling tired, poor appetite, feeling bad about himself, trouble concentrating, moving or speaking slow or fidgety. He was identified as needing extensive assistance of 2 with dressing and toileting, and extensive assistance of 1 for personal hygiene, and total dependence for bathing. The care plan, dated 2/19/15, indicated Resident #101 had self care-deficit related to weakness and impaired mobility. An approach indicated assist with ADL's. During an interview on, 4/21/2016 at 9:41 a.m., CNA #23 indicated Resident #101 was often naked. She indicated she had seen him naked many times from the hall. She indicated he was a set up with clothing, but didn't always get dressed right away, and staff had to go back and recheck him.			

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	During an interview, on 4/21/2016 at 9:43 a.m., the Housekeeping Supervisor indicated he had seen Resident #101 naked from the hall in the past. During an interview, on 4/20/16 at 3:10 p.m., the Director of Nursing Services (DNS) indicated she would expect her staff to provide for privacy. She indicated the facility did not have a policy on providing privacy, but it would fall under resident rights. A copy of the facility resident rights was provided. 3. During a medication administration observation on 4/20/2016 at 9:49 a.m., Licensed Practical Nurse (LPN) #17 was redirected by the Director of Nursing Services (DNS) from passing Resident #93's medications in the hallway. Resident #93's shared room was unavailable due to her roommate receiving care, so LPN #17 transported Resident #93 to the hallway shower room. LPN #17 administered Resident #93's medications, including two fiber cookies, while Resident #93 was seated in her wheelchair next to a toilet and in front of a bathroom sink. During an interview on 4/20/16 at 9:49 a.m., Resident #93 indicated she was uncomfortable taking her medications in the shower room.			

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	During an interview on 4/20/16 at 10:02 a.m., LPN #17 indicated she was unaware she was unable to pass medications to residents in the hallway, but she had been informed by the DNS prior to giving Resident #93's medication that she needed to go to a private location. LPN#17 indicated Resident #93 usually took her medications in the hall. LPN #17 indicated she had never passed medication in the shower room before. On 4/20/16 at 3:00 p.m., the Director of Nursing Services (DNS) provided the policy titled, "Residents Rights," and indicated it was current. The policy indicated, "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...Attached is a set of 'Resident Rights' (Attachment A) according to 42 C.F.R. ss483.10. Executive Directors are responsible for ensuring that any state-specific requirements for Resident Rights are addressed in the facility-specific 'Resident Rights' documents...." On 4/20/16 at 3:00 p.m., the DNS provided a current copy of Attachment A of the "Resident Rights." The document indicated, "...You keep all your			

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	fundamental civil or human rights and liberties when you are admitted to a nursing home....You have the right to be treated with respect and dignity in recognition of your individuality and preferences...You have the right to quality care and treatment that is fair and free from discrimination...Relatives or a legal representative may act on your behalf to exercise these rights when you are unable to do so yourself...." The document indicated residents had the right to privacy during, but not limited to the following, "...Visits with family and friends...Contact and meet with certain agency representatives or individuals who provide health, legal, social, or other services...Privacy during your visits or meetings...Privacy in your room and during bathing, medical treatment, and personal care...Keep your personal and health records confidential...." The document indicated residents had the right to the following, "...Receive care in a manner which promotes and enhances your quality of life...Services necessary to attain or maintain your highest practicable level of functioning...." 3.1-3(t)			
F 0242	483.15(b)			

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SS=D Bldg. 00	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. Based on interview and record review, the facility failed to ensure residents were allowed to make choices regarding changes in their care and treatment. This deficient practice affected 1 of 3 residents reviewed for choices (Resident #35). Finding includes: During an interview on 4/13/16 at 1:51 p.m., Resident #35 indicated staff had not included her in decisions regarding her care. She indicated staff "make" her get up at 4:30 a.m., and she would rather stay in bed until 8:00-8:30 a.m. She indicated staff "make" her go to bed at 9:00 p.m., and she would rather stay up until 11:00 p.m. She stated, "No matter what I say...they are the boss...." She further indicated when she questioned as to why she couldn't stay in bed in the morning or stay up late at night the aides told her she had to get up and/or go to bed before their shift ended. Resident #35's record was reviewed on	F 0242	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · A new personal preference list was completed for Resident #35 · Resident #35'scare plan was updated to reflect her preferences for wake up and bedtimes. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential to be affected. · Allresidents will have updated personal preferences completed. Those residents whose preferences havechanged or were inaccurate will have care plans updated to reflect appropriatepreferences. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · All resident's preferences will be updated a minimum of quarterly inconjunction with the quarterly care	05/20/2016

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	4/14/16 at 9:15 a.m. A Minimum Data Set (MDS) assessment, dated 1/18/16, indicated Resident #35 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, required extensive assistance from two staff for bed mobility and transfers, and had indicated it was very important for her to choose a bedtime. A document titled "Night Shift Get Up List" was reviewed on 4/14/2016 at 9:41 a.m. The document indicated Resident #35 was on the night shift get up list. The document indicated, "...CNAs please follow the get up list as directed. The purpose of the get up list is to help ensure a smooth shift for all involved. Patients are purposely divided according to their preference and acuity. Failure to comply with the list can result in disciplinary actions per the ASC (American Seniors Community) hand book. Thank you!! Nursing...." During an interview on 4/14/2016 at 9:37 a.m., Certified Nursing Assistant (CNA) #28 indicated residents were woke up based on a "get up list." During an interview on 4/14/16 at 9:41 a.m., Licensed Practical Nurse (LPN) #29 indicated the "get up list" was determined by "what the need is and their personal		plan. · Residents' care plans and profiles will beupdated to reflect the most current preferences · All staff will be re-educated on the use ofresident profiles and adhering to the resident's preferences. Education will be conducted by the ClinicalEducation Coordinator and completed by May 14, 2016 **How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** · CustomerCare Coordinator or designee will be responsible for the completion of theAccommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2months, monthly times 4 and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed.	

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	preference." During an interview on 4/21/16 at 10:00 a.m., the Director of Nursing (DON) indicated Resident #59 had several falls due to getting up without assistance in the morning and falling asleep in her recliner at night. She indicated fall interventions of getting her out of bed early and putting her to bed early were implemented. The DON indicated documentation was not available which indicated Resident #35 had been given a choice in the decision to implement bedtimes as fall interventions. 3.1-3(u)(1)			
F 0248 SS=D Bldg. 00	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.			
	Based on observation, record review, and interview, the facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being for 2 of 3 residents reviewed	F 0248	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · Families of Resident #4 and #59 were interviewed to obtain theresidents' activity preferences. · Residents #4 and #59's care	05/20/2016

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	for activities (Residents #4 and #59). Findings include: 1. Resident #4's record was reviewed on 4/18/16 at 11:00 a.m. Resident #4 had diagnoses which included, but were not limited to, Downs syndrome and dementia. During observations on 4/13/16 at 9:52 a.m., 10:08 a.m., and 10:20 a.m., Resident #4 was observed seated in a broda chair that was positioned in the corner of the room away from other residents. Resident #4 had her eyes open. No activities were occurring in the room. Music was not playing in the room. Up in the corner of the room a TV was turned on. The TV volume was low and could barely be heard. Sensory stimulation activities were not provided. On 4/13/16 at 11:43 a.m., Resident #4 was observed seated in a broda chair in the main dining room with her eyes closed. Activities were not occurring in the room. Music was not playing in the room. Sensory stimulation activities were not provided. On 4/13/2016 at 1:21 p.m., Resident #4 was observed in her bed positioned on her back with her eyes closed. The room		plans were updated to reflect thepreferences and activity staff was educated on the updated preferences. · Residents #4 and #59 are being offeredactivities per their updated plan of care. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents with cognitive impairment have the potential to beaffected. · All residents with cognitive impairment will have their care plan reviewed andupdated accordingly to ensure that activities to meet their interest and theirphysical, mental, and social well being by the Activity Director/designee byMay 14, 2016 **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · Activitiesstaff will be in-serviced by the Social Services/Activities Consultant/designeeby May 14, 2016 on the Activities Assessment Policy and Procedure, developmentof activities to meet cognitively impaired residents interest and theirphysical, mental, and social well being, as well as how to properly documentattendance and participation of activites. · The Customer Care Representatives/designee	

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	was dark. Music or TV was not playing. During an observation on 4/14/16 at 9:10 a.m. and 9:47 a.m., Resident #4 was observed in the Activity room reclined in a broda chair with her eyes opened. Her chair was pushed up to a table. Activities were not occurring in the room. Music was not playing in the room. Sensory stimulation activities were not provided. During an observation on 4/14/2016 from at 10:59 a.m., Resident #4 was observed in the dining room. She was seated in a broda chair at the end of a table with her eyes opened. Several residents were seated at the table. An activity staff was standing at the opposite end of the table. She was overheard asking residents about old movies. She was not observed interacting with Resident #4. On 4/14/2016 at 1:35 p.m. and 2:00 p.m., Resident #4 was observed in her bed positioned on her back with her eyes open. The room was dark. Music or TV was not playing. On 4/15/16 at 11:18 a.m., Resident #4 was observed in the dining room. A group exercise activity was occurring. Resident #4 was observed seated reclined in a broda chair with her eyes opened. Staff was not observed encouraging		willmake rounds daily to ensure that activities meet residents are engaged incurrent activity, and are encouraged to participate. **How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** · TheActivity Director or designee will be responsible for the completion of the ActivityCQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 andthen quarterly to encompass all shifts until continued compliance is maintainedfor 2 consecutive quarters. The resultsof these audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved, an action plan will be developed.	

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	Resident #4 to participate in the activity. On 4/15/16 at 2:04 p.m., Resident #4 was observed positioned on her back in her bed with her eyes open. The room was dark and music or TV was not playing. On 4/18/16 at 9:30 a.m., Resident #4 was observed in the Activity room. She was reclined in a broda chair with her eyes open. Activities were not occurring at this time. Sensory stimulation activities were not provided. On 4/18/16 at 11:30 a.m., Resident #4 was observed in the dining room, reclined in a broda chair, with her eyes closed. A group activity was occurring. The person observed leading the skipped Resident #4 when she passed out papers to the residents. On 4/18/2016 at 1:40 p.m., Resident #4 was observed positioned on her back in her room with her eyes closed. The room was dark and music or TV was not playing. On 4/19/2016 at 9:15 a.m., Resident #4 was observed reclined in a broda chair with her eyes closed. Her chair was located in a corner away from the other residents. Activities were not occurring at this time. Music was not playing.			

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	Sensory stimulation activities were not provided. A MDS, dated 6/9/15, indicated staff had not interviewed Resident #4's family to obtain her preferences for activities. Staff determined her preferences were: snack between meals, listening to music, being around animals, participating in her favorite activities, religious activities, and doing things with groups of people. A Minimum Data Set (MDS) assessment, dated 3/8/16, indicated Resident #4 was totally dependent on staff for locomotion, had severe cognitive impairment, and a Brief Interview for Mental Status (BIMS) could not be completed. A current activity care plan, dated 3/2016, indicated Resident #4 had diagnoses of Downs syndrome, dementia, and limited mobility. The care plan indicated she was engaged in nearly all group events, had family visits daily, enjoyed being seated in the activity room for bird and people watching, had a strong rapport with activity staff, enjoyed Disney, coloring books, sticker books, and story books. A goal indicated she would remain active in group events as well as independent pursuits daily. Interventions indicated assistance to and from activities, cueing and			

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	encouragement, for scheduled events. Interventions had not been added or changed since 1/16/13. The care plan lacked indication of individualized meaningful interventions designed to meet Resident #4's cognitive abilities. Activity attendance calendars, dated February, March, and April 2016, were reviewed on 4/19/16 at 9:30 a.m. The attendance calendars indicated Resident #4 actively participated in daily activities which included coffee/bulletin board trivia, exercise, word finds, brain appetizer prizes, and snack cart. The calendars lacked indication she was provided individualized activities designed to meet her cognitive abilities. During an interview on 4/19/16 at 10:15 a.m., the Activity Director (AD) indicated Resident #4's sister was involved in her care and wanted her taken to group activities. She indicated she was a passive participate during these activities. She further indicated other than the group activities she was not provided individualized activities designed to meet her cognitive and physical abilities. She indicated the activity care plan had not been revised to ensure meaningful individualized activities which met Resident #4's mental and physical needs.			

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	2. Resident #59's record was reviewed on 4/18/2016 at 1:57 p.m. She had a diagnoses which included, pain, anxiety, and dementia." During observations on 4/14/16 from 9:45 a.m. to 10:58 a.m., Resident #59 was observed in her room in bed, positioned slightly on her right side facing towards the wall. She was overheard repeatedly screaming out "nurse," "Jesus," "I have to pee," and "give me water." The residents' TV was not on nor was there music playing in the room. At 10:24 a.m., Licensed Practical Nurse (LPN) #24 was observed entering her room. Resident #59 was overheard saying, "I want up." LPN #24 was overheard responding, "you want up?" Resident #59 replied, "yes." LPN #24 was exited her room and proceeded to pass medications. At 10:30 a.m., an unknown staff entered her room and asked her if she wanted her head phones. She was observed looking for Resident #59's headphones. Without finding her headphones she exited the room. At 10:35 a.m., she reentered her room and turned the radio on. She immediately exited the room while Resident #59 continued to make request for water and tolieting.			

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	On 4/14/2016 at 1:35 p.m., Resident #59 was observed in bed on her back positioned slightly on her right side facing towards the wall. The room was dark. Music or TV was not playing. Resident #59 was overheard repeatedly yelling, "Jesus help me." During an observation on 4/15/16 at 10:06 a.m., Resident #59 was observed in a wheel chair in her room with her eyes open. The TV was on. During an observation on 4/15/2016 at 11:18 a.m., Resident #59 was observed seated in her wheel chair in her room. The TV was on. She was looking out towards the hallway yelling "nurse." During an observation on 04/15/2016 at 2:04 p.m., Resident #59 was observed in her bed, positioned slightly on her right side facing towards the wall, with her eyes open. Music or TV was not playing. She was overheard yelling "help nurse." During an observation on 4/18/2016 at 11:26 a.m., Resident #59 was observed in a wheel chair in her room positioned in front of the TV. Her eyes were open and her chin was resting on her chest. She was not looking towards the TV. During an observation on 4/18/2016 at			

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	1:41 p.m., Resident #59 was observed in her room, in bed, positioned slightly on her right side facing towards the wall, with her eyes open. The room was dark and music or TV was not playing. A Minimum Data Set Assessment (MDS) tool, dated 2/25/16, indicated Resident #59 was dependent on staff for bed mobility, transfers, and locomotion; had severe cognitive impairment, and a Brief Interview for Mental Status (BIMS) could not be completed, exhibited verbal behaviors but they had not significantly interfered with her participation in activities or social interaction. The MDS indicated staff had determined her activity preferences without attempting to interview her family to be: listening to music, reading books, new paper or magazines, participation in religious activities or practices. A psycho-social care plan, dated 2/26/16, indicated Resident #59 exhibited psychosocial distress as evidence by finding little interest or pleasure in doing things. Interventions included staff was to encourage her to interact with others while up and in activity room. An activity care plan, dated 3/2016, indicted Resident #59 lacked a sense of initiative involvement related to			

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	dementia. Staff anticipated most of her wants and needs. "Potential for little time in activity due to napping through out the day and memory deficit." She continues to yell out throughout most of the day. A goal indicated she would express satisfaction with the quantity of and quality of socialization. Interventions included assessments of her mod and behavior, offer praise for positive socialization, provide activity calendar in her room, provide assistance to and from activities, and provide adaptive equipment. Activity attendance calendars, dated February, March, and April 2016, were reviewed on 4/19/16 at 9:30 a.m. The calendars indicated Resident #59 passively participated in several activities daily. During an interview on 4/14/16 at 10:38 a.m., Certified Nursing Assistant (CNA) #25 indicated she did not know much about Resident #59 except she "screamed and talked all day." She indicated the only intervention that made her happy was to be with her and talk to her. During a telephone interview on 4/15/16 at 12:31 p.m., Resident #59's daughter indicated, Resident #59 was "not big" on TV but "loves" gospel music and enjoyed			

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	being talked to. She indicated she use to sew and would enjoy talking about it. She further indicated no one had ever inquired about her mother's activity preferences. During an interview on 4/19/2016 at 10:46 a.m., the Activity Director (AD) indicated she was responsible for completing the preference section on the MDS and no she had not attempted to contact Resident #59's daughter to obtain her activity preferences. The AD indicated Resident #59 was not taken to group activities because residents didn't like it when she yelled out. She indicated Resident #59 was not provided one on one activities either. During an interview on 4/19/16 at 11:00 p.m., with the Activity Director, Activity Staff #26, and Activity Staff #27 present, Activity Staff #26 indicated, they used the same "color" to record "passive activity" attendance as well as "not available" for activity. She indicated sometimes nothing was documented if the resident was "not available" for an activity. The AD indicated because the activity attendance had been incorrectly coded they did not have a system to monitor activity attendance for cognitively impaired residents who were passive participants.			

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	An Activity policy, identified as current by the Administrator on 4/20/16 at 3:17 p.m., indicated, "Activity Assessment Policy and Procedure...It is the responsibility of the Activity department to complete an activity assessment for each resident within the facility. The assessment will be used to develop a plan of care designed to meet the preferences, interests, physical, mental psychosocial well being of each resident. The Activity Director will complete the activity Assessment with each new resident within seven days of admission. The resident will be interviewed as to their preferences and interests. If the resident is not able to be understood, interview should be attempted with family/significant other to determine preferences. The Activity Assessment will be completed annually and upon change in condition to ensure that updated preferences and interests are obtained. Information gathered in the Activity Assessment will be incorporated in the plan of car for activities as appropriate. Quarterly the resident will be interviewed in order to complete the Quarterly Activity Assessment. If the resident is not able to be understood, interview should be attempted with family/significant other. The assessment will focus on opportunities for activity			

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	involvement that reflect the resident's preferences and interest. The Quarterly Assessment will also provide a review of the resident's level of activity participation in the past quarter and updates to the Activity plan of care...." The Activity policy indicated, "...Activity Calendar...The activity department will develop a calendar of activities that reflects the needs and interest of the residents..." The Activity policy indicated, "...Participation Records (Group, Independent and 1:1...The activity department will maintain participation records which indicate each resident's participation in activity programming including group programs, independent activity pursuits and/or one on one visitation. Group activity attendance will be recorded using the activity calendar. Color coding may be used to denote the level of activity participation (active vs passive) or reasons for lack of participation (refused, unavailable, etc)...One on one visitation may be necessary for residents who are unable physically, cognitively, or behaviorally to participate in group programming. One on on e visitation incorporate past preferences whenever possible. These visits may include sensory or cognitive			

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	155291		04/22/2016

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	stimulation (music, textures, aromas); social engagement (directed conversation, etc); spiritual//nurturing (devotions, Bible reading); creative, task activities (letter writing, puzzles). One on one activities will be recorded including the date of the visit, type of activity offered and the resident's response to the activity. Participation records will be kept for one year...." 3.1-33(a) 3.1-33(c)			
F 0272 SS=D Bldg. 00	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. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural			

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	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.			
	Based on observation, interview, and record review, the facility failed to ensure comprehensive and accurate assessments for 3 of 35 residents reviewed for assessments (Residents #173, #107, and #59). Findings include: 1. During an interview on 4/13/16 at 12:11 p.m., Licensed Practical Nurse (LPN) #31 indicated Resident #173 was admitted with a stage 4 pressure ulcer to her right medial malleolus. On 4/18/2016 at 10:47 a.m., Resident #173's record was reviewed. The admission nursing note, dated 4/1/16 at 9:26 p.m., indicated Resident #173 had a, "...Laceration to right big toe. Small open area to right medial malleolus with	F 0272	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · Resident #173's MDS was modified to indicate the diabetic ulcer. · Resident #107'sMDS was modified to indicate hospice services. · Residents #59's MDS was modified to indicateactivity preferences **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential to be affected. · NewMDS Coordinator has started and all residents will be auditedto ensure all MDS assessments match current wounds, hospice services, andactivity	05/20/2016

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	treatment in place." The document titled, "New Skin Event," dated 4/1/16, indicated an open area was found on admission to Resident #173's right medial malleolus and measured 0.5 centimeters (cm) in length by 0.5 cm in width. The form titled, "Pressure Wound Skin Evaluation Report," dated 4/4/16, indicated Resident #173 had, "...Stage 4 (full thickness tissue loss) with yellow slough (yellow fibrinous tissue) on right medial malleolus...." The note indicated the pressure ulcer was found on admission on 4/1/16 and measured 1 cm in length by 1 cm in width by 0.2 cm in depth. The admission Minimum data set (MDS) assessment, dated 4/8/16, indicated Resident #173 had an unhealed Stage 4 (full thickness tissue loss) pressure ulcer on admission. The document titled, "Non-Pressure Wound Skin Evaluation Report," dated 4/12/16, indicated Resident #173 had a diabetic ulcer to the right medial ankle. The document indicated the diabetic ulcer was an, "existing area from admission 4/1/16," and measured 1cm in length by 1cm in width by 0.2 cm in		preferences. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** ·The MDS/designee will conduct a fullhouse audit of all residents to ensure all MDS assessments matchcurrent wounds, hospice services and activity preferences. ·MDS consultant will re-educate allstaff responsible for completing assessments on how to accurately completeassessments. This education will be completed by May 14, 2016. **How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** · TheMDS coordinator or designee will be responsible for the completion of the RAIProcess CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times4 and then quarterly to encompass all shifts until continued compliance is maintainedfor 2 consecutive quarters. The resultsof these audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved, an action plan will be developed.	

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	depth. On 4/19/16 at 4:15 p.m., the Wound Nurse (WN) obtained the following faxed progress notes from Podiatry. The Podiatry Associates Progress note, dated 3/11/16, indicated Resident #173 was seen for follow up of an ulcer on her right ankle and doppler results. The progress note indicated "...ulceration at medial right ankle over medial malleolus measures 0.5 cm x 0.4 cm with surrounding erythema around ulceration that has a fibrotic wound bed...Diagnosis: Ulcer of right ankle, fat layer exposed...type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene...." During an interview on 4/19/16 at 3:26 p.m., the WN indicated she had made a documentation error when she had classified Resident #173's ulcer as a stage 4 and it had always been a diabetic ulcer. During an interview on 4/22/16 at 11:46 a.m., the Minimum Data Set (MDS) Coordinator indicated she had used the Wound Nurse's assessment indicating Resident #173's wound on her right ankle was a stage 4 pressure ulcer. 2. During an interview on 4/19/2016 at12:41 p.m., Charge Nurse #30 indicated			

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	Resident #173 was receiving hospice services. On 4/19/16 at 1:10 p.m., Resident #173's record was reviewed. The quarterly Minimum Data Set (MDS) assessment, dated 1/12/16, indicated Resident #173 was on hospice. The quarterly Minimum Data Set (MDS) assessment, dated 4/6/16, lacked documentation Resident #173 received hospice services. The physician orders recapitulation as of 4/19/16, indicated Resident #173 was to receive hospice services. During an interview on 4/20/16 at 12:38 p.m., the Minimum Data Set (MDS) Coordinator indicated Resident #173's MDS, dated 4/6/16, was incorrect, and the MDS should have indicated the resident received hospice services. 3. Resident #59's record was reviewed on 4/18/2016 at 1:57 p.m. She had a diagnoses which included, pain, anxiety, and dementia." A Minimum Data Set Assessment (MDS) tool, dated 2/25/16, indicated Resident #59 was dependent on staff for bed mobility, transfers, and locomotion; had severe cognitive impairment, and a Brief Interview for Mental Status (BIMS) could not be completed, exhibited verbal behaviors but they had not significantly			

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	interfered with her participation in activities or social interaction. The MDS indicated staff had determined her activity preferences without attempting to interview her family to be: listening to music, reading books, new paper or magazines, participation in religious activities or practices. During a telephone interview on 4/15/16 at 12:31 p.m., Resident #59's daughter indicated, Resident #59 was "not big" on TV but "loves" gospel music and enjoyed being talked to. She indicated she use to sew and would enjoy talking about it. She further indicated no one had ever inquired about her mother's activity preferences. During an interview on 4/19/2016 at 10:46 a.m., the Activity Director (AD) indicated she was responsible for completing the preference section on the MDS and no she had not attempted to contact Resident #59's daughter to obtain her activity preferences. An Activity policy, identified as current by the Administrator on 4/20/16 at 3:17 p.m., indicated, "Activity Assessment Policy and Procedure...It is the responsibility of the Activity department to complete an activity assessment for each resident within the facility. The			

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	assessment will be used to develop a plan of care designed to meet the preferences, interests, physical, mental psychosocial well being of each resident. The Activity Director will complete the activity Assessment with each new resident within seven days of admission. The resident will be interviewed as to their preferences and interests. If the resident is not able to be understood, interview should be attempted with family/significant other to determine preferences. The Activity Assessment will be completed annually and upon change in condition to ensure that updated preferences and interests are obtained. Information gathered in the Activity Assessment will be incorporated in the plan of car for activities as appropriate. Quarterly the resident will be interviewed in order to complete the Quarterly Activity Assessment. If the resident is not able to be understood, interview should be attempted with family/significant other. The assessment will focus on opportunities for activity involvement that reflect the resident's preferences and interest. The Quarterly Assessment will also provide a review of the resident's level of activity participation in the past quarter and updates to the Activity plan of care. During an interview on 4/22/16 at 3:00			

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	p.m., the Administrator indicated a policy regarding MDS documentation was not available. He indicated they followed the guidelines and instructions from the RAI (Resident Assessment Instrument) manual. 3.1-3(c)1 3.1-3(c)10			
F 0279 SS=D Bldg. 00	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 the Minimum Data Set (MDS) was utilized	F 0279	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?**	05/20/2016

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	to develop an appropriate denture care plan for 1 of 3 residents reviewed for dental care plans (Resident #166). Finding includes: On 4/13/16 at 12:59 p.m. and 4/21/16 at 10:24 a.m., Resident #166 was observed without teeth and without her dentures. On 4/21/2016 at 11:41 a.m., Resident #166's record was reviewed. The social service progress note, dated 4/15/16 at 12:49 p.m., indicated, "...initial MDS (Minimum Data Set) assessment for period ending on 4/15/16...She utilizes upper and lower dentures without any issues...." The dental care plan, dated 4/18/16, indicated, "...Resident has own teeth...." The dietary progress note, dated 4/20/16, indicated, "...Resident has dentures but does not wear them." The admission Minimum Data Set (MDS) assessment, dated 4/15/16, indicated Resident #166 had no natural teeth or tooth fragments. During an interview on 4/13/16 at 12:59 p.m., Resident #166 indicated she had dentures and they were located on her		· Resident #166's care plans have been updated to indicate the utilizationof dentures. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents have the potential to be affected. · The MDS Coordinator/designee will review all residents' dental careplans to ensure accuracy and documented use of dentures when appropriate. Care plans will be updated accordingly. **What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · The Interdisciplinary Team will review all physician's orders, facilityactivity report, new admissions and re-admissions, and residents withsignificant changes in the clinical meeting utilizing the IDTadmission/readmission review form, and IDT Quarterly Resident Review FormTool. Resident care plans will beupdated with all appropriate changes. **How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?**	

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	bedside dresser. During an interview on 4/21/2016 at 11:33 a.m., the Social Services Director indicated Resident #166 had dentures. During an interview on 4/21/2016 at 1:15 p.m., the MDS Coordinator indicated Resident #166 had upper and lower dentures and the current dental care plan was incorrect. On 4/22/16 at 1:40 p.m., the Executive Director provided the current policy titled, "IDT (interdisciplinary team) Care Plan Review." The policy indicated, "...each resident will have a comprehensive care plan developed based on comprehensive assessment...." 3.1-35(a)		· TheMDS coordinator or designee will be responsible for the completion of the CarePlan Updating CQI tool weekly times 4weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these auditswill be reviewed by the CQI committee overseen by the ED. If threshold of 95%is not achieved, an action plan will be developed.	
F 0282 SS=D Bldg. 00	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 provide oral care for 1 of 15 residents	F 0282	The services provided or arranged bythe facility must be provided by qualified person in accordance with eachresident's	05/20/2016

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	reviewed for oral care, and incontinence care for 1 of 15 residents reviewed for incontinence care, in accordance with their written plans of care (Resident #108 and #34). Findings include: 1. During an observation and interview, on 4/13/2016 at 12:55 p.m., Resident #108's teeth had thick whitish buildup on her lower teeth. She was also missing lower teeth, and all of her upper teeth. Resident #108 became tearful and indicated her oral care was not being done. During an observation, on 4/15/2016 at 2:41 p.m., Resident #108's teeth continued to have thick whitish yellow build up. Resident #108 indicated her teeth were not brushed that day. During an observation, on 4/18/16 at 11:00 a.m., Resident #108's teeth continued to have thick yellowish white build up. Resident indicated she had not had her teeth brushed that day. During an observation of Resident #108's room, on 4/19/2016 at 12:43 p.m., no tooth brush or tooth paste was observed in the resident's room with in easy reach.		written plan of care. **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** ·Resident #108 was provided oral care ·Resident #34 had refused to receiveincontinence care. Executive Directorspoke with Resident #34 and only after that conversation, and the location of hisfavorite black pants would he agree to receive incontinence care. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** ·Allresidents who require assistance with oral care are potentially affected. ·Allresidents who require assistance with incontinence care are potentiallyaffected. ·Nursingstaff will assess all residents for the need with assistance with ADL's. Resident care plans and profiles will be updatedaccordingly. ·Staffwill be re-educated on providing appropriate ADL care. **What measures will be putinto place or what systemic changes you will make to**	

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	During an observation, on 4/19/2016 at 12:46 p.m., Resident #108 indicated she didn't know if she had a toothbrush or tooth paste. She further indicated they had not brushed her teeth that day, the night before, or in the last week. Her teeth were observed to have a large amount of thick whitish yellow build up. During an observation and interview, on 4/19/2016 at 12:48 p.m., Licensed Practical Nurse (LPN) #27 indicated she was working as a Certified Nurses Assistant (CNA). She was unable to locate tooth paste or a toothbrush after 136 seconds of looking. Toothpaste was finally found in the bottom back corner of the Residents top drawer, under personal items. No tooth brush was found. LPN #27 indicated oral care should be done after every meal and when she gets up in the morning and when she goes to bed at night. She indicated she did not do oral care on Resident #108 today and did not know when she last had oral care. Resident #108's record was reviewed on 4/19/2016 at 1:03 p.m. A Minimum Data Set (MDS) assessment, dated 4/7/16, indicated she had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and was cognitively intact. The MDS also indicated she needed extensive assistance of 1 person for personal		**ensure that the deficientpractice does not recur?** ·Oralcare supplies were passed to all residents. Central supply clerk will check supply levels weekly and will passsupplies as appropriate. ·Skillsvalidations will be conducted with all Certified Nursing Assistants for bothOral Care and Incontinence Care. Validations will be completed by the Clinical Education Coordinator ordesignee. Validations will be completedby May 14, 2016. ·CustomerCare Representatives will complete resident observation tool daily to ensureproper ADL care has been provided. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?** · TheCustomer Care Coordinator or designee will be responsible for the completion ofthe Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2months, monthly times 4 and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the CQI committee overseen by the ED. If	

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	hygiene including oral hygiene. Under behaviors/rejection of care, the MDS indicated behavior not exhibited. Diagnoses includes but were not limited to depression, intracranial hemorrhage, and hemiplegia dominant side. A care plan, dated 3/16/15, indicated Resident #108 required assistance and/or monitoring for ADL care. An approach identified morning care, including oral care, and evening care, including oral care. A care plan, dated 5/15/14, for self care deficit related to diagnosis of cerebral vascular accident (CVA) with hemiplegia, aphagia, chronic obstructive pulmonary disease (COPD), and shoulder hand syndrome. Required staff assist with all activities of daily living. Approach identified to provide oral care at least 2 times daily, set up for hygiene and grooming equipment to be in easy reach. During an interview on 4/19/2016 at 1:00 p.m., Certified Nursing Assistant (CNA) #28 indicated she got Resident 108 up that morning and did not brush her teeth. CNA #28 indicated she should brush the resident's teeth during morning care when she gets them up. She further indicated she was not sure when Resident 108 last had her teeth brushed. During an interview, on 4/19/2016 at		threshold of 95% is not achieved,an action plan will be developed.	

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NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214	

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	12:49 p.m., CNA #29 indicated oral care was done when residents get up in the morning, and after meals. She indicated she was not sure when the last time Resident #108 had her teeth brushed. During an interview, on 4/20/2016 at 09:40 a.m., CNA #19 indicated she got oral care supplies for Resident #108, and assisted her with oral care. During an interview, on 4/20/2016 at 9:57 a.m., the Director of Nursing Services (DNS) indicated oral care was bundled with a.m. and p.m. care, and CNAs do not specifically chart on oral care. She further indicated oral care should be done two times a day. She indicated they do not have a policy on oral care specifically, but did provide a form for CNA skills evaluations for morning and evening care that indicated staff should assist residents with oral hygiene. 2. During a continued observation, on 4/20/2016 from 9:22 a.m. to 9:42 a.m., Resident #34 was observed in his wheel chair on hall A with the front crotch of his pants visibly wet. Resident #34 was yelling in the hall for assistance, and no one was addressing him. Licensed Practical Nurse (LPN) #15 was passing medication on the hall in front of			

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	Resident #34's room, she did not address him. LPN #17 and LPN #18 walked past resident #34 and did not offered to assist him with incontinence care. LPN #18 walked past him again, at which time she looked down at him in his wheel chair but did not offer to assist him. LPN #22 looked down at Resident #34, spoke with him, gave him water and then pushed him into his room and closed the door. She did not perform incontinence care, turn on his call light, or get assistance for Resident #34. Resident #34 came out of his room and returned to yelling in the hall "please come help." Shortly after LPN #27 observed Resident #34 in the hall and she offered to change him when she finished with her current task. He refused, she then offered to take him outside if he changed his pants, he then agreed. While he waited for LPN #27, LPN #16 and #18 passed in front of him again and did not address him. LPN #27 finished what she was doing then assisted Resident #34 with changing his pants. Resident #34's record was reviewed on 4/18/2016 at 11:00 a.m. Diagnoses include but were not limited to other depressive episodes, anxiety disorder, osteoarthritis, unspecified fall initial encounter, lymphedemia, and depression. A Minimum Date Set (MDS) assessment, dated 2/17/16, indicated a Brief Interview			

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	for Mental Status (BIMS) score of 14 out of 15. The mood section identified feelings of feeling down, depressed or hopeless, trouble falling asleep and staying asleep, feeling tiered or little energy, feeling bad about himself, and trouble concentrating. Resident #34's functional status was identified as needing extensive assistance of 1 for dressing self, extensive of 2 for toilet use, and extensive of 1 for personal hygiene. Resident #34 was identified to occasionally be incontinent of bladder, and bowel. A care plan, dated 1/5/16, indicated Resident #34 required a toileting program but often refused to be assisted to the toilet by staff members, he often states he doesn't need assistance and utilizes a urinal at times, resident does prefer to keep urinal at bedside. The approach indicated incontinent care as needed using peri wash and moisture barrier. A care plan, dated 11/24/15, indicated Resident #34 was at risk for incontinence due to weakness, and impaired mobility. The approach indicated staff will assist with incontinent care as needed and check every 2 hours for incontinence. May keep urinal at bedside per resident preference.			

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	A care plan, dated 11/24/15, indicated self care deficit related to weakness and impaired mobility. The approach indicated staff would do incontinence care as needed. During an interview on 4/20/2016 at 10:15 a.m., LPN #18 indicated she observed Resident #34 with wet pants. During an interview on 4/20/2016 at 12:34 p.m., LPN #27 indicated she noticed Resident #34 was incontinent and initiated steps to provide incontinence care. During an interview on 4/21/2016 at 10:17 a.m., LPN #14 indicated Resident #34 was often incontinent and as needed incontinence should be provided. She further indicated he was to be asked hourly about toileting and changing. She indicated he also wore a brief, and utilized a urinal. During an interview, on 4/20/16 at 3:15 p.m., the Director of Nursing Services indicated she would expect her staff to provide incontinence care to residents as needed. A current policy received from the Director of Nursing Services, on 4/20/16 at 3:00 p.m., titled Bladder Program,			

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	indicated residents should be checked for incontinence and offered toileting. 3.1-35(g)(2)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure residents who were unable to carry out activities of daily living received nail care, incontinence care and/or dental care for 3 of 40 residents reviewed for activity of daily living. (Resident #44, #34, and #108). Findings include: 1. Resident #44 was observed with long unpainted nails which had a thick layer of a brown substance under 10 of 10 nail beds on 4/14/16 at 11:05 a.m. and 2:00 p.m., on 4/15/16 at 9:40 a.m., on 4/19/16	F 0312	**What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?** ·Resident #44 was provided a showerand fingernail care and continues to do so per the plan of care. ·Resident #34 received incontinencecare and continues to do so per the plan of care. ·Resident #108 was provided oral careand continues to do so per the plan of care. **How will you identify**	05/20/2016

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	at 1:12 p.m., 1:21 p.m., and 2:40 p.m., and on 4/20/16 at 10:15 a.m. Resident #44's record was reviewed on 4/20/16 at 11:34 a.m. A Minimum Data Set (MDS) assessment dated 3/22/16, indicated Resident #44 had a Brief Interview for Mental Status (BIMS) score of 13 out of 17, had not rejected care, and needed the assistance of one staff for personal hygiene. An ADL care plan, dated 3/16/16, indicated Resident #44 required assistance and/or monitoring for ADL care. A goal indicated all her ADL needs would be met including AM care and PM care. Interventions included showers twice weekly. An intervention, dated 9/11/13, indicated she had a history of refusing showers with a goal for her to receive at least one shower per week. Interventions indicted staff would approach her calmly with guided comments and if she continued to refuse have another staff reproach at a later time. The care plan lacked indication Resident #44 refused nail care. During an interview on 4/20/16 at 10:18 a.m., Certified Nursing Assistant (CNA) #30 indicated occasionally Resident #35 had refused bathing/nail care but "most days" she had not refused. She indicated		**otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** ·Allresidents who require assistance with oral care are potentially affected. ·Allresidents who require assistance with incontinence care are potentiallyaffected. ·Allresidents who require assistance with bathing and fingernail care arepotentially affected. ·Nursingstaff will assess all residents for the need with assistance with ADL's. Resident care plans and profiles will beupdated accordingly. ·Staffwill be re-educated on providing appropriate ADL care. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur?** ·Oralcare supplies were passed to all residents. Central supply clerk will check supply levels weekly and will passsupplies as appropriate. ·Skillsvalidations will be conducted with all Certified Nursing Assistants regardingOral Care, Incontinence Care, Bathing, Fingernail care. Validations will be completed by the ClinicalEducation Coordinator or designee. Validations will be	

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	Resident #35 was supposed to have help going to the toilet but she had been known to take her self and "that's probably the stuff in her nails." During an interview on 4/20/2016 at 10:24 a.m., Licensed Practical Nurse (LPN) #31 indicated if a resident refused ADL care by the CNAs they should be reproached by a nurse and the results documented. During an interview on 4/20/2016 at 11:12 a.m., CNA #32 indicated nail care was provided during showers/bathing. She indicated Resident #44 refused showers at times but she would take a complete bed bath. She indicated she had not refused nail care. She indicated Resident #44 "would dig and scratch" at her bottom and she was assigned to Resident #44 on 4/19/16. She indicated at 6:30 a.m., she informed Resident #44 it was her shower day and Resident #44 had responded "OK honey." CNA #32 indicated when she took Resident #44 her breakfast tray she again reminded her it was her shower day and she replied "ok." CNA #32 indicated when she returned to get the breakfast tray a therapy staff was in the room. At that time she again reminded her it was her shower day at which time Resident #44 "shook her head" and waved her hand at her as to		completed by May 14, 2016. ·CustomerCare Representatives will complete resident observation tool daily to ensureproper ADL care has been provided. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?** · TheCustomer Care Coordinator or designee will be responsible for the completion ofthe Accommodation of Needs CQI tool weekly times 4 weeks, bi-monthly times 2months, monthly times 4 and then quarterly to encompass all shifts until continuedcompliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed.	

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	dismiss her. CNA #44 indicated the next time she saw Resident #44 she was dressed so she assumed therapy gave her a bath/shower however, her hair was a mess so she brushed her hair. CNA #44 indicated she had not confirmed with therapy they had provided her with a bath or offered to provide nail care. During an interview on 4/20/16 at 11:20 a.m., the Director of Nursing (DON) indicated documentation specifically for nail care was not available for any residents. She indicated documentation which indicated Resident #44 had been provided or offered but refused nail care was not available. She indicated nail care was part of ADL care and was provided during bathing. She further indicated Resident #44 kept chocolate at her bedside and the brown substance "could be chocolate." 2. During a continued observation, on 4/20/2016 from 9:22 a.m. to 9:42 a.m., Resident #34 was observed in his wheel chair on hall A with the front crotch of his pants visibly wet. Resident #34 was yelling in the hall for assistance, and no one was addressing him. Licensed Practical Nurse (LPN) #15 was passing medication on the hall in front of Resident #34's room, she did not address him. LPN #17, and LPN #18 walked past Resident #34 and did not offered to assist			

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	him with incontinence care. LPN #18 walked past him again, at which time she looked down at him in his wheel chair but did not offer to assist him. LPN #22 looked down at Resident #34, spoke with him, gave him water and then pushed him into his room and closed the door. She did not perform incontinence care, turn on his call light, or get assistance for Resident #34. Resident #34 came out of his room and returned to yelling in the hall "please come help." Shortly after LPN #27 observed Resident #34 in the hall and she offered to change him when she finished with her current task. He refused, she then offered to take him outside if he changed his pants, he then agreed. While he waited for LPN #27, LPN #16 and #18 passed in front of him again and did not address him. LPN #27 finished what she was doing then assisted Resident #34 with incontinence care. Resident #34's record was reviewed on 4/18/2016 at 11:00 a.m. Diagnoses included but were not limited to other depressive episodes, anxiety disorder, osteoarthritis, unspecified fall initial encounter, lymphedema, and depression. A Minimum Date Set (MDS), dated 2/17/16, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15. The mood section identified feelings of feeling down, depressed or hopeless,			

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	trouble falling asleep and staying asleep, feeling tiered or little energy, feeling bad about himself, and trouble concentrating. Resident #34's functional status was identified as needing extensive assistance of 1 for dressing self, extensive of 2 for toilet use, and extensive of 1 for personal hygiene. Resident #34 was identified to occasionally be incontinent of bladder, and bowel. A care plan, dated 1/5/16, indicated Resident #34 required a toileting program but often refused to be assisted to the toilet by staff members, he often states he doesn't need assistance and utilizes a urinal at times, resident does prefer to keep urinal at bedside. The approach indicated incontinent care as needed using peri wash and moisture barrier. A care plan, dated 11/24/15, indicated Resident #34 was at risk for incontinence due to weakness, and impaired mobility. The approach indicated staff will assist with incontinent care as needed and check every 2 hours for incontinence. May keep urinal at bedside per resident preference. A care plan, dated 11/24/15, indicated self care deficit related to weakness and impaired mobility. The approach indicated staff would do incontinence			

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	care as needed. During an interview on 4/20/2016 at 10:15 a.m., LPN #18 indicated she observed Resident #34 with wet pants. During an interview on 4/20/2016 at 12:34 p.m., LPN #27 indicated she noticed Resident #34 was incontinent and initiated steps to provide incontinence care. During an interview on 4/21/2016 at 10:17 a.m., LPN #14 indicated Resident #34 was often incontinent and as needed incontinence should be provided. She further indicated he was to be asked hourly about toileting and changing. She indicated he also wore a brief, and utilized a urinal. During an interview, on 4/20/16 at 3:15 p.m., the Director of Nursing Services indicated she would expect her staff to provide incontinence care to residents as needed. 3. During an observation and interview, on 4/13/2016 at 12:55 p.m., Resident #108's teeth had thick whitish buildup on her lower teeth. She was also missing lower teeth, and all of her upper teeth. Resident #108 became tearful and indicated her oral care in not being done.			

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	During an observation, on 4/15/2016 at 2:41 p.m., Resident #108's teeth continued to have thick whitish yellow build up. Resident #108 indicated her teeth were not brushed that day. During an observation, on 4/18/16 at 11:00 a.m., Resident #108's teeth continued to have thick yellowish white build up. Resident indicated she had not had her teeth brushed that day. During an observation of Resident #108's room, on 4/19/2016 at 12:43 p.m., no tooth brush or tooth paste was observed in the resident's room with in easy reach. During an observation, on 4/19/2016 at 12:46 p.m., Resident #108 indicated she didn't know if she had a toothbrush or tooth paste. She further indicated they had not brushed her teeth that day, the night before, or in the last week. Her teeth were observed to have a large amount of thick whitish yellow build up. Resident #108's record was reviewed on 4/19/2016 at 1:03 p.m. A Minimum Data Set (MDS), dated 4/7/16, indicated she had a Brief Interview for Mental Status (BIMS) of 15 out of 15. The MDS also indicated she needed extensive assistance of 1 for personal hygiene including oral			

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	hygiene. Under behaviors/rejection of care, the MDS indicated behavior not exhibited. Diagnoses included but were not limited to depression, intracranial hemorrhage, and hemiplegia dominant side. A care plan, dated 3/16/15, indicated Resident #108 required assistance and/or monitoring for ADL care. An approach identified morning care, including oral care, and evening care, including oral care. A care plan, dated 5/15/14, for self care deficit related to diagnosis of cerebral vascular accident (CVA) with hemiplegia, aphasia, chronic obstructive pulmonary disease (COPD), and shoulder hand syndrome. Required staff assist with all activities of daily living. Approach identified to provide oral care at least 2 times daily, set up for hygiene and grooming equipment to be in easy reach. During interview and observation, on 4/19/2016 12:48 p.m., Licensed Practical Nurse (LPN) #27 indicated she was working as a Certified Nurses Assistant (CNA). She was unable to locate tooth paste or a toothbrush after 136 seconds of looking. Toothpaste was finally found in the bottom back corner of the Residents			

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	top drawer, under personal items. No tooth brush was found. LPN #27 Indicated oral care should be done after every meal and when she gets up in the morning and when she goes to bed at night. She indicated she did not do oral care on Resident #108 today and did not know when she last had oral care. During an interview, on 4/19/2016 at 1:00 p.m., CNA #28 indicated she got Resident #108 up that morning and did not brush her teeth. CNA #28 indicated she should brush the resident's teeth during morning care when she gets them up. She further indicated she was not sure when Resident #108 last had her teeth brushed. During an interview, on 4/19/2016 at 12:49 p.m., CNA #29 indicated oral care is done when residents get up in the morning, and after meals. She indicated she was not sure when the last time Resident 108 had her teeth brushed. During an interview, on 4/20/2016 at 09:40 a.m., CNA #19 indicated she got oral care supplies for Resident 108, and assisted her with oral care. During an interview, on 4/20/2016 at 9:57 a.m., the Director of Nursing Services (DNS) indicated oral care is			

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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
	bundled with a.m. and p.m. care, and CNAs do not specifically chart on oral care. She further indicated oral care should be done two times a day. She indicated they do not have a policy on oral care specifically, but did provide a form for CNA skills evaluations for morning and evening care that indicated staff should assist residents with oral hygiene. 3.1-38(3)(E) 3.1-38(b)(1) 3.1-38(b)(4)			
F 0314 SS=G Bldg. 00	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 pressure reducing interventions were	F 0314	Eagle Valley Meadows respectfully requests additional evidentiaryinformation be considered to reduce or delete F 314	05/20/2016

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NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214	

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	implemented to prevent a resident who was admitted without pressure ulcers from developing a pressure ulcer to his right heal originally staged as unstageable - deep tissue pressure ulcer which became a stage 3 (partial thickness loss) pressure ulcer for 1 of 3 residents reviewed with pressure ulcers (Resident #104). Finding includes: During observations on 4/13/2016 at 9:56 a.m.,10:08 a.m.,10:20 a.m., 11:44 a.m., 12:30 p.m., and 1:20 p.m., and on 4/14/16 at 9:00 a.m. and 1:35 p.m., Resident #104 was observed seated in a broda chair (special wheel chair) He had gray non - skid socks on both feet and the heels of his feet were positioned flat against the foot board of his chair. During an observation on 4/15/16 at 9:17 a.m., Resident #104 was observed in his bed positioned on his back. The heels of both feet were positioned flat against his foot board. He was observed alternating his feet, pushing his heels into the foot board. Heels were not offloaded. During an observation on 4/15/16 at 10:06 a.m., Resident #104 was observed in bed positioned on his back. He had a blue soft pressure reducing boot on his		from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** · Resident #104 is receiving pressure relief to the heels andcare plan is being followed for wound care Resident #104's woundcontinues to heal and reduce in size **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** ·Allresidents who enter the facility have the potential to be affected by thealleged deficient practice ·DNSand Nurse Managers will conduct a facility wide skin sweep using the BedsideWound Minutes Form to ensure all wound interventions and preventative measuresare in place. Corrective actions will beput in place immediately for any noted issues. **What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?** ·Allnursing staff will be re-educated on wound documentation and wound	

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	right foot. His heels were not offloaded. During an observation on 4/15/16 at 11:18 a.m., Resident #104 was observed seated in a broda chair. His left foot was positioned on top of his right foot. The heel of his right foot was flat against the foot board. Pressure reducing boots were not observed. During an observation on 4/15/16 at 2:04 p.m., Resident #104 was observed in his bed positioned on his back. His left leg was bent at the knee with his left heel pressed into the mattress. His right leg and heel was flat on the mattress. His heels were not offloaded nor were pressure reducing boots observed. During an observation of wound care on 4/19/16 at 2:15 p.m., with the Director of Nursing (DON) present, the Wound Care Nurse, indicated the wound on the outer right heel measured 1 cm (centimeter) x 1.1 cm x 0.2 cm without including the purple colored tissue and indicted the entire wound measured 3.0 cm x 1.0 cm x 0.2 cm. The wound bed was 95 percent yellow slough with a small amount of pin granulation. The proximal end of the wound's peri-tissue was purplish in color. Resident #104's record was reviewed on 04/14/2016 at 2:33 p.m. Resident #104		preventionsuch turning and repositioning and pressure relief and following care plans. Education will be conducted by the ClinicalEducation Coordinator or designee and completed by May 14, 2016. ·DNSand Nurse Managers will conduct weekly facility skin sweeps using the BedsideWound Minutes Form to ensure all wound interventions and preventative measuresare in place ·IDTwill review all new admissions using the IDT Admission Review Tool to ensurepreventative measure are put into place upon admission for residents who are atrisk for skin breakdown ·DNS/Designeewill conduct rounds each shift to ensure preventative measures are implementedper plan of care **How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** · TheDirector of Nursing Services or designee will be responsible for the completionof the Pressure Ulcer CQI tool weekly times 4 weeks, bi-monthly times 2 months,monthly times 4 and then quarterly to encompass all shifts until continuedcompliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the CQI committee overseen by the ED. If	

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	had diagnosis which included dementia and a stage 3 pressure ulcer to his right heel. A Minimum Data Set (MDS) assessment, dated 12/13/15, indicated Resident #104 had severe cognitive impairment, did not have pressure ulcers, was a risk for pressure ulcers, and required extensive assistance from staff for bed mobility. An Admission/Readmission record, dated 12/6/15, indicated Resident #104 admitted to the facility on 12/6/15. The record indicated he did not have pressure ulcers on admission. A Weekly Summary, dated 12/14/15, indicated Resident #104 did not have pressure ulcers. A Weekly Update Skin Event record, dated 12/16/15, indicated Resident #104 had developed an "unstageable, suspected deep tissue injury" to his right heel which measured 4.5 centimeters (cm) Length (L) x 3.6 cm Width (W) x 0.0 cm Depth (D). Weekly Update Skin Event records indicated wound measurements: a. 12/22/15 - 7.0 x 6.5 x 0.0, unstageable. b. 12/29/15 - 3.8 x 4.2 x 0.0 c. 1/05/16 - 5.9 x 6.5 x 0.1		threshold of 95% is not achieved,an action plan will be developed.	

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	d. 1/12/16 - 3.9 x 3.9 x 0.1 e. 1/19/16 - 2.9 x 3.9 x 0.1 f. 1/26/16 - 2.1 x 3.7 x 0.1 g. 2/2/16 - 2.3 x 3.0 x 0.1 h. 2/9/16 - 2.3 x 3.0 x 0.1 i. 2/16/16 - 2.8 x 3.5 x 0.2 j. 2/23/16 - 2.5 x 3.5 x 0.2 k. 3/1/16 - 3.5 x 2.5 x 0.2 l. 3/8/16 - 3/2 x 2.1 x 0.2 m. 3/15/16 - the staging was changed from an unstageable to a stage 3 pressure ulcer with measurements of 2.6 x 2.2 x 0.2 n. 3/22/16 - 2.5 x 3.0 x 0.2 0. 3/29/16 - 1.0 x 1.2 x 0.2 p. 4/5/16 - 1.4 x 0.9 x 0.2 q. 4/12/16 - 1.0 x 0.9 x 0 A physician's order, dated 12/16/15, indicated an order for the application of skin prep to Resident #104's right heel and right lateral heel, orders for a pressure relieving boot to his right foot at all times, and an order to float his heels when he was in bed. A physician's order, dated 12/22/16, indicated a treatment to cleanse the area on Resident #104's right heel with normal saline, pat dry, apply hydrogel to the wound bed and cover with foam dressing. Treatment Administration Records, dated from April 1-18, 2016 were reviewed on			

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	04/18/2016 at 3:38 p.m. Interventions for heels floated had daily documentation for each shift that his heels had been floated. Interventions for the right heel protector had daily documentation for each shift that the boot was in place with the exception of 4/2/16 at 10:02 a.m., 4/3/16 at 10:20 a.m., 4/10/16 at 9:48 a.m., 4/10/16 at 2:35 a.m., and 4/16/16 at 9:40 a.m. The record indicated at these times the heel protective boot was not administered due to "Refused." The record lacked indication attempts to reproach were made. During an interview on 4/18/2016 at 2:04 p.m., the Wound Care Nurse indicated Resident #104 developed a pressure ulcer on his right heel two weeks after he was readmitted to the facility from the hospital status post hip surgery. She indicated he was "really" at risk for the development of a pressure ulcer due to his immobility, pain, and dependence on staff for bed mobility. She indicated areas at risk for pressure included heels, ankles, buttocks, head, and shoulders. She indicated at the time of readmission "only" standard interventions such as turn and reposition every two hours, weekly skin rounds, and pressure reduction mattress were implemented. She indicated interventions protect his heels were not implemented until after he			

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	developed a pressure area to his heel. During an interview on 4/18/2016 at 3:45 p.m., the Wound Care Nurse indicated a plan of care should be developed if residents refused services needed to promote healing or prevent the development of pressure ulcers. She indicated Resident #104 did not have a plan of care which indicated he refused services to prevent and/or promote healing of pressure ulcers. She further indicated if residents refused services of any kind, attempts to reproach should have been made. She indicated Resident #104 had refused care at times but "would cooperate" when reproached. She further indicated although the care plan indicated a 1/20/16, intervention for a pressure relieving boot as a preventative measure to the left heel, a physician's order was not obtained until 4/18/16. She indicated without a physician's order, the TAR would not reflect the interventions, and nurses would not have documented the boot was on. During an interview on 4/19/2016 at 10:14 a.m., the Wound Care Nurse, indicated Resident was admitted to the facility with intact skin. She indicated he was at risk for the development of pressure ulcers due a hip fracture, decreased mobility, and dependence on			

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	staff for bed mobility. She indicated within two weeks he developed a pressure ulcer to his right heel staged at an unstageable which later was staged a stage 3. A Skin Management Program policy, identified as current by the DON on 4/22/16 at 1:44 p.m., indicated, "...it is the policy of American Senior Communities to assess each resident to determine the risk of potential skin integrity impairment, upon admission...A plan of care will be initiated to include resident specific risk factors with appropriate interventions...Residents identified at risk for skin breakdown will have appropriate prevention interventions put into place 3.1-40(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on interview and record review, the facility failed to clarify what kind of assistance was required for transferring a resident resulting in a laceration to the left lower extremity that required sutures to repair for 1 of 1 resident reviewed for accidents (Resident #59). Finding includes: During a telephone interview with Resident #59 ' s daughter on 04/21/2016 at 1:08 p.m., indicated her mother was injured during a transfer from her bed to a chair and had to be sent to the emergency room for sutures. Resident #59's record was reviewed on 4/18/2016 at 1:57 p.m. She had a diagnoses which included, pain, anxiety, and dementia. A Minimum Data Set Assessment (MDS) tool, dated 5/11/15, indicated Resident #59 was dependent on staff for bed mobility, transfers, and locomotion; and had severe cognitive impairment. A physical therapy discharge summary, dated, 5/14/15, recommended Resident #59 be transferred with the use of a Hoyer lift (mechanical lift) to maximize safety. An occupational therapy note, dated	F 0323	Eagle Valley Meadows respectfully requests additional evidentiaryinformation be considered to reduce or delete F 323 from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** · Resident #59 was sent to ER for evaluation and treatment ofinjury. Resident #59's laceration hassense healed. CNA #34 and #35 were re-educated onproper transfer and safety precautions at the time of the incident. Prior to the noted incident, theresident's family did not wish to have her transferred by Hoyer lift. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** ·Allresidents requiring a mechanical transfer would have the potential to beaffected by the alleged deficient practice. ·RehabServices Manager or designee will review all residents for proper transferstatus. Resident care plans and profileswill be updated as appropriate. **What measures will be put into placeor what**	05/20/2016

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	10/30/15, recommended Resident #59 be transferred with a Hoyer lift due to postural instability to maximize safety. An event report, dated 11/27/15, indicated Resident #59 had a "laceration" to her left lower extremity. The record lacked indication of cause of the laceration. An emergency room report, dated 11/27/15 at 6:45 p.m., indicated Resident #59 was evaluated in the emergency room due to "a left lower extremity cut." The record indicated, "...patient has a approximate 8 cm curved laceration to the left lower extremity. The wound is gaping and deep...It overlies the distal posterior medial aspect of the left lower leg..." The record indicated she required 9 sutures to close the wound. During an interview on 4/21/16 at 10:13 a.m., Physical Therapist (PT) #33 indicated Resident #59 was a "high fall risk" and required a Hoyer lift for transfers. During an interview on 4/21/16 at 12:32 a.m., PT #33 indicated discharge recommendations on 5/14/15 were for staff to use a mechanical lift for transfers. He indicated she was on "therapy's case load" again from October 1-30, 2015, due		**systemic changes you will make to ensure that the deficient practicedoes not recur?** ·Skillsvalidations will be conducted for all Nursing Assistants regarding MechanicalTransfers and Two Person Transfers. Validations will be conducted by Clinical Education Coordinator ordesignee. All skills validations will becompleted by May 14, 2016. ·IDTwill review resident condition changes, new orders, and new admission duringdaily clinical meeting to ensure the most appropriate form of transfer is beingutilized. Care plans and profiles willbe updated as appropriate. **How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** · TheRehab Services Manager or designee will be responsible for the completion ofthe Mechanical Lift Transfer CQI tool weekly times 4 weeks, bi-monthly times 2months, monthly times 4 and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed.	

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	to a "decline in range of motion and to confirm her appropriate transfer status." He indicated at discharge staff was educated on her being a Hoyer lift for transfers. During an interview on 4/21/16 at 3:30 p.m., Certified Nursing Assistant (CNA) #34 indicated she and CNA #35 transferred Resident #59 from her bed to her wheel chair without a Hoyer lift on the day she required sutures. The CNA indicated she was on the resident ' s right side and indicated the resident ' s leg got caught on the rod of the foot rest during the transfer. She indicated the leg bled and the nurse was notified and assumed care of the resident. During interviews on 4/21/16 at 3:53 p.m., 4/22/16 at 9:20 a.m., and 11:50 a.m., the Director of Nursing (DON) indicated Resident #59 was not transferred with the Hoyer lift when she received the laceration on her leg that required sutures. She indicated she was aware therapy ' s recommendation for Hoyer lift for transfers, but had not clarified or obtained an order from the physician for the Hoyer lift. During an interview on 4/22/16 at 1:44 p.m., indicated a policy for incident/injury prevention was not			

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	available. 3.1-45(a)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, and interview, the facility failed to remove previously opened and outdated foods from refrigeration and dry storage for 1 of 2 kitchen observations. This deficient practice had the potential to effect 106 residents, who received food from the cafeteria, out of 108 residents. Finding includes: a. During an observation of food storage, on 4/13/2016 at 9:30 a.m., loose spaghetti was observed in an opened cardboard box, with the top flaps of the box wide open, a package of sugar was laying in	F 0371	**What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** · All identified expired food was immediately discarded. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?** ·Allresidents have the potential to be affected by the alleged deficient practice. ·TheDietary manager conducted a thorough audit of all	05/20/2016

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	the box on top of the spaghetti. The spaghetti box was dated as opened on 1/29/16 with a date for removal of 3/29/16. An opened bag of loose sugar packages was observed on the shelf above the pasta. b. A bag of opened penne pasta, wrapped in cling wrap, and dated as opened 10/6/15 and dated to be removed from supply on 11/9/15 was observed in dry storage. c. A bag of opened pasta, wrapped in cling wrap, and dated as opened 2/7/16 and dated to be removed on 3/18/16 was observed in dry storage. d. An opened bag of chocolate chips dated as opened on 3/2/16 and dated to be removed on 4/1/16 was observed in dry storage. e. An opened bag of butterscotch chips dated as opened on 2/16/16 and dated to be removed on 3/5/16 was observed in dry storage. f. An opened package of cheese cake mix dated as opened on 2/21/16 and dated to be removed on 3/20/16 was observed in dry storage. g. An opened bag of parmesan cheese was observed in the refrigerator, dated as opened on 3/9/16 and dated to be removed on 4/8/16. During an interview, on 4/13/2016 at 9:49 a.m., the Dietary Manager indicated		food storage to ensure allfood items were within date and stored correctly. **What measures will be put into placeor what systemic changes you will make to ensure that the deficient practicedoes not recur?** ·TheDietary Manager or designee will conduct a daily audit of all food storageareas, utilizing the dietary sanitation short form, to ensure all food isstored correctly and within date. Corrective action will immediately be implemented for any noted concerns. ·TheExecutive Director will do random audits of all food storage areas, at minimumof weekly to ensure all items are stored correctly and within date. ·AllDietary staff will be re-educated regarding proper food storage and dating. **How the corrective action (s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?** · TheDietary Manager or designee will be responsible for the completion of theKitchen Sanitation tool weekly times 4weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results	

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	staff should have used open stock first and she was unsure how the expired food items were missed. A current policy titled "Food Storage " , received from the Executive Director on 4/20/16 at 3:15 p.m., indicated, " POLICY ...4. Containers with tight-fitting covers must be used for storing ...broken lots of bulk foods. 9. All stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods.... " During an interview on 4/21/2016 at 10:31 a.m., the Dietary Manager indicated the policy that she followed in the kitchen was to throw out items that have been opened 30 days from the date that they were opened. 3.1-21(i)(3)		of these auditswill be reviewed by the CQI committee overseen by the ED. If threshold of 95%is not achieved, an action plan will be developed.	
F 0406 SS=D Bldg. 00	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental			

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	155291		04/22/2016

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	retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.			
	Based on observation, record review, and interview, the facility failed to follow residents Pre-Admission Screening and Annual Record Review (PASARR) level ll recommendations for 1 of 1 resident reviewed for (Residents #4). Finding includes: 1. Resident #4's record was reviewed on 4/18/16 at 11:00 a.m. Resident #4 had diagnoses which included, but were not limited to, Down syndrome and dementia. During observations on 4/13/16 at 9:52 a.m., 10:08 a.m., and 10:20 a.m., Resident #4 was observed seated in a broda chair that was positioned in the corner of the room away from other residents. Resident #4 had her eyes open. No activities were occurring in the room. No music was playing in the room. Up in the corner of the room a TV was turned on. The TV volume was low and could barely be heard. Sensory stimulation activities were not provided.	F 0406	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?—** · Family of Resident #4 was interviewed to obtain the residents' activitypreferences. · Residents #4'sPASARR Level II recommendations were reviewed. Resident's care plans andprofile were updated with the Level II recommendations and preferences. · Residents #4 is being offered activities pertheir updated plan of care. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · All residents requiring a PASARR Level II assessment have the potentialto be affected by the alleged deficient practice. · All residents requiring a PASARR Level II assessment will have theirrecommendations reviewed and care plans updated accordingly to ensure that allrecommendations are being addressed and activities are offered to meet theirinterest and their physical, mental, and social well being by the SocialService Director/designee by May 14, 2016	05/20/2016

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	On 4/13/16 at 11:43 a.m., Resident #4 was observed seated in a broda chair in the main dining room with her eyes closed. Activities were not occurring in the room. Music was not playing in the room. Sensory stimulation activities were not provided. On 4/13/2016 at 1:21 p.m., Resident #4 was observed in her bed positioned on her back with her eyes closed. The room was dark. Music or TV was not playing. During an observation on 4/14/16 at 9:10 a.m. and 9:47 a.m., Resident #4 was observed in the Activity room reclined in a broda chair with her eyes opened. Her chair was pushed up to a table. Activities were not occurring in the room. Music was not playing in the room. Sensory stimulation activities were not provided. On 4/14/2016 at 1:35 p.m. and 2:00 p.m., Resident #4 was observed in her bed positioned on her back with her eyes open. The room was dark. Music or TV was not playing. On 4/15/16 at 11:18 a.m., Resident #4 was observed in the dining room. A group exercise activity was occurring. Resident #4 was observed seated reclined in a broda chair with her eyes opened. Staff was not observed encouraging		**What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur?** · SocialService Director will be re-educated by the Social Services/Activities Consultant/designeeby May 14, 2016 on following PASARR II recommendations, and incorporating therecommendations in the residents' plan of care. **How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** · TheSocial Service Director or designee will be responsible for the completion ofthe PASARR Level II CQI tool weeklytimes 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly toencompass all shifts until continued compliance is maintained for 2 consecutivequarters. The results of these audits willbe reviewed by the CQI committee overseen by the ED. If threshold of 95% is notachieved, an action plan will be developed.	

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	Resident #4 to participate in the activity. On 4/15/16 at 2:04 p.m., Resident #4 was observed positioned on her back in her bed with her eyes open. The room was dark and music or TV was not playing. On 4/18/16 at 9:30 a.m., Resident #4 was observed in the Activity room. She was reclined in a broda chair with her eyes open. Activities were not occurring at this time. Sensory stimulation activities were not provided. On 4/18/16 at 11:30 a.m., Resident #4 was observed in the dining room, reclined in a broda chair, with her eyes closed. A group activity was occurring. The person observed leading the skipped Resident #4 when she passed out papers to the residents. On 4/18/2016 at 1:40 p.m., Resident #4 was observed positioned on her back in her room with her eyes closed. The room was dark and music or TV was not playing. On 4/19/2016 at 9:15 a.m., Resident #4 was observed reclined in a broda chair with her eyes closed. Her chair was located in a corner away from the other residents. Activities were not occurring at this time. Music was not playing.			

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	Sensory stimulation activities were not provided. A MDS, dated 6/9/15, indicated staff had not interviewed Resident #4's family to obtain her preferences for activities. Staff determined her preferences were: snack between meals, listening to music, being around animals, participating in her favorite activities, religious activities, and doing things with groups of people. Resident #4's (PASARR) level ll assessment, dated 10/21/15, indicated Resident #4, "...had a developmental disability and required a review in one year...she is reported to need specialized learning strategies including hand over hand assistance, verbal cues, and repetition..appears to be alert to self and familiar others...seems to be aware of her surroundings...diagnosis of down syndrome...has severely impaired expressive and receptive communication skills...depends on others to anticipate her wants and needs...Recommendations... She may benefit from opportunities for leisure activities that promote cognitive stimulation, socialization, and community involvement...." A Minimum Data Set (MDS) assessment, dated 3/8/16, indicated Resident #4 was			

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	totally dependent on staff for locomotion, had severe cognitive impairment, and a Brief Interview for Mental Status (BIMS) could not be completed. A current activity care plan, dated 3/2016, indicated Resident #4 had diagnoses of Down syndrome and dementia and had limited mobility. The care plan indicated she was engaged in nearly all group events, had family visits daily, enjoyed being seated in the activity room for bird and had people watching, had a strong rapport with activity staff, enjoyed Disney, coloring books, sticker books, and story books. A goal indicated she would remain active in group events as well as independent pursuits daily. Interventions indicated assistance to and from activities, cueing and encouragement, for scheduled events. Interventions had not been added or changed since 1/16/13. The care plan lacked indication of one on one activities. During an interview on 4/19/16 at 10:15 a.m., the Activity Director (AD) indicated Resident #4's sister wanted her to be taken to group activities. She indicated staff took her to group activities because her sister wanted her taken. Other than the group activities she was not provided individualized activities designed to meet her cognitive and			

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	physical abilities. She indicated the activity care plan had not been revised to ensure meaningful individualized activities which met Resident #4's needs. During an interview on 4/19/2016 at 9:42 a.m., with the Director of Nursing and Social Service Director (SSD) present, the SSD indicated Resident #4 passively participated in group activities. She indicated she was not aware of individualized, meaningful activities designed to meet the needs of a four year old developmentally disabled person with dementia. During an interview on 04/21/2016 at 11:39 a.m., the SSD indicated she reviewed the Level 2 recommendations and depending on what the recommendations would follow up to ensure they were implemented. She indicated "general activities" wasn't a recommendation she monitored. During an interview on 4/22/16 at 3:00 p.m., the DON indicated a policy regarding PASARR Level 2 assessments was not available. 3.1-23(a)(1)			

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F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure accurate documentation of a resident's diabetic ulcer and skin impairments, and failed to obtain physician progress notes related to the resident's diabetic ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident #173). Finding includes: During an interview on 4/13/16 at 12:11 p.m., Licensed Practical Nurse (LPN) #31 indicated Resident #173 was admitted with a stage 4 pressure ulcer to her right medial malleolus. On 4/18/2016 at 10:47 a.m., Resident #173's record was reviewed. The admission nursing note, dated 4/1/16 at	F 0514	**What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice?** · Resident #173's MDS has been modified to indicate a diabetic ulcer, andappropriate documentation is noted in the record. **How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?** · Allresidents with pressure ulcers have the potential to be affected by the allegeddeficient practice. · Medicalrecords of all residents with wounds were reviewed by DNS/Designee to ensuredocumentation of wound location, treatment and source are	05/20/2016

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	9:26 p.m., indicated "...Laceration to right big toe. Small open area to right medial malleolus with treatment in place." The document titled, "New Skin Event," dated 4/1/16, indicated an open area was found on admission to Resident #173's right medial malleolus and measured 0.5 centimeters (cm) in length by 0.5 cm in width. The form titled, "Pressure Wound Skin Evaluation Report," dated 4/4/16, indicated Resident #173 had, "...Stage 4 (full thickness tissue loss) with yellow slough (yellow fibrinous tissue) on right medial malleolus...." The note indicated the pressure ulcer was found on admission on 4/1/16 and measured 1 cm in length by 1 cm in width by 0.2 cm in depth. A physician order from podiatry, dated 4/1/16, ordered, "Please dress ankle wound right medial malleolus daily with Silvercell (antimicrobial alginate dressing) and then 2x2 (2 inches by 2 inches) gauze with light coban (elastic support) wrap." Resident #173's comprehensive admission assessment, dated 4/1/16, indicated, "...Skin		accurate. **What measureswill be put into place or what systemic changes you will make to ensure thatthe deficient practice does not recur?** · Allnursing staff will be re-educated on accurately documenting on wound location,treatment and source. Education will be conducted by Clinical EducationCoordinator or designee. Education willbe completed by May 14, 2015 · WoundNurse or designee will review Facility Activity Report daily to ensure accuratedocumentation of wounds per plan of care. ·Director of Nursing Services or Designee willreview all new skin areas to ensure correct origin is noted. **How the corrective action(s) will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programwill be put into place?** · TheDirector of Nursing Services or designee will be responsible for the completionof the Facility Activity Report CQI tool weekly times 4 weeks, bi-monthly times2 months, monthly times 4 and then quarterly to encompass all shifts untilcontinued compliance is maintained for 2 consecutive quarters. The results of these audits	

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	conditions-wounds:...none of the above...Does res (resident) have history of pressure wounds...no...." Resident #173's care plan dated 4/4/16 and last revised on 4/4/16, indicated "Resident is at risk for skin breakdown having a pressure wound in right ankle...." The pain care plan, dated 4/4/16, indicated Resident #173 was at risk for pain, "related to: pressure wound on right ankle...." The skin impairment care plan, initiated on 4/6/16 and last revised on 4/12/16, indicated, "Resident has impaired skin integrity: diabetic area to inner right malleolus and arterial area to right great toe...." The admission Minimum data set (MDS) assessment, dated 4/8/16, indicated Resident #173 had an unhealed Stage 4 (full thickness tissue loss) pressure ulcer on admission. The weekly skin sheets, dated 4/8/16 and 4/16/16, indicated Resident #173 had no open skin areas or wounds. The form titled, "New skin Event," dated 4/11/16, indicated Resident #173 had a new open area on the right great toe and measured 0.6 centimeters in length by 1.7 cm in width by 0.1 cm in depth. The document titled, "Non-Pressure Wound		will be reviewedby the CQI committee overseen by the ED. If threshold of 95% is not achieved,an action plan will be developed.	

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	Skin Evaluation Report," dated 4/12/16, indicated Resident #173 had an arterial ulcer to the right great toe. The document titled, "Non-Pressure Wound Skin Evaluation Report," dated 4/12/16, indicated Resident #173 had a diabetic ulcer to the right medial ankle. The document indicated the diabetic ulcer was an, "existing area from admission 4/1/16," and measured 1 cm in length by 1 cm in width by 0.2 cm in depth. An Interdisciplinary Team (IDT) note, dated 4/15/16 at 4:17 p.m., indicated, "Wound review: DNS (Director of Nursing Services), ADNS/WN (Assistant Director of Nursing/Wound Nurse) and DM (Dietary Manager) present. Resident being followed for area to right medial ankle. Resident was admitted to facility with diabetic area to right medial ankle...." As of 4/18/16 at 4:06 p.m., Resident #173's record lacked documentation of diagnosis of diabetic or arterial ulcers, physician progress notes, physician history and physical, and/or podiatry consultation progress notes. Resident #173's record lacked documentation to confirm the right great toe ulcer was an arterial ulcer and the right ankle ulcer			

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	was a diabetic ulcer. On 4/19/16 at 4:15 p.m., the Wound Nurse (WN) obtained the following faxed progress notes from Podiatry. The Podiatry Associates Progress note, dated 3/11/16, indicated, "...Diagnosis: Ulcer of right ankle, fat layer exposed...type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene...." The Podiatry Associates Progress Note, dated 4/1/16, indicated Resident #173 seen for follow-up of right ankle ulcer. The progress note indicated, "...Her blood flows studies indicate monophasic waveforms with calcified vessels...Wound has improved slightly and will continue with silver dressings and follow every few weeks...." During an interview on 4/19/16 at 12:56 p.m., the WN indicated Resident #173 had a diabetic ulcer on her right ankle. She indicated she was admitted with the ulcer and it was diagnosed as a diabetic ulcer by the family doctor approximately six months prior to admission. The WN indicated she changed the ulcer status from a pressure ulcer to a diabetic ulcer because Resident #173's daughter stated her family doctor had called it a diabetic ulcer. The WN was unsure if there was documentation the physician had			

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	diagnosed it as a diabetic ulcer. During an interview on 4/19/16 at 1:45 p.m., the WN indicated Resident #173's family physician's office was faxing documentation over related to her diabetic ulcer. The WN indicated the nurse who admitted the resident did not usually measure wounds so the measurements differed when she measured the ankle wound the first time. During an interview on 4/19/16 at 3:26 p.m., the WN indicated she had made a documentation error when she had classified Resident #173's ulcer as a stage 4 and it had always been a diabetic ulcer. The WN indicated the ulcer on the right great toe was arterial based on her clinical judgement and indicated the physician did not want to perform tests to confirm the ulcer type. During an interview on 4/21/16 at 9:50 a.m., the Director of Nursing Services (DNS) indicated staff typically had 24 to 72 hours to confirm orders from physicians after admission and to request the most recent progress notes from specialists. The DNS indicated they typically took information regarding diagnoses and treatment from the family on admission and then confirmed it with the physician after admission. The DNS			

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	indicated Resident #173's family had informed them Resident #173 had a diabetic ulcer and she was unaware there had not been documentation of progress notes in Resident #173's record prior to 4/19/16. On 4/21/16 at 11:06 a.m., the Executive Director provided the current policy on physician orders. The policy did not address the need to obtain physician's progress notes and confirming diagnoses on admission. 3.1-50(a)(1) 3.1-50(f)(5)			
F 0520 SS=D Bldg. 00	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are			

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	necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation,interview and record review, the facility failed to ensure a process for quality improvement to ensure meaningful activities for 2 of 4 residents. Findings include: 1. The facility failed to ensure residents were provided with activities designed to meet their interest and their physical, mental, and psychosocial well-being. During observations made on 4/13/16, 4/14/16 , 4/15/16, 4/18/16, and 4/19/16, Resident #4 was observed not provided meaningful, individualized activities designed to meet her cognitive and physical abilities. Resident #59's record was reviewed on 4/18/2016 at 1:57 p.m. She had a diagnoses which included, pain, anxiety,	F 0520	Eagle Valley Meadows respectfully requests additional evidentiaryinformation be considered to reduce or delete F 520 from the 2567. Thecurrent statement of deficiency on the 2567 omits significant facilityinformation and therefore misrepresents the care and services administered bythe provider to its residents. **What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?** ·The facility IDT continues to meet monthly and reviews all noted items identified in the QA audits. Progress with Action Plans are reviewed and updated as appropriate ·Resident #59 Activity care plan has been updated to reflect preferences. ·Resident #59 is currently offered activities per her plan of care. **How will you identify other**	05/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155291	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/22/2016
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	and dementia." During observations on 4/14/16, 4/15/16, 4/18/16, Resident #59 was not observed provided with activities or items for cognitive stimulation. During an interview on 04/22/2016 at 1:27 a.m., the Administrator indicated the Quality Assessment and Assurance (QAA) meetings were held routinely, and issues identified by the QAA were reviewed. He indicated when issues were identified plans were put in place to correct the identified issues. An Activity policy, identified as current by the Administrator on 4/20/16 at 3:17 p.m., indicated, "Activity Assessment Policy and Procedure...It is the responsibility of the Activity department to complete an activity assessment for each resident within the facility. The assessment will be used to develop a plan of care designed to meet the preferences, interests, physical, mental psychosocial well being of each resident...." During an interview on 4/22/16 at 1:45 p.m. the Administrator provided documentation which indicated in 2/16, the QAA had identified concerns with activities. He indicated a consultant had came in and made recommendations.		**residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?** ·All residents have the potential to beaffected by the alleged deficient practice ·The facility continues to work theidentified action plan regarding Activity participation and engament. **What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?** ·The facility will continue to conductmonthly QA audits and self identify operational concerns and issues. ·The Facility will address all notedconcerns immediately and execute action plans accordingly. ·Follow up will continue monthly toensure appropriate progress with the action plans and resolution to theconcerns. **How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?** Executive Director or designee will conduct the monthly QAmeeting. The Medical Director willattend the monthly meeting and approve the minutes from the monthly QAmeeting.	

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	But documentation which indicated the recommendations were acted on was not available. He provided the recommendations and the action plan. 3.1-52(b)(2)			