STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155797	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/22/2014
NAME OF PROVIDER OR SUPPLIER ASPEN PLACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 N MONTGOMERY ROAD GREENSBURG, IN 47240	

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F000000	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 14, 15, 16, 17, 20, 21 and 22 Facility number: 012854 Provider number: 155797 AIM number: 201104690 Survey team: Leslie Parrett RN, TC Diana Sidell RN Angel Tomlinson RN Barb Gray RN Census bed type: SNF: 23 SNF/NF: 31 Residential: 32 Total: 86 Census payor type: Medicare: 9 Medicaid: 26 Other: 19 Total: 35 Residential sample: 32	F000000		

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-31. and 16.2-5. Quality review completed on October 28, 2014 by Cheryl Fielden, RN.			
F000242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview and record review the facility failed to assist a dependent resident out of bed into a chair for 1 of 1 resident who met the criteria for choices in a total sample of 15 (Resident #1). Finding include: During observation on 10/15/14 at 10:46 a.m., Resident #1 was laying in bed. Interview with Resident #1's family member on 10/15/14 at 2:28 p.m., indicated the resident did not get up in the morning according to his previous routine. The family member indicated the	F000242	**F 242 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #1 was asessed by therapy and plan formulated for resident to be up out of the bed. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Facility determined that there were no other residents at risk for the alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Staff will be re educated on the facilities policy of	11/21/2014

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	resident got up daily in wheelchair when he lived at home. The family member indicated the resident stayed in bed all the time at the facility. During observation on 10/15/14 at 3:00 p.m., Resident #1 was laying in bed. During observation on 10/16/14 at 10:06 a.m., Resident #1 was laying in bed. During observation on 10/16/14 at 2:50 p.m., Resident #1 was laying in bed. During observation on 10/17/14 at 10:00 a.m.., Resident #1 was laying in bed. During observation on 10/17/14 at 12:30 p.m., Resident #1 was laying in bed. During observation on 10/17/14 at 2:00 p.m., Resident #1 was laying in bed. During observation on 10/20/14 at 10:50 a.m., Resident #1 was laying in bed. Review of the record of Resident #1 on 10/20/14 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage, seizure disorder and aphasia (loss of the ability to communicate).		accomadation of needs and resident profile **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Admission audits for profiles for preferences will be conducted daily at the clinical care meeting 5 days a week, resident first meetings for any changes,and semi annual Peer reviews Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	The record of Resident #1 indicated the resident was admitted to the facility on 2/23/14. The Interdisciplinary progress note for Resident #1 dated, 3/26/14 at 12:00 p.m., indicated "working on getting" a wheelchair that family approves of. The resident's chair from home was in need of repair before it can be brought to the facility. The Occupational Therapy progress and discharge summary for Resident #1 dated 4/16/14, indicated the resident goal was met to tolerate being up in a wheelchair for approximately 1 hour with good positioning. The Quarterly Minimum Data Set (MDS) assessment for Resident 1 dated, 8/14/14, indicated the following: The resident was in a persistent vegetative state, bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- activity did not occur, locomotion on or off unit- activity did not occur, nutritional approach- feeding tube. Interview with CNA #8 on 10/20/14 at 11:45 a.m., indicated the resident does not get out of bed except on his shower days on evening shift two times a week. CNA #8 indicated the resident's family			

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	gave him the showers. Interview with the Therapy Manager on 10/20/14 at 1:15 p.m., indicated the reason the resident did not get up in a chair was because the resident's family did not like the chair the facility had. Requested documentation of this. Interview with the Social Service Director (S.S.D.) on 10/20/14 at 1:35 p.m., indicated Resident #1's family member had not told her not to get the resident up out of bed. Interview with CNA #7 on 10/20/14 at 1:35 p.m., indicated she did not know why Resident #1 did not get out of bed. Interview with LPN #9 on 10/20/14 at 1:40 p.m., indicated the resident got out of bed three times a week when he got his showers. LPN #9 indicated she did not know why the resident did not get out of bed and she "assumed" his family member did not want him to get up. LPN #9 indicated the resident's family member had not told her not to get the resident up. Interview with CNA #8 on 10/20/14 at 1:46 p.m., indicated she did not know why Resident #1 did not get out of bed. Interview with LPN #14 on 10/20/14 at			

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	1:47 p.m., indicated she "just figured" his family member would not let the facility get him up out of bed. When queried if the family member had every told her not to get him up?, LPN #14 stated "no". Interview with Resident #1's family member on 10/21/14 at 10:22 a.m., indicated the resident tolerated being up in a wheelchair well when he was home. The family member indicated the resident appeared to enjoy being up in a wheelchair. The family member indicated she would get him out of bed every day when he was home whenever he woke up and it was between 7:30 a.m. to 12:00 p.m. The family member indicated the resident got out of bed three times a week at the facility when she gave the resident his showers. The family member indicated the facility wanted her to bring the resident's wheelchair in from home, but it was broke and could not be repaired. The family member indicated she did not know why the facility did not get another chair for Resident #1. The family member indicated she had not voiced concerns about getting the resident out of bed. The family member indicated the resident was getting out of bed when he was in therapy and she did not know why they stopped getting him up. The family member indicated she had not voiced concerns to the facility related			

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	to a chair or getting the resident up. Interview with the Therapy Manager on 10/21/14 at 3:50 p.m., indicated there was documentation about Resident #1's family member's concerns related to the resident being up in a chair. 3.1-3(u)(1) 3.1-3(u)(3)			
F000246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview, and record review, the facility failed to ensure resident's call lights were in reach for 5 observations and 4 of 54 residents. (Residents #95, #67, #93, and #66) Findings include: During an observation, on 10/14/14 at 1:33 p.m., Resident #95's call light was observed lying on the floor. CNA #1 indicated at that time that the one hundred hall nurse brought the resident back from lunch and she was unsure why his call light was on the floor.	F000246	**F 246 Reasonable Accomadation of needs-call lights Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The call lights for residents # 95, #67, # 93 and # 66 were place within easy reach 10/22/14 **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee performed rounds on 100, 200 and 300 hallways to ensure call lghts were within reach for residents 10/23/14 and any deficient practice was	11/21/2014

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	During an observation, on 10/15/14 at 2:36 p.m., Resident #67's pad call light was observed lying on the bed. QMA #2 moved the resident's call light from the bed to the recliner where the resident was seated with his feet elevated. QMA #2 indicated the resident's family member had returned him to his room. During an interview, on 10/21/14 at 1:41 p.m., the family member indicated she puts the call light where he can reach it before she leaves the room, but often it is out of reach when she arrives to the room. During an observation, on 10/17/14 at 2:30 p.m., Resident #93 was heard yelling "Help me". The resident was observed sitting in a wheel chair and the call light was laying on the floor. The nurse on duty was notified the resident was calling for help and the call light was on the floor. During an observation, on 10/29/14 at 1:41 p.m., Resident #93 was observed sitting in a wheel chair with her call light tied to the bed rail. CNA #16 placed the call light in reach of the resident. During an observation, on 10/21/2014 at 1:50 p.m., Resident #66's call light was observed laying across his recliner, beside his bed. Resident #66 was lying in the bed and the call light was out of his		correced **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will reeducate staff on the facility policy on call lights, and facilities expectations. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will conduct random audits of 5 residents per 100, 200 and 300 hallways 3 times weekly for 8 weeks and weekly times 1 month, then monthly times 4 months Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	reach. When asked if he could reach his call light, Resident #66 said "No". A Policy titled "Guidelines for Answering Call Lights" was provided by Corporate Nurse Consultant #1 on 10/21/14 at 2:55 p.m. The policy indicated, but was not limited to: "Purpose: to respond to the resident's requests and needs. Procedure...2. Ensure the call light is plugged in securely to the outlet and in reach of the resident...16. If nothing else is needed, return the call light to within reach of the resident." 3.1-3(v)(1)			
F000248 SS=D	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, interview and record review the facility failed to provide stimulating activities for a resident according to his previous life routine for 1 of 1 resident's who met the criteria for activities in a total sample of 15 (Resident #1). Finding include:	F000248	**F248 Activities- Plan of Correction** 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. · Resident #1 will be assessed by Life Enrichment Director (LED). LED will interview resident's family to identify routine and preferences when resident lived	11/21/2014

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	During observation on 10/15/2014 10:46 a.m., Resident #1 was in bed, the resident had a TV in his area of the room but it was not turned on, there was no music playing in the resident's room. Interview with Resident #1's family member on 10/15/2014 02:29 p.m., indicated the staff did not encourage the resident to attend activities or provide assistance to attend them. The family member indicated she was not aware of any activities done for Resident #1. The family member indicated the resident had been living at the facility almost a year and did not get in a wheelchair anymore. The family member indicated the resident stayed in bed. The family member indicated she had never seen staff provide any type activity with the resident and she visited him almost daily. During observation on 10/15/14 at 3:00 p.m., the resident was laying in bed, there was no music or TV playing. During observation on 10/16/14 at 10:06 a.m., Resident #1 was laying in bed with no music or TV or any type of activity. During observation on 10/16/14 at 2:50 p.m., Resident #1 was laying in bed. The resident had no TV on or music playing.		at home. Care plan will be rewritten and implemented. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken. · Residents who have been identified as unable or unwilling to participate in group programs will be reassessed to determine if there are any preferred activities that we are currently not providing. If they are unable to articulate preferences, LED will contact family. Care plans will be updated and implemented. 3. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not occur. · The Life Enrichment Director/ Designee will provide reeducation by November 21 to all Nursing, Social Service, Environmental Services and Life Enrichment staff regarding the need to be aware and honor activity preferences that are meaningful to the resident. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. · Life Enrichment Director will audit on a weekly basis that 1:1's are occurring and residents are engaging/or being engaged in activity preferences as identified in the care planned. 5. By what date the systematic changes will be completed is	

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	There was no type of stimulating activity occurring. During observation on 10/17/14 at 10:00 a.m., Resident #1 was laying in bed. The resident had no TV on or music playing. There was no type of stimulating activity occurring. During observation on 10/17/14 at 12:30 p.m., Resident #1 was laying in bed. The resident had no TV on or music playing. There was no type of stimulating activity occurring. During observation on 10/17/14 at 2:00 p.m., Resident #1 was laying in bed. The resident had no TV on or music playing. There was no type of stimulating activity occurring. During observation on 10/20/14 at 10:50 a.m., Resident #1 was laying in bed. The resident had no TV on or music playing. There was no type of stimulating activity occurring. Review of the record of Resident #1 on 10/20/14 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage and aphasia.		11-21-14 · Trends or patterns identified will be reviewed in monthly QA for any additional follow up and/or reeducation needs for 6 months.	

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	The Admission Minimum Data Set (MDS) assessment for Resident #1, dated 3/2/14, indicated the following: the resident was in a persistent vegetative state/no discernible consciousness, preferences for customary routine and activities were blank, bed mobility-extensive assistance of two people, transfer- total dependence of two people, locomotion on unit- activity occurred once or twice with two people's assist and mobility device-none. The "activities of interest" plan of care for Resident #1 dated, 9/14/14, indicated due to the resident's medical condition he would receive three 1:1 visits from Life enrichment staff every week. The resident would receive hand massages for stimulation, wheelchair rides, the resident would be offered music and TV, read the newspaper and short stories and will continue to have consistent and frequent visits from his family. The one to one participating log for Resident #1 dated, June 1st to June 30th 2014, indicated the resident received a hand message one time and had music played one time. There were no other activities documented. The one to one participating log for Resident #1 dated, July 1st to July 31st			

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	2014, indicated the resident had current events five times, music played one time and activity staff said hello 12 times. There were no other documented activities. The one to one participating log for Resident #1 dated, August 1st to August 31st 2014, indicated the resident had current events 8 times, music played one time and activity staff checked in and said "hi" 11 times. There were no other documented activities. The one to one participating log for Resident #1 dated, September 1st to September 30th 2014, indicated the resident had music played 9 times, and activity staff checked in and said hello 12 times. September 3rd 2014 indicated the resident went on a wheelchair ride with Life enrichment associate #11. There were no other documented activities. The one to one participating log for Resident #1 dated, October 1st to October 17th 2014, indicated the resident had current events 3 times and music played 7 times. There was no other documented activities. Interview with Life enrichment associate #10 on 10/21/14 at 2:32 p.m., indicated the activities provided for Resident #1			

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	was the activity staff take a cd player from activity room in his room and play country music for 10 minutes or longer. The activity staff also read current events to him and check in and say hello to the resident. Life enrichment associate #10 indicated she knew of one time the resident was taken a ride in his wheelchair through the facility by therapy. The Life enrichment associate #10 indicated she was not aware of anyone who had talked with the resident's family member related to the activities he liked. Interview with Life enrichment associate #11 on 10/21/14 at 2:45 p.m. indicated she had initialed Resident #1's activity sheet dated, 9/3/14, that the resident went on a wheelchair ride, but it was a mistake and the resident did not go for a wheelchair ride. During observation of Resident #1 on 10/22/14 at 10:25 a.m., Resident #1 was laying in bed on his back with no TV or music or any type of stimulation. Interview with Resident #1's family member on 10/21/14 at 10:22 a.m., indicated the resident enjoyed listening to the TV, music and books on tape when he lived at home. The family member indicated the facility staff had not talked			

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	with her related to the activities the resident enjoyed. Interview on 10/22/14 at 12:25 p.m., with MDS Coordinator #1 indicated she did not know why Resident #1's MDS dated, 3/2/14, was not filled out for preferences for customary routine and activities. MDS Coordinator #1 indicated the Activity Director should have contacted Resident #1's family member for an interview of what the resident enjoyed. MDS Coordinator #1 indicated the Activity Director was off work at this time. The "Life Enrichment" policy provided by the Director of Health Services (DHS) on 10/21/14 at 2:05 p.m., indicated the facility strived to creatively engage, inspire, and involve every resident with purposeful life interests according to areas of proactive, ongoing relationship-based experiences that foster and promote the enrichment of each persons well being. 3.1-33(a)			
F000272 SS=D	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.			

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	A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; 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 interview and record review the facility failed to complete an Admission Minimum Data Set (MDS) assessment for preferences for customary routine and activities for 1 of 1 resident who met the criteria for activities in a total sample of 15 (Resident #1). Finding include:	F000272	**F 272 careplans Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #1 will be assessed by Life Enrichment Director. LED will interview resident's family to identify routine and preferences when resident lived at home. Care plan will be developed and implemented. **Identification of other residents**	11/21/2014

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	Review of the record of Resident #1 on 10/20/14 at 10:55 a.m., indicated the resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage and aphasia. The Admission Minimum Data Set (MDS) assessment for Resident #1, dated 3/2/14, indicated the following: the resident was in a persistent vegetative state/no discernible consciousness, preferences for customary routine and activities were blank. Interview with Resident #1's family member on 10/21/14 at 10:22 a.m., indicated the resident enjoyed listening to the TV, music and books on tape when he lived at home. The family member indicated the facility staff had not talked with her related to the activities the resident enjoyed. Interview on 10/22/14 at 12:25 p.m., with MDS Coordinator #1 indicated she did not know why Resident #1's MDS dated, 3/2/14, was not filled out for preferences for customary routine and activities. MDS Coordinator #1 indicated the Activity Director should have contacted Resident #1's family member for an interview of what the resident enjoyed. MDS Coordinator #1 indicated the		**having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Residents identified as not having their preferences implemented on the careplan will be interviewed by the LED and preferences implemented **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** MDS coordinator will re educate the interdisciplinary team on completion of the prefernces for the MDS **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Audits will be completed of the admission MDS to ensure preferences /activites section is complete weekly times 8 weeks then monthly times 4 months. Completion Date:11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	Activity Director was off work at this time. 3.1-31(a) 3.1-31(c)(10)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review, observation and interview the facility failed to develop a care plan to address the side effects of an anti-coagulant for a Resident on Coumadin medication, the facility failed to develop a care plan for falls for a Resident admitted with a high risk for falls and the facility failed to develop a	F000279	**F 279 Develop of care plans Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 97's careplan was updated to reflect her coumadin useage, Resident # 1's careplan was updated to reflect his ROM plan and	11/21/2014

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	care plan for range of motion to prevent contractures for a Resident with a decline in contractures. (Resident # 97, # 95 and # 1) Findings include: 1. Review on 10/20/14 at 10:30 a.m., of Resident # 97's Physician's admission orders dated 10/3/14 through 10/31/14 indicated diagnoses included but were not limited to anxiety, depression, diffuse microvascular disease, osteoarthritis, osteoporosis and history of cerebral vascular accident (CVA). Medications included but were not limited to Coumadin 5 mg tablet take every Sunday, Tuesday, Thursday, Saturday and Coumadin 6 mg on Monday, Wednesday, Friday. Diagnosis: CVA. On 10/20/14 at 10:40 a.m., review of a Physician's order dated 10/14/14 indicated decrease Coumadin to 5 mg daily. Review of all of Resident # 97's care plans indicated there was no care plan found for anti-coagulant, Coumadin. On 10/21/14 at 2:55 p.m., interview with Minimum Data Set (MDS) Coordinator #		Resident # 95's careplan was updated to reflect being at risk for falls. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Audit of residents receiving coumadin and or anticoagulant therapy will be performed to ensure care plans are in place, audit of residents with limited ROM will be conducted to ensure they have a care plan in place , New admissions will be audited to ensure they have careplans in place for risk of falls **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Staff will be re educated on the developing comprehensive careplan for residents receiving coumadin, contracture prevention and fall risk **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** New admission audits will be completed daily at the clinical care meeting 5 days a week for 4 weeks, then weekly times 4 weeks, then monthly for 4 months to ensure the facility has developed and implemented careplan for residents at risk for fall, receiving coumadin and have limited ROM Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended***	

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	1, indicated there was not a care plan for Coumadin administration but may be listed on the Assessment Review and Considerations document that was completed on admission, dated 10/3/14. She review the Assessment Review and Considerations document and indicated "no, coumadin was not addressed under the immediate care plans on the Assessment Review and Considerations document." 2.) During observation on 10/15/14 at 10:46 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. Interview with Resident #1's family member on 10/15/14 at 2:29 p.m., indicated they visit the resident almost daily. Resident #1's family member indicated the resident stayed in bed all of the time. During observation on 10/16/14 at 10:06 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. During observation on 10/17/14 at 10:00		***for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. Review of the record of Resident #1 on 10/20/14 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage, seizure disorder and aphasia (loss of the ability to communicate). The Minimum Data Set (MDS) assessment for Resident #1, dated 8/14/14, indicated the resident had functional limitation in Range Of Motion (ROM) of upper and lower extremities-impairment on both sides. Review of Resident #1's careplan's dated, 4/11/14 to 9/14/14, indicated no plan of care related to the resident's contractures or Passive Range Of Motion (PROM) program. Interview with Minimum Data Assessment (MDS) Coordinator #1 on 10/20/14 at 2:04 p.m., indicated Resident #1 did not have a careplan with interventions related to PROM or the resident's contractures.			

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	3.) Interview with LPN #17 on 10/14/14 at 12:02 p.m., indicated Resident #95 had fall on 10/11/14. LPN #17 indicated the resident had a skin tear on the right elbow and a skin tear on the top of the head from the fall. Review of the record of Resident #95 on 10/17/14 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, frequent falls, venous stasis, leg weakness, diabetes mellitus, dependent edema and pace maker. The physician order for Resident #95 dated, 10/10/14 (no time), indicated the resident was an emergency admit to the facility for frequent falls, venous stasis and bilateral leg weakness. The fall risk assessment for Resident #95 dated, 10/10/14, indicated the resident had a past history of falls and visual impairment. The nursing admission assessment and data collection for Resident #95 dated, 10/10/14, indicated the resident was one assist for ambulation, one assist for bathing, one assist for toileting, the resident was always continent of bowel and bladder, the resident had severely impaired vision and the resident was alert and oriented. The safety plan of care			

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	section was blank. The nurse's note for Resident #95 dated, 10/10/14 at 8:00 p.m., indicated the resident was admitted to the facility. The resident had frequent falls at home. The resident was alert and oriented to person and place and confused at times. The resident was hard of hearing and had "very poor eyesight". The resident walked with a walker and was oriented to his room and call light. The note was signed by RN #5. The nurse's note for Resident #95 dated, 10/11/14 at 10:00 a.m., indicated the resident was in the bathroom to void. The resident was standing in front of the toilet and fell backward and hit his head on the wall and right elbow on the floor. The resident had a skin tear on top of his scalp and steri strips applied, the resident had a skin tear on his right elbow and steri strips applied. The fall circumstance assessment and intervention for Resident #95 dated 10/11/14 at 10:00 a.m., indicated the resident fell in the bathroom and hit his head. The environmental factors were- wet floor. The prevention update indicated bed and/or chair alarm. The Interdisciplinary review dated, 10/15/14, indicated the root cause was "balance".			

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	The refusal of care circumstance assessment and intervention for Resident #95 dated, 10/13/14 (no time), indicated the resident had refused the bed alarm because it was disturbing his sleep. The documentation indicated no other safety interventions were implemented. Interview with the Minimum Data Set (MDS) Coordinator #2 on 10/17/14 at 1:37 p.m., indicated Resident #95 did not have a plan of care to prevent falls. The MDS Coordinator #2 indicated the only careplan's the resident had was for nutrition. MDS Coordinator #2 indicated it was the nurse's responsibility to put a plan of care in place on admission if there was something pertinent that needed to be place at that time. MDS Coordinator #2 indicated it was MDS responsibility to put other careplan's in place. Interview with Medical Record staff on 10/17/14 at 2:36 p.m., indicated RN #5 was Resident #95's admitting nurse and should have put a safety plan of care in place for the resident on admission. The "Interdisciplinary Team Care Plan Guideline" policy provided by the Director of Health Services on 10/21/14 at 10:36 a.m., indicated the purpose was appropriateness of services and			

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	communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines. 3.1-35(a) 3.1-35(b)(1)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review the facility failed to correctly assess and monitor five abrasions acquired from a fall located on a resident's scalp and failed to clean and treat the abrasions that had dirty black steri strips and black substance on the abrasions for 1 of 6 residents who met the criteria for skin conditions (non pressure) in a total sample of 15 (Resident #95). Finding include: Interview with LPN #17 on 10/14/14 at 12:02 p.m., indicated Resident #95 had fall on 10/11/14. LPN #17 indicated the	F000309	**F 309 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The 5 abrasions on resident #95's head was reassesed and monitoring via the nonpressure skin form 10/21/14 **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Will reveiw falls with injuries for the past 30 days to ensure follow up was completed **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Licensed nursing staff will	11/21/2014

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	resident had a skin tear on the right elbow and a skin tear on the top of the head from the fall. During observation and interview with Resident #95 on 10/14/14 at 2:13 p.m., the resident had an abrasion on his right elbow and abrasions on the his head with two dirty black steri strips on them. Resident #95 indicated he got the abrasions when he fell. During observation on 10/15/14 at 9:30 a.m., Resident #95 had two dirty black steri strips on the abrasions on top of his head. Review of the record of Resident #95 on 10/17/14 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, frequent falls, venous stasis, leg weakness, diabetes mellitus, dependent edema and pace maker. The physician order for Resident #95 dated, 10/10/14 (no time), indicated the resident was an emergency admit to the facility for frequent falls, venous stasis and bilateral leg weakness. The nurse's note for Resident #95 dated, 10/11/14 at 10:00 a.m., indicated the resident was in the bathroom to void. The resident was standing in front of the toilet		be reeducated on the post fall assessment and documentation including follow up required. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Falls will be reveiwed during the daily clinical meeting 5 days a week times 4 weeks then weekly times 4 weeks then monthly times 4 months, scheduled resident first meetings, peer review bi annually and monthly QA to ensre follow up is complete. Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	and fell backward and hit his head on the wall and right elbow on the floor. The resident had a skin tear on top of his scalp and steri strips applied, the resident had a skin tear on his right elbow and steri strips applied. The fall circumstance assessment and intervention for Resident #95 dated 10/11/14 at 10:00 a.m., indicated the resident fell in the bathroom and hit his head. The 72 hour follow up located on the back of the assessment dated 10/11/14 from 6 a.m. to 2 p.m. indicated no injury evident, 10/11/4 from 2:00 p.m. to 10:00 p.m. indicated no injury evident, 10/11/14 from 10:00 p.m. to 6:00 a.m. indicated the resident had a laceration to the back of his head. The 72 hour follow up dated 10/12/14 for all shift indicated no injury evident and the 72 hour follow up dated 10/13/14 for all shifts indicated no injury evident. The skin impairment assessment for Resident #95 dated, 10/11/14, indicated the resident had a skin tear and bruise on top of his head that measured 3 centimeters (cm) by 4 cm. The treatment was steri strips. The documentation indicated no other measurements. The skin impairment assessment for Resident #95 dated, 10/11/14, indicated			

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	the resident had a skin tear on his right elbow that measured 1 cm by 1 cm. The treatment was steri strips. The documentation indicated no other measurements. During observation and interview with Resident #95 on 10/17/14 at 10:30 a.m., the resident's steri strips were not on the resident's abrasions on the top of his head. Resident #95 indicated he took "those band aids" off the night of 10/15/14 because they were itching him. The resident had 5 abrasions on the top of his head, the resident's hair was visibly dirty with particles in his hair and scalp. The resident's right elbow had a scab on it. This indicated the resident had the steri strips on for five days after they were applied to his abrasions with no documentation of cleaning the abrasions or monitoring the abrasions for infection and healing. During observation on 10/17/14 at 1:23 p.m., LPN #15 measured Resident #95's abrasions on top of the resident's scalp the measurements were as followed: Abrasion #1 measured 2 cm round, Abrasion #2 measured 4 cm by 2 cm and was pink, Abrasion #3 measured 1 cm by 1 cm, Abrasion #4 measured 1 cm by 2 cm and Abrasion #5 measured 2 cm by 2 cm. The scabbed abrasion with pink			

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	around the scab on the right elbow measured 2 cm by 2 cm. Interview with the Director of Health Services (DHS) on 10/21/14 at 2:04 p.m., indicated the nurses who did Resident #95's follow up after his fall on 10/11/14 was responsible to monitor and treat the abrasions on his head and elbow. Interview with DHS on 10/21/14 at 2:22 p.m., indicated she was unable to find an treatment physician order for Resident #95's abrasions. The other skin assessment guidelines provided by DHS on 10/21/14 at 10:10 a.m., indicated the purpose was to describe and monitor the healing process of skin impairments other than pressure or stasis ulcers. 3.1-37(a)			
F000312 SS=D	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, interview and	F000312	**F 312 ADL Care Corrective**	11/21/2014

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	record review the facility failed to assist and resident with a shower and failed to have clean clothes for a resident that required assistance for grooming and hygiene for 1 of 4 residents who met the criteria for Activities of daily living, cleanliness and grooming in a total sample of 15 (Resident #95). Finding include: During observation and interview on 10/14/14 at 1:46 p.m., Resident #95 indicated he did not get to choose how many times he received a shower. Resident #95 indicated he had not received a shower since he was admitted to the facility on 10/10/14. Resident #95 indicated he wanted to take a shower after breakfast but he did not bring any towels with him to the facility and he was unsure how to get any towels to take a shower. Resident #95 indicated the staff had told him, he would get a shower every four days. The resident had on a white T-shirt with dried dark substance down the front of it. The resident indicated the stains were from chocolate ice cream. The resident indicated he had not had clean clothes for two days and liked to wear to wear button up shirts when he was out in the facility but someone had took his clothes to laundry and had not brought them back. CNA #2		**actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 95 received a shower and profile was updated to refelect residents preferences and family brought in clothing **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Kiosk was reviewed for any residents not receiving a shower in 12 shift reports **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Nursing staff will be reeducated on resident preferences for ADL care and receive the necessary services to maintain or promote their highest functional level. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will review the no shower report daily at the clinical care meeting 5 days a week for 8 weeks , then weekly times 4 weeks then monthly for 4 months Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further***	

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	came in the resident's room and indicated the resident did not have any clean clothes. CNA #2 indicated she had looked for clean clothes for the resident that morning and could not find any. During observation and interview with Resident #95 on 10/16/14 at 9:59 a.m., indicated he had not had a shower yet, but he did take a sponge bath at his bathroom sink. The resident had a blue button up long sleeved shirt on. Review of the record of Resident #95 on 10/17/14 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, frequent falls, venous stasis, leg weakness, diabetes mellitus, dependent edema and pace maker. The nursing admission assessment and data collection for Resident #95 dated, 10/10/14, indicated the resident was one assist for bathing, one assist for dressing and was alert and oriented. The record of Resident #95 had a blank inventory sheet located in the back of the chart. During observation and interview wit Resident #95 on 10/17/14 at 10:30 a.m., Resident #95 was sitting in his bedroom with the same button up blue shirt on that		***recommendation.***	

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	he had on 10/16/14. Resident #95 indicated he cried this morning because he did not have any clean clothes to put on and he had to wear the same shirt that he wore yesterday. Resident #95 indicated he "begged" staff to give him a shower on the evening of 10/16/14, but they told me it was not my time to get a shower. Resident #95 indicated this "hurt" his feelings. The resident indicated he had a shower on 10/10/14 at home before he went to his doctors appointment and that was the last shower he had. The resident indicated the staff just kept telling him it was not his time. Resident #95 hair and scalp was visibly dirty with particles. The resident's face had slight beard with peeling skin on the right side. Interview with LPN #15 on 10/17/14 at 11:00 a.m., indicated Resident #95's shower days were Tuesdays and Fridays. LPN #15 went though the ADL shower book for the hallway and indicated there were no shower sheets for Resident #95. LPN #15 indicated when a CNA gave a resident a shower, a shower sheet was suppose to be made out and the nurse and CNA was suppose to sign it. LPN #15 also looked at Medication Administration Record (MAR) for Resident #95 and indicated it had not been signed off that resident had a shower. When queried			

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	what did the staff do if a resident requested a shower when it was not their scheduled shower time, LPN #15 indicated staff are suppose to give the resident a shower if they ask for one. Interview with Resident #95's family member on 10/20/14 at 10:20 a.m., indicated Resident #95 took a shower at home normally on Wednesday and Sunday. Resident #95's family member indicated he had bought new jeans and shirts for the resident at the local store, but unfortunately he had not marked them with the resident's name. The family member indicated he had the laundry staff looking for the resident's clothes. The family member indicated he took Resident #95 to an doctor's appointment on 10/10/14 and the Physician had done an emergency admit to the facility from the doctor office. 3.1-38(a)(2)(A)			
F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and			

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	services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to immediately provide a resident with a wheelchair pressure relieving device who was at an increased risk for developing a pressure ulcer, resulting in a stage III coccyx pressure ulcer and a stage IV buttock pressure ulcer, for 1 of 3 resident's reviewed for pressure of 6 who met the criteria for pressure. (Resident #90) Findings include: Resident #90's record was reviewed on 10/17/14 at 1:20 p.m. Resident #90 was admitted to the facility on 8/28/14. His diagnoses included but were not limited to, adrenoleukodystrophy (ALD), anemia, coronary artery disease, osteoporosis, and symptomatic mitral regurgitation. An "Assessment Review and Considerations" for Resident #90 dated 8/28/14, indicated he was a potential risk for skin breakdown related to his mobility impairment and current medical diagnosis affecting skin oxygenation. An individualized care plan had been initiated to address his skin risk factors and minimize his risk of skin breakdown.	F000314	**F 314 treatment Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 90 chart has an order to change gelcushion to roho cushion on 9/16/14 **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All other residents have the potential to be affected. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee re assessed all residents to verify all residents at risk for development of pressure ulcers are properly identified and interventions are care planned. New admissions will be reveiwed daily 5 days a week during the clinical care meeting to verify that potential risk factors for pressure ulcer development have been properly identified and care plan devloped by nursing management team. Nursiung staff was reeducated on the pressure prevention guidelines and wound care Plan by DHS or designee. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** New admission will be	11/21/2014

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	A "Nursing Admission Assessment" for Resident #90 dated 8/28/14, indicated he had a post surgery chest incision. He had no pressure ulcers and had no history of skin impairment. He was at risk for developing pressure areas. He had a pressure relieving device to his bed. He was able to maintain his position in his bed and chair. He had no pain and was able to respond to pain/discomfort. The "Skin Plan of Care" documented on the form indicated the following: Resident #90 would be turned and repositioned for comfort with care. He would be provided a pressure relieving device to his bed. Consequences of refusal of treatment and/or prevention interventions would be explained. Staff would ensure adequate hydration. He would be provided vitamins and supplements per physician orders. He would be assisted with positioning in his bed and chair. He would be administered medications per his physician orders. His skin would be observed for signs of pain with skin condition. A "Skilled Charting Evaluation" for Resident #90 dated 8/29/14, indicated he had a surgical incision related to valve replacement for mitral valve insufficiency. He had no chest pain. He had no pressure ulcers. His oxygen		reveiewed daily 5 days a week at the clinical care meeeting for 8 weeks to ensure they have been identified and care plans developed for at risk for pressure ulcer delopement, then weekly times 8 weeks and monthly times 4 months. Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	saturation was 100% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Skilled Charting Evaluation" for Resident #90 dated 8/30/14, indicated he denied pain. He had no pressure ulcers. His oxygen saturation was 95% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Skilled Charting Evaluation" for Resident #90 dated 8/31/14, indicated he denied pain. He had no pressure ulcers. His oxygen saturation was 98% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 9/1/14, indicated Resident #90 had developed a pressure ulcer on his coccyx not present on admission. The pressure ulcer area measured 2 centimeters (cm) long by 1.5 cm wide. The area was red with no signs or symptoms of infection and surrounding tissue was intact. A "Change In Condition" for Resident #90 faxed to the physician on 9/1/14, indicated Resident #90 had developed a 2 cm long by 3 cm wide coccyx pressure ulcer and the nurse requested an order to apply optifoam to the wound and change			

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	every 3 days. A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 9/2/14, indicated Resident #90's coccyx pressure ulcer had 3 different measurements including a red area measuring 10 cm long by 8 cm wide by 0.1 cm deep, a black/purple area measuring 6 cm long by 4.6 cm wide, by 0.1 cm deep, and a open area measuring 2 cm long by 1.5 cm wide by 0.1 cm deep. The wound margins were irregular and surrounding tissue was black/purple/red. The wound treatment was optifoam and medihoney. Preventive interventions were to turn and reposition him. There was pain at the wound bed. A "Skilled Charting Evaluation" for Resident #90 dated 9/2/14, indicated his chest incision was well approximated with no drainage and no chest pain. He had a pressure ulcer. His oxygen saturation was 92% at rest and his nail beds were pink. A "Change In Condition" for Resident #90 faxed to the physician on 9/2/14, indicated Resident #90's coccyx pressure ulcer was 10 cm by 8 cm, red and non-blanchable, with a purple black area in the center of that area that was 6 cm by 4.6 cm , with an open area in the center			

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	of that area that was black/purple. The nurse requested an order to add medihoney to the optifoam order. A "Skilled Charting Evaluation" for Resident #90 dated 9/3/14, indicated his chest incision was well approximated with no drainage and no chest pain. He had stage II coccyx pressure ulcer. His oxygen saturation was 98% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Skin Impairment Circumstance, Assessment and Intervention" for Resident #90 reviewed by the Interdisciplinary Team (IDT) on 9/3/14, indicated he had recent coronary artery bypass graft surgery. He did not have a history of skin impairment. He had developed a stage II pressure ulcer on his coccyx with suspected deep tissue injury. Pain was present. His treatment included optifoam and medihoney to the area. He was compliant with care plan interventions. He was compliant with turning and repositioning and/or treatment interventions. His prevention update indicated treatment had been implemented and to turn him. Resident #90's admission Minimum Data Set (MDS) assessment dated 9/4/14, indicated he was understood and had the			

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	ability to understand others. He was moderately impaired in his skills for daily decision making. He required extensive assistance of 2 plus persons for bed mobility, transfers, dressing, toileting, and hygiene. He had functional limitation his his range of motion in both of his lower extremities. He used a wheelchair for mobility. He was at risk for developing pressure ulcers. He had a surgical wound. His skin and ulcer treatment included a pressure relieving device for his bed and surgical wound care. He had participated in 255 minutes of Occupational (OT) Therapy and 245 minutes of Physical Therapy (PT). A physician's order for Resident #90 dated 9/4/14, indicated his coccyx wound would be cleaned with normal saline. Medihoney would be applied and covered with a sacral optifoam dressing. A "Skilled Charting Evaluation" form for Resident #90 dated 9/6/14, indicated he had no chest pain. He had stage II coccyx pressure ulcer. His oxygen saturation was 95% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Skilled Charting Evaluation" form for Resident #90 dated 9/10/14, indicated his surgical incision was well approximated			

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	with no drainage or chest pain. He had a stage III coccyx pressure ulcer. His oxygen saturation was 94% at rest. His facial color/flesh tones were normal and his nail beds were pink. A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 9/10/14, indicated Resident #90's stage III coccyx pressure ulcer measured 13 cm long by 10.2 cm wide by x 0.3 deep. There was pain. The wound bed was beefy red with slight yellow slough. The wound margin was irregular with red surrounding tissue. The treatment was optifoam and medihoney. Preventive interventions included an air loss mattress was ordered. Medical interventions included a Wound Clinic evaluation. A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 9/10/14, indicated Resident #90 had developed a right lower hip area pressure ulcer that was not present on admission. The pressure ulcer measured 5 cm long by 2.8 cm wide. The area was black/purple in color. There was pain. A physician's order for Resident #90 dated 9/10/14, indicated he would receive a wound culture on his coccyx ulcer. He would receive Augmentin 875 milligrams (mg) everyday for 10 days. He would be			

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	seen by the Wound Clinic. He would be turned every 2 hours. A "Change in Condition" for Resident #90 dated 9/10/14, indicated he had a new pressure area that was black/purple in color, located on his right lower hip next to his buttock. An order was requested for optifoam and skin prep to be changed every 3 days and as needed. The area measured 5 cm by 2.8 cm. On 9/11/14, the physician's response to the "Change in Condition" faxed 9/10//14. He indicated he had seen the resident on 9/10/14, and had ordered for him to be seen at the Wound Clinic. A "Resident First Conference Notes" dated 9/10/14, indicated the following: Pressure reduction devices: mattress and cushion. A "Skin Impairment Circumstance, Assessment and Intervention" for Resident #90 reviewed by the IDT on 9/12/14, indicated he had a stage I pressure ulcer to his right lower hip next to his buttock. Other contributing factors indicated he did not like to lay down or turn side to side. His prevention update indicated a speciality surface for his bed (low air loss mattress), treatment had been implemented, moisture would be			

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	applied to keep his skin supple, fluids would be encouraged, and the Wound Clinic would evaluate and treat him. An OT Daily Treatment" note dated 9/15/14, indicated the following: "Patient with gel foam cushion replaced with (name brand) multi cell bladder cushion with increased disbursement of pressure for buttocks. Patient with multiple decubitis ulcers related immobility and unable to complete self pressure relief due to sternal precautions." An initial local "Wound Clinic History and Physical" note for Resident #90 dated 9/17/14, indicated he was wheelchair bound due to the inability to use his legs secondary to his adrenoleukodystrophy. His wound measurements indicated his coccyx pressure ulcer measured 5 cm long by 6.6 cm wide by 0.4 cm deep. His right buttock ulcer measured 2.5 cm long by 1.6 cm wide by 0.2 cm deep. The wounds were debrided. His Assessment/Plan indicated medihoney would be used in the wounds. An Allevyn sacral pad would be placed over the sacral area and an ABD pad would be placed over the deeper wound on the buttock. A Wound Vac was ordered for the deeper wound, believed necessary for filling in the depth of the wound. He was encouraged to increase his nutrition and			

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	to offload the wounds. He was expected to do well. He would be seen for a followup in 1 week. A local "Wound Clinic Progress" note for Resident #90 dated 9/26/14, indicated his coccyx pressure ulcer measured 5 cm long by 5 cm wide by 0.1 cm deep. His right buttock ulcer measured 2.5 cm long by 3.2 cm wide by 0.7 cm deep. The wounds were debrided. His Assessment/Plan indicated he would continue the Wound Vac. He would need to offload the pressure ulcer areas. He should only be up in his wheelchair for meals approximately 45 minutes at a time. Otherwise he would need to be in bed and off of the areas. He would be seen for a followup in 1 week. A Skin Plan Of Care for Resident #90 indicated he had pressure ulcers present on his buttocks and coccyx related to impaired mobility. He was at risk for breakdown because of his diagnoses of leukodystrophy and paralysis in his bilateral lower extremities. His interventions included an air mattress on his bed to reduce the risk of further breakdown and to aide in healing his wound. He was being seen by the Wound Clinic doctor weekly for wound care and any changes in treatment. He currently had a Wound Vac appliance on			

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	his right buttock wound to aide in healing. The nursing staff changed the dressing every Monday, Wednesday, and Friday and would monitor the dressing every shift. The nursing staff would monitor monitor the Wound Vac canister every shift and document the amount of drainage. The nurse would continue to complete a full skin assessment weekly to observe for changes in skin integrity. He would be encouraged to have good nutritional intake and drink adequate fluids. His Plan of Care would be reviewed by 12/22/14. A Skin Plan Of Care for Resident #90 indicated he often was noncompliant with turning and repositioning every 2 hours per his physician's orders. He was encouraged and assisted by staff to turn and reposition every 2 hours. He was supposed to only be up in his wheelchair for meals, no more than 45 minutes. At times, he choose to stay up in his wheelchair for longer periods than 45 minutes. The nursing staff encouraged him to be off of his bony prominence's as much as possible. He had been given the information of the risk of not laying down and being turned often, and he voiced understanding. The nursing staff would continue to provide wound care and preventative skin care per his physician's orders and recommendations			

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	and would continue to provide weekly full skin assessments and daily checks with his personal care. His Care Plan would be reviewed by 12/29/14. A local Wound Clinic "Nursing Wound/Ulcer Assessment" for Resident #90 dated 10/15/14, indicated his coccyx pressure ulcer measured 2.3 cm long by 1.5 cm wide by 0.1 cm deep. His right buttock wound measured 3.8 cm long by 2.4 cm wide by 2.8 cm deep. The note indicated his wounds were improving with no necrotic areas noted. An interview with RN #17 on 10/14/14 at 11:50 a.m., indicated Resident #90 had a stage III pressure ulcer on his coccyx and a stage IV pressure ulcer on his right buttock, he acquired in the facility. On 10/16/14 at 3:30 p.m., Resident #90 was observed lying on an air mattress on his left side with pillows behind his back and under his head. He indicated he had received the air mattress after he had developed his pressure ulcers and the air mattress was comfortable. He had a trapeze bar above his head and indicated he used it for exercise. He indicated he turned in bed every 2 hours with the assistance of staff. He indicated he believed he developed pressure ulcers on his buttock because he had spent a lot of			

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	time sitting up in his wheelchair when he should have spent more time in bed. He indicated he went to a local Wound Care Center weekly. He indicated he was participating in therapy and the therapy staff were going to help him build his strength. He indicated therapy staff had helped him stand which he hadn't done in a long time. He indicated he had not sat in a wheelchair at home. On 10/17/14 at 9:10 a.m., Resident #90 was observed seated upright in his wheelchair on a seat cushion in the dining room. He had a Wound Vac bag hanging on the back of his wheelchair. On 10/17/14 at 10:27 a.m., Resident #90 was observed receiving wound care in his bedroom from the Assistant Director of Health Services (ADHS) and RN #5. RN #5 held resident on his left side and the DHS provided him with his right buttock Wound Vac dressing change near his hip. The Wound Vac container was replaced and the Wound Vac set on 150 mm/hg. The right buttock pressure ulcer was approximately the size of a half dollar in circumference. The wound bed was deep, pinkish/red in color. The surrounding skin was pinkish/white and no odor was noted. RN # 5 provided him with the coccyx ulcer dressing . The wound edges were irregular. The wound			

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	bed was red/beefy looking. The surrounding skin was pinkish/white and then surrounding tissue around that pinkish/red. No odor noted. He tolerated the procedure well and denied having any pain. On 10/17/14 at 1:40 p.m., Resident #90's wife indicated when he first arrived at the facility he often sat up in his wheelchair, going outside and different areas of the building. She indicated she believed he developed the pressure ulcer because he had spent so much time sitting up in his wheelchair. On 10/21/14 at 9:35 a.m., Resident #90 was lying in bed on his left side. Resident #90 was queried how long he had a wheelchair cushion in his wheelchair. He indicated he didn't know but therapy staff would know because they had ordered it. He indicated he could not recall if he had any pressure relieving device in his wheelchair prior to that one. On 10/21/14 at 2:03 p.m., Certified Occupational Therapy Assistant (COTA) #6 indicated Resident #90 was admitted to the facility with his own wheelchair. She indicated the wheelchair did not have a pressure relieving cushion and he spent a lot of time up in his wheelchair. She			

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	indicated he had started to get some breakdown on his buttock and she had informed the Therapy Manager she believed Resident #90 would benefit from a (name brand) cushion to relieve pressure off of his buttock. COTA #6 left the room and returned with the printed "OT Daily Treatment" note for Resident #90 dated 9/15/14, to provide information of when the (name brand) cushion had been ordered. After reviewing the note she indicated maybe Resident #90 had received a gel foam cushion prior to the (name brand) cushion but she did not know what date that would have been placed in his wheelchair. On 10/21/14 at 2:21 p.m., the Therapy Manager indicated Resident #90 was admitted to the facility with his own wheelchair. He indicated he did not remember what date Resident #90 had a gel foam pressure relieving cushion placed in his wheelchair prior to the (name brand) cushion. He indicated it would have been within the first week or two of admission. He indicated it would have likely been himself or COTA #6 who had provided him with a gel foam cushion out of the stock supply. He indicated he had ordered the (name brand) pressure relieving cushion for Resident #90's wheelchair because a staff			

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	member in morning meeting had mentioned he was getting pressure ulcers and a (name brand) cushion was better than a gel cushion. He indicated there was no protocol related to providing a resident with a wheelchair seat cushion. He indicated Resident #90 had not used a wheelchair cushion at home so the cushion was new to him when he received it. He indicated Resident #90 was currently in OT and PT and had been since admission. On 10/21/14 at 4:45 p.m., the Therapy Manager indicated he was unable to locate any therapy documentation when Resident #90 received a gel foam pressure relieving cushion for his wheelchair prior to receiving his (name brand) cushion. No documentation was available Resident #90 had a pressure relieving device in his wheelchair until the "Resident First Conference Notes" dated 9/10/14. The facility was unable to provide any information Resident #90 had any pressure relieving device in his wheelchair prior to the "Resident First Conference Notes" dated 9/10/14. The "Pressure Prevention Guidelines"			

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	provided by the Director of Health Care Services on 10/21/14 at 5:00 p.m., indicated the following: "Purpose: To maintain good skin integrity and avoid development of pressure ulcers. Procedure: Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include but not be limited to: ...Place on pressure reduction support surface (bed - chair). Obtain an advanced pressure reduction cushion for wheelchair...." 3.1-40(a)(1) 3.1-40(a)(2)			
F000318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review the facility failed to provide a restorative Passive Range Of Motion (PROM) program for a resident with limited range of motion resulting in the resident experiencing a decline in joint mobility for 1 of 4 residents who met the criteria for a contractures without a splint device in a total sample of 15	F000318	**F 318 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #1's careplan was updated to reflect that he was place on a PROM plan 10/24/14 **Identification of other residents having the potential to be affected by the same alleged deficient practice and**	11/21/2014

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	(Resident #1). Finding include: During observation on 10/15/14 at 10:46 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. Interview with Resident #1's family member on 10/15/14 at 2:29 p.m., indicated they visit the resident almost daily. Resident #1's family member indicated the resident stayed in bed all of the time. During observation on 10/16/14 at 10:06 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. During observation on 10/17/14 at 10:00 a.m.., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. Review of the record of Resident #1 on 10/20/14 at 11:45 a.m., indicated the		**corrective actions taken**: Review of current ROM assessments were performed on all residents with any decline in limited ROM were refered to therapy for evaluation. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Residents will be identified during the CCM for change in Rom and evaluated for a ROM plan and careplan updated to reflect the plan **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** Audits of changes in ROM will be performed on 3 residents weekly times 8 weeks, then monthly times 4 months Completion Date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage, seizure disorder and aphasia (loss of the ability to communicate). The record of Resident #1 indicated the resident was admitted to the facility on 2/23/14. Review of Resident #1's careplan's dated, 4/11/14 to 9/14/14, indicated no plan of care related to the resident's contractures or PROM program. The Occupational Therapy (O.T.) initial assessment for Resident #1, dated 3/3/14, indicated the following: "The patient has shown a clinical need for PROM and positioning intervention for reduced risk of contractures and promote optimal skin integrity while in long term care. Therapy is necessary for PROM and positioning intervention. Without therapy the resident is at risk for contractures and skin breakdown. The discharge plans was to remain in the skilled nursing facility with a Restorative Nursing Program (RNP). The Range of Motion assessment for Resident #1 indicated the following: the right upper extremity had 75 % of normal range, the right lower extremity had 75% of normal range of motion, the left upper extremity had 75% of normal range of			

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	motion, the left lower extremity had 75% of normal range of motion." All the Range Of Motion (ROM) was completed passively with contractures of digits, however able to range digits to table top position for good hygiene. " "Patient with fixed bilateral inversion contractures of ankles." "Changing and maintaining body positron functional limitation, current status has been documented based on patient is in a persistent vegetative state and requires O.T. to establish RNP for decreased risk of contractures." The assessment was electronically signed by the Therapy Manager. The O.T. progress and discharge summary for Resident #1, dated 4/16/14, indicated the following: Goal #1- "The goal for ROM was the resident would achieve 75% ROM for wrists and digits while rest of joints are also at 75% PROM or better in prep for RNP." The start date of the goal status, dated 3/3/14, was the resident demonstrated 75% PROM for bilateral shoulders, elbows, knees, and hips. The resident had bilateral hands PROM at approximately 50% for digits and wrists. "Bilateral ankles with fixed contractures. The end of goal status, dated 4/16/14, indicated the goal was met and the resident demonstrated 75% PROM all major joints such as the hips, knees,			

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	shoulders, elbows and approximately 75% PROM for wrist and digits. The resident will have overall Bilateral lower extremities and bilateral upper extremities ROM RNP established to decrease risk of further contractures development. Education with staff related to PROM to be completed daily. The discharge summary was electronically signed by the Therapy Manager. The change in condition form for Resident #1, dated 8/7/14, indicated the resident's family were requesting an increase in Baclofen (skeletal muscle relaxant) due to the resident's muscles have gotten very stiff and unable to bend legs worse than usual. The Minimum Data Set (MDS) assessment for Resident #1, dated 8/14/14, indicated the following: bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- activity did not occur, functional limitation in ROM of upper and lower extremities- impairment on both sides and Restorative Nursing Program for PROM- none. During observation and interview on 10/20/14 at 11:45 a.m., CNA #7 and CNA #8 was repositioning Resident #1 in bed. CNA #7 indicated the resident did			

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	not get out of the bed except on shower days. When queried what PROM exercises were done for the resident, CNA #8 indicated when they repositioned the resident in bed they tried to move the resident's fingers,. CNA #8 indicated the resident could not move his wrist or ankles. CNA #8 indicated the resident did not wear any splints. CNA #8 demonstrated PROM on the resident's fingers on left and right hand. The resident fingers on both hands were able to be moved very little with the assistance of CNA #8. CNA #8 attempted to move the resident's wrist on both hands and indicated she was unable to and attempted to move both of the resident's ankles and indicated she was unable to. Interview with MDS coordinator #1 on 10/20/14 at 2:04 p.m., indicated she was unable to find documentation that Resident #1 received PROM exercises. Interview with the Assistance Director Of Health Services (ADHS) on 10/20/14 at 2:40 p.m., indicated Resident #1 did not have a restorative program for PROM. Interview with the Therapy Manager on 10/20/14 at 4:15 p.m., indicated the facility did not have a Restorative Nursing Program. The Therapy Manager			

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	indicated the facility was going to have one at one time but the program did not get started. The Therapy Manager indicated he did education with the nursing staff on how to do PROM for Resident #1 and would look for documentation on the training was and who was trained. The Therapy Manager indicated when the resident was discharged from therapy the resident was able to move his wrist. Interview with Resident #1's family member on 10/21/14 at 10:22 a.m., indicated when the resident lived at home, PROM was done by the family twice a day. The family member indicated they had never seen the facility staff provide PROM to the resident except when the resident was receiving therapy. The family member indicated the resident use to be able to move his wrist and now he could not. The family member indicated the resident's fingers, legs and knee joints have "deteriorated" since admission to the facility. Interview with the ADHS and Therapy Manager on 10/21/14 at 11:10 a.m., when queried who was responsible for the contractures prevention and management program, the Therapy Manager indicated it would be collaborative effort of the staff to put a program in place. The			

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	ADHS indicated the facility did not currently have a contractures prevention and management program in place. Requested for the ADHS and the Therapy Manager to do a joint assessment on Resident #1 as to see the resident's current joint mobility. During observation on 10/21/14 at 11:20 a.m., ADHS did a joint assessment on Resident #1 with the Therapy Manager present. The following was observed: The ADHS indicated the following: she was unable to move the resident's left wrist, the resident's neck had 75% PROM, the digits on the left hand had less than 50% PROM, the resident's left elbow had less than 50% PROM, the resident's left shoulder had less than 50% PROM, the resident's left hip was less than 50% PROM, the ADHS indicated she was unable to move the resident's left knee, the resident's toes on the left foot had less than 50% PROM, the ADHS indicated she was unable to move the resident's left ankle. The ADHS indicated the following for the right side- she was unable to move the resident's right wrist or right ankle, the resident's digits on the right hand was at 10% PROM, the right shoulder, elbow, hip, knee and toes were 75% PROM. The Therapy Manager agreed with the ADHS assessment of the resident's joint's. During the observation			

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	the resident's joints could be heard popping and the resident had some facial grimacing. Interview with MDS Coordinator #1 on 10/21/14 at 3:10 p.m., indicated she was responsible to put a Restorative Program in place. MDS Coordinator #1 indicated there was not specific program in place because of the specific criteria for a restorative program. Interview with the Therapy Manager on 10/21/14 at 3:50 p.m., indicated he was unable to find any documentation of training for staff related to PROM. Interview with CNA #12 on 10/22/14 at 10:30 a.m., indicated there was no specific PROM exercises for Resident #1. When queried if the facility provided any guidance for Resident #1's PROM limitations, CNA #12 indicated no. CNA #12 indicated normally when she gave the resident a bed bath she would try to bend his knee's, but they did not move much. CNA #12 indicated she was unable to move his hands wrist or feet. Interview with CNA #2 on 10/22/14 at 10:37 a.m., indicated there was no specific PROM exercises for Resident #1. CNA #2 indicated she did not bend the resident's knee's but did place a			

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	pillow between his legs. CNA #2 indicated she could move his arms when she washed him, but he was stiff. CNA #2 indicated she did not know if Resident #1 could move his toes. CNA #2 indicated the resident's hands were in a fist and she had not attempted to move them. Interview with CNA #7 on 10/22/14 at 11:05 a.m., indicated there were no guidelines on how far to move Resident #1 during PROM. CNA #7 indicated the facility had talked about putting a Restorative Range Of Motion program in, but they never did. CNA#7 indicated she moved the resident's arms up and down. CNA #7 indicated she could move his knee's and hands very little. The "Contracture Prevention and Management Program" provided by the Director Of Health Services (DHS) on 10/21/14 at 10:10 a.m., indicated the purpose was to prevent or reduce contractures and deformity, and/or preserve range of motion of residual limb to allow for use of prosthesis if needed through eh provision of range of motion, stimulation of circulation, and muscle strengthening exercises. The procedure included, but were not limited to, complete the initial restorative assessment to establish a baseline of			

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	residents with potential or actual range of motion limitations, determine the type of exercises required based on the assessment and the resident's abilities, determine the goal of the range of motion activity, enter the resident specific interventions and goals on the Restorative/Functional Maintenance Plan interventions and goals and approaches. Inform care giving team of the plan. Document daily participation and/or number of minutes that interventions are provided. 3.1-42(a)(2)			
F000323 SS=D	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. Based on observation, interview and record review that facility to implement interventions to prevent falls, ensure the resident had proper fitting footwear and failed to ensure the call light was available for a resident that was at high risk for falls resulting in a fall causing abrasions to the head and a skin tear to the right elbow for 1 of 4 residents who met the criteria for accidents in a total sample of 15 (Resident #95).	F000323	**F 323 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #95's careplan was updated to reflect interventions to prevent falls, proper foot wear was obtained for resident to wear and call light was placed with in easy reach . **Identification of other residents having the potential to be affected by the same alleged deficient practice and**	11/21/2014

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	Finding include: Interview with LPN #17 on 10/14/14 at 12:02 p.m., indicated Resident #95 had fall on 10/11/14. LPN #17 indicated the resident had a skin tear on the right elbow and a skin tear on the top of the head from the fall. During observation on 10/14/14 at 1:33 p.m., Resident #95 was in his bedroom standing at the bed and asked if I would get his cane, back scratcher and call light for him. The resident's call light, back scratcher and cane was laying on the floor behind the resident's bed. CNA #2 came into the resident's bedroom and indicated a nurse from another hall had assisted the resident back to his room after lunch and she was unsure why these items where laying on the floor behind his bed. CNA #2 indicated the nurse must not have noticed these items were out of reach. During observation and interview on 10/14/14 at 2:10 p.m., Resident #95 had on black shoes, the right shoe laces were not tied and the left shoe did not have shoe laces in them. Resident #95 indicated he did not know what happened to the shoe laces for the left shoe. During observation on 10/16/14 at 2:35		**corrective actions taken**: Facility determined that there were no other like residents. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Staff will be educated on ensuring that new residents interventions to prevent falls are implemented, that residents have appropriate foot wear and call lights are in easy reach **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will conduct audits of new residents to ensure that residents identified at risk for falls have appropriate interventions in place to prevent falls, which include appropriate foot wear, call light with in easy reach. Will review all new residents at the daily CCM meeting 5 days a week times 8 weeks, then weekly times 4 weeks, then monthly times 3 months. Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	p.m., Resident #95 was asleep in his chair, the resident had on black shoes with no shoe string in the left shoe and the right shoe was loosely tied. Review of the record of Resident #95 on 10/17/14 at 9:50 a.m., indicated the resident's diagnoses included, but were not limited to, frequent falls, venous stasis, leg weakness, diabetes mellitus, dependent edema and pace maker. The physician order for Resident #95 dated, 10/10/14 (no time), indicated the resident was an emergency admit to the facility for frequent falls, venous stasis and bilateral leg weakness. The fall risk assessment for Resident #95 dated, 10/10/14, indicated the resident had a past history of falls and visual impairment. The nursing admission assessment and data collection for Resident #95 dated, 10/10/14, indicated the resident was one assist for ambulation, one assist for bathing, one assist for toileting, the resident was always continent of bowel and bladder, the resident had severely impaired vision and the resident was alert and oriented. The safety plan of care section was blank.			

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	The nurse's note for Resident #95 dated, 10/10/14 at 8:00 p.m., indicated the resident was admitted to the facility. The resident had frequent falls at home. The resident was alert and oriented to person and place and confused at times. The resident was hard of hearing and had "very poor eyesight". The resident walked with a walker and was oriented to his room and call light. The note was signed by RN #5. The nurse's note for Resident #95 dated, 10/11/14 at 10:00 a.m., indicated the resident was in the bathroom to void. The resident was standing in front of the toilet and fell backward and hit his head on the wall and right elbow on the floor. The resident had a skin tear on top of his scalp and steri strips applied, the resident had a skin tear on his right elbow and steri strips applied. The fall circumstance assessment and intervention for Resident #95 dated 10/11/14 at 10:00 a.m., indicated the resident fell in the bathroom and hit his head. The environmental factors were- wet floor. The prevention update indicated bed and/or chair alarm. The Interdisciplinary review dated, 10/15/14, indicated the root cause was "balance". The skin impairment assessment for			

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	Resident #95 dated, 10/11/14, indicated the resident had a skin tear and bruise on top of his head that measured 3 centimeters (cm) by 4 cm. The treatment was steri strips. The skin impairment assessment for Resident #95 dated, 10/11/14, indicated the resident had a skin tear on his right elbow that measured 1 cm by 1 cm. The treatment was steri strips. The refusal of care circumstance assessment and intervention for Resident #95 dated, 10/13/14 (no time), indicated the resident had refused the bed alarm because it was disturbing his sleep. The documentation indicated no other safety interventions were implemented. During observation and interview with Resident #95 on 10/17/14 at 10:30 a.m., indicated the resident was wearing the same black shoes with no shoe strings in the left shoe and the right shoe not tied. The resident indicated he never did find his shoe string, but he needed some. Physical Therapist (P.T.) #18 came into Resident #95's bedroom and indicated this was the resident's first day to be evaluated for walking. P.T. #18 indicated she had not been notified of the resident's of the resident's improper fitting shoes. P.T. #18 asked Resident #95 if those			

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	were his shoes and where his shoe strings were. The resident indicated he did not know where shoe strings went, but that he needed some. Interview with LPN #15 on 10/17/14 at 11:00 a.m., indicated she was not aware of Resident #95's shoe's not fitting properly. LPN #15 indicated she would contact the resident's family to see if they could bring the resident some different shoes. Observation at this time P.T.#18 was walking with Resident #95 down the hallway with a walker and a gait belt. The resident was walking out of his shoes. Interview with the Minimum Data Set (MDS) Coordinator #2 on 10/17/14 at 1:37 p.m., indicated Resident #95 did not have a plan of care to prevent falls. The MDS Coordinator #2 indicated the only careplan's the resident had was for nutrition. MDS Coordinator #2 indicated it was the nurse's responsibility to put a plan of care in place on admission if there was something pertinent that needed to be place at that time. MDS Coordinator #2 indicated it was MDS responsibility to put other careplan's in place. Interview with Medical Record staff on 10/17/14 at 2:36 p.m., indicated RN #5 was Resident #95's admitting nurse and should have put a safety plan of care in			

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	place for the resident on admission. Interview with Resident #95's family member on 10/20/14 at 10:20 a.m., indicated the facility had not contacted him about the resident's shoes not fitting properly. The family member indicated he had new shoes for the resident and would bring them to the facility. The family member indicated he was at the facility the morning of 10/11/14 when the resident fell. The family member indicated the resident was laying in bed and asked the family member about some clothes. The family member indicated he went to his truck to get the resident's clothes and the resident got up while he was gone to go to the bathroom and fell. Interview with the Director of Health Services (DHS) on 10/21/14 at 2:04 p.m., indicated all staff were responsible to monitor residents have proper fitting footwear on. The falls management program guidelines provided by DHS on 10/21/14 at 10:10 a.m., indicated the facility strived to maintain a hazard free environment, mitigate fall risk factors and implement preventative measures. The fall risk assessment is included as part of the Admission and Monthly nursing assessments and review.			

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	Identified risk factors should be evaluated for the contribution they may have to the resident's likelihood of falling. Care plan interventions should be implemented that address the resident's fall risk factors. 3.1-45(a)(1) 3.1-45(a)(2)			
F000387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on interview and record review the facility failed to ensure a resident was seen by a physician as required for 1 of 4 residents who met the criteria for contractures without a splint device in a total sample of 15 (Resident #1). Finding include: During observation on 10/15/14 at 10:46 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place.	F000387	**F 387 Frequency & timeliness of physician visit Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 1 's chart was updated to show the MD was in the facility to see the resident and sign the chart 10/29/14 **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: An audit will be completed of the residents in the campus to ensure their MD visits are timely. **Measures put in place and systemic changes made to ensure the alleged deficient**	11/21/2014

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	Interview with Resident #1's family member on 10/15/14 at 2:29 p.m., indicated they visit the resident almost daily. Resident #1's family member indicated the resident stayed in bed all of the time. During observation on 10/16/14 at 10:06 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. During observation on 10/17/14 at 10:00 a.m.., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place. Review of the record of Resident #1 on 10/20/14 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, brain injury, constipation, urinary incontinence, anoxic brain damage, seizure disorder and aphasia (loss of the ability to communicate). The record of Resident #1 indicated the resident was admitted to the facility on 2/23/14. The record of Resident #1 indicated the		**practice does not recur:** Medical Records will be reeducated on the regulations of frequency of physician visits **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will complete random audits of 3residents charts per 100, 200, and 300 hallways weekly times 4 weeks then monthly times 5 months. Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	

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	last recent physician visit was dated, 5/21/14, the physician visit indicated the resident was non verbal, chess wall within normal limits, the resident was unlabored and clear to auscultation. The resident's extremities were without clubbing with a contractures of the right ankle. The resident had traumatic brain injury. The resident had a gastrostomy-tube and an old tracheostomy site. The Minimum Data Set (MDS) assessment for Resident #1, dated 8/14/14, indicated the following: bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- activity did not occur, functional limitation in ROM of upper and lower extremities- impairment on both sides. Interview with the Assistant Director Of Health Services on 10/20/14 at 2:40 p.m., indicated Resident #1 most recent physician visit was 5/21/14. Interview with the Director of Health Services (DHS) on 10/22/14 at 3:43 p.m., indicated Medical Records staff were responsible to provide the Physicians with a list of residents names and when they were due to be seen by the Physician. DHS indicated Medical			

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	Records had not sent residents names to the Physician. 3.1-22(d)(1)			
F000406 SS=D	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 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, interview and record review the facility failed to follow the recommendations of a Pre-admission screening/Annual review for Restorative Range Of Motion therapy for 1 of 1 resident's reviewed for Preadmission screening in a total sample of 15 (Resident #1). Finding include: During observation on 10/15/14 at 10:46 a.m., Resident #1 was laying in bed, both of the resident's right and left wrist and fingers were curled in towards the resident's chest. Resident #1 did not have a splint device in place.	F000406	**F 406 Provide/Obtain Specialized Rehab Service Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #1's careplan was updated to reflect the recommendation from his pre admission screening for PROM and plan was developed and implemented **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** The facility reviewed the PASSAR for all residents and there where no other like residents **Measures put in place and systemic changes**	11/21/2014

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	Review of Resident #1's careplan's dated, 4/11/14 to 9/14/14, indicated no plan of care related to the resident's contractures or Passive Range Of Motion (PROM) program. The Occupational Therapy progress and discharge summary for Resident #1, dated 4/16/14, indicated the following: Goal #1- "The goal for ROM was the resident would achieve 75% ROM for wrists and digits while rest of joints are also at 75% PROM or better in prep for RNP." The start date of the goal status, dated 3/3/14, was the resident demonstrated 75% PROM for bilateral shoulders, elbows, knees, and hips. The resident had bilateral hands PROM at approximately 50% for digits and wrists. "Bilateral ankles with fixed contractures. The end of goal status, dated 4/16/14, indicated the goal was met and the resident demonstrated 75% PROM all major joints such as the hips, knees, shoulders, elbows and approximately 75% PROM for wrist and digits. The resident would have overall Bilateral lower extremities and bilateral upper extremities ROM RNP established to decrease risk of further contractures development. Education with staff related to PROM to be completed daily. The discharge summary was electronically signed by the Therapy Manager.			

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	The Minimum Data Set (MDS) assessment for Resident #1, dated 8/14/14, indicated the following: bed mobility- total dependence of two people, transfer- total dependence of two people, walk in room- activity did not occur, functional limitation in ROM of upper and lower extremities- impairment on both sides and Restorative Nursing Program for PROM- none. Interview with MDS coordinator #1 on 10/20/14 at 2:04 p.m., indicated she was unable to find documentation that Resident #1 received PROM exercises. Interview with the Assistance Director Of Health Services (ADHS) on 10/20/14 at 2:40 p.m., indicated Resident #1 did not have a restorative program for PROM. The Preadmission screening for Resident #1 dated, 3/13/14, indicated the resident met the criteria for PASRR level II assessment. The screening indicated the recommendations were "needs restorative range of motion therapies for help to reduce contractures as well as to provide him with human contact." 'He may benefit from 1:1 interactions and stimulation." The screening indicated the resident current cognitive skills was estimated to at some two months of age			

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	or less. The resident's diagnoses was unspecified Intellectual Disability, Major Neurocognitive Disorder due to Traumatic Brain Injury. The summary indicated the resident suffered a severe traumatic brain injury during an automobile accident when the resident was 21 years of age. Interview with the Social Service Director (S.S.D.) on 10/21/14 at 2:15 p.m., when queried who was responsible to ensure Level II recommendations were followed: it is a team approach to ensure it is done, also families will participate. Nursing would do the nursing aspect, she would do the social service part and activities would take care of their part. 3.1-23(a)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual			

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	resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview, and record review, the facility failed to wear gloves with insulin administration for 1 of 2 residents observed for insulin administration. (Resident #93) Findings include: On 10/20/14 at 4:16 p.m., RN #4 was observed providing resident #93 with 5 units of Humalog insulin in her left upper arm. RN #4 did not wear gloves. She indicated she did not normally wear gloves when she provided residents with insulin injections.	F000441	**F 441 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The nurse was inserviced on the facility guidelines of wearing gloves while administering injections(insulin) resident suffered no negative outcome for no glove use **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The facility has determined that all residents receiving injections have the potential to be affected by the deficient practice	11/21/2014

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	The "Specific Medication Administration Procedures" provided by the Corporate Nurse on 10/21/14 at 2:55 p.m., indicated the following: "Purpose: To administer a parenteral medication into the subcutaneous tissue in order to promote slow medication absorption and prolong medication action. Equipment required: ...E. Gloves. Procedures: ...B. Apply gloves and select an appropriate site for injection... P. Remove gloves and wash hands...." 3.1- 18(l)		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will inservice licensed nurses on the facility policy on medication administration with emphasis on-injections and perform competency check list for subcutaneous injection **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** DHS or designee will complete random audits of subcutaneous injections 2 times per week for 8 weeks and then monthly for 4 months Completion date: 11/21/14 ***The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.***	
R000000	Aspen Place Health Campus was found to be in compliance with 410 16.2-5, in regard to the State Residential Survey.	R000000		