

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2013
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00122004.</p> <p>Survey dates: January 7, 8, 9, 10, 11, 14, 15, and 16, 2012</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>Survey Team: Shannon Pietraszewski, RN-TC Regina Sanders, RN Amber Bloss, QMRP</p> <p>Census bed type: SNF/NF: 134 SNF: 16 Total: 150</p> <p>Census Payor Type: Medicare: 28 Medicaid: 77 Other: 45 Total: 150</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F0000	Attached please find the revised "ABUSE AND NEGLECT OF A RESIDENT Policy" (#5 Internal Reporting) indicating the administrator will be immediately notified for abuse/neglect complaints. Attached please find attachment "E-3" Wittenberg's policy for "Reference and Background Checks".	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	IAC 16.2. Quality review completed on January 24, 2013, by Janelyn Kulik, RN.				

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

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

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to inform residents of the services available in the facility related to charges for such services not covered by Medicare when presented with their ABN (Notice of Medicare Non-coverage) and failed to provide documentation indicating timely notification of the ABN notice, for 3 of 3 residents reviewed. (Resident #85, #18, #89)</p> <p>Findings include:</p> <p>1. Review of the ABN (Notice of Medicare Non-coverage) on 1/10/13 for Resident #85 indicated his Medicare was ending on 9/17/12 and the daughter-in-law was notified by phone on 9/17/12. The facility failed to give the required two day notice. There was no signature or date</p>	F0156	<p>F Tag: 156 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? We are unable to correct the area identified for the 3 residents due to: 1 resident discharged in September, 1 resident expired, and the 3 rd resident does remain in facility but end of coverage occurred in 11/2012. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents coming off of Medicare services have the potential to be effected by the alleged deficient practice. Moving forward, any resident coming off of Medicare services will be informed of the services available in the facility and charges for such services not covered by Medicare when given</p>	02/15/2013

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	<p>indicating the form was reviewed. No documentation was provided indicating the facility attempted to obtain a signature by mail.</p> <p>2. Review of the ABN for Resident #18 indicated her Medicare coverage was ending on 11/30/12. A note on the bottom indicated her daughter was notified by email on 11/20/12. There was no signature or date indicating the form was reviewed. No documentation was provided indicating the facility attempted to obtain a signature by mail.</p> <p>3. Review of the ABN for Resident #89 indicated his Medicare coverage ended on 9/13/12. A note on the bottom of the ABN indicated that the daughter was informed by phone on 9/11/12. There was no signature or date indicating the form was reviewed. No documentation was provided indicating the facility made attempts to obtain a signature by mail.</p> <p>3.1-4(a)</p>		<p>their ABN notice and timely notification of the ABN notice will be provided by Social Service Dept. Audit Created - Attachment A 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. When informing a beneficiary or their responsible party of non-coverage, at least 48 hours will be given. All alert residents will review their own forms and sign the letter. Any verbal notifications to responsible parties will be witnessed by 2 people and a copy of the notice will be mailed standard mail to allow for a signature to be made. We will continue to mail via certified mail any letters that we have not verbally spoken to the beneficiary or responsible party. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. An audit will be conducted weekly for 4 weeks, monthly for 3 months, and then quarterly for 3 consecutive quarters to review ABN notices to ensure that services not covered were provided, adequate notification was given and that proper signatures and/or attempts for signatures was made.</p>		

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F0225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review</p>	F0225	F225 Investigate/Report	02/15/2013	

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	<p>and interview the facility failed to thoroughly investigate and report to Indiana State Department of Health unusual occurrences/injuries of unknown origin, allegations of sexual abuse, and staff to resident abuse in 3 of 5 abuse investigations reviewed. (Residents #B, #D, #F and #L)</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia (bleeding disorder).</p> <p>A Re-Admission Nursing Evaluation dated 11/11/12 indicated Resident #B had a bruise near the rectum. No measurements were written.</p> <p>A nursing note on 11/17/12 at 11:35 p.m. indicated the resident was readmitted from the hospital. There was no documentation indicating a bruise near the rectum.</p> <p>An incident report dated 11/28/12 at 7:50 a.m. indicated the resident had a 2.3 x 0.4 x <0.1 red/purple area on the right lateral rectum. The measurements did not indicate</p>		<p>Allegations/Individuals 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice for resident B, D, F and L. Repost send to ISDH for Resident B on 1-17-13 Report sent to ISDH for Resident F and resident L on 1-17-13 Staff #8 interviewed on 2-4-13 regarding "rough handling" as reported by resident D Resident D discharged – unable to interview. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents with unusual occurrences/injuries of unknown origin audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13 · Residents with allegations of sexual abuse audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13. · Residents with staff to resident abuse audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13. · All nursing staff to be educated on Abuse and Neglect of a Resident Policy (attachment B) and ISDH guidelines on Reporting Unusual Occurrences (Attachment C). Education to be</p>		

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	<p>centimeters or inches. A note was written on the back page indicating "the resident did receive rectal cream for hemorrhoids, currently on Levaquin (antibiotic), labs 'slightly off', the resident had been sent out for intravenous fluids on 11/29/12, the resident does have large bowel movements and 'pushes bowel movements out per staff'. The resident is transferred with a mega mover, the skin is frail, the rectal area has no pain when touched. Labs drawn on 11/30/12. Does have a diagnoses of hemorrhoids, monitor rectum every shift for 7 days. 10/10/12 to 10/23/12 platelets dropped and doctor was aware. On 11/26/12, platelet count was down, and per CNA, daughter checks the rectum." This note was copied from the nursing progress notes dated 11/30/12 at 2:00 p.m., and copied to the back of the investigation report.</p> <p>A nursing note on 11/30/12 at 11:25 p.m. indicated, problem number three as discoloration to the right side of the rectum. The evaluation indicated "...Discoloration to right side of rectum is faded nearly visible [sic]..."</p> <p>A nursing note dated 12/1/12 at 11:15 p.m. indicated problem number two as discoloration to the rectum. The</p>		<p>completed on 2-15-13 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · Inter disciplinary team will meet weekly and review all resident reports with unusual occurrences/injuries of unknown origin, allegations of sexual abuse and staff to resident abuse to ensure investigation is complete and submitted to ISDH. · Audit created (Attachment D)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audit will be presented to the QA/A committee until substantial compliance is obtained ·</p>		

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	<p>evaluation indicated "...No discoloration to rectum observed..."</p> <p>On 1/11/13 at 2:00 p.m., wound care to the sacral pressure sore was observed. A long, rectangle shaped, dark/purple area was observed coming from the inner buttocks to the outer/upper left buttocks. The wound care nurse indicated this was a bruise and not a pressure area.</p> <p>On 1/14/13 at 1:25 p.m., the wound nurse and DoN observed the dark/purple area on left buttocks. The wound nurse indicated this was the same "bruise" since November of 2012. The wound nurse indicated maybe the documentation was incorrect regarding the bruise observed on the left buttock and documentation indicated the right buttock.</p> <p>An interview with LPN #114 and the DoN (Director of Nursing) on 1/14/13 at 1:45 p.m., indicated a report was filled out on the bruise to the left buttocks. LPN #114 indicated the bruise started on the right side of the buttocks, had gotten larger, and moved to the left. The DoN indicated during this same time, the resident was diagnosed with thrombocytopenia (bleeding disorder).</p>			

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	<p>Interview with LPN #3 on 1/15/13 at 3:00 p.m. indicated a CNA told her the resident's daughter tends to "mess" around with the resident. LPN #3 could not indicate whether the resident's daughter was actually observed "messaging" with the resident. LPN #3 indicated the bruise was not investigated due to the resident being diagnosed with thrombocytopenia.</p> <p>Interview with the DoN on 1/16/13 at 5:00 p.m. indicated the bruise near the rectum was not investigated nor reported to Indiana State Department of Health due to the diagnoses of thrombocytopenia.</p> <p>2. On 1/15/2013 at 4:02 PM, an investigation was reviewed for an allegation Resident #D made against an Employee #8 for mistreatment. According to the investigations, Resident #D's daughter reported an allegation of rough handling during a transfer on 11/27/12. The investigation lacked documentation that any interviews with staff occurred. The investigation lacked documentation that actual harm or injury were ruled out or investigated.</p> <p>During an interview with the Social Service Director on 1/16/13 at 4:31 PM, she indicated she was in charge</p>				

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	<p>of the investigation but did not know whether interviews with staff were done nor whether a skin check was done on Resident #D to rule out an injury. Documentation showed the Interdisciplinary Team concluded no mistreatment occurred and Employee #8 returned to work. No further documentation was provided.</p> <p>3. An incident report, dated 8/4/12 (no time documented), was reviewed on 1/15/13 at 4:02 PM., indicated that Resident #F told a visitor Resident #L had inappropriately touched her. The visitor reported the abuse allegation to the facility.</p> <p>During an interview on 1/15/13 at 1:52 PM, the Social Service Director confirmed the allegation was not reported to the State Department of Health. She indicated she understood allegations of this nature should be reported to the State Department of Health but concluded after the resident's interview, the allegation was untrue. The Social Service Director indicated there was no reason to do other interviews for potential witnesses of staff and residents because the incident "did not happen". She indicated she didn't know whether Resident #L (who allegedly touched Resident #F</p>				

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	<p>inappropriately) had been interviewed.</p> <p>No further documentation was provided.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>			

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F0226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to followed their policy related to unusual occurrences/injuries of an unknown source, accusations of sexual abuse, and staff to resident abuse to be fully investigated and reported to the Indiana State Department of Health and staffing agency therapists references were not verified prior to working in the facility. (Residents #B, #D, #F and #L) and (Therapist #93)</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia (bleeding disorder).</p> <p>A Re-Admission Nursing Evaluation dated 11/11/12 indicated Resident #B had a bruise near the rectum. No measurements were written.</p>	F0226	<p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Residents B, D, F , L and Therapist #83)</p> <p>Report sent to ISDH for Resident B on 1-17-13 · Report sent to ISDH for Resident F and resident L on 1-17-13 · Resident L interviewed on 1-17-13 · Staff #8 interviewed on 2-4-13 regarding "rough handling" as reported by resident D · Resident D discharged – unable to interview. · Unable to correct the alleged deficient practice for the Therapy Department. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · All residents have the ability to be affected by the alleged deficient practice. · Residents with unusual occurrences/injuries of unknown origin audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13 ·</p>	02/15/2013	

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	<p>A nursing note on 11/17/12 at 11:35 p.m. indicated the resident was readmitted from the hospital. There was no documentation indicating a bruise near the rectum.</p> <p>An incident report dated 11/28/12 at 7:50 a.m. indicated the resident had a 2.3 x 0.4 x <0.1 red/purple area on the right lateral rectum. The measurements did not indicate centimeters or inches. A note was written on the back page indicating "the resident did receive rectal cream for hemorrhoids, currently on Levaquin (antibiotic), labs 'slightly off', the resident had been sent out for intravenous fluids on 11/29/12, the resident does have large bowel movements and 'pushes bowel movements out per staff'. The resident is transferred with a mega mover, the skin is frail, the rectal area has no pain when touched. Labs drawn on 11/30/12. Does have a diagnoses of hemorrhoids, monitor rectum every shift for 7 days. 10/10/12 to 10/23/12 platelets dropped and doctor was aware. On 11/26/12, platelet count was down, and per CNA, daughter checks the rectum." This note was copied from the nursing progress notes dated 11/30/12 at 2:00 p.m., and copied to the back of the investigation report.</p>		<p>Residents with allegations of sexual abuse audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13.</p> <p>Residents with staff to resident abuse audited from October 1, 2012 through present with no discrepancies. Audit completed on 2-4-13. All nursing staff to be in-serviced on "Abuse and Neglect of a Resident Policy" (Attachment B) and ISDH guidelines on Reportable Unusual Occurrences (Attachment C) In-seervice to be completed by 2-15-13. Alliance Therapy audited their staff for reference checks - completed 2-1-13</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Inter disciplinary team will meet weekly and review all resident reports with unusual occurrences/injuries of unknown origin, allegations of sexual abuse and staff to resident abuse to ensure investigation is complete and submitted to ISDH per reporting guidelines. Audit created (Attachment D) Therapy Manager educated on 2-15-13 to audit Alliance Policy Reference Checks and reviewed HR policy "Reference and Background checks" Alliance Policy created on 2-1-13 (attachment E-1) Audit created (Attachment E-2) Attachment (E-3)</p> <p>4. How the</p>	

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	<p>A nursing note on 11/30/12 at 11:25 p.m. indicated, problem number three as discoloration to the right side of the rectum. The evaluation indicated "...Discoloration to right side of rectum is faded nearly visible [sic]..."</p> <p>A nursing note dated 12/1/12 at 11:15 p.m. indicated problem number two as discoloration to the rectum. The evaluation indicated "...No discoloration to rectum observed..."</p> <p>On 1/11/13 at 2:00 p.m., wound care to the sacral pressure sore was observed. A long, rectangle shaped, dark/purple area was observed coming from the inner buttocks to the outer/upper left buttocks. The wound care nurse indicated this was a bruise and not a pressure area.</p> <p>On 1/14/13 at 1:25 p.m., the wound nurse and DoN observed the dark/purple area on left buttocks. The wound nurse indicated this was the same "bruise" since November of 2012. The wound nurse indicated maybe the documentation was incorrect regarding the bruise observed on the left buttock and documentation indicated the right buttock.</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audits to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A committee until substantial compliance is obtained.</p>	
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	<p>An interview with LPN #114 and the DoN (Director of Nursing) on 1/14/13 at 1:45 p.m., indicated a report was filled out on the bruise to the left buttocks. LPN #114 indicated the bruise started on the right side of the buttocks, had gotten larger, and moved to the left. The DoN indicated during this same time, the resident was diagnosed with thrombocytopenia (bleeding disorder).</p> <p>Interview with LPN #3 on 1/15/13 at 3:00 p.m. indicated a CNA told her the resident's daughter tends to "mess" around with the resident. LPN #3 could not indicate whether the resident's daughter was actually observed "messing" with the resident. LPN #3 indicated the bruise was not investigated due to the resident being diagnosed with thrombocytopenia.</p> <p>Interview with the DoN on 1/16/13 at 5:00 p.m. indicated the bruise near the rectum was not investigated nor reported to Indiana State Department of Health due to the diagnoses of thrombocytopenia.</p> <p>2. On 1/15/2013 at 4:02 PM, an investigation was reviewed for an allegation Resident #D made against an Employee #8 for mistreatment. According to the investigations,</p>			

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	<p>Resident #D's daughter reported an allegation of rough handling during a transfer on 11/27/12. The investigation lacked documentation that any interviews with staff occurred. The investigation lacked documentation that actual harm or injury were ruled out or investigated.</p> <p>During an interview with the Social Service Director on 1/16/13 at 4:31 PM, she indicated she was in charge of the investigation but did not know whether interviews with staff were done nor whether a skin check was done on Resident #D to rule out an injury. Documentation showed the Interdisciplinary Team concluded no mistreatment occurred and Employee #8 returned to work. No further documentation was provided.</p> <p>3. An incident report, dated 8/4/12 (no time documented), was reviewed on 1/15/13 at 4:02 PM., indicated that Resident #F told a visitor Resident #L had inappropriately touched her. The visitor reported the abuse allegation to the facility.</p> <p>During an interview on 1/15/13 at 1:52 PM, the Social Service Director confirmed the allegation was not reported to the State Department of Health. She indicated she</p>			

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	<p>understood allegations of this nature should be reported to the State Department of Health but concluded after the resident's interview, the allegation was untrue. The Social Service Director indicated there was no reason to do other interviews for potential witnesses of staff and residents because the incident "did not happen". She indicated she didn't know whether Resident #L (who allegedly touched Resident #F inappropriately) had been interviewed.</p> <p>No further documentation was provided.</p> <p>4. There were 23 therapy employees listed on the Employee Records form.</p> <p>During employee record reviews on 01/15/13 at 2 p.m., Therapist #93's personal record lacked documentation past work references were obtained.</p> <p>During an interview on 01/15/13 at 3 p.m., the Therapy Manager indicated it is not the Therapy Companies policy to obtain references.</p> <p>During an interview on 01/16/13 at 10:45 a.m., the Therapy Regional Manager indicated they call for</p>			

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	<p>references prior to hiring employees, but they do not have a form to write it down on.</p> <p>The Abuse and Neglect of a Resident Policy dated 11/2/11, was provided on 1/15/13 at 3:30 p.m. The policy indicated "...Physical Abuse--the use of physical force that may result in bodily injury, physical injury, physical pain, or impairment...Sexual--Sexual contact that result from threats, force, or the inability of the person to give consent, and involving a range of activities, including, but not limited to, assault, rape, or sexual harassment...Injuries of Unknown Source--An injury should be classified as an "injury of unknown source" when both of the following conditions are met:</p> <p>a) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident: and</p> <p>b) The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time...</p> <p>The policy indicated procedures for internal investigations of allegations. The procedures include:</p>			

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	<p>a) Documented interview of the resident regarding alleged abuse.</p> <p>b) Documented interview of any witnesses to the alleged incident of abuse.</p> <p>c) Review of appropriate documentation including, but not limited to, chart review, the Preliminary Incident Investigation Form and Internal Investigation Form for Suspected Abuse/Neglect.</p> <p>d) Investigations for potential 'injuries of unknown source' will include interviews with staff, resident and families. Inquiries will include but are not limited to: When the injury was discovered? When the resident was last seen injury free? The time period between injury free and injury discovery will become the target of further inquiry such as: What was the resident observed doing during this time period and where were they doing it? What care did the resident receive during this period? Did the resident manifest behaviors that could have resulted in the injury? Does the resident have physical tendencies, positioning, ambulation/mobility issues that could lead to the injury?</p> <p>The policy indicated procedures for external reporting of potential abuse. The procedures include:</p> <p>a) The administrator or designee</p>			

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	<p>will report all alleged violations and all substantiated incidents to the resident's representative, the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation. Included in this report will be: Name, age, diagnosis and mental status of the resident allegedly abused or neglected. Type of abuse reported. Date, time, location and circumstances of the alleged incident. Any obvious injuries or complaints of injury. Steps the facility has taken to protect the resident.</p> <p>b) Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation will be sent to the ISDH. The final report shall include: Name, age....The original allegation. Facts determined during the process of the investigation, review of medical record and interviews of witnesses. Conclusion of the investigation based on known facts.</p> <p>c) Additional information to attach to concern log may include: police reports if conducted. The validated perpetrator information (if an employee) and their status</p>			

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	<p>(suspended, terminated, still working). Attached summary of all interviews conducted, with the names, addresses, and phone numbers.</p> <p>The policy procedures for pre-employment screening of potential employees indicated the facility will not knowingly employ any individual convicted of resident abuse or misappropriation of resident property. Will not knowingly employ any direct care staff convicted of any of the crimes listed in the Indiana State Police Criminal Background Check...Prior to a new employee starting a work schedule, "this" facility will:</p> <ul style="list-style-type: none"> a) initiate a reference check from previous employer(s), in accordance with facility policy b) Obtain a copy of the state license of any individual being hired for a position requiring a professional license. c) check the Indiana State Aide Registry on any individual being hired for a Certified Nurse Aide position d) File an Indiana State Police Criminal Background Check application on any individual being hired. 			

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	<p>The facility policy and procedures for conducting a healthcare Worker Background Check will be followed.</p> <p>3.1-28(a)</p>			

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F0247 SS=A	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to notify a resident in a timely manner of a transfer related to a new room mate for 1 of 2 resident's reviewed for notifications. (Resident #F)</p> <p>Finding included:</p> <p>During an interview on 1/8/13, Resident #F indicated she did not get notice when she had a new roommate move in.</p> <p>During a clinical record review on 1/9/13 at 1:40 PM, Resident #F's Social Service notes from 1/11/12 to present which did not indicate any recent roommate change notification.</p> <p>An interview with the Social Service Director on 1/9/13 at 1:58 PM indicated Resident #F was informed 12/13/12 of the new roommate, the same day she moved in. The Social Service Director said no documentation was taken for notifying Resident #F. She said the facility gives advance notice to those residents who are switching rooms</p>	F0247	<p>F Tag: 247 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? We are unable to correct the deficient practice identified for Resident #F due to her receipt of a new roommate occurred in the past.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents residing in a semi-private room within the facility have the potential to be effected by the deficient practice. Moving forward, any resident who is to receive a new roommate will be given notice as soon as it is identified that a roommate will be moving in and notice will be documented in the social service progress notes.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. "Room Move policy" (attachment F) was revised on 2-4-13 to include that notice of receiving a new roommate will be documented as current policy only indicated that resident will be</p>	02/15/2013

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	<p>but does not give advance notice to the residents receiving a new roommate. She indicated many residents would get too anxious if you gave them too many days advance notice so the usually tell them the same day the move occurs.</p> <p>3.1-3(v)(2)</p>		<p>notified. Social service department staff educated on new policy 2-5-13. Audit created (attachment G)4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. An audit will be conducted weekly for 4 weeks, monthly for 3 months, and then quarterly for 3 consecutive quarters to review notices of resident's receiving new roommate in a timely manner and that documentation is in place to identify notice occurred.</p>		

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to provide medically-related social services, related to implementation of interventions for residents with signs and symptoms of depression for 3 of 13 residents reviewed who received antidepressant medication. (Residents #32, #81, and #149)</p> <p>Findings include:</p> <p>1. Resident #149's record was reviewed on 01/14/13 at 11:16 a.m. The resident's diagnoses included, but were not limited to depression and Alzheimer's Disease with psychosis.</p> <p>The Physician's Recapitulation Orders, dated 01/13, indicated an order of Prozac (antidepressant) 10 milligrams at bedtime, which had an original order date of 10/02/12.</p> <p>A Social Service Assessment, dated 10/12/12, indicated, "...Mood Interview:...PHQ9 (Resident Mood Interview Severity Score)=18 (15 or</p>	F0250	<p>F Tag: 250 Provision of medically related social service</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident 32, 81, 149) Care plans written on 2-4-13 to implement interventions for the 2 of 3 residents identified as being affected by the deficient practice to address their signs and symptoms of depression. Resident D is discharged. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the deficient practice. All resident charts will be reviewed to identify those who use anti-depressant and/or display signs or symptoms of depression. Audit completed on 2-4-13. Those identified as using an anti-depressant and/or display signs or symptoms of depression, as defined as having a PHQ-9 score of 5 or higher or by nursing assessment will be evaluated through RAI/CAA process for care planning and</p>	02/15/2013

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	<p>higher indicated moderate major depression). Resident reported having little interest in doing things daily. Resident reported feeling down daily. Resident reported having trouble sleeping daily and feeling tired daily. Resident reported having trouble concentrating daily. Resident stated 'so much goes through my mind!...'"</p> <p>The resident's care plan, dated 10/17/12 , lacked documentation to indicate the resident had signs and symptoms of depression.</p> <p>A Social Service Note, dated 10/23/12, indicated, "Care plan meeting held on this date with resident's son. Reviewed resident care plans, weight, meal intake report, labs, medications, and overall status...There are no concerns being voiced at this time..."</p> <p>A Social Service Note, dated 10/24/12, indicated, "SS (Social Service) referral received related to resident consistently getting out of bed...offered her a room change and resident voiced 'it would be nice to have a window'...There are no concerns being voiced at this time, will observe for any changes and assist further as able."</p>		<p>interventions.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> · During the MDS mood interview and chart review, any resident scoring a 5 or higher on the PHQ-9 or identified as using an anti-depressant will be evaluated through RAI/CAA process for care planning and interventions. · If a resident is displaying sign/symptoms of depression a care plan will be initiated or adjusted. Nursing to be in-serviced by 2-15-13 · Nursing 24 Hour Condition Report sheet will be utilized for anyone with signs/symptoms of depression. (attachment H)Audit created (attachment I) <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <ul style="list-style-type: none"> · Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audit will be presented to the QA/A committee until substantial compliance is obtained. 	

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	<p>A Social Service note, dated 10/25/12, indicated, "Resident adjusting well to room change."</p> <p>There was a lack of documentation in the Social Service Progress Notes to indicate the resident had signs and symptoms of depression and Social Service interventions for the signs and symptoms.</p> <p>A Social Service Assessment, dated 10/30/12, indicated, "Mood Interview:...PHQ9 =12. Resident reported feeling down daily and feeling bad about self. Resident reported feeling little energy daily. Resident reported having trouble concentrating daily. Resident reported 'I have a lot on my mind'..."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>A Social Service Assessment, dated 11/29/12, indicated, "Mood Interview:...PHQ9=15. Resident reported feeling depressed daily. Resident reported feeling tired daily. Resident reported having poor</p>						

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	<p>appetite daily. Resident stated 'I'm hungry but when I get food I don't eat that much.' Resident reported feeling bad about self daily. Resident reported having trouble concentrating..."</p> <p>A Social Service note, dated 12/04/12, indicated, "updated: called and made son aware of res (resident's) PT (physical therapy) to end...no concerns at this time."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>A Social Service Assessment, dated 01/08/13, indicated, "Mood Interview:...PHQ9=0 (no signs or symptoms of depression). Resident reported feeling down at times..."</p> <p>There was a lack of documentation to indicate the facility was tracking the resident's mood status.</p> <p>During an interview on 01/14/13 at 11:45 a.m., the Social Service Director indicated she does not care plan for depression if the resident is not having any problems. She</p>						

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	<p>indicated she was unaware the resident had scored high on the mood interview and had signs and symptoms of depression.</p> <p>2. On 1/9/13 at 2:45 PM, a clinical record review of Resident #32 indicated a diagnoses including, but were not limited to, dementia with behaviors, acute renal insufficiency, thoracic back pain, hypothyroidism, depressive disorder, and left eye prosthesis. Review of the Physician's Orders dated 1/01/13 to 1/31/13 indicated Resident #32 was prescribed an anti-depressant (Sertraline HCL 50 MG Tab/daily) with a start date of 12/02/2011.</p> <p>Resident #32 received a behavioral health consult on 12/17/2012. The consult stated Resident #32 "presented with a very agitated mood and was very short and blunt with the examiner". In regards to her receptive and expressive language skills, the consult stated these were impacted by "patient's mood and her desire not to divulge information. This may be due to paranoia or simply be due to significant agitation and an unwillingness to engage with others. It appears too that the patient is quite depressed at this time. She has a history of stating 'I just want to die'....patient's attention and</p>			

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	<p>concentration were significantly impaired due to agitation and/or unwillingness."</p> <p>The Social Service Assessments for Resident #32 were reviewed. The assessment dated 6/25/12 indicated a PHQ9 score of 6 (which falls into the range of mild depression). During the mood interview, Resident #32 "reported feeling down daily" and "reported feeling tired daily".</p> <p>The Social Service Assessments dated 9/20/12 and 12/21/12 indicated Resident #32 refused to be interviewed.</p> <p>There was a lack of documentation in the clinical records to indicate a care plan had been implemented for depression.</p> <p>Social Service notes from 2/15/12 to 12/28/12 were reviewed. A note dated 10/8/12 indicated a Social Service referral was made because Resident #32 told a nurse, "I'm no good, I just want to die". A note dated 12/28/12 indicated Resident #32 had a care plan conference but no documentation of follow up regarding the behavioral health consult findings of 12/17/12 indicating Resident #32 was "quite depressed at</p>			

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	<p>this time".</p> <p>The Social Service Director (SSD) was interviewed on 1/14/13 at 11:11 AM. She indicated depression was not care planned because Resident #32 didn't score high on the PHQ9 (mood assessment) and had no active tearfulness and no active signs of depression. SSD indicated they monitor the effectiveness of the anti-depressant by care planning it as a risk for falls.</p> <p>3. Resident #D's clinical record was reviewed on 1/15/12 at 1:51 PM. Resident #D's diagnoses included, but were not limited to, low back pain, dysphagia, depression, gerd, anxiety, bipolar, COPD (Chronic obstructive pulmonary disease). Resident #D was admitted on 10/15/12.</p> <p>A Social Service assessment on 10/21/12 indicated a PHQ9 (mood assessment) score of 6 (which falls in the range of mild depression). Resident #D indicated in the mood interview he felt down or depressed at times. The assessment states "no active signs of depression, though resident is getting treatment for depression and has diagnosis Bipolar".</p> <p>The Social Service Assessment dated 10/27/12 indicated Resident #D</p>						

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	<p>reported feeling down in the last 2-6 days, trouble sleeping at times, feeling tired daily and trouble concentrating. Resident #D had a PHQ9 score of 4 (which falls below the range of mild depression). The Social Service Assessment dated 11/12/12 indicated Resident #D had a PHQ9 score of 6 (which falls into range of mild depression). The Physician Order dated 1/1/2013 indicated Resident #D was on an anti-depressant (Citalopram 20 MG Tab/daily). There was lack of documentation that Resident #D's depression was care planned. There was a lack of documentation the anti-depressant was being monitored continuously for effectiveness. On 1/15/13 at 11:00 AM, the Social Service Director was interviewed regarding Resident #D's depression. She indicated he was not care planned for depression because his PHQ9 (mood assessment) score wasn't high enough. She indicated Resident #D never told anyone he was "depressed".</p> <p>3.1-34(a)</p>			

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F0272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure an assessment was completed for the Minimum Data Set (MDS) Assessment related to range of</p>	F0272	F272 COMPREHENSIVE ASSESSMENTS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	02/15/2013

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	<p>motion for 1 of 25 resident reviewed for assessments. (Resident #161)</p> <p>Findings include:</p> <p>During an interview on 01/08/13 at 11:43 a.m., RN #1 indicated Resident #161 had a contracture of the left arm.</p> <p>Resident #161's record review was completed on 01/14/13 at 1:27 p.m. The resident's diagnoses included, but were not limited to, stroke with left hemiparesis and dementia.</p> <p>A Quarterly MDS Assessment, dated 12/20/12, indicated the resident had upper extremity impairment on one side.</p> <p>There was a lack of documentation to indicate the resident's range of motion had been assessed prior to the Quarterly MDS Assessment on 12/20/12. The last range of motion assessment had been completed on 09/22/12.</p> <p>During an interview on 01/14/13 at 11:05 a.m., MDS Nurse #2 indicated a range of motion assessment should have been completed.</p> <p>3.1-31(a)</p>		<p>practice? (Resident 161) Unable to correct the alleged deficient practice for resident 161· Range of Motion Assessment completed on 1-14-13· Functional Needs Assessment completed on 2-4-132. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · All residents have the potential to be affected by the alleged deficient practice.· All charts audited to verify a Functional Needs Assessment has been completed with OBRA/MDS assessments for Residents not receiving skilled therapy services.· Audit completed on 2-4-133. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · All Therapy Department educated on completion of Functional Needs Assessment on 2-4-13· MDS/Careplan IDT will audit for completion of the Functional Needs Assessment (attachment N) during weekly care plan meetings. Audit created (attachment J)· 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic</p>		

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			changes will be completed. Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A committee until substantial compliance is obtained	

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F0279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to develop care plans for residents who utilized side rails, had diagnoses of behavior and/or depression, and developed urinary incontinence for 5 of 24 resident care plans reviewed. (Resident #B, #32, #D, #149, #188)</p> <p>Findings include:</p> <p>1. Resident #B was observed in bed on 1/8/13 at 9:30 a.m. The resident's had upper right and left side rails up.</p>	F0279	<p>F279 DEVELOP COMPREHENSIVE CAREPLANS 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident B, 32, D, 149 and 188) Resident B's care plan have been updated to reflect side rails on 1-29-13. Resident 32 care plan updated 2-4-13 to reflect signs/symptoms of depression. Resident 149's care plan updated 2-4-13 to reflect signs/symptoms of depression. Resident 188's care plan updated to reflect urinary incontinence</p>	02/15/2013			

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	<p>Interview with RN #1 on 1/8/13 at 10:20 a.m., indicated there were no side rails used on the resident's bed</p> <p>Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia.</p> <p>A Side Rail Assessment Initial and Quarterly assessment dated 8/23/12, 10/3/12, 10/22/12, and 12/5/12 indicated the resident does not use the side rail to assist with transfers to get in or out of bed, it was not used for positioning or support, and family did not express desire for raised side rails.</p> <p>Interview with LPN #3 on 1/16/13 at 3:20 p.m., indicated she had contacted a family member on 1/11/13 to see if she wanted side rails for the resident. The daughter indicated she did and had signed consent papers for the resident to have side rails upon admission. LPN #3 indicated the family member did not want the resident to fall out of bed and LPN #3 educated the family member on side rail use. LPN #3 was unable to locate signed consent paperwork from May 2012 admission</p>		<p>2-4-13 Unable to correct resident D care plan - resident is discharged.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · Any resident that utilizes side rails, with a diagnosis of depression or signs/symptoms of depression and any resident with urinary incontinence have the potential to be affected by the alleged deficient practice· Any resident with a diagnosis of depression, sign/symptoms of depression, any resident that has side rails and any resident that is incontinent were reviewed for appropriate care plans. Audit completed 2-4-13 All nurses will be in-serviced on Comprehensive Care Plans (attachment K) by 2-15-133.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · Care plans to be audited weekly during MDS/Care Plan meetings. · MDS/Care Plan IDT will audit for completion of all Comprehensive Care Plans during weekly care plan meetings. Audit created (attachment L) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>		

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	<p>but did locate the signed consent form from the January 2012 admission. LPN #3 indicated new consent forms was not signed in May 2012.</p> <p>2. Resident #188's clinical record was review on 1/11/13 at 8:40 a.m. Resident #188's diagnoses included, but were not limited to, CHF (congestive heart failure), history of UTI (urinary tract infection), acute pancreatitis, chronic kidney disease, shortness of breath, acute kidney failure, disorder of kidney, and congenital cystic kidney disease.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 8/14/12, indicated the resident was always continent.</p> <p>A discharge MDS assessment dated 8/20/12, indicated the resident was occasionally incontinent.</p> <p>A change of therapy MDS assessment dated 9/27/12, indicated the resident was on a toileting program that managed the urinary incontinence.</p> <p>A quarterly MDS assessment dated 11/9/12, indicated the resident was occasionally incontinent.</p>		<p>program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A committee until substantial compliance is obtained.</p>		

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	<p>On 11/12/12, the SSD (Social Service Director) note indicated the facility met with the family regarding the resident refusing care.</p> <p>On 11/18/12, a nursing note indicated the resident was incontinent of urine and "usually is". The note also indicated the resident was showing signs of increased urination and frequency.</p> <p>Interview with MDS Coordinator #2 on 1/11/13 at 10:00 a.m. indicated the resident was incontinent one time for the decline to trigger at the 90 day assessment. The MDS Coordinator #2 was not aware of the resident having an increase in incontinence after the assessment and also indicated the nursing staff are allowed to initiate care plans when a resident has any type of change in condition.</p> <p>3. Resident #32's clinical record was reviewed on 1/9/13 at 2:45 PM. Resident #32's diagnoses included, but were not limited to dementia with behaviors, acute renal insufficiency, thoracic back pain, hypothyroidism, depressive disorder, and left eye prosthesis. Review of the Physician's Orders dated 1/01/13 to 1/31/13 indicated Resident #32 was prescribed an anti-depressant</p>			

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	<p>(Sertraline HCL 50 MG Tab/daily) with a start date of 12/02/2011.</p> <p>Resident #32 received a behavioral health consult on 12/17/2012. The consult stated Resident #32 "presented with a very agitated mood and was very short and blunt with the examiner". In regards to her receptive and expressive language skills, the consult stated these were impacted by "patient's mood and her desire not to divulge information. This may be due to paranoia or simply be due to significant agitation and an unwillingness to engage with others. It appears too that the patient is quite depressed at this time. She has a history of stating 'I just want to die'....patient's attention and concentration were significantly impaired due to agitation and/or unwillingness."</p> <p>The Social Service Assessments for Resident #32 were reviewed. The assessment dated 6/25/12 indicated a PHQ9 score of 6 (which falls into the range of mild depression). During the mood interview, Resident #32 "reported feeling down daily" and "reported feeling tired daily".</p> <p>The Social Service Assessments dated 9/20/12 and 12/21/12 indicated</p>			

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	<p>Resident #32 refused to be interviewed.</p> <p>There was a lack of documentation in the clinical records to indicate a care plan had been implemented for depression.</p> <p>The Social Service Director was interviewed on 1/14/13 at 11:11 AM. She indicated depression was not care planned because Resident #32 didn't score high on the PHQ9 (mood assessment) and has no active tearfulness and no active signs of depression. When asked how they monitor the effectiveness of the anti-depressant, she indicated the anti-depressant was care planned as a risk for falls under Resident #32's fall care plan.</p> <p>4. Resident #D's clinical record was reviewed on 1/15/12 at 1:51 PM. Resident #D's diagnoses included, but were not limited to, low back pain, dysphagia, depression, gerd, anxiety, bipolar, and COPD (Chronic obstructive pulmonary disease). Resident #81 was admitted on 10/15/12. A Social Service assessment on 10/21/12 indicated a PHQ9 (mood assessment) score of 6 (which falls in the range of mild depression).</p>						

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	<p>Resident #D indicated in the mood interview he felt down or depressed at times. The assessment states "no active signs of depression, though resident is getting treatment for depression and has diagnosis Bipolar".</p> <p>The Social Service Assessment dated 10/27/12 indicated Resident #D reported "feeling down in the last 2-6 days", trouble sleeping at times, felt tired daily and had trouble concentrating. Resident #D had a PHQ9 score of 4 (which falls below the range of mild depression).</p> <p>The Social Service Assessment dated 11/12/12 indicated Resident #D had a PHQ9 score of 6 (which falls into range of mild depression).</p> <p>The Physician Order dated 1/1/2013 indicated Resident #D was on an anti-depressant (Citalopram 20 MG Tab/daily).</p> <p>There was no care plan of Resident #D's depression and there was lack of documentation of the anti-depressant being monitored continuously for effectiveness.</p> <p>On 1/15/13 at 11:00 AM, the Social Service Director was interviewed regarding Resident #D's depression. She indicated he was not care planned for depression because his PHQ9 (mood assessment) score wasn't high enough. She indicated</p>						

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	<p>Resident #D never told anyone he was "depressed".</p> <p>5. Resident #149's record was reviewed on 01/14/13 at 11:16 a.m. The resident's diagnoses included, but were not limited to depression and Alzheimer's Disease with psychosis.</p> <p>The Physician's Recapitulation Orders, dated 01/13, indicated an order of Prozac (antidepressant) 10 milligrams at bedtime, which had an original order date of 10/02/12.</p> <p>A Social Service Assessment, dated 10/12/12, indicated, "...Mood Interview:...PHQ9 (Resident Mood Interview Severity Score)=18 (15 or higher indicated moderate major depression). Resident reported having little interest in doing things daily. Resident reported feeling down daily. Resident reported having trouble sleeping daily and feeling tired daily. Resident reported having trouble concentrating daily. Resident stated 'so much goes through my mind.'..."</p> <p>The resident's care plan, dated 10/17/12, lacked documentation to indicate the resident had signs and symptoms of depression.</p>				

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	<p>There was a lack of documentation in the Social Service Progress Notes to indicate the resident had signs and symptoms of depression and Social Service interventions for the signs and symptoms.</p> <p>A Social Service Assessment, dated 10/30/12, indicated, "Mood Interview:...PHQ9 =12. Resident reported feeling down daily and feeling bad about self. Resident reported feeling little energy daily. Resident reported having trouble concentrating daily. Resident reported 'I have a lot on my mind'..."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>A Social Service Assessment, dated 11/29/12, indicated, "Mood Interview:...PHQ9=15. Resident reported feeling depressed daily. Resident reported feeling tired daily. Resident reported having poor appetite daily. Resident stated 'I'm hungry but when I get food I don't eat that much.' Resident reported feeling bad about self daily. Resident reported having trouble</p>						

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	<p>concentrating..."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>During an interview on 01/14/13 at 11:45 a.m., the Social Service Director indicated she does not care plan for depression if the resident is not having any problems. She indicated she was unaware the resident had scored high on the mood interview and had signs and symptoms of depression.</p> <p>3.1-35(a)</p>				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview the facility failed to update care plans for resident who displayed noncompliance and medication refusals for 1 of 25 residents reviewed for care plans. (Resident #159)</p> <p>Findings include:</p> <p>Resident #159's record was reviewed on 1/14/13 at 9:52 a.m. Resident #159's diagnoses included, but were not limited to, anxiety, insulin dependent diabetic, hypertension, chronic obstructive pulmonary (lung) disease, and aortic valve disease</p>	F0280	<p>F280 RIGHT TO PARTICIAPE PLANNING CARE-REVISE CARE PLANS1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident 159) Care plan revised for resident 159 on 2-5-13.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Any resident that displays noncompliance and medication refusals have the potential to be affected by this alleged deficient practice. An</p>	02/15/2013			

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	<p>(heart valve disease).</p> <p>On 10/12/12, a social service note indicated the resident had fallen twice in one day due to clutter in her room. The note indicated the resident was resistant to staff moving furniture and fell twice during use of the bed side commode. SSD (Social Service Director) had met with the resident and offered to move some furniture to help alleviate clutter. SSD reviewed the risk of having more falls due to her room being cluttered, resident voiced she was just in a hurry and that was what caused her to fall.</p> <p>An incident report dated 11/2/12 indicated Resident #159 had fallen transferring herself from the bedside commode to her bed. The report indicated the resident was noncompliant with utilizing the call light.</p> <p>An incident report dated 11/19/12 indicated Resident #159 had fallen with an injury from transferring self.</p> <p>An incident report dated 12/15/12 indicated Resident #159 had fallen from sliding off her bed.</p> <p>On 1/2/13, a social service note indicated she had received a referral</p>		<p>Audit was completed for any resident that display noncompliance and for residents that have medication refusals. Appropriate revisions to careplans or new care plans were added as indicated by audit. Audit comopleted on 2-4-13. Nurses are to initiate/revise care plans for medication refusals and for residents that displays noncompliance - daily as indicated Nursing staff to be inserviced on revision of care plans (Comprehensive Care Plan Policy attachment K). In-service to be completed by 2-15-133.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Care Plans to be audited weekly dung MDS/Care Plan meetings MDS/Care Plan IDT will audit for completion of all comprehensive care plans and revision of care Plans during weekly care plan meetings. Audit created (attachment L) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x four weeks, then monthly x three months, then quarterly for 3 consecutive quarters. The</p>		

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	<p>again regarding Resident #159's clutter in her room, limiting space for resident to move, and resulting in bruises to her body. SSD met with resident and offered the resident assistance in reorganizing her room and she stated that she needs her room as it is. SSD reviewed staff concerns with the bruises</p> <p>A potential for injury care plan updated on 1/3/13 indicated the resident has a history of falls. The interventions were not updated indicating the resident was noncompliant with utilizing the call light and uncooperative in arranging her room for safety precautions.</p> <p>3.1-35(d)(2)(B)</p>		<p>results of these audits will be presented to the QA&A Committee monthly until substantial compliance is obtained.</p>		

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to follow physician orders and care plan interventions related to pressure ulcer interventions, contracture interventions, medication error and urinary incontinence for 3 of 25 residents reviewed. (Resident #B, #H and #J)</p> <p>Findings include:</p> <p>1) Resident #B's clinical record was reviewed on 1/14/13 at 3:10 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia.</p> <p>A care plan for risk of developing pressure areas dated 11/5/12 was reviewed. Interventions indicated "...elevate BLE (bilateral lower extremities) on a pillow while in bed as tolerated..."</p> <p>A physician order on 11/27/12 indicated staff may used rolled wash clothes to bilateral hands as palm</p>	F0282	<p>F282 SERVICE QUALIFIED PERSONS/PER CARE PLAN1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident B, H and J): Unable to correct the alleged deficient practice for resident B, H and J. · Rescheduled an MDS assessment for resident J and will reevaluate her incontinence at that time. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · Any resident that requires: pillows for positioning palm protectors, all residents on medication and any resident with a referral for Urinary Incontinence program with therapy have the potential to be affected by the alleged deficient practice. An audit was completed on 2-4-13 for anyone that requires pillows for positioning and palm protectors to verify that the interventions were being used as ordered. Urinary Incontinence referrals were audited on 2-4-13 verifying follow through from 1-14-13 with no</p>	02/15/2013			

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	<p>protectors as the resident tolerates.</p> <p>The January 2013 Physician Recapitulation orders indicated palm protectors to bilateral hands at all times as resident tolerates and elevate bilateral lower extremities on a pillow while in bed as tolerated.</p> <p>On 1/8/13 at 9:40 a.m., Resident #B was observed lying in bed without a pillow under the bilateral lower extremities and only a wash cloth in the right hand.</p> <p>On 1/10/12 at 8:40 a.m., Resident #B was observed lying in bed with a wash cloth only in the left hand.</p> <p>On 1/11/13 at 9:20 a.m., Resident #B was observed lying in bed with a wash cloth only in the right hand. Interview with CNA #7 during this time indicated the resident was suppose to have one rolled wash cloth in each hand and did not know where the left hand wash cloth was.</p> <p>On 1/11/13 at 2:00 p.m., Resident #B was observed lying in bed without a pillow under the bilateral lower extremities.</p> <p>On 1/14/13 at 8:45 a.m., Resident #B was observed lying in bed without a</p>		<p>discrepancies. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · Nursing and Therapy to meet daily during normal working hours/days to discuss Urinary Incontinence Referrals· Referrals to be added to nurses 24 Hour Condition ReportSheet (attachment H) · Nurses and QMA's to be in-serviced on medication administration by 2-15-13.Nursing to review 24 hour condition report sheets daily to ensure referrals are followed through with. Nursing to review CNA Care Sheet (attachment M) daily to ensure interventions are in place.Audit created (attachment L)4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. · Audit to be completed weekly x four weeks, then monthly x 3 months, then quarterly for 3 consecutive quarters . The results of these audits will be presented to the QA&A Committee monthly until substantial compliance is obtained.</p>		

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	<p>pillow under the bilateral lower extremities.</p> <p>On 1/15/13 at 9:45 a.m., Resident #B was observed lying in bed without a pillow under the bilateral lower extremities. Interview with CNA #5 during this time indicated the resident was on a low air loss mattress and did not require pillows under her lower extremities.</p> <p>Reviewed the CNA assignment sheet on 1/15/13 at 10:00 a.m. The assignment sheet had indicated the resident's bilateral lower extremities were to be elevated on a pillow while in bed and palm protectors to bilateral hands.</p> <p>2. Resident #H's clinical record was reviewed on 1/9/13 at 3:10 p.m. Resident #H's diagnoses included, but were not limited to, stroke with left hemiparesis, insulin dependent diabetic, depression, history of hallucinations and aortic valve disease.</p> <p>A physician order dated 11/2011 indicated to increase the resident's seroquel (antipsychotic medication) to 125 mg at bedtime.</p> <p>Physician recapitulation orders dated</p>				

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	<p>4/24/12 indicated for the resident to resume on 125 mg of seroquel after being hospitalized.</p> <p>The MAR (Medication Administration Record) for 4/24/12 to 4/30/12 and the MAR for 5/1/12 to 5/10/12, indicated the resident was receiving 125 mg [sic] of seroquel at bedtime.</p> <p>A Psych NP (Nurse Practitioner) note on 5/11/12 indicated clarification of dosage of seroquel. The note indicated the resident was previously receiving 125 mg and was currently receiving 25 mg [sic]. An arrow pointing down with a question mark was located next to the date of 4/24/12 (indicating a decrease in dose). A physician order dated 5/11/12 indicated a clarification of seroquel 25 mg [sic] at bedtime with different handwriting indicating to discontinue 12.5 mg of seroquel.</p> <p>A Medication Error report dated 5/11/12 indicated the facility pharmacy had sent the wrong dosage of seroquel (sent 12.5 mg) and not the 125 mg as ordered. The facility nursing staff had been giving 12.5 mg at bedtime to the resident from 4/24/12 to 5/11/12.</p> <p>Interview with the Pharmacist on</p>			

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	<p>1/10/13 at 11:00 a.m. indicated he had spoke with the Director of Pharmacy and this medication error was an "Intellectual error" meaning the Data Tech who received the order and the Pharmacist who filled the order, did so incorrectly. The Pharmacist indicated he was in the facility on 5/14/12 and observed the increase, but the error was corrected and he did not see the actual dose written.</p> <p>Interview with LPN #3 on 1/10/13 at 9:25 a.m., indicated the pharmacy had sent the wrong dose of seroquel when the resident returned from the hospital. A QMA(Qualified Medication Administrator) had found the error and reported it to the Nursing Supervisor. The Psych NP (Nurse Practitioner) was in the building and was informed. The NP informed LPN #3 that seroquel can't be immediately increased back up to 125 mg and she would increase it as needed. LPN #3 indicated she wrote 12.5 mg on the 5/11/12 order in error. 3. Resident #J's record was reviewed on 01/11/13 9:00 a.m., the resident's diagnoses included, but were not limited to, hypertension and anxiety. The resident was admitted into the facility on 09/12/12.</p>			

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	<p>An Urinary Incontinence Assessment, dated 09/18/12, indicated the resident had been living independently prior to admission into the facility, the resident had dribbling of urine, was on oxybutin (incontinence medications), had impaired mobility, used diuretics and narcotics, could comprehend and follow through on educations and instructions, could identify urinary urge sensation, could contract the pelvic floor muscle, was able to get to the toilet, could use call light, was motivated to learn, and was cooperative with toileting attempts.</p> <p>The assessment indicated the resident had urge incontinence and stress incontinence. The resident was placed on prompted voiding, and bladder retraining. The referral had been sent on 09/19/12. The comments indicated, "Admitted c/ (with) having frequent episodes of incontinence...voiding program initiated. Referral for therapy will be sent (UI program) (urinary incontinence)..."</p> <p>The MDS (Minimum Data Set) Admission Assessment, dated 09/18/12, indicated the resident was frequently incontinent of urine.</p> <p>The CAA (Care Areas Assessment),</p>			

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	<p>dated 09/24/12, indicated the resident was put on a prompted voiding program and a referral would be given to therapy for the UI program.</p> <p>A care plan, dated 09/20/12, indicated the resident had urinary incontinence. The interventions included, referral to therapy for the UI program was sent 09/19/12.</p> <p>The therapy records and care plan lacked documentation to indicate the resident was assessed for the UI program.</p> <p>During an interview on 01/11/13 at 9:54 a.m., the Therapy Manager indicated they did not receive a referral and the assessment had not been completed.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>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.</p> <p>Based on observation, record review and interview the facility failed to properly assess a resident in relation to injuries of unknown origin in 1 of 1 resident's reviewed. (Residents #B)</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia (bleeding disorder).</p> <p>An Admission Nursing Evaluation dated 11/11/12 indicated Resident #B had a bruise near the rectum. No measurements were written.</p> <p>A physician order dated 11/11/12 at 8:15 p.m. indicated to monitor discoloration to rectum every shift for 7 days.</p> <p>A skin check form dated 11/7/12,</p>	F0309	<p>F309 Provide Care/Services for Highest Well Being1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident B)· Unable to correct the alleged deficient practice for resident B. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents with injuries of unknown origin have the ability to be affected by the alleged deficient practice. Residents with unusual occurrences/injuries of unknown origin audited from October 1, 2012 through present with no discrepancies. Audit completed 2-4-13.· Residents with allegations of sexual abuse audited from October 1, 2012 through present with no discrepancies. Audit completed 2-4-13· Residents with staff to resident abuse audited from October 1, 2012 through present with no discrepancies. Audit</p>	02/15/2013	

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	<p>11/14/12, 11/17/12, 11/24/12, and 11/27/12 indicated there were no skin issues or bruises. CNAs (certified nursing assistants) signatures and legible/illegible nursing signatures were observed.</p> <p>A nursing note on 11/17/12 at 11:35 p.m. indicated the resident was readmitted from the hospital. There was no documentation indicating a bruise near the rectum.</p> <p>An incident report dated 11/28/12 at 7:50 a.m. indicated the resident had a 2.3 x 0.4 x <0.1 red/purple area on the right lateral rectum. The measurements did not indicate centimeters or inches. A note was written on the back page indicating "the resident did receive rectal cream for hemorrhoids, currently on Levaquin (antibiotic), labs 'slightly off', the resident had been sent out for intravenous fluids on 11/29/12, the resident does have large bowel movements and 'pushes bowel movements out per staff'. The resident is transferred with a mega mover, the skin is frail, the rectal area has no pain when touched. Labs drawn on 11/30/12. Does have a diagnoses of hemorrhoids, monitor rectum every shift for 7 days. 10/10/12 to 10/23/12 platelets</p>		<p>completed on 2-4-13. All nursing staff to be in-serviced on "Abuse and Neglect of a Resident Policy" (attachment B) and ISDH guidelines on Reportable Unusual Occurrences (attachment C) education to be completed by 2-15-13. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Inter disciplinary team will meet weekly and review all resident reports with unusual occurrences/injuries of unknown origin, allegations of sexual abuse and staff to resident abuse to ensure investigation is complete and submitted to ISDH verifying policy was followed. Audit created (attachment D). 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed weekly x4 weeks, monthly for three months, then quarterly for 3 consecutive quarters to. The results of these audits will be presented to the QA&A Committee monthly until substantial compliance is obtained.</p>				

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	<p>dropped and doctor was aware. On 11/26/12, platelet count was down, and per CNA, daughter checks the rectum." This note was found in the nursing progress notes dated 11/30/12 at 2:00 p.m.</p> <p>A nursing note on 11/30/12 at 11:25 p.m. indicated, problem number three as discoloration to the right side of the rectum. The evaluation indicated "...Discoloration to right side of rectum is faded nearly visible [sic]..."</p> <p>A skin check form with illegible date that was done after 11/27/12 and before 12/1/12 indicated the resident had no skin issues or bruises. A CNA and a nurse's signature were observed.</p> <p>A skin check form on 12/1/12, 12/5/12, 12/8/12, 12/12/12, 12/15/12, 12/19/12, 12/22/12, and 12/26/12 indicated the resident had no skin issues or bruises. CNA and nursing signatures were observed.</p> <p>A nursing note dated 12/1/12 at 11:15 p.m. indicated problem number two as discoloration to the rectum. The evaluation indicated "...No discoloration to rectum observed..."</p> <p>A nursing assessment dated 12/5/12</p>			

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	<p>(no time) did not indicate any bruising on the coccyx/buttocks/rectum area.</p> <p>A nursing note on 12/12/12 at 1:22 p.m. indicated the Pharmacist was contacted and indicated "Four of res' (resident's) med's (medications) do have a 'rare' s/e (side effect) listed of Thrombocytopenia."(bleeding disorder) Medications listed were tylenol, aspirin, exelon and tramadol.</p> <p>A skin check on 1/2/13, 1/5/13, 1/9/13, 1/12/13 indicated the resident had no skin issues or bruises. CNA and nursing signatures were observed.</p> <p>On 1/11/13 at 2:00 p.m., wound care to the sacral pressure sore was observed. A long, rectangle shaped, dark/purple area was observed coming from the inner buttocks to the outer/upper left buttocks. The wound care nurse indicated this was a bruise and not a pressure area.</p> <p>On 1/14/13 at 1:25 p.m., the wound nurse and DoN observed the dark/purple area on left buttocks. The wound nurse indicated this was the same "bruise" since November of 2012. The wound nurse indicated maybe the documentation was incorrect regarding the bruise that</p>			

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	<p>was observed on the left buttock and documentation indicated the right buttock.</p> <p>An interview with LPN #114 and the DoN (Director of Nursing) on 1/14/13 at 1:45 p.m., indicated a report was filled out on the bruise to the left buttocks. LPN #114 indicated the bruise started on the right side of the buttocks, had gotten larger, and moved to the left. The DoN indicated during this same time, the resident was diagnosed with thrombocytopenia. LPN #114 indicated the resident had a history of hemorrhoids. LPN #114 indicated monitoring of the bruise was for three days. LPN #114 indicated she had not documented movement of the bruise.</p> <p>Interview with LPN #3 on 1/15/13 at 3:00 p.m. indicated she did not know why the nurse documented in the nursing note on 12/1/12 that the bruised area around the rectum was gone. LPN #3 indicated a CNA told her the resident's daughter tends to "mess" around with the resident. LPN #3 could not indicate if the resident's daughter was actually observed "messing" with the resident.</p> <p>Interview with LPN #3 on 1/16/13 at</p>			

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	<p>2:20 p.m. indicated the bruise on the left buttock was not measured and documented.</p> <p>A "Skin Conditions other than Pressure Ulcers" policy dated 8/30/2005 was provided on 1/15/13 at 3:30 pm. The policy indicated "It is the responsibility of the Healthcare Services Directors to assure consistent documentation of skin conditions other than pressure ulcers...Bruising will not require weekly documentation but will be assessed and documented in the nurse's notes for 72 hours after the bruising is first noted. On admission the Licensed Nurse on duty will complete a head to toe skin assessment...Routine skin observations will also be completed by the CNA's during the resident's bath and daily during routine care...When a new skin condition is discovered on admission or after, the nurse is to follow skin condition protocol...The assessment is to be documented on the skin condition identification form and turned into the Clinical Care Coordinator for continued follow up (including size of the area will be measured in centimeters measuring length x width x depth)...The Clinical Care Coordinator will be responsible to</p>						

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	ensure appropriate treatment and documentation of the skin condition..." 3.1-37(a)						

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure residents who were incontinent of urine receive the appropriate treatment and services to restore as much normal bladder functioning as possible related to a decline in incontinence and failure to assess/reassess residents for the urinary incontinence program for 3 of 3 residents reviewed. (Resident #73, #J, #188)</p> <p>Findings include:</p> <p>1. Resident #188's closed clinical record was reviewed on 1/11/13 at 8:40 a.m. Resident #188's diagnoses included, but were not limited to, CHF (congestive heart failure), history of UTI (urinary tract infection), acute pancreatitis, chronic kidney disease, shortness of breath, acute kidney</p>	F0315	<p>F315 No Catheter, Prevent UTI., Restore Bladder1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident 73, J and 188): Unable to correct the alleged deficient practice for resident 73, J and 188. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Any resident with a referral for Urinary Incontinence program with therapy have the potential to be affected by the alleged deficient practice. An audit was completed 2-4-13 to ensure Urinary Incontinence referrals are being implemented from 1-14-13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	02/15/2013	

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	<p>failure, disorder of kidney, and congenital cystic kidney disease.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 8/14/12, indicated the resident was always continent.</p> <p>A Urinary Assessment on 8/14/12 indicated the resident did not have urinary incontinence.</p> <p>A discharge MDS assessment dated 8/20/12, indicated the resident was occasionally incontinent.</p> <p>A change of therapy MDS assessment dated 9/27/12, indicated the resident was on a toileting program that managed the urinary incontinence.</p> <p>On 10/9/12, the resident was sent to the emergency room and had an abscess to the right lower extremely lanced.</p> <p>A quarterly MDS assessment dated 11/9/12, indicated the resident was occasionally incontinent.</p> <p>On 11/18/12, a nursing note indicated the resident was incontinent of urine and "usually is". The note also indicated the resident was showing signs of increased urination and</p>		<p>practice does not recur. Nursing and Therapy to meet daily during normal working hours/days to discuss Urinary Incontinence Referrals. Referrals to be added to nurses 24 Hour Report Sheet (attachment H) Daily audits to be done by nursing to ensure that all referrals are added to the 24 Hour Report Sheet (attachment H) Audit created. (attachment L) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed weekly x four weeks, then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A Committee monthly until substantial compliance is obtained</p>		

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	<p>frequency.</p> <p>Interview with the MDS Coordinators #2 and #111 on 1/11/13 at 10:00 a.m., indicated during the first 90 days of admission, the resident was incontinent one time. After the 90 days, the resident was becoming more incontinent until she went to the hospital and had a positive UTI (urinary tract infection) on 11/23/13.</p> <p>A Urinary Incontinence Policy dated 1/23/06 was provided on 1/11/13 at 12:15 p.m. The policy indicated "...A repeat assessment will be completed when the criteria is met to complete a significant change in status assessment..."</p> <p>2. Resident #J's record was reviewed on 01/11/13 9:00 a.m., the resident's diagnoses included, but were not limited to, hypertension and anxiety. The resident was admitted into the facility on 09/12/12.</p> <p>An Urinary Incontinence Assessment, dated 09/18/12, indicated the resident had been living independently prior to admission into the facility, the resident had dribbling of urine, was on oxybutnin (incontinence medications), had impaired mobility, used diuretics and narcotics, could</p>			

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	<p>comprehend and follow through on educations and instructions, could identify urinary urge sensation, could contract the pelvic floor muscle, was able to get to the toilet, could use call light, was motivated to learn, and was cooperative with toileting attempts.</p> <p>The assessment indicated the resident had urge incontinence and stress incontinence, the resident was placed on prompted voiding, and bladder retraining and the referral had been sent on 09/19/12. The comments indicated, "Admitted c/ (with) having frequent episodes of incontinence...voiding program initiated. Referral for therapy will be sent (UI program) (urinary incontinence)..."</p> <p>The MDS Admission Assessment, dated 09/18/12, indicated the resident was frequently incontinent of urine.</p> <p>The CAA (Care Areas Assessment), dated 09/24/12, indicated the resident was put on a prompted voiding program and a referral would be given to therapy for the UI program.</p> <p>MDS Quarterly Assessment, dated 12/19/12, indicated the resident was frequently incontinent.</p>			

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	<p>A care plan, dated 09/20/12, indicated the resident had urinary incontinence. The interventions included, referral to therapy for the UI program was sent 09/19/12.</p> <p>The therapy records and care plan lacked documentation to indicate the resident was assessed for the UI program.</p> <p>During an interview on 01/11/13 at 9:54 a.m., the Therapy Manager indicated they did not receive a referral and the assessment had not been completed. She indicated the UI program consisted of doing a voiding diary, and if the resident was a candidate, they would put the resident on a program with exercises to see if they could improve the resident's incontinency. She indicated she was unable to determine if resident would have improved in urinary continence since the assessment had not been completed.</p> <p>3. Resident # 73's was reviewed on 01/15/13 at 8 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and chronic obstructive pulmonary disease. The resident was admitted into the facility on 08/24/12 and returned to the facility from a hospital</p>				

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	<p>admission on 09/24/12 .</p> <p>An Admission Assessment of Urinary Incontinence, dated 9/24/12, indicated the resident was incontinent, had dementia and a seizure disorder. The assessment indicated the resident could identify the urge to urinate and could get to the toilet or be transferred to the toilet and was cooperative with attempts at toileting. The comments indicated the resident would have prompted toileting and would be referred to the UI program.</p> <p>An Admission Minimum Data Set Assessment (MDS), dated 08/30/12, indicated the resident was occasionally incontinent (less than 7 episodes of incontinence) of urine.</p> <p>The CAA, dated 08/30/12, indicated the resident had urinary incontinence and needed toileting assistance at times. The CAA indicated a prompted voiding plan had been initiated and the resident had been referred to therapy for the UI program.</p> <p>A Quarterly MDS Assessment, dated 11/14/12, indicated the resident was frequently incontinent (7 or more episodes of urinary incontinence, but</p>			

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	<p>at least one episode of continent voiding) of urine.</p> <p>The therapy records and care plan lacked documentation to indicate the resident was assessed for the UI program.</p> <p>The Therapy Manager during an interview on 01/15/13 at 8:26 a.m. indicated she did not remember getting a referral for the UI program. She indicated an assessment had not been completed. She indicated therapy did not get a referral. She indicated no assessment had been completed to see if resident was a candidate for the UI program.</p> <p>3.1-41(a)(2)</p>				

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F0317 SS=D	<p>483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident did not have a reduction in range of motion related to range of motion of a wrist for 1 of 8 residents reviewed for range of motion. (Resident #161)</p> <p>Findings include:</p> <p>During an interview on 01/08/13 at 11:43 a.m., RN #1 indicated Resident #161 had a contracture of the left arm. RN #1 indicated the resident refused to wear the brace, which was ordered for the left hand/arm. RN #1 indicated the resident had received Restorative Nursing for range of motion, but she refused it so Restorative Nursing was only doing range of motion on the resident's lower extremities.</p> <p>During an observation on 1/14/13 at 1:20 p.m. observation of Resident #161 was unable to open her left</p>	F0317	<p>F317 NO REDUCTION IN ROM UNLESS UNAVOIDABLE 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident 161)Unable to correct the alleged deficient practice for resident 161 Functional needs assessment completed on 2-4-15 Range of Motion assessment completed on-----2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. All charts audited to verify Functional Needs Assessment has been completed quarterly and with a significant change. Audit completed on 2-4-133. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All</p>	02/15/2013	

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	<p>fingers all the way and had flexion and extension of wrist but no rotator movement.</p> <p>Resident #161's record review was completed on 01/14/13 at 1:27 p.m. The resident's diagnoses included, but were not limited to, stroke with left hemiparesis and dementia.</p> <p>A Joint Mobility Evaluation, dated 6/28/12, indicated the resident had, "within functional limits (75-100%)" of the left wrist.</p> <p>A Joint Mobility Evaluation, dated 09/22/12, indicated the resident's left wrist had moderate limitation (50-75%).</p> <p>A Joint Mobility Evaluation, dated 01/14/12, indicated the resident's left wrist had moderate/severe limitation (25-50%).</p> <p>The Quarterly MDS (Minimum Data Set) Assessment, dated 06/28/12, indicated the resident had upper extremity impairment on one side.</p> <p>A Quarterly MDS Assessment, dated 12/20/12, indicated the resident had upper extremity impairment on one side.</p>		<p>nursing staff and therapy staff in-serviced on completion of Functional Needs Assessment. To be completed by 2-15-13MDS/Careplan IDT will audit for completion of Functional Needs Assessment (attachment N) during weekly care plan meetings. Audit created: (attachment J) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed weekly x 4 weeks, then tmonthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A committee until substantial compliance is obtained.</p>	

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	<p>A physician's order, dated 07/18/12, indicated an order for a splint to the left hand to be worn throughout the daytime hours and at night as needed to prevent contractures.</p> <p>There was a lack of documentation to indicate the resident had received active and/or passive range of motion of the left wrist to prevent loss of range of motion.</p> <p>During an interview on 01/14/13 at 10:15 a.m., the Therapy Manager indicated the resident was not on the therapy caseload. She indicated the therapy had been discontinued on 10/03/12 because the resident had plateaued. She indicated the resident had been referred to Restorative Nursing.</p> <p>A Physical Therapy note, dated 10/03/12, indicated therapy was discontinued. The note indicated the resident's left upper extremity was within normal function except the left shoulder secondary to the stroke.</p> <p>A Restorative Program Sheet, dated 10/01/12, indicated restorative for ambulation and active range of motion of the lower extremities.</p> <p>A Restorative Note, dated 12/20/12,</p>			

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	<p>indicated the nursing restorative program was no longer needed, and nursing would continue to assist with activities of daily living and ambulation.</p> <p>During an interview on 01/14/12 at 11:05 a.m., MDS Nurse #2 indicated Restorative Nursing was doing range of motion of the lower extremities. He indicated he was not sure why they were not doing range of motion to the upper extremities. He indicated he thought the CNA's did that with morning care. He indicated therapy only recommended range of motion to the lower extremities.</p> <p>During an interview on 01/14/13 at 1:15 p.m., CNA #6 indicated the resident received range of motion with daily care, but not to her left side because it did not move well.</p> <p>3.1-42(a)(1)</p>				

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F0329 SS=E	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to ensure residents' were free from unnecessary drugs related to inadequate monitoring of antidepressants for 3 of 13 residents reviewed who received antidepressant medication. (Residents #32, #81, and #149)</p> <p>Findings include:</p> <p>1. Resident #149's record was</p>	F0329	<p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? (Resident 32, 81, 149) · Unable to correct the alleged deficient practice (resident 149 discharged)</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be</p>	02/15/2013

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	<p>reviewed on 01/14/13 at 11:16 a.m. The resident's diagnoses included, but were not limited to depression and Alzheimer's Disease with psychosis.</p> <p>The Physician's Recapitulation Orders, dated 01/13, indicated an order of Prozac (antidepressant) 10 milligrams at bedtime, which had an original order date of 10/02/12.</p> <p>A Social Service Assessment, dated 10/12/12, indicated, "...Mood Interview:...PHQ9 (Resident Mood Interview Severity Score)=18 (15 or higher indicated moderate major depression). Resident reported having little interest in doing things daily. Resident reported feeling down daily. Resident reported having trouble sleeping daily and feeling tired daily. Resident reported having trouble concentrating daily. Resident stated 'so much goes through my mind.'..."</p> <p>There was a lack of documentation in the resident's record to indicate the staff was monitoring the resident's mood status and the effectiveness of the Prozac.</p> <p>The resident's care plan, dated 10/17/12, lacked documentation to</p>		<p>taken. · All residents on an antidepressant and those who display signs/symptoms of depression the potential to be affected by the alleged deficient practice · All resident charts will be reviewed to identify those who use anti-depressant and/or display signs or symptoms of depression. Audit completed 2-4-13. · Those identified as using an anti-depressant and/or display signs or symptoms of depression, as defined as having a PHQ-9 score of 5 or higher or by nursing assessment will be evaluated through RAI/CAA process for care planning and intervention.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · Nursing Staff and Life Enrichment staff will document in Care Tracker (attachment 0) when they observe a resident displaying signs/symptoms of depression. · Nursing staff and Life Enrichment staff will be educated on signs/symptoms of depression by 2-15-13· Nursing Staff and Life Enrichment staff will be in-serviced in logging signs/symptoms of depression into Care Tracker via KIOSK by 2-15-13.Nursing will pull the Care Tracker Log regarding signs/symptoms of depression daily.Social Service will randomly audit logs monthly to assure follow through documentation is</p>	

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	<p>indicate the resident had signs and symptoms of depression.</p> <p>A Social Service Note, dated 10/23/12, indicated, "Care plan meeting held on this date with resident's son. Reviewed resident care plans, weight, meal intake report, labs, medications, and overall status...There are no concerns being voiced at this time..."</p> <p>A Social Service Note, dated 10/24/12, indicated, "SS (Social Service) referral received related to resident consistently getting out of bed...offered her a room change and resident voiced 'it would be nice to have a window'...There are no concerns being voiced at this time, will observe for any changes and assist further as able."</p> <p>There was a lack of documentation in the Social Service Progress Notes to indicate the resident had signs and symptoms of depression and Social Service interventions for the signs and symptoms.</p> <p>There was lack of documentation in the resident's record to indicate the staff was monitoring the resident's mood status and the effectiveness of the Prozac.</p>		<p>completed. (attachment 0)4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audit will be presented to the QA/A committee until substantial compliance is obtained.</p>		

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	<p>A Social Service Assessment, dated 10/30/12, indicated, "Mood Interview:...PHQ9 =12. Resident reported feeling down daily and felt bad about self. Resident reported feeling little energy daily. Resident reported having trouble concentrating daily. Resident reported 'I have a lot on my mind'..."</p> <p>There was lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>There was a lack of documentation in the resident's record to indicate the staff was monitoring the resident's mood status and the effectiveness of the Prozac.</p> <p>A Social Service Assessment, dated 11/29/12, indicated, "Mood Interview:...PHQ9=15. Resident reported feeling depressed daily. Resident reported feeling tired daily. Resident reported having poor appetite daily. Resident stated 'I'm hungry but when I get food I don't eat that much.' Resident reported feeling bad about self daily. Resident reported having trouble</p>			

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	<p>concentrating..."</p> <p>A Social Service note, dated 12/04/12, indicated, "updated: called and made son aware of res (resident's) PT (physical therapy) to end...no concerns at this time."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>There was a lack of documentation in the resident's record to indicate the staff was monitoring the resident's mood status and the effectiveness of the Prozac.</p> <p>A Social Service Assessment, dated 01/08/13, indicated, "Mood Interview:...PHQ9=0 (no signs or symptoms of depression). Resident reported feeling down at times..."</p> <p>There was a lack of documentation to indicate the facility was tracking the resident's mood status.</p> <p>During an interview on 01/14/13 at 11:45 a.m., the Social Service Director indicated she does not care plan for depression if the resident was</p>			

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	<p>not having any problems. She indicated she was unaware the resident had scored high on the mood interview and had signs and symptoms of depression.</p> <p>2. Resident #32's clinical record was reviewed on 1/9/13 at 2:45 PM. Resident #32's a diagnoses included, but were not limited to, dementia with behaviors, acute renal insufficiency, thoracic back pain, hypothyroidism, depressive disorder, and left eye prosthesis.</p> <p>Review of the Physician's Orders dated 1/01/13 to 1/31/13 indicated Resident #32 was prescribed an anti-depressant (Sertraline HCL 50 MG Tab/daily) start date of 12/02/2011.</p> <p>Resident #32 received a behavioral health consult on 12/17/2012. The consult stated Resident #32 "presented with a very agitated mood and was very short and blunt with the examiner". In regards to her receptive and expressive language skills, the consult stated these were impacted by "patient's mood and her desire not to divulge information. This may be due to paranoia or simply be due to significant agitation and an unwillingness to engage with others. It appears too that the patient</p>			

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	<p>is quite depressed at this time. She has a history of stating 'I just want to die'....patient's attention and concentration were significantly impaired due to agitation and/or unwillingness."</p> <p>The Social Service Assessments for Resident #32 were reviewed. The assessment dated 6/25/12 indicated a PHQ9 score of 6 (which falls into the range of mild depression). During the mood interview, Resident #32 "reported feeling down daily" and "reported feeling tired daily".</p> <p>The Social Service Assessments dated 9/20/12 and 12/21/12 indicated Resident #32 refused to be interviewed.</p> <p>There was a lack of documentation in the clinical records to indicate Resident #32's prescribed anti-depressant was being monitored continuously for it's effectiveness. There was a lack of documentation to indicate a care plan for depression had been implemented for Resident #32.</p> <p>Social Service notes from 2/15/12 to 12/28/12 were reviewed. A note dated 10/8/12 indicated a Social Service referral was made because</p>			

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	<p>Resident #32 told a nurse, "I'm no good, I just want to die". A note dated 12/28/12 indicated Resident #32 had a care plan conference but no documentation was located to indicate the resident was receiving adequate and continuous monitoring of the signs and symptoms of depression and the overall effectiveness of the prescribed anti-depressant.</p> <p>The Social Service Director (SSD) was interviewed on 1/14/13 at 11:11 AM. SSD indicated they monitor the effectiveness of the anti-depressant by care planning it as a risk for falls.</p> <p>3. Resident #D's clinical record was reviewed on 1/15/12 at 1:51 PM. Resident #D's diagnoses included, but were not limited to, low back pain, dysphagia, depression, gerd, anxiety, bipolar, COPD (Chronic obstructive pulmonary disease). Resident #D was admitted on 10/15/12.</p> <p>A Social Service assessment on 10/21/12 indicated a PHQ9 (mood assessment) score of 6 (which falls in the range of mild depression). Resident #D indicated in the mood interview he felt down or depressed at times. The assessment states "no active signs of depression, though resident is getting treatment for</p>			

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	<p>depression and has diagnosis Bipolar".</p> <p>The Social Service Assessment dated 10/27/12 indicated Resident #D reported "feeling down in the last 2-6 days", trouble sleeping at times, felt tired daily and trouble concentrating. Resident #D had a PHQ9 score of 4 (which falls below the range of mild depression).</p> <p>The Social Service Assessment dated 11/12/12 indicated Resident #D had a PHQ9 score of 6 (which falls into range of mild depression).</p> <p>The Physician Order dated 1/1/2013 indicated Resident #D was prescribed an anti-depressant (Citalopram 20 MG Tab/daily). Review of Resident #D's Fall Care Plan indicated "use of psychotropic medications" as a risk for fall. Further review of the Physician Orders indicate Resident #D was prescribed another psychotropic medication, an anti-anxiety (Ativan 0.5 mg/2 times daily). No documentation was provided to show the anti-depressant was being monitored continuously for effectiveness.</p> <p>On 1/15/13 at 11:00 AM, the Social Service Director was interviewed regarding Resident #D's depression. She indicated his anti-depression was listed as a risk on his Fall Care Plan.</p> <p>3.1-48(a)(3)</p>			

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F0364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review and interview, the facility failed to serve dairy and juice products at proper temperatures for 2 of 4 dining rooms observed which had the potential to affect 61 out of 149 residents who eat in dining rooms. (Main Dining Room #1 and #2).</p> <p>During dining observation on 1/7/13 at 11:17 AM, the staff were observed pouring drinks and setting out desserts before the residents entered the dining room for lunch. Residents were still arriving to eat their lunch at 11:50 AM.</p> <p>During dining observation in the Main Dining Room on 1/11/13 at 11:40 AM, Employee #78 took the temperature of a milk at a dining spot that was set but the resident hadn't arrived to eat yet. The milk temperature read 60 degrees. Employee #78 indicated the milk had been poured 30 minutes ago. Employee #78 took the temperature of another glass of milk before it was served to the resident</p>	F0364	<p>F364 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice for 61 out of 149 residents in the Main Dining Room (room 1 and 2). Dietary Manager replaced all milk that had not been served on 1-7-132. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. Dietary Aid educated on Food Temp Policy on 2-7-13 Milk and juices are no longer preprepared 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Milk and juices are no longer preprepared Milk and juices are to be kept on ice up until service Dietary staff to be educated on "Food Temperature Policy"</p>	02/15/2013			

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	<p>and the temperature was 60 degrees. Employee #78 took another temperature of a milk on the other side of the Main Dining Room (Dining #2) and measured the temperature at 60 degrees. The Dietary Manager was contacted and indicated to replace all milks that had not been served yet.</p> <p>On 1/11/13 at 11:50 AM, the Dietary Manager was observed removing the glasses of milk from the empty spots and indicated she wasn't going to repour the milk until residents were seated. The Dietary Manager took the temperature of the gallon of milk which was being stored in the dining room on ice. The temperature read 48 degrees. The Dietary Manager at this time indicated she was going to dispose of the milk due to the milk was not kept in the acceptable range of below 41 degrees. The Dietary Manager indicated they recently changed how they serve the milk in order to make a quicker serving time for the residents. She indicated she will be assessing that practice for safe food temperatures.</p> <p>3.1-21(a)(2)</p>		<p>(attachment P) by 2-15-13Audit created (attachment Q)4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audit will be presented to the QA/A committee until substantial compliance is obtained.</p>		

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to store and prepare food under sanitary conditions related to dented cans of food in 1 of 1 kitchen and unlabeled and undated items in the refrigerator, accumulation of crumbs in the toaster, and dirty microwave in 1 of 4 dining rooms (500 Hall Dining Room/Activity Room), which had the potential to affect 149 of 150 residents who consume meals in the facility. (Kitchen and 500 Hall Dining Room/Activity Room.)</p> <p>Findings include:</p> <p>1. During on observation on 01/07/13 at 11:58 a.m., with the Dietary Manager present, there were two, unopened cans of prunes dented on the storage cart.</p> <p>During an observation on 01/07/13 at 11:30 a.m. with Dietary Employee #82 present, the two dented cans of prunes remained on the cart, and</p>	F0371	<p>F371 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice for 149 - 150 residents in 500 hall dining room as well as activity room. Dented cans were disposed of on 1-7-13 Microwave and toaster were cleaned on 1-10-13 All undated items in the refrigerator were disposed of on 1-10-13 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by the alleged deficient practice. Dining Area and Food Storage Areas were audited for dented cans on 1-7-13 All microwaves and refrigerators were cleaned on 1-10-13 All undated items in the refrigerator were disposed of on 1-10-133. What measures will be put into place or what systemic changes will be made</p>	02/15/2013

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	<p>there were unopened, dented cans of salsa (1) and olives (1) on the cart. Interview with the Dietary Employee #82 during this time, indicated the person who puts the food away, rotates the cans.</p> <p>A facility policy, dated 06/12/11, titled, "Damaged Containers", received from the Director of Nursing as current, indicated, "...Disposal of the following will occur and vendor to be notified for appropriate account credits...Any can that is dented, rusted, leaking or bulging."</p> <p>2. During an environmental tour on 01/10/13 at 10 a.m. with the Director of Maintenance and the Housekeeping Supervisor, there was an opened, undated, bag of cheese and an uncovered, undated whole pie in the refrigerator in the 500 Hall Dining Room/Activity Room. The refrigerator also contained employee food, stored along with the resident's food. The toaster had an accumulation of crumbs and the microwave had splatters of a red substance.</p> <p>During an interview at the time of the observation, Activity Assistant #112 indicated the cheese and the pie is for the residents and staff store their food</p>		<p>to ensure that the deficient practice does not recur. Dietary staff to be educated on policy for Damaged Containers (attachment R). To be completed by 2-15-13 Audit created (attachment S-1) Life Enrichment aide educated on keeping microwave and toaster clean and dating items in the refrigerator 1-10-13. Life Enrichment staff to be educated on keeping microwave and toaster clean and dating items in the refrigerator by 2-15-13 Audit created (attachment S-2))4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audit will be presented to the QA/A committee until substantial compliance is obtained.</p>		

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	in the refrigerator. She indicated the areas needed cleaned. 3.1-21(i)(3)				

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F0520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview the failed to ensure the facility QAA (Quality Assessment and Assurance) committee identified system failure concerning: (1) Investigating and reporting of abuse, for 3 out of 5 resident reviewed (2) Failed to provide medically-related social services, related to implementation of interventions and monitoring of residents for signs and symptoms of depression for 3 of 13 residents</p>	F0520	<p>F520 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct the alleged deficient practice. AlthoughQA-A meets monthly and monitors for trends/patterns that are reported by sub-committees. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	02/15/2013

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	<p>reviewed who received antidepressant medication; (3) Failed to follow physician orders and care plan interventions related to pressure ulcer interventions, contracture interventions, medication error and urinary incontinence for 3 of 25 residents reviewed; (4) Failed to ensure residents who were incontinent of urine receive the appropriate treatment and services to restore as much normal bladder functioning as possible related to a decline in incontinence and failure to assess/reassess residents for the urinary incontinence program for 3 of 3 residents reviewed. (Residents #B, #J, #32, #73, #81, #149, #162, #188). (5) The facility also failed to ensure facility staff received six and three hours of dementia specific training annually for 98 of 257 employees who had been employed at the facility for more than six months. (CNA's #5, #8, #10, #12, #14, #15, #16, #17, #18, #19, #20, #21, #23, #25, #26, #27, #28, #32, #34, #38, #39, #40, and #44. RN's #11, #22, #30, #33, and #41. LPN's #9, #13, #24, #31, #35, #36, #37, #42, #43, #45, #46, #47, #48, and #83. Security #49, #50, #51. Environmental Services #84, #85, #86, #87. Dietary #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #68, #69, #70,</p>		<p>action(s) will be taken. Resident were identified during ISDH annual survey as listed on Survey Event ID WXGC11.QA-A subcommittees on Investigating and reporting of Abuse, Anti Depressant IDT, SKin Bowel and Bladder Committee, Restorative Nursing committee, Risk Committee, Memory Support Committee will meet weekly to note trends and patterns based off of survey/quality deficiencies that were noted during survey. Nursing to be in-serviced on QA policy by 2-15-13.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. QA-A subcommittees for Investigating and reporting of Abuse, Anti Depressant IDT, Skin, Bowel and Bladder Committee, Restorative Nursing committee, Risk Committee, Memory Support Committee will meet weekly to note trends and patterns based off of survey/quality deficiencies that were noted during survey. When there is a trend/pattern noted each committee will answer the Four Step questions which will help to identify and implement an action plan. DON or designee will audit minutes from subcommittees weekly. Audit created (attachment T) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</p>				

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	<p>#71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81. Life Enrichment #88. Marketing #89, #90, #91. Chaplain #92. Laundry #109. Social Service #110. Therapy #93, #94, #95, #96, #97, #98, #100, #101, #103, #104, #106, #107, and #108.</p> <p>Findings include:</p> <p>1. Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia (inability for blood to clot appropriately).</p> <p>A Re-Admission Nursing Evaluation dated 11/11/12 indicated Resident #B had a bruise near the rectum. No measurements were written.</p> <p>A nursing note on 11/17/12 at 11:35 p.m. indicated the resident was readmitted from the hospital. There was no documentation indicating a bruise near the rectum.</p> <p>An incident report dated 11/28/12 at 7:50 a.m. indicated the resident had a 2.3 x 0.4 x <0.1 red/purple area on the right lateral rectum. The measurements did not indicate</p>		<p>i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x four weeks then twice a month x 3 months, then monthly x 3 months, auditing will be ongoing until substantial compliance is obtained. · Quality Assurance Committee to monitor monthly for trends and compliance</p>		

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	<p>centimeters or inches. A note was written on the back page indicating "the resident did receive rectal cream for hemorrhoids, currently on Levaquin (antibiotic), labs 'slightly off', the resident had been sent out for intravenous fluids on 11/29/12, the resident does have large bowel movements and 'pushes bowel movements out per staff'. The resident is transferred with a mega mover, the skin is frail, the rectal area has no pain when touched. Labs drawn on 11/30/12. Does have a diagnoses of hemorrhoids, monitor rectum every shift for 7 days. 10/10/12 to 10/23/12 platelets dropped and doctor was aware. On 11/26/12, platelet count was down, and per CNA, daughter checks the rectum." This note was copied from the nursing progress notes dated 11/30/12 at 2:00 p.m., and copied to the back of the investigation report.</p> <p>A nursing note on 11/30/12 at 11:25 p.m. indicated, problem number three as discoloration to the right side of the rectum. The evaluation indicated "...Discoloration to right side of rectum is faded nearly visible [sic]..."</p> <p>A nursing note dated 12/1/12 at 11:15 p.m. indicated problem number two as discoloration to the rectum. The</p>			

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	<p>evaluation indicated "...No discoloration to rectum observed..."</p> <p>On 1/11/13 at 2:00 p.m., wound care to the sacral decubitus (open area) was observed. A long, rectangle shaped, dark/purple area was observed coming from the inner buttocks to the outer/upper left buttocks. The wound care nurse indicated this was a bruise and not a pressure area.</p> <p>On 1/14/13 at 1:25 p.m., the wound nurse and DoN observed the dark/purple area on left buttocks. The wound nurse indicated this was the same "bruise" since November of 2012. The wound nurse indicated maybe the documentation was incorrect regarding the bruise that was observed on the left buttock and documentation indicating the right buttock.</p> <p>An interview with LPN #114 and the DoN (Director of Nursing) on 1/14/13 at 1:45 p.m., indicated a report was filled out on the bruise to the left buttocks. LPN #114 indicated the bruise started on the right side of the buttocks, had gotten larger, and moved to the left. The DoN indicated during this same time, the resident was diagnosed with</p>			

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	<p>thrombocytopenia.</p> <p>Interview with LPN #3 on 1/15/13 at 3:00 p.m. indicated a CNA told her the resident's daughter tends to "mess" around with the resident. LPN #3 could not indicate whether the resident's daughter was actually observed "messing" with the resident. LPN #3 indicated the bruise was not investigated due to the resident being diagnosed with thrombocytopenia.</p> <p>Interview with the DoN on 1/16/13 at 5:00 p.m. indicated the bruise near the rectum was not investigated nor reported to Indiana State Department of Health due to the diagnoses of thrombocytopenia.</p> <p>Resident #B was observed in bed on 1/8/13 at 9:30 a.m. The resident's had upper right and left side rails up.</p> <p>Interview with RN #1 on 1/8/13 at 10:20 a.m., indicated there were no side rails used on the resident's bed</p> <p>Resident #B's clinical record was reviewed on 1/11/13 at 3:00 p.m. Resident #B's diagnoses included, but were not limited to, Alzheimer/dementia, failure to thrive, contractures, and thrombocytopenia.</p>						

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	<p>A Side Rail Assessment Initial and Quarterly assessment dated 8/23/12, 10/3/12, 10/22/12, and 12/5/12 indicated the resident does not use the side rail to assist with transfers to get in or out of bed, it was not used for positioning or support, and family did not express desire for raised side rails.</p> <p>Interview with LPN #3 on 1/16/13 at 3:20 p.m., indicated she had contacted a family member on 1/11/13 to see if she wanted side rails for the resident. The daughter indicated she did and had signed consent papers for the resident to have side rails upon admission. LPN #3 indicated the family member did not want the resident to fall out of bed and LPN #3 educated the family member on side rail use. LPN #3 was unable to locate signed consent paperwork from May 2012 admission but did locate the signed consent form from the January 2012 admission. LPN #3 indicated new consent forms was not signed in May 2012.</p> <p>2. On 1/15/2013 at 4:02 PM, an investigation was reviewed for an allegation Resident #D made against an Employee #8 for mistreatment. According to the investigations,</p>				

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	<p>Resident #D's daughter reported an allegation of rough handling during a transfer on 11/27/12. The investigation lacked documentation that any interviews with staff occurred. The investigation lacked documentation that actual harm or injury were ruled out or investigated.</p> <p>During an interview with the Social Service Director on 1/16/13 at 4:31 PM, she indicated she was in charge of the investigation but did not know whether interviews with staff were done or whether a skin check was done on Resident #D to rule out an injury. Documentation showed the Interdisciplinary Team concluded no mistreatment occurred and Employee #8 returned to work. No further documentation was provided.</p> <p>Resident #D's clinical record was reviewed on 1/15/12 at 1:51 PM. Resident #D's diagnoses included, but were not limited to, low back pain, dysphagia, depression, gerd, anxiety, bipolar, COPD (Chronic obstructive pulmonary disease). Resident #D was admitted on 10/15/12.</p> <p>A Social Service assessment on 10/21/12 indicated a PHQ9 (mood assessment) score of 6 (which falls in the range of mild depression). Resident #D indicated in the mood</p>			

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	<p>interview he feels down or depressed at times. The assessment stated "no active signs of depression, though resident is getting treatment for depression and has diagnosis Bipolar".</p> <p>The Social Service Assessment dated 10/27/12 indicated Resident #D reported "feeling down in the last 2-6 days", trouble sleeping at times, feeling tired daily and trouble concentrating. Resident #D had a PHQ9 score of 4 (which falls below the range of mild depression).</p> <p>The Social Service Assessment dated 11/12/12 indicated Resident #D had a PHQ9 score of 6 (which falls into range of mild depression).</p> <p>The Physician Order dated 1/1/2013 indicated Resident #D was on an anti-depressant (Citalopram 20 MG Tab/daily).</p> <p>There was lack of documentation that Resident #D's depression was care planned. There was lack of documentation the anti-depressant was being monitored continuously for effectiveness.</p> <p>On 1/15/13 at 11:00 AM, the Social Service Director was interviewed regarding Resident #D's depression. She indicated he was not care planned for depression because his PHQ9 (mood assessment) score wasn't high enough. She indicated</p>			

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	<p>Resident #D never told anyone he was "depressed".</p> <p>3. On 8/4/12 (no time documented), Resident #F reported an allegation of sexual abuse which was not reported to the Indiana State Department of Health which was confirmed by interview with the Social Service Director. The investigation lacked inclusion of interviews of potential staff and resident witnesses and lacked inclusion of documentation that actual harm was ruled out.</p> <p>The incident report, reviewed on 1/15/13 at 4:02 PM, indicated that Resident #F told a visitor Resident #L had touched her inappropriately. The visitor reported the abuse allegation to the facility. During an interview on 1/15/13 at 1:52 PM, the Social Service Director confirmed the allegation was not reported to the State Department of Health. She indicated she understood allegations of this nature should be reported to the State Department of Health but concluded after resident interview, the allegation was untrue. The Social Service Director indicated there was no reason to do other interviews for potential witnesses of staff and residents because the incident "did not happen". She indicated she didn't</p>			

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	<p>know whether Resident #L (who allegedly touched Resident #F inappropriately) had been interviewed.</p> <p>No further documentation was provided.</p> <p>4. Resident #149's record was reviewed on 01/14/13 at 11:16 a.m. The resident's diagnoses included, but were not limited to, depression and Alzheimer's Disease with psychosis.</p> <p>The Physician's Recapitulation Orders, dated 01/13, indicated an order of Prozac (antidepressant) 10 milligrams at bedtime, which had an original order date of 10/02/12.</p> <p>A Social Service Assessment, dated 10/12/12, indicated, "...Mood Interview:...PHQ9 (Resident Mood Interview Severity Score)=18 (15 or higher indicated moderate major depression). Resident reported having little interest in doing things daily. Resident reported feeling down daily. Resident reported having trouble sleeping daily and feeling tired daily. Resident reported having trouble concentrating daily. Resident stated 'so much goes through my mind!...'"</p>			

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	<p>The resident's care plan, dated 10/17/12, lacked documentation to indicate the resident had signs and symptoms of depression.</p> <p>A Social Service Note, dated 10/23/12, indicated, "Care plan meeting held on this date with resident's son. Reviewed resident care plans, weight, meal intake report, labs, medications, and overall status...There are no concerns being voiced at this time..."</p> <p>A Social Service Note, dated 10/24/12, indicated, "SS (Social Service) referral received related to resident consistently getting out of bed...offered her a room change and resident voiced 'it would be nice to have a window'...There were no concerns being voiced at this time, will observe for any changes and assist further as able."</p> <p>A Social Service note, dated 10/25/12, indicated, "Resident adjusting well to room change."</p> <p>There was a lack of documentation in the Social Service Progress Notes to indicate the resident had signs and symptoms of depression and Social Service interventions for the signs</p>			

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	<p>and symptoms.</p> <p>A Social Service Assessment, dated 10/30/12, indicated, "Mood Interview:...PHQ9 =12. Resident reported feeling down daily and felt bad about self. Resident reported feeling little energy daily. Resident reported having trouble concentrating daily. Resident reported 'I have a lot on my mind'..."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>A Social Service Assessment, dated 11/29/12, indicated, "Mood Interview:...PHQ9=15. Resident reported feeling depressed daily. Resident reported feeling tired daily. Resident reported having poor appetite daily. Resident stated 'I'm hungry but when I get food I don't eat that much.' Resident reported feeling bad about self daily. Resident reported having trouble concentrating..."</p> <p>A Social Service note, dated 12/04/12, indicated, "updated: called and made son aware of res</p>			

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	<p>(resident's) PT (physical therapy) to end...no concerns at this time."</p> <p>There was a lack of documentation to indicate Social Service had implemented a care plan, interventions and further assessment for the signs and symptoms of depression.</p> <p>A Social Service Assessment, dated 01/08/13, indicated, "Mood Interview:...PHQ9=0 (no signs or symptoms of depression). Resident reported feeling down at times..."</p> <p>There was a lack of documentation to indicate the facility was tracking the resident's mood status.</p> <p>During an interview on 01/14/13 at 11:45 a.m., the Social Service Director indicated she does not care plan for depression if the resident was not having any problems. She indicated she was unaware the resident had scored high on the mood interview and had signs and symptoms of depression.</p> <p>5. Resident #32's clinical record was reviewed on 1/9/13 at 2:45 PM. Resident #32's diagnoses included, but were not limited to, dementia with behaviors, acute renal insufficiency,</p>				

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	<p>thoracic back pain, hypothyroidism, depressive disorder, and left eye prosthesis. Review of the Physician's Orders dated 1/01/13 to 1/31/13 indicated Resident #32 was prescribed an anti-depressant (Sertraline HCL 50 MG Tab/daily) start date of 12/02/2011.</p> <p>Resident #32 received a behavioral health consult on 12/17/2012. The consult stated Resident #32 "presented with a very agitated mood and was very short and blunt with the examiner". In regards to her receptive and expressive language skills, the consult stated these were impacted by "patient's mood and her desire not to divulge information. This may be due to paranoia or simply be due to significant agitation and an unwillingness to engage with others. It appears too that the patient is quite depressed at this time. She has a history of stating 'I just want to die'....patient's attention and concentration were significantly impaired due to agitation and/or unwillingness."</p> <p>The Social Service Assessments for Resident #32 were reviewed. The assessment dated 6/25/12 indicated a PHQ9 score of 6 (which falls into the range of mild depression). During the</p>			

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	<p>mood interview, Resident #32 "reported feeling down daily" and "reported feeling tired daily".</p> <p>The Social Service Assessments dated 9/20/12 and 12/21/12 indicated Resident #32 refused to be interviewed.</p> <p>There was a lack of documentation in the clinical records to indicate a care plan had been implemented for depression.</p> <p>Social Service notes from 2/15/12 to 12/28/12 were reviewed. A note dated 10/8/12 indicated a Social Service referral was made because Resident #32 told a nurse, "I'm no good, I just want to die". A note dated 12/28/12 indicated Resident #32 had a care plan conference but no documentation of follow up regarding the behavioral health consult findings of 12/17/12 indicating Resident #32 was "quite depressed at this time".</p> <p>The Social Service Director was interviewed on 1/14/13 at 11:11 AM. She indicated depression was not care planned because Resident #32 didn't score high on the PHQ9 (mood assessment) and had no active tearfulness and no active signs of</p>						

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	<p>depression. SSD indicated the monitoring of the effectiveness of the anti-depressant was care planned as a risk for fall under Resident #32's fall care plan.</p> <p>6. Resident #188's clinical record was review on 1/11/13 at 8:40 a.m. Resident #188's diagnoses included, but were not limited to, CHF (congestive heart failure), history of UTI (urinary tract infection), acute pancreatitis, chronic kidney disease, shortness of breath, acute kidney failure, disorder of kidney, and congenital cystic kidney disease.</p> <p>A 5 day MDS (Minimum Data Set) Assessment dated 8/14/12, indicated the resident was always continent.</p> <p>A discharge MDS assessment dated 8/20/12, indicated the resident was occasionally incontinent.</p> <p>A change of therapy MDS assessment dated 9/27/12, indicated the resident was on a toileting program that managed the urinary incontinence.</p> <p>A quarterly MDS assessment dated 11/9/12, indicated the resident was occasionally incontinent.</p>				

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	<p>On 11/12/12, the SSD (Social Service Director) note indicated the facility met with the family regarding the resident refusing care.</p> <p>On 11/18/12, a nursing note indicated the resident was incontinent of urine and "usually is". The note also indicated the resident was showing signs of increased urination and frequency.</p> <p>Interview with MDS Coordinator #2 on 1/11/13 at 10:00 a.m. indicated the resident was incontinent one time for the decline to trigger at the 90 day assessment. The MDS Coordinator #2 was not aware of the resident having an increase in incontinence after the assessment and also indicated the nursing staff are allowed to initiate care plans when a resident has any type of change in condition.</p> <p>A Urinary Incontinence Policy dated 1/23/06 was provided on 1/11/13 at 12:15 p.m. The policy indicated "...A repeat assessment will be completed when the criteria is met to complete a significant change in status assessment..."</p> <p>7. Resident #J's record was reviewed on 01/11/13 9:00 a.m., the resident's diagnoses included, but were not</p>				

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	<p>limited to, hypertension and anxiety. The resident was admitted into the facility on 09/12/12.</p> <p>An Urinary Incontinence Assessment, dated 09/18/12, indicated the resident had been living independently prior to admission into the facility, the resident had dribbling of urine, was on oxybutnin (incontinence medications), had impaired mobility, used diuretics and narcotics, could comprehend and follow through on educations and instructions, could identify urinary urge sensation, could contract the pelvic floor muscle, was able to get to the toilet, could use call light, was motivated to learn, and was cooperative with toileting attempts.</p> <p>The assessment indicated the resident had urge incontinence and stress incontinence, the resident was placed on prompted voiding, and bladder retraining and the referral had been sent on 09/19/12. The comments indicated, "Admitted c/ (with) having frequent episodes of incontinence...voiding program initiated. Referral for therapy will be sent (UI program) (urinary incontinence)..."</p> <p>The MDS (Minimum Data Set) Admission Assessment, dated</p>						

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	<p>09/18/12, indicated the resident was frequently incontinent of urine.</p> <p>The CAA (Care Areas Assessment), dated 09/24/12, indicated the resident was put on a prompted voiding program and a referral would be given to therapy for the UI program.</p> <p>MDS Quarterly Assessment, dated 12/19/12, indicated the resident was frequently incontinent.</p> <p>A care plan, dated 09/20/12, indicated the resident had urinary incontinence. The interventions included, referral to therapy for the UI program was sent 09/19/12.</p> <p>The therapy records and care plan lacked documentation to indicate the resident was assessed for the UI program.</p> <p>During an interview on 01/11/13 at 9:54 a.m., the Therapy Manager indicated they did not receive a referral and the assessment had not been completed. She indicated the UI program consisted of doing a voiding diary, and if the resident was a candidate, they would put the resident on a program with exercises to see if they could improve the resident's incontinency. She indicated she was</p>				

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	<p>unable to determine if resident would have improved in urinary continence since the assessment had not been completed.</p> <p>8. Resident # 73's was reviewed on 01/15/13 at 8 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease and chronic obstructive pulmonary disease. The resident was admitted into the facility on 08/24/12 and returned to the facility from a hospital admission on 09/24/12 .</p> <p>An Admission Assessment of Urinary Incontinence, dated 9/24/12, indicated the resident was incontinent, had dementia and a seizure disorder. The assessment indicated the resident could identify the urge to urinate and could get to the toilet or be transferred to the toilet and was cooperative with attempts at toileting. The comments indicated the resident would have prompted toileting and would be referred to the UI program.</p> <p>An Admission Minimum Data Set Assessment (MDS), dated 08/30/12, indicated the resident was occasionally incontinent (less than 7 episodes of incontinence) of urine.</p>			

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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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	<p>The CAA, dated 08/30/12, indicated the resident had urinary incontinence and needed toileting assistance at times. The CAA indicated a prompted voiding plan had been initiated and the resident had been referred to therapy for the UI program.</p> <p>A Quarterly MDS Assessment, dated 11/14/12, indicated the resident was 2 frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) of urine.</p> <p>The therapy records and care plan lacked documentation to indicate the resident was assessed for the UI program.</p> <p>The Therapy Manager during an interview on 01/15/13 at 8:26 a.m. indicated she did not remember getting a referral for the UI program. She indicated an assessment had not been completed. She indicated therapy did not get a referral. She indicated no assessment had been completed to see if resident was a candidate for the UI program.</p> <p>(5) 98 employees who had been employed by the facility for over four months, records were reviewed on</p>			

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	<p>01/15/13 at 2 p.m. There was a lack of documentation in the facility's dementia training inservices to indicate 98 of the 257 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2012.</p> <p>During an interview on 01/16/13 at 8:05 a.m., the Director of Nursing indicated with the change of process with no longer having an Educational Nurse, no one had followed up on the Dementia Training.</p>				

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F9999	<p>3.1-14 PERSONNEL</p> <p>In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure facility staff received six and three hours of dementia specific training annually for 98 of 257 employees who had been employed at the facility for more than six months. (CNA's #5, #8, #10, #12, #14, #15, #16, #17, #18, #19, #20, #21, #23, #25, #26, #27, #28, #32, #34, #38, #39, #40, and #44. RN's #11, #22, #30, #33, and #41. LPN's #9, #13, #24, #31, #35,</p>	F9999	<p>F9999 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Unable to correct the alleged deficient practice 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. · All residents have the potential to be affected by the alleged deficient practice. · All documentation reviewed for staff who needed Dementia Training for compliance on 1-30-13. · Staff that need the required dementia training were contacted to attend one of the dementia trainings. (attached U-1)) · For staff that are requiring Dementia Training for compliance, In-services to be completed by 2-15-13 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. · New Hires are required to attend 6 hours of Dementia training within 30 days of hire. · Employees are then required 3 hours of Dementia Training yearly Staff that are assigned to the Dementia Unit will require 6 hours of Dementia training per year. (attachment U-1) · All staff will be audited monthly to verify</p>	02/15/2013			

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	<p>#36, #37, #42, #43, #45, #46, #47, #48, and #83. Security #49, #50, #51. Environmental Services #84, #85, #86, #87. Dietary #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #65, #66, #68, #69, #70, #71, #72, #73, #74, #75, #76, #77, #78, #79, #80, #81. Life Enrichment #88. Marketing #89, #90, #91. Chaplain #92. Laundry #109. Social Service #110. Therapy #93, #94, #95, #96, #97, #98, #100, #101, #103, #104, #106, #107, and #108.</p> <p>Findings include:</p> <p>Ninety eight employees who had been employed by the facility for over four months, records were reviewed on 01/15/13 at 2 p.m. There was a lack of documentation in the facility's dementia training inservices to indicate 98 of the 257 employees had received the initial six hours of dementia training or the three hours of dementia training required yearly for the year of 2012.</p> <p>During an interview on 01/16/13 at 8:05 a.m., the Director of Nursing indicated with the change of process they no longer having an Educational Nurse, no one had followed up on the Dementia Training.</p>		<p>that they are in compliance. Audit (attachment U) 3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audit to be completed weekly x 4 weeks then monthly x 3 months, then quarterly for 3 consecutive quarters. The results of these audits will be presented to the QA&A committee until substantial compliance is obtained.</p>		

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	3.1-14(u)				