

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155073	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2013
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NAME OF PROVIDER OR SUPPLIER  PILGRIM MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PLYMOUTH, IN 46563
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: September 9, 10, 11, 12, 13, and 16, 2013.</p> <p>Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260</p> <p>Survey Team: Deborá Kammeyer, RN-TL Julie Wagoner, RN Lora Swanson, RN (9/9, 9/10, 9/11, 9/12, 9/13, 2013) Tim Long, RN ( 9/11, 9/12, 9/13, 9/16, 2013)</p> <p>Census Bed Type SNF: 5 SNF/NF: 51 Residential: 0 Total: 56</p> <p>Census Payor Type: Medicare: 6 Medicaid: 35 Private: 11 Other: 4 Total: 56</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>Please accept this plan of correction as our allegation of compliance. This plan of correction has been reviewed and input given by the Medical Director. Disclaimer: Pilgrim Manor does not believe and does not admit that any deficiency existed, either before, during or after the survey. Pilgrim Manor reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Pilgrim Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Pilgrim Manor does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Pilgrim Manor offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. Pilgrim Manor reserves the right to modify policies/procedures and quality</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	IAC 16.2.  Quality Review completed on September 23, 2013, by Brenda Meredith, R.N.		improvement systems as necessary to better meet the needs of the residents and the facility. The systemic changes will be in effect as of October 15, 2013 Thank you, Lori A. SmithAdministrator		

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to timely notify the family and physician, for 1 of 3 residents reviewed for weight loss. (Resident #74)</p>	F000157	Please accept this plan of correction as our allegation of compliance F157 1. Resident #74 is deceased. This alleged deficient practice did not affect this resident. 2. All resident's	10/15/2013			

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	<p>Findings include:</p> <p>Resident #74's clinical record was reviewed on 9/13/13 at 1:00 P.M. The record indicated the resident was admitted to the facility, on 6/3/13, with diagnoses including, but not limited to: pneumonia.</p> <p>The resident's weight on admission was 129.8 pounds (lbs). On 6/18/13, resident #74's weight was 125.3 lbs. On 6/21/13 the resident's weight was 107.9 lbs. A nurse's note on 6/21/13 at 2:09 P.M., indicated the resident's weight was 107.9 lbs with reweighs of 108.3 lbs and 108.4 lbs. The nurse's note indicated the facility was to weigh the resident for the next 3 days and reevaluate. The nurse's notes indicated the next weight completed for resident #74 was 107.8 lbs, on 6/23/13 at 12:05 P.M.</p> <p>On 6/23/13 at 7:15 P.M., a nurse's note indicated a call was placed to Resident #74's family/Power of Attorney (POA) and a message was left on an answering machine to call the facility. A nurse's note, on 6/23/13 at 8:35 P.M., indicated a call was placed to the family/POA to report the 13.4% weight loss.</p>		<p>weights have been reviewed and physicians were notified. This alleged deficient practice did not affect any residents. 3. The "Weighing Residents" policy has been updated (See Exhibit I), to reflect the time frames of when a physician and family should be notified. If there is a 5% weight loss or gain in 30 days the physician and family will be notified within 24 hours. For weight loss or gain of 7.5% or more in 90-180 days the physician and family will be notified within 48 hours, during normal physician office hours. All nurses will be in-serviced on "Weighing Residents" policy (See Exhibit I) on 10-8-13 through 10-10-13. 4. The Unit Manager and Dietary Manager will be notified through the Electronic Chart System (ECS) of all 5, 7.5 and 10% weight loss/gains, per the policy (See Exhibit II - example). The Dietary Manager, during normal business days, will calculate weight loss/gain for accuracy and review medical record to ensure timely physician /family notifications were completed. If the physician or family was not notified, the Dietary Manager will notify the Unit Manager for immediate follow-up. The Unit Manager will report weekly to the Weekly QA (See Exhibit III) Committee meeting. The Weekly QA Committee is represented by: Dietary Manager, Administrator,</p>				

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	<p>On 6/24/13 at 9:31 A.M., a nurse's note indicated a fax was sent to the resident's physician regarding "notified of 13.4% wt [weight] loss and that we will review supplements; was also recently started on Lasix."</p> <p>An interview with the dietary manager (DM) on 9/13/13 at 2:20 P.M., indicated the facility's policy was to notify family and the physician of a weight loss of over 5%. The DM indicated the dietary assessment, dated 6/27/13 at 2:33 P.M., documented Resident #74's weight was 108.2 on 6/23/13, a weight loss of 17.1 lbs, a 13.6% weight loss over a 5 day period.</p> <p>On 9/13/13 at 2:20 P.M., the DM provided the facility policy, titled "Weighing Residents," dated 5/1/11. Review of the policy indicated under section 5: "If the resident's monthly weight and/or re-weight is a loss/gain of 5% 30 days or 10% 180 days or more, the nurse unit manager and the dietary manager will be notified electronic. The physician, resident and/or significant other will be notified by the charge nurse."</p> <p>3.1-5(a)(2)</p>		DON, Medical Records, Activity Director, Business Office Manager, Environmental Director, Maintenance Director, In-Service Director, MDS Coordinator, Unit Managers (2) and Social Service Director.		

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F000174 SS=D	<p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on observation, record reviews and interviews, the facility failed to ensure residents had access to the use of a private telephone for 3 of 3 residents in a sample of 16 reviewed for privacy issues. (Residents #17, 20 and 61)</p> <p>Findings include:</p> <p>1. During an interview, on 09/10/13 at 9:06 A.M., alert and oriented Resident #17 indicated the only phone for residents to use was located by the nurses station and was not private.</p> <p>An interview with Resident #17, on 09/12/13 at 2:23 P.M., indicated if she needed to use the phone, she used the phone across from the nurses station. She indicated she called her brother numerous times and asked him to come to the facility because there were private things she needed to discuss with him and she could not do that on the phone in the hallway because it was not private. She further indicated she had never heard</p>	F000174	<p>Please accept this plan of correction as our allegation of compliance. F174 1. Resident #17, #20, and #61 have been given the new "Telephone Access" policy (See Exhibit IV). The cordless phone is available on the unit and a hearing impaired telephone is available in the Business Office. 2. All residents have the potential to be affected by this alleged deficient practice. All residents will receive and be educated on the "Telephone Access" policy (See Exhibit IV). 3. The "Telephone Access" policy (See Exhibit IV) has been updated to include information about the cordless telephone availability and the hearing impaired telephone that is available 24 hours a day 7 days a week in the Business Office, where they will be afforded privacy. A new cordless telephone has been purchased that will reach all areas of the facility. The "Telephone Access" policy will be available and reviewed when new clients are given the admission packet. All staff will be in-serviced on "Telephone Access" policy on 10-8-13 through 10-10-13. 4. All Department Managers that</p>	10/15/2013	

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	<p>of the facility having a portable phone available to residents. She indicated no one had ever brought or offered her a portable phone.</p> <p>On 09/12/13 at 3:00 P.M., Resident #17, who was ambulating with staff by the nurses station, indicated the resident's phone was a black and silver phone, which resembled a pay phone, which was hanging on a wall across from the nurse's station.</p> <p>2. During an interview, on 09/09/13 at 3:03 P.M., alert and oriented Resident #20 indicated the only phone available to residents was located out in the hallway by the nurses station. She indicated the phone was not private.</p> <p>An interview with Resident #20, on 09/12/13 at 9:00 A.M., indicated she did not utilize the telephone because she could not hear very well on the phone. She indicated her daughter sometimes called and left her messages but the messages did not always get relayed to her and she missed the messages. She also indicated she would like to hear from her grandsons if there was a phone on which she could hear. Resident #20 did not seem to think they had a portable phone available. She</p>		<p>conduct Abaqis interviews with residents, on a quarterly basis, will ask "Do you have privacy when on the telephone?". If there are answers that they do not have privacy, they will review that the cordless telephone is available and the hearing impaired telephone is available for their privacy. The Department Managers will report weekly to the Weekly QA Committee (See Exhibit III), any resident issues with the telephone privacy. The Weekly QA Committee is represented by: Dietary Manager, Administrator, DON, Medical Records, Activity Director, Business Office Manager, Environmental Director, Maintenance Director, In-Service Director, MDS Coordinator, Unit Managers (2) and Social Service Director.</p>				

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	<p>indicated no one had offered a portable phone to her. She reiterated several times she was not concerned about this because she did not prefer to use the phone because could not hear on a phone. She did not seem to know if there were phones available to aide the hearing impaired. She conceded she might enjoy talking to her daughter and 5 grandsons if she could hear.</p> <p>3. The clinical record for Resident #61 was reviewed on 09/16/13 at 10:30 A.M. Resident #61 was admitted to the facility on 11/07/11, with diagnoses, including but not limited to: chronic pain, peripheral vascular disease, constipation, generalized osteoarthritis, depressive disorder, asthma, and anemia.</p> <p>Resident #61 was interviewed on 09/16/13 at 11:00 A.M. He indicated the phone across from the nurses station that looks like a pay phone but wasn't a pay phone was not private. He indicated staff tell him they will give him a portable phone but they do not assist him with this issue. He indicated if someone calls him, they will allow him to use the phone at the nurses station but it was not private and he has a hard time standing at the station to use it. He indicated</p>				

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	<p>only on a few occasions when he was in another room did staff ever bring him the portable phone to his room. He indicated he could not always get reception with the portable phone in his previous room. He indicated he received a call this weekend and they transferred it to the telephone in the activity room, however, there were 3 other residents and a staff member in the room playing cards and the staff member was even commenting on his private conversation while he was on the phone. He indicated although he had been told he could have privacy on the telephone, the facility did not really provide the privacy he desired.</p> <p>An interview with RN #1, the West unit manager, on 09/12/13 at 9:14 A.M., indicated there was a portable phone available at the nurse's station. A portable phone was observed on top of a copy machine behind the counter of the nurse's station. She indicated the nurse's would take the phone to residents if they got a call.</p> <p>Interview with the Administrator, on 09/12/13 at 9:15 A.M., indicated the residents could use the resident phone across from the nurse's station or the portable phone. She indicated the facility did have an amplified phone available. The amplified</p>						

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	<p>phone for the hearing impaired was observed locked in a computer room in a box, unused. She indicated to her knowledge no resident had requested the phone and it had not been used yet. She indicated the phone was purchased due to a required law to aide the handicapped. She indicated the phone availability was in the Admission packet, but she did not think the hearing impaired phone was denoted in the admission information.</p> <p>A review of the facility policy and procedure regarding telephone use, located in the Admission packet, dated 07/27/01, indicated the following: " Pilgrim Manor will provide its residents access to the telephone when requested. Procedure: A telephone is located in the Activity room for resident use. Should auditory and/or visual privacy be necessary, the residents may utilize the telephone located in the Social Service Office or the Director of Nursing Office. The charge nurse has a key for after hours utilization. A phone is also adapted for the hearing impaired....Someone will be available to assist residents with telephone usage if necessary."</p> <p>Observation of the Activity room, on</p>						

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	<p>09/13/13 at 11:40 A.M., indicated there was a facility desk phone sitting beside a computer in the built in counter along the wall. The Director of Nursing indicated there was not a "resident" specific telephone in the Activity room but there was a telephone in the room and residents could and sometimes did use the phone.</p> <p>3.1-3(f)</p>				

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Base on observation, record reviews and interviews, the facility failed to ensure visual privacy was maintained during personal care for 1 of 30 residents observed for care in a sample of 30. (Resident #10)</p> <p>Finding includes:</p> <p>On 09/10/13 at 10:28 A.M., the door to Resident #10's room was noted to be closed. After knocking on the door to Room #10, CNA #2 indicated "Come on in." When the door was opened, CNA #2 was noted to be in the middle of giving Resident #10 a bed bath. Resident #10's bed was noted to be by the window. The privacy curtain was not pulled and Resident #10 was observed lying unclothed with a wadded up hospital gown on her abdomen. CNA #2 did not attempt to provide any privacy for Resident #10, but continued the bed bath. Resident #10 was observed to try to cover herself with the gown.</p> <p>The clinical record for Resident #10</p>	F000241	F241 1. Resident #10 was not affected by this alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. 3. A "Privacy/Dignity" policy has been written (See Exhibit V). All staff will be in-serviced on "Privacy/Dignity" policy on 10-8-13 through 10-10-13. Staff will be trained on how to use privacy curtains, close doors and how to respond when someone knocks on the door. This will allow privacy and dignity for all residents. 4. The assigned weekend manager, will conduct a privacy/dignity audit (See Exhibit VI) of 10% of the residents, while staff are giving care. The audits will be completed on various shifts. The weekend managers are part of the QA team. They will report weekly to the Weekly QA Committee (See Exhibit III), any resident issues with privacy and dignity. The Weekly QA Committee is represented by: Dietary Manager, Administrator, DON, Medical Records, Activity Director, Business Office Manager, Environmental Director, Maintenance Director, In-Service	10/15/2013			

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	<p>was reviewed on 09/12/13 at 12:00 P.M. Resident #10 was admitted to the facility, on 09/14/12, with diagnoses, including but not limited to: dementia without behavioral disturbances, atrial fibrillation, hypertension, malaise and fatigue, personal history of falls, anemia, osteoarthritis.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident #10, completed on 06/18/13, indicated she was cognitively impaired and required extensive staff assistance for bathing and personal hygiene issues.</p> <p>3.1-3(t)</p>		Director, MDS Coordinator, Unit Managers (2) and Social Service Director.		

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interviews, the facility failed to allow 2 of 3 residents in a sample of 16, interviewed to choose their bathing schedules. (Resident #20 and 48)</p> <p>Findings include:</p> <p>1. During an interview, conducted on 09/09/2013 at 2:50 P.M., alert and oriented Resident #20 indicated she did not get to choose her bathing schedule. She indicated she received showers on Wednesday and Sundays. She indicated she wished she could have a shower every other day because she did not feel clean since she was only showered twice a week.</p> <p>An interview with Resident #20, on 09/12/13 at 9:00 A.M., indicated she could not remember if she had told the facility her preference for bathing. She indicated she did prefer every other day bathing as she felt the two</p>	F000242	Please accept this plan of correction as our allegation of compliance F242 1. Staff met with Resident #20 and discussed when and how many times she would like her showers. Resident #20 requested to get a shower 3x a week, in the morning, and would like the 3rd day of showers to be on Friday morning. This was adjusted on 9-12-13 (See Exhibit VII & VIII) Staff met with Resident #48 and discussed when and how many times she would like her showers. Resident #48 requested to get a shower 3x a week, in the morning, and would like the 3rd day of showers to be on Saturday morning. This was adjusted on 10-2-13 (See Exhibit IX & X). 2. 28 residents were interviewed through Abaqis, between July 1 and September 30, 2013, and asked the question "Do you choose how many times a week you take a bath or shower? If No: How many times a week do you get a bath or shower? How many times a week would you like to bathe?"	10/15/2013			

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	<p>showers a week were not enough. She indicated there had been some people in last week asking questions very similar to the interview questions. The resident could not specifically remember being asked about bathing preferences. She indicated she had been to a care plan conference but it had been awhile. She further indicated she probably told them her bathing preference but could not remember if she told them specifically. She did not recall any time she definitely told them her bathing preference.</p> <p>An interview with Administrator, on 09/12/13 at 9:15 A.M., indicated an outside group hired by government had interviewed all of the residents last week to determine their "satisfaction" in order to link it to the reimbursement, but the information had not been shared with the facility. The Administrator indicated the facility did use the "Abicus" (a facility survey preparedness tool) surveys periodically on a random basis.</p> <p>An interview, on 09/13/13 at 11:00 A.M., with the Social Service Director (SSD), Employee #3, RN #1, and the MDS Coordinator, RN #4, indicated Resident #20 was interviewed by a staff member and asked the exact</p>		<p>"Three residents answered no. Resident #20 &amp; #48 were 2 of the 3 and were addressed (see #1 above), the 3rd resident, Medical Record #4377 was identified as answering that question negatively. Resident #4377 has been interviewed and her shower schedule is 2 times per week and she would like it to remain at 2 times per week (See Exhibit XI). 3. Upon admission the resident or resident family will be asked their preferences for types of bathing and frequency (See Exhibit XII Sample). Showers and frequency will be reviewed at quarterly care plan meetings (See Exhibit XIII). All reasonable requests will be implemented and care planned. For the quarterly QA meeting, residents are randomly selected to be interviewed through Abaqis. Any negative responses, in regards to frequency of showers, will be sent to the Unit Manager to be addressed with the resident. 4. Reasonable requests from residents will be implemented and care planned. The Unit Managers will report weekly to the Weekly QA Committee (See Exhibit III), any resident issues with frequency of showers and report how the issues were addressed. The Weekly QA Committee is represented by: Dietary Manager, Administrator, DON, Medical Records, Activity Director, Business Office</p>		

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	<p>questions we ask on the survey. The SSD, and Employee #3, indicated on 08/27/13 when Resident #20 was interviewed, she had answered "No" when asked if she was able to choose her bathing schedule. Employee #3 indicated Resident #20 further indicated she received a bathing opportunity twice a week and she preferred every other day. The SSD indicated staff were supposed to use the information gathered to update the care plans with personal preferences. They indicated the staff member who had completed the interview with Resident #20 had evidently not updated the care plan to individualize the information.</p> <p>A review of the most recent Minimum Data Set (MDS) assessment for Resident #20, completed on 08/15/13, indicated it was "very important" for Resident #20 to choose between a tub, shower or bed bath. There was no assessment question regarding the frequency of bathing.</p> <p>2. During an interview, conducted on 09/09/13 at 2:38 P.M. with alert and oriented Resident #48, the resident indicated she did not get to choose how many times a week she took a bath or shower. She indicated she received two showers a week at the</p>		<p>Manager, Environmental Director, Maintenance Director, In-Service Director, MDS Coordinator, Unit Managers (2) and Social Service Director.</p>				

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	<p>facility but she had showered daily when she lived at home. She indicated she would prefer to shower more often.</p> <p>An interview with Resident #48 and her husband, on 09/12/13 at 10:45 A.M., indicated she was used to showering daily at home and would still prefer to be showered daily. She indicated she did not recall anyone specifically asking her how often she would prefer to be bathed. She indicated when she was admitted they told her she would be showered two times a week. The resident's husband indicated approximately 2 weeks ago they were talking to staff member (Employee #5) and Resident #48 had requested more frequent showers.</p> <p>An interview with Employee #5, the business office manager, on 09/12/13 at 11:22 A.M., indicated during an Abicus interview she had conducted with Resident #48 she did voice that she took daily showers at home and only received two showers a week at the facility. Employee #5 did not seem to remember if Resident #48 desired or requested any change from the two showers a week the facility offered.</p>						

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	<p>Documentation provided by RN #1, on 09/12/13 at 2:54 P.M., indicated the resident was interviewed for Abicus, regarding bathing preferences, on 08/28/13 and indicated "No, I get (a shower) one-two times a week but used to take them daily."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>				

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F000282 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 interviews, the facility failed to ensure a fall prevention care plan was followed for 1 of 3 residents reviewed for accidents (Resident #48)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #48 was reviewed on 09/11/13 at 2:00 P.M. Resident #48 was admitted to the facility, on 05/29/12 at 10:00 A.M., with diagnoses, including but not limited to: ataxia, hypertension, hyperlipidemia, hypothyroidism, constipation, osteoarthritis, osteoporosis, hypertonicity of bladder, and mental disorder- dementia.</p> <p>Resident #48 was observed on 09/11/13 at 2:15 P.M., in her room seated in a side chair beside her bed. An alarm was noted to be connected to a pad underneath the resident, a black, thin floor mat was noted beside her bed, and an adaptive call light was within her reach, on the bedrail. Resident #48 acknowledged she had</p>	F000282	<p>Please accept this plan of correction as our allegation of compliance. F282 1. Resident #48 was not injured when the fall occurred. The employee responsible for not following the individual care plan for #48 was counseling in writing. 2. All residents who have a fall prevention car plan have the potential to be affected by this alledged deficient practice. All nursing staff will receive staff education on following plan of care pertaining to falls. 3. The "CNA Care Plan" policy (See Exhibit XIV) was reviewed and updated to include fall/safety interventions. The Falls, Accidents, Incidents and Restraints (FAIR) committee policy (See Exhibit XV) has been revised to include criteria for not following safety interventions. The General Orientation checklist (See Exhibit XVI), used for all nursing staff, has been revised to include CNA care plans - location and contain fall interventions. The revised General Orientation Checklist will be utilized for all new employees as of 10-10-13. All nursing staff will be in-serviced on "CNA Care Plan" policy and revised "FAIR Committee" policy</p>	10/15/2013			

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	<p>fallen in the past, but she indicated she had not fallen recently.</p> <p>Resident #48 observed, on 09/12/13 at 2:52 P.M., in her room in rocker side chair. An alarmed pad was noted underneath the resident a light on the alarm box indicated it was functioning.</p> <p>The most current Minimum Data Set (MDS) assessment for Resident #48, completed on 09/03/13, indicated the resident was alert and oriented, required limited assistance of one staff for transferring, ambulating, and toileting needs, was not steady and only able to stabilize her balance during transitions of every type with staff assistance, and had experience two or more falls without injuries since the last MDS assessment .</p> <p>The initial Fall risk assessment for Resident #48, completed on 05/29/13, indicated the resident was a high risk for falls and required one person assist with transfers. The most recent Fall risk assessment, completed on 08/20/13, indicated the resident had experienced 1-2 falls in the past 3 months, was still at high risk for falls, and still required one person assistance for transfers.</p>		<p>on 10-8-13 through 10-10-13. 4. The Unit Managers will present to the FAIR Committee in the daily QA meeting, all falls for review. The investigation of the fall will include whether there was a concern with a fall intervention not followed. If this was a concern the criteria list will be followed. This FAIR committee consists of: Administrator, DON, Unit Managers (2), Maintenance Director, Environmental Director, MDS Coordinator, Medical Records and Social Services. The Unit Managers will report weekly to the Weekly QA Committee (See Exhibit III), any concerns with staff not following plan of care and what actions have been taken. The Weekly QA Committee is represented by: Dietary Manager, Administrator, DON, Medical Records, Activity Director, Business Office Manager, Environmental Director, Maintenance Director, In-Service Director, MDS Coordinator, Unit Managers (2) and Social Service Director.</p>				

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	<p>The care plan, titled "Potential for Injury From Falls," initiated on 05/29/12, when the resident was admitted, included an intervention for the resident not to be left unattended in the bathroom. The intervention was added to the care plan on 06/29/12.</p> <p>Review of nursing progress notes and fall incident reports, dated 01/28/13 at 11:15 A.M. indicated Resident #48 was found on the floor in the bathroom. The resident had been attempting to transfer herself from the toilet to the wheelchair. She had also turned off her wheelchair alarms. There were no staff present in the bathroom with the resident at the time of the fall.</p> <p>Review of the "FAIR" (fall,accident, incident review) committee notes, completed on 01/28/13 at 2:12 P.M., indicated the only intervention implemented after this fall was "staff counseling to be done." Interview, on 09/13/13 at 10:00 A.M., with unit manager, RN #1, indicated staff was counseled because the resident had apparently been left in the bathroom alone and fell trying to transfer herself off of the toilet.</p> <p>3.1-35(g)(2)</p>						

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to provide adequate supervision to prevent falls for 1 of 3 residents reviewed for accidents (Resident #48)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident #48 was reviewed on 09/11/13 at 2:00 P.M. Resident #48 was admitted to the facility on 05/29/12 at 10:00 A.M., with diagnoses, including but not limited to: ataxia, hypertension, hyperlipidemia, hypothyroidism, constipation, osteoarthritis, osteoporosis, hypertonicity of bladder, and mental disorder- dementia.</p> <p>Resident #48 was observed, on 09/11/13 at 2:15 P.M., seated in a side chair beside her bed in her room. An alarm was noted to be connected to a pad underneath the resident, a black, thin floor mat was noted beside her bed, and an adaptive call light</p>	F000323	<p>Please accept this plan of correction as our allegation of compliance. F323 1. Resident #48 was not injured when the fall occurred. The employee responsible for not following the individual care plan for #48 was counseled, in writing. 2. All residents who have a fall prevention care plan have the potential to be affected by this alleged deficient practice. All staff are being in-serviced on 10-8-13 through 10-10-13 on fall prevention plan of care. 3. All alarmed boxes for alarmed bed/chair pad alarms have been replaced with automatic reset boxes (no on/off button). The facility will no longer use boxes that can be turned on/off manually. For those residents that have been identified to be a fall risk and are care planned to use an alarmed chair pad, they will have a yellow ribbon attached to the handle of their wheelchair or other chair they may use, per revised "Alarm Policy" (See Exhibit XVII). This visual aide will be listed on each individual care plan, and CNA care plans which is posted at the head of the bed and in the electronic chart system</p>	10/15/2013			

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	<p>was within her reach, on the bedrail. Resident #48 acknowledged she had fallen in the past, but she indicated she had not fallen recently.</p> <p>Resident #48 observed, on 09/12/13 at 2:52 P.M., in her room in rocker side chair. An alarmed pad was noted underneath the resident a light on the alarm box indicated it was functioning. There was a detailed instruction sheet behind the resident's headboard with instruction for fall prevention measures, including use of an infrared light motion alarm at night, an alarmed sensor pad, in the wheelchair and in her bed, a thin black mat on floor beside her bed, a dyson (nonslip) pad beneath part of rubber mat, keeping her fly swatter on a hook in reach, keeping the resident's dresser on other side of rocker side chair, directions regarding the placement of chairs and a bedside commode at night, and instructions to monitor the resident's footwear to ensure there were shoes or non-skid socks. Interview with Resident #48 and her husband, indicated there was also a photograph of the chair placement and bedside commode placement on the board across from the resident's bed. Resident #48's husband indicated the resident had</p>		<p>under CNA sign by 10-14-13. All staff will be in-serviced on the change over to the automatic reset alarm boxes and the revised "Alarm Policy" on 10-8-13 through 10-10-13. On 10-8-13 through 10-10-13 all nursing staff will be in-serviced on CNA care plans to identify fall interventions, including not leaving a resident in the bathroom alone and the use of alarms. 4. The Unit Manager, when completing the "Weekly Walk Through Audit" (See Exhibit XVIII), will check 10% of residents who are care planned for safety interventions to ensure they are in place as appropriate for the time of day the audit is completed. Concerns will be noted on the audit and how the concern was addressed. The Unit Managers will report weekly the the weekly QA committee (See Exhibit III), any concerns with safety intervention not in place/utilized and how it was addressed. The weekly QA committee is represented by: Administrator, DON, Business Office Manager, MDS Coordinator, In-Service Director, Social Services Director, Unit Managers (2), Dietary Manager, Medical Records, Activity Director, Environmental and Maintenance Director.</p>				

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	<p>experienced multiple falls prior to her admission to the facility.</p> <p>The most current Minimum Data Set (MDS) assessment for Resident #48, completed on 09/03/13, indicated the resident was alert and oriented, required limited assistance of one staff for transferring, ambulating, and toileting needs, was not steady and only able to stabilize her balance during transitions of every type with staff assistance, and had experience two or more falls without injuries since the last MDS assessment.</p> <p>The initial Fall risk assessment for Resident #48, completed on 05/29/13, indicated the resident was a high risk for falls and required one person assist with transfers. The most recent Fall risk assessment, completed on 08/20/13, indicated the resident had experienced 1-2 falls in the past 3 months, was still at high risk for falls, and still required one person assistance for transfers.</p> <p>The care plan, titled "Potential for Injury From Falls," initiated on 05/29/12, when the resident was admitted, included an intervention for the resident not to be left unattended in the bathroom. The intervention was added to the care plan on</p>			

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	<p>06/29/12.</p> <p>Review of incident reports, from October 05, 2012 - September 13, 2013, indicated the resident had experienced 14 falls in the 11 1/2 month time frame. Nine of the 14 falls involved the resident's need to use the toilet.</p> <p>Review of nursing progress notes and fall incident reports, dated 01/28/13 at 11:15 A.M., indicated Resident #48 was found on the floor in the bathroom. The resident had been attempting to transfer herself from the toilet to the wheelchair. She had also turned off her wheelchair alarms. There were no staff present in the bathroom with the resident at the time of the fall.</p> <p>Review of the "FAIR" (fall,accident, incident review) committee notes, completed on 01/28/13 at 2:12 P.M., indicated the only intervention implemented after this fall was "staff counseling to be done." Interview, on 09/13/13 at 10:00 A.M., with unit manager, RN #1, indicated staff was counseled because the resident had apparently been left in the bathroom alone and fell trying to transfer herself off of the toilet. RN #1 indicated although Resident #48 was alert and</p>						

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	<p>oriented, she was insistent on transferring herself and attempting to ambulate by herself and her balance and gait were very unsteady. RN #1 indicated staff had tried multiple interventions and continued to try new interventions to keep the resident safe.</p> <p>3.1-45(a)(2)</p>			

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F000329 SS=D	<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 1 of 5 resident's reviewed for unnecessary medications had adequate monitoring for targeted behavior(s) with use of psychotropic medications. (Resident #59)</p> <p>Findings include:</p> <p>Resident #59's clinical record was reviewed on 9/11/13 at 1:00 P.M. The record indicated the resident was</p>	F000329	Please accept this plan of correction as our allegation of compliance. F329 1. Resident #59 was not affected by this alleged deficient practice. A targeted behavior (See Exhibit XIX) was wrote on 9-11-13. 2. All residents that were receiving Anti-depressants, Anti-anxiety, Psychotropics, Hypnotics were reviewed to ensure that all have targeted behaviors in place. All residents had targeted behaviors in place.3. At the "Monthly Behavioral Meetings" the IDT team will review all targeted	10/15/2013	

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	<p>admitted to the facility on 7/11/13, and had diagnoses including, but not limited to: Alzheimer's disease; depressive disorder; anxiety state.</p> <p>Resident #59's current medications include, but were not limited to: Lorazepam 0.5 milligrams (mg) at bedtime for anxiety and Lexapro 10 mg daily for depression.</p> <p>Review of Resident #59's health care plans indicated: Problem: potential for anxiety related to dementia with a goal of will appear relaxed in surroundings, will have no adverse side effects from meds. Interventions for nurses included, but were not limited to, behavior tracking per shift.</p> <p>An interview with the Social Service Director (SSD) on 9/11/13 at 1:55 P.M., indicated tracking for behavior's for the use of Lexapro and Lorazepam was to be completed by nurses on the medication administration record (MAR) or treatment administration record (TAR).</p> <p>An interview with RN #1, the unit manager, on 9/11/13 at 2:05 P.M. indicated there was no behavior tracking on the MAR or TAR for resident #59 and stated it was her</p>		<p>behaviors to ensure they are in place and will revise as needed (See Exhibit XX). Medical Records will complete an audit, through ECS, (See Exhibit XXI - Example), that will identify any resident that is on an anti-depressant, anti-anxiety, hypnotic, anti-psychotic or any mood altering medication and does not have a targeted behavior to monitor. This report will be given to the Unit Managers to ensure a targeted behavior is added. 4. The Unit Managers will bring any residents identified as not having a targeted behavior to the Monthly QA meeting (See Exhibit XXII). The Monthly QA committee is represented by: Administrator, DON, Unit Managers (2), MDS Coordinator, In-Service Director, Business Office Manager, Social Service Director, Dietary Manager, Activity Director, Social Service Director, Maintenance Director and Environmental Director.</p>		

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	<p>fault and she would fix it right away.</p> <p>A policy provided by the Administrator on 9/11/13 at 3:00 P.M., with the subject of "Behavioral Symptoms", effective date of 4/1/08, indicated under #1: "If a resident displays behavior's that need to be monitored, are on an anti-depressant, anti-anxiety, hypnotic, anti-psychotic or any mood altering medication behavior(s) will be documented in ECS (electronic charting system) -Nursing folder-Behavior or Mood folder."</p> <p>3.1-48(b)(1)</p>			

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F000441 SS=F	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interviews, the facility failed to</p>	F000441	Please accept this plan of correction as our allegation of	10/15/2013			

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	<p>ensure the infection control program policies and procedures were easily accessible, thorough, and defined how the facility was to utilize the information to investigate, control, and prevent the spread of infection. This deficient practice potentially affected 56 of 56 residents. In addition, the facility failed to ensure 1 of 4 staff observed providing care changed gloves appropriately for 1 of 4 residents observed receiving care. (Resident #59)</p> <p>Finding Includes:</p> <p>1. An interview, with LPN #6, the infection control nurse, was conducted on 09/13/13 between 1:45 P.M. - 4:05 P.M. LPN #6 indicated she monitored the current infections on a form, titled "Monthly Infection Control Log." The form indicated the resident's name, the resident's admission date, type of infection, body site, date of onset, date a culture was taken, any organism identified, if the organism was multi-antibiotic resistant, if a follow up was done, and if the infection was present on admission, developed in house, and if there was any isolation ordered. The form did not indicate if the physician was notified timely, ordered appropriate treatment, and if</p>		<p>compliance F441 #1. No resident was affected by this alleged deficient practice. #2. No residents were affected by this alleged deficient practice. 3. Multiple Responses to findings #3: 1a. Monthly Infection Control Log - Revised to include physician was notified timely, ordered appropriate treatment, and if the infection was resolved (See Exhibit XXIII). Revised Monthly Infection Control Report policy (See Exhibit XXIV) to give instruction on how to complete the Monthly Infection Control Log. In-Service will be completed for all Nurses on 10-8-13 through 10-10-13. 1b. Infection Control Policy Book is now located at the Nurse's Station. An In-service will be held for all staff on 10-8-13 through 10-10-13. 1c. Infection Control Surveillance Audits - A new "Infection Control Surveillance Audit Policy (See Exhibit XXV) has been written. The policy includes the Criteria and Frequency of the audits. An In-Service will be held for all staff in regards to infection control on 10-8-13 through 10-10-13 1d. Outbreaks - A new "Outbreak Management policy" (See Exhibit XXVI) has been written. Criteria for defining an Outbreak is included for Norovirus, Influenza, highly contagious infection - tuberculosis, Salmonella, or E.</p>				

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	<p>the infection resolved.</p> <p>In addition, LPN #6 could not locate the Infection Control Manuals for her reference. She indicated as part of the infection control program, she completed random care audits and handwashing audits but there was no documentation available regarding the frequency and type of audits utilized.</p> <p>During this interview, LPN #6 was queried regarding the policy and procedure regarding infection "outbreaks." She indicated she thought if there were 6 residents with a contagious infection it was to be considered an "outbreak." She then changed her mind and indicated maybe it was "10" residents. She again confirmed she had no policy and procedure to reference regarding outbreaks. She indicated if there was an "outbreak" she would start "checking," doing more peri care audits, and/or other audits depending on the type of infection.</p> <p>On 09/13/13 at 4:05 P.M., an Infection Control Manual was located. The manual was located in the Administrator's office. Review of the manual indicated there various policies and procedures but there was</p>		<p>Coli 1057, acquired infections by the same causative organism and infections that have doubled in a month. An In-Service will be held for all Nurses in regards to Infection Control Outbreaks on 10-8-13 through 10-10-13. 1e. Germicidal disinfectant - The "Environmental Services Cleaning and Disinfecting policy" (See Exhibit XXVII) has been revised to include the name, dilution and properties of the cleaners. An In-service will be held on 10-8-13 through 10-10-13 in regards to chemicals and cleaning/disinfecting. 2a. Resident #59 was not affected by this alleged deficient practice. 2b. All residents have the potential to be affected by this alleged deficient practice. 2c. Use of Gloves policy (See Exhibit XXVIII) has been revised to include when gloves should be changed and removed. A weekly QA audit for CNA Supervision of Care has been revised (See Exhibit XXIX) to include observation of proper Glove Use. The weekly audit will be completed on at least 5-10 employees per week. An in-service will be held for all staff in regards to proper use and removal of gloves on 10-8-13 through 10-10-13 #4. Issue 1a - The Infection Control Nurse will report at the weekly QA meeting (See Exhibit III) the following: any issues with, physician being notified timely,</p>				

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	<p>no specific policies regarding staff surveillance audits.</p> <p>In addition, the policy and procedure for handling an "outbreak" indicated the Medical Director was responsible for reporting very unusual specific infections to the health department in very specific time frames and only instructed the facility to report "diarrhea" in newborns, but there was no procedure outlined to handle more common outbreaks of infections in the long term care setting. The policy and procedure for cleaning various environmental and resident use items indicated a "germicide" or "germicide, disinfectant, and deodorizer" was to be used, depending on the item and type of cleaning, but the name of the cleaner utilized by the facility was not identified in the policy. The policy indicated "... A daily comprehensive cleaning and disinfecting program using proven effective germicide cleaning products is in effect..." However, the name, dilution and properties of the cleaners were not specified.</p> <p>An interview with LPN #6, on 09/16/13 at 11:29 A.M. indicated she did not know if there was a policy in the manual regarding how she was to</p>		<p>appropriate treatment being ordered and if the infection was resolved. Issue 1b - The Infection Control nurse will report at the Monthly QA meeting (See Exhibit XXII) if the policy manual is at the Nurse's Station. Issue 1c - Infection Control Audits will be reviewed at the Weekly QA Meeting (See Exhibit III). The weekly and monthly QA committee is represented by: Administrator, DON, Unit Managers (2), MDS Coordinator, In-Service Director, Business Office Manager, Social Service Director, Dietary Manager, Activity Director, Social Service Director, Maintenance Director and Environmental Director. Issue 1d &amp; 1e - Outbreaks will be reported by the Infection Control Nurse and new or changed chemicals will be reviewed by the Environmental Director at the monthly QA meetings (See Exhibit XXII). Issue 2 - Use and removal of gloves: The Infection Control Nurse will report at the weekly QA meetings (See Exhibit III) on the QA CNA Supervision of Care Audit. The Weekly QA committee is represented by: Administrator, DON, Unit Managers (2), MDS Coordinator, In-Service Director, Business Office Manager, Social Service Director, Dietary Manager, Activity Director, Social Service Director, Maintenance Director and Environmental Director</p>		

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	<p>do her infection tracking and surveillance but she would check.</p> <p>2. During an observation of personal care for Resident #59, who was returning on a shower chair from the shower room to her room, the following was noted: CNA #7 was observed placing a undershirt and shirt on the resident. She then positioned the stand up lift and went and put gloves on, then she placed a clean brief and then stood the resident up. The resident had had a liquid green bowel movement in the shower chair. The CNA had soapy washcloth and wiped the resident's bottom, then rinsed the resident's bottom with another washcloth, then dried the resident with a towel, then pulled up the resident's clean brief and pants and pulled down her shirt before she removed her gloves.</p> <p>Review of the facility's policy and procedure regarding "Standard" precautions, dated 01/01/09, and indicated as current, included the following instructions regarding glove use: "...Wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items...Change gloves between tasks and procedures on the same resident after contact with blood, body fluids,</p>						

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	<p>secretions, excretions or contaminated items. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces...."</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(3)</p>			