

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155505	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2016
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NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 8, 9, 10, 11, 12, and 15, 2016.</p> <p>Facility number: 001156 Provider number: 155505 AIM number: 100453350</p> <p>Census bed type: SNF: 20 SNF/NF: 56 Total: 76</p> <p>Census payor type: Medicare: 13 Medicaid: 42 Other: 21 Total: 76</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The following is the Plan of Correction for Robin Run Health Center regarding the Statement of Deficiencies dated 2/15/16. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specifications in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.</p>	
F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p>			

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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	<p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure a resident was not physically abused by another resident for 1 of 2 residents reviewed for allegations of abuse (Resident #5).</p> <p>Finding includes:</p> <p>The facility's reportable incidents were reviewed on 02/11/2016 at 10:08 a.m. A report, dated March 10, 2015, indicated Resident #55 entered Resident #5's room at 2:00 a.m. and made physical contact with Resident #5. The report indicated the contact was made through clothing and blankets and indicated Resident #55 was escorted back to her room, one room away from Resident #5's room, and was placed on "heightened monitoring."</p> <p>Resident #55's record was reviewed on 02/12/2016 at 1:22 p.m. A Minimum Data Set (MDS) assessment, dated 3/31/15, indicated the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15 and indicated Resident #55 required supervision with bed mobility and walking. A MDS assessment, dated 2/1/2016 indicated her BIMS score was a 3 out of 15 and indicated the resident</p>	F 0223	<p>It is the practice of the provider to ensure a resident is not physically abused by another resident.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #5 is not currently able to mobilize self, and therefore no longer poses a risk of intrusive wandering. Resident #55 received an immediate physical assessment by the direct care nurse, and psychosocial follow-up by the Director of Social Service following the event that took place on March 10, 2015. Physician was notified, with no new orders. All follow-up measures reflected no harm.</p> <p><b>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?</b> One resident in the community has been identified as exhibiting intrusive wandering behavior within the past 30 days. This resident has been appropriately care planned for both proactive and reactive interventions to this behavior, and is easily redirected. This resident has not been involved in resident to resident unwanted physical contact. <b>What measures will be put into place or what</b></p>	03/01/2016

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	<p>required extensive assistance with bed mobility and walking. Diagnoses included, but were not limited to dementia with psychosis, cataracts, glaucoma, hypertension (high blood pressure) and diabetes mellitus.</p> <p>A nurse's note, dated 3/6/15 at 9:41 p.m. indicated Resident #55 paced the unit continuously looking for her children and was redirected three times before retiring to bed.</p> <p>A nurse's note, dated, 3/10/15 at 5:42 a.m. indicated Resident #55 was "very agitated" and wandered in and out of other residents' rooms and thought the residents were in her bed. The record indicated, "...attacked [Resident #5 named], standing over [Resident #5 named] bed spanking her like a child telling [Resident #5 name] to get out of her bed...."</p> <p>A nurse's note, dated 3/10/15 at 1:11 p.m., indicated Resident #55 had one on one supervision with a sitter.</p> <p>A nurse's note, dated 3/10/15 at 11:39 p.m., indicated staff heard loud noises in another resident 's room and found Resident #55 standing over the resident hitting her buttock and saying, "get out of my bed". The nurse's note indicated</p>		<p><b>systemic changes will be made to ensure that the deficient practice does not recur?</b> Residents, including cognitively impaired residents, will be monitored, on an ongoing basis by direct care staff for the potential of intrusive wandering activity. This monitoring will be a part of the daily observation of, and engagement with, residents to identify any changes in behavior or customary routines that would place the resident at higher risk for intrusive wandering. When a change in condition with increased risk of intrusive wandering behavior is identified, it will be documented in the medical record and reported to the Director of Social Service or Director of Clinical Services, and a resident plan of care will be developed by the Interdisciplinary Team to address this need. Immediate interventions will be implemented to minimize the risk of recurrence of the behavior. All staff have been re-educated on abuse prevention protocols by the Administrator/designee since the event on March 10, 2015. This re-education included, but was not limited to, what constitutes abuse, and when and to whom to report abuse allegations. Families and residents are educated on the community's Grievance Policy as a part of the admission process. The Resident Rights document is</p>	

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	<p>Resident #55 was placed on continuous observation.</p> <p>An undated care plan, initiated 3/11/15, indicated Resident #55 had intrusive wandering into others rooms and had an intervention to provide "constant reminders" of where Resident #55's room was located. The care plan indicated, "Resolved 8/22/15."</p> <p>A document, dated 3/10/15 and 3/11/15, indicated Resident #55 had one on one supervision on 3/10/15 from 6:00 a.m. until 3:15 p.m. and received monitoring every 15 minutes the remainder of 3/10/15, 3/11/15, and 3/12/15. The document did not indicate staff who were responsible for monitoring the resident.</p> <p>Resident #5's record was reviewed on 02/12/2016 at 1:35 p.m. A MDS assessment, dated 12/4/15, indicated Resident #5 was cognitively impaired and had a BIMS score of 3 out of 15 and required extensive assistance of one person for bed mobility.</p> <p>During an interview on 02/12/2016 at 10:25 a.m., the Executive Director (ED) indicated Resident #55 wandered in the facility but had not wandered into Resident #5's room prior to 3/10/2015. The ED indicated Resident #55 was</p>		<p>publically posted within the community. The Administrator/designee will re-educate the Family Council regarding the Grievance Policy on March 14, 2016, and upon invitation thereafter. <b>How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance Improvement Committee audit tool will be completed by the Administrator/designee and reviewed and evaluated at each meeting times six (6) months.</p>	

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	<p>placed on heightened monitoring prior to the resident entering Resident #5's room and hitting her. The ED indicated the monitoring system worked because staff "found" the resident in another resident's room. At 12:26 p.m. the ED indicated staff were monitoring Resident #55 every 15 minutes and she did not interview other residents to determine if additional residents were abused because the monitoring system was effective and indicated if Resident #55 wandered into other residents' rooms facility staff would have found the resident in their rooms.</p> <p>During an interview on 02/12/2016 at 12:39 p.m. the ED indicated in some cases she would do a broad investigation, but in this case, she felt like she knew the resident and could confidently say it was an isolated incident and no other residents were affected. She indicated if Resident #55 went into another resident's room she would not have been able to exit the room without staff seeing her leave the room.</p> <p>During an interview on 2/15/16 at 12:06 p.m., Unit Manager (UM) #1 indicated Resident #55 "had a tendency" to go into Resident #5's room 1-2 times per month. She indicated the resident was easily redirected from the wrong room as long as she didn't lay down in the other</p>			

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	<p>resident's bed. UM#1 indicated she couldn't recall how many times in the past few months Resident #55 wandered into Resident #5's room.</p> <p>An abuse policy containing "Preventing Resident Abuse"; "Coordination of Abuse Prevention"; " Abuse Investigations"; "Protection of Residents during Abuse Investigations"; and "Reporting Abuse and Neglect," with effective dates of 4/1/2011, was provided on 2/11/15 at 10:20 a.m., by the ED. The policy was reviewed on 2/11/2016 at 10:30 a.m., and indicated, "...Our Community will not condone any form of resident abuse and will continually monitor our community's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...The Administrator has the overall responsibility for the coordination and implementation of our community's abuse prevention program policies and procedures...Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to</p>			

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F 0225 SS=D Bldg. 00	<p>investigate the alleged incident...."</p> <p>3.1-27(a)(1)</p> <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</p>			

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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of resident to resident abuse was thoroughly investigated for 1 of 2 residents reviewed for allegations of abuse (Resident #5).</p> <p>Finding includes:</p> <p>The facility's reportable incidents were reviewed on 02/11/2016 at 10:08 a.m. A report, dated March 10, 2015, indicated Resident #55 entered Resident #5's room at 2:00 a.m. and made physical contact with Resident #5. The report indicated the contact was made through clothing and blankets and indicated Resident #55 was escorted back to her room, one room away from Resident #5's room, and was placed on "heightened monitoring,"</p> <p>Resident #55's record was reviewed on 02/12/2016 at 1:22 p.m. A Minimum Data Set (MDS) assessment, dated 3/31/15, indicated the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15 and indicated Resident #55 required supervision with bed mobility and walking. A MDS assessment, dated 2/1/2016 indicated her BIMS score was a</p>	F 0225	<p>It is the practice of the provider to ensure an allegation of resident to resident abuse is thoroughly investigated. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #55 received an immediate physical assessment by the direct care nurse, and psychosocial follow-up by the Director of Social Service following the event that took place on March 10, 2015. The direct care nurse immediately notified the physician, and there were no new orders. All follow-up measures reflected no harm. <b>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?</b> Cognitively intact residents, who were residing in the community on March 10, 2015, have been interviewed by the Director of Social Service on 2/28/16 and 3/1/16 to determine whether they have experienced unwanted resident to resident physical contact. No additional occurrences were identified. <b>What measures will be put into place or what systemic changes will be made to ensure that the</b></p>	03/01/2016	

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	<p>3 out of 15 and indicated the resident required extensive assistance with bed mobility and walking. Diagnoses included, but were not limited to dementia with psychosis, cataracts, glaucoma, hypertension (high blood pressure) and diabetes mellitus.</p> <p>A nurse's note, dated 3/6/15 at 9:41 p.m. indicated Resident #55 paced the unit continuously looking for her children and was redirected three times before retiring to bed.</p> <p>A nurse's note, dated, 3/10/15 at 5:42 a.m. indicated Resident #55 was "very agitated" and wandered in and out of other residents' rooms and thought the residents were in her bed. The record indicated, "...attacked [Resident #5 named], standing over [Resident #5 named] bed spanking her like a child telling [Resident #5 name] to get out of her bed..."</p> <p>A nurse's note, dated 3/10/15 at 1:11 p.m., indicated Resident #55 had one on one supervision with a sitter.</p> <p>A nurse's note, dated 3/10/15 at 11:39 p.m., indicated staff heard loud noises in another resident 's room and found Resident #55 standing over the resident hitting her buttock and saying, "get out of</p>		<p><b>deficientpractice does not recur?</b> Investigations of resident to resident physical contact will include an interview of appropriate residents by the Administrator/designee to determine whether there was additional involvement. Cognitively impaired residents will be observed by the direct care staff for any changes in behavior or customary routines that would indicate the potential that additional involvement occurred. Appropriate assessment and follow-up will be implemented as indicated based upon interviews and observations. All staff have been re-educated on abuse prevention protocols by the Administrator/designee since the event on March 10, 2015. This re-education included, but was not limited to, what constitutes abuse, and when and to whom to report abuse allegations. Families and residents are educated on the community's Grievance Policy as a part of the admission process. The Resident Rights document is publically posted within the community. The Administrator/designee will re-educate the Family Council regarding the Grievance Policy on March 14, 2016, and upon invitation thereafter. <b>How the corrective action(s)will be monitored to ensure that deficient practice will not recur,</b></p>	

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	<p>my bed". The nurse's note indicated Resident #55 was placed on continuous observation.</p> <p>An undated care plan, initiated 3/11/15, indicated Resident #55 had intrusive wandering into others rooms and had an intervention to provide "constant reminders" of where Resident #55's room was located. The care plan indicated, "Resolved 8/22/15."</p> <p>A document, dated 3/10/15 and 3/11/15, indicated Resident #55 had one on one supervision on 3/10/15 from 6:00 a.m. until 3:15 p.m. and received monitoring every 15 minutes the remainder of 3/10/15, 3/11/15, and 3/12/15. The document did not indicate staff who were responsible for monitoring the resident.</p> <p>Resident #5's record was reviewed on 02/12/2016 at 1:35 p.m. A MDS assessment, dated 12/4/15, indicated Resident #5 was cognitively impaired and had a BIMS score of 3 out of 15 and required extensive assistance of one person for bed mobility.</p> <p>During an interview on 02/12/2016 at 10:25 a.m., the Executive Director (ED) indicated Resident #55 wandered in the facility but had not wandered into Resident #5's room prior to 3/10/2015.</p>		<p><b>i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance Improvement Committee audit tool will be completed by the Administrator/designee and reviewed and evaluated at each Committee meeting times six (6) months.</p>	

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	<p>The ED indicated Resident #55 was placed on heightened monitoring prior to the resident entering Resident #5's room and hitting her. The ED indicated the monitoring system worked because staff "found" the resident in another resident's room. At 12:26 p.m. the ED indicated staff were monitoring Resident #55 every 15 minutes and she did not interview other residents to determine if additional residents were abused because the monitoring system was effective and indicated if Resident #55 wandered into other residents' rooms facility staff would have found the resident in their rooms.</p> <p>During an interview on 02/12/2016 at 12:39 p.m. the ED indicated in some cases she would do a broad investigation, but in this case, she felt like she knew the resident and could confidently say it was an isolated incident and no other residents were affected. She indicated if Resident #55 went into another resident's room she would not have been able to exit the room without staff seeing her leave the room.</p> <p>During an interview on 2/15/16 at 12:06 p.m., Unit Manager (UM) #1 indicated Resident #55 "had a tendency" to go into Resident #5's room 1-2 times per month. She indicated the resident was easily redirected from the wrong room as long</p>			

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	<p>as she didn't lay down in the other resident's bed. UM#1 indicated she couldn't recall how many times in the past few months Resident #55 wandered into Resident #5's room.</p> <p>An abuse policy containing "Preventing Resident Abuse"; "Coordination of Abuse Prevention"; " Abuse Investigations"; "Protection of Residents during Abuse Investigations"; and "Reporting Abuse and Neglect," with effective dates of 4/1/2011, was provided on 2/11/15 at 10:20 a.m., by the ED. The policy was reviewed on 2/11/2016 at 10:30 a.m., and indicated, "...Our Community will not condone any form of resident abuse and will continually monitor our community's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...The Administrator has the overall responsibility for the coordination and implementation of our community's abuse prevention program policies and procedures...Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will</p>			

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F 0226 SS=D Bldg. 00	<p>appoint a member of management to investigate the alleged incident...."</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement its policies and procedures to ensure a resident was was not physically abused by another resident for 1 of 2 residents reviewed for allegations of abuse (Resident #5).</p> <p>Finding includes:</p> <p>The facility's reportable incidents were reviewed on 02/11/2016 at 10:08 a.m. A report, dated March 10, 2015, indicated Resident #55 entered Resident #5's room at 2:00 a.m. and made physical contact with Resident #5. The report indicated the contact was made through clothing and blankets and indicated Resident #55 was escorted back to her room, one room away from Resident #5's room, and was placed on "heightened monitoring,"</p>	F 0226	<p>It is the practice of the provider to implement its policies and procedures to ensure a resident isnot physically abused by another resident. <b>What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #55 received an immediate physical assessment by the direct care nurse, and psychosocial follow-up by the Director of Social Service following the event that took place on March 10, 2015. The direct care nurse immediately notified the physician,with no new orders given. All follow-up measures reflected no harm. <b>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?</b> Cognitively intact residents, who</p>	03/01/2016	

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	<p>Resident #55's record was reviewed on 02/12/2016 at 1:22 p.m. A Minimum Data Set (MDS) assessment, dated 3/31/15, indicated the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 3 out of 15 and indicated Resident #55 required supervision with bed mobility and walking. A MDS assessment, dated 2/1/2016 indicated her BIMS score was a 3 out of 15 and indicated the resident required extensive assistance with bed mobility and walking. Diagnoses included, but were not limited to dementia with psychosis, cataracts, glaucoma, hypertension (high blood pressure) and diabetes mellitus.</p> <p>A nurse's note, dated 3/6/15 at 9:41 p.m. indicated Resident #55 paced the unit continuously looking for her children and was redirected three times before retiring to bed.</p> <p>A nurse's note, dated, 3/10/15 at 5:42 a.m. indicated Resident #55 was "very agitated" and wandered in and out of other residents' rooms and thought the residents were in her bed. The record indicated, "...attacked [Resident #5 named], standing over [Resident #5 named] bed spanking her like a child telling [Resident #5 name] to get out of her bed...."</p>		<p>were residing in the community on March 10, 2015, were interviewed by the Director of Social Service on 2/28/16 and 3/1/16 to determine whether they have experienced unwanted resident to resident physical contact. No additional occurrences were identified.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Investigations of resident to resident physical contact will include an interview of appropriate residents by the Administrator/designee to determine whether there was additional involvement. Cognitively impaired residents will be observed by the direct care staff for any changes in behavior or customary routines that would indicate the potential that additional involvement occurred. Appropriate assessment and follow-up will be implemented as indicated based upon interviews and observations. All staff have been re-educated on abuse prevention protocols by the Administrator/designee since the event on March 10, 2015. This re-education included, but was not limited to, what constitutes abuse, and when and to whom to report abuse allegations. Families and residents are educated on the community's</p>	

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	<p>A nurse's note, dated 3/10/15 at 1:11 p.m., indicated Resident #55 had one on one supervision with a sitter.</p> <p>A nurse's note, dated 3/10/15 at 11:39 p.m., indicated staff heard loud noises in another resident ' s room and found Resident #55 standing over the resident hitting her buttock and saying, "get out of my bed". The nurse's note indicated Resident #55 was placed on continuous observation.</p> <p>An undated care plan, initiated 3/11/15, indicated Resident #55 had intrusive wandering into others rooms and had an intervention to provide "constant reminders" of where Resident #55's room was located. The care plan indicated, "Resolved 8/22/15."</p> <p>A document, dated 3/10/15 and 3/11/15, indicated Resident #55 had one on one supervision on 3/10/15 from 6:00 a.m. until 3:15 p.m. and received monitoring every 15 minutes the remainder of 3/10/15, 3/11/15, and 3/12/15. The document did not indicate staff who were responsible for monitoring the resident.</p> <p>Resident #'5's record was reviewed on 02/12/2016 at 1:35 p.m. A MDS assessment, dated 12/4/15, indicated</p>		<p>Grievance Policy as a part of the admission process. The Resident Rights document is publically posted within the community. The Administrator/designee will re-educate the Family Council regarding the Grievance Policy on March 14, 2016, and upon invitation thereafter. <b>How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance Improvement Committee audit tool will be completed by the Administrator/designee and reviewed and evaluated at each Committee meeting times six (6) months.</p>	

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	<p>Resident #5 was cognitively impaired and had a BIMS score of 3 out of 15 and required extensive assistance of one person for bed mobility.</p> <p>During an interview on 02/12/2016 at 10:25 a.m., the Executive Director (ED) indicated Resident #55 wandered in the facility but had not wandered into Resident #5's room prior to 3/10/2015. The ED indicated Resident #55 was placed on heightened monitoring prior to the resident entering Resident #5's room and hitting her. The ED indicated the monitoring system worked because staff "found" the resident in another resident's room. At 12:26 p.m. the ED indicated staff were monitoring Resident #55 every 15 minutes and she did not interview other residents to determine if additional residents were abused because the monitoring system was effective and indicated if Resident #55 wandered into other residents' rooms facility staff would have found the resident in their rooms.</p> <p>During an interview on 02/12/2016 at 12:39 p.m. the ED indicated in some cases she would do a broad investigation, but in this case, she felt like she knew the resident and could confidently say it was an isolated incident and no other residents were affected. She indicated if Resident #55 went into another resident's</p>			

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	<p>room she would not have been able to exit the room without staff seeing her leave the room.</p> <p>During an interview on 2/15/16 at 12:06 p.m., Unit Manager (UM) #1 indicated Resident #55 "had a tendency" to go into Resident #5's room 1-2 times per month. She indicated the resident was easily redirected from the wrong room as long as she didn't lay down in the other resident's bed. UM#1 indicated she couldn't recall how many times in the past few months Resident #55 wandered into Resident #5's room.</p> <p>An abuse policy containing "Preventing Resident Abuse"; "Coordination of Abuse Prevention"; " Abuse Investigations"; "Protection of Residents during Abuse Investigations"; and "Reporting Abuse and Neglect," with effective dates of 4/1/2011, was provided on 2/11/15 at 10:20 a.m., by the ED. The policy was reviewed on 2/11/2016 at 10:30 a.m., and indicated, "...Our Community will not condone any form of resident abuse and will continually monitor our community's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse...Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans</p>			

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F 0314 SS=G Bldg. 00	<p>to address behavioral issues...The Administrator has the overall responsibility for the coordination and implementation of our community's abuse prevention program policies and procedures...Should an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident...."</p> <p>3.1-28(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure pressure ulcer prevention interventions were evaluated and revised to prevent a resident, who was admitted without a pressure ulcer, from developing a stage 2 (partial thickness skin loss) pressure ulcer</p>	F 0314	<p>It is the practice of the provider to ensure that pressure ulcer prevention interventions are evaluated and revised to prevent a resident from developing a pressure ulcer. <b>What corrective action(s) will be accomplished for those residents found to have been affected by</b></p>	03/04/2016

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	<p>that increased to a stage 4 (full thickness skin loss) pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident #3).</p> <p>Finding includes:</p> <p>Resident #3's record was reviewed on 2/9/2016 at 11:32 a.m. The record indicated Resident #3 had a stage 4 (full thickness tissue loss with exposure of bone) pressure ulcer to her sacrum (vertebra at the bottom of the spine). Resident #3's diagnoses included, but were not limited to, anorexia, dysphagia (difficulty or discomfort with swallowing), Parkinson's disease, Type 2 Diabetes Mellitus, and anemia.</p> <p>A "Nursing Admission Data Collection," dated 11/9/2015, indicated Resident #3 had no history of skin issues and no pressure ulcer on admission. The resident had diabetes, with a history of decreased appetite, and did not have a terminal diagnosis.</p> <p>A care plan, dated 11/9/2015, indicated Resident #3 had a potential for an impairment to skin integrity due to being incontinent of bowel. A goal, dated 11/16/2015, indicated the resident would be free from skin breakdown. Interventions included: apply moisture</p>		<p><b>thedeficient practice?</b> Resident#3 was assessed by the Registered Dietician on 2/12/16, 2/18/16, 2/26/16, and 3/4/16 with resulting recommendations made and implemented. Resident #3 received treatment and ongoing oversight of wound treatment by the wound specialist physician at the Wound Center on 2/25/16 and 3/10/16. All supplements ordered have been added to the MAR for ongoing documentation of intake. <b>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?</b> Residents with pressure areas have been evaluated by the Registered Dietician with resulting recommendations documented in a progress notes on 2/26/16 and 3/4/16. The required supplements for identified residents have been added to the MAR for ongoing documentation of intake. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Collaborative Care Team (IDT) will review weekly the efficacy of all interventions, including nutritional interventions, for all residents with identified pressure areas. Weekly wound sheets will be submitted by the Director of Clinical Services/designee to Brookdale's Wound Care</p>	

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	<p>barrier as needed and as indicated by the physician; assist with turning and repositioning as needed; Braden scale and skin assessment per protocol; observe skin for any alteration in skin such as rash, persistent redness or skin discoloration, open areas and report to physician; pressure redistribution/reduction mattress on bed to help prevent skin breakdown; use disposable pads with specialty beds or mattress. No linen with low air loss mattress; use caution during transfers and bed mobility to prevent striking all body surfaces.</p> <p>A Braden scale, dated 11/9/2015, indicated Resident #3 had a score of 13 out of 23 with a potential for impairment to skin integrity.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 11/16/2015 indicated Resident #3 was not admitted with a pressure ulcer and not at risk of developing pressure ulcers. The record indicated Resident #3 required extensive assistance of one person with bed mobility, transfers, toileting, and locomotion on the unit.</p> <p>A physician's order, dated 11/16/2015, indicated Resident #3 had a low air loss mattress.</p>		<p>Specialist for review and recommendations. Brookdale's Wound Care Specialist provided education to the Director of Clinical Services/designee and the Administrator/designee regarding interventions for pressure ulcers on 3/3/16 and 3/10/16. The wound review and education will continue weekly through 4/7/16. Brookdale's Wound Care Specialist will provide live, distant interactive re-education to the Nurse Management Team on 3/14/16 that is specific to pressure ulcers and evidence-based best practices including but not limited to prevention and intervention. The Nurse Management Team will then educate the members of the nursing department (licensed and non-licensed) based on that training. The training sessions with the nursing department associates will begin on 3/15/16, and continue until all associates have received this education. The Director of ClinicalServices/designee will participate in a monthly live, distant interactive wound and skin education. The Director of Clinical Services will schedule re-education for licensed nurses through the skin care/treatment product representative for pressure ulcer prevention and intervention. <b>How the corrective action(s) will be monitored to ensure that</b></p>	

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	<p>A lab specimen report, dated 11/17/2015, indicated Resident #3 had a complete blood count with a red blood cell (RBC) lab value of 3.48 (normal levels 3.9- 5.4), hemoglobin (protein molecule in red blood cells that carries oxygen to the body's tissues) lab value of 10.8 (normal levels 12- 16), and a hematocrit (volume of blood that consists of red blood cells) lab value of 33% (normal levels 36- 48%).</p> <p>A Braden scale, dated 12/1/2015, indicated Resident #3 had a score of 12 out of 23, indicating the potential for impairment to skin integrity. The record indicated Resident #3's usual food intake pattern was probably inadequate (rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement).</p> <p>A "Weekly Skin Integrity Review," dated 12/17/2015, indicated Resident #3 had an observation of 2 areas of redness to her buttocks.</p> <p>A "Weekly Wound Data Collection," dated 12/23/2015, indicated Resident #3 acquired a stage 2 pressure ulcer to the</p>		<p><b>deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance Improvement Committee audit tool will be completed by the Administrator/designee weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly times one month and quarterly thereafter.</p>	

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	<p>sacrum. The 12/23/2015 document indicated, "Summary: resident is not eating meals well, will follow up with dietitian."</p> <p>A Dietary Progress note, dated 1/11/2016, indicated Resident #3 had a stage 2 pressure ulcer to her sacrum and lacked documentation of nutritional interventions to facilitate wound healing.</p> <p>A "Weekly Wound Data Collection," dated 1/27/2016, indicated Resident #3's pressure ulcer to her sacrum had increased to a stage 4 pressure ulcer with measurements of 3 centimeters (cm) x 2.8 cm x 1.4 cm, with tunneling of 1.4 cm at 11 o'clock. The wound base included 80% granulation (new connective tissue), 10% slough (yellow fibrinous tissue thought to be associated with bacterial activity), and 10% of bone exposure. Resident interventions included: air mattress, wheelchair cushion, and vitamin therapy. The document indicated, "Summary: wound has continued to decline. Resident is only eating around 25% of most meals. Staff is encouraging resident at meals. Resident receives Magic Cup and multivitamin daily."</p> <p>A "Weekly Wound Data Collection," dated 2/4/2016, indicated Resident #3's</p>			

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	<p>stage 4 pressure ulcer to her sacrum increased in size with measurements of 3.3 cm x 3 cm x 1.2 cm with tunneling from 10 to 12 o'clock 2 cm deep. The wound base included 90% granulation tissue and 10% of bone exposure. The document indicated, "Summary: has appt [appointment]. with wound clinic 2/5/16."</p> <p>A physician's order, dated 2/5/2016, indicated Prostat (liquid protein nutritional supplement) 15 milliliters (ml) by mouth three times a day for wound healing.</p> <p>A care plan, dated 2/8/2016, indicated Resident #3 had a stage 4 pressure ulcer to her sacral area. The goal, dated 2/8/2016, indicated the resident will show signs of healing as evidenced by a decrease in size. Interventions included: administer treatments and medications as ordered by physician; keep resident clean and dry as often as necessary throughout the day; keep physician and family informed of any change in condition; provide resident with pressure relieving device on bed as needed i.e.; low air loss mattress; provide diet as ordered and observe nutritional status and dietary needs and offer supplements as indicated; turn and reposition as regularly as needed; wound rounds to be completed</p>			

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	<p>per protocol.</p> <p>A "Weights and Vitals Summary" was reviewed on 2/9/2016 and indicated Resident #3 had a negative 7.5% weight loss from her admission weight of 117.8 lbs. on 11/9/2015 to her 2/8/2016 weight of 104.8 lbs.</p> <p>A Dietary Progress note, dated 2/12/2016, indicated Resident #3 had a 5.2 % weight loss in 1 month, a 10.4% weight loss in 3 months, and an estimated consumption of 25%, which had decreased in the last 30 days. Her BMI had decreased to 18.6. The record indicated Resident #3's pressure ulcer had increased from a stage 2 pressure ulcer to a stage 4 pressure ulcer and the resident required increased protein requirements.</p> <p>During an observation on 2/12/2016 at 3:00 p.m., Resident #3's wound dressing change was observed with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). Resident #3's wound measurements to her stage 4 pressure ulcer to her sacrum were 4 cm x 3.3 cm x 3 cm, with tunneling from 10 to 1 o'clock of 2.9 cm, and tunneling from 6 to 8 o'clock with 2.1 cm, and 40% of bone exposure and a minimal odor. No slough or drainage was observed. The resident did not display verbal or non-verbal</p>			

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	<p>symptoms of pain or tearfulness. The DON indicated the pressure ulcer had declined with increased measurements and tunneling.</p> <p>During an interview on 2/11/2016 at 3:43 p.m., CNA #33 indicated her assignment sheet did not specify a turning schedule for Resident #3. She indicated she turned Resident #3 every 2 hours and she was "a check and change every 2 hours" for incontinence.</p> <p>During an interview on 2/12/2016 at 9:33 a.m., the DON indicated she performed wound rounds weekly and assessed Resident #3's acquired stage 2 pressure ulcer on 12/23/2015 and determined the resident's declining nutritional status had contributed to the development of the pressure ulcer. She indicated Resident #3 had a history of pressure ulcers and the stage 2 pressure ulcer, acquired in the facility on 12/23/15, had been a prior open area before her admission. She indicated nutritional interventions had not been revised until the pressure ulcer increased to a stage 4 on 1/27/2016. She indicated Resident #3 had not been evaluated by the wound clinic until 2/5/2016. The DON indicated she determined efficacy of Resident #3's wound and nutritional interventions by assessment of weekly weights and wound</p>			

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F 0325 SS=G	<p>status. She indicated the current interventions failed based on her decreased weight and increased pressure ulcer status from a stage 2 to a stage 4.</p> <p>During an interview on 2/12/2016 at 11:24:27 a.m., the Registered Dietitian (RD) indicated he recommended nutritional interventions based on standard dietary guidelines that also included pressure areas. He indicated he had not recommended a pre-albumin lab draw or increased protein until he assessed her on 2/12/16 for significant weight loss and increased pressure ulcer status to a stage 4.</p> <p>A policy, titled, "Wound Observation and Pressure Ulcer Staging," dated 11/2007, and identified by the DON as current on 2/12/2016 at 4:00 p.m., indicated, "All licensed nurses should follow established guidelines and protocols to observe, describe tissue, evaluating, measuring wounds and staging of pressure ulcers...notify the health care provider of any changes, progress or alternative interventions to promote healing."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS</p>						

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Bldg. 00	<p><b>UNAVOIDABLE</b></p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview, and record review, the facility failed to support a resident's nutrition to facilitate wound healing and prevent significant weight loss for 1 of 2 residents reviewed for nutrition (Resident #3).</p> <p>Findings include:</p> <p>Resident #3's record was reviewed on 2/9/2016 at 11:32 a.m. The record indicated Resident #3 had a stage 4 (full thickness tissue loss with exposure of bone) pressure ulcer to her sacrum (vertebra at the bottom of the spine). Resident #3's diagnoses included, but were not limited to, anorexia, dysphagia (difficulty or discomfort with swallowing), Parkinson's disease, Type 2 Diabetes Mellitus, and anemia. The record lacked indication a prealbumin (blood test to determine protein levels and possible malnutrition) or albumin (blood test to determine protein levels) labs had been drawn from Resident #3's</p>	F 0325	<p>It is the practice of the provider to support a resident's nutrition to facilitate wound healing and prevent significant weight loss. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #3 has been assessed by the Registered Dietician on 2/12/16, 2/18/16, 2/26/16, and 3/4/16 with resulting recommendations documented. Resident #3 received treatment and ongoing oversight of wound treatment by the wound specialist physician at the Wound Center on 2/25/16 and 3/10/16. All supplements ordered have been added to the MAR for ongoing documentation of intake. <b>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?</b> Residents with pressure areas, and residents who have experienced a significant weight loss within the past 30 days, have been</p>	03/04/2016

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	<p>admission to the facility to 2/9/2016.</p> <p>A "Weights and Vitals Summary" was reviewed on 2/9/2016. The record indicated Resident #3 had a negative 7.5% weight change from her admission weight from 1/26/2016 to 2/8/2016 and indicated the following weights for Resident #3:</p> <ul style="list-style-type: none"> <li>a. 11/9/2015: 117.8 pounds (lbs.)</li> <li>b. 11/17/2015: 117 lbs.</li> <li>c. 11/19/2015: 117 lbs.</li> <li>d. 11/25/2015: 117 lbs.</li> <li>e. 12/1/2015: 114.8 lbs.</li> <li>f. 12/4/2015: 114.8 lbs.</li> <li>g. 1/5/2016: 111.2 lbs.</li> <li>h. 1/6/2016: 110.6 lbs.</li> <li>i. 1/12/2016: 110.6 lbs.</li> <li>j. 1/26/2016: 106 lbs.</li> <li>k. 2/5/2016: 102 lbs.</li> <li>l. 2/8/2016: 104.8 lbs.</li> </ul> <p>A "Nutrition Lookback," dated 11/10/2015 to 2/10/2016 was reviewed on 2/12/2016. The record lacked documentation of meal consumption intakes, or if resident was unavailable for meal, for Resident #3, on 12/25/2015, 12/26/2015, 1/3/2016, 1/9/2016, 1/10/2016, 1/11/2016, 1/14/2016. The record lacked documentation of meal consumption intakes of lunch and dinner, or if resident was unavailable for meal, for Resident #3, on 12/27/2015,</p>		<p>evaluated by the Registered Dietician on 2/26/16 with resulting recommendations documented and implemented. For this group of residents, all ordered supplements have been added to the MAR for ongoing documentation of intake. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b> The Collaborative Care Team (IDT) will review weekly the efficacy of nutritional interventions for residents with pressure areas and/or significant weight loss within the past 30 days. Licensed and non-licensed members of the nursing department have been re-educated by the Assistant Director of Clinical Services on 2/29/16 and 3/1/16 on 1) how to measure the amount of intake, 2) how to document meal intake in the electronic medical record, and 3) the expectation to provide documentation to record meal intake with each meal. <b>How the corrective action(s) will be monitored to ensure that deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance Improvement Committee audit tool will be completed by the Administrator/designee weekly times 4 weeks, then bi-weekly times 4 weeks, then monthly</p>	

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	<p>12/28/2015, 12/29/2015, 1/1/2016, 1/4/2016, 1/6/2016, 1/12/2016, 1/13/2016, 1/15/2016, 1/18/2016, 1/23/2016, 1/24/2016, 1/26/2016, 1/27/2016, 1/28/2016, 1/29/2016, 2/3/2016, 2/5/2016, 2/6/2016, and 2/7/2016. The record indicated Resident #3 had varied intakes from 0- 25% to 75-100% of meals.</p> <p>A physician's order, dated 11/9/2015, indicated Resident #3 was to have a Magic Cup (nutritional supplement) two times a day for vitamin insufficiency with lunch and dinner. The Medication Administration Record (MAR) lacked documentation of consumption percentage of the supplement.</p> <p>A physician's order, dated 11/9/2015, indicated an order for Mirtazapine (appetite stimulant) 7.5 milligrams (mg), give one tablet by mouth one time a day for appetite.</p> <p>A physician's order, dated 11/9/2015, indicated an order for Tab-A-Vite (multiple vitamin), give one tablet by mouth one time a day for vitamin insufficiency.</p> <p>A "Nutrition Risk Review," dated 11/12/2015, indicated Resident #3 weighed 117 lbs., was 63 inches tall, and</p>		times one month, and quarterly thereafter.	

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	<p>had a BMI (Body Mass Index) of 20.7 (normal weight: 18.5- 24.9) on admission. The resident's ideal weight range was between 103 to 127 lbs. The record indicated Resident #3 had intakes of 51 to 75% with a diet consistency of puree with nectar thick liquids. Resident #3 had intact skin without history of pressure ulcers and left 25% plus at most meals. The record lacked indication an albumin (protein) level had been drawn on admission and that nutritional supplement recommendations were provided on admission.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 11/16/2015 indicated Resident #3 was not admitted with a pressure ulcer. The record indicated Resident #3 required extensive assistance of one person with eating, with an admission weight of 118 lbs and 63 inches tall, without or unknown weight loss of 5 percent or more in the last month or loss of 10 percent or more in the last 6 months, and required a mechanically altered diet (change in texture of food or liquids).</p> <p>A physician's order, dated 11/16/2015, indicated Resident #3 was to receive a pureed diet with honey liquids consistency. A physician's order, dated 11/16/2015, indicated Resident #3 was to</p>			

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	<p>be weighed monthly.</p> <p>A care plan, dated 11/19/2015, indicated Resident #3 was at nutritional risk as evidenced by: dysphagia, need of a mechanically altered diet, and leaving 25 percent of some meals. A goal, dated 2/5/2015, indicated Resident #3 would have no significant weight change through review. Interventions included: diet as ordered, monitor labs as ordered, monitor meal intake with each meal, and monitor weights as ordered.</p> <p>A "Weekly Wound Data Collection," dated 12/23/2015, indicated Resident #3 acquired a stage 2 (partial thickness skin loss) pressure ulcer to the sacrum. The 12/23/2015 document indicated, "Summary: resident is not eating meals well, will follow up with dietitian."</p> <p>A Dietary Progress note, dated 1/11/2016, indicated, "Has stage 2 area to sacrum. Has a poor appetite...Current weight at 111 lbs. Is given Magic Cup twice a day for lunch and dinner. Is given 8 ounces (oz) of nectar milk with meals, 8 oz water nectar thick with meal. Have requested to weigh weekly."</p> <p>A "Weekly Wound Data Collection," dated 1/27/2016, indicated Resident #3's pressure ulcer to her sacrum had</p>			

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	<p>increased to a stage 4 (full thickness tissue loss with exposure of bone) pressure ulcer. The document indicated, "Summary: wound has continued to decline. Resident is only eating around 25% of most meals. Staff is encouraging resident at meals. Resident receives Magic Cup and multivitamin daily."</p> <p>A physician's order, dated 2/5/2016, indicated Prostat (liquid protein nutritional supplement) 15 milliliters (ml) by mouth three times a day for wound.</p> <p>A Dietary Progress note, dated 2/12/2016, indicated, "Weight for 2/16 at 104.8 lbs., a 5.2% weight loss in 1 month. Is weighed weekly. Has a 10.4% weight loss in 3 months. Ideal weight range 103- 127 lbs. BMI of 18.6. Magic Cup offered BID [twice a day]. Has stage 4 area to sacrum. Protein requirements of 62 to 71 grams (gm) daily. Physician's order on 2/5/16 for Promod (protein supplement) and Prostat 15 ml three times a day. Consumes an estimated 25%, has decreased in last 30 days...Recommend to order a prealbumin level next lab day, provide 2 cal med pass supplement 60 ml three times a day, Vitamin C 500 mg BID, and Zinc Sulfate 220 mg daily."</p> <p>During an observation on 2/11/2016 at</p>			

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	<p>9:27 a.m., Resident #3 was observed eating 75% of her puree breakfast and 120 ml of her thickened fluids in the dining room. She required total assistance from staff with eating.</p> <p>During an observation on 2/12/2016 at 12:58 p.m., Resident #3 was observed eating 25% of her lunch and 50% of her Magic Cup in the dining room. She required total assistance from staff with eating. Thickened milk was not observed to be served to the resident and her dietary card lacked documentation milk was to be served with her meal.</p> <p>During an observation on 2/15/2016 at 9:19 a.m., Resident #3 was observed eating 25% of her meal in the dining room and consumed 120 ml of fluids. She required total assistance from staff with eating.</p> <p>During an interview on 2/11/2016 at 9:28 a.m., Restorative Nursing Assistant (RNA) #30 indicated Resident #3 ate in the dining room and required total assistance from staff with eating her meals. She received her Magic Cup at lunch and dinner with her meals from the kitchen. She indicated the resident ate her Magic Cup and consumption varied from 25 to 100%. She indicated Resident #3's intake varied daily and she was aware the</p>			

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	<p>resident had weight loss. She indicated Resident #3 did not have identified food preferences and she was offered substitutes when she refused to eat a meal.</p> <p>During an interview on 2/11/2016 at 3:49 p.m., Licensed Practical Nurse (LPN) #31 indicated Resident #3 received a Magic Cup supplement twice a day with her meals. She indicated the nursing staff did not administer or document consumption of the supplement.</p> <p>During an interview on 2/12/2016 at 9:33 a.m., the Director of Nursing (DON) indicated she assessed Resident #3's acquired stage 2 pressure ulcer on 12/23/2015 and determined the resident's declining nutritional status contributed to the development of the pressure ulcer. She requested a consult with the Registered Dietitian and he had not recommended additional nutritional supplement. The facility began to weigh the resident weekly in January 2016. She indicated Resident #3's consumption decreased to an average of 25% of meals when Resident #3's pressure ulcer increased from a stage 2 to a stage 4 on 1/27/2016. New nutritional interventions included: increased encouragement of consumption from staff and family, family brought in puree meals from</p>			

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	<p>home, and increased butter and seasoning of food. The DON indicated she could not provide documentation of the nutritional interventions. She indicated there was no documentation of Resident #3's Magic Cup consumption. The DON indicated she measured the efficacy of nutritional interventions by assessment of weekly weights and wound status. She indicated the current interventions failed based on her decreased weight and increased pressure ulcer status from a stage 2 to a stage 4.</p> <p>During an interview on 2/12/2016 at 11:24 a.m., the Registered Dietitian (RD) indicated he recommended nutritional interventions based on standard dietary guidelines that also included pressure areas. He indicated he was notified of Resident #3's increased pressure ulcer to a stage 4 and he had scheduled to assess the resident on 2/12/2016. He indicated he was at the facility weekly. He indicated Resident #3's dietary card should have indicates milk with meals since January 2016 and he couldn't provide documentation of milk consumption. The RD indicated Resident #3's current BMI was 18.6 and in normal range parameters. He indicated he had not recommended a pre-albumin lab draw or increased protein needs until her significant weight loss and increased</p>			

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	<p>pressure ulcer status.</p> <p>During an interview on 2/12/2016 at 3:24 p.m., the DON indicated weights are monitored every Tuesday by the DON and Dietary Manager. She indicated Resident #3 had significant weight loss on 2/5/2016 and the resident's physician had been notified. The physician referred Resident #3 to be evaluated by the RD. The RD had been out of the facility that week and could not evaluate the resident until 2/12/2016. She indicated the facility had no other dietitian coverage.</p> <p>During an interview on 2/15/2016 at 11:40 a.m., the DON indicated meal consumption documentation is completed by the CNAs in their computer system and the Unit Manager was responsible for ensuring completion of the charting. She indicated she was aware of incomplete consumption charting for Resident #3. She indicated the facility had experienced difficulties with the computer system and she could not provide documentation of consumption for the dates without consumption charting.</p> <p>During an interview on 2/15/2016 at 11:42 a.m., the Dietary Manager indicated she monitored Resident #3's intakes and the trend had shown the resident had a poor appetite and had</p>			

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F 0371 SS=E Bldg. 00	<p>weight loss. She indicated the decreased consumption indicated a new supplement should have been introduced to Resident #3. She indicated she had not provided Resident #3 with new nutritional supplements based on her decreased intake.</p> <p>A policy, titled "Resident Nutrition Services," dated 10/2015, and identified by the DON as current on 2/12/2016 at 2 p.m., indicated, "...The interdisciplinary team, including Clinical Services, the Healthcare Provider and the Dining Services shall review each resident's nutritional needs, food likes, dislikes and eating habits. The shall develop a resident care plan based on this review...clinical services shall review and document food intake. Clinical services will evaluate food intake per Healthcare provider order...Significant variations from usual eating or intake patterns shall be recorded in the resident's medical record. Clinical services and/or Dining Services shall review significance of such information and report it, as indicated, to the Healthcare Provider and legal representative...."</p> <p>3.1-46(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p>			

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	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure the food processor used to puree food was adequately sanitized between modifying textures of 3 food items. This deficient practice had the potential to affect 12 of 76 residents who received puree diets (Residents #6, #10, #60, #55, #5, #49, #3, #47, #23, #44, #40, #30, and #1).</p> <p>Findings include:</p> <p>During an observation of puree food preparation on 2/15/2016 at 9:10 a.m., Cook #2 pureed broccoli, bean salad, and potatoes. After the broccoli was pureed. Cook #2 rinsed the puree chopping container, lid, spatula, and blades in hot water. He immediately wiped the items with Oasis 146 Multi-Quat Sanitizer. Without allowing the sanitizer to remain in contact with the surfaces for at least 1 minute, he pureed bean salad. He wore gloves, opened the steam oven, then went back to pureeing the bean salad, stopped the mixer and removed the container. He put his hand in the pureed bean salad to check the consistency without</p>	F 0371	<p>It is the practice of the provider to ensure the equipment used to puree food is adequately sanitized per the community policy. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Cook #2 has been re-educated by the Certified Dietary Manager and Registered Dietician on 3/1/16, and provided a return demonstration, on appropriate sanitization of equipment used to puree food items. <b>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?</b> Dietary staff who complete the job task of preparing pureed food items have been re-educated by the Certified Dietary Manager and Registered Dietician on 3/1/16, and provided return demonstration, on appropriate sanitization of equipment used to puree food items. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</b></p>	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155505	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/15/2016
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NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268
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	<p>handwashing and donning a new glove. Cook #2 followed the same procedure of rinsing the equipment, then wiping it with the sanitizer, and immediately pureeing potatoes.</p> <p>During an interview on 2/15/2016 at 9:36 a.m., the Dietary Director (DD) indicated it was their normal practice to proceed with pureeing food without allowing a dry time. A policy for cleaning the puree equipment was requested. At 9:40 a.m., the DD indicated staff should have sent the puree equipment through the dish washer and let it dry completely between uses.</p> <p>During an interview on 2/15/2016 11:08 a.m., the Dietary Manger (DM) indicated 12 residents ate pureed diets.</p> <p>A policy, titled "Clean Food Processor," updated May 2007, and identified as current, was provided by the ED on 2/15/2016 at 10:40 a.m. The policy indicated, "...Sanitation-Cleaning Guidelines...To provide a guideline for cleaning and sanitizing equipment...5. Wash, rinse and sanitize the bowl cover and blades in the pot and pan sink or run them through the dish machine...."</p> <p>An "Oasis 146 Multi-Quat Sanitizer" instruction sheet was provided by the ED</p>		<p><b>recur?</b> Education by the Certified Dietary Manager on appropriate sanitization for the equipment used to pureefood items will be provided to all new associates who will be assigned this job task.</p> <p>Equipment sanitization will be monitored by the Certified Dietary Manager per the audit tool schedule, and presented to the Quality Assurance Performance Improvement committee <b>How the correctiveaction(s) will be monitored to ensure that deficient practice will not recur,i.e., what quality assurance program will be put into place?</b> The Quality Assurance Performance ImprovementCommittee tool will be completed weekly times 4 weeks, then bi-weekly times 4weeks, then monthly times one month, and quarterly thereafter.</p>	

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	<p>on 2/15/16 at 10:40 a.m. The directions indicated, "...DIRECTIONS FOR USE: ...To sanitize ...Food Processing Equipment...Prior to application, remove gros food particlea and soil by a pre-scraoe or when necessary, a pre-soak. Then thoroughly wash or flus objects with a good detergent or compatible cleaner followed by a potable water rinse befor application of the sanitizing solution...Expose all surfaces to the sanitizing solution for a period of not less than 1 minute. Allow equipment to drain thoroughly and air dry .... "</p> <p>3.1-21(i)(1)</p>			