

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
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NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180752.</p> <p>Complaint IN00180752 - Substantiated, Federal/State deficiencies related to the allegations are cited at F279, F323, F353, and F515 .</p> <p>Survey dates: November 9 and 10, 2015</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 100266240</p> <p>Census bed type: SNF/NF: 70 Total: 70</p> <p>Census payor type: Medicare: 10 Medicaid: 54 Other: 6 Total: 70</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>November 27, 2015 Ms. Kim Rhoades Ms. Jodi Meyer Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204-3003 RE: TranscendentHealthcare of Boonville Complaint Survey November 9th & 10th, 2015 Dear Ms. Rhoades & Ms. Meyer; The Indiana State Department of Health visited our facility on November 9th and 10th, 2015 to investigate a complaint. According to the investigation the complaint was substantiated. Transcendent immediately addresses any citations and complies with the attached submission specific to this POC and internally implements its four step quality assurance process to support a return visit or a requested desk review. We respectfully request our plan of correction be considered our allegation of compliance effective December 3rd, 2015 and request a desk review. If you have any questions please feel free to contact me at the facility. Respectfully submitted, Brody O'Niones, BA, HFA, RAC-CT Executive Director</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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F 0279 SS=D Bldg. 00	<p>Quality review completed by #02748 on 11/16/15.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to ensure a plan of care</p>	F 0279	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or	12/03/2015

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	<p>was developed and accessible to staff regarding a resident with a history of falls; and failed to develop a care plan for a residents with a history of frequent urinary tract infections (UTIs), for 3 of 3 residents reviewed for care plans, in a sample of 6. Resident A, Resident B, Resident C</p> <p>Findings include:</p> <p>1. On 11/9/15 at 11:40 A.M., the Administrator provided a list of residents who had fallen in October 2015. Resident A was listed as falling on 10/15/15 and 10/26/15.</p> <p>On 11/9/15 at 11:55 A.M., Resident A was observed sitting in a recliner in her room. Resident A was tearful, and indicated, "My mom and dad don't know I'm here." The resident was observed to be sitting on a pressure alarmed cushion. Resident A complained of her left wrist hurting, and indicated, "I fell."</p> <p>On 11/9/15 at 12:00 P.M., QMA # 1 indicated the resident's care plans were in her chart.</p> <p>The clinical record of Resident A was reviewed on 11/9/15 at 12:05 P.M. Diagnoses included, but were not limited to, dementia and fractured left humerus.</p>		<p>allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective December 3, 2015 to the state findings of the complaints survey conducted on November 9th and 10th, 2015.</p> <p>F 279</p> <p>1.) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A has been reviewed by the interdisciplinary team related to their history of falls. Resident A's fall risk care plan has been revised and contains appropriate safety interventions. The revised care plan is on the resident's clinical record. The CNA assignment sheets have also been up-dated to reflect the current safety interventions. It should also be noted that the resident has not had any additional falls at this time.</p> <p>2.) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident B no longer resides at the facility.</p> <p>3.) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident C has had their plan of care reviewed by the interdisciplinary team. A care plan has been developed and implemented to address the</p>	

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	<p>An admission Minimum Data Set (MDS) assessment, dated 10/10/15, indicated Resident A had scored a 4 out of 15 for cognition, with 15 indicating no memory problem. The resident required extensive assistance of one staff for transfer and ambulation in her room. A test for balance indicated, "Not steady, only able to stabilize self with staff assistance" while moving from seated to standing position, walking, and surface-to-surface transfer. The resident had fallen in the previous month before admission to the facility, and had a fall with a fracture in the 6 months prior to admission.</p> <p>Nurse's Notes, dated 10/15/15, indicated, "Resident noted with increase [sic] confusion this am, tearful...Reassurance given... [Name of physician] notified and orders received...get U/A, C/S [urinalysis, culture and sensitivity]...."</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-15-15. Time of Incident: 12:00 pm. Fall Unwitnessed. She had a pressure pad alarm [and] it was sounding...I was standing at the med cart in the hallway heard an alarm sound walked into room found resident sitting on the floor in the bathroom...Additional intervention/Care Plan Up-dated, U/A C&S - Pull tab alarm chair, D/C</p>		<p>resident's history of chronic urinary tractinfections. The care plan has beenprinted and placed on the clinical record.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that all residents have the potential to be affectedby this deficient practice. A housewidereview of all care plans has been completed by the interdisciplinary team. Care plans have been revised asindicated. Any resident at fall risk orwith a history of urinary tract infections have had their care plan up-dated toinclude appropriate interventions based on the residents' individualizedneeds. All care plans have been printedout and placed on the clinical record. The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that the facility has reviewed its care plan policy. The facility has implemented the process thatduring each IPOC meeting which is conducted daily Monday – Friday all neworders or changes in residents' conditions are reviewed. The care plan is reviewed and revised at theIPOC meetings and printed out and placed on the clinical record making the careplan readily accessible to all nursing staff. A mandatory in-service has been conducted for the members of the IPOCteam and licensed nurses to instructthem on the process whereby care plans are being reviewed/revised</i></p>				

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	<p>[discontinue] PPA [personal pull alarm]...."</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-26-15. Time of Incident: 0355 [3:55 A.M.]. Fall Unwitnessed. Resident has been confused and using call light frequently throughout the night. Aides responded to resident calling out less than 5 min after last being in the rm [sic], resident found on floor. resident stated she slid off edge of bed while attempting to get up. Small abrasion [left] knee noted, no other injuries or complaints. Assisted to bed...Additional intervention/Care Plan Updated [left blank], Physician Notified [Left blank]. Responsible Party Notified [Left blank]. The Nurse's Signature and Date was also left blank. Documentation on whether an alarm was or was not sounding was not found.</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-26-15. Time of Incident: 8:45 [A.M.]. Fall Unwitnessed. Therapy walked into room [number] and found resident sitting on her butt. She tried to get out of the wheel chair unassisted and fell on her butt...New Intervention/Care Plan Updated: Move resident closer to nurse's station. Physician Notified - Date [Name] 10-26-15, Time [Left Blank].</p>		<p>and printedout upon review at the IPOC meeting and placed on the clinical record. The licensed nurses were also instructed thatwhen a change of condition occurs on the week-ends or holidays that the nurseis responsible for up-dating the care plan in writing on the clinicalrecord. The care plan will then bereviewed by the IPOC team at the next available IPOC meeting.</p> <p><i>The corrective actionwill be monitored to ensure the deficient practice will not recur through thequality assurance program by the development and implementation of aQuality Assurance tool. This tool willmonitor the content of the care plans to ensure that all of the residents' needs have been appropriate addressed and that the care plan is on the clinicalrecord readily accessible to all nursing staff. This tool will be completed by the Director of Nursing and/or herdesignee daily for one week, then weekly for four weeks, then monthly for threemonths and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility QualityAssurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>Responsible Party Notified - Date 10-26-15, Time [Left Blank]. Nurse's Signature [Left Blank]." Documentation on whether an alarm was sounding or not was not found.</p> <p>An "Interim Plan of Care," undated, indicated, "Mobility, Cane, By Staff, Transfer Assist, 1 person, SBA [stand-by assist] [with] ambulation [and] transfer." An additional plan of care regarding the resident's falls was not found in the clinical record.</p> <p>The resident was observed to be in the same room on this date, as documented on the 10/26/15 fall note.</p> <p>On 11/9/15 at 12:24 P.M., the Unit Manager indicated Resident A's care plans were in her chart.</p> <p>On 11/9/15 at 2:40 P.M., the MDS Coordinator provided an additional care plan for Resident A. A care plan indicated, "The resident is at risk of falls r/t [related to] Unaware of safety needs, Confusion, Gait/balance problems. Date Initiated: 10/16/15, Revision on 10/16/15. Interventions: 10/15 pull tab to w/c [wheelchair], 10/15 U/A, 10/16 move room closer to nurses station, Anticipate and meet the resident's needs. 10/26 pressure pad alarm to bed...."</p>			

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	<p>The MDS Coordinator indicated at that time that the care plans had been in the computer, and she should have printed them off when she printed the resident's admission MDS assessment on 10/10/15.</p> <p>On 11/9/15 at 2:50 P.M., during an interview with the Administrator, he indicated the resident's family had refused to move the resident to a room closer to the nurse's station.</p> <p>2. The closed clinical record of Resident B was reviewed on 11/9/15 at 3:00 P.M. Diagnoses included, but were not limited to, history of CVA (stroke), BPH (benign prostatic hypertrophy), history of UTI, and dementia.</p> <p>Documentation indicated the resident was treated for a UTI on 4/10/15 and on 4/25/15. The resident had a urinalysis on 7/2/15, and the culture indicated, "No growth."</p> <p>Nurses Notes, dated 8/10/15 and untimed, indicated, "Pt [patient] has moderate amount of blood in urine...MD notified requesting lab."</p> <p>Nurses Notes, dated 8/10/10 and untimed, indicated, "New order for UA [urinalysis]. UA sent to lab. Lab results</p>			

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	<p>sent to MD. New order for Cipro [antibiotic] 500 mg x 10 days."</p> <p>The resident was transferred to the hospital on 8/15/15, and was admitted with diagnoses including UTI.</p> <p>A Care Plan regarding the resident's history of UTIs was not found in the clinical record.</p> <p>3. The clinical record of Resident C was reviewed on 11/10/15 at 10:25 A.M. Diagnoses included, but were not limited to, renal failure.</p> <p>Physician orders indicated the resident was started on Ceftin (an antibiotic) on 7/30/15, 8/24/15 and on 9/14/15 for a UTI.</p> <p>Physician orders indicated the resident was started on Ceftin, and then changed to Cipro (an antibiotic), on 10/6/15 for a UTI. The resident was to receive the antibiotic until 11/19/15.</p> <p>Documentation of a care plan regarding the resident's frequency of UTIs was not found in the clinical record.</p> <p>On 11/10/15 at 2:40 P.M., the Director of Nursing provided the current facility policy on Comprehensive Care Plans,</p>			

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F 0323 SS=D Bldg. 00	<p>revised November 2010. The policy included: "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change...."</p> <p>This Federal tag relates to Complaint IN00180752.</p> <p>3.1-35(a) 3.1-35(f)</p> <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.</p> <p>Based on observation, interview, and record review, the facility failed to develop and revise different interventions for a resident with repeated falls, and used alarms in place of supervision, for 1</p>	F 0323	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	12/03/2015

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	<p>of 3 residents reviewed who had recently fallen, in a sample of 3. Resident A</p> <p>Findings include:</p> <p>1. On 11/9/15 at 11:40 A.M., the Administrator provided a list of residents who had fallen in October 2015. Resident A was listed as falling on 10/15/15 and 10/26/15.</p> <p>On 11/9/15 at 11:55 A.M., Resident A was observed sitting in a recliner in her room. Resident A was tearful, and indicated, "My mom and dad don't know I'm here." The resident was observed to be sitting on a pressure alarmed cushion. Resident A complained of her left wrist hurting, and indicated, "I fell."</p> <p>On 11/9/15 at 12:00 P.M., QMA # 1 indicated the resident's care plans were in her chart.</p> <p>The clinical record of Resident A was reviewed on 11/9/15 at 12:05 P.M. Diagnoses included, but were not limited to, dementia and fractured left humerus.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 10/10/15, indicated Resident A had scored a 4 out of 15 for cognition, with 15 indicating no memory problem. The resident required extensive</p>		<p>regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective December 3, 2015 to the state findings of the complaints survey conducted on November 9th and 10th, 2015. F – 323</p> <p>1.) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident A has been reviewed by the interdisciplinary team related to the resident's risk for falls. The interventions have been revised in an effort to continue to ensure the resident's safety. The resident has not had any additional falls at this time.</p> <p>2.) The corrective action taken for those residents found to be affected by the deficient practice is that all though no specific residents were mentioned, the facility has re-distributed its staffing pattern in an effort to provide adequate supervision to meet the needs of those residents at risk for falls.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed on all residents at risk for falls. Each resident at fall risk has had their safety interventions reviewed and revised if indicated in an effort to ensure that all interventions are appropriate and include adequate supervision to meet the residents individualized</i></p>	

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	<p>assistance of one staff for transfer and ambulation in her room. A test for balance indicated, "Not steady, only able to stabilize self with staff assistance" while moving from seated to standing position, walking, and surface-to-surface transfer. The resident had fallen in the previous month before admission to the facility, and had a fall with a fracture in the 6 months prior to admission.</p> <p>Nurse's Notes, dated 10/15/15, indicated, "Resident noted with increase [sic] confusion this am, tearful...Reassurance given... [Name of physician] notified and orders received...get U/A, C/S [urinalysis, culture and sensitivity]...."</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-15-15. Time of Incident: 12:00 pm. Fall Unwitnessed. She had a pressure pad alarm [and] it was sounding...I was standing at the med cart in the hallway heard an alarm sound walked into room found resident sitting on the floor in the bathroom...Additional intervention/Care Plan Up-dated, U/A C&S - Pull tab alarm chair, D/C [discontinue] PPA [personal pull alarm]...."</p> <p>A Fall Risk Assessment, dated 10/15/15, indicated, "Disoriented x 2, 1-2 falls the past 3 months, Balance problem while</p>		<p>needs. Fall risk residents who currently utilizesafety alarms were reviewed to ensure that the safety alarm was effective inthe prevention of falls and if not the safety alarm was discontinued and otherappropriate interventions put in place.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for allnursing staff on the facility's fall prevention program. The in-service included instructions onchoosing those interventions which meets each resident's individualized needsas well as providing adequate supervision in an effort to prevent future falls.</p> <p><i>The corrective actiontaken to monitor to assure performance to assure compliance through qualityassurance is a Quality Assurance tool has been developed and implemented tomonitor the effectiveness of the residents' safety interventions. The tool will monitor to ensure that thesafety care plans include new interventions when other interventions appear tobe ineffective. The tool will also monitor to ensure that adequate supervision is provided when warranted toensure the resident's safety. This tool will be completed by the Director ofNursing and/or her designee daily for one week, then weekly for four weeks,then monthly for three months and then quarterly</i></p>	

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	<p>standing/walking, Requires assistive device...Total score 12. A Score of 10 or more represents high risk of falls."</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-26-15. Time of Incident: 0355 [3:55 A.M.]. Fall Unwitnessed. Resident has been confused and using call light frequently throughout the night. Aides responded to resident calling out less than 5 min after last being in the rm [sic], resident found on floor. resident stated she slid off edge of bed while attempting to get up. Small abrasion [left] knee noted, no other injuries or complaints. Assisted to bed...Additional intervention/Care Plan Updated [left blank], Physician Notified [Left blank]. Responsible Party Notified [Left blank]. The Nurse's Signature and Date was also left blank. Documentation on whether an alarm was or was not sounding was not found."</p> <p>Nursing Fall Documentation indicated: "Date of Incident: 10-26-15. Time of Incident: 8:45 [A.M.]. Fall Unwitnessed. Therapy walked into room [number] and found resident sitting on her butt. She tried to get out of the wheel chair unassisted and fell on her butt...New Intervention/Care Plan Updated: Move resident closer to nurse's station. Physician Notified - Date [Name]</p>		<p>for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</p>				

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	<p>10-26-15, Time [Left Blank]. Responsible Party Notified - Date 10-26-15, Time [Left Blank]. Nurse's Signature [Left Blank]." Documentation on whether an alarm was in place and sounding was not found in the record.</p> <p>An "Interim Plan of Care," undated, indicated, "Mobility, Cane, By Staff, Transfer Assist, 1 person, SBA [stand-by assist] [with] ambulation [and] transfer." An additional plan of care regarding the resident's falls was not found in the clinical record.</p> <p>The resident was observed to be in the same room on this date, as documented on the 10/26/15 fall note.</p> <p>On 11/9/15 at 12:24 P.M., the Unit Manager indicated Resident A's care plans were in her chart.</p> <p>On 11/9/15 at 2:40 P.M., the MDS Coordinator provided an additional care plan for Resident A. A care plan indicated, "The resident is at risk of falls r/t [related to] Unaware of safety needs, Confusion, Gait/balance problems. Date Initiated: 10/16/15, Revision on 10/16/15. Interventions: 10/15 pull tab to w/c [wheelchair], 10/15 U/A, 10/16 move room closer to nurses station, Anticipate and meet the resident's needs. 10/26</p>			

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	<p>pressure pad alarm to bed...."</p> <p>The MDS Coordinaltor indicated at that time that the care plans had been in the computer, and she should have printed them off when she printed the resident's admission MDS assessment on 10/10/15.</p> <p>On 11/9/15 at 2:50 P.M., during an interview with the Administrator, he indicated the resident's family had refused to move the resident to a room closer to the nurse's station.</p> <p>2. On 11/9/15 at 11:40 A.M., the Administrator provided a list of residents who had fallen in October and November 2015. The list indicated the facility had 23 falls the month of October 2015, and 5 falls from November 1-9.</p> <p>On 11/9/15 at 11:45 A.M., the Administrator provided CNA assignment sheet for the facility. The sheets indicated the West Unit had 34 residents and 16 residents had 1 or more alarms. The East Unit had 21 residents, and 5 residents had 1 or more alarms. 3 of 15 residents on the locked unit had 1 or more alarms.</p> <p>On 11/10/15 at 2:40 P.M., the Director of Nursing provided the current facility policy on Managing Falls and Fall Risk, Dated 1/22/15. The policy included:</p>			

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	<p>"Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...If falling recurs despite initial interventions, staff will implement additional or different interventions...."</p> <p>This Federal tag relates to Complaint IN00180752.</p> <p>3.1-45(a)(2)</p>			

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure staff was sufficient to answer call lights timely, pass ice water, assist residents to bed timely, and manage falls, for 1 of 3 units</p>	F 0353	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective December 3,	12/03/2015	

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	<p>reviewed for staffing. (West Unit, Residents C, D, F, G)</p> <p>Findings include:</p> <p>On 11/9/15 at 11:40 A.M., the Administrator provided a list of residents who had fallen in October and November 2015. The list indicated the facility had 23 falls the month of October 2015, and 5 falls from November 1-9. Twelve (12) of those falls were residents on the West Unit.</p> <p>On 11/9/15 at 11:40 A.M., the Administrator provided a list of residents considered interviewable. Residents C, D, F, and G were considered interviewable.</p> <p>The following interviews were completed on 11/9/15 and 11/10/15:</p> <p>Resident C indicated, "We are supposed to receive fresh ice water every day, but don't always. There isn't enough staff." Resident C indicated he/she required assistance for all transfers and toileting, and had to wait for her call light to be answered. Resident C indicated the wait had been as long as 4 hours. Resident C indicated the night shift was "much worse."</p>		<p>2015 to the state findings of the complaintsurvey conducted on November 9th and 10th, 2015. F – 353</p> <p>The facility has carefullyreviewed the current nursing staffing patterns. Based on the needs of the residents the staffing pattern seem more thanadequate however the facility has made changes in the distribution of thestaff to ensure that each resident'sneeds are being met in a timely manner. In addition the facility has transferred an experienced Unit Manager tothe West Unit to oversee the daily operations of the nursing care on that unitto ensure that each resident's individual needs are being met.</p> <p>1.) The correctiveaction taken for those residents found to be affected by the deficient practiceis that the resident identified as resident Cis now receiving fresh ice water every shift. The resident's call light is also being answered in a timely manner toensure that the resident's needs are being met.</p> <p>2.) The correctiveaction taken for those residents found to be affected by the deficient practiceis that the resident identified as resident Dis now having their call light answered in a timely manner on all shifts in aneffort to meet the resident's needs.</p> <p>3.) The correctiveaction taken for those residents found to be affected by the deficient practiceis that the resident identified as resident Fis now having his call light answered in a timely manner in an effort to</p>		

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	<p>Resident D indicated, "There isn't enough help, especially on this hall (West Unit). Call lights are a problem." Resident D indicated he/she had to wait 30-40 minutes or more for a call light to be answered. Resident D indicated, "On 3rd shift it's impossible to get your light answered."</p> <p>Resident F indicated he had to wait a long time for his/her call light to be answered. Resident F indicated, "It seems like hours."</p> <p>Resident G indicated, "Call lights are a problem. I don't think there is enough help." Resident G indicated he/she had observed residents waiting "a long time" to be assisted to bed. Resident G indicated he/she had observed call lights being on for long periods of time. Resident G indicated, "Staff call in all the time."</p> <p>On 11/10/15 at 10:00 A.M., the Director of Nursing (DON) indicated she assisted with scheduling. She indicated staff worked 12 hours, from 6:00 A.M. until 6:00 P.M. She indicated on the West Unit, she tried to plan 2-3 nurses and 2-3 CNAs on day shift, plus one CNA who worked from 8:00 A.M.-8:00 P.M. The DON indicated she had 1 nurse and 2 CNAs on night shift.</p>		<p>meetthe resident's needs.</p> <p>4.) The corrective action taken for thoseresidents found to be affected by the deficient practice is that the resident identified as resident G did notindicate that they personally had any issues with the timely answering of theircall light. They have not reported anyadditional observations of call lights not be answered in a timely manner.</p> <p><i>The corrective actiontaken for the other residents having the potential to be affected by the samedeficient practice is that all residents have the potential to be affectedby this deficient practice. Eachresident's call light is being answered in a timely manner in an effort to meeteach resident's individualized needs.</i></p> <p>The measures or systematic changes that have been put intoplace to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for allnursing staff on the facility's policy of answering call lights in a timelymanner to ensure that each residents' needs are being met. In addition the redistribution of nursingstaff has been completed to ensure adequate staff is assigned to each unitbased on the needs of those residents of each unit.</p> <p><i>The corrective actiontaken to monitor to assure performance to assure compliance through qualityassurance is a Quality Assurance tool has been developed and implemented toensure that there</i></p>				

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	<p>On 11/10/15 at 10:20 A.M., CNA assignment sheets were reviewed. The assignment sheets indicated 34 residents resided on the West Unit. Sixteen (16) residents required the assistance of 1 staff for transfer and ADLs (activities of daily living). Sixteen (16) residents required the assistance of 2 staff for transfer and ADLs. 27 residents were either incontinent, or required the assistance of 1 or 2 staff for toileting. Sixteen (16) residents had alarms for fall prevention.</p> <p>On 11/10/15 at 11:30 A.M., during an interview with the Administrator, he indicated staff calling in to work was a problem. The Administrator indicated he did not think the problem was the number of staff, but that the staff may need to be redistributed to put more on the night shift.</p> <p>This Federal tag relates to Complaint IN00180752.</p> <p>3.1-17(a)</p>		is adequate staff to meet each resident's individualized needs in a timely manner. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.		

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F 0515 SS=D Bldg. 00	<p>483.75(l)(2) RETENTION OF RESIDENT CLINICAL RECORDS Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.</p> <p>Based on interview and record review, the facility failed to ensure a closed clinical record contained all of the Medication Administration Records (MARs), for 1 of 3 closed records reviewed, in a sample of 6. (Resident B)</p>	F 0515	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective December 3, 2015 to the state findings of the complaint survey conducted on November 9th and 10th, 2015. F - 515</p>	12/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155508	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
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	<p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed on 11/9/15 at 3:00 P.M. The resident was discharged from the facility on 8/15/15.</p> <p>Physician orders included the following notations:</p> <p>8/10/15: "Cipro [an antibiotic] 500 mg BID [twice daily]."</p> <p>8/10/15: "Clarification: Cipro 500 mg BID x 10 days."</p> <p>8/13/15: Clarification - Cipro 250 mg TID [three times daily] x 10 D [days] then [one] QD [every day] x 3 weeks then D/C [discontinue]."</p> <p>The resident's MAR, dated August 2015, was not found in the closed clinical record.</p> <p>On 11/10/15 at 10:30 A.M., during an interview with the Administrator, he indicated the August 2015 MAR should have been in the closed record. He indicated he had looked everywhere and had not been able to locate it. He indicated he currently had a staff member who took care of Medical Records part time.</p>		<p>The corrective action taken for those residents found to be affected by the deficient practice is that the facility has not located the August 2015 MAR of the resident identified as resident B. The facility will continue to search for the missing MAR in case it has been misfiled in another clinical record by accident. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that an audit has been conducted of all closed clinical records that have been closed in the past thirty days to ensure that all documents are present. No other missing documents were identified.</i></p> <p>The measures or systematic changes that have been put in place to ensure that the deficient practice does not recur is that the facility has developed and implemented policies and procedures related to medical records. The facility has implemented an audit tool which is to be completed on each closed clinical record to ensure all components of the record are accounted for. A mandatory in-service has been provided for the Medical Records staff on the new policies and procedures as it relates to the auditing of closed clinical records.</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed</i></p>	

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	<p>On 11/10/15 at 2:40 P.M., the Director of Nursing provided the current facility policy on "Medical Records," dated June 2008. The policy did not specify who was to perform the closing of the clinical records, nor the staff person responsible for verifying the record was complete.</p> <p>This Federal tag relates to Complaint IN00180752.</p> <p>3.1-50(b)(1)</p>		<p>and implemented to ensure that all components of the closed clinical record are present in the clinical record at the time of discharge. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility Quality Assurance meeting to determine if additional action is warranted.</p>	