

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2012
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NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00105304.</p> <p>Complaint IN00105304 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: April 9, 10, 11, 12, 13, 16, & 17, 2012</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Survey team: Janet Adams, RN, TC Lara Richards, RN Kathleen Vargas, RN</p> <p>Census bed type: SNF/NF: 111 Total: 111</p> <p>Census payor type: Medicare: 13 Medicaid: 89 Other: 9 Total: 111</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F0000	<p>Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.</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>IAC 16.2.</p> <p>Quality review 4/23/12 by Suzanne Williams, RN</p>			
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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interviews, the facility failed to ensure a resident's grievance was documented, filed and resolved according to the facility's policy related to missing articles of clothing for 1 of 3 residents reviewed for personal property of the 3 residents who met the criteria for personal property. (Resident #88)</p> <p>Findings include:</p> <p>Resident #88 was interviewed on 4/9/12 at 3:58 p.m. She indicated she had a skirt missing for one month. She also indicated her name was written on the skirt. Continued interview with the resident, indicated the skirt had not been found and she had not had a resolution to the concern. She indicated she reported the skirt missing to Social Worker #3 one month ago.</p> <p>The record for Resident #88 was reviewed on 4/11/12 at 9:11 a.m. Review of the Quarterly Minimum</p>	F0166	<p>F166</p> <p>It is this facility's practice to ensure a resident's grievance is documented, filed and resolved according to this facility's policy related to missing articles.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The facility has completed a grievance form related to Resident #88 missing skirt. The facility will conduct a search in attempt to resolve this concern. All resident/family grievances will be written on formal grievance forms and copies will be provided to the facility Administrator. All grievances will discussed at each morning Manager's meeting to ensure that the department managers are working on a resolution. The Administrator will sign off on all formal grievances.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p>	05/15/2012			

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	<p>Data Set (MDS) assessment completed on 3/12/12, indicated the resident was cognitively intact.</p> <p>On 4/12/12 at 10:45 a.m., Social Worker #1 was interviewed. She indicated she was not aware of any missing clothing for Resident #88. She indicated she would speak with her assistant.</p> <p>Review of the grievance log provided by Social Worker #1 on 4/12/12, indicated there was no documentation of a grievance voiced by Resident #88 related to missing clothing entered on the grievance log.</p> <p>Interview with Social Worker #3 on 4/12/12 at 3:45 p.m., indicated Resident #88 informed her that her skirt was missing about 3 weeks ago. She indicated she looked for the skirt at that time. Continued interview with Social Worker #3 indicated she did not complete a grievance form 3 weeks ago when the resident informed her the skirt was missing. She indicated she was still in training and did not know that she was to complete a grievance/complaint form.</p> <p>Interview on 4/13/12 at 10:30 a.m., with Social Worker #1, indicated that at the time of hire, during orientation,</p>		<p>·All residents have the potential to be affected by the same alleged deficient practice. ·Social Services Staff have been re-educated on the facility grievance policy. ·All current residents were interviewed as to any unresolved concerns. ·No unresolved concerns were noted.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Social Services Director/designee will conduct random audits of all formal grievances to ensure the facility has addressed the concern, the resident and/or family has been notified and the facility Administrator has signed off on the grievance.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place. Results of all compliance audits identified above will be reviewed at morning Management meetings and a summary of compliance audit results will be provided to the Quality Assurance committee at each monthly meeting to identify additional trends/patterns warranting action if facility policy guidelines are not met.</p>		

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	<p>Social Worker #3 was informed of the need to complete a grievance form when a resident stated an item was missing. She indicated a grievance form should have been initiated three weeks ago when the resident voiced that a piece of clothing was missing.</p> <p>The policy titled "Filing Grievance/Complaints" that was revised on December 2004, was provided by the Administrator on 4/16/12. He indicated the policy was current.</p> <p>The policy indicated: "Our facility will assist residents, their representatives (sponsors), family member, or appointed advocates in filing grievances or complaints when such request are made. Any resident, his or her representative (sponsor), family member or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other resident, staff member theft of property, etc., without fear of threat or reprisal in any form. Grievances and/or complaints may be submitted orally or in writing. The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct</p>		<p>Date by which systemic corrections will be completed is 5/15/2012</p>		

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	<p>any identified problems. Such report will be made orally by the administrator, or his or her designee, within 5 working days of the filing of the grievance or complaint with the facility."</p> <p>3.1-7(a)(2)</p>			

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F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observation and interview, the facility failed to ensure a sanitary and orderly interior was maintained on 3 of 3 units throughout the facility related to scratched and marred walls and doors, stained ceiling tiles, dust on ceiling vents, scratched and stained furniture, soiled shower chairs, and a chipped toilet tank lid. This deficient practice had the potential to affect 111 of 111 residents in the facility. (The Main Unit, Bakersfield and Daisy Lane)</p> <p>Findings include:</p> <p>1. During the Environmental Tour on 4/16/12 at 2:25 p.m., with the Administrator and Maintenance Director, the following was observed on the Main Unit:</p> <p>a. The seat of a shower chair located in one of the shower stalls, in the Main Shower Room, was soiled with a dried brown substance. There was an odor in the shower room at this time.</p>	F0253	<p>F 253</p> <p>It is the practice of this facility to ensure a sanitary and orderly interior.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1a. The shower chair in the main shower room was cleaned and sanitized. This shower area had just been used to shower a resident and was cleaned before the next resident was showered. The odor was addressed with the cleaning.</p> <p>1b. The toilet seat in the Main Shower Room bathroom was cleaned.</p> <p>1c. The scratches and mars on the doors were resurfaced/repaired.</p> <p>1d. The grab bar was repaired.</p> <p>2a. The chair rail in the Bakersfield dining room was repainted. The ceiling tile was replaced and the ceiling vent was cleaned.</p> <p>2b. The shower room door on Bakersfield Unit was repaired.</p> <p>2c. The walls in the Bakersfield lounge area were repainted. The round table was removed from</p>	05/15/2012
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	<p>b. The toilet seat in the Main Shower Room bathroom was soiled with a brown substance. Further, there was an odor in the bathroom.</p> <p>c. The door leading to the shower room bathroom and the door leading out of the shower room were scratched and marred at the base. .</p> <p>d. The grab bar located to the left of the toilet in the Main Shower Room bathroom was loose and detached from the wall.</p> <p>2. During the Environmental Tour on 4/16/12 at 2:53 p.m., with the Administrator and Maintenance Director, the following was observed on the Bakersfield Unit:</p> <p>a. The paint was scratched and marred along the chair rail in the Bakersfield dining room. There was a stained ceiling tile and an accumulation of dust on one the ceiling vents located in the corner of the Bakersfield dining room.</p> <p>b. The door to the Shower Room was scratched and marred at the base.</p> <p>c. In the Bakersfield lounge area, the walls were paint chipped and marred along the base. A round table located</p>		<p>the facility.</p> <p>3a. The toilet tank lid was replaced in the Daisy Lane shower room.</p> <p>3b. The walls and base of the Daisy Lane dining room were painted and cleaned. The ceiling vent was cleaned.</p> <p>3c. New grab bars were installed on the toilet seat in the Daisy Lane shower room.</p> <p>- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents have the potential to be affected by this alleged deficient practice. These areas will be included in a preventive maintenance program to assure that these areas remain in good condition/repair.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>An Audit tool has been established to monitor these common areas for condition/repair and completion dates of areas identified in these audits. The Maintenance Director/designee will do these audits 3 times weekly. Maintenance/safety areas identified will be reported to the Administrator/designee along with</p>				

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	<p>beneath the television in the lounge area was stained and discolored.</p> <p>3. During the Environmental Tour on 4/16/12 at 3:05 p.m., with the Administrator and the Maintenance Director, the following was observed on Daisy Lane:</p> <p>a. The toilet tank lid in the Shower Room was chipped along the edge in two areas.</p> <p>b. In the Daisy Lane dining room, the base of the walls were scratched and marred. The ceiling vent located above the hand sanitizer dispenser had a thick accumulation of dust.</p> <p>c. The grab bars located next to both sides of the toilet in the Daisy Lane Shower Room were loose.</p> <p>Interview with the Administrator and Maintenance Director at the time, indicated the grab bars needed to be tightened.</p> <p>Interview with the Administrator and Maintenance Director at the time, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p>		<p>an estimated correction date.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 9 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing.</p> <p>Date by which systemic corrections will be completed is 5/15/2012</p>		

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F0278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was completed accurately related to range of motion, for 1 of 3 residents of the 21 who met the criteria for range of motion. (Resident #135)</p>	F0278	<p>F 278 It is the practice of this facility to ensure the MDS Assessment is completed accurately related to range of motion.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	05/15/2012			

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	<p>Findings include:</p> <p>On 4/10/12 at 3:29 p.m., Resident #135 was observed seated in a geri-chair. The resident's legs were bent at the knees and her legs were not extended.</p> <p>The record for Resident #135 was reviewed on 4/12/12 at 9:07 a.m. The resident's diagnoses included, but were not limited to, multiple joint contractures.</p> <p>The Quarterly MDS Assessment dated 12/17/11, indicated the resident had no impairment in lower extremity range of motion which consisted of the hip, knee, ankle and foot areas.</p> <p>The 2/10/12 Significant change MDS Assessment, indicated the resident again had no impairment in lower extremity range of motion.</p> <p>The 12/11/11 Joint mobility assessment, indicated the resident had moderate/severe limitation in range of motion to the left and right hip, and the left and right knee.</p> <p>Interview with the Restorative Nurse on 4/12/12 at 12:15 p.m., indicated the resident's Quarterly MDS Assessment completed in 12/11 and</p>		<p>The 12/17/11 quarterly Minimum Data Set Assessment and the 2/10/12 significant change Minimum Data Set Assessment for Resident #135 was modified.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. On 4-17-12 the Restorative Nurse reassessed Resident #135's Joint Mobility for range of motion and loss of voluntary movement. The last MDS functional limitation in range of motion score was compared with the last Joint Mobility for range of motion and loss of voluntary movement observation for all residents in the facility. Any concerns were addressed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The R.N. M.D.S. coordinator in-serviced the Restorative Nurse on the importance of accurate coding with emphasis given to coding accurate range of motion.</p> <p>The Director of Nursing/ designee in-serviced nursing staff on the</p>				

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	<p>the Significant Change MDS Assessment completed in 2/12 were coded inaccurately related to range of motion limitations.</p> <p>3.1-31(i)</p>		<p>importance of coding accurate information for the MDS with the example of the Joint Mobility for range of motion and loss of voluntary movement used as an example.</p> <ul style="list-style-type: none"> ·Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. ·After completing observations for the MDS ensure accurate information is transcribed from the observation to the MDS. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Weekly the MDS nurse / Designee will audit three residents Minimum Data Set for accurate coding. Any inaccuracies will be immediately corrected/modified.</p> <p>The MDS nurse /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic</p>		

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F0282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure physicians' orders and/or the plan of care were followed as written related to restorative services for 2 of 3 residents of the 21 who met the criteria for range of motion, and also failed to ensure bruises were monitored for 1 of 3 residents of the 5 who met the criteria for skin conditions, non-pressure related and the facility also failed to ensure the correct tube feeding was infusing for 1 of 2 tube feedings observed. (Residents #41, #45, #59, and #135) (LPN #3)</p> <p>Findings include:</p> <p>1. The record for Resident #135 was reviewed on 4/12/12 at 9:07 a.m. The resident's diagnoses included, but were not limited to, multiple joint contractures.</p> <p>The plan of care dated 12/3/11 and reviewed in February 2012, indicated the resident was to receive passive range of motion (PROM) from</p>	F0282	<p>F 282</p> <p>It is the practice of this facility to ensure physician's orders and/or plan of care are followed as written relating to restorative services.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #135 was reassessed by the restorative nurse and currently is receiving ROM as ordered.</p> <p>Resident #45's Physician was made aware of the bruise to the right hand near the thumb/wrist area. The bruise is now resolved and the resident has a new diagnosis of Purpura.</p> <p>Resident #41 was reassessed by the restorative nurse and currently is receiving ROM as ordered.</p> <p>On 4-11-12 the Physician and Guardian for Resident #59 were made aware of the tube feeding. No changes or recommendations in tube feeding orders were made.</p>	05/15/2012			

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	<p>Restorative Nursing due to the resident was limited in voluntary movement to the bilateral upper and lower extremities related to dexterity, range of motion, and flexibility. One of the interventions indicated, the resident was to receive PROM to the bilateral upper and lower extremities 10 repetitions times 3 sets, 6-7 days a week.</p> <p>The Nursing rehab time log, indicating the number of minutes PROM was provided, was reviewed on 4/12/12 at 12:18 p.m. The log was provided by the Restorative Nurse. PROM was signed out as being completed on 2/22-2/29, 3/10, 3/13, 3/24, 4/4 and 4/7/12. Interview with the Restorative Nurse at the time, indicated these are the times the resident received restorative services. She further indicated that several of her Restorative CNAs had been on medical leave. Interview at 1:08 p.m., indicated the resident only received PROM 3 times for the month of March 2012 and 2 times so far for the month of April 2012.</p> <p>2. On 4/10/12 at 3:24 p.m. and 4/11/12 at 8:25 a.m., Resident #45 was observed with a light green bruise on her right hand near her thumb/wrist area.</p>		<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All facility residents with orders for ROM, laboratory blood draws, and tube feedings have the potential to be affected by the same alleged deficient practice. Residents who have orders for anticoagulant therapy and lab draws in the past week have been observed for bruising. Residents with orders for tube feedings were audited. No concerns with tube feeding formulas noted.</p> <p>The Restorative Nurse and Restorative C.N.A.'s were in serviced on:</p> <ul style="list-style-type: none"> · The importance of following Physician orders and the plan of care related to restorative/ Range of Motion (ROM) · Providing ROM. · Timely documentation/accurate documentation. <p>The nurse who cared for Resident #59 was in serviced by the nurse consultant on:</p> <ul style="list-style-type: none"> ·Following Physicians orders related to tube feeding. ·The importance of following Physicians orders related to tube feeding. ·Ensure the correct tube 		

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	<p>The record for Resident #45 was reviewed on 4/11/12 at 9:12 a.m.</p> <p>There was no documentation in the Nursing Progress Notes on 4/10/12 related to the bruising.</p> <p>The current plan of care indicated, the resident was at risk for abnormal bleeding or bruising related to receiving anti-coagulant therapy. The care plan was initiated on 5/31/11. One of the interventions indicated the resident was to be observed for signs of active bleeding i.e. ecchymotic areas.</p> <p>The resident also had a current plan of care indicating she was at risk for alteration in skin integrity related to dementia, depression, atrial fibrillation, history of deep vein thrombosis, incontinence of bowel and bladder, and decreased mobility. The care plan was initiated on 5/31/2011. One of the interventions indicated the resident's skin was to be observed daily with care for changes such as redness or bruising. These changes were to be reported to the nurse.</p> <p>Interview with CNA #2 on 4/11/12 at 11:10 a.m., indicated if she would</p>		<p>feeding is hung. ·Ensure the tube feeding is infusing as ordered.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Director of Nursing/ Designee spoke with NICL lab to discuss the importance of laboratory staff documenting the site of the blood draw and any attempted blood draw sites.</p> <p>The Director of Nursing/ designee in-serviced nursing staff on the importance of: ·Ensuring that a resident with limited ROM receives appropriate treatment and services to increase ROM and/or to prevent further decrease in range of motion. ·Ensuring that appropriate observations are completed on admit, readmit and following the MDS schedule (including significant changes) within the seven-day look back period from the Assessment reference date. Example: The Joint Mobility Limitation ROM and Loss of Voluntary Movement Assessment. ·The importance of following Physician orders and the plan of care related to restorative/ ROM. ·Providing ROM. ·Timely</p>				

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	<p>observe a bruise on a resident, she would notify the nurse. She indicated the resident's skin was to be observed daily during care for any new areas. She indicated that she was caring for the resident this day and she was not aware of any new bruises. When shown the resident's skin, the CNA indicated the resident gets lab draws weekly.</p> <p>Interview with LPN #4 on 4/11/12 at 11:17 a.m., indicated residents were to be monitored after lab draws for bruising, if bruising was noted, the physician was notified and event charting was to be started. When the resident's wrist was observed, she indicated the area was new and must have been from the resident's lab draw on Monday.</p>		<p>documentation/accurate documentation.</p> <p>The DON/designee in serviced licensed nurses on:</p> <ul style="list-style-type: none"> · Residents at risk for alteration in skin integrity. · Monitoring for bruising with emphasis on residents with orders for anticoagulant therapy after laboratory blood draws · Timely and accuracy of monitoring/ documentation of bruises. · Investigation of potential cause of bruising and the importance of laboratory staff documenting the site of the blood draw and any attempted blood draw sites · Following Physicians orders related to tube feeding. · The importance of following Physicians orders related to tube feeding. · Ensure the correct tube feeding is hung. · Ensure the tube feeding is infusing as ordered. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The DON / Designee will audit five residents weekly with orders for ROM to ensure that the</p>		

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	3. On 4/11/12 at 8:20 a.m., Resident #41 was observed in a Broda chair (a reclining specialty chair) in the Main Dining Room. Both of the resident's knees were bent up in a fetal type position. The resident did not have any boots, braces, or splints on either of her legs or feet.		<p>residents are receiving ROM services per physician's orders.</p> <p>The DON/ designee will audit five residents who have had laboratory blood draws weekly to ensure monitoring/ documentation for bruising is completed timely and accurately.</p> <p>The DON/designee will review 5 residents weekly with orders for tube feedings to ensure that Physicians orders related to the tube feeding formula are followed.</p> <p>The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed 5/15/2012</p>		

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	<p>The record for Resident #41 was reviewed on 4/11/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic pain, anorexia, muscular atrophy, osteoporosis, and adult failure to thrive.</p> <p>A care plan for Restorative initiated on 1/23/12 indicated the resident's passive range of motion to her bilateral upper and lower extremities was limited. Care plan interventions were for the staff to provide passive range of motion to her upper and lower extremities consisting of 3 sets of 10 repetitions 6-7 days a week. The current Physician orders indicated there was an order written on 1/21/2012 for the resident to receive passive range of motion, 3 sets of 10 repetitions 6-7 days a week to the upper and lower extremities.</p> <p>The Restorative logs for 3/1/12 thru 3/31/12 indicated Restorative range of motion was provided on 17 days of the 31 days.</p> <p>When interviewed on 4/12/12 at 12:20 p.m., the Restorative Nurse indicated there had been times in the past months when several restorative aides were off sick or hospitalized</p>						

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	<p>and all restorative may not have been during this period of time. The Restorative Nurse also indicated the log is the only place the aides sign out treatments.</p> <p>When interviewed on 4/12/12 at 3:00 p.m., the Restorative Nurse indicated the increased limitation in range of motion was noted upon completing the Joint Mobility Assessment for the significant change MDS. The Restorative Nurse indicated there were times between February and current when the resident did not receive her ordered range of motion.</p> <p>4. Resident #59 was observed on 4/11/12 at 8:42 a.m. The resident was in bed. Jevity 1.2 (an enteral formula) was infusing at 65 cc (cubic centimeters) per hour through the resident's gastrostomy tube (a tube surgically inserted through the abdomen for delivery of nutrition and fluids). Interview with the Clinical Specialist, at that time, indicated the resident was receiving Jevity 1.2 formula through the gastrostomy tube.</p> <p>The record for Resident #59 was reviewed on 4/11/12 at 9:17 a.m. The resident had diagnoses that included, but were not limited to, dementia, malnutrition, dysphagia (difficulty</p>			

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	<p>swallowing) and gastrostomy tube.</p> <p>The current Physician's orders indicated the resident was NPO (to have nothing by mouth). A Physician order dated 3/5/12, indicated the tube feeding formula was, "Glucerna 1.2 at 65 cc/hour on at 4:00 p.m. and off at 10:00 a.m."</p> <p>The significant change Minimum Data Set (MDS) full assessment completed on 3/12/12, indicated the resident's height was 60 inches and her weight was 85 pounds. The assessment indicated the resident had a feeding tube in place.</p> <p>There was a progress note, dated 4/10/12 at 12:24 p.m., written by the Registered Dietician. The note indicated, ". . . Resident discussed at NAR (Nutrition at Risk) today. NPO/TF (tube feeding): Glucerna 1.2 at 65cc/hour for 18 hours with 250 cc water flush every shift . . . "</p> <p>On 4/11/12 at 3:34 p.m., a bottle of Jevity 1.2 enteral feeding was hanging in the resident's room on a pole next to the resident's bed. Interview with the Assistant Director of Nursing (ADON), at that time, indicated Jevity 1.2 was on the enteral feeding pole in the resident's</p>			

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	<p>room.</p> <p>Continued interview with the ADON, on 4/11/12 at 3:34 p.m., indicated the resident had a Physician's order to receive Glucerna 1.2, not Jevity 1.2, through the feeding tube. She removed the container of Jevity.</p> <p>On 4/12/12 at 8:06 a.m., interview with the Clinical Specialist indicated she had spoken to the nurse who hung the enteral feeding on 4/11/12. She indicated the nurse stated she did indeed hang Jevity 1.2 instead of Glucerna 1.2. She indicated the Physician was notified of the error.</p> <p>On 4/13/12 at 11:13 a.m., LPN #3 was interviewed. She indicated she was the nurse who hung the wrong bottle of tube feeding formula for Resident #59 on 4/11/12. She indicated she did not follow the Physician's order.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to monitoring of bruises for 1 of 3 residents of the 5 who met the criteria for skin conditions, non-pressure related. (Resident #45)</p> <p>Findings include:</p> <p>On 4/9/12 at 11:00 a.m., Resident #45 was observed with a band-aid on her right wrist.</p> <p>On 4/10 at 10:18 a.m. and 3:24 p.m., and on 4/11/12 at 8:25 a.m., the resident was observed with a light green bruise on her right hand near her thumb/wrist area.</p> <p>The record for Resident #45 was reviewed on 4/11/12 at 9:12 a.m. The resident's diagnoses included, but were not limited to, senile dementia</p>	F0309	<p>F 309 It is the practice of this facility to ensure the necessary care and services are provided related to monitoring of bruises.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #45's Physician was made aware of the bruise to the right hand near the thumb/wrist area. No orders were received. The bruise is now resolved.</p> <p>Resident #45 has a new diagnosis of Purpura.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents who have orders for laboratory blood draws have the potential to be affected by the same deficient practice. Residents who have orders for anticoagulant therapy and lab</p>	05/15/2012			

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	<p>and atrial fibrillation.</p> <p>Review of the April 2012 Physician's Order Summary (POS), indicated the resident was to have a prothrombin time (a lab test to determine blood clotting) drawn every Monday.</p> <p>A Physician's order dated 4/9/12, indicated the resident's Warfarin (Coumadin - a blood thinner) was increased from 4 to 5 milligrams (mg).</p> <p>Documentation in the Nursing Progress Notes dated 4/10/12 at 12:50 a.m., 1:30 p.m., and 10 p.m., indicated the resident's Coumadin increase continued and no abnormal bleeding or bruising was observed.</p> <p>The plan of care dated 5/31/11 and reviewed 4/12, indicated the resident was at risk for alteration in skin integrity related to dementia, depression, atrial fibrillation, history of deep vein thrombosis, incontinence of bowel and bladder, and decreased mobility. One of the interventions indicated the resident's skin was to be observed daily with care for changes such as redness or bruising.</p> <p>Interview with CNA #2 on 4/11/12 at 11:10 a.m., indicated that if she would observe a bruise on a resident, she</p>		<p>draws in the past week have been observed for bruising.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Director of Nursing/ Designee spoke with NICL lab to discuss the importance of laboratory staff documenting the site of the blood draw and any attempted blood draw sites.</p> <p>The DON/designee in serviced licensed nurses on:</p> <ul style="list-style-type: none"> · Residents at risk for alteration in skin integrity. · Monitoring for bruising with emphasis on residents with orders for anticoagulant therapy after laboratory blood draws · Timely and accuracy of monitoring/ documentation of bruises. · Investigation of potential cause of bruising and the importance of laboratory staff documenting the site of the blood draw and any attempted blood draw sites <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The DON/ designee will audit five</p>		

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	<p>would notify the nurse. She indicated the resident's skin was observed daily during care for any new areas. The CNA indicated that she was caring for the resident on this day and she was not aware of any new bruises. When shown the resident's skin, the CNA indicated the resident gets lab draws weekly.</p> <p>Interview with LPN #4 on 4/11/12 at 11:17 a.m., indicated residents were to be monitored after lab draws for bruising, if bruising was noted, the physician was notified and event charting was started. When the resident's wrist was observed, the LPN indicated the area was new and due from the resident's lab draw on Monday.</p> <p>Documentation related to the bruising was not completed until 4/11/12 at 11:45 a.m.</p> <p>3.1-37(a)</p>		<p>residents who have had laboratory blood draws weekly to ensure monitoring/ documentation for bruising is completed timely and accurately. Any compliance concerns will be addressed immediately. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed 5/15/2012</p>		

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F0313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on observation, record review, and interview, the facility failed to ensure vision abilities were maintained related to ordering and assisting with the use of ordered glasses for 2 of 3 residents reviewed for vision services of the 28 who met the criteria for vision. (Residents #59 & #125)</p> <p>Findings include:</p> <p>1. On 4/10/12 at 3:34 p.m., Resident #125 was observed sitting in a chair in the Activity Room. The resident was participating in the activity. The resident did not have eyeglasses on.</p> <p>On 4/11/12 at 7:41 a.m., the resident was observed walking down the hallway to the Dining Room pushing a wheel chair. The resident was not wearing any eyeglasses. The resident was served her breakfast</p>	F0313	<p>F313</p> <p>It is the practice of this facility to ensure vision abilities are maintained related to ordering and assisting with the use of eye glasses.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The guardian for Resident #59 was contacted and has given consent to schedule this resident with an optometrist. The optometrist has been contacted to add this resident to their next visit.</p> <p>The glasses for Resident #125 were located and offered to resident.</p> <p>-</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will</p>	05/15/2012			

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	<p>meal tray in the Dining Room at 7:45 a.m. and began feeding herself. The resident did not have eyeglasses on.</p> <p>On 4/12/12 at 7:45 a.m., the resident was observed sitting in a chair in the Activity Room. The resident did not have eyeglasses on.</p> <p>On 4/12/12 at 1;13 p.m., CNA #1 was observed putting a pair of eyeglasses on the resident.</p> <p>The record for Resident #125 was reviewed on 4/12/12 at 10:47 a.m. The resident's diagnoses included, but were not limited to, senile dementia, depressive disorder, high blood pressure, and congestive heart failure. The resident was admitted to the facility on 4/13/2011</p> <p>The 3/16/12 annual Minimum Data Set (MDS) assessment indicated the resident BIMS (Resident Interview for Cognitive Status) score was three. A score of three indicated the resident's cognitive skills for decision making were severely impaired. The MDS assessment also indicated the resident's vision was impaired as she was able to see large print, but not regular print in newspapers or books. The assessment also indicated the resident had no corrective lens such</p>		<p>be taken.</p> <p>All residents who have been seen by an Optometrist and have glasses have the potential to be affected by this alleged deficient practice. The facility Optometrist supplied facility a list of residents who received eye exams and those that received glasses. These residents where audited to assure those residents that require glasses have them and are able to wear them. Social Services compiled a list of residents that wear glasses in the facility and Care Cards were updated.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>An audit tool was developed to monitor residents referred and/or seen by Optometry services, if glasses were ordered and date that glasses were delivered to the resident. This audit tool will be reviewed weekly at the morning Management Meeting for compliance. Social Services was in-serviced on insuring that all residents who wear glasses have their care cards updated to reflect use of eye glasses.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place.</p>		

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	<p>as glasses, contacts, or magnifying glass. The MDS assessment also indicated the resident required limited assistance of one person for dressing.</p> <p>The resident received an Optometry Exam on 6/20/11. The 6/20/11 "Optometric Exam Form" indicated the resident was seen for blurred vision and options for frames were selected.</p> <p>An "Eyewear Delivery Notice" from the Optometry provider was completed on 11/4/11. The notice indicated an "authorized facility representative" signed verification glasses were delivered to the resident on the above date.</p> <p>When interviewed on 4/12/12 at 1:30 p.m., MDS Nurse #1 indicated she was not aware the resident had eye glasses. The MDS Nurse indicated when they complete the Vision section on the MDS they check the resident's room for any glasses and will also ask the Nurse on the unit if the resident has eye glasses.</p> <p>When interviewed on 4/12/12 at 1:13 p.m., CNA #1 and LPN #1 indicated they had not seen the resident wearing any glasses for the past</p>		<p>·The Social Service Director/designee will conduct a weekly audit of 10 residents who wear glasses to assure the care card reflects that they have glasses and glasses are being worn.</p> <p>·The Social Services Director/designee will conduct an audit after each Optometrist visit to track each resident who requires glasses and delivery of ordered glasses. Social Services will present a summary of these audits to the monthly Quality Assurance committee. Audits will be on going.</p> <p>Date by which systemic corrections will be completed is 5/15/2012</p>		

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	<p>several months. CNA #1 indicated she has not seen glasses on the resident since she was admitted and she was not aware the resident had any glasses.</p> <p>When interviewed on 4/16/12 at 9:37 a.m., Social Worker #1 indicated the resident did not have glasses when she was admitted. The Social Worker indicated the glasses were delivered on 11/4/11. The Social worker indicated the resident should have been assisted to wear the glasses when they were delivered.</p> <p>2. Resident #59 was observed on 4/11/12 at 12:39 p.m. The resident was in bed and she did not have glasses on.</p> <p>The resident was observed on 4/12/12 at 11:47 a.m. in bed. The resident had a pair of glasses on. When interviewed at that time, she indicated the glasses were for reading only.</p> <p>The record for Resident #59 was reviewed on 4/11/12 at 9:17 a.m. The resident had diagnoses that included, but were not limited to, dementia, malnutrition, and osteoarthritis.</p> <p>The significant change Minimum Data</p>				

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	<p>Set (MDS) full assessment dated 3/12/12, indicated the resident's vision was moderately impaired and no corrective lenses were in use.</p> <p>Interview with MDS Coordinator #2 on 4/12/12 at 1:48 p.m., indicated the resident was ill at the time the MDS was completed. She indicated the resident was not wearing her glasses at that time. She indicated the resident had recently started wearing her reading glasses again.</p> <p>There was a Care Plan dated 1/11/12, that indicated the resident had impaired vision but was able to see large print without difficulty. Interventions included: -observe for changes -provide adequate lighting -provide large print material -remind to clean glasses -schedule eye exam as indicated</p> <p>The resident was seen by the Optometrist on 11/7/11. Review of the form titled, "Optometrist Exam Form" dated 11/7/11, indicated the reason the resident was seen by the Optometrist was due to "Blurry" vision. The Optometrist indicated the blurred vision had a duration of months and was noted while watching television. The Optometrist indicated</p>						

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	<p>the resident was evaluated and new glasses were ordered for the resident at that time.</p> <p>Interview with Social Worker #1 on 4/12/12 at 11:58 a.m., indicated when the optometry company delivered glasses to the facility for the residents, she would sign the receipt and would be aware of any eyeglasses being delivered for the residents.</p> <p>Review of the Social Service progress notes dated 11/7/11 through 4/11/12, indicated there was no evidence the Social Worker was aware the Optometrist had evaluated the resident and ordered eyeglasses for her or that the eyeglasses had never been delivered. There was no evidence the Social worker had followed up with the Optometrist for the procurement of the eyeglasses.</p> <p>Interview with Social Worker #1 on 4/12/12 at 3:00 p.m., indicated the resident's glasses were ordered but they were never delivered. She indicated the resident was private pay at that time and had Medicaid Insurance pending. The optometry company was sending the estimated cost of the glasses to her primary emergency contact who did not</p>						

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	<p>respond. The optometry company canceled the order. The Social Worker indicated she was aware there was a recommendation for eyeglasses. She also indicated there was no follow up by the facility with the emergency contact person to obtain the eyeglasses that were ordered by the Optometrist. She indicated there should have been attempts made by the facility to procure the eyeglasses for the resident.</p> <p>3.1-39(a)(2)</p>			

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review and interview, the facility failed to ensure range of motion services were provided as ordered for 2 of 3 residents of the 21 who met the criteria for range of motion. (Residents #41 and #135)</p> <p>Findings include:</p> <p>1. On 4/10/12 at 3:29 p.m., Resident #135 was observed seated in her geri-chair. The resident's legs were bent at the knees and her legs were not extended.</p> <p>On 4/11/12 at 8:25 a.m., the resident was observed in bed. The resident's legs were flexed at the knees and her legs were not extended. At 1:00 p.m. and 3:30 p.m., the resident was in her geri-chair, again her legs were bent at the knee and her legs were not extended.</p> <p>On 4/12/12 at 8:40 a.m., the resident was observed in her room in bed. Bed</p>	F0318	<p>F 318</p> <p>It is the practice of this facility to ensure range of motion services are provided as ordered.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #135 was reassessed by the restorative nurse and currently is receiving ROM as ordered.</p> <p>Resident #41 was reassessed by the restorative nurse and currently is receiving ROM as ordered.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All facility residents with orders for ROM have the potential to be affected by the same alleged deficient practice. The Restorative Nurse and Restorative C.N.A.'s were</p>	05/15/2012

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	<p>in low position. The residents legs were bent at the knee and her legs were not extended.</p> <p>The record for Resident #135 was reviewed on 4/12/12 at 9:07 a.m. The resident's diagnoses included, but was not limited to, multiple joint contractures.</p> <p>The 2/10/12 Significant Change Minimum Data Set (MDS) Assessment and the 12/17/11 Quarterly MDS Assessment, indicated the resident had no impairment in her lower extremity range of motion.</p> <p>The 12/11/11 Joint mobility assessment, indicated the resident had moderate/severe limitation in her left and right hip and her left and right knee. A Joint Mobility Assessment was not completed after the resident's significant change in February 2012.</p> <p>The plan of care dated 12/3/11 and reviewed in February 2012, indicated the resident was receiving Restorative Services for passive range of motion (PROM) due to the resident was limited in voluntary movement to the bilateral upper and lower extremities related to dexterity, range of motion, and flexibility. The interventions indicated the resident was to receive</p>		<p>in-serviced on:</p> <ul style="list-style-type: none"> · The importance of following Physician orders and the plan of care related to restorative/ Range of Motion (ROM) · Providing ROM. · Timely documentation/accurate documentation. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Director of Nursing/ designee in-serviced nursing staff on the importance of:</p> <ul style="list-style-type: none"> · Ensuring that a resident with limited ROM receives appropriate treatment and services to increase ROM and/or to prevent further decrease in range of motion. · Ensuring that appropriate observations are completed on admit, readmit and following the MDS schedule (including significant changes) within the seven-day look back period from the Assessment reference date. Example: The Joint Mobility Limitation ROM and Loss of Voluntary Movement Assessment. · The importance of following Physician orders and the plan of care related to restorative/ ROM. · Providing ROM. · Timely documentation/accurate documentation. 		

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	<p>PROM to the bilateral upper and lower extremities 10 repetitions times 3 sets, 6-7 days a week and the restorative nurse was to evaluate the resident's joint mobility quarterly and as needed.</p> <p>The Quarterly Restorative Nursing Program Documentation dated 12/11/11, indicated the resident was limited in voluntary movement to the bilateral upper and lower extremities related to decreased mobility and dexterity. ROM to bilateral upper and lower extremities helps maintain present joint mobility function with minimal pain, discomfort, and limits decline with range of motion. Resident participates with extensive assist of 1 staff, verbal cues, and re-direction, with rest periods as needed. Status of resident progression: Maintenance. Resident will maintain current joint mobility as evidenced by the joint mobility assessment.</p> <p>Interview with the Restorative Nurse on 4/12/12 at 10:45 a.m., indicated the last Quarterly Joint Mobility Assessment was completed in December and she was scheduled to be completed on 4/27/12. Further interview at 12:15 p.m., indicated the resident's MDS in 12/11 and 2/12</p>		<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Weekly the DON / Designee will audit five residents with orders for ROM to ensure that the residents are receiving ROM services per physician's orders.</p> <p>Monthly the DON/Designee will audit 5 residents within their assessment reference date to ensure the Joint Mobility Limitation ROM and Loss of Voluntary Movement Assessment is completed timely and accurately.</p> <p>The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed 5/15/2012</p>		

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	<p>were coded inaccurately related to ROM limitations. She further indicated a Joint Mobility Assessment had not been completed at the time of the Significant Change Assessment. She indicated the resident has maintained her current level of ROM to her lower extremities and has not suffered a decline. She indicated her Restorative CNAs were usually pretty good about communicating to her if the residents suffer a decline.</p> <p>The Nursing Rehab Time Log for number of minutes for PROM was reviewed on 4/12/12 at 12:18 p.m. The time log was provided by the Restorative Nurse. PROM was signed out 2/22-2/29, 3/10, 3/13, 3/24, 4/4 and 4/7/12. Interview with the Restorative Nurse at the time, indicated these were the times the resident received restorative services. She further indicated that several of her Restorative CNAs have been on medical leave. Interview with the Restorative Nurse at 1:08 p.m., indicated the resident only received PROM 3 times for the month of March 2012 and 2 times so far for the month of April 2012.</p> <p>2. On 4/11/12 at 8:20 a.m., Resident #41</p>				

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	<p>was observed in a Broda chair (a reclining specialty chair) in the Main Dining Room. Both of the resident's knees were bent up in a fetal type position. The resident did not have any boots, braces, or splints on either of her legs or feet.</p> <p>On 4/11/12 at 11:00 a.m., the resident was observed in bed laying on her left side. The residents knees were bent up. The resident did not have any braces, boots, or splints on either of her legs or feet.</p> <p>On 4/11/12 at 3:30 p.m., the resident was observed in bed laying on her left side. The resident's knees were bent with her right leg positioned on top of her left leg.</p> <p>On 4/12/12 at 3:00 p.m., the Restorative Nurse was observed assessing the resident's joint mobility in her lower extremities. The resident was able to extend her toes pointing down in normal range but was not able to flex her foot up towards her knees any more then a 90 degree ankle on either foot.</p> <p>The record for Resident #41 was reviewed on 4/11/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic pain, anorexia, muscular atrophy, osteoporosis, and adult failure to thrive.</p>			

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	<p>A Physician's order was written on 3/21/12 for the resident to be placed under Hospice Care.</p> <p>A care plan for Restorative initiated on 1/23/12 indicated the resident's passive range of motion to her bilateral upper and lower extremities was limited. Care plan interventions were for the staff to provide passive range of motion to her upper and lower extremities consisting of 3 sets of 10 repetitions 6-7 days a week. The current Physician orders indicated there was an order written on 1/21/2012 for the resident to receive passive range of motion, 3 sets of 10 repetitions 6-7 days a week to the upper and lower extremities.</p> <p>The 4/3/12 significant change MDS (Minimum Data Set) full assessment indicated the resident had impairment in range of motion to her hips, ankles, feet, and knees on both sides. The MDS assessment indicated the resident received passive range of motion two times for at least 15 minutes in the last 7 days.</p> <p>An admission Joint Mobility Assessment completed on 1/23/12 indicated the resident had 51-75% of range of motion available in her left and right hips, 76-100% of range of motion available in her right and left ankle, and 0-25% of range of motion available in her right and</p>						

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	<p>left knees. A significant change Joint Mobility Assessment was completed on 4/2/12. The assessment indicated the resident had 0-25% of range of motion available in her right ankle, left ankle, right knee, and left knee.</p> <p>The Restorative logs for 3/1/12 thru 3/31/12 indicated Restorative range of motion was provided on 17 days of the 31 days.</p> <p>When interviewed on 4/12/12 at 12:20 p.m., the Restorative Nurse indicated there had been times in the past months when several restorative aides were off sick or hospitalized and all restorative may not have been during this period of time. The Restorative Nurse also indicated the logs are the only place the aides sign out treatments.</p> <p>When interviewed on 4/12/12 at 3:00 p.m., the Restorative Nurse indicated the increased limitation in range of motion was noted upon completing the Joint Mobility Assessment for the above significant change MDS. The Restorative Nurse indicated there were times between February and current when the resident did not receive her ordered range of motion.</p> <p>When interviewed on 4/17/12 at 8:05</p>				

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	<p>a.m., the Assistant Director of Nursing indicated the resident was currently on Hospice for a diagnosis of adult failure to thrive. The Assistant Director of Nursing indicated the resident has had an overall decline in condition due to wounds and decreased eating and the family just recently agreed on Hospice services for the resident.</p> <p>3.1-42(a)(2)</p>			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review and interview, the facility failed to ensure that a resident with a gastrostomy tube (a tube surgically inserted through the abdomen for delivery of nutrition and fluids) received appropriate treatment and services related to the infusion of an incorrect enteral formula for 1 of 1 resident observed and reviewed for a feeding tube. (Resident #59)</p> <p>Findings include:</p> <p>Resident #59 was observed on 4/11/12 at 8:42 a.m. The resident was in bed. Jevity 1.2 (an enteral formula) was infusing at 65 cc (cubic centimeters) per hour through the resident's gastrostomy tube. Interview with the Clinical Specialist, at that time, indicated the resident was receiving Jevity 1.2 formula through the gastrostomy tube.</p>	F0322	<p>F 322</p> <p>It is the practice of this facility to ensure that residents with a gastrostomy tube receive appropriate treatment and services related to infusion.</p> <p>What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice?</p> <p>On 4/11/2012 the Physician and Guardian for Resident #59 was made aware of the tube feeding. No changes or recommendations in tube feeding orders were made.</p> <p>How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice?</p> <p>All facility residents with orders for tube feedings have the potential to be affected by the same deficient practice.</p>	05/15/2012			

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	<p>The record for Resident #59 was reviewed on 4/11/12 at 9:17 a.m. The resident had diagnoses that included, but were not limited to, dementia, malnutrition, dysphagia (difficulty swallowing) and gastrostomy tube.</p> <p>The current Physician's orders indicated the resident was NPO (to receive nothing by mouth). A Physician order dated 3/5/12, indicated the tube feeding formula was, "Glucerna 1.2 at 65 cc/hour on at 4:00 p.m. and off at 10:00 a.m."</p> <p>The significant change Minimum Data Set (MDS) full assessment completed on 3/12/12, indicated the resident's height was 60 inches and her weight was 85 pounds. The assessment indicated the resident had a feeding tube in place.</p> <p>There was a progress note, dated 4/10/12 at 12:24 p.m., that was written by the Registered Dietician. The note indicated, ". . . Resident discussed at NAR (Nutrition at Risk) today. NPO/TF (tube feeding): Glucerna 1.2 at 65 cc/hour for 18 hours with 250 cc water flush every shift. WT 107# (4/10/12) . . . res (resident's) estimated nutritional needs are 1200-1450 cal (calories),</p>		<p>The nurse who cared for resident #59 was in serviced by the nurse consultant on:</p> <ul style="list-style-type: none"> ·Following Physicians orders related to tube feeding. ·The importance of following Physicians orders related to tube feeding. ·Ensure the correct tube feeding is hung. ·Ensure the tube feeding is infusing as ordered. <p>What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?</p> <p>Licensed nurses were in serviced on the importance of:</p> <ul style="list-style-type: none"> ·Following Physicians orders related to tube feeding. ·The importance of following Physicians orders related to tube feeding. ·Ensure the correct tube feeding is hung. ·Ensure the tube feeding is infusing as ordered. <p>What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?</p> <p>The DON/designee will review 5 residents weekly with orders for tube feedings to ensure that Physicians orders related to the tube feeding formula are followed.</p>		

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	<p>73-87 pro (protein) and 1200-1400 cc free fluid. Current TF provides 1404 calories, 85 grams of protein, (with 30 cc of Prostate). Res TF meets 100% of estimated needs at this time. . . Resident receives Glucerna due to increased glucose level on 3/5/12 from hospital . . . "</p> <p>On 4/11/12 at 3:34 p.m., the bottle of Jevity 1.2 enteral feeding was hanging in the resident's room on a pole next to the resident's bed. Interview with the Assistant Director of Nursing (ADON), at that time, indicated Jevity 1.2 was on the enteral feeding pole in the resident's room.</p> <p>Continued interview with the ADON on 4/11/12 at 3:34 p.m., indicated the current Physician's order indicated the resident was to receive Glucerna 1.2, not Jevity 1.2 through the feeding tube. She removed the container of Jevity.</p> <p>On 4/12/12 at 8:06 a.m., interview with the Clinical Specialist indicated she had spoken to the nurse who hung the enteral feeding on 4/11/12. She indicated the nurse stated she did indeed hang Jevity 1.2 instead of Glucerna 1.2. She indicated the Physician was notified of the error on</p>		<p>The DON/designee will present a summary of the audits to the QA committee monthly for nine months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing.</p> <p>Date by which systemic corrections will be completed 5/15/2012</p>				

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	<p>4/11/12 at 4:22 p.m. The Physician ordered the resident's blood glucose level to be checked at that time.</p> <p>On 4/13/12 at 11:13 a.m., LPN #3 was interviewed. She indicated she was the nurse who hung the wrong bottle of tube feeding formula for Resident #59 on 4/11/12. She indicated she made a mistake and hung the wrong bottle.</p> <p>3.1-44(a)(2)</p>			
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F0323 SS=E	<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 and interview, the facility failed to ensure the resident's environment remained free of hazards related to an unattended work site with a ladder and a hanging water hose on 1 of 5 units. This had the potential to affect 5 of 27 residents who resided on the unit and were independent with ambulation. (Daisy Lane)</p> <p>Findings include:</p> <p>On 4/9/12 at 9:25 a.m., there was a 6 foot tall aluminum ladder in the hall next to the nursing station on Daisy Lane. There was a water hose hanging from the ceiling next to the ladder. The end of the hose was connected to the water sprinkler head. The hose dropped down from the ceiling and made a loop back up to the ceiling. The bottom of the hose loop hung approximately 5 feet from the floor. At the end of the loop the hose dropped down to the floor, it laid across the floor going into the soiled utility room. The entire width of the</p>	F0323	<p>F323</p> <p>It is the practice of this facility to ensure the resident's environment remains free of hazards. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility staff addressed the concern immediately and the residents were not directly affected by the deficient practice.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All ambulatory residents on this unit have the potential of being affected by this alleged deficient practice. The contractor was educated on not leaving a work area unattended. The Maintenance Director/staff were in-serviced on educating all contractors prior to beginning their work in the facility, and monitoring for compliance while in the facility.</p>	05/15/2012

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	<p>hall was obstructed with either a hose on the floor, and a loop of hose hanging from the ceiling or a ladder. The area with the hose and the ladder was in the hallway where the residents, staff and visitors walk. There was no way to walk through the unit without walking over or under a section of the water hose.</p> <p>Residents were observed seated within 10 feet of the water hose. There were no staff members near the area to supervise the residents for safety.</p> <p>At 9:35 a.m., Social Worker #2 walked to the area. He immediately called maintenance for assistance. Interview with Social Worker #2 at that time, indicated the area was a hazard for the residents and should not be unsupervised. He stated there was a construction company putting in a new sprinkler system.</p> <p>Interview with the Nurse Consultant on 4/16/12 at 9:07 a.m., indicated there were 5 residents who were independent with ambulation who resided on the Daisy Lane Unit. She also indicated there were a total 27 residents who resided on the unit.</p> <p>3.1-45(a)(1)</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director/designee will meet with any contractors prior to conducting work within the facility. The Maintenance Director/designee will conduct daily audits of all worksite areas to ensure safety. Any compliance concerns will be addressed immediately.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on-going.</p> <p>Date by which systemic corrections will be completed is 5/15/2012</p>		

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F0441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F0441	F 441 It is the practice of this facility to	05/15/2012	

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	<p>ensure gloves were worn by staff while performing glucometer blood sugar testing, for 1 of 1 resident observed during glucometer testing. (Resident #93) (LPN #4)</p> <p>Findings include:</p> <p>On 4/11/12 at 8:45 a.m., LPN #4 entered Resident #93's room to perform a glucometer. The LPN proceeded to check the resident's blood sugar. The LPN was not wearing gloves at this time. After checking the resident's blood sugar, the LPN left the room and used an alcohol hand gel when she got back to her medication cart.</p> <p>The facility policy titled "Obtaining a Fingerstick Glucose Level" was reviewed on 4/16/12 at 9:29 a.m. The policy was provided by the Assistant Director of Nursing and identified as current. The policy indicated personal protective equipment (e.g. gowns, gloves, mask, etc.) was to be used.</p> <p>On 4/16/12 at 9:50 a.m., interview with the Nursing Consultant indicated gloves should be worn for a finger stick.</p>		<p>ensure gloves are worn by staff while performing glucometer testing.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #93 did not suffer any ill effects. Gloves are worn during blood glucose monitoring.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents who have orders for blood glucose monitoring have the potential to be affected by the same deficient practice.</p> <p>The nurse who cared for Resident #93 was educated by the nurse consultant on the policies titled: 1. Obtaining a Finger stick Glucose Level with an emphasis given on the importance of wearing gloves. 2. Personal Protective Equipment- Using Gloves</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>				

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	3.1-18(l)		<p>practice does not recur; The DON/designee in serviced licensed nurses on:</p> <ol style="list-style-type: none"> Obtaining a Finger stick Glucose Level with an emphasis given on the importance of wearing gloves. Personal Protective Equipment- Using Gloves <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/ designee will audit five licensed nurses weekly to ensure gloves are used when obtaining a finger stick glucose level. Any compliance concerns will be addressed immediately. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed 5/15/2012</p>		

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F0520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to ensure the Quality Assurance Committee implemented interventions related to range of motion serviced not provided for 2 of 3 residents reviewed for range of motion of the 21 who met the criteria for range of motion. (Residents #41 & #135)</p> <p>Findings include:</p>	F0520	<p>F520</p> <p>It is the practice of this facility to ensure the Quality Assurance committee would implement interventions relating to range of motion services not being provided as ordered.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #41 was re-assessed as</p>	05/15/2012

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	<p>The Quality Assessment and Assurance Task was completed on 4/16/12 at 3:45 p.m. The facility Administrator was interviewed at this time related to the Quality Assessment and Assurance team. The facility Administrator was informed of the Survey Team's identified concern related to range of motion services not being provided for Residents #41 and #135. The facility Administrator indicated he was aware Restorative staff were short of some aides but did not think it was for a long period. The Administrator indicated he was not aware the residents were not getting the treatments done. The Administrator indicated it had not been brought up at Quality Assurance meetings and it should have been. The Administrator indicated he would have put measures into place and reviewed this at Quality Assurance if he had been aware.</p> <p>The Survey Team identified a concern related to two residents not receiving range of motion by Restorative Nursing as per their plan of care.</p> <p>On 4/11/12 at 8:20 a.m., Resident #41 was observed in a Broda chair (a reclining specialty chair) in the Main</p>		<p>to the status of upper and lower extremity joint mobility status on 4/17/2012, showing identical range of motion as documented on the previous assessment of 4/02/2012.</p> <p>Resident #135 was re-assessed as to the status of upper and lower extremity joint mobility status on 4/17/2012, showing identical range of motion as documented on the previous assessment of 12/11/2011.</p> <p>At the end of each day shift, the Restorative Nurse/designee will review documentation of ROM services for each of these residents to assure that ordered services have been provided per the plans of care.</p> <p>- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents receiving restorative range of motion services have the potential to be affected by the alleged practice identified. The restorative aide assignment sheets for ROM services were reviewed and identified issues were addressed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2012
NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342		
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	<p>Dining Room. Both of the resident's knees were bent up in a fetal type position. The resident did not have any boots, braces, or splints on either of her legs or feet.</p> <p>The record for Resident #41 was reviewed on 4/11/12 at 9:35 a.m. The resident's diagnoses included, but were not limited to, chronic pain, anorexia, muscular atrophy, osteoporosis, and adult failure to thrive.</p> <p>A care plan for Restorative initiated on 1/23/12 indicated the resident's passive range of motion to her bilateral upper and lower extremities was limited. Care plan interventions were for the staff to provide passive range of motion to her upper and lower extremities consisting of 3 sets of 10 repetitions 6-7 days a week. The current Physician orders indicated there was an order written on 1/21/2012 for the resident to receive passive range of motion, 3 sets of 10 repetitions 6-7 days a week to the upper and lower extremities.</p> <p>The Restorative logs for 3/1/12 thru 3/31/12 indicated Restorative range of motion was provided on 17 days of the 31 days.</p>		<p>practice does not recur. The Restorative Nurse/designee will document that scheduled restorative aides are on duty daily, reporting any staffing issues at weekday management meetings. Alternative staffing will be assigned when required to ensure restorative programs are provided as per resident plans of care.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place. The records of five (5) residents receiving ROM services will be audited weekly to validate reception of those services as per the plan of care.</p> <p>The Restorative Nurse/designee will present a summary of the audits to the Quality Assurance committee monthly for 9 months. Thereafter if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</p> <p>Date by which systemic corrections will be completed is 5/15/2012</p>		

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	<p>When interviewed on 4/12/12 at 12:20 p.m., the Restorative Nurse indicated there had been times in the past months when several restorative aides were off sick or hospitalized and all restorative may not have been during this period of time. The Restorative Nurse also indicated the log are the only place the aides sign out treatments.</p> <p>When interviewed on 4/12/12 at 3:00 p.m., the Restorative Nurse indicated the increased limitation in range of motion was noted upon completing the Joint Mobility Assessment for the significant change MDS. The Restorative Nurse indicated there were times between February and current when the resident did not receive her ordered range of motion.</p> <p>The record for Resident #135 was reviewed on 4/12/12 at 9:07 a.m. The resident's diagnoses included, but was not limited to, multiple joint contractures.</p> <p>The plan of care dated 12/3/11 and reviewed in February 2012, indicated the resident was to receive passive range of motion (PROM) from Restorative Nursing due to the resident was limited in voluntary movement to the bilateral upper and</p>						

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	<p>lower extremities related to dexterity, range of motion, and flexibility. One of the interventions indicated, the resident was to receive PROM to the bilateral upper and lower extremities 10 repetitions times 3 sets, 6-7 days a week.</p> <p>The Nursing rehab time log, indicating the number of minutes PROM was provided, was reviewed on 4/12/12 at 12:18 p.m. The log was provided by the Restorative Nurse. PROM was signed out as being completed on 2/22-2/29, 3/10, 3/13, 3/24, 4/4 and 4/7/12. Interview with the Restorative Nurse at the time, indicated these are the times the resident received restorative services. She further indicated that several of her Restorative CNAs had been on medical leave. Interview at 1:08 p.m., indicated the resident only received PROM 3 times for the month of March 2012 and 2 times so far for the month of April 2012.</p> <p>3.1-52(b)(2)</p>			