

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00194318.</p> <p>Survey dates: February 24, 25, 26, 29, and March 1, 2016</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 6 Medicaid: 70 Other: 24 Total: 100</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on March 7, 2016.</p>	F 0000		

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 0244 SS=E Bldg. 00	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on interview and record review, the facility failed to ensure Resident Council concerns were addressed appropriately in relation to missing clothing items for 10 of 12 months of Resident Council minutes reviewed.</p> <p>Findings include:</p> <p>During an interview on 02/26/2015 at 11:16 A.M., the Resident Council President indicated problems with laundry came up often during Resident Council meetings.</p> <p>During an interview on 02/29/2015 at 2:44 P.M., the Activities Director indicated it was her responsibility to write down resident grievances during Resident Council meetings and that she documented every concern that was brought up. She further indicated after the meeting she took the concerns to the Administrator and the Social Services</p>	F 0244	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. F-244 (Resident Council) • No resident was identified. • Residents who reside in the facility have the potential to be affected by this alleged deficient practice. The Executive Director (ED) will review 5 months(11/2015-3/2016) of Resident Council meeting minutes by March 28, 2016for unresolved grievances. Any issues identified will be addressed immediately. • Resident Council process will be changed to: any concerns addressed during Resident Council meeting will be placed on concern form, forwarded to the appropriate department manager and the Social Services Director (SSD) for timely resolution. The</p>	03/29/2016

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	<p>Director. The Social Services Director would then fill out a grievance form for the concerns. The Activities Director further indicated she took the Resident Council Minutes to the head of whichever department listed in the concern. That department would write their plan of action on the form. The Activities Director indicated missing clothing in laundry was a reoccurring concern during Resident Council.</p> <p>Resident Council Minutes were reviewed, with permission of the Resident Council President, on 02/29/2016 at 1:21 P.M. Concerns regarding missing clothing was brought up in April, May, June, July, September, October, November, December, 2015 and January, February, 2016.</p> <p>The current facility policy, titled "Resident Related Concerns/Grievances" and dated 11/30/2014, was provided by the ADON (Assistant Director of Nursing) on 03/01/2016 at 11:46 A.M. It was reviewed at that time. The policy indicated, "...The Executive Director/designee shall act on the concern and begin an investigation of the concern or submit it to the appropriate department director for follow-up...."</p> <p>The current facility policy, titled</p>		<p>ED/Director of Clinical Services (DCS) will educate the Activities Director and department managers on the process Resident Council concerns and the facility's policy on Resident Related Concerns/Grievances by March 28, 2016. • The SSD/Activities Director (AD) will conduct QI monitoring of the regulation F-244 to ensure grievances brought forth by the Resident Council are responded to and resolved in a timely manner. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months. The Social Services Director will report findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. • Date of Compliance: March 29, 2016</p>				

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F 0279 SS=D Bldg. 00	<p>"Resident Council" and dated 11/30/2014, was provided by the ADON on 03/01/2016 at 11:46 A.M. It was reviewed at that time. The policy indicated, "Resident council may be involved in the following areas:...Discussing suggestions or concerns of the resident population...."</p> <p>3.1-3(l)</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 observation, interview and record review, the facility failed to</p>	F 0279	<p>F-279 (Developing the plan of care)</p> <ul style="list-style-type: none"> Resident #133's care plan was 	03/29/2016			

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	<p>develop care plans in relation to weight loss and non-pressure skin conditions for 2 of 13 residents reviewed for care plans. (Resident #31 and #133)</p> <p>Findings include:</p> <p>1. Record review was conducted on 02/29/2016 at 1:05 P.M. Resident #133 weights were as follows: 10/05/2015-10/11/2015 - 228 10/12/2015-10/18/2015 - 208 10/19/2015-10/25/2015 - 198 10/26/15-11/01/2015 - 201</p> <p>The nutrition admission care plan for Resident #133 indicated "diet as ordered: regular, no added salt with thin fluids." It further indicated to "monitor meal intakes and report problems to the nurse." There were no other care plans related to nutrition for the resident.</p> <p>The "Clinically at Risk Individual Monitoring Sheet" for Resident #133, dated 10/16/2015, indicated the reason for discussion was weight loss. It further indicated the facility was to monitor the resident's weight weekly and follow the no salt added diet. The monitoring sheet indicated the care plan was up to date.</p> <p>The Interdisciplinary Progress Note, dated 10/20/2015 and completed by the</p>		<p>updated on March 16, 2016, by the DCS to include interventions for weight loss.</p> <p>Resident #31's care plan was updated on March 16, 2016, by the DCS to include non-pressure skin issues.</p> <ul style="list-style-type: none"> · Residents who reside in the facility have the potential to be affected by not ensuring care plans are developed to address the assessed needs of the residents. The DCS/Assistant Director of Clinical Services (ADCS)/ Nurse Manager will review residents identified with weight loss and/or non-pressure skin issues for care plan development March 28, 2016. Any discrepancies identified will be corrected immediately. · The Director of Clinical Services will re-educate the Interdisciplinary Team (IDT) to include: the SSD, AD, Minimum Data Set (MDS) Nurse, ADCS and the Nurse Manager on the facility's comprehensive care plan policy by March 28, 2015. • The Director of Clinical Services/ Nurse Manager will conduct QI monitoring of the regulation F-279 to ensure the development of a comprehensive care plan for residents with weight loss or non-pressure skin issues. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly 	

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	<p>Dietician, indicated Resident #133 was on weekly weights and requested a reweigh to clarify the weight loss.</p> <p>The Interdisciplinary Progress Note, dated 10/28/2015 and completed by the Dietician, indicated Resident #133's current body weight was 201 pounds and would continue to be monitored with follow-ups as needed.</p> <p>During an interview on 02/29/2016 at 1:36 P.M., the DON (Director of Nursing) indicated the MDS (Minimum Data Set) Coordinator should have created a care plan that included Resident #133's weight loss.</p> <p>During an interview on 02/29/2016 at 1:53 P.M., the MDS (Minimum Data Set) Coordinator indicated the facility had 21 days after a resident was admitted to create working care plans. She further indicated the initial care plans only covered the first 21 days of a resident's stay. The MDS Coordinator indicated health services completed the dietary care plans and there should have been one if there was weight loss.</p> <p>During an interview on 03/01/2016 at 10:50 A.M., the Dietician indicated they tried to create a care plan for each resident within the first few weeks of</p>		<p>for four weeks, then monthly for three months using a sample size of five random residents. The Director of Clinical Services, Assistant Director of Clinical Services or Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>Date of Compliance: March 29, 2016</p>				

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	<p>admission. The Dietician further indicated, during Resident #133's stay, they had been in a transition period of who was taking care of the charting and paperwork and that Resident #133 must have been missed.</p> <p>2. During an observation on 02/25/2016 at 11:21 A.M., Resident #31 was sitting on the edge of his bed. Resident #31 had a strong body odor.</p> <p>During an interview on 02/26/2016 at 11:58 A.M., Licensed Practical Nurse (LPN) #4 indicated Resident #31 had a strong body odor from the non-pressure skin issues under the skin folds and was to receive daily treatments of Nystop topical powder to the abdominal fold, perineum and bilateral groin. LPN #4 further indicated Resident #31 came to the facility with the non-pressure skin fold issues.</p> <p>During an interview on 02/26/2016 at 1:03 P.M., the Minimum Data Set (MDS) Coordinator indicated, if Resident #31 had skin issues, they would be care planned by the Director of Nursing (DON) or a wound nurse.</p> <p>During an interview on 02/26/2016 at 1:35 P.M., LPN #4 indicated non-pressure skin issues were supposed to be care planned on acute care plans.</p>			

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	<p>Resident #31 had the skin fold issues since admission. LPN #4 indicated he/she could not find a non-pressure skin care plan for Resident #31.</p> <p>During an interview on 02/26/2016 at 1:41 P.M., the DON indicated she monitored all pressure ulcer related skin issues and the nursing staff and MDS Coordinator worked together to created non-pressure skin care plans.</p> <p>The quarterly MDS assessments, dated 07/06/2015 and 01/04/2016, were reviewed on 02/26/2016 at 10:20 A.M. The MDS indicated Resident #31 had moisture associated skin damage. The care plan, updated on 2/10/2016, was reviewed. Resident #31 had a care plan for at risk for pressure ulcers, but no care plan for non-pressure skin issues.</p> <p>The current facility policy, titled "Plans of Care" and dated 11/30/2014, was provided by the DON on 03/01/2016 at 4:49 P.M. and was reviewed at that time. The policy indicated, "...An interdisciplinary plan of care will be established for each resident and updated in accordance with state and federal regulatory requirements and on an as needed basis...A Comprehensive plan of care will be developed within seven days after completion of the comprehensive</p>			

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F 0280 SS=D Bldg. 00	<p>assessment...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update the written plan of care related to range of motion services and urinary incontinence for 2 of 13 residents reviewed for care plans. (Resident #37 & #C)</p> <p>Findings include:</p> <p>1. During an interview on 02/29/2016 at 3:37 P.M., Physical Therapist (PT) #6</p>	F 0280	<p>F-280 (Revising the plan of care)</p> <ul style="list-style-type: none"> Resident #37 showed no apparent adverse effects. Resident #37 will be evaluated for Range of Motion program by March28, 2016. Resident #C no longer resides at the facility. Residents who reside in the facility have the potential to be affected by not updating the written plan of care. <p>DCS/Nurse Manager/Therapy</p>	03/29/2016			

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	<p>indicated Resident #37 was seen by Occupational Therapy and Physical Therapy from 10/7/2015 until 10/23/2015. PT #6 indicated Resident #37 was discharged from both Occupational Therapy and Physical Therapy with recommendations for Resident #37 to be placed on the restorative program.</p> <p>During an interview on 02/29/2016 at 3:58 P.M., Certified Nursing Aide (CNA) #9 indicated there were two restorative ROM CNAs and they did the restorative range of motion (ROM) on the locked unit. CNA #9 indicated Resident #37 was currently not on the list to receive restorative care and had not been on the list since admission to the facility.</p> <p>During an interview on 02/29/2016 at 4:05 P.M., the Minimum Data Set (MDS) Coordinator indicated Resident #37 was currently not on therapy case load and should have been on the restorative program.</p> <p>During an interview on 02/29/2016 at 4:15 P.M., the Director of Nursing (DON) indicated there was no care plan for ROM for Resident #37 and therapy care plan had not been updated to reflect ROM services. The DON further indicated during a previous admission the</p>		<p>Director will review residents discharged from therapy in the past thirty (30) days for need for Restorative Program by March 28, 2016. Any issues identified will be corrected immediately.</p> <p>The DCS/Nurse Manager will re-educate the nursing staff on the facility's Range of Motion Policy by March 28, 2016.</p> <p>The DCS/Nurse Manager will review and update, as indicated, the plan of care for those residents with urinary incontinence by March 28, 2016.</p> <p>The DCS/Nurse Manager will re-educate the licensed nursing staff on the facility's care plan policy.</p> <ul style="list-style-type: none"> The DCS/Nurse Manager will conduct QI monitoring of the regulation F-280 to ensure resident's written plan of care is updated related to range of motion services and urinary incontinence. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The Director of Clinical Services, Assistant Director of Clinical Services or Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. Date of Compliance: March 29, 2016 				

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	<p>resident had refused ROM. During the current admission the resident was not offered the ROM program, "however the resident does refuse care on a regular basis". The DON indicated she could not find a care plan for refusal of care.</p> <p>During an interview on 02/29/2016 at 4:47 P.M., Resident #37 indicated he enjoyed therapy when he was going, but due to lack of improvement he was discharged. Resident #37 indicated staff only moved his leg or arm when sliding his clothing on or turning him in bed.</p> <p>During an interview on 03/01/2016 at 9:02 A.M., the Director of Therapy indicated Resident #37 was recommended to be on restorative range of motion to maintain or prevent a decrease in range of motion.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 10/13/2015, indicated Resident #37 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was alert and oriented. The diagnoses included, but were not limited to, cerebrovascular accident and hemiplegia. The resident required extensive assistance of two staff members for transfer between surfaces and required only supervision with eating. Compared</p>			

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	<p>to the quarterly MDS (Minimum Data Set) assessment, dated 01/18/2016, which indicated Resident #37 was completely dependant on staff for transfer between surfaces and required extensive assistance of one staff for eating.</p> <p>2. The closed clinical record for Resident #C was reviewed on 02/29/2016 at 1:48 P.M., the diagnoses for Resident #C included, but were not limited to, hemiplegia and diabetes.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 01/15/2016, indicated Resident #C was always incontinent of bladder.</p> <p>The Bladder and Bowel report, dated 01/09/2016 through 01/15/2016, indicated Resident #C was incontinent of bladder every day.</p> <p>Resident #C's Urinary Incontinence Care Plan, which was initiated on 10/26/2015 and revised on 01/24/2016, indicated Resident #C was occasionally incontinent of urine.</p> <p>During an interview on 03/01/2016 at 1:09 P.M., the MDS Coordinator indicated Resident #C's assessment was done based on the seven day look back. The resident had a change from</p>			

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F 0282 SS=D Bldg. 00	<p>occasionally incontinent to always incontinent of urine. The MDS Coordinator indicated the care plan for urinary incontinence should have been revised based on the MDS findings and the CNA bladder reports.</p> <p>The current facility policy, titled "Plans of Care" and dated 11/30/2014, was provided by the DON on 03/01/2016 at 4:49 P.M. and was reviewed at that time. The policy indicated, "...The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical mental and psychosocial well-being..."</p> <p>3.1-35(c)(1) 3.1-35(d)(2)(b)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>			

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to follow the resident care plan as written related to dialysis care and failed to following physician orders related to providing non-pressure skin treatments for 2 of 13 residents reviewed for care plans and physician orders. (Resident #31 and #102)</p> <p>Findings include:</p> <p>1. Record review for Resident #102 was conducted on 02/26/2016 at 12:53 P.M. The Minimum Data Set (MDS) assessment, dated 01/31/2016, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively alert and oriented. The Resident had an admitting diagnosis of acute kidney injury.</p> <p>Resident #102's care plan indicated the resident required renal dialysis. The approaches included, but were not limited to, complete the pre and post dialysis communication form and observe the resident's shunt for patency.</p> <p>The "Dialysis Communication Record" sheets were provided by the DON</p>	F 0282	<p>F-282 (Services by Qualified Personnel)</p> <ul style="list-style-type: none"> Resident #102 showed no apparent adverse effects. Resident #102's dialysis site will be assessed and vital signs taken before and after dialysis. Resident #31 had Nystop topical powder applied to the abdominal fold, perineum and bilateral groin on March 1, 2016 by licensed nurse and Treatment and Medication Administration Record was initialed. Those who reside in the facility have the potential to be affected by this alleged deficient practice. The DCS/ Nurse Manager will re-educate the licensed nurses on the facility's Clinical/Medical Records Policy to include the timeliness of treatments and the Coordination of Hemodialysis Services Policy by March 28, 2016. The DCS/Nurse Manager will conduct QI monitoring of the regulation F-282 to ensure the resident's plan of care is followed, treatments are administered per the physician's order and resident's receiving dialysis are assessed pre and post visit. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The Director of Clinical 	03/29/2016

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	<p>(Director of Nursing) on 03/01/2016 at 9:24 A.M. The following dates had incomplete vital signs or assessments:</p> <p>02/03/2016 - no post dialysis vital signs or site assessment 02/05/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment 02/08/2016 - no post dialysis vital signs or site assessment 02/10/2016 - no pre dialysis site assessment, no post dialysis site assessment 02/15/2016 - no post dialysis vital signs or site assessment 02/17/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment 02/22/2016 - no post dialysis vital signs or site assessment 02/24/2016 - no pre dialysis site assessment, no post dialysis site assessment 02/26/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment</p> <p>During an interview on 03/01/2016 at 9:00 A.M., LPN #1 indicated Resident #102 went to dialysis three days a week. She further indicated vital signs were completed before the resident was sent to dialysis and put on the communication</p>		<p>Services, Assistant Director of Clinical Services or Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <ul style="list-style-type: none"> Date of Compliance: March 29, 2016 				

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	<p>form. The form went with the resident to the dialysis center. When the resident got back another set of vital signs was completed. LPN #1 indicated Resident #102's dialysis site was supposed to be assessed before the resident went to dialysis and when he returned and that was also supposed to be documented on the communication form. Upon looking through the dialysis record, the LPN indicated she didn't know why there was no documentation.</p> <p>During interviews on 03/01/2016 at 9:14 A.M. and 10:02 A.M., the DON (Director of Nursing) indicated the nurses completed the dialysis communication form, which included taking vital signs and assessing the dialysis site, and sent it with the resident to dialysis. She indicated the dialysis center would usually attach a printout of the resident's dialysis session to the communication form and upon return, the nurse would take the resident's vital signs, assessed the dialysis site, and make sure there was no pain or bleeding. The DON indicated she could not find anything in the nurse's notes documenting Resident #102's dialysis site was assessed and there were no vital signs documented for the post dialysis assessments.</p> <p>During an interview on 03/01/2016 at</p>			

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	<p>11:41 A.M., Resident #102 indicated the nurses had not been checking his vital signs or assessing his dialysis catheter when he returned from dialysis.</p> <p>2. The clinical record for Resident #31 was reviewed on 02/26/2016 09:41 A.M. The current physician order initiated on 05/22/2013, indicated Nystop 100,000 units gram powder was to be applied with a light coat to abdominal fold, perineum, and bilateral groin daily and as needed for redness.</p> <p>Review of the "Treatment Administration Record" (TAR), dated December 1, 2015 through February 25, 2016, under treatments indicated Resident #31 was to receive Nystop 100,000 units/gram powder to abdominal fold, perineum, and bilateral groin daily and as needed for redness.</p> <p>The "Treatment Administration Record" (TAR) for Nystop application contained no documentation for the following dates: December 5, 6, 7, 11, 12, 14 - 21, 25, 2015, January 22, 27, 28, and February 16, 17, 19, 23, 24, 25, 2016.</p> <p>During an interview on 02/26/2016 at 11:58 A.M., Licensed Practical Nurse (LPN) #4 indicated Resident #31 was to receive daily treatments of Nystop topical powder to the abdominal fold, perineum</p>			

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F 0309 SS=D Bldg. 00	<p>and bilateral groin. LPN #4 further indicated she/he could only confirm treatments were provided when nursing staff initialed the TAR.</p> <p>During an interview on 03/01/2016 at 9:23 A.M., the Medical Records officer indicated the nurses were required to sign when providing treatments on the TAR.</p> <p>During an interview on 03/01/2016 at 10:56 A.M., the Director of Nursing (DON) indicated the documentation for treatments should have been on the TAR and there was no other place the treatments would have been documented. The DON further indicated nursing staff must initial the TAR when a treatment had been provided.</p> <p>The current facility policy, titled "Plans of Care" and dated 11/30/2014, was provided by the DON on 03/01/2016 at 4:49 P.M. and was reviewed at that time. The policy indicated, "...Direct care staff should...follow their Resident's Plan of Care...."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility</p>			

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	<p>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 interview and record review, the facility failed to provide the necessary services to ensure appropriate dialysis care for 1 of 1 residents reviewed for dialysis. (Resident #102)</p> <p>Findings include:</p> <p>Record review for Resident #102 was conducted on 02/26/2016 at 12:53 P.M. The Resident had a BIMS (Brief Interview for Mental Status) of 15, indicating the resident was cognitively alert and oriented. The Resident had an admitting diagnosis of acute kidney injury.</p> <p>The "Dialysis Communication Record" sheets were provided by the DON (Director of Nursing) on 03/01/2016 at 9:24 A.M. The following dates had incomplete vital signs or assessments:</p> <p>02/03/2016 - no post dialysis vital signs or site assessment 02/05/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment 02/08/2016 - no post dialysis vital signs</p>	F 0309	<p>F-309 (Care and Services including coordinating services with Dialysis Center)</p> <ul style="list-style-type: none"> Resident #102 showed no apparent adverse effects. . Residents receiving dialysis services have the potential to be affected by this alleged deficient practice. The DCS/ Nurse Manager will re-educate licensed nurses on the facility's Coordination of Hemodialysis Services Policy by March 28, 2016. The DCS? Nurse Manager will conduct QI monitoring of the regulation F-309 to ensure residents receiving dialysis services are assessed pre and post visit. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. TheDCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. <p>Date of Compliance: March 29, 2016</p>	03/29/2016

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	<p>or site assessment 02/10/2016 - no pre dialysis site assessment, no post dialysis site assessment 02/15/2016 - no post dialysis vital signs or site assessment 02/17/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment 02/22/2016 - no post dialysis vital signs or site assessment 02/24/2016 - no pre dialysis site assessment, no post dialysis site assessment 02/26/2016 - no pre dialysis site assessment, no post dialysis vital signs or site assessment</p> <p>The current facility policy, titled "Coordination of Hemodialysis Services" and dated 11/30/2016, was provided by the DON on 03/01/2016 at 10:00 A.M. and was reviewed at that time. The policy indicated, "...The Dialysis Communication form will be initiated by the facility...Nursing will collect and complete the information regarding the resident...The facility will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's Clinical record..."</p> <p>During an interview on 03/01/2016 at</p>			

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	<p>9:00 A.M., LPN #1 indicated Resident #102 went to dialysis three days a week. She further indicated vital signs were completed before the resident was sent to dialysis and put on the communication form, the form went with the resident to the dialysis center, and when the resident got back another set of vitals was completed. LPN #1 indicated Resident #102's dialysis site was supposed to be assessed before the resident went to dialysis and when he returned and that was also supposed to be documented on the communication form. Upon looking through the dialysis record, the LPN indicated she didn't know why there was no documentation.</p> <p>During interviews on 03/01/2016 at 9:14 A.M. and 10:02 A.M., the DON (Director of Nursing) indicated the nurses completed the dialysis communication form, which included taking vitals and assessing the dialysis site, and sent it with the resident to dialysis. She indicated the dialysis center would usually attach a printout of the resident's dialysis session to the communication form and upon return, the nurse would take the resident's vitals, assessed the dialysis site, and made sure there was no pain or bleeding. The DON indicated she could not find anything in the nurse's notes documenting Resident #102's dialysis site was assessed</p>			

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F 0318 SS=D Bldg. 00	<p>and there were no vital signs documented for the post dialysis assessments.</p> <p>During an interview on 03/01/2016 at 11:41 A.M., Resident #102 indicated the nurses had not been checking his vital signs or assessing his dialysis catheter when he returned from dialysis.</p> <p>3.1-37(a)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION 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. Based on interview and record review, the facility failed to ensure a resident with limited range of motion received restorative range of motion to prevent further decline in range of motion for 1 of 1 resident reviewed for range of motion. (Resident #37)</p> <p>Findings include:</p> <p>1. The admission Minimum Data Set (MDS) assessment, dated 10/13/2015, indicated Resident #37 had a BIMS score of 14, and was alert and oriented. The</p>	F 0318	<p>F-318 (ROM) • Resident #37 showed no apparent adverse effects. Resident #37 will be evaluated for Range of Motion program by therapy by March 28, 2016. • Residents with limited range of motion have the potential to be affected by this alleged deficient practice. DCS/Nurse Manager/Therapy Director will review residents discharged from therapy in the past thirty (30) days for need for Restorative Program by March 28, 2016. Any issues identified will be corrected immediately. • The DCS/Nurse Manager will</p>	03/29/2016

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	<p>diagnoses included but were not limited to: Cerebrovascular Accident and hemiplegia. The resident had limited range of motion on one upper extremity and one lower extremity. The resident required extensive assistance of two staff members for transfer between surfaces and required only supervision with eating. Compared to the quarterly MDS (Minimum Data Set) assessment, dated 01/18/2016, which indicated Resident #37 was completely dependant on staff for transfer between surfaces and required extensive assistance of one staff for eating.</p> <p>During an interview on 02/29/2016 at 3:37 P.M., Physical Therapist (PT) #6 indicated Resident #37 was seen by Occupational Therapy and Physical Therapy from 10/7/2015 until 10/23/2015. PT #6 indicated Resident #37 was discharged from both Occupational Therapy and Physical Therapy with recommendations for Resident #37 to be placed on the restorative program.</p> <p>During an interview on 02/29/2016 at 3:58 P.M., CNA #9 indicated Resident #37 was currently not on the list to receive restorative care and had not been on the list since admission to the facility.</p>		<p>re-educate the nursing staff on the facility's Range of Motion Policy by March 28, 2016. • The DCS/ Nurse Manager will conduct QI monitoring of the regulation F-318 to ensure residents with limited range of motion receive services to prevent further decline. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCS will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring. Date of Compliance: March 29, 2016</p>		

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	<p>During an interview on 02/29/2016 at 4:05 P.M., the Minimum Data Set (MDS) officer indicated Resident #37 was currently not on the therapy case load and should have been on the restorative program.</p> <p>During an interview on 02/29/2016 at 4:15 P.M., the Director of Nursing (DON) indicated, during a previous admission, the resident had refused range of motion (ROM) therapy. During this admission the resident was not offered the ROM program, "however the resident does refuse care on a regular basis". The DON indicated she could not find a care plan for refusal of care.</p> <p>During an interview on 02/29/2016 at 4:28 P.M., the MDS Coordinator indicated she was not aware of Resident #37 refusing care. The MDS Coordinator indicated she would usually be advised if a resident was refusing care and a resident whom was resisting care would be brought up in the morning meetings.</p> <p>During an interview on 02/29/2016 at 4:42 P.M., The Social Service Director (SSD) indicated she was not aware of Resident #37 refusing care.</p> <p>During an interview on 02/29/2016 at 4:47:13 P.M., Resident #37 indicated he</p>			

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F 0364 SS=E Bldg. 00	<p>enjoyed therapy but he was no longer going to therapy. The resident further indicated staff were not moving his arm or leg in a regular movement other than sliding his clothes on. The resident indicated he would like for the staff to work his arm and leg.</p> <p>During an interview on 03/01/2016 at 9:02 A.M., The Director of Therapy indicated Resident #37 was recommended to be on restorative range of motion to maintain or prevent a decrease in range of motion.</p> <p>3.1-42(a)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed ensure palatable temperatures were maintained during meal services and to honor resident preferences related to food choices. This deficient practice affected 9 of 16 residents reviewed for food choices</p>	F 0364	<p>F-364 (Food Palatability)</p> <ul style="list-style-type: none"> Residents #117, #62, #37, #15, #6, #290, #71 and #38 suffered no physical harm as a result of unpalatable or cold foods or receiving food not on their tray card. Residents served from the 	03/29/2016

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	<p>and 2 of 4 meal test trays. (Resident #6, #15, #24, # 37, #38, #62, #71, #117, and #290)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an interview on 02/24/2016 at 3:25 P.M., Resident #117 indicated food was cold in the mornings. 2. During an interview on 02/25/2016 at 10:55 A.M., Resident #62 indicated the food was cold most of the time. 3. During an interview on 02/25/2016 at 11:25 A.M., Resident #37 indicated the food was "yucky" and the food was cold on several occasions. Resident #37 also indicated he did not like greens and his plate was always full of greens. CNA #8 indicated Resident #37 received greens on his tray regularly. 4. During an interview 02/25/2016 at 2:27 P.M., Resident #15 indicated the food was often cold. 5. During an interview on 02/24/2016 at 2:12 P.M., Resident #6 indicated food was often cold in the morning, especially the eggs and the oatmeal. Resident # 6 also indicated she often did not receive her cottage cheese with breakfast and when she asked for something it often 		<p>kitchen have the potential to be affected by this alleged deficient practice. The Regional Dietary Manager conducted a review of meal trays for nutritive value, appearance, palatability and acceptable foodtemperature on February 26, 2016 with satisfactory results.</p> <ul style="list-style-type: none"> • The Regional Dietary Manager/Dietary Manager will re-educate the Dietary Department on the facility's policy Proper Tray Card Accuracy by March 28, 2016. • The ED/Dietary Manager will perform QI monitoring of regulation F-364 to ensure that food is delivered and served in a manner that maintains resident choice, nutritive value, appearance, palatability, and acceptable food temperature. QI monitoring will be conducted one time per day, 5 days per week for four weeks, at alternating meals; then one time per day, 4 days per week for four weeks, at alternating meals; then one time per day, 3 days per week for four weeks, at alternating meals; then one time per day, 2 days per week for four weeks, at alternating meals; then one time per day, 1 day per week for four weeks, at alternating meals; then 1 time per week, for four weeks, at alternating meals and/or until substantial compliance is obtained. The ED/ Dietary Manager will report findings to the QAPI Committee meetings. The QAPI Committee will determine 	

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	<p>didn't get brought to her.</p> <p>During an interview 02/26/2016 at 11:21 A.M., Resident #6 indicated she often got cornflakes with her meal, even though her ticket indicated she wasn't supposed to get them.</p> <p>Resident meal tickets were provided by the Administrator on 02/29/2016 at 10:40 A.M. The meal ticket for Resident #6 indicated "No Corn Flakes" in bold at the top of the meal ticket. Corn flakes were listed to be served on the breakfast meal ticket. The meal ticket also indicated cottage cheese at every meal.</p> <p>6. During a confidential interview on 02/25/2016 at 9:54 A.M., Resident #290 indicated the food was often cold. Resident #290 indicated they had yet to receive a meal that didn't have items missing. The resident indicated they had ordered the soup of the week every day for more than a week and had only received it twice. Resident #290 indicated when they marked on their menu they didn't want an item, it was put on the plate anyway. The resident further indicated this was an everyday occurrence.</p> <p>7. During an observation on 02/25/2016 at 12:35 P.M., a lunch meal tray was</p>		<p>substantial compliance, determine if further action needs to be taken, and determine the continued time schedule for further monitoring.</p> <ul style="list-style-type: none"> Date of compliance: March 29, 2016 	

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	<p>tested for temperature and taste. The pureed broccoli was 124 degrees Fahrenheit upon arrival. The pureed broccoli was lukewarm to taste.</p> <p>8. During an observation on 02/26/2016 at 8:57 A.M., a breakfast meal tray was tested for temperature and taste. The egg omelet was 116.8 degrees Fahrenheit and the oatmeal was 116 degrees Fahrenheit upon arrival. The egg omelet and oatmeal were both lukewarm to taste.</p> <p>During an interview at 02/26/2016 at 8:35 A.M., the DM (Dietary Manager) indicated the food service was taking a longer time and she was worried the food would not be a good temperature.</p> <p>9. During an interview on 02/25/2016 at 2:38 P.M., Resident #71 indicated the facility did not follow the menu and she often received food different than what she chose for her meal.</p> <p>10. During an interview on 02/25/2016 at 3:58 P.M., Resident #38 indicated they didn't usually get the food they wanted or ordered.</p> <p>11. During an interview on 02/29/2016 at 5:27 P.M., CNA #8 indicated Resident #24 received mashed potatoes nearly every day, but it was on his meal ticket</p>			

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F 0514	<p>not to receive mashed potatoes. The CNA further indicated the CNA's were not allowed to talk to the kitchen staff about incorrect meals, that they were supposed to tell the nurse on the unit about the problem.</p> <p>During an observation and interview on 03/01/2016 at 12:13 P.M., Resident #24's meal was delivered to the B hall dining room. The resident's meal ticket indicated, in bold, for the resident to not receive mashed potatoes and to have pudding with all meals. CNA #2 indicated there was no pudding on the resident's tray.</p> <p>The current facility policy, titled "Food Preferences & Preliminary Dietary Fact Sheet" and dated 11/30/2014, was provided by the ADON (Assistant Director of Nursing) on 03/01/2016 at 12:18 P.M. It was reviewed at that time. The policy indicated, "...The Resident's food preferences will be considered at meal service time, unless medically contraindicated...."</p> <p>3.1-3(u)(3) 3.1-21(a)(2)</p> <p>483.75(l)(1)</p>			

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SS=E Bldg. 00	<p>RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation interview and record review, the facility failed to complete documentation related to venous access line flushes, skin assessments and skin treatments. This had the potential to affect 6 of 15 residents reviewed for documentation. (Residents #31, 57, 84, 87, 100, 102)</p> <p>Findings include:</p> <p>Treatment records and skin assessment records were provided by the Administrator on 02/26/2016 at 1:25 P.M. for Residents #57, 84, 87, 100, and 102 and reviewed at that time.</p> <p>1. A treatment record for Resident #84, with an order start date of 12/29/2015, indicated his arterial access line was to be flushed every 24 hours with normal</p>	F 0514	<p>F-514 (Records – Complete/Accurate/Accessible)</p> <ul style="list-style-type: none"> Residents #31, 57, 84, 87, 100, and 102 suffered no apparent physical harm as a result of incomplete documentation. Those who reside in the facility have the potential to be affected by incomplete documentation. <p>By March 28, 2015, current in-house residents receiving skin treatments will have their current treatment administration record (TAR) and physician's orders reviewed by the DCS/ Nurse Manager. Any issues identified will be corrected immediately.</p> <p>By March 28, 2016, current in-house residents with venous access lines will have their current medication administration record (MAR) and physician's orders reviewed by the</p>	03/29/2016

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	<p>saline. Documentation from February 1, 2016 to February 25, 2016, was initialed on February 4, 6, 11, 15, 20, and 25, 2016, indicating it had been flushed on those days. The other 19 days out of the 25 in that time frame were left blank.</p> <p>A treatment record for Resident #84, with an order start date of 11/10/2015, indicated weekly skin checks should be completed on Wednesdays. The date of 2/10/2016 was left blank as was the, "Weekly Skin Integrity Review," assessment for that date. The, "Weekly Skin Integrity Review," assessment was also left blank on 02/24/2016.</p> <p>2. A treatment record for Resident #102, with an order start date of 02/17/2016, indicated a treatment of steri strips, telfa, and kerlix to a skin tear on the right lower extremity changed daily and as needed. Documentation from February 17, 2016 to February 25, 2016, was initialed on February 17, 23, and 25, 2016, indicating it had been changed on those days. The other 6 of the 9 days in that time frame were left blank.</p> <p>A treatment record for Resident #102, with an order start date of 11/02/2015, indicated weekly skin checks should be completed on Mondays. The date of February 1, 2016 was left blank as was</p>		<p>DCS/Nurse Manager. Any issues identified will be corrected immediately.</p> <p>By March 28, 2016, the DCS/Nurse Manager will re-educate the licensed nursing staff on the facility's Clinical Medical records policy emphasis will be placed on maintaining a complete and accurate medical record. The DCS/Nurse Manager will re-educate the licensed nursing staff on the facility's weekly skin assessment policy by March 28, 2016.</p> <p>The DCS/ Nurse Manager will conduct QI monitoring of the regulation F-514 to ensure complete documentation related to skin assessments, medication and treatment administration records. QI monitoring will be conducted five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months using a sample size of five random residents. The DCSwill report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> <p>Date of Compliance: March 29, 2016</p>		

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	<p>the, "Weekly Skin Integrity Review" assessment for that date.</p> <p>3. A treatment record for Resident #57, with an order start date of 01/31/2016, indicated skin prep to right lateral ankle every shift. Documentation from February 1, 2016 to February 25, 2016, was left blank on 7 out of 75 shifts throughout that time frame.</p> <p>A treatment record for Resident #57, with an order start date of 03/18/2015, indicated weekly skin checks should be completed on Fridays. The date of February 5, 2016 was left blank as was the, "Weekly Skin Integrity Review," assessment for that date.</p> <p>4. A treatment record for Resident #100, with an order start date of 09/13/2014, indicated periguard ointment applied every shift and as needed to pink/reddened areas on right inner thigh and buttocks. Documentation from February 1, 2016 to February 25, 2016, was left blank on 6 out of 75 shifts throughout that time frame</p> <p>A treatment record for Resident #100, with an order start date of 03/25/2015, indicated weekly skin checks should be completed on Wednesdays. The dates of February 10 and 24, 2016 were left blank</p>			

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	<p>as were the, "Weekly Skin Integrity Review," assessments for those dates.</p> <p>5. A treatment record for Resident #87, with an order start date of 01/21/2015, indicated nystop powder applied to abdominal and breast folds two times a day for redness. Documentation from February 1, 2016 to February 25, 2016, was left blank 4 out of 50 times throughout that time frame</p> <p>A treatment record for Resident #87, with an order start date of 11/21/2014, indicated weekly skin checks should be completed on Saturdays. The date of February 13, 2016 was left blank as was the, "Weekly Skin Integrity Review" assessment for that date.</p> <p>During an interview on 03/01/2016 at 4:00 P.M., the DON (Director of Nursing) indicated all skin assessments and treatments are documented in the TAR (Treatment Administration Record) and documentation on the, "Weekly Skin Integrity Review", should be check marked on, "Skin Intact" or written in, "No skin issues," if none were found.</p> <p>6. The clinical record for Resident #31 was reviewed on 02/26/2016 09:41 A.M., the current physician order initiated on 05/22/2013 indicated Nystop 1000,000 units gram powder to be applied with a</p>			

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	<p>light coat to abdominal fold, perineum, & bilateral groin daily and as needed for redness.</p> <p>The "Treatment Administration Record" for Nystop application contained no documentation for the following dates: December 5, 6, 7, 11, 12, 14 - 21, 25, 2015, January 22, 27, 28, and February 16, 17, 19, 23, 24, 25, 2016. There were 14 days out of 31 days in December 2015, 3 days out of 31 days in January 2016, and 6 days out of 29 days in February 2016 that the treatment was not documented as being provided.</p> <p>During an interview on 03/01/2016 at 9:23 A.M., the Medical Records officer indicated there had been holes in the nursing documentation. The nursing staff were required to sign off from shift to shift as a corrective measure.</p> <p>During an interview on 03/01/2016 at 10:56 A.M., the Director of Nursing (DON) indicated the documentation for treatments should have been on the TAR and there was no other place the treatments would have been documented. The DON further indicated nursing staff must initial the TAR when a treatment had been provided.</p> <p>3.1-50(a)(1)</p>			

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F 0520 SS=D Bldg. 00	<p>3.1-50(f)(2)</p> <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 observation, interview and record review, the facility failed to identify concerns and successfully implement a plan of action to correct quality deficiencies related to complete and accurate documentation, food</p>	F 0520	<p>F520 (QAA Committee-Members/Meet Quarterly/Plans)</p> <ul style="list-style-type: none"> Residents #117, #62, #37, #15, #6, #290, #71 and #38 suffered no physical harm as a result of unpalatable or cold foods or 	03/29/2016

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	<p>services and responding to resident grievances. This deficient practice had the potential to affect 11 plus resident council attendees of the 100 residents in the facility.</p> <p>Findings include:</p> <p>1. The "Treatment Administration Record" for Resident #31's daily Nystop application contained no documentation for the following dates: December 5, 6, 7, 11, 12, 14 - 21, 25, 2015, January 22, 27, 28, and February 16, 17, 19, 23, 24, 25, 2016.</p> <p>A treatment record for Resident #84, with an order start date of 12/29/2015, indicated his arterial access line was to be flushed every 24 hours with normal saline. Documentation from February 1, 2016 to February 25, 2016 was initialed on February 4, 6, 11, 15, 20, and 25, 2016, indicating it had been flushed on those days. All other days in that time frame were left blank.</p> <p>A treatment record for Resident #84, with an order start date of 11/10/2015, indicated weekly skin checks should be completed on Wednesdays. The date of February 10, 2016 was left blank as was the "Weekly Skin Integrity Review" assessment for that date. The, "Weekly</p>		<p>receiving food not on their tray card.</p> <p>Residents #31, 57, 84, 87, 100, and 102 suffered no apparent physical harm as a result of incomplete documentation.</p> <ul style="list-style-type: none"> Residents who reside in the facility had the potential to be affected by this alleged deficient practice. <p>The Executive Director (ED) will review 5 months (11/2015-3/2016) of Resident Council meeting minutes by March 28, 2016 for unresolved grievances. Any issues identified will be addressed immediately.</p> <p>The Regional Dietary Manager conducted a review of meal trays for nutritive value, appearance, palatability and acceptable food temperature on February 26, 2016 with satisfactory results.</p> <p>By March 28, 2015, current in-house residents receiving skin treatments will have their current treatment administration record (TAR) and physician's orders reviewed by the DCS/ Nurse Manager. Any issues identified will be corrected immediately.</p> <p>By March 28, 2016, current in-house residents with venous access lines will have their current medication administration record (MAR) and physician's orders reviewed by the DCS/Nurse Manager. Any issues identified will be corrected immediately.</p>	

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	<p>Skin Integrity Review," assessment was also left blank on 02/24/2016.</p> <p>A treatment record for Resident #102, with an order start date of 02/17/2016, indicated a treatment of steri strips, telfa, and kerlix to a skin tear on the right lower extremity changed daily and as needed. Documentation from February 17, 2016 to February 25, 2016 was initialed on February 17, 23, and 25, 2016, indicating it had been changed on those days. All other days in that time frame were left blank.</p> <p>A treatment record for Resident #102, with an order start date of 11/02/2015, indicated weekly skin checks should be completed on Mondays. The date of February 1, 2016 was left blank as was the "Weekly Skin Integrity Review" assessment for that date.</p> <p>A treatment record for Resident #57, with an order start date of 01/31/2016, indicated skin prep to right lateral ankle every shift. Documentation from February 1, 2016 to February 25, 2016 was left blank on seven shifts throughout that time frame.</p> <p>A treatment record for Resident #57, with an order start date of 03/18/2015, indicated weekly skin checks should be</p>		<ul style="list-style-type: none"> The ED will re-educate the Department Managers on the facility's QAPI process by March 28, 2016. The Regional Vice-President of Operations (RVPO)/Regional Director of Clinical Services will monitor the QAPI monthly times six months to ensure substantial compliance. A member of the regional team will attend two quarterly QAPI committee meetings. The QAPI committee will determine if further action is indicated. Date of compliance: March 29, 2016 		

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	<p>completed on Fridays. The date of February 5, 2016 was left blank as was the "Weekly Skin Integrity Review" assessment for that date.</p> <p>A treatment record for Resident #100, with an order start date of 09/13/2014, indicated periguard ointment applied every shift and as needed to pink/reddened areas on right inner thigh and buttocks. Documentation from February 1, 2016 to February 25, 2016 was left blank on six shifts throughout that time frame</p> <p>A treatment record for Resident #100, with an order start date of 03/25/2015, indicated weekly skin checks should be completed on Wednesdays. The dates of February 10 and 24, 2016 were left blank as were the "Weekly Skin Integrity Review" assessments for those dates.</p> <p>A treatment record for Resident #87, with an order start date of 01/21/2015, indicated Nystop powder applied to abdominal and breast folds two times a day for redness. Documentation from February 1, 2016 to February 25, 2016 was left blank four times throughout that time frame</p> <p>A treatment record for Resident #87, with an order start date of 11/21/2014,</p>			

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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated weekly skin checks should be completed on Saturdays. The date of February 13, 2016 was left blank as was the "Weekly Skin Integrity Review" assessment for that date.</p> <p>2. During an interview on 02/25/2016 at 2:38 P.M., Resident #71 indicated the facility does not follow the menu and she often receives food different than what she chose for her meal.</p> <p>During an interview on 02/25/2016 at 3:58 P.M., Resident #38 indicated they don't usually get the food they want or ordered.</p> <p>During a confidential interview on 02/25/2016 at 9:54 A.M., Resident #290 indicated they had yet to receive a meal that didn't have items missing. The resident indicated they had ordered the soup of the week every day for more than a week and had only received it twice. Resident #290 indicated when they mark on their menu they don't want an item, it got put on the plate anyway. The resident further indicated this was an everyday occurrence.</p> <p>During an interview 02/26/2016 at 11:21 A.M., Resident #6 indicated she often got cornflakes with her meal, even though her ticket indicated she wasn't supposed</p>			

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	<p>to get them.</p> <p>During an interview on 02/29/2016 at 5:27 P.M., CNA #8 indicated Resident #24 received mashed potatoes nearly every day, but it was on his meal ticket not to receive mashed potatoes. The CNA further indicated the CNA's were not allowed to talk to the kitchen staff about incorrect meals, that they were supposed to tell the nurse on the unit about the problem.</p> <p>3. During an interview on 02/29/2015 at 2:44 P.M., the Activities Director indicated it was her responsibility to write down resident grievances during Resident Council meetings and that she documented every concern that was brought up. She further indicated after the meeting she took the concerns to the Administrator and the Social Services Director. The Social Services Director would then fill out a grievance form for the concerns. The Activities Director further indicated she took the Resident Council Minutes to the head of whichever department listed in the concern and that department would write their plan of action on the form. The Activities Director indicated missing clothing in laundry was a reoccurring concern during Resident Council.</p>			

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	<p>Resident Council Minutes were reviewed, with permission of the Resident Council President, on 02/29/2016 at 1:21 P.M. Concerns regarding missing clothing was brought up in April, May, June, July, September, October, November, December, 2015 and January, February, 2016.</p> <p>During an interview on 03/01/2016 at 4:15 P.M., the DON indicated she and the department heads audit the deficiencies on a regular basis. The DON indicated documentation and treatments were being monitored by management. She further indicated preferences for meals should be honored and override what was planned for the meal, but not the doctor's order.</p> <p>During an interview on 03/01/2016 at 4:17 P.M., the Administrator indicated the facility was aware of several dining concerns, missing laundry, and lack of documentation. The Administrator further indicated the facility was working on the issues but had yet to resolve them.</p> <p>3.1-52(b)(2)</p>				