

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/09/2012
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: March 4, 5, 6, 7, 8, & 9, 2012</p> <p>Facility number: 000077 Provider number: 155157 AIM Number: 100266490</p> <p>Survey team: Angel Tomlinson RN TC Leslie Parrett RN Barbara Gray RN Sharon Lasher RN [March 6, 7, 8, & 9 2012]</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 17 Medicaid: 40 Other: 35 Total: 92</p> <p>Sample: Stage two sample 22</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</u></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	Quality review completed 3/15/12 Cathy Emswiller RN			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician of a resident experiencing pain causing the resident not to be able to get out of</p>	F0157	F157 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R147's primary physician was notified	04/08/2012	

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	<p>bed and not being repositioned due to the pain for 1 of 1 resident's sampled for pain (Resident #47) and failed to notify the physician of a resident who experienced weight loss for 1 of 8 that met the criteria for weight loss in an stage two sample of 22 (Resident #147).</p> <p>Findings include:</p> <p>1.) During observation on 3-6-12 at 11:15 a.m., Resident #47 was in her bedroom lying in bed on her back. Resident #47 indicated she wanted pulled up in her bed. LPN # 17 and CNA #18 assisted the resident up in her bed. The resident remained on her back.</p> <p>Interview with LPN #17 on 3-7-12 at 11:01 a.m., indicated the reason Resident #47 was not assisted out of bed was because when the resident was out of bed, she complained of her bottom hurting and her back hurting. LPN #17 indicated on 3-4-12 the facility staff assisted the resident up and the resident was unable to tolerate being up for 5 minutes due to pain. LPN #17 indicated the resident's physician was aware of the resident's pain, but did not want to give the resident any medication too strong</p>		<p>of the weight loss on 3-27-12. R47's pain assessment was updated on 3-27-12 and physician notified. All licensed Nursing staff have been in serviced on Notification of Change in resident health status and pain assessments. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Facility residents were reviewed to ensure if there was a weight loss or change in pain that they were assessed and physicians notified if indicated. Licensed Nursing staff were in serviced on 3-27-12 on Notification of Change in resident health status and pain assessments. New licensed nursing staff will have education on Notification of Change in resident health status and pain assessments. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing Staff were in serviced on 3-27-12 on Notification of Change in resident health status and pain assessments. New staff will have education on Notification of Change in resident health status and pain. ED and DNS or designee will</p>		

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	<p>because of her age, respiratory status and the resident was frail. LPN #17 indicated the physician ordered the resident Tylenol and an kidder patch. LPN #17 indicated the physician was aware that Resident #47 was unable to get out of bed due to pain.</p> <p>Review of the record of Resident #47 on 3-7-12 at 10:55 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, depression, Chronic Obstructive Pulmonary disease (COPD), congestive heart failure and dementia.</p> <p>The physician orders for Resident #47 dated, 2-9-12 indicated the resident was ordered Tylenol 500 mg every day.</p> <p>The physician recapitulation for Resident #47 dated, February 2012 indicated the resident had an order for Tylenol 650 mg every 4 hours for pain PRN (as needed) and Lidoderm 5% patch every twelve hours everyday for pain.</p> <p>Review of the Medication Administration Record (MAR) for Resident #47 dated March 2012 indicated the resident had not received any Tylenol PRN medication</p>		<p>monitor daily 24 hour reports, nurses notes, concern forms, Clinical Start up, Care Management meetings and morning meetings for Notifications of Change in resident health status and pain 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED and DNS or designee will monitor daily 24 hour reports, nurses notes, concern forms, Clinical Start up, Care Management meetings and morning meetings for Notifications of Change in resident health status and pain 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. Results of audits will be reviewed at monthly QAA meetings for 3 months or until compliant. The audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>for pain.</p> <p>Interview with CNA #18 on 3-8-12 at 11:30 a.m. indicated the reason Resident #47 had not been repositioned in bed was because the resident had too much pain. CNA #18 indicated she had reported to LPN #17 and RN #19 that she was unable to reposition the resident due to pain. CNA #18 indicated she encouraged Resident #47 to lay on her side, but the resident says it hurts too much. When queried if she had attempted to prop the resident on her side with a pillow, CNA #18 indicated she had not and that she would try to prop the resident up with a pillow.</p> <p>Interview with the Director Of Nursing (DON) on 3-8-12 at 11:40 a.m., indicated Resident #47 had an pain assessment on 2-1-12 and it indicated the resident had no pain. The DON indicated if a resident was experiencing pain than an pain monitoring tool would be initiated. The DON indicted Resident #47 did not have a pain monitoring tool. The DON indicated she was not able to find any documentation in February or March 2012 that Resident #47 had been experiencing pain or the resident's physician was notified of the resident experiencing pain.</p>						

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	<p>2.) Review of Resident # 147's record on 3/8 /12 at 4:30 p.m. indicated diagnoses included, but were not limited to, Unspecified hypothyroidism, shortness of breath, diabetes without complications type 2/unspecified not stated uncontrolled, pressure ulcer stage IV and pressure ulcer stage II.</p> <p>The height (in inches) of Resident # 147 was: 68 The Admission Weight Data for this resident was: Date: 01/13/2012; Weight: 128; BMI: 19 Date: 01/30/2012; Weight: 122; BMI: 19 Date: 02/13/2012; Weight: 118; BMI: 18 Date: Unavailable; Weight: Unavailable The resident loss 4.69% from the first weight to the second weight The resident loss 7.81% from the first weight to the third weight. Unable to calculate the weight loss from the first weight to the fourth weight because of unavailable weight.</p> <p>Resident # 147'S Care Plan: dated 1/16/12 indicated, Focus: Inconsistent carbohydrate intake as related to Diabetes Resident has stage 4 and</p>	F0157	<p>F157 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R147's primary physician was notified of the weight loss on 3-27-12. R47's pain assessment was updated on 3-27-12 and physician notified. All licensed Nursing staff have been in serviced on Notification of Change in resident health status and pain assessments. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Facility residents were reviewed to ensure if there was a weight loss or change in pain that they were assessed and physicians notified if indicated. Licensed Nursing staff were in serviced on 3-27-12 on Notification of Change in resident health status and pain assessments. New licensed nursing staff will have education on Notification of Change in resident health status and pain assessments. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing Staff were in serviced on 3-27-12 on Notification of</p>	04/08/2012			

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	<p>stage 2 wounds. Goals: Resident will be free of significant weight changes. Interventions: Diet as ordered medication as ordered monitor meal consumption daily monthly weights house supplement per order fortified soup at lunch and dinner care plan last updated 2/17/12</p> <p>The Dietitian notes dated 2/16/12 indicated the resident's diet was changed to "Puree Con CHO (high fat, low carbohydrate diet) may have mech. soft per request of family. Meal intake avg. 23% and 11% of hs snack... Receives house supplement TID (three times a day) and pureed cottage cheese bid to help provide additional Kcal... Will provide fortified soup at lunch and dinner to help provide additional Kcal. Will request to have physician evaluate for possible appetite stimulant."</p> <p>Review of Resident # 147's record lacked evidence of Physician notification.</p> <p>3.1-5(a)(2)</p>		<p>Change in resident health status and pain assessments. New staff will have education on Notification of Change in resident health status and pain. ED and DNS or designee will monitor daily 24 hour reports, nurses notes, concern forms, Clinical Start up, Care Management meetings and morning meetings for Notifications of Change in resident health status and pain 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: ED and DNS or designee will monitor daily 24 hour reports, nurses notes, concern forms, Clinical Start up, Care Management meetings and morning meetings for Notifications of Change in resident health status and pain 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. Results of audits will be reviewed at monthly QAA meetings for 3 months or until compliant. The audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the Abuse Policy Guidelines for reporting and investigating allegations of abuse, to the State Agency and protecting the resident after an allegation was made 1 of 22 residents reviewed for abuse in the stage 2 sample of 22. (Resident # 159)</p> <p>Findings include:</p> <p>On 3/6/12 at 8:45 a.m. interview with Resident # 159's daughter indicated that on the evening of the Resident's admission on 2/9/12 a staff person came into the Residents room when she called out for help because she could not find the call light. The staff person slapped the call light into the Resident's hand and stated in a hateful manner that "here's the call light" and squeezed resident's hand tightly around call light then stated "we don't yell for help, there are other residents here trying to sleep." Resident # 159 indicated she had requested to speak with the DON.</p>	F0224	<p>F224 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: On the morning of 3/7/12 when the survey team brought the allegation to the attention of the ED, he immediately began an investigation of the alleged abuse. Interviews were conducted with the staff working in the Unit where R159 resides. SSD interviewed the resident. Upon completion of the investigation the facility was unable to substantiate that any alleged abuse had happen. The ED reported the allegation to ISDH on 3-08-12. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: ED reviewed Grievance reports for last 3 months to ensure there were no other potential allegations that needed to be investigated and none were found. Staff was educated on 3-08-12 regarding reporting</p>	04/08/2012	

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	<p>The Resident indicated when the DON and another staff member came into her room the DON introduced herself then left before the Resident could speak with her in private.</p> <p>Interview with Administrator on 3/8/12 at 11:10 a.m. indicated that he received a call from the ADON on 3/15/12 and she indicated that Resident # 159 was "upset and had several complaints such as being left on the bedpan to long, breakfast was cold and a couple of other things." He indicated he was informed about the call light being given to the Resident and what the staff person said but was not informed that the Resident thought the staff person was abusive.</p> <p>On 3/8/12 at 2:00 p.m. interview with Occupational Therapy Assistant (OTA) indicated that Resident # 159 had attempted to talk to the DON but had not talked with her yet. The OTA indicated the Resident was not specific about what she wanted to talk with the DON about. OTA left a note on DON's door on 2/15/12.</p> <p>Review of a document provided by the OTA on 3/8/12 at 2:30 p.m. indicated that Resident # 159 would like to talk with the DON as soon as possible. The Resident indicated to</p>		<p>allegations. ED and DNS were educated by 4-5-12 by Nurse Consultant regarding reporting and investigations. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Staff was educated on 3-08-12 regarding reporting allegations. ED and DNS were educated by 4-5-12 by Nurse Consultant regarding reporting and investigations. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: All allegations and investigations reported to ISDH will be reviewed during monthly QAA meetings until compliant. All allegations will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>the OTA that she had asked for this before and was introduced to the DON but was never given the chance to discuss a concern she had. The OTA indicated she had explained to the Resident that the DON was not available until Thursday and that she would leave a note for the DON's return on Thursday.</p> <p>Document indicated OTA had filled out grievance form regarding 3 complaints Resident # 159 had voiced to her and that what she wanted to discuss with the DON was separate from the issues she had discussed with the OTA.</p> <p>On 3/8/12 at 5:15 p.m. interview with RN # 8 indicated she was on the unit on 2/9/12 and was sitting at the nurses station, she indicated it was "between 10:30 p.m. and 11:00 p.m. because it was shift change." She indicated that "she heard Resident # 159 call out for help and saw RN # 7 go into Resident # 159's room and heard her state to the Resident that "we don't yell out" this was not said in a mean or hateful way."</p> <p>3/9/12 at 2:30 p.m. interview with the DON indicated she received a phone call on 2/15/12 from the ADON. "ADON told me that there was a note on my door and since she knew I was</p>				

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	<p>out of town she read the note and it was in regards to Resident # 159. The Resident had some complaints and one of them was she was yelling out and someone told her to not be yelling out. The Administrator was sitting next to me at a meeting when I received the call and was informed of the incident. We discussed the matter with the ADON and determined it did not sound like abuse. We instructed her to write the concerns on a grievance form and have the unit manager to follow up for a couple of weeks to make sure there were no more concerns. I went to the Resident's room with unit manager to check on the resident. Her daughter was taking about different staff members good and bad. The daughter made a statement that she liked the unit manager and she was doing a good job. The Resident did not inform the staff that she felt the staff person who told her about the call light did so in a mean or hateful manner." The DON did not follow up as she was unaware the Resident felt abuse had occurred.</p> <p>Review of a document provided by the Administrator on 3/8/12 at 6:00 p.m. indicated "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving</p>				

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	<p>Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property..."</p> <p>"Resident protection: if the suspected perpetrator is an associate... the ED places the associate on immediate investigatory suspension while completing the investigation. It is explained to the associate that if the investigation results do not require suspension or termination, the associate may be allowed to return to work and any scheduled days missed during the suspension time may be paid... The results of the investigation will determine the future contact with the resident."</p> <p>"Investigation: All investigations shall be conducted by the ED or DNS. In the event an alleged violation occurs when neither of these people is in the facility, the charge nurse is responsible for initiating the investigation procedure..."</p> <p>3.1-27(a)(3)</p>				

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE 1042 OAK DR RICHMOND, IN 47374			
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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to follow the Abuse</p>	F0225	F225The corrective actions accomplished for those residents found to have been	04/08/2012			

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	<p>Policy Guidelines for reporting allegations of abuse and protecting the resident after allegation was made to the State Agency for 1 of 22 residents reviewed for abuse in the stage 2 sample of 22. (Resident # 159)</p> <p>Findings include:</p> <p>On 3/6/12 at 8:45 a.m. interview with Resident # 159's daughter indicated that on the evening of the Resident's admission on 2/9/12 a staff person came into the Residents room when she called out for help because she could not find the call light. The staff person slapped the call light into the Resident's hand and stated in a hateful manner that "here's the call light" and squeezed resident's hand tightly around call light then stated "we don't yell for help, there are other residents here trying to sleep." Resident # 159 indicated she had requested to speak with the DON. The Resident indicated when the DON and another staff member came into her room the DON introduced herself then left before the Resident could speak with her in private.</p> <p>Interview with Administrator on 3/8/12 at 11:10 a.m. indicated that he received a call from the ADON on 3/15/12 and she indicated that</p>		<p>affected by the deficient practice are as follows: On the morning of 3/7/12 when the survey team brought the allegation to the attention of the ED, he immediately began an investigation of the alleged abuse. Interviews were conducted with the staff working in the Unit where R159 resides. SSD interviewed the resident. Upon completion of the investigation the facility was unable to substantiate that any alleged abuse had happen. The ED reported the allegation to ISDH on 3-08-12. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: ED reviewed Grievance reports for last 3 months to ensure there were no other potential allegations that needed to be investigated and none were found. Staff was educated on 3-08-12 regarding reporting allegations. ED and DNS were educated by 4-5-12 by Nurse Consultant regarding reporting allegations. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Staff was educated on 3-08-12 regarding reporting allegations. ED and DNS were educated by 4-6-12</p>				

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	<p>Resident # 159 was "upset and had several complaints such as being left on the bedpan to long, breakfast was cold and a couple of other things." He indicated he was informed about the call light being given to the Resident and what the staff person said but was not informed that the Resident thought staff person was abusive.</p> <p>On 3/8/12 at 2:00 p.m. interview with Occupational Therapy Assistant (OTA) indicated that Resident # 159 had attempted to talk to the DON but had not talked with her yet. The OTA indicated the Resident was not specific about what she wanted to talk with the DON about. OTA left a note on DON's door on 2/15/12.</p> <p>Review of a document provided by the OTA on 3/8/12 at 2:30 p.m. indicated that Resident # 159 would like to talk with the DON as soon as possible. The Resident indicated to the OTA that she had asked for this before and was introduced to the DON but was never given the chance to discuss a concern she had. The OTA indicated she had explained to the Resident that the DON was not available until Thursday and that she would leave a note for the DON's return on Thursday. Document indicated OTA had filled</p>		<p>by Nurse Consultant regarding reporting and investigations. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: All allegations and investigations reported to ISDH will be reviewed during monthly QAA meetings until compliant. All allegaitons will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>				

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	<p>out grievance form regarding 3 complaints Resident # 159 had voiced to her and that what she wanted to discuss with the DON was separate from the issues she had discussed with the OTA.</p> <p>On 3/8/12 at 5:15 p.m. interview with RN # 8 indicated she was on the unit on 2/9/12 and was sitting at the nurses station, she indicated it was "between 10:30 p.m. and 11:00 p.m. because it was shift change." She indicated that "she heard Resident # 159 call out for help and saw RN # 7 go into Resident # 159's room and heard her state to the Resident that "we don't yell out" this was not said in a mean or hateful way."</p> <p>3/9/12 at 2:30 p.m. interview with the DON indicated she received a phone call on 2/15/12 from the ADON. "ADON told me that there was a note on my door and since she knew I was out of town she read the note and it was in regards to Resident # 159. The Resident had some complaints and one of them was she was yelling out and someone told her to not be yelling out. The Administrator was sitting next to me at a meeting when I received the call and was informed of the incident. We discussed the matter with the ADON and determined it did</p>				

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	<p>not sound like abuse. We instructed her to write the concerns on a grievance form and have the unit manager to follow up for a couple of weeks to make sure there were no more concerns. I went to the Resident's room with unit manager to check on the resident. Her daughter was taking about different staff members good and bad. The daughter made a statement that she liked the unit manager and she was doing a good job. The Resident did not inform the staff that she felt the staff person who told her about the call light did so in a mean or hateful manner." The DON did not follow up as she was unaware the Resident felt abuse had occurred.</p> <p>Review of a document provided by the Administrator on 3/8/12 at 6:00 p.m. indicated "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property..."</p> <p>"Resident protection: if the suspected perpetrator is an associate... the ED places the associate on immediate investigatory suspension while completing the investigation. It is</p>				

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	<p>explained to the associate that if the investigation results do not require suspension or termination, the associate may be allowed to return to work and any scheduled days missed during the suspension time may be paid... The results of the investigation will determine the future contact with the resident."</p> <p>3.1-28(d)</p>			

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow the Abuse Policy Guidelines for reporting allegations of abuse to the State Agency for 1 of 22 residents reviewed for abuse in the stage 2 sample of 22. (Resident # 159)</p> <p>Findings include:</p> <p>On 3/6/12 at 8:45 a.m. interview with Resident # 159's daughter indicated that on the evening of the Resident's admission on 2/9/12 a staff person came into the Residents room when she called out for help because she could not find the call light. The staff person slapped the call light into the Resident's hand and stated in a hateful manner that "here's the call light" and squeezed resident's hand tightly around call light then stated "we don't yell for help, there are other residents here trying to sleep." Resident # 159 indicated she had requested to speak with the DON. The Resident indicated when the DON and another staff member came into her room the DON introduced</p>	F0226	<p>F226The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: On the morning of 3/7/12 when the survey team brought the allegation to the attention of the ED, he immediately began an investigation of the alleged abuse. Interviews were conducted with the staff working in the Unit where R159 resides. SSD interviewed the resident. Upon completion of the investigation the facility was unable to substantiate that any alleged abuse had happen. The ED reported the allegation to ISDH on 3-08-12. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: ED reviewed Grievance reports for last 3 months to ensure there were no other potential allegations that needed to be investigated and none were found. Staff was educated on 3-08-12 regarding reporting allegations. ED and DNS were</p>	04/08/2012

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	<p>herself then left before the Resident could speak with her in private.</p> <p>Interview with Administrator on 3/8/12 at 11:10 a.m. indicated that he received a call from the ADON on 3/15/12 and she indicated that Resident # 159 was "upset and had several complaints such as being left on the bedpan to long, breakfast was cold and a couple of other things." He indicated he was informed about the call light being given to the Resident and what the staff person said but was not informed that the Resident thought staff person was abusive.</p> <p>On 3/8/12 at 2:00 p.m. interview with Occupational Therapy Assistant (OTA) indicated that Resident # 159 had attempted to talk to the DON but had not talked with her yet. The OTA indicated the Resident was not specific about what she wanted to talk with the DON about. OTA left a note on DON's door on 2/15/12.</p> <p>Review of a document provided by the OTA on 3/8/12 at 2:30 p.m. indicated that Resident # 159 would like to talk with the DON as soon as possible. The Resident indicated to the OTA that she had asked for this before and was introduced to the DON but was never given the chance</p>		<p>educated by 4-5-12 by Nurse Consultant regarding reporting and investigations. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Staff was educated on 3-08-12 regarding reporting allegations. ED and DNS were educated by 4-5-12 by Nurse Consultant regarding reporting and investigations. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: All allegations and investigations reported to ISDH will be reviewed during monthly QAA meetings until compliant. All Allegations will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>to discuss a concern she had. The OTA indicated she had explained to the Resident that the DON was not available until Thursday and that she would leave a note for the DON's return on Thursday.</p> <p>Document indicated OTA had filled out grievance form regarding 3 complaints Resident # 159 had voiced to her and that what she wanted to discuss with the DON was separate from the issues she had discussed with the OTA.</p> <p>On 3/8/12 at 5:15 p.m. interview with RN # 8 indicated she was on the unit on 2/9/12 and was sitting at the nurses station, she indicated it was "between 10:30 p.m. and 11:00 p.m. because it was shift change." She indicated that "she heard Resident # 159 call out for help and saw RN # 7 go into Resident # 159's room and heard her state to the Resident that "we don't yell out" this was not said in a mean or hateful way."</p> <p>3/9/12 at 2:30 p.m. interview with the DON indicated she received a phone call on 2/15/12 from the ADON. "ADON told me that there was a note on my door and since she knew I was out of town she read the note and it was in regards to Resident # 159. The Resident had some complaints</p>			

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	<p>and one of them was she was yelling out and someone told her to not be yelling out. The Administrator was sitting next to me at a meeting when I received the call and was informed of the incident. We discussed the matter with the ADON and determined it did not sound like abuse. We instructed her to write the concerns on a grievance form and have the unit manager to follow up for a couple of weeks to make sure there were no more concerns. I went to the Resident's room with unit manager to check on the resident. Her daughter was taking about different staff members good and bad. The daughter made a statement that she liked the unit manager and she was doing a good job. The Resident did not inform the staff that she felt the staff person who told her about the call light did so in a mean or hateful manner." The DON did not follow up as she was unaware the Resident felt abuse had occurred.</p> <p>Review of a document provided by the Administrator on 3/8/12 at 6:00 p.m. indicated "Investigation and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's</p>			
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	<p>Property..."</p> <p>"Reporting: Any employee who suspects an alleged violation shall immediately notify the ED or her designee. The ED shall also notify the appropriate state agency, in accordance with state law, as well as notify the Director of Operations."</p> <p>"Resident protection: if the suspected perpetrator is an associate... the ED places the associate on immediate investigatory suspension while completing the investigation. It is explained to the associate that if the investigation results do not require suspension or termination, the associate may be allowed to return to work and any scheduled days missed during the suspension time may be paid... The results of the investigation will determine the future contact with the resident."</p> <p>"Investigation: All investigations shall be conducted by the ED or DNS. In the event an alleged violation occurs when neither of these people is in the facility, the charge nurse is responsible for initiating the investigation procedure..."</p> <p>"Federal law requires the facility to have evidence of investigations of</p>				

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	<p>alleged violations. The "Verification of Investigation" form shall be completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law. This form shall be maintained in the ED's office as an administrative file..."</p> <p>3.1-28(a)</p>			
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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to keep a residents bed pan clean and answer the call light in a timely manner for 1 of 22 residents reviewed for dignity issues in the stage 2 sample of 22.(Resident # 159)</p> <p>Findings include:</p> <p>On 3/5/12 at 3:45 p.m. observed Resident # 159's bed pan that was in a plastic bag on the floor by the door, daughter indicated she had placed bed pan in the bag and on the floor by the door. The bed pan was covered in feces with a very strong foul odor. Daughter indicated Resident # 159 reported to her that she had the bowel movement at approximately 8:30 a.m. and was found by daughter between 12:30 p.m. and 1:30 p.m. in the bathroom today. Daughter indicated this is the fourth time it has been found this way. "The first time was on 2/16/12, the second time was 2/24/12, third was yesterday (3/4/12)</p>	F0241	<p>F241The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R159's bed pan was immediately cleaned and sanitized. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Facility checked all other residents who use bed pans and ensured that all were clean and sanitized The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Facility will audit bed pans 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly to ensure all bed pans are clean. Nursing staff reeducated on cleaning and sanitizing bed pans on 3-27-12. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: Facility will</p>	04/08/2012			

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	<p>in the morning, my Dad cleaned it then and I notified unit manager # 10 and yesterday and today I notified the ADON." Daughter indicated this has been an ongoing problem since admission.</p> <p>Daughter indicated that on 2/13/12 at 11:23 p.m. she was assisting the Resident to change her brief, brief had bowel movement on it but was dry. Daughter indicated that the bed linens under the Resident were soaked with urine and the Resident had been lying in bed since daughter arrived 30 minutes before, she indicated it was unknown how long the Resident had been lying in the urine.</p> <p>Resident # 159's daughter indicated that the Resident has not been getting her call light answered in a timely manner. This has happened on numerous occasions.</p> <p>3.1-3(t)</p>		<p>audit bed pans 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly to ensure all bed pans are clean. All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review the facility failed to develop a comprehensive care plan for range of motion for 1 resident with a decline in range of motion and for 1 resident that did not have a care plan for oral care for 22 residents reviewed for care plans in the stage 2 sample of 22. (Resident #74, and #109)</p> <p>Findings include:</p> <p>1.) The record of Resident #74 was reviewed on 3/7/12 at 1:00 p.m.</p>	F0279	<p>F279The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R74's and R109's care plans were immediately updated. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents care plans were audited to ensure that any resident that had had a decline in range of motion or any resident that depended on staff</p>	04/08/2012	

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	<p>Resident #74's MDS (Minimum Data Set), assessment, dated, 2/7/12, indicated functional limitation in range of motion, upper extremity, impairment on both sides functional limitation in range of motion, lower extremity, impairment on both sides.</p> <p>Resident #74's "Care Area Assessment (CAA) Summary dated, 2/7/12, indicated Activity of Daily Living functional/rehabilitation potential, triggered and indicated a new care plan or care plan revision is necessary to address the problems.</p> <p>Resident #74's MDS, assessment, dated, 11/7/11, indicated functional limitation in range of motion, upper extremity, impairment on one side and functional limitation in range of motion, lower extremity, impairment on one side</p> <p>Resident #74's clinical record care plans dated, 2/5/12, lacked evidence of a care plan for range of motion.</p> <p>During an interview with Staff LPN #23, on 3/9/12 at 2:29 p.m. stated "no there is not a care plan for range of motion for (Resident #74)"</p> <p>2.) During interview on 3-6-12 at 2:30</p>		<p>for oral care had a care plan to reflect the decline or assist with oral care. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff was educated on 3-27-12 regarding oral care. MDS department was educated on 3-29-12 regarding care planning residents with a decline in range of motion. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will conduct audits of care plans to ensure that any resident with a decline in range of motion or dependant on staff for oral care is care planned. The audits will be conducted 4 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly. All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. The audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>p.m. with family member #1 of Resident #109 indicated the resident does not receive routine oral hygiene that the resident needs. Family member #1 indicated on 3-6-12 when the family was visiting, the resident had a white build up around her mouth. The family member indicated they had to ask the facility staff to clean the resident's mouth.</p> <p>During observation on 3-8-12 at 9:51 a.m., Resident #109's mouth was dry with a dry white substance around lips, the resident's mouth did not appear to be clean. The resident stuck her tongue out and her tongue also had white dry crusty substance on it.</p> <p>During observation on 3-8-12 at 11:30 a.m. Resident #109 mouth had white dry substance around the mouth. The resident was asleep.</p> <p>During interview with LPN #20 on 3-8-12 at 12:15 p.m., indicated the CNA's were responsible to keep Resident #109's mouth clean and moist. LPN #20 indicated she would have the CNA clean the resident's mouth.</p> <p>Record review of Resident #109 on</p>			

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	<p>3-9-12 at 10:00 a.m. indicated the resident's diagnoses included, but were not limited to, dysphasia (difficulty swallowing), ulcer of esophagus with bleeding, aphasia (communication impaired), acute respiratory failure and Cerebrovascular accident (CVA-stroke).</p> <p>The record of Resident #109 indicated the resident had a tracheostomy tube (artificial respiration), an gastrostomy tube (nutritional and hydration support) and was NPO (nothing by mouth).</p> <p>The Minimum Data Set (MDS) assessment for Resident #109 dated, 2-2-12 indicated the resident required extensive assistance of two people for personal hygiene.</p> <p>During interview with RN #27 and the Director Of Nursing (DON) on 3-9-12 at 10:20 a.m., RN #27 indicated she was unable to find a care plan related to resident #109's oral care. The DON indicated the aides knew which residents require special attention for oral care through report from the nurse a couple times a shift.</p> <p>3.1-35(b)(1)</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, interview and record, review the facility failed to provide assistance for 2 of 2 residents that required help getting out of bed and failed to evaluate or treat 1 of 1 resident sampled for pain in the stage 2 sample of 22. (Resident #74 and #47)</p> <p>Findings include:</p> <p>1.) The record of Resident #74 was reviewed on 3/7/12 at 1:00 p.m. Resident #74's diagnoses included but were not limited to depression, hemiplegia (total or partial paralysis of one side) right side due to stroke.</p> <p>Resident #74's MDS (Minimum Data Set), assessment, dated, 2/7/12, indicated the following: "- BIMS (brief interview for mental status) 9, 8-12 indicates moderately impaired - transfer, activity did not occur - walk in room or corridor, activity did</p>	F0309	<p>F309 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R74 was interviewed by ED regarding getting out of bed, results were addressed and care plan updated with residents preferences. R74 had his pain assessment updated and MD notified. R47 had his pain assessment updated and MD notified. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All residents that require assistance of staff to get out of bed had pain assessments updated. ED/Designee interviewed residents to ensure any that if they stayed in bed for meals that was their preference and if not staff would assist them. C.N.A. assignment sheets were updated to reflect residents' choice. Any residents that are</p>	04/08/2012			

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	<p>not occur"</p> <p>Resident #74's care plan dated, 2/5/12, "Problem, patient prefers to stay in bed majority of the time per his own choice. Goals, patient will have no skin breakdown related to bedfast. Interventions, will be encouraged to get out of bed as tolerated.</p> <p>During an interview with Resident #74 on 3/8/12 at 9:30 a.m., stated "yes, I would like to get up but they can't get me up because my arm and leg won't move.</p> <p>Observation of on 3/7/12 at 1:29 p.m., Resident #74's right arm and right leg were contracted (condition of fixed high resistance to passive stretch of muscle).</p> <p>During an interview with Staff CNA #25 on 3/8/12 at 10:05 a.m., indicated we don't get Resident #74 up because he does not want to get up.</p> <p>During an interview with Staff LPN #20 on 3/8/12 at 10:30 a.m., stated "he does not like to get up because I think it hurts him to get up."</p> <p>During an interview with Resident #74 on 3/8/12 at 5:45 p.m., indicated he would like to get out of bed but they</p>		<p>on pain medication had assessments reviewed to ensure the assessments were correct. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing staff educated on pain assessments and resident choice on 3-28-12 These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will audit residents with pain assessment to ensure that assessment is correct, if not assess will be updated and MD notified. The audits will be completed 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly. All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>couldn't get him up with the way his arm and leg was.</p> <p>2.) During observation on 3-5-12 at 9:30 a.m., Resident #47 was in her bedroom lying in bed on her back.</p> <p>During observation on 3-5-12 at 11:45 a.m., Resident #47 was in her bedroom lying in bed on her back in the same position as she was 9:30 a.m.</p> <p>During observation on 3-6-12 at 8:45 a.m. Resident #47 was in her bedroom lying in bed on her back.</p> <p>During observation on 3-6-12 at 11:15 a.m., Resident #47 was in her bedroom lying in bed on her back. Resident #47 indicated she wanted pulled up in her bed. LPN # 17 and CNA #18 assisted the resident up in her bed. The resident remained on her back.</p> <p>During observation on 3-7-12 at 10:25 a.m., Resident #47 was in her bedroom lying in bed on her back.</p> <p>During interview with Activity staff #16 on 3-7-12 at 10:30 a.m., indicated Resident #47 use be all around the facility in her wheelchair.</p>						

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	<p>During observation on 3-7-12 at 10:50 a.m., Resident #47 was lying in bed on her back and indicated she could not sleep. LPN #17 indicated to the resident "it's daytime your not suppose to sleep".</p> <p>Interview with LPN #17 on 3-7-12 at 11:01 a.m., indicated the reason Resident #47 was not assisted out of bed was because when the resident was out of bed, she complained of her bottom hurting and her back hurting. LPN #17 indicated on 3-4-12 the facility staff assisted the resident up and the resident was unable to tolerate being up for 5 minutes due to pain. LPN #17 indicated the resident's physician was aware of the resident's pain, but did not want to give the resident any medication too strong because of her age, respiratory status and the resident was frail. LPN #17 indicated the physician ordered the resident Tylenol and an kidder patch. LPN #17 indicated the physician was aware that Resident #47 was unable to get out of bed due to pain.</p> <p>Interview with Resident #47 on 3-7-12 at 11:06 a.m., the resident indicated she wanted to get out of bed and sit in her wheelchair.</p>				

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	<p>Interview with LPN #17 on 3-7-12 at 11:13 a.m. indicated she would let the aides know to get Resident #47 out of bed.</p> <p>Review of the record of Resident #47 on 3-7-12 at 10:55 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, depression, Chronic Obstructive Pulmonary disease (COPD), congestive heart failure and dementia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #47 dated, 2-21-12 indicated the following: bed mobility- extensive assistance of two people, transfer- extensive assistance of two people and walk in room- did not occur.</p> <p>The physician orders for Resident #47 dated, 2-9-12 indicated the resident was ordered Tylenol 500 mg every day.</p> <p>The physician recapitulation for Resident #47 dated, February 2012 indicated the resident had an order for Tylenol 650 mg every 4 hours for pain PRN (as needed) and Lidoderm 5% patch every twelve hours everyday for pain.</p>						

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	<p>Review of the Medication Administration Record (MAR) for Resident #47 dated March 2012 indicated the resident had not received any Tylenol PRN medication for pain.</p> <p>During observation on 3-8-12 at 8:50 a.m. Resident #47 was in her bedroom in bed lying on her back.</p> <p>During observation on 3-8-12 at 11:25 a.m. Resident #47 was in her bedroom in bed lying on her back in the same position.</p> <p>Interview with CNA #18 on 3-8-12 at 11:30 a.m. indicated the reason Resident #47 had not been repositioned in bed was because the resident had too much pain. CNA #18 indicated she had reported to LPN #17 and RN #19 that she was unable to reposition the resident due to pain. CNA #18 indicated she encouraged Resident #47 to lay on her side, but the resident says it hurts too much. When queried if she had attempted to prop the resident on her side with a pillow, CNA #18 indicated she had not and that she would try to prop the resident up with a pillow.</p> <p>Interview with the Director Of Nursing (DON) on 3-8-12 at 11:40 a.m.,</p>				

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	<p>indicated Resident #47 had an pain assessment on 2-1-12 and it indicated the resident had no pain. The DON indicated if a resident was experiencing pain than an pain monitoring tool would be initiated. The DON indicted Resident #47 did not have a pain monitoring tool. The DON indicated she was not able to find any documentation in February or March 2012 that Resident #47 had been experiencing pain or the resident's physician was notified of the resident experiencing pain.</p> <p>During observation on 3-8-12 at 1:30 p.m. Resident #47 was lying in bed on her back. Resident #47 indicated her bottom and right heel was sore.</p> <p>Interview with the DON on 3-9-12 at 5:02 p.m., indicated the floor nurses were responsible for ensuring the Aides are assisting residents out of bed. The DON indicated the unit managers would also do periodic checks to ensure residents are assisted.</p> <p>3.1-37(a)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to provide oral mouth care for 1 resident that was total dependence of staff for mouth care and failed to assist 1 resident with appropriate positioning for meals for 2 of 3 residents that met the criteria for Activities Of Daily Living (ADL), cleanliness and grooming (Resident #109 and # 74).</p> <p>Findings include:</p> <p>1.) During interview on 3-6-12 at 2:30 p.m. with family member #1 of Resident #109 indicated the resident does not receive routine oral hygiene that the resident needs. Family member #1 indicated on 3-6-12 when the family was visiting, the resident had a white build up around her mouth. The family member indicated they had to ask the facility staff to clean the resident's mouth.</p> <p>During observation on 3-8-12 at 9:51 a.m., Resident #109's mouth was dry</p>	F0312	<p>F312 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R109 had oral care given. R74 was repositioned in bed and food arranged so he could reach and assistance given as needed. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: DNS/Designee reviewed all residents that are dependant on staff for oral care to ensure that all oral mouths were clean. DNS/Designee reviewed all residents that eat meals in bed were reviewed to ensure that they are positioned correctly in bed while eating. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Any resident that is dependant on staff for oral care had C.N.A. assignment sheets reviewed to ensure that it was noted that staff was to do oral care. Any resident found to have</p>	04/08/2012	

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	<p>with a dry white substance around lips, the resident's mouth did not appear to be clean. The resident stuck her tongue out and her tongue also had white dry crusty substance on it.</p> <p>During observation on 3-8-12 at 11:30 a.m. Resident #109 mouth had white dry substance around the mouth. The resident was asleep.</p> <p>During interview with LPN #20 on 3-8-12 at 12:15 p.m., indicated the CNA's were responsible to keep Resident #109's mouth clean and moist. LPN #20 indicated she would have the CNA clean the resident's mouth.</p> <p>Record review of Resident #109 on 3-9-12 at 10:00 a.m. indicated the resident's diagnoses included, but were not limited to, dysphasia (difficulty swallowing), ulcer of esophagus with bleeding, aphasia (communication impaired), acute respiratory failure and Cerebrovascular accident (CVA).</p> <p>The record of Resident #109 indicated the resident had a tracheostomy tube (artificial</p>		<p>positioning issues while eating meals in bed were referred to therapy. Nursing education was held 3-28-12 on oral care and proper positioning and tray preparation. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will audit dependant residents with oral care and positioning of residents in bed while eating, 5 times a week for 4 weeks, 3 times a week for 4 weeks, and then weekly. All audits will be reviewed during monthly QAA meetings for 3 mongs or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>respiration), an gastrostomy tube (nutritional and hydration support) and was NPO (nothing by mouth).</p> <p>The Minimum Data Set (MDS) assessment for Resident #109 dated, 2-2-12 indicated the resident required extensive assistance of two people for personal hygiene.</p> <p>During interview with RN #27 and the Director Of Nursing (DON) on 3-9-12 at 10:20 a.m., RN #27 indicated she was unable to find a care plan related to resident #109's oral care. The DON indicated the aides knew which residents require special attention for oral care through report from the nurse a couple times a shift.</p> <p>2.) The record of Resident #74 was reviewed on 3/7/12 at 1:00 p.m. Resident #74's diagnoses included but were not limited to depression, adult failure to thrive and hemiplegia (total or partial paralysis of one side) right side due to stroke.</p> <p>During observation on 3/8/12 at 12:15 p.m., Resident #74 was in bed his right arm contracted (condition of fixed high resistance to passive stretch of muscle) therefore he could not use his right arm or hand.</p>						

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	<p>Resident #74's head was up at a 30 degree angle and his lunch tray was on his bedside table. The bedside table was parallel with his bed. The tray had 4 small glasses of juice and milk with plastic lids still on the glasses, a small bowl of pudding was on the tray with the plastic wrap still on it and a plate of ground potatoes and meat. Resident #74 could not see the food but would reach up with his left hand and get a bite of the ground meat and potatoes with his spoon while getting it on his fingers twice and he only took two bites. Then he reached up and took the bowl of pudding off of the tray laid it on his stomach but just put it back when he saw the plastic wrap on it. He did not attempt to drink the juice that still had the plastic lids on them.</p> <p>During interview at 12:20 p.m. Resident #74 on 3/8/12 at 12:15 p.m. indicated he was having trouble reaching his food and eating.</p> <p>During interview at 12:25 P.M., Staff CNA #24 agreed Resident #74 was positioned poorly.</p> <p>Observation on 3/8/12 at 5:29 p.m. Resident #74 was attempting his evening meal. The head of his bed was up 30 degrees and his diner tray</p>						

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	<p>was on his bedside table parallel with his bed. He could not see his food but did reach up and get his sandwich and take a few bites of it.</p> <p>During an interview with Staff CNA #28 on 3/8/12 at 6:05 indicated Resident #74 needed to be positioned better for eating.</p> <p>3.1-38(a)(2)(D)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to reposition 1 resident with pressure ulcers for over eight hours, to turn and reposition 1 resident with a pressure ulcer and failed to accurately assess pressure ulcers for 2 of 10 residents reviewed for pressure ulcers in the stage 2 sample of 22. (Resident #76 and # 47)</p> <p>Findings include:</p> <p>1.) The record of Resident #76 was reviewed on 3/7/12 at 9:57 a.m. Resident #76's diagnoses included but were not limited to dementia, chronic obstructive pulmonary disease, shortness of breath, bilateral above the knee amputation, depression, pressure ulcers, neurogenic (damaged nervous) bladder and multiple sclerosis.</p>	F0314	<p>F314 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R76 had all areas assessed and current wound sheets are in place. R76 had a pressure relieving cushion applied to wheel chair. R47 immediately had heels assessed, area measured, MD notified, skin sheet implemented and pressure relieving boots applied. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: DNS/Designee completed a facility skin sweep to ensure all residents with skin concerns were identified and proper interventions were implemented. Nursing staff educated on 3-28-12 regarding positioning, pressure relieving cushions and interventions for</p>	04/08/2012			

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	<p>Resident #76's physician's recapitulation orders dated, 2/12, indicated oxygen at 2 liters nasal canula continuously and to be up in chair three times a day.</p> <p>Resident #76's physician's order dated, 2/21/12, "Orders for open areas", Bacitracin (500/unit/gm(grams) Bacitracin topical external dose 1 tube once daily apply to open lesions to left upper back, cover with Tegaderm (a thin, clear sterile dressing) pad dressing, change every day. Wash area with normal saline in between changes of ointment.</p> <p>Bacitracin (500 units/gm) Bacitracin topical external dose 1 tube once daily apply to open lesions to right inner buttock area cover with Tegaderm pad dressing, change every day and wash area with normal saline in between applications of ointment.</p> <p>Resident #76's MDS (Minimum Data Set), assessment, dated, 12/16/11, indicated the following: "- makes self understood, usually understood - ability to understand, usually understands - BIMS (brief interview for mental</p>		<p>pressure relief for heels, The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: DNS/Designee completed a facility skin sweep to ensure all residents with skin concerns were identified and proper interventions were implemented. Nursing staff educated on 3-28-12 regarding turning and repositioning, pressure relieving cushions and interventions for pressure relief for heels, DNS/Designee will complete audits regarding wheel chair cushions, turn and repositioning and pressure relief for heels 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will complete audits regarding wheel chair cushions, turn and repositioning and pressure relief for heels 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then</p>				

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	<p>status) 7, 0-, indicates severe impairment</p> <ul style="list-style-type: none"> - transfer, extensive assistance - walk in room or corridor, activity did not occur - self performance, total dependence - mobility devices, wheelchair - urinary continence, not rated, supra pubic catheter above the pubis - bowel continence, always incontinent - risk of pressure ulcers, yes - unhealed pressure ulcer, 0 <p>Resident #76's care plan for pressure ulcers dated 12/20/11, "Problem, at risk for pressure ulcers. Goal, skin integrity will be maintained intact. Interventions, assist with turning and repositioning at least 3 times per shift, pressure relieving device for bed and chair, staff to observe the skin daily with a.m. and p.m. care, weekly skin assessment by Licensed Nurse, use mild cleansing agent and warm water to wash skin when soiled no hot water, treat dry skin with moisturizer, when transferring, turning and positioning use proper technique so as to avoid friction and shear, maintain head of the bed in lowest positioning consistent with residents condition and comfort and do not massage over bony prominence's."</p>		<p>weekly. All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>				

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	<p>Resident #76's Braden Scale for predicting pressure sore risk, dated, 3/12/12, indicated total score 12, a score of 10--12, high risk for pressure score risk.</p> <p>Resident #76's "Wound Evaluation Flow Sheet" dated 2/21/12, had a check mark beside other wound and no check mark beside pressure ulcer. The instructions on the "Wound Evaluation Flow Sheet" indicated stage only pressure ulcers. Description of wound location "left upper back" "- 2/21/12, indicated measurements 0.9 cm (centimeters) long, 0.8 cm and 0.2 cm, deep, exudate (drainage) none, wound bed pain, 0, wound margins red, surrounding tissue pink. Current treatment Bacitracin/Tegaderm - 3/5/12, indicated measurements 0.6 cm long 0.4 cm wide, deep, space left blank, exudate, none, wound bed pain, 0 and wound margins red, surrounding tissue pink. Current treatment Bacitracin/Tegaderm"</p> <p>Resident #76's "Wound Evaluation Flow Sheet" dated 2/21/12, had a check mark beside other wound and no check mark beside pressure ulcer. The instructions on the "Wound Evaluation Flow Sheet" indicated</p>				

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	<p>stage only pressure ulcers.</p> <p>Description of wound location "right inner buttock"</p> <p>"- 2/21/12, indicated measurements 0.5 cm long, 0.5 cm wide and 0.1 cm deep, exudate, none, wound bed pain, none, wound margins red and surrounding tissue pink. Current treatment Bacitracin/Tegaderm"</p> <p>During an interview on 3/9/12 at 5:02 p.m., the DON (Director of Nursing), indicated when the nurses find an open area on a resident they are trained to check other wound on the "Wound Evaluation Flow Sheet" if the area in not on a bony prominence it is not a pressure area</p> <p>On 3/7/12 at 1:54 p.m., Staff LPN #17 was observed changing the dressing on Resident #76's left upper back and right inner buttock. The area on resident #76's left upper back was round and measured 0.6 cm x .8 cm. Staff LPN #17 cleaned the area with normal saline, applied Bacitracin and covered the area with a Tegaderm dressing. Staff LPN #17 also changed the dressing on Resident #17's right inner buttocks. The old dressing had a small amount of blood on it. The open area was 0.5 cm. A small area below the open area (little larger than a pin point) was open and</p>			

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	<p>had fresh blood on it.</p> <p>During an interview with Staff LPN #17 on 3/7/12 at 2:15 indicated Resident #17 had a history on open areas and the area on his right inner buttocks looked a lot better. Staff LPN #17 stated "the new area is from the tape that was covering the dressing."</p> <p>Observation on 3/5/12 at 10:00 a.m., Resident #76, observed in activities, in his high back wheelchair and his high back wheelchair did not have a cushion for the resident's back, his eyes were closed and he appeared to be asleep. At 11:30 a.m., resident was moved to the dining room and he still appeared to be asleep. At 11:45 a.m., Resident #76 woke up and started chewing. At 1:00 p.m. Resident #76 was still up in his high back wheelchair, in the hall way with his eyes closed and appeared to be asleep. At 1:10 p.m., the Social Services Director was informed of Resident #76 observed up in the high back wheelchair since 11:45 a.m. The Social Service Director was also informed of Resident #76's high back wheelchair not having a cushion in it.</p> <p>Observation on 3/8/12 Resident #76 was observed up in his high backed</p>				

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	<p>wheelchair continuously from 9:47 a.m. until 6:30 p.m. The following was observed on 3/8/12:</p> <ul style="list-style-type: none"> - 9:47 a.m., up in hall in high back wheelchair in the hall way next to his room until 11:30 a.m. - 11:30 a.m., taken to dining room in his high back wheelchair - 12:45 a.m., remains in high back wheelchair and received lunch tray at this time - 1:10 p.m., moved in high back wheelchair from dining room into the hall way by his room - 3:50 p.m., moved from hall way to activity room for music entertainment - 5:15 p.m., moved from activity room to the dining room - 6:18 p.m., remains in dining room eating evening meal, ADON informed of Resident #76 being up in high back wheelchair all day <p>On 3/9/12 at 1:55 p.m. Staff RN #22 was observed providing wound care to Resident #76's right lower buttocks. The old dressing with blood on it was removed by Staff RN #22. The open area was 0.5 cm (same as on 3/7/12) and had the one same small open area at the bottom of it (same as on 3/7/12). The open area had 2 new small open areas below the open area both a little larger than a pin point. Above the open area were 2</p>						

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	<p>new open areas #1, measured, 0.2 cm x 0.3 cm and #2, measured, 0.2 cm x 0.2 cm. Another new open area above the two new areas measured, 0.1 cm x 0.1 cm. On Resident #76's coccyx a 1 cm linear crease was observed caked with dried feces. Staff RN #22 removed the dried feces from the crease.</p> <p>During an interview with Staff RN #22 on 3/9/12 at 2:15 p.m. indicated Resident #76 was not a resident she was used to taking caring of and she had not seen his wounds until today. Staff RN #22 also indicated the 1 cm linear crease caked with dried feces on resident #76's coccyx looked like scar tissue from a open area that had healed.</p> <p>2.) During observation on 3-5-12 at 9:30 a.m., Resident #47 was in her bedroom lying in bed on her back. The resident did not have any pressure relieving interventions in place for her heels.</p> <p>During observation on 3-5-12 at 11:45 a.m., Resident #47 was in her bedroom lying in bed on her back in the same position as she was 9:30 a.m. The resident did not have any pressure relieving interventions in place for her heels.</p>			

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	<p>During observation on 3-6-12 at 8:45 a.m. Resident #47 was in her bedroom lying in bed on her back. The resident did not have any pressure relieving interventions in place for her heels.</p> <p>During observation on 3-6-12 at 11:15 a.m., Resident #47 was in her bedroom lying in bed on her back. Resident #47 indicated she wanted pulled up in her bed. LPN # 17 and CNA #18 assisted the resident up in her bed. The resident remained on her back. The resident did not have any pressure relieving interventions in place for her heels.</p> <p>During observation on 3-7-12 at 10:25 a.m., Resident #47 was in her bedroom lying in bed on her back. The resident did not have any pressure relieving interventions in place for her heels..</p> <p>During observation on 3-7-12 at 10:50 a.m., Resident #47 was lying in bed on her back and indicated she could not sleep. LPN #17 indicated to the resident "it's daytime your not suppose to sleep".</p> <p>During observation on 3-7-12 11:27</p>						

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	<p>a.m. CNA #18 took Resident #47's socks off and the resident had an red and pink area with a dark circle in the middle on the outer part of her right heel. CNA #18 indicated she did not know about the area and it must have been new. CNA #18 indicated she would normally prop the resident's heels up with an pillow, but lately the resident had not wanted a pillow under her heels.</p> <p>During observation with LPN #17 on 3-7-12 at 1:30 p.m. Resident #47 had an red open area on her left buttock measuring 0.3 centimeters (cm) by 0.2 cm. Resident #47 had an dark circle on her outer right heel measuring 0.3 by 0.2 cm and an purplish area on her outer right heel measured 0.5 cm by 0.2 cm.</p> <p>Review of the record of Resident #47 on 3-7-12 at 10:55 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, depression, Chronic Obstructive Pulmonary disease (COPD), congestive heart failure and dementia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #47 dated, 2-21-12 indicated the following: bed</p>						

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	<p>mobility- extensive assistance of two people, transfer- extensive assistance of two people and walk in room- did not occur.</p> <p>The care plan for Resident #47 dated, 1-8-12 indicated the resident was at risk for pressure ulcer due to assistance with bed mobility. The interventions were conduct weekly skin inspection, do no massage over bony prominence, nutritional and hydration support, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress and assist with turning and repositioning at least three times a shift.</p> <p>The change in condition progress note for Resident #47 dated, 1-15-12 indicated an open area was observed on the resident's left buttock measuring 1.2 centimeters (cm) by 0.8 cm. The physician response was apply optase to left bottom and cover with mepore every day until healed.</p> <p>The wound evaluation flow sheet for Resident #47 dated, 1-15-12 indicated the resident had marked other wound on left bottom. The wound bed had granulation and the surrounding tissue was red.</p>						

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	<p>The wound evaluation flow sheet for Resident #47 dated, 2-1-12 indicated the resident had marked other wound, open area on left bottom. The most recent measurement dated 3-1-12 indicated 1.2 cm by 1.1 cm. The wound was red. The treatment was optase/mepore every day.</p> <p>The change in condition progress note for Resident #47 dated, 3-7-12 at 4:00 p.m. indicated the resident had redness and purplish area to right outer heel. The resident's background was decreased bed mobility. The redness are to the right outer heel measured 0.3 cm by 0.2 cm and the purplish area on the right outer heel measured 0.5 cm by 0.2 cm. The physician and family notified. The resident received an order for cavilon barrier cream every day and bilateral heel boots were applied.</p> <p>During interview with the Director Of Nursing (DON) on 3-7-12 at 12:11 p.m., indicated the facility did not have specific wound nurse. The DON indicated the nurse that finds an area did the assessment . The DON indicated the resident would be seen by a doctor if an area was not improving and the facility had changed the treatment, than the facility would send the resident to the</p>				

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	<p>wound center.</p> <p>During observation on 3-8-12 at 8:50 a.m. Resident #47 was in her bedroom in bed lying on her back. The resident had pressure relieving boots on both feet.</p> <p>During observation on 3-8-12 at 11:25 a.m. Resident #47 was in her bedroom in bed lying on her back in the same position.</p> <p>Interview with CNA #18 on 3-8-12 at 11:30 a.m. indicated the reason Resident #47 had not been repositioned in bed was because the resident had too much pain. CNA #18 indicated she had reported to LPN #17 and RN #19 that she was unable to reposition the resident due to pain. CNA #18 indicated she encouraged Resident #47 to lay on her side, but the resident says it hurts too much. When queried if she had attempted to prop the resident on her side with a pillow, CNA #18 indicated she had not and that she would try to prop the resident up with a pillow.</p> <p>During observation on 3-8-12 at 1:30 p.m. Resident #47 was lying in bed on her back. Resident #47 indicated her bottom and right heel was sore.</p>				

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	<p>The "Skin Integrity Guideline" policy dated January 2011 provided by the Administrator on 3-8-12 at 6:00 p.m. indicated the purpose of the policy was to provide a systemic approach and monitoring process for skin and to decrease pressure ulcer formation by identifying those residents who are at risk and developing interventions. The care interventions included, but were not limited to, initiate positioning schedule to meet individual needs and minimize concentrated pressure to the skin.</p> <p>3.1-40(a)(1) 3.1-40(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, interview, and record review, the facility failed to provide range of motion exercises and splint application for 2 of 4 residents who had a decline in range of motion, and met the criteria for range of motion in the stage 2 sample of 22. (Resident # 98 and #74)</p> <p>Findings include:</p> <p>1.) Resident #98's record was reviewed on 3/7/12 at 2:58 P.M. Diagnoses included but were not limited to cerebrovascular disease (stroke) and hemiplegia/hemiparesis due to the stroke.</p> <p>Resident #98's significant change Minimum Data Set assessment dated 12/22/11, indicated his cognitive skills for daily decision making were intact and he had functional limitation for range of motion in his upper and lower extremities.</p> <p>An Occupational Therapy (OT) Plan</p>	F0318	<p>F318 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Residents #74 and #98 were referred to Therapy for evaluation for Splinting and ROM. Care plans were updated to reflect indicated interventions. Restorative Aid #3's employment was terminated for falsification of records. Nursing Staff were educated on 4-02-12 regarding ROM and Splinting. MDS department was educated on 4-02-12 regarding care planning residents with a decline in range of motion and splinting. DNS/Designee will complete audits regarding ROM and splinting heels 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: All residents who have a decline in ROM will be</p>	04/08/2012	

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	<p>of Care for Resident #98 dated 12/5/11, indicated the following: Reason for referral-Resident #98 was re-admitted from a local hospital with a diagnosis of urinary tract infection and was referred to occupational therapy for evaluation and treatment. "Resident presents with concern that his left wrist is tighter and would like to wear his hand splint for a longer period of time, currently an hour a day. Resident demonstrates decline in functional transfers, toileting, dressing and will benefit from skilled OT treatment to improve strength, activity tolerance and to address left wrist contracture and splint appropriateness. Previous therapy-Resident participates in Restorative program at this facility. Short term goal-The patient will donn left hand splint with minimal assist and participate in development of wear schedule appropriate for his needs".</p> <p>An OT Progress Report and Discharge Summary for Resident #98 dated 12/29/11, indicated the following: "Goal-The patient will donn left hand splint with minimal assist and participate in development of wear schedule appropriate for his needs. Prior Level of Function 12/14/11-Resident is dependent for</p>		<p>referred to Therapy for evaluation for Splinting and ROM. Care plans were updated to reflect indicated interventions. Residents care plans were audited to ensure that any resident that had had a decline in range of motion or any resident that dependent for splinting had a care plan to reflect the decline and need for ROM or Splinting. Restorative Aid #3's employment was terminated for falsification of records. Nursing Staff were educated on 4-02-12 regarding ROM and Splinting. MDS department was educated on 4-02-12 regarding care planning residents with a decline in range of motion and splinting. DNS/Designee will complete audits regarding ROM and splinting heels 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:All residents who have a decline in ROM were referred to Therapy for evaluation for Splinting and ROM. Care plans were updated to reflect indicated interventions. Residents care plans were audited to ensure that any resident that had had a decline in range of motion or</p>		

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	<p>donning of left hand/wrist/forearm splint. Resident can remove splint independently. Resident prefers to wear splint no longer than an hour saying it gets in his way. Current Level of Function-Resident is dependent upon staff for donning split to left hand/wrist/forearm, is independent for removing splint. Resident will wear splint up to 2 hours before taking off independently. Analysis of Functional Outcome/clinical Impression-Resident has made good progress. Does not want to wear left splint more than two hours at this time due to it getting in his way. Patient/Caregiver Training-Restorative Nursing Program for splint wear in place. Discharge Plans-Skilled Nursing Facility with Restorative Nursing Program".</p> <p>An interview with OT #2 on 3/8/12 at 4:50 P.M., indicated she had worked with Resident #98 after he was re-admitted from a local hospital in December, 2011. OT #2 indicated Resident #98 performed arm exercises and was taught how to apply his left hand splint. OT #2 indicated prior to working with Resident #98 in December, 2011, he was receiving Restorative Nursing for his left hand splint. OT #2 indicated Resident #98 would wear the left</p>		<p>any resident that dependent for splinting had a care plan to reflect the decline and need for ROM or Splinting. Restorative Aid #3's employment was terminated for falsification of records. Nursing Staff were educated on 4-02-12 regarding ROM and Splinting. MDS department was educated on 4-02-12 regarding care planning residents with a decline in range of motion and splinting. DNS/Designee will complete audits regarding ROM and splinting heels 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>				

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	<p>hand splint in restorative at least 15 minutes. OT #2 indicated she worked with him to see if he could tolerate the left hand splint for more than 15 minutes at a time. OT#2 indicated Resident #98 would wear the left hand splint for up to 2 hours, but he would sometimes remove it sooner than 2 hours. OT #2 indicated when she discharged him in December, 2011, she recommended he go back to his original Restorative Nursing plan and wear the splint during his restorative exercises. OT #2 indicated Resident #98 never complained of pain or refused to wear the left hand splint while she had him in therapy.</p> <p>A restorative splint application plan of care initiated 12/21/11, indicted the following: Restorative splint application, 6 times a week, with a 15 minute minimum per day.</p> <p>Documentation provided by Restorative Aide #3 on 3/8/12 at 1:38 P.M., indicated the following: From February 1, 2012 to March 8, 2012, Resident #98 donned his splint 15 minutes daily on 2/1, 2/2, 2/6, 2/7, 2/8, 2/9, 2/11, 2/13, 2/14, 2/15, 2/16, 2/17, 2/20, 2/21, 2/22, 2/23, 2/29, 3/1, 3/2, 3/3, 3/5, 3/7, and 3/8, 2012.</p>				

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	<p>An interview with Restorative Aide #3 on 3/8/12 at 1:38 P.M., indicated when Resident #98 was in the Restorative Nursing program prior to his hospitalization in December 2011, he would tolerate wearing the left hand splint for approximately 30 minutes, before removing it on his own. Restorative Aide #3 indicated she had not applied Resident #98's left hand splint during his current restorative exercises or any other time during the day, since he was re-admitted to the Restorative Nursing program on 12/29/11. Restorative Aide #3 indicated she did not do Resident #98's splint restorative because she had no idea where the splint was. Restorative Aide #3 indicated the splint application documentation from February 1, 2012 to March 8, 2012, was incorrect, because the resident had never wore the splint on those days. Restorative Aide #3 indicated she had been signing the restorative splint application record as completed for Resident #98 since his re-admission to the Restorative Nursing program on 12/29/11, when actually she had not been applying the splint.</p> <p>On 3/7/12 at 11:14 A.M., Resident #98 was observed seated in his wheelchair in his bedroom. He had a</p>						

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	<p>contracted left hand, with his small left fingers turned in and touching his left palm. Resident #98 indicated he was born with the smaller left arm and hand. Resident #98 indicated he had also suffered a stroke on his left side. Resident #98 indicated he had "pretty good use" of his left hand until he had a stroke. Resident #98 indicated he never wore the left hand splint. Resident #98 stated "Babe, I think that would be useless".</p> <p>An interview with Resident #98 on 3/8/12 at 1:55 P.M., indicated he had never refused to wear the left hand splint. Resident #98 stated "I will wear it if you think it will do any good".</p> <p>An interview with the Director of Nursing (DoN) on 3/9/12 at 5:02 P.M., indicated a therapist would determine if a resident needed a splint and if so, the Restorative Nurse would write a program for the splint.</p> <p>2.) The record of Resident #74 was reviewed on 3/7/12 at 1:00 p.m. Resident #74's diagnoses included but were not limited to depression and hemiplegia (total or partial paralysis of one side) right side due to stroke.</p> <p>Resident #74's MDS (Minimum Data Set), assessment, dated, 2/7/12,</p>				

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	<p>indicated the following:</p> <ul style="list-style-type: none"> "- BIMS (brief interview for mental status) 9, 8-12 indicates moderately impaired - transfer, activity did not occur - walk in room or corridor, activity did not occur - functional limitation in range of motion, upper extremity (shoulder, elbow, wrist and hand), impairment on both sides - functional limitation in range of motion, lower extremity (hip, knee, ankle and foot), impairment on both sides - physical therapy, 0 - restorative nursing program, 0, passive, active or splint or brace assistance <p>Resident #74's "Care Area Assessment (CAA) Summary dated, 2/7/12, indicated Activity of Daily Living functional/rehabilitation potential, triggered and indicated a new care plan or care plan revision is necessary to address the problems.</p> <p>Resident #74's MDS, assessment, dated, 11/7/11 indicated the following:</p> <ul style="list-style-type: none"> - BIMS, 7, 0-7 indicates severe impairment - transfer, activity did not occur - walk in room or corridor, activity did not occur 			

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	<p>- functional limitation in range of motion, upper extremity (shoulder, elbow, wrist and hand), impairment on one side</p> <p>- functional limitation in range of motion, lower extremity (hip, knee, ankle and foot), impairment on one side</p> <p>- physical therapy, 0</p> <p>- restorative nursing program, 0, passive, active or splint or brace assistance</p> <p>Resident #74's clinical record lacked evidence of a care plan for range of motion.</p> <p>During an interview with Staff LPN on 3/9/12 at 2:29 p.m. stated "no there is not a care plan for range of motion for (Resident #74)"</p> <p>Observation on 3/7/12 at 1:29 p.m., Staff CNA #24 was observed unable to move Resident #74's right arm away from his chest (his arm was bent at a 90 degree angle and against his chest) and unable to open Resident #74's hand.</p> <p>During interview with Staff Physical Therapist #1 on 3/7/12 at 2:37 p.m., indicated Resident #74 was not receiving any occupational therapy or physical therapy and was not in the</p>			

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	<p>restorative program.</p> <p>During an interview with Staff Restorative CNA #3 on 3/8/12 at 10:14 a.m., indicated Resident #74 was not in the restorative program.</p> <p>During an interview with Staff CNA #24 on 3/8/12 at 10:58 a.m. stated "no, (Resident #74) does not receive range of motion therapy.</p> <p>During an interview with Resident #74 on 3/8/12 at 11:20 a.m., indicated the staff did not exercise his arms or legs.</p> <p>During an interview with the DON (Director of Nursing) on 3/9/12 at 5:02 p.m., indicated the MDS nurse makes rounds to determine if any therapy for activities of daily living may benefit a resident and if it is determined they need range of motion therapy, the Restorative nurse will make a program for that resident.</p> <p>A document titled "Range of Motion (Active, Active Assistance, Passive)" provided by the administrator on 3/8/12 at 6:00 p.m., and dated May, 2001, indicated by the Administrator to be the most current policy. "Responsibility, the following individuals may have responsibility for monitoring range of motion (active,</p>				

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	<p>active assistance and passive) specific to state professional licensing requirements, RN, LPN/LVN, or CNAs. Purpose, the purpose of performing range of motion exercises is to , move the resident's joints through as full a range of motion as possible, improve or maintain joint mobility and muscle strength, prevent contractors, increase strength and activity tolerance, reduce pain, and prevent complications of mobility.</p> <p>3.1-42(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, interview and record review, the facility failed to put interventions in place to prevent skin tears and failed to transfer a resident safely to prevent skin tears for 1 of 6 residents (Resident #47) that met the criteria for skin conditions (non pressure related) and failed to implement fall interventions for 3 of 4 residents that met the criteria for accidents in the stage 2 sample of 22(Resident #50, #68, & #111).</p> <p>Findings include:</p> <p>1.) During observation on 3-5-12 at 10:49 a.m. Resident #47 had an abrasion on her forehead and an bandage dated 3-5-12 on the upper right arm. The resident had a sling on her left arm.</p> <p>Review of the record of Resident #47 on 3-7-12 at 10:55 a.m. indicated the resident's diagnoses included, but were not limited to, anxiety, depression, Chronic Obstructive</p>	F0323	<p>F323The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R47's care plan was reviewed and updated to include new intervention of Geri sleeves to arms and legs. R50 and R111 had fall mats immediately placed at bedside. R68's batteries were replaced and functioning alarm replaced. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents with a history of skin tears were reviewed and new interventions implemented if indicated. C.N.A. assignment sheets were reviewed and updated as needed to ensure residents at risk for falls that had interventions of fall mats had intervention on sheet. Residents that have alarms had alarms checked to ensure that all alarms were functioning and batteries were changed is indicated. The measures put into place and the systemic</p>	04/08/2012			

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	<p>Pulmonary disease (COPD), congestive heart failure and dementia.</p> <p>The Minimum Data Set (MDS) assessment for Resident #47 dated, 2-21-12 indicated the following: bed mobility- extensive assistance of two people, transfer- extensive assistance of two people and walk in room- did not occur.</p> <p>The wound evaluation flow sheet for Resident #47 dated 2-8-12 indicated the resident had skin tear to the left lower extremity measuring 2.6 centimeters (cm) by 1.7 cm.</p> <p>The wound evaluation flow sheet for Resident #47 dated 2-16-12 indicated the resident had a skin tear on the right forearm measuring 2.0 cm by 2.0 cm.</p> <p>The wound evaluation flow sheet for Resident #47 dated 2-17-12 indicated the resident had a skin tear on the right upper extremity, measuring 6.0 cm by 0.5 cm.</p> <p>The care plan for Resident #47 dated 2-8-12 indicated the resident had skin tears. The interventions were encourage meals/fluid/extra protein if indicated, notify doctor/family of</p>		<p>changes made to ensure that this deficient practice does not recur are as follows: Nursing staff was educated regarding skin tears, mats at bedside and alarms on 3-28-12. Alarms will have batteries changed monthly, prn. Nursing continues to check each shift for placement and function of Alarms. DNS/Designee will audit resident care plans for skin tears, C.N.A. assignment sheets and alarms 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: DNS/Designee will audit resident care plans for skin tears, C.N.A. assignment sheets and alarms 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly. All audits will be reviewed during monthly QAA meetings for 3 months or until compliant. Audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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	<p>occurrence, obtain an treatment order, observe for signs of infection, notify doctor if wound does not improve and change dressings as ordered. No interventions were documented to prevent the skin tears.</p> <p>During observation on 3-7-12 at 11:27 a.m. CNA #18 and restorative aide #3 placed a gait belt around Resident #47's under the right and over the left arm and tighten the gait belt. The resident had a sling on her left arm. When queried if that was the way Resident #47 should be transferred safely, restorative aide #3 indicated she had been transferring the resident by putting the gait belt under the resident's arms. CNA #18 indicated the resident can not use a lift because of her shoulder hurting and she had been transferring the resident with the gait belt over her left arm, so the resident's shoulder would not move. CNA #18 indicated the CNA assignment sheet said "transfer with extensive assistance of one" and no further directions for transferring the resident. Restorative aide #3 took the gait belt off the resident's arm and applied it around the resident's waist. CNA #18 and restorative Aide #3 transferred the resident from the bed to her wheelchair. CNA #18 indicated she was not aware how the resident</p>			

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	<p>acquired skin tears. CNA #18 indicated she thought the resident might be scratching her self.</p> <p>Interview with LPN #17 indicated she was unsure how Resident #47 acquired skin tears. LPN #17 indicated the resident may scratch herself.</p> <p>Interview with the Director Of Nursing (DON) on 3-8-12 at 11:53 a.m., indicated Resident #47 acquired a fracture of left shoulder on 1-2-12 from a fall. When queried who was responsible to do an assessment for safe transfer the resident the DON indicated she would find out who did the resident's transfer assessment. The DON indicated she would look for intervention the facility had put in place to prevent skin tears and the cause of the resident's skin tears.</p> <p>Interview with the Assistant Director Of Nursing (ADON) on 3-8-12 at 2:27 p.m., therapy screening on 1-2-12 for Resident #47's transfer. The ADON indicated she had applied geri sleeves on the resident today twice and the resident had taken them off. The ADON provided a piece of paper and indicated it was documentation of the cause of the resident's skin tears. The paper indicated the following: on</p>						

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	<p>12-23-12 the resident acquired a skin tear on right hand from the handrail in bathroom, on 1-2-12 the resident acquired a skin tear on the left hand from bumping it on hand rail in the bathroom, on 1-13-12 the resident acquired a skin tear on the right leg when transferred to the toilet, on 2-17-11 the resident acquired a skin tear on the right arm from the call light clip. No documentation was provided in regards to prevention interventions for the resident's skin tears. The ADON provided a therapy screen form for Resident #47 dated 1-2-12, indicated transfer resident with a gait belt with the assistance of one or two people and left upper extremity immobilized.</p> <p>2.) Resident #50's record was reviewed on 3/9/12 at 9:58 A.M. Diagnoses included but were not limited to cerebrovascular disease (stroke), debility, and cerebral ataxia disease.</p> <p>Resident #50's quarterly Minimum Data Set assessment (MDS) dated 1/31/12, indicated Resident #50 required extensive assistance of 2 persons for bed mobility and transfer, and she did not walk.</p> <p>A care plan for Resident #50 reviewed by the facility on 2/19/12,</p>				

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	<p>indicated the following: Focus-The resident was at risk for falls related to a history of falls. Goal-To reduce the number of falls. The resident would have no fall related injuries. Intervention-Initiated 2/19/12- A mat would be placed beside the bed.</p> <p>A nurses note dated 3/3/12 at 6:27 A.M., indicated Resident #50 was found on her bedroom floor sitting on her bottom with no injuries. Resident #50 indicated she was getting up to check on her roommate.</p> <p>On 3/7/12 at 11:44 A.M., Resident #50 was observed lying in bed on he right side. One side of her bed was positioned against the wall and the other side of the bed was open for exit. A floor mat was folded and positioned leaning against her oxygen concentrator.</p> <p>On 3/7/12 at 11:54 A.M., LPN #4 indicated the mat should have been positioned next to the open side of Resident #50's bed on the floor.</p> <p>An interview with LPN #6 on 3/8/12 at 12:02 P.M., indicted Resident #50 had fell on 1/15/12, 2/19/12, 3/1/12, and 3/3/12.</p> <p>3.) Resident #68's record was</p>						

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	<p>reviewed on 3/8/12 at 5:06 P.M. Diagnoses included but were not limited to dementia with behavioral disturbances and Alzheimer's disease.</p> <p>Resident #68's significant change MDS dated 2/15/12, indicated Resident #68 required extensive assistance of 2 persons for bed mobility and transfer, and she did not walk.</p> <p>A February, 2012 physician's recapitulation order for Resident #68 initiated 9/18/10, indicated the following: The resident has a bed and chair alarm for safety that is checked every shift.</p> <p>A Change in Condition-Post Fall/Trauma report for Resident #68 dated 2/12/12 at 6:30 P.M., indicated the following: Interventions prior to fall-The resident had a bed and chair alarm. Recommendations and interventions post fall-The resident would have a bed and chair alarm.</p> <p>On 3/7/12 at 12:04 P.M., Resident #68 was observed with LPN #6 lying in bed. One side of the bed was positioned against the wall and the other side of the bed was open for exit. She had a pad alarm under her</p>						

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	<p>with the alarm box lying on the floor under her bed. The pad alarm did not alarm when tested. 2 Batteries to the alarm box were laying near the wall under her bed. LPN #6 indicated the batteries must have come out and the nurse probably tested the alarm near the beginning of her shift.</p> <p>An interview with LPN #6 on 3/9/12 at 12:06 P.M., indicated Resident #68 had fell 3 times in 2012. Resident #68 had 2 falls out of her chair and 1 fall out of her bed.</p> <p>4.) Resident #111's record was reviewed on 3/7/12 at 3:41 P.M. Diagnoses included but were not limited to cerebrovascular disease and hemiplegia/hemiparesis due to the stroke.</p> <p>Resident #111's quarterly MDS dated 1/19/12, indicated Resident #111 required extensive assistance of 2 persons for bed mobility and transfer, and he did not walk.</p> <p>A care plan for Resident #111 reviewed by the facility on 3/7/12, indicated the following: Focus-The resident was at risk for falls related to a history of falls, weakness, and use of antidepressant medication. Goal-The resident would be safe from</p>						

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	<p>injury secondary to falls through the next review period.</p> <p>Intervention-Initiated 1/10/12- The resident would have a mat on floor beside the bed.</p> <p>Nurses notes for Resident #111 indicated the following: 1/6/12 at 3:51 P.M.-Resident #111 was heard hollering for help. Upon entering his room Resident #111 was found on the floor beside the bed on his left side. Resident #111 had a hematoma on the left side of his face. 1/10/12 at 6:28 P.M.-Resident #111 was found on the floor beside his bed. No injury noted.</p> <p>On 3/8/12 at 3:06 P.M., Resident #111 was observed with LPN #6 lying in bed. One side of his bed was positioned against the wall and the other side was open for exit. A floor mat was folded and observed positioned leaning against the wall at the end of his bed. LPN #6 indicated the mat should have been positioned next to the open side of Resident #111's bed on the floor. LPN #6 indicated the bed side mat intervention was not listed on the CNA assignment sheet and the assignment sheet needed to be updated.</p>			

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	<p>An interview with LPN #6 on 3/9/12 at 12:01 P.M., indicated Resident #111 had 2 falls in 2012. He rolled out of bed both times.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>			

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F0325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation and record review, the facility failed to notify the Physician of Dietitians recommendations for 1 of 8 residents who met the criteria for nutrition in the stage 2 sample of 22 to seek treatment options for assistance with the resident's significant weight loss. (Resident # 147)</p> <p>Findings include:</p> <p>Review of Resident # 147's record on 3/8 /12 at 4:30 p.m. indicated diagnoses included but were not limited to Unspecified hypothyroidism, shortness of breath, diabetes without complications type 2/unspecified not stated uncontrolled, pressure ulcer stage IV and pressure ulcer stage II.</p> <p>The height (in inches) of Resident # 147 is: 68 The Admission Weight Data for this</p>	F0325	<p>F325 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: R47's primary physician was notified of the Dietitians recommendations and residents wt. loss on 3-27-12. All licensed Nursing staff have been in serviced on Notification of Change in resident health status. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Facility residents were reviewed to ensure if there was a weight loss or recommendations of the dietitian that they were addressed and physicians notified if indicated. Licensed Nursing staff were in serviced on 3-27-12 on Notification of Change in resident health</p>	04/08/2012	

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	<p>resident is: Date: 01/13/2012; Weight: 128; BMI: 19 Date: 01/30/2012; Weight: 122; BMI: 19 Date: 02/13/2012; Weight: 118; BMI: 18 Date: Unavailable; Weight: Unavailable The resident loss 4.69% from the first weight to the second weight The resident loss 7.81% from the first weight to the third weight. Unable to calculate the weight loss from the first weight to the fourth weight because of unavailable weight.</p> <p>The resident's Care Plan: dated 1/16/12 indicated, Focus: Inconsistent carbohydrate intake as related to Diabetes Resident has stage 4 and stage 2 wounds. Goals: Resident will be free of significant weight changes. Interventions: Diet as ordered medication as ordered monitor meal consumption daily monthly weights house supplement per order fortified soup at lunch and dinner care plan last updated 2/17/12</p> <p>Dietitian notes dated 2/16/12 indicated the resident's diet was changed to "Puree Con CHO (high</p>		<p>status. New licensed nursing staff will have education on Notification of Change in resident health status. The DSM/ Designee will take Dietitians recommendations to Clinical Start-up. Orders will be reviewed in Clinical Start-up to ensure Dietitians recommendations were completed. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nursing Staff were in serviced on 3-27-12 on Notification of Change in resident health status. The DSM/ Designee will take Dietitians recommendations to Clinical Start-up. Orders will be reviewed in Clinical Start-up to ensure Dietitians recommendations were completed. New staff will have education on Notification of Change in resident health status. DNS/designee will monitor daily the Dietitians recommendations and wt losses that are addressed in Clinical Start-up for Notifications of Change in resident health status 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. These corrective actions will be monitored and a quality assurance program</p>				

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	<p>fat, low carbohydrate diet) may have mech. soft per request of family. Meal intake avg. 23% and 11% of hs snack... Receives house supplement TID (three times a day) and pureed cottage cheese bid to help provide additional Kcal... Will provide fortified soup at lunch and dinner to help provide additional Kcal. Will request to have physician evaluate for possible appetite stimulant."</p> <p>Review of Resident # 147's record lacked evidence of Physician notification of the resident's significant weight loss or approaches to seek treatment options to prevent the resident's significant weight loss or prevent potential future loss.</p> <p>3.1-46(a)(1)</p>		<p>implemented to ensure the deficient practice will not recur per the following: DNS/designee will monitor daily the Dietitians recommendations and wt losses that are addressed in Clinical Start-up for Notifications of Change in resident health status 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly for 4 weeks. Results of audits will be reviewed at monthly QAA meetings for 3 months or until compliant. audits will be evaluated for trends or patterns and action plans will be implemented if indicated.</p>		

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F0368 SS=D	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation and interview the facility failed to provide meals to 2 residents for 2 days after admission and to deliver 1 resident meals in a timely manner for 3 of 3 residents reviewed for timely meal service. (Resident #162, # 159 & # 42)</p> <p>Findings include:</p> <p>1.) During observation and interview on 3/4/12 at 5:55 p.m. Resident # 162 indicated she had not received her dinner tray yet. She indicated "they'll bring it eventually." At 6:00 p.m. CNA # 15 indicated</p>	F0368	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Residents #159, #162 and #42 Residents #159 and # 162 have discharged and Resident # 42 was interviewed by the ED to address any issues she has with the times her meals are delivered. Resident stated she usually receives her tray at 5:15 to 5:30 not 6:30 to 7 pm. as indicated in the 2567and has dx of Alzheimer's.</p>	04/08/2012	

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	<p>"there's some confusion some of them (residents) haven't gotten their trays because they wanted something different." Resident # 162 indicated she has had to ask for her meals since she was admitted on the evening of 3/3/12.</p> <p>At 6:10 p.m. observation of all trays having been passed and food cart returned to kitchen area.</p> <p>At 6:25 p.m. Resident # 162 indicated the nurse that had just left her room was "going right now to check on my tray." Observed nurse leaving Resident # 162's room, walking down the hall into another residents room then closed the door.</p> <p>At 6:30 p.m. interview with the Dietary Manager indicated Resident # 162's tray was taken to her. She indicated the Resident refused the tray because she does not like fish. The Dietary Manager indicated the Resident had asked for something else but it was not ready yet.</p> <p>At 6:35 p.m. interview with Resident # 162 indicated "they have not brought any tray in my room I think I'd remember that."</p> <p>Observation of Resident # 162 at 6:45 p.m. indicated a bowl of soup and crackers with no other food on over bed table where the Resident was sitting at.</p>		<p>Nursing and Dietary staff have been in serviced on Meal times and importance of timely meal service on 4-02-12</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Dietary Manager/Designee will interview all alert and oriented residents who eat in there room to identify and address any issues with the time that they receive there meal trays.</p> <p>Dietary will be informed of new admission and diet orders prior to the next meal service after admission.</p> <p>Nursing and Dietary staff have been educated on notification of new residents, Meal times and importance of timely meal service.</p> <p>New staff will have education on educated on notification of new residents, Meal times and importance of timely meal service.</p> <p>Dietary services managers will audit completion of meal service tray pass, grievance's, 48 hour interviews of new patients and those residents who prefer to eat in their room</p>				

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	<p>2.) On 3/6/12 at 9:15 a.m. interview with Resident # 159's family indicated the first 2 days after Resident # 159 was admitted on 2/9/12, the family had to request her meals. The family indicated the facility did not bring her meals without the family requesting them.</p> <p>3.) Interview on 3/6/12 at 3:14 p.m. with Resident # 42 indicated the meal trays are late on evening shift. She indicated they usually are delivered any where between 6:30 p.m. to 7:00 p.m.</p> <p>On 3/5/12 at 8:45 a.m. the Administrator provided a document that indicated a 4:30 p.m. meal time for the dinner hall trays to be delivered.</p> <p>Interview with the Administrator on 3/6/12 at 2:30 p.m. indicated the facility has been having problems with the meals being served on time.</p> <p>3.1-21(c)</p>		<p>satisfaction. 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Dietary services managers will audit completion on meal service tray pass, grievance's, 48 hour interviews of new patients and those residents who prefer to eat in there room's satisfaction. 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks.</p> <p>Results of audits will be reviewed at the monthly QAA meetings for 3 months or until compliant. The Facility will evaluate the audits for trends or patterns and action plans will be implemented if indicated.</p>		

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