

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER WI VETERANS HOME-BOLAND HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 21425 E SPRING ST UNION GROVE, WI 53182	
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F 000	INITIAL COMMENTS Surveyor: 22692 This was a recertification/complaint /self report investigation conducted at WI Veteran's Home-Boland Hall on from 7/13/15 to 7/16/15. # of federal citations issued: 9 The most serious citation was F-241 cited at a scope/severity level of E (no actual harm/pattern). Census: 150 Sample size: 24 Survey coordinator: #22692	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Surveyor: 22692 Based upon observation and interview, the facility did not promote care for 4 (Resident's #1, #16, #11, and #10) of 21 observed, sampled Residents in a manner and environment that maintained or enhanced their dignity. * Resident's #1, #16, #11, and #10 were observed to have signage in their rooms directing their care. Findings Include: 1. Resident #1 was admitted to the facility on 5/11/13 with diagnosis that included Dementia. On 7/13/15 at 11:45 a.m., Surveyor #22692	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 241	<p>Continued From page 1</p> <p>observed Resident #1 in his broad chair in his room. On his walls was signage that read: shave every other day, make sure hearing aides are in, please have a barber shave his neck, clean fingernails, nectar thick fluids only, pureed diet only, pills to be given crushed in applesauce or pudding, reposition every two hours, to be fed all meals sitting up in chair, up in chair for breakfast and lunch, down for lunch after nap, up for supper in chair, keep upright in chair 30 minutes after meals, oxygen on at all times. The above signage was also observed in Resident #1's room on 7/14/15 at 8:45 a.m.</p> <p>On 7/14/15 at 3:00 p.m. the above findings were shared with the Administrator, Director of Nurses and Unit Manager-D who stated the family wanted the signs in Resident #1's room. Additional information was requested if available. None was provided.</p> <p>2. Resident #16 was admitted to the facility on 9/13/11 with diagnosis that included dementia. On 7/15/15 at 3:35 p.m. Surveyor #22692 observed signage in Resident #16's bathroom that read: Member not to have sharp objects in room including nail clippers and razors. On 7/16/15 at 10:00 a.m. Surveyor #22692 shared the above findings with the Director of Nurses who stated she would have the sign removed right away. The above findings were shared with the Administrator and Director of Nurses on 7/16/15 at 3:30p.m. at the pre exit meeting additional information was requested if available. None was provided.</p> <p>Surveyor: 03357</p> <p>3. On 7/15/15 at 9:40 a.m., Surveyor #03357 conducted a resident room review for Resident #11. Surveyor observed a sign taped on Resident</p>	F 241			

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F 241	<p>Continued From page 2</p> <p>#11's wall upon entry into resident's room. This sign was observable to anyone walking into resident's room. The sign was dated 4/11/15 and labeled, "Swallowing Exercises." The swallowing exercise instructions on the sign stated, "Swallow 25 times, 3 times per day, think about swallowing hard, you may need to take small sips nectar thick liquid to help trigger swallow." This sign was signed by the speech therapist.</p> <p>Surveyor #03357 also observed an additional sign placed on Resident #11's wall above the chair in the room. This additional sign was not signed by anyone. This sign stated, "Please put clothing away, do not leave clothing on chair."</p> <p>According to Resident #11's Minimum Data Sets dated 5/26/15, Resident #11 is cognitively intact. Surveyor #03357 attempted to interview Resident #11 on 7/16/15 at 8:15 a.m. but this attempted interview brought forth minimal responses. On 7/16/15 at 9:05 a.m., Surveyor #03357 attempted to contact Resident #11's Activated Power of Attorney for Health Care to conduct a Family interview, however; obtaining an interview the Activated Power of Attorney for Health Care was not successful.</p> <p>On 7/15/15 at 3:05 p.m., Surveyor #03357 shared the concerns with signage in Resident #11's room with administrative staff.</p> <p>On 7/16/15 at 8:15 a.m., Surveyor #03357 observed that the signs had been removed from the walls in Resident #11's room.</p> <p>4. On 7/14/15 at 4:25 p.m., Surveyor #03357 conducted a resident room review for Resident</p>	F 241			

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F 241	Continued From page 3 #10. Surveyor #03357 observed signs on Resident #10's bulletin board above Resident #10's bed that stated, "...is allowed 3 cookies sitting on his bed right before bed time," dated 1/31/14. This sign is not signed by anyone. An additional sign dated 2/19/10 also on the bulletin board stated, "please leave head of bed 30 degrees at all times due to swallowing issues." This sign was also not signed by anyone. According to Resident #10's Minimum Data Sets dated 3/23/15 and 6/15/15, Resident #10 is moderately cognitively impaired. On 7/15/15 at 10:37 a.m., Surveyor #03357 attempted to contact Resident #10's Activated Power of Attorney for Health Care to conduct a family interview however, obtaining the family interview from the Activated Power of Attorney for Health Care was not successful. On 7/15/15 at 3:05 p.m., Surveyor #03357 shared the concerns with signage in Resident #11's room with administrative staff.	F 241			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272			

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F 272	Continued From page 4 Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 13472 Based on record review and staff interviews, the facility did not complete a thorough and accurate comprehensive assessment for 2 of 11 (Resident #5 and Resident #10) sampled residents reviewed for incontinence of bowel. * On 5/04/15 Resident #5 had a decline in bowel continence status. The facility did not complete an accurate and thorough bowel assessment for the Resident's incontinence. * According to an annual Minimum Data Set	F 272			

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F 272	<p>Continued From page 5</p> <p>(MDS) completed on 6/15/15 with a reference date of 6/9/15, Resident #10 had a decline in bowel continence from being continent (0) to being frequently incontinent (2). The 5/31/15 bowel assessment did not accurately reflect resident's bowel continence status. When the MDS indicated a decline in bowel continence, there was no explanation within the urinary incontinence care area assessment (which included information pertaining to Resident #10's bowels) or a bowel reassessment to determine if Resident #10 actually had a decline in bowel continence or whether the decline was attributed to an isolated cause.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 7/14/15 Surveyor #13472 reviewed Resident #5's medical record. The quarterly Minimum Data Set (MDS), dated 2/10/15, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 11 (moderately impaired cognitive skills), requires extensive assistance of 1 staff for transfers and for toilet use, and is always continent of bowel. The annual Minimum Data Set (MDS), dated 5/05/14, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 14 (cognitively intact), requires extensive assistance of 1 staff for transfers and for toilet use, and is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one episode of continent bowel movement). The Care Area Assessment (CAA), dated for the annual MDS complete on 5/05/15, indicates Resident #5 as having functional bowel incontinence and requiring extensive assist with toileting task, transfers, clothing, product and hygiene. The CAA indicates the facility will monitor the Resident's bowel pattern and develop a plan of care, 	F 272			

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F 272	<p>Continued From page 6</p> <p>On 7/14/15, Surveyor #13472 reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. The record indicates Resident #5 had 4 bowel incontinence episodes during these dates.</p> <p>The Bowel Assessment, dated 5/04/15, indicates Resident #5 is not incontinent of bowel and is aware of the need to have a bowel movement. On 7/15/15 at 8:35 a.m., and on 7/16/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse/ MDS Nurse-G who indicated that when completing the MDS Bowel Assessment, she completes a review of Resident's medical record for bowel elimination and bowel incontinence during the 7-day look-back period. Registered Nurse/ MDS Nurse-G indicated that she identified that Resident #5 is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one episode of continent bowel movement) and that the Resident was triggered to proceed to the development of a plan of care for bowel incontinence.</p> <p>On 7/15/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse (RN)-H who completed the Bowel Assessment dated 5/04/15. RN-H indicated he reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. RN-H indicated he did not capture the documented episodes of bowel incontinence during the assessment reference dates.</p> <p>On 7/15/15, at 1:30 p.m., Surveyor #13472 spoke with RN Manager-F who verified that Resident #5 did not have an accurate Bowel Assessment</p>	F 272			

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F 272	<p>Continued From page 7 completed for his bowel incontinence.</p> <p>Surveyor: 03357</p> <p>2. On 7/13 through 7/16/15, Surveyor #03357 reviewed Resident #10's medical recorded and conducted observations of Resident #10.</p> <p>The quarterly Minimum data Set (MDS) dated 3/23/15 indicated Resident is continent of bowel (0). The annual MDS dated 6/15/15 with a reference date of 6/9/15 indicates Resident #10 is now (2) frequently incontinent of bowel. In comparison of the two MDS', Surveyor #03357 noted Resident #10 had a decline in bowel continence.</p> <p>The Care Area Assessment (CAA) for urinary incontinence/catheter, which also addresses components of resident's bowel continence, indicates, Resident does not alert staff of need to eliminate, impaired mobility, self care deficit, cognitive impairment, ...functional (can't get to toilet on time due to physical disability, external obstacles, or problems thinking or communicating.) Will develop care plan, monitor bowel characteristics, monitor bowel pattern...assist with elimination needs..see ADL/Functional Rehab CAA.</p> <p>A bowel Assessment completed by the unit nurse dated 5/31/15 states Resident is incontinent of stool 2 to 3 times a week, no apparent pattern, diminished awareness with the need to stool, check and change upon rising after meals, before bed, with NOC (night) rounds.</p> <p>Resident #10's care plan includes an ADL</p>	F 272			

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F 272	<p>Continued From page 8</p> <p>(activities of daily living) care plan states: Toileting: incontinent briefs, extensive assist 1 person assist, toileting upon rising, toilet before meal, after meal, at HS and upon request, check and change. Resident #10's incontinence care plan initiated on 8/17/10 indicates Incontinence, functional related to external factors, may not make it to the toilet in time urinary related to cognitive deficit, mobility deficit, sensory deficit, resistive to toileting. On 02/08/13, the care plan was updated to reflect urinary incontinence, bowel incontinence. The approaches dated 3/21/2010 include toilet upon rising, toilet at HS (evening), toilet before meal, toilet after meal, toilet upon request, pericare when incontinent, use protective pads, open to air during night, cleanse peri-area and apply barrier cream after incontinent episodes and PRN, keep clean and dry.</p> <p>A potential for constipation care plan initiated on 4/22/14 has approaches which include: patterned bowel care, administer PRN (as needed) medications to promote bowel evacuation as needed... The Nurse aide component of this care plan dated 7/3/15 includes approaches such as maintain resident dignity, provide privacy, prompt toilet use, toilet upon rising, prior to HS, after meals, record # of stools, etc.</p> <p>On 7/14/15 at 12:20 p.m., Surveyor #03357 asked LPN-N (unit nurse) about Resident #10's decline in bowel continence. LPN-N stated, "I almost never know him to be incontinent." Together LPN-N and Surveyor #03357 reviewed Resident's 5/31/15 bowel incontinence assessment which indicates Resident is incontinent of stool 2 to 3 times a week. LPN-N stated that the nurse who completed this incontinence assessment doesn't usually work</p>	F 272			

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F 272	<p>Continued From page 9 the floor.</p> <p>LPN-N and Surveyor #03357 reviewed Resident #10's bowel recordings from 6/1 through 6/9/15 to see how often Resident #10 had been incontinent during 7 day look back from 6/9/15 which was used when when completing the 6/15/15 MDS (with a reference date of 6/9/15), identifying a decline in Resident #10's bowel incontinence.</p> <p>The bowel recordings indicated from 6/1 through 6/9/15, Resident #10 had 5 days when Resident had a bowel movement. Of the 5 days, Resident had 1 day-6/4/15 where resident was incontinent 4 times on that day. The remaining 4 days, Resident #10 was continent of bowel.</p> <p>The 6/15/15 MDS with a reference date of 6/9/15 was accurately record as a 2 (frequently incontinent) based off of the 6/4/15 date of Resident having 4 bowel incontinence episodes for the 1 day. The recording of a 2 (frequently incontinent) would show a decline in Resident #10's bowels.</p> <p>LPN-N and Surveyor #03357 reviewed the bowel tracking system and noted that in the last 1 1/2 months (6/1 through 7/14/15) Resident had only 3 days where Resident had been incontinent of stool which included the 6/4/15 day.</p> <p>LPN-N indicated that someone "should look into this" referring to the accuracy of Resident #10 having 4 incontinence episodes on 6/4/15 as recorded on the bowel tacking system, the bowel assessment dated 5/31/15 indicating resident is incontinent of bowel 2 to 3 times a week and the noted decline in Resident's bowel continence per the MDS.</p>	F 272			

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F 272	Continued From page 10 The 5/31/15 bowel incontinence assessment does not accurately reflect Resident's bowel incontinence. The most recent Care Area Assessments for Urinary incontinence for the 6/15/15 MDS, includes documentation of monitoring resident's bowels but does not indicate whether Resident actually had a decline in bowel continence and the cause of this decline or whether the 6/4/15 of 4 bowel incontinence episodes was attributed to an isolated incident. There was no reassessment of Resident #10's bowels after the MDS indicated a decline from continent to frequently incontinent to determine if Resident #10 actually had a decline in bowel continence and the cause of this decline or whether the 6/4/15 bowel incontinence episodes were attributed to an isolated incident.	F 272			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279			

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F 279	<p>Continued From page 11</p> <p>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>This REQUIREMENT is not met as evidenced by: Surveyor: 13472 Based on record review and staff interviews the facility did not use the results of a thorough and accurate bowel assessment to develop 1 of 11 sampled resident's (Resident #5) comprehensive plan of care. On 5/04/15 Resident #5 had a decline in bowel status. The facility did not accurately complete the Bowel Continence assessment and did not develop and implement a care plan with individualized, resident specific bowel toileting program interventions based on an assessment of the resident's unique bowel patterns. Findings include: 1. On 7/14/15 Surveyor #13472 reviewed Resident #5's medical record. The quarterly Minimum Data Set (MDS), dated 2/10/15, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 11 (moderately impaired cognitive skills), requires extensive assistance of 1 staff for transfers and for toilet use, and is always continent of bowel. The annual Minimum Data Set (MDS), dated 5/05/14, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 14 (cognitively intact), requires extensive assistance of 1 staff for transfers and for toilet use, and is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER WI VETERANS HOME-BOLAND HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 21425 E SPRING ST UNION GROVE, WI 53182		
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F 279	<p>Continued From page 12</p> <p>episode of continent bowel movement). The Care Area Assessment (CAA), dated for the annual MDS complete on 5/05/15, indicates Resident #5 as having functional bowel incontinence and requiring extensive assist with toileting task, transfers, clothing, product and hygiene. The CAA indicates the facility will monitor the Resident ' s bowel pattern and develop a plan of care,</p> <p>On 7/14/15, Surveyor #13472 reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. The record indicates Resident #5 had 4 bowel incontinence episodes during these dates.</p> <p>The Bowel Assessment, dated 5/04/15, indicates Resident #5 is not incontinent of bowel and is aware of the need to have a bowel movement. The record review indicated the facility did not develop and implement an individualized, resident specific bowel toileting program based on an assessment of the resident's unique bowel pattern and bowel incontinence.</p> <p>On 7/15/15 at 8:35 a.m., and on 7/16/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse/ MDS Nurse-G who indicated that when completing the MDS Bowel Assessment, she completes a review of Resident's medical record for bowel elimination and bowel incontinence during the 7-day look-back period. Registered Nurse/ MDS Nurse-G indicated that she identified that Resident #5 is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one episode of continent bowel movement) and that the Resident was triggered to proceed to the development of a plan of care for bowel incontinence.</p>	F 279			

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F 279	Continued From page 13 On 7/15/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse (RN)-H who completed the Bowel Assessment dated 5/04/15. RN-H indicated he reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. RN-H indicated he did not capture the documented episodes of bowel incontinence during the assessment reference dates and did not develop a plan of care for the Resident's bowel incontinence. On 7/15/15, at 1:30 p.m., Surveyor #13472 spoke with RN Manager-F who verified that Resident #5 did not have an accurate Bowel Assessment completed or a plan of care developed for his bowel incontinence. There was no evidence that the facility accurately completed the Bowel Continence assessment, and developed and implemented an individualized resident specific bowel toileting program, based on an assessment of the resident's unique bowel patterns.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280			

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F 280	<p>Continued From page 14</p> <p>disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 03357 Based on observation, interview and record review, the facility did not update a care plan to include the utilization of a bed alarm when implemented for 1 of 13 residents reviewed who were at risk for falls.</p> <p>On 11/21/14, the facility added the use of the bed alarm after an unwitnessed fall from bed with no injury, however; Resident #21's care plan was not updated to reflect the use of a bed alarm. The bed alarm was observed on Resident #21's bed on 7/15/15.</p> <p>Findings include:</p> <p>On 7/15/15 at 1:16 p.m., Surveyor #03357 observed CNA I transfer Resident #21 from his wheelchair onto the toilet using the E/Z Stand lift. While Resident #21 was in the bathroom, Surveyor #03357 observed a bed alarm on Resident #21's bed. Surveyor #03357 asked CNA I if the bed alarm was relatively new for Resident #21. CNA I stated that she was not familiar with Resident #21 as she is a float between floors.</p> <p>On 7/15/15 at 1:25 p.m. LPN J indicated Resident</p>	F 280			

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F 280	<p>Continued From page 15</p> <p>#21 is a fall risk and that the bed alarm was implemented a awhile ago.</p> <p>On 7/15 through 7/16/15, Surveyor #03357 reviewed Resident #21's medial record. Surveyor #03357's review of Resident #21's medical record indicates Resident #21 is at risk for falls. The 5/5/15 and 5/26/15 Minimum Data Sets indicate Resident is moderately cognitively impaired. The 5/5/15 and 2/10/15 quarterly MDS' indicate Resident #21 had 2 or more falls with no injury. The 2/10/15 quarterly MDS indicates Resident had 1 fall with injury.</p> <p>Resident #21's plan of care identifies a fall problem initiated on 12/01/14. Approaches dated 6/17/15 include: place items in reach, body pillow when in bed, floor mat next to bed, scoop mattress...The Falls plan of care approaches do not not include the use of the bed alarm/sensor pad. A review of the ADL care plan located in Resident #21's bathroom cabinet does not include the use of the bed alarm/sensor pad.</p> <p>A review of Resident's falls indicates that the facility evaluates the circumstances surrounding the falls and implements new interventions/actions. Resident #21's has had 19 falls from 11/18/14 through 6/18/15. A fall with injury was sustained on 12/8/14, when Resident #21 was noted to fall out of his wheelchair. The facility added the use of the bed alarm after an unwitnessed fall from bed with no injury occurring on 11/21/14, however; Resident #21's care plan was not updated to reflect this new intervention.</p> <p>The above observations were shared with Administrative staff on 7/15/15 at 3:05 p.m.</p>	F 280			

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F 309 F 309 SS=D	Continued From page 16 483.25 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. This REQUIREMENT is not met as evidenced by: Surveyor: 13472 Based on record review and staff interview the facility did not provide services to allow 1 of 11 (Resident #5) sampled residents reviewed for bowel incontinence to attain or maintain their highest level of well-being. On 5/04/15 Resident #5 had a decline in bowel continence status. The facility did not accurately complete the Bowel Continence assessment and did not develop and implement a care plan with individualized, resident specific bowel toileting program interventions based on an assessment of the resident's unique bowel patterns. Findings include: 1. On 7/14/15 Surveyor #13472 reviewed Resident #5's medical record. The quarterly Minimum Data Set (MDS), dated 2/10/15, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 11 (moderately impaired cognitive skills), requires extensive assistance of 1 staff for transfers and for toilet use, and is always continent of bowel. The annual Minimum Data Set (MDS), dated 5/05/14, indicates Resident #5 has Brief Interview for Cognitive Status (BIMS) score of 14	F 309 F 309			

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F 309	<p>Continued From page 17</p> <p>(cognitively intact), requires extensive assistance of 1 staff for transfers and for toilet use, and is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one episode of continent bowel movement).</p> <p>The Care Area Assessment (CAA), dated for the annual MDS complete on 5/05/15, indicates Resident #5 as having functional bowel incontinence and requiring extensive assist with toileting task, transfers, clothing, product and hygiene. The CAA indicates the facility will monitor the Resident's bowel pattern and develop a plan of care,</p> <p>On 7/14/15, Surveyor #13472 reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. The record indicates Resident #5 had 4 bowel incontinence episodes during these dates.</p> <p>The Bowel Assessment, dated 5/04/15, indicates Resident #5 is not incontinent of bowel and is aware of the need to have a bowel movement. The record review indicated the facility did not develop and implement an individualized, resident specific bowel toileting program based on an assessment of the resident's unique bowel pattern and bowel incontinence.</p> <p>On 7/15/15 at 8:35 a.m., and on 7/16/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse/ MDS Nurse-G who indicated that when completing the MDS Bowel Assessment, she completes a review of Resident's medical record for bowel elimination and bowel incontinence during the 7-day look-back period. Registered Nurse/ MDS Nurse-G indicated that she identified that Resident #5 is frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at</p>	F 309			

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F 309	Continued From page 18 least one episode of continent bowel movement) and that the Resident was triggered to proceed to the development of a plan of care for bowel incontinence. On 7/15/15 at 1:30 p.m., Surveyor #13472 spoke with Registered Nurse (RN)-H who completed the Bowel Assessment dated 5/04/15. RN-H indicated he reviewed the documentation of Resident #5's bowel movements from the bowel and bladder diary for the 7-day look-back period for the MDS Assessment Reference Dates (ARD) of 4/29/15 through 5/04/15. RN-H indicated he did not capture the documented episodes of bowel incontinence during the assessment reference dates and did not develop a plan of care for the Resident's bowel incontinence. On 7/15/15, at 1:30 p.m., Surveyor #13472 spoke with RN Manager-F who verified that Resident #5 did not have an accurate Bowel Assessment completed or a plan of care developed for his bowel incontinence. There was no evidence that the facilities accurately completed the Bowel Continence assessment, and developed and implement an individualized resident specific bowel toileting program, based on an assessment of the resident's unique bowel patterns.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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	F 314			

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F 314	<p>Continued From page 19 prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 13472</p> <p>Based on record review, observation, and staff interview the facility did not ensure that 2 of 13 (Resident 6 and 4) residents with pressure ulcers received the necessary treatment and services to promote healing and prevent new ulcers from developing.</p> <p>*Resident #6 had a decline in bed mobility. The facility did not promptly assess the decline and revise the plan of care to include new interventions to prevent an avoidable deep tissue injury (DTI) to the Resident's right heel. On 7/04/15, when Resident #6 developed a DTI to the right heel, the facility obtained protector pads for the heels to be worn when the Resident is in bed. The protector pads protect against pressure ulcers, but are not support devices that elevate the heels from the surface of the bed, completing offloading of the pressure ulcer. Resident #6 has a plan of care that includes measuring the area weekly. There was no documentation to indicate that the facility completed measurements on the DTI from 7/04/15 through 7/14/15. On 7/13/14 and 7/14/15 Resident #6 was observed in the wheelchair with heavy gripper socks and tennis shoes on. Pressure to the right heel DTI was not offloaded. On 7/14/15 the Resident was observed in bed with his heels positioned directly on the mattress. Pressure to the right heel DTI was not offloaded.</p> <p>*Resident #4 was admitted to the facility with a deep tissue injury (DTI) on the left heel. The</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>facility did not provide proper support surfaces to offload the pressure to the left heel when the Resident is up in the wheelchair and when the Resident is in bed. The Resident has a plan of care that includes a weekly assessment of the DTI. On 7/08/15 the facility did not accurately assess the DTI.</p> <p>The "Pressure Ulcer Prevention, Quick Reference Guide" (National Pressure Ulcer Advisory Panel, 2014) indicates that for repositioning to prevent heel pressure ulcers, ensure that the heels are free of the surface of the bed and to use heel suspension devices that elevate and offload the heel completely. The guidelines indicate that when repositioning for treating existing unstageable heel pressure ulcers, to place the leg in a device that elevates the heel from the surface of the bed, completely offloading the pressure ulcer. The guidelines indicate the support surfaces are specialized devices for pressure redistribution designed for management of tissue load, and that with suspected deep tissue injury a support surface that enhances pressure redistribution should be selected.</p> <p>The "Pressure Ulcer Prevention, Quick Reference Guide " (National Pressure Ulcer Advisory Panel, 2014) indicates that pressure ulcers should be assessed at least weekly. The guideline indicates that the assessment should include physical characteristics including location, category/stage, tissue type, color, peri-wound condition, wound edges, exudate and odor. The guideline indicates that a uniform, consistent method for measuring wound length and width or wound area should be selected to facilitate meaningful comparisons of wound measurements across time.</p> <p>Findings include:</p> <p>1. On 7/14/15, Surveyor #13472 reviewed</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>Resident #6's medical record</p> <p>The quarterly Minimal Data Set (MDS), dated 5/15/15, indicates Resident #6 has a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive impairment), requires limited assistance of one staff for bed mobility and for transfers, is at risk for pressure ulcers, and has no pressure ulcers.</p> <p>The significant change Minimal Data Set (MDS), dated 6/09/15, indicates Resident #6 has moderately impaired cognition (decisions poor; cues/supervision required), requires extensive assistance of one staff for bed mobility and for transfers (a decline from the 5/15/15 assessment), is at risk for pressure ulcers, and has 2 stage one pressure ulcers.</p> <p>The plan of care for skin integrity impairment, dated 6/15/15, includes Resident #6 has a deep tissue injury (DTI) to the right heel. Interventions on the plan of care includes measuring the area weekly and assessing for the need for pressure reduction devices and minimizing pressure on bony prominences. The plan of care does not include support surface/heel suspension devices for enhancing pressure redistribution that would elevate and offload the heel.</p> <p>The CNA (Certified Nursing Assistant) Care plan (undated) indicates Resident #6 requires extensive assist with bed mobility. The care plan does not include support surface/heel suspension devices for enhancing pressure redistribution that would elevate and offload the heel.</p> <p>The progress note for skin condition, dated 7/04/15, indicates Resident #6 has fragile skin surfaces described as "purple" on the right heel. The note indicates the cause is due to the Resident sleeping more and in bed more. The note indicates actions taken that include floating heels when in bed.</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>The notes dated 7/04/15 through 7/10/15 were reviewed and indicate the Resident continues to have deep purple discoloration to the right heel, the skin is intact, blue heel boots are being applied at hours of sleep, and skin prep to the right heel is applied twice daily. There was no documentation to indicate that the facility completed measurements on the DTI.</p> <p>On 7/13/15 at 11:50 a.m., Surveyor #13472 and Licensed Practical Nurse (LPN)-J observed Resident #6's heels. The Resident had an approximate 4 centimeter by 3 cm dark purplish colored area to the outer heel. LPN-J indicated the Resident wears soft blue cloth boots to both feet when in bed. LPN-J indicated the boots were ordered after the Resident developed a DTI to the right heel.</p> <p>On 7/13/15, from 12:00 p.m. through 12:25 p.m., on 7/14/15 at 7:45 a.m., on 7/14/15 from 8:15 a.m. through 9:00 a.m., and on 7/14/15 at 12:50 p.m., Surveyor #13472 observed Resident #6 sitting in a wheelchair in the West Unit dining room. Resident #6 was wearing heavy, tight fitting gripper socks and tennis shoes. The Resident was observed to be self-propelling his wheelchair using his feet. Pressure to the right heel DTI was not offloaded.</p> <p>On 7/14/15 at 10:00 a.m., at 10:30 a.m., at 11:00 a.m., Surveyor #13472 observed Resident #6 in bed. Resident #6 was wearing a pair of gripper socks and his heels were positioned directly on the mattress. Pressure to the right heel DTI was not offloaded with either a pillow under the calves to "float" the heels or with the use of a heel suspension device.</p> <p>On 7/14/15, at 1:00 p.m., Surveyor #13472 spoke with Registered Nurse Unit Manager-F who indicated Resident #6 developed the DTI to his right heel when he experienced a decline in bed</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>mobility. Registered Nurse Unit Manager-F indicated that the Certified Nursing Assistants (CNA) did not inform the nursing staff of the resident's decline in bed mobility and no care plan interventions put into place to offload the Resident's heels.</p> <p>On 7/14/15, at 1:00 p.m., Surveyor #13472 and Registered Nurse Unit Manager-F observed Resident #6. Resident #6 was sitting in a wheelchair with heavy weight gripper socks and tennis shoes on. Registered Nurse Unit Manager-F verified the Resident should not have the heavy weight socks and tennis shoes on. Registered Nurse Unit Manager-F verified that pressure to the right heel DTI was not offloaded. During the observation CNA-I verified that the Resident was in bed earlier in the day and that the Resident's heels were positioned directly on the mattress and not floated.</p> <p>Surveyor #13472 reviewed the manufacture information for the soft blue cloth heel protectors that were being utilized for Resident #6's DTI on the right heel. The product information indicates the boots are a heel protector pad made of polyester/spun fiber and are used to protect against pressure ulcers. The product information does not include information that would indicate the device is a support surface that is a specialized devices for pressure redistribution designed for management of tissue load.</p> <p>On 7/14/15 at 1:45 p.m., Surveyor #13472 spoke with the Director of Nursing who indicated that the soft blue cloth heel protectors were not a proper support surface for managing tissue load for a DTI.</p> <p>The facility's policy and procedure for Wound Prevention and Treatment, dated 3/15/15, was reviewed. The policy indicates for prevention of pressure ulcers the facility will utilize the Pressure</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>Ulcer Prevention Quick Reference Guide for reposition and support surfaces and that pressure ulcers will be documented weekly. The policy indicates on-going weekly documentation will include a complete description of findings including measurements, condition of peri-wound, condition of wound bed, percentage and type of tissue, type and amount of drainage, presence or absence of odor.</p> <p>2. On 7/14/15, Surveyor #13472 reviewed Resident #4's medical record. The record indicates the resident was re-admitted back to the facility on 6/03/15.</p> <p>The Skin Condition progress note, dated 6/03/15, indicates Resident #4's left heel has a 2.3 centimeter (cm) by 3.5 cm wound that is purple in appearance with redness. The report indicates the wound edges are well defined and attached to wound base. The pre-wound is described as bright red-blanches.</p> <p>The Physician's Orders, dated 6/03/15, include the order for pressure relieving boots to bilateral feet, on at all times until healed.</p> <p>The plan of care for skin integrity impairment, dated 7/13/15, and the CNA (Certified Nursing Assistant) Care plan (undated) indicate Resident #4 has a deep tissue injury (DTI) to the heel. Interventions on the plan of care include heel boots to be worn all times.</p> <p>The Skin Condition progress notes dated, 6/06/15 through 6/08/15, indicate the Resident wears heel boots at all times to relieve pressure.</p> <p>The 5-day PPS assessment Minimal Data Set (MDS), dated 6/10/15, indicates Resident #4 has a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment), requires extensive assistance of one staff for bed mobility, is dependent on staff for transfers, is at risk for</p>	F 314			

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F 314	<p>Continued From page 25</p> <p>pressure ulcers, and has one unstageable pressure ulcer with suspected deep tissue injury that was present upon reentry to the facility. The Skin Condition progress note, dated 6/10/15, indicates the purple area to Resident #4's left heel remains. Skin intact, measuring 1.5 cm by 2.2 cm, with the peri-wound described as pink. The Skin Condition progress notes dated, 6/16/15, indicate the Resident wears heel boots at all times to relieve pressure. The Skin Condition progress notes, dated 6/17/15, 6/19/15 and 6/23/15, indicate the purple area to Resident #4's left heel remains and measures 1.4 cm by 2.0 cm with the peri-wound described as pink. The Skin Condition progress note, dated 6/24/15 and 7/01/15, indicates the purple area to Resident #4's left heel remains and measures 1.3 cm by 2.0 cm with the peri-wound described as pink. The next documented assessment of Resident #4's left heel DTI is dated 7/08/15. The assessment indicates the Resident has an 8.1 cm in length by 12.0 cm in width pressure ulcer to the left heel that is closed. The note does not include physical characteristics of the pressure ulcer including category/stage, tissue type, color, peri-wound condition, wound edges, exudate and odor. On 7/14/15 at 11:00 a.m., Surveyor #13472 and Registered Nurse (RN)-K observed Resident #4's heels. The right heel did not have any redness or open areas. The Resident had a purple area to the left heel measuring approximately 1.3 cm by 2.0 cm with pink colored peri-wound. RN-K indicated the Resident wears soft blue cloth boots to both feet at all times. The RN indicated the boots were ordered when the Resident returned to the facility from the hospital with a DTI to the</p>	F 314			

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F 314	Continued From page 26 left heel. On 7/13/15, from 11:45 a.m. through 12:00 p.m., on 7/14/15 at 7:45 a.m. through 9:00 a.m., and on 7/14/15 at 10:35 a.m., Surveyor #13472 observed Resident #4 sitting in a wheelchair in the West Unit dining room and hallway. Resident #4 was wearing heavy, tight fitting gripper socks and soft cloth blue boots. The Resident was observed to be self-propelling his wheel chair using his feet. Pressure to the right heel DTI was not offloaded. On 7/14/15, at 1:00 p.m., Surveyor #13472 spoke with Registered Nurse Unit Manager-F who indicated Resident #4 developed the DTI to his left heel when he was in the hospital. On 7/14/15 at 1:00 p.m., Surveyor #13472 and Registered Nurse Unit Manager-F observed Resident #4. Resident #4 was sitting in a wheelchair with heavy weight gripper socks and the soft blue cloth boots. Registered Nurse Unit Manager-F verified that pressure to the right heel DTI was not offloaded with the use of the blue soft blue cloth boots. Surveyor #13472 and Registered Nurse Unit Manager-F observed Resident #4's DTI to the left heel. The Resident had a purple area to the left heel measuring approximately 1.3 cm by 2.0 cm with pink colored peri-wound. Registered Nurse Unit Manager-F verified that the weekly skin condition assessment, dated 7/08/15, was incomplete and inaccurate (documented to be 8.1 cm in length by 12.0 cm in width and without the assessment of physical characteristics including category/stage, tissue type, color, peri-wound condition, wound edges, exudate and odor). The Surveyor reviewed the manufacture information for the soft blue cloth heel protectors that were being utilized for Resident #4's DTI on the left heel. The product information indicates the boots are a heel protector pad made of	F 314			

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F 314	Continued From page 27 polyester/spun fiber and are used to protect against pressure ulcers. The product information does not include information that would indicate the device is a support surface that is a specialized devices for pressure redistribution designed for management of tissue load. On 7/14/15 at 1:45 p.m., Surveyor #13472 spoke with the Director of Nursing who indicated that the soft blue cloth heel protectors were not a proper support surface for managing tissue load for a DTI. The facility's policy and procedure for Wound Prevention and Treatment, dated 3/15/15, was reviewed. The policy indicates for prevention of pressure ulcers the facility will utilize the Pressure Ulcer Prevention Quick Reference Guide for reposition and support surfaces and that pressure ulcers will be documented weekly. The policy indicates on-going weekly documentation will include a complete description of findings including measurements, condition of peri-wound, condition of wound bed, percentage and type of tissue, type and amount of drainage, presence or absence of odor.	F 314			
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by:	F 323			

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F 323	<p>Continued From page 28</p> <p>Surveyor: 03357</p> <p>Based upon observation, interview and record review the facility did not ensure that devices to prevent the potential for falls were applied to Residents wheelchairs as per Residents care plan for 2 of 13 residents (Residents #11 and #21) reviewed who were at risk for falls.</p> <p>* On 7/15/15, Resident #11 who is at risk for falls did not have Dycem on top of his wheelchair cushion as per Resident #11's plan of care.</p> <p>* On 7/15/15, Resident #21 who is at risk for falls did not have Dycem on top of his wheelchair cushion as per Resident #21's plan of care.</p> <p>Findings include:</p> <p>1. On 7/15/15 at 9:40 a.m., Surveyor #03357 observed CNA- transfer Resident #11 from his wheelchair to the toilet. Surveyor #03357 observed Resident #11 to have a wheelchair cushion in his wheelchair. Surveyor #03357 did not observe Dycem on top of Resident #11's wheelchair cushion as indicated per the not dated ADL (activities of daily living) care plan, located in the bathroom cupboard. The ADL care plan has documented, Devices Used: "Wheelchair: Standard, Dycem above wheelchair cushion."</p> <p>On 7/13 through 7/16/15, Surveyor #03357 reviewed Resident #11's medical record.</p> <p>The 4/10/15 Minimum Data Set indicates Resident #11 is moderately cognitively impaired. Resident #11 requires extensive assistance with 2 for transfers and extensive assist with one for</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>toilet use. Resident #11 is not steady, only able to stabilize with human assistance with surface-to-surface transfer. The Care Area Assessment (CAA) summary indicates that falls were triggered and care planned for. The CAA indicates Resident's last fall was on 7/15/14 and that member had a fall on 4/8/15. The CAA states Resident has impaired balance during transitions, will develop care plan, follow therapy recommendations, place items in reach, promote comfort levels, remind to call for assist with transfers, positional assist provided, assess and treat medical conditions per MD order...</p> <p>A fall risk assessment dated 5/16/15 indicates Resident is at risk for falls, does not lock wheelchair, does not call for assist with transfers, low bed, check foot wear, call light within reach.</p> <p>The 5/19/15 MDS indicates Resident #11 is cognitively intact. He usually is understood and understands others. Resident #11 requires extensive assist with 2 staff for transfers and extensive assist with 1 for toilet use. Resident has had 2 falls with no injury since admission/entry or reentry or prior assessment. The CAA summary reflects that falls were triggered and care planned for. The Falls CAA indicates Resident has a history of falls in the last quarter, has impaired balance during transitions, extensive assist using the standup lift, decreased safety awareness, see fall risk assessment, fall history with resulting injury over the last quarter, eval room, place items in reach, anticipate needs, follow therapy recs. (recommendations)...</p> <p>Resident #11's falls care plan initiated on 9/28/13 includes approaches dated 3/7/15 wide bed ...instruct on safety, lock wheelchair breaks prior</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>to bending in wheelchair. Additional interventions dated 5/11/15 include low bed, dresser moved away from bed, thin mat to floor, position member away from edge of bed while in bed, Dycem to wheelchair. The not dated ADL Care Plan under safety includes: low bed/thin mat next to be, in bed position away from edge, gripper socks, Dycem in wheelchair/check floor for clutter, keep urinal by bed... Under Devices Used: Wheelchair: Standard, Dycem above wheelchair cushion.</p> <p>Resident #11 has had a history of falls and remains at risk for falls. Resident #11 has had falls on 10/21/13, 4/26/14, 6/19/14, 4/8/15 with injury and falls on 10/31/13 7/15/14, 5/7/15, 5/14/15, 6/6/15 with no injury. A review of Resident's falls indicate that the facility evaluates the circumstances surrounding the falls and implements new interventions/actions. Surveyor #03357 noted that the facility implemented the Dycem to Resident #11's wheelchair after the 4/26/14 fall.</p> <p>On 7/15/15 at 1:00 p.m., Surveyor #03357 informed CNA-L that during the transfer observed earlier on 7/15/15 involving Resident #11, that there was no Dycem on top of Resident #11's wheelchair cushion. At 1:05 p.m., RN Manager F provided CNA-L with Dycem to be applied to Resident #11's wheelchair.</p> <p>On 7/15/15, Surveyor #03357 informed Administrative staff that Resident #11 did not have a Dycem on top of the wheelchair cushion.</p> <p>2. On 7/15/15 at 1:16 p.m., Surveyor #03357 observed CNA I transfer Resident #21 from his wheelchair onto the toilet using the E/Z Stand lift. Surveyor #03357 observed Resident #21's</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>wheelchair cushion had a Dycem under the cushion however, there was no Dycem on top of the wheelchair cushion as per Resident #21's not dated ADL Care Plan located in Resident #21's cabinet in the bathroom. The not dated ADL Care Plan located in Resident #21's bathroom under Safety states: "Dycem under the WC wheelchair pad & on top of pad at all times." CNA I informed Surveyor #03357 that she floats between floors and was not familiar with Resident.</p> <p>On 7/15 through 7/16/15, Surveyor #03357 reviewed Resident #21's medical record. Surveyor #03357's review of Resident #21's medical record indicates Resident #21 is at risk for falls. The 5/5/15 and 5/26/15 Minimum Data Sets indicate Resident is moderately cognitively impaired. Resident requires extensive assistance of 1 with transferring and with toilet use. Resident is not steady and only able to stabilize with human assistance in the areas of moving from seated to standing and surface to surface transfers.</p> <p>Resident #21's plan of care identifies a fall problem initiated on 12/01/14. Approaches dated 6/17/15 include: place items in reach, body pillow when in bed...Dycem underneath the wheelchair pad and another piece on top of the wheelchair to prevent member from scooting down...The not dated ADL Care plan states, Dycem under the wheelchair pad & on top of the pad at all times.</p> <p>A review of Resident's falls indicate that the facility evaluates the circumstances surrounding the falls and implements new interventions/actions. Resident #21's has had 19 falls from 11/18/14 through 6/18/15. A fall with injury was sustained on 12/8/14. The facility</p>	F 323			

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F 323	Continued From page 32 added Dycem underneath the wheelchair cushion and on top of the wheelchair cushion after the 11/25/14 fall. The facility again added the intervention of Dycem to Resident #21's wheelchair as a fall prevention intervention/action after a fall on 5/3/15. On 7/15/15 at 1:25 p.m., Surveyor #03357 asked LPN J about the Dycem on top of Resident #21's wheelchair pad. LPN J stated that he may have taken it off, he has been seen taking it off, could have taken it off if it is not on, probably was and he took it off. On 7/15/15 at 1:36 p.m. CNA M informed Surveyor #03357 that she had was assigned to get Resident #21 up this morning. CNA M stated she was not familiar with Resident #21 having Dycem on top of the wheelchair seat cushion. CNA M stated, I know there was none (Dycem) on top ...I can reassure that there was not one on top of the seat cushion (referring to this morning), was not familiar with this approach and that she takes care of Resident #21 on a routine basis. CNA M stated, I didn't know there was to be one (Dycem) on top and bottom. CNA M then went to check Resident #21's ADL Care Plan located in Resident #21's bathroom and acknowledged that the ADL Care Plan included the need for a Dycem to be applied on the top and bottom of the wheelchair cushion. CNA M and LPN J then notified RN Manager F of the need for Dycem to be applied on top of Resident #21's wheelchair cushion.	F 323			
F 325	The above observations were shared with Administrative staff on 7/15/15 at 3:05 p.m. 483.25(i) MAINTAIN NUTRITION STATUS	F 325			

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F 325 SS=D	Continued From page 33 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. This REQUIREMENT is not met as evidenced by: Surveyor: 22692 Based on observation, record review and interview, the facility did not ensure residents received thickened liquids when there was a swallowing problem for 1 (Residents' #1) of 4 residents sampled who had thickened liquids ordered. * Resident #1 was observed to receive thin coffee at breakfast on 7/14/15 even though he had a physician's order for nectar thick liquids due to dysphasia. Findings include: Resident #1 was admitted to the facility on 5/11/13 and has diagnoses that include dysphasia and dementia. On 7/14/15 at 8:05 a.m. Surveyor #22692 observed Resident #1 sitting alone at the dining room table with a cup of unthickened coffee in front of him. Until 8:35 a.m. the coffee sat in front of him with no supervision. Resident #1 was not observed to drink the coffee. At 8:35 a.m. Certified Nursing Assistant(CNA)-C sat down next	F 325			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525688	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER WI VETERANS HOME-BOLAND HALL			STREET ADDRESS, CITY, STATE, ZIP CODE 21425 E SPRING ST UNION GROVE, WI 53182		
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F 325	Continued From page 34 to Resident #1 to assist him with breakfast Resident #1 picked up a glass of thickened juice and drank it independently. Surveyor #22692 asked CNA-C if the coffee in front of Resident #1 was thickened. CNA-C stated she did not know. CNA-C then spoke to Nurse Manger-D and asked her if she thickened Resident #1's coffee before she gave it to him. Nurse Manager-D stated, "no, I didn't." CNA-C then dumped out the coffee and made Resident #1 a new cup of thickened coffee. On 7/14/15 Surveyor #22692 reviewed Resident #1's current physician's orders which read: Diet mechanical soft, nectar thickened liquids. The above findings were shared with the Administrator and Director of Nurses at the daily exit meeting on 7/14/15 at 3:00 p.m. Additional information was requested if available. None was provided.	F 325			
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Surveyor: 22692 Based on observation, record review and staff	F 328			

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F 328	<p>Continued From page 35</p> <p>interview, the facility did not ensure residents were receiving oxygen per the physician ordered dose. This was observed with 1 of 3 residents receiving oxygen. Resident #1 was observed with oxygen doses different then their prescribed physician orders.</p> <p>Findings include:</p> <p>On 7/13/15 at 12:15 p.m. Surveyor #22692 observed Resident #1 in his chair in the dining room. Resident #1 was receiving oxygen therapy via nasal cannula at 2 LPM (liters per minute).</p> <p>On 7/13/15 at 2:53 p.m. Surveyor #22692 observed Resident #1 in bed. Resident #1 was receiving oxygen therapy via nasal cannula at 2 LPM.</p> <p>On 7/13/15 at 2:55 p.m. Surveyor #22692 asked Licensed Practical Nurse (LPN)-E to take Resident #1's pulse oxygen level as his oxygen was not at the correct level. The reading was 95% (normal). LPN-E adjusted the oxygen level to 3 LPM which she stated it was supposed to be at.</p> <p>On 7/13/15 Surveyor #22692 reviewed Resident #1's current physician orders indicate to administer oxygen at 3 LPM continuous per nasal cannula.</p> <p>The above findings were shared with the Administrator and Director of Nurses at the daily exit meeting on 7/14/15 at 3:00 p.m. Additional information was requested if available. None was provided.</p>	F 328			