

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/13/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for the investigation of complaint #IN00156483.</p> <p>Complaint #IN00156483: Substantiated, Federal and State deficiencies related to the allegations are cited at W137, W149, W189, W240, W331 and W436.</p> <p>Dates of Survey: October 2, 3 and 13, 2014.</p> <p>Facility Number: 000622 Provider Number: 15G079 AIMS Number: 100272170</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These federal deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed October 22, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and</p>			

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

TITLE

(X6) DATE

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

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	<p>clothing.</p> <p>Based on observation and interview for 1 additional client (client D), the facility failed to ensure client D's rights by ensuring the client had clean clothing due to excessive saliva.</p> <p>Findings include:</p> <p>During observations on the second floor west hallway on 10/3/14 between 1:30 PM to 2:30 PM client D sat in her wheelchair in her room. Client D's shirt had a large area on her shirt that was wet with saliva. During this time CNAs (Certified Nursing Assistants) #1 and #2 came in the room to reposition client C (client D's roommate). CNAs #1 and #2 looked at client D while in the room but did not offer to assist client D in changing her shirt.</p> <p>Interview with RN #3 on 10/3/14 at 3 PM stated whenever a client's clothing was wet "for whatever reason" the client's shirt should be changed.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-9(a)</p>	W000137	<p>I. North Willow does ensure that clients have the right to retain and use appropriate personal possessions and clothing. Client D's room was checked and Client D does have clean clothing available.</p> <p>II. This deficiency may impact all people residing in the facility who may soil their clothing.</p> <p>III. The QIDP will check that Client D has at least 3 clean changes of shirts available. If 3 changes are not available, the QIDP will notify housekeepers to obtain clean clothing. The ED or designee will also be notified of any issues.</p> <p>IV. To help prevent reoccurrence, all staff will be trained to monitor and attend to all clients they encounter, whether or not as part of their assigned group. This monitoring will include checking that the person is dressed, in weather and occasion appropriate clothing, that undergarments are worn, and that clothing is clean, dry and in good repair. Training will include that the CNA is responsible for changing or assisting in getting changed anyone who needs it. QIDPs will be trained regarding the same issues as well as to check that adequate clothing is available as part of his/her regular environmental rounds. Program Directors will also complete monthly environmental rounds for</p>	11/12/2014			

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 3 of 3 sample clients with g-tubes (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach) (A, B and C), the facility failed to implement its written policies and procedures to ensure the clients were adequately supervised and monitored to prevent the repeated dislodgment of their g-tubes and to ensure all staff were trained in regard to client B's needs while in the shower.</p> <p>Findings include:</p> <p>1. Observations were conducted on the first floor of the facility on the north hallway on 10/2/14 between 2:30 PM and 3 PM and on 10/3/14 between 5:25 PM and 5:45 PM. Client A was in his bed, his head and body were covered with a comforter. During the 10/3/14 observation period at 5:25 PM a 15 minute check sheet was observed on client A's over bed stand. Review of the 15 minute check sheet indicated initials of a staff checking on client A at 5:30</p>	W000149	<p>their area of responsibility.</p> <p>I. North Willow does have in place policies and procedures that prohibit mistreatment, neglect and abuse of the client. For Client A, the QIDP has revised his active treatment schedule to encourage increased time out of his bed/bedroom. Client A had his g-tube replaced with a Mic-Key on 10/30/14. Client A was receiving 1:1 supervision until the procedure takes place. The 15 minute check form is being revised to accurately reflect the expectation that the person be checked within a 15 minute interval and not a specific minute and to define specific expectations regarding what the staff are to be checking for and/or what and to whom the staff are to report. The Interdisciplinary Team Meetings (IDTs) are addendums to the ISP. Client A's staff have been retrained on required documentation. Client B's staff have been retrained on caring for his Mic-Key during ADL's. Training also defines what supervising Client B in the shower entails. Client B's nurses will also observe bathing weekly for 1 monthly and then monthly thereafter. Client C's staff have been trained to protect her g-tube by watching for the location/placement of the g-tube when repositioning or</p>	11/12/2014
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	<p>PM. No staff was observed going in and/or out of client A's room from 5:25 PM to 5:35 PM.</p> <p>The facility's reportable and investigative records were reviewed on 10/2/14 at 3 PM. __The 5/5/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 5/5/14 at 6:20 AM the staff discovered client A had pulled his g-tube out. Client A was sent to the ER (Emergency Room) to have his g-tube replaced.</p> <p>__The 6/15/14 BDDS report indicated on 6/15/14 at 8:20 PM client A pulled his g-tube out and was sent to the ER (Emergency Room) to have the g-tube replaced. The 6/15/14 investigative summary indicated "Nurse found client holding g-tube in his hand while visiting client for med (medication) administration. Balloon was slightly deflated and dislodged from client. Client was sent to ER for assessment and g-tube replacement. Nurse reported that balloon was slightly deflated, it is possible for this balloon to not be (sic) inserted securely at [client A's] visit to the ER on 5/5/14. All g-tube care is completed by licensed nurses.... Client (A) has history of masturbation while in bed. Un-intentionally he reaches for his penis but gets hold of his tube.... Client [A] returned to facility on 6/15/14 without</p>		<p>moving her, encouraging the use of long shirts to help cover the tube, offering her items to hold during personal care, and keeping her hands over clothing/blankets/sheets.</p> <p>Training also included notifying nursing if any redness or signs of irritation around the g-tube site are noted during personal care. The IDT's for Clients A, B, and C will meet to determine if changes are needed to care plans.</p> <p>II. This deficiency may impact all people residing in the facility who have feeding tubes.</p> <p>III. North Willow will provide additional training to CNAs regarding care for g-tubes, Mic-Key tubes or other feeding tubes during dressing, changing, bathing and ADL care. Training includes completing Behavior Incident Reports (BIRs) for any problems encountered or observed. This includes noting if a tube is pulled and if it was found out where it was found and the condition of the bulb. This training is also to be included in the new-hire training for CNAs. Nursing has also been retrained to document on the condition of the g-tube when administering nutrition and/or medications including if there are any changes in the status of the tube/site and the requirement to monitor bathing for Client B. Nursing, QIDPs and CNAs have been trained on the revised 15 minute check form and the requirement that</p>	

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	<p>g-tube replaced.... Client (A) was sent out on 6/16/14 by ambulance to replace g-tube at MD (Medical Doctor's) office...."</p> <p>The 9/6/14 BDDS report indicated on 9/6/14 at 1:25 AM the night shift nurse noticed water leaking from client A's g-tube during a routine water flush. Client A was transferred to a local ER. The 9/6/14 investigative summary indicated client A's g-tube was replaced while in the ER on 9/6/14. The report indicated "Conclusion: Resident's g-tube was last replaced on 6/16/14. This g-tube was replaced due to leaking/deterioration of tube. Nursing continues to monitor for patency of g-tube as well as condition of stoma site each shift...."</p> <p>The 9/11/14 BDDS report indicated on 9/11/14 at 3:15 PM client A had pulled his g-tube out and was sent to the ER to have it replaced. The 9/11/14 investigative summary indicated "Client (A) found in bedroom with tube out. Client sent out for replacement g-tube.... G-tube dislodgement un-witnessed.... Licensed nurses continue to care for g-tube each shift during med administration and/or g-tube feeding. [Client A] has an appointment with [name of gastroenterologist's office] on 10/10/2014 at 1:15 pm for a mickey (a</p>		<p>the form be placed in the BIR box daily.</p> <p>IV. To help prevent reoccurrence, PD's and QIDP's will review patterns and trends to identify clients who have had more than 1 occurrence in 90 days of a g-tube being pulled out/dislodged. For those instances where it is not an issue of g-tube failure (such as deflated bulb), the IDTs will develop safety plans. Initiation and discontinuation of 15 minute checks will be documented as part of IDTs and will include the specifics of what is to be monitored during these checks. The new 15 minute check form has been implemented. The Director of Clinical Education, with the PDs, will compile documentation of training to capture training for staff working in different areas of the building. PDs will review safety plans to monitor that client specific needs are addressed on the assigned QIDP.</p>	

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	<p>type of button g-tube) to be placed."</p> <p>The 9/12/14 BDDS report indicated on 9/12/14 at 5:50 AM client A's g-tube had "came out" and client A was sent to the local ER to have the g-tube replaced. The Follow up BDDS report dated 9/17/14 indicated on 9/12/14 at 5:50 AM client A's g-tube was noted to be pulled out with the bulb inflated. Client A has a history of "pulling out g-tube unintentionally. Client (A) enjoys masturbating while in bed." The report indicated client A was returned to the facility from the ER with a new 14 inch g-tube and wearing an abdominal binder that was removed upon the client's return to the facility. The report indicated "It is possible for the client's balloon to have deflated and (sic) little and g-tube dislodged on its own. The new tube is a 14 french compared to the 12 french inserted previously. However, due to [client A's] numerous dislodgements the team feels that a mickey button (a type of gastrostomy button that is placed in the abdomen creating an artificial opening into the stomach) should be trialed. [Client A] has an appointment on 10/10/14 at 1:15 PM for a mickey to be placed. Licensed nurses continue to care for g-tube each shift during med (medication) administration and/or g-tube feeding."</p>						

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	<p>The 9/15/14 BDDS report indicated on 9/15/14 at 8 AM the staff noted client A's alarm to his feeding pump was going off and client A's g-tube was lying deflated on the client's abdomen. Client A was sent to the ER to have the g-tube replaced. The 9/15/14 investigative summary indicated "G-tube observed by staff to be dislodged at 3:10 AM. 15 minute checks were being completed to keep client from pulling out g-tube. Client had not been bothering tube. Water flush was fine at 0000 (sic). Staff stated, alarm was going off, tube observed to be out. Balloon was deflated and tube was seen lying on client's (client A's) abdomen. [Client A] was sent to [name of hospital] for replacement.... Hx (History): pulling out g-tube unintentionally. Client (A) enjoys masturbating while in bed.... Due to [client A's] numerous dislodgements the team feels that a mickey button should be trialed. Therefore an appointment was scheduled with [name of gastroenterologist's office] for 10/10/2014 at 1:15 pm for a mickey to be placed. Licensed nurses continue to care for g-tube each shift during med administration and/or g-tube feeding."</p> <p>Client A's record was reviewed on 10/3/14 at 2:45 PM. Client A's record</p>						

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	<p>indicated client A was dependent on tube feedings for all nutrition.</p> <p>Client A's IDT (Interdisciplinary Team) notes indicated:</p> <p>__5/6/14 "Team met to discuss [client A's] ER visit on 5/5/14. [Client A] pulled out his g-tube and he was transferred to [name of hospital] ER at 7:05 AM for replacement. [Client A] returned to the facility at 11:50 AM with a new g-tube.... The g-tube is observed at least each shift daily by a licensed nurse prior to feedings, medication administration and flushes. [Client A] has a care plan in place for dysphagia (difficulty swallowing) which remains appropriate at this time."</p> <p>__6/18/14 "Team met to discuss [client A's] ER visit on 6/15/14. [Client A] pulled out his g-tube and he was transferred to [name of hospital] for replacement. [Client A] returned to the facility without the g-tube replaced. New order received on 6/16/14 to send [client A] to [name of local hospital] for g-tube replacement..."</p> <p>__9/15/14 "Team met today to discuss [client A's] ER visit on 9/6/14. Night shift nurse noted water leaking from [client A's] G-tube during routine water flush of G-tube. [Client A] was transferred to [name of hospital] ER at 1:25 AM for G-tube replacement. [Client</p>			

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	<p>A] returned to the facility at 6:05 AM with new 16" (inch) French G-tube anchored with saline bulb.... The G-tube is observed at least each shift daily by a licensed nurse prior to feedings, medication administrations and flushes. [Client A] has a care plan in place for dysphagia which remains appropriate at this time."</p> <p>__9/18/14 "Team met today to discuss [client A's] ER visits. [Client A] was sent to [name of hospital] ER on 9/11/14 for pulling his g-tube out. He returned to the facility with 14" (14 inch) French G-tube. ER nurse stated that [client A] had minor bleeding upon G-tube reinsertion but bleeding stopped. No skin issues noted. [Client A] tolerated feeding and medication without difficulty. Furthermore, [client A] was sent to [name of hospital] on 9/12/14 at 6:30 am for pulling out his G-tube. He returned to the facility with 14" French G-tube with abdominal binder and ID (identification) band on right wrist; both were removed. No changes of skin condition with binder once removed.... [Client A] is currently on 15 minutes (sic) checks until Mickey is in place. GI/Mickey appointment (sic) scheduled for October 10th, 2014. The G-tube is observed at least each shift daily by a licensed nurse prior to feedings, medication administrations, and flushes. [Client A] has a care plan in</p>						

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	<p>place for dysphagia which remains appropriate at this time." ___ 10/2/14 IDT the team met and discussed client A's ER visit on 9/15/14. The note indicated client A was to see the gastroenterologist on 10/10/14 and the facility's nurses would continue to monitor client A "prior to feedings, medication administrations, and flushes. [Client A] has a care plan in place for dysphagia which remains appropriate at this time." No changes were made to client A's plan.</p> <p>Client A's record indicated the IDT made no further changes in client A's plan of care after the dislodgement of client A's g-tube on 9/15/14.</p> <p>Client A's 2014 dysphagia care plan indicated the following interventions: ___ "Check tube placement every feeding. ___ Elevate HOB (head of bed) at least 30 - 45 degrees during and for 30-60 minutes after feeding. ___ Enteral formula and feedings (delivery of a nutrition through the g-tube) as ordered. ___ Hold feeding if residual (amount of liquid in the stomach prior to a feeding) is above 100 mg (milliliters). ___ Monitor data as available. ___ Monthly Weights. ___ NPO (Nothing by mouth).</p>						

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	<p><u> </u> Observe and report skin irritation at the tube site.</p> <p><u> </u> Water flushes as ordered."</p> <p>Client A's ISP (Individual Support Plan) and client A's program plans failed to include the 15 checks, what the staff were to be checking for and/or what the staff were to report and to whom.</p> <p>Review of client A's September and October 2014 15 minute checks sheets indicated the 15 minute checks were implemented on 9/13/14 at 6:30 AM. The 15 minute check sheets indicated no documentation of the 15 minute checks:</p> <p><u> </u> For the 1st shift (from 6:15 PM to 2:15 PM) on September 14, 15, 17, 18, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30 and October 1, 2014.</p> <p><u> </u> For the 2nd shift (from 2:30 PM to 10:15 PM) on September 14, 15, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30, 2014.</p> <p><u> </u> For the 3rd shift (from 10:30 PM to 6:15 AM) on September 14, 15, 20, 23, 24, 25, 26, 27, 28, 29, 30 and October 1, 2014.</p> <p>Interview with the D.O.N. (Director of Nursing) on 10/3/14 at 3:30 PM indicated due to client A's frequent dislodgement of his g-tube and client A's desire to masturbate, the facility had scheduled</p>			

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	<p>client A to see his gastroenterologist to consider placing a Mickey button instead of the long French tube which the client could get caught up in and pull out accidentally while masturbating. The D.O.N. indicated nursing checks client A's tube daily when doing feedings, flushes and medications.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 10/3/14 at 4 PM. QIDP #1: ___ Indicated the IDT believed client A would catch his g-tube unintentionally while masturbating and pull his g-tube out. ___ Indicated client A was placed on 15 minute checks on 9/13/14 to ensure client A's g-tube was not dislodged again. ___ Indicated client A's g-tube came out again on 9/15/14 with client A was on 15 minute checks. ___ Indicated no further documentation of the 15 minute checks could be found. ___ Stated, "The 15 minute checks did not ensure he (client A) didn't pull his tube out because the staff could check him (client A), walk out of his room and he could pull it (the g-tube) out." ___ Indicated no further changes in client A's plan of care after client A's g-tube dislodgement of 9/15/14. ___ When asked what the facility was doing to prevent further occurrences of</p>			

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	<p>client A's tube being dislodged the QIDP stated, "I see what you mean. He has an appointment to see his doctor on the 10th for a Mickey but maybe we need to think about 1:1 (one staff to one client supervision) instead of the 15 minute checks."</p> <p>During interview with the D.O.N. and the facility administrator on 10/3/14 at 5:45 PM, the D.O.N. stated, "He (client A) is now on 1:1 staff supervision until we can get him a Mickey button."</p> <p>2. The facility's reportable and investigative records were reviewed on 10/2/14 at 3 PM. The 6/18/14 BDDS report indicated on 6/18/14 at 9 PM client B's mickey tube was dislodged and client B was sent to the ER for replacement. The 6/26/14 follow up BDDS report indicated on 6/18/14 at 9 PM "Assigned CNA (Certified Nursing Assistant) informed nurse client's (client B's) feeding tube was out.... G-tube (mickey) malfunction. It was not pulled out by client or staff. Balloon deflated. G-tube was not dislodged intentionally. Client was in a happy mood in his bedroom. Last (check) documentation by nurse at 7:57 pm on 6/18/14." The report indicated client B returned to the facility with a 14 French g-tube.</p>			
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	<p>The 8/28/14 BDDS report indicated on 8/28/14 at 6:55 PM client B was sent to the ER for an evaluation of a "Migrating Mickey Tube."</p> <p>The 8/31/14 BDDS report indicated on 8/31/14 at 3:35 PM client B's Mickey tube was dislodged and the client was sent to the ER to have the tube replaced. The facility's 9/2/14 investigative summary indicated "Client (B) in shower at 3:10 pm, staff observed tube out while in shower. Sent to [name of hospital] ER for g-tube replacement.... Nursing will continue to monitor...."</p> <p>The 9/2/14 BDDS report indicated on 9/2/14 at 11 AM client B's g-tube fell out. Client B was sent to the ER for replacement. The facility's 9/2/14 investigative summary indicated "[Client B] observed by nursing with mickey button dislodged during assessment. Dislodgment was not witnessed by staff.... Nursing will continue to assess client's g-tube (placement and patency) per shift as per facility policy."</p> <p>The 9/22/14 BDDS report indicated on 9/22/14 at 9:15 PM client B's g-tube was dislodged. The facility's 9/22/14 investigative summary indicated "Resident [client B] transferred to [name</p>			

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	<p>of hospital] for replacement of G-tube after G-tube dislodged in shower room. Nursing notes G-tube was deflated.... [Client B] has a BSP (Behavior Support Plan) addressing Refusals of Care, Verbal Aggression and Physical Aggression. Maladaptive behaviors noted on 9/22/14 x (times) 3, during colostomy care in AM and PM as well as during shower.... QDDP (Qualified Developmental Disabilities Professional) is to in-service staff to use caution while assisting [client B] in shower as well as following BSP for maladaptive behaviors. Nursing continues to monitor Mic-key for condition and patency each shift."</p> <p>Client B's record was reviewed on 10/3/14 at 3:15 PM. Client B's 2014 IDT (Interdisciplinary Team) notes indicated: ___ "On 6/18/14 staff informed nurse that [client B's] feeding tube was out.... Nursing assessed [client B] and sent him to [name of hospital] ER at 7:57 pm." The note indicated tube was not pulled out intentionally. ___ "On 8/21/14 [client B] was trying to enter the central bath when he fell over in his wheelchair. The central bathroom door was left open and [client B] tried to enter. Upon going up ramp [client B] fell backwards in his wheel chair.... Staff are to be reeducated on the importance of keeping the central bath shower room</p>			
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	<p>door closed at all times and always knowing the whereabouts of all clients." ___ "On 8/28/14 [client B] was observed by nurse with migrating g-tube. Sent out for g-tube replacement." ___ "On 8/31/14 [client B] was observed to have his g-tube out while in the shower. [Client B] was sent out to [name of hospital] for g-tube replacement.... Nursing will continue to monitor [client B]." ___ "On 9/2/14 [client B] was observed to have his g-tube out while in the shower. [Client B] was sent out to [name of hospital] for g-tube replacement.... Nursing will continue to monitor [client B]." ___ "On 9/22/14 [client B] was transferred to the [name of hospital] ER for replacement of G-tube after G-tube came out while bathing.... QDDP to in-service staff on using caution with [client B's] G-tube as well as following BSP for maladaptive behaviors." Client B's 9/8/14 faxed hospital ER visit note for 9/2/14 indicated "Pt (patient) present with c/o (complaint of) G-tube pulled out. This is the 3rd episode since 8/28 (2014) and 4th ED (Emergency Department) visit since 8/28 (2014)." Client B's BIRs (Behavior Incident Reports) of 9/22/14 indicated:</p>			
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	<p>__At 8:20 PM the staff were in the shower room trying to change client B's colostomy bag and client B began cursing and yelling at the staff.</p> <p>__At 9 PM the staff were in the shower room trying to give client B a shower when client B became "violent and belligerent" and began cursing, hitting, kicking, spitting and throwing things at several staff.</p> <p>Review of the facility inservice dated 9/2/14 on 10/3/14 at 3 PM indicated a staff training in regard to client B's "precautionary measures while showering." The inservice indicated seven facility staff were inserviced.</p> <p>Review of a list of staff assigned to work the 3rd floor provided to this surveyor by the administrator on 10/3/14 at 3 PM indicated a total of eleven staff working the first shift, eleven staff working the second shift and six staff working the night shift on the third floor of the facility. The facility records did not indicate all staff working the third floor were retrained on client B's needs while showering and/or how to supervise client B while in the shower to ensure client B's g-tube was not dislodged.</p> <p>Interview with RN #1 on 10/2/14 at 1:15 PM indicated client A did not</p>						

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	<p>intentionally pull his g-tube out. RN #1 stated client A would "occasionally have behaviors and I think he would pull it (the g-tube) out on accident."</p> <p>During interview with QIDP (Qualified Intellectual Disabilities Professional) #2 and PD (Program Director) #2 on 10/3/14 at 3:30 PM, the PD indicated client B would have behaviors and while having a behavior client B "might pull his tube out." PD #2 indicated two of the most current incidents of client B's g-tube coming out happened while the client was in the shower room and the IDT agreed the staff would be retrained in regard to client B's BSP and monitoring client B while in the shower. The QIDP indicated all staff on the third floor were to be retrained.</p> <p>3. The facility's reportable and investigative records were reviewed on 10/2/14 at 3 PM.</p> <p>__The investigative summary of 4/30/14 indicated on 4/30/14 client C was found in bed by the staff and the client's g-tube was pulled out and the balloon was still inflated. Client C was taken to the ER and the g-tube was replaced. The summary indicated client C continues to be assessed by nursing.</p> <p>__The investigative summary of 6/23/14 indicated on 6/23/14 while a continuous</p>			

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	<p>feed was in progress a CNA (Certified Nursing Assistant) reported client C's g-tube was out. The report indicated the dislodgment was not observed and the g-tube balloon was deflated. The summary indicated client C continues to be assessed by nursing.</p> <p>__The investigative summary of 7/16/14 indicated on 7/16/14 client C was observed with g-tube deflated and sent to the ER to have tube replaced. The summary indicated client C continues to be assessed by nursing.</p> <p>__The investigative summary of 8/27/14 indicated on 8/27/14 while client C was sitting in her wheelchair in her bedroom nursing found client C's g-tube dislodged. The summary indicated client C was taken to the ER and the g-tube was replaced. "Staff will be reminded to check on [client C's] g-tube placement when [client C] is awake or in bed due to [client C] moving in bed and possibility of tube getting under her and be (sic) tugged. They will also be reminded that during changing briefs, sheet and clothing needs to be pulled over the tube, since it is possible for [client C] to unintentionally tug at tube due to uncontrollable hand movements. Client (C) continues to be assessed by nursing each shift...."</p> <p>Client C's record was reviewed on</p>						

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	<p>10/3/14 at 3:30 PM.</p> <p>__ Client C's 5/1/14 IDT note indicated staff reported finding client C's g-tube out "at about 9:15 pm.... Nursing noted [client C] had her mickey button in her hand with the balloon still inflated. The g-tube stoma was pink and irritated with 4 main scratches around it. An order was obtained to send [client C] to [name of hospital] for g-tube replacement.... The team notes that [client C] does not have a history of pulling out her g-tube. It is not clear why she pulled the tube at this time. The team does not expect future episodes but will continue to monitor."</p> <p>__ Client C's 7/11/14 IDT note indicated on 6/23/14 staff reported to nursing that client C's tube was out. Client C was sent to the ER for the g-tube to be replaced.... [Client C's] care plans remain appropriate at this time. Team will continue to monitor."</p> <p>__ Client C's 8/11/14 IDT indicated "On 7/16 (2014) staff found [client C's] g-tube with the bulb deflated.... [Client C's] care plans remain appropriate at this time. Team will continue to monitor."</p> <p>__ Client C's 10/2/14 IDT note indicated on 8/27/14 client C's tube was dislodged and client C was sent to the ER to have her g-tube replaced. The note indicated client C "will continue to be assessed by nursing each shift prior to feeding/meds.... Staff will continue to</p>						

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	<p>check [client C's g-tube placement when she is awake or in bed to ensure that the g-tube is not under her and be (sic) tugged. They will also continue to ensure that during changing briefs, sheets and clothing needs to be pulled over the tube since it is possible for [client C] to unintentionally tug at the tube due to uncontrolled hand movement."</p> <p>Client C's ISP dated 4/24/14 indicated "Dependent on tube feeding/inadequate oral intake due to: Dysphagia.... Check tube placement every feeding. Elevate HOB (head of bed) 30-45 degrees during and for 30-60 minutes after feeding. Enteral formula and feedings as ordered. Monitor for S/SX (Signs or Symptoms) of intolerance to TF (tube feeding):... Monitor lung sounds for respiratory complications.... NPO (Nothing by mouth). Observe and report skin irritation at the tube site. Water flushes as ordered...."</p> <p>Client C's ISP indicated no changes in client C's plan of care after the dislodgement of client C's g-tube on 5/1/14, 7/11/14, 8/11/14 and 10/2/14.</p> <p>Interview with QIDP #1 on 10/3/14 at 4 PM indicated client C did not have a history of pulling her g-tube out. QIDP #1 indicated if any changes had been</p>			

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W000189	<p>made to client C's plan of care, the changes would have been documented in client C's IDT notes.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-28(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 sample clients (client B), the facility failed to ensure the staff were trained/retrained in regard to assisting and supervising client B while in the shower to ensure the client did not dislodge his g-tube (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach).</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/2/14 at 3 PM.</p> <p>The 6/18/14 BDDS report indicated on</p>	W000189	<p>I. North Willow does provide initial and on-going training to enable employees to perform their duties effectively, efficiently, and competently. Client B's staff have been retrained on caring for his Mic-Key during ADL's. Training also defines what supervising Client B in the shower entails. Client B's nurses have also been trained to monitor bathing weekly for 1 month and monthly thereafter.</p> <p>II. This deficiency may impact all people residing in the facility who have feeding tubes.</p> <p>III. North Willow will provide additional training to CNAs regarding care for g-tubes, Mic-Key tubes or other feeding tubes during</p>	11/12/2014			

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	<p>6/18/14 at 9 PM client B's mickey tube was dislodged and client B was sent to the ER for replacement. The 6/26/14 follow up BDDS report indicated on 6/18/14 at 9 PM "Assigned CNA (Certified Nursing Assistant) informed nurse client's (client B's) feeding tube was out.... G-tube (mickey) malfunction. It was not pulled out by client or staff. Balloon deflated. G-tube was not dislodged intentionally. Client was in a happy mood in his bedroom. Last (check) documentation by nurse at 7:57 pm on 6/18/14." The report indicated client B returned to the facility with a 14 French g-tube.</p> <p>The 8/28/14 BDDS report indicated on 8/28/14 at 6:55 PM client B was sent to the ER for an evaluation of a "Migrating Mickey Tube."</p> <p>The 8/31/14 BDDS report indicated on 8/31/14 at 3:35 PM client B's Mickey tube was dislodged and the client was sent to the ER to have the tube replaced. The facility's 9/2/14 investigative summary indicated "Client (B) in shower at 3:10 pm, staff observed tube out while in shower. Sent to [name of hospital] ER for g-tube replacement.... Nursing will continue to monitor...."</p> <p>The 9/2/14 BDDS report indicated on</p>		<p>dressing, changing, bathing and ADL care. Training includes completing Behavior Incident Reports (BIRs) for any problems encountered or observed. This includes noting if a tube is pulled and if it was found out where it was found and the condition of the bulb. This training is also to be included in the new-hire training for CNAs. Nursing has also been retrained to document on the condition of the g-tube when administering nutrition and/or medications including if there are any changes in the status of the tube. Nursing, QIDPs and CNAs have been trained on the revised 15 minute check form and the requirement that the form be placed in the BIR box daily.</p> <p>IV. To help prevent reoccurrence, the Director of Clinical Education, with the PDs, will compile documentation of training to capture training for staff working in different areas of the building.</p>	

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	<p>9/2/14 at 11 AM client B's g-tube fell out. Client B was sent to the ER for replacement. The facility's 9/2/14 investigative summary indicated "[Client B] observed by nursing with mickey button dislodged during assessment. Dislodgment was not witnessed by staff.... Nursing will continue to assess client g-tube (placement and patency) per shift as per facility policy."</p> <p>The 9/22/14 BDDS report indicated on 9/22/14 at 9:15 PM client B's g-tube was dislodged. The facility's 9/22/14 investigative summary indicated "Resident [client B] transferred to [name of hospital] for replacement of G-tube after G-tube dislodged in shower room. Nursing notes G-tube was deflated.... [Client B] has a BSP (Behavior Support Plan) addressing Refusals of Care, Verbal Aggression and Physical Aggression. Maladaptive behaviors noted on 9/22/14 x (times) 3, during colostomy care in AM and PM as well as during shower.... QDDP (Qualified Developmental Disabilities Professional) is to in-service staff to use caution while assisting [client B] in shower as well as following BSP for maladaptive behaviors. Nursing continues to monitor Mic-key for condition and patency each shift."</p> <p>Client B's record was reviewed on</p>			

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	<p>10/3/14 at 3 PM. Client B's 2014 IDT (Interdisciplinary Team) notes indicated: ___ "On 6/18/14 staff informed nurse that [client B's] feeding tube was out.... Nursing assessed [client B] and sent him to [name of hospital] ER at 7:57 pm." The note indicated tube was not pulled out intentionally.</p> <p>___ "On 8/21/14 [client B] was trying to enter the central bath when he fell over in his wheelchair. The central bathroom door was left open and [client B] tried to enter. Upon going up ramp [client B] fell backwards in his wheel chair.... Staff are to be reeducated on the importance of keeping the central bath shower room door closed at all times and always knowing the whereabouts of all clients."</p> <p>___ "On 8/28/14 [client B] was observed by nurse with migrating g-tube. Sent out for g-tube replacement."</p> <p>___ "On 8/31/14 [client B] was observed to have his g-tube out while in the shower. [Client B] was sent out to [name of hospital] for g-tube replacement.... Nursing will continue to monitor [client B]."</p> <p>___ "On 9/2/14 [client B] was observed to have his g-tube out while in the shower. [Client B] was sent out to [name of hospital] for g-tube replacement.... Nursing will continue to monitor [client B]."</p> <p>___ "On 9/22/14 [client B] was transferred</p>			

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	<p>to the [name of hospital] ER for replacement of G-tube after G-tube came out while bathing.... QDDP to in-service staff on using caution with [client B's] G-tube as well as following BSP for maladaptive behaviors."</p> <p>Client B's 9/8/14 faxed hospital ER visit note for 9/2/14 indicated "Pt (patient) present with c/o (complaint of) G-tube pulled out. This is the 3rd episode since 8/28 (2014) and 4th ED (Emergency Department) visit since 8/28 (2014)."</p> <p>Client B's BIRs (Behavior Incident Reports) of 9/22/14 at 8:20 PM indicated the staff were in the shower room trying to change client B's colostomy bag and client B began cursing and yelling at the staff. Another BIR dated 9/22/14 at 9 PM indicated the staff was in the shower room trying to give client B a shower when client B became "violent and belligerent" and began cursing, hitting, kicking, spitting and throwing things at several staff.</p> <p>Review of the facility inservice dated 9/2/14 on 10/3/14 at 3 PM indicated a staff training in regard to client B's "precautionary measures while showering." The inservice indicated seven facility staff were inserviced.</p>						

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	<p>Review of a list of staff assigned to work the 3rd floor provided to this surveyor by the administrator on 10/3/14 at 3 PM indicated a total of eleven staff working the first shift, eleven staff working the second shift and six staff working the night shift on the third floor of the facility. The facility records did not indicate all staff working the third floor were retrained on client B's needs while showering and/or how to supervise client B while in the shower to ensure client B's g-tube was not dislodged.</p> <p>During interview with QIDP (Qualified Intellectual Disabilities Professional) #2 and PD (Program Director) #2 on 10/3/14 at 3:30 PM, the PD indicated client B would have behaviors and while having a behavior client B "might pull his tube out." PD #2 indicated two of the most current incidents of client B's g-tube coming out happened while the client was in the shower room and the IDT agreed the staff would be retrained in regard to client B's BSP and monitoring client B while in the shower. The QIDP indicated all staff on the third floor were to be retrained.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-13(b)(2)</p>						

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W000240	<p>2-7-3(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client A), the client's Individualized Support Plans (ISP) failed to address how and what the staff were to monitor while doing 15 minute checks for client A.</p> <p>Findings include:</p> <p>During observations on the first floor of the facility on the north hallway on 10/2/14 between 2:30 PM and 3 PM and on 10/3/14 between 5:25 PM and 5:45 PM. Client A was in his bed, his head and body were covered with a comforter. During the 10/3/14 observation period at 5:25 PM, a 15 minute check sheet was observed on client A's over bed stand. Review of the 15 minute check sheet indicated initials of a staff checking on client A at 5:30 PM. No staff was observed going in and/or out of client A's room from 5:25 PM to 5:35 PM.</p> <p>The facility's reportable and investigative records were reviewed on 10/2/14 at 3</p>	W000240	<p>I. IDT meetings are addendums to the ISP and address new or changes in relevant interventions to support the individual. Client A form is now on 1:1 supervision so the 15 minute check is no longer in place. The form is being revised to accurately reflect the expectation that the person be checked within a 15 minute interval and not a specific minute and to define specific expectations regarding what the staff are to be checking for and/or what and to whom the staff are to report. The Interdisciplinary Team Meetings (IDTs) are addendums to the ISP. Client A's staff have been retrained on required documentation.</p> <p>II. This deficiency may impact any person assigned 15 minute checks.</p> <p>III. For any client assigned 15 minute checks, initiation and discontinuation of 15 minute checks will be documented as part of IDTs and will include the specifics of what is to be monitored during these checks. The 15 minute check form has been amended to include a spot</p>	11/12/2014

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	<p>PM. __ The 6/15/14 investigative summary indicated "Nurse found client holding g-tube (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach) in his hand while visiting client for med (medication) administration. Balloon was slightly deflated and dislodged from client. Client was sent to ER (Emergency Room) for assessment and g-tube replacement. Nurse reported that balloon was slightly deflated, it is possible for this balloon to not be (sic) inserted securely at [client A's] visit to the ER on 5/5/14. All g-tube care is completed by licensed nurses Client (A) has history of masturbation while in bed. Un-intentionally he reaches for his penis but gets hold of his tube."</p> <p>__ The 9/6/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 9/6/14 at 1:25 AM the night shift nurse noticed water leaking from client A's g-tube during a routine water flush. Client A was transferred to a local ER. The 9/6/14 investigative summary indicated client A's g-tube was replaced while in the ER on 9/6/14 due to leaking/deterioration of tube. Nursing continues to monitor for patency of g-tube as well as condition of stoma site each shift...."</p> <p>__ The 9/11/14 BDDS report indicated on 9/11/14 at 3:15 PM client A had pulled</p>		<p>to specify what the staff are to be watching for and who to notify of problems. 15 minute checks are to be turned in to the QIDP/nurse/designee daily.</p> <p>IV. To help prevent reoccurrence, the new 15 minute check form has been implemented and staff trained. 15 minute check forms are to be put in the BIR box daily for PD/designee review.</p>				

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	<p>his g-tube out and was sent to the ER to have it replaced. The 9/11/14 investigative summary indicated "Client (A) found in bedroom with tube out.... G-tube dislodgement un-witnessed.... Licensed nurses continue to care for g-tube each shift."</p> <p>__ The 9/12/14 BDDS report indicated on 9/12/14 at 5:50 AM client A's g-tube had "came out" and client A was sent to the local ER to have the g-tube replaced. The follow up BDDS report dated 9/17/14 indicated on 9/12/14 at 5:50 AM client A's g-tube was noted to be pulled out with the bulb inflated and client A has a history of "pulling out g-tube unintentionally. Client (A) enjoys masturbating while in bed." The report indicated client A was returned to the facility from the ER with a new 14 inch g-tube and wearing an abdominal binder that was removed upon the client's return to the facility. The report indicated "It is possible for the client's balloon to have deflated and (sic) little and g-tube dislodged on its own. The new tube is a 14 french compared to the 12 french inserted previously. However, due to [client A's] numerous dislodgements the team feels that a mickey button (a type of gastrostomy button that is placed in the abdomen creating an artificial opening into the stomach) should be trialed. [Client A] has an appointment on</p>			
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	<p>10/10/14 at 1:15 PM for a mickey to be placed. Licensed nurses continue to care for g-tube each shift during med (medication) administration and/or g-tube feeding."</p> <p>The 9/15/14 BDDS report indicated on 9/15/14 at 8 AM the staff noted client A's alarm to his feeding pump was going off and client A's g-tube was lying deflated on the client's abdomen. Client A was sent to the ER to have the g-tube replaced. The 9/15/14 investigative summary indicated "G-tube observed by staff to be dislodged at 3:10 AM. 15 minute checks were being completed to keep client from pulling out g-tube. Client had not been bothering tube. Water flush was fine at 0000 (sic). Staff stated, alarm was going off, tube observed to be out. Balloon was deflated and tube was seen lying on client's (client A's) abdomen. [Client A] was sent to [name of hospital] for replacement.... Hx (History): pulling out g-tube unintentionally. Client (A) enjoys masturbating while in bed.... Due to [client A's] numerous dislodgements the team feels that a mickey button should be trialed. Therefore an appointment was scheduled with [name of gastroenterologist's office] for 10/10/2014 at 1:15 pm for a mickey to be placed. Licensed nurses continue to care</p>						

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	<p>for g-tube each shift during medication administration and/or g-tube feeding."</p> <p>Client A's record was reviewed on 10/3/14 at 1:30 PM. Client A's IDT (Interdisciplinary Team) notes indicated: __5/6/14 "Team met to discuss [client A's] ER visit on 5/5/14. [Client A] pulled out his g-tube and he was transferred to [name of hospital] ER at 7:05 AM for replacement.... The g-tube is observed at least each shift daily by a licensed nurse prior to feedings, medication administration and flushes. [Client A] has a care plan in place for dysphagia (difficulty swallowing) which remains appropriate at this time." __6/18/14 "Team met to discuss [client A's] ER visit on 6/15/14. [Client A] pulled out his g-tube and he was transferred to [name of hospital] for replacement...." __9/15/14 "Team met today to discuss [client A's] ER visit on 9/6/14. Night shift nurse noted water leaking from [client A's] G-tube during routine water flush of G-tube. [Client A] was transferred to [name of hospital] ER at 1:25 AM for G-tube replacement.... The G-tube is observed at least each shift daily by a licensed nurse.... [Client A] has a care plan in place for dysphagia which remains appropriate at this time." __9/18/14 "Team met today to discuss</p>						

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	<p>[client A's] ER visits. [Client A] was sent to [name of hospital] ER on 9/11/14 for pulling his g-tube out.... He (client A) returned to the facility with 14 inch French G-tube with abdominal binder and ID (identification) band on wrist; both were removed. No changes of skin condition with binder once removed.... [Client A] is currently on 15 minutes (sic) checks until Mickey is in place. GI/Mickey appointment (sic) scheduled for October 10th, 2014. The G-tube is observed at least each shift daily by a licensed nurse.... [Client A] has a care plan in place for dysphagia which remains appropriate at this time." __10/2/14 IDT the team met and discussed client A's ER visit on 9/15/14. The note indicated client A was to see the gastroenterologist on 10/10/14 and the facility's nurses would continue to monitor client A "[Client A] has a care plan in place for dysphagia which remains appropriate at this time."</p> <p>Client A's 2014 dysphagia care plan indicated the following interventions: __ "Check tube placement every feeding. __ Elevate HOB (head of bed) at least 30 - 45 degrees during and for 30-60 minutes after feeding. __ Enteral formula and feedings (delivery of a nutrition through the g-tube) as ordered.</p>						

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	<p><input type="checkbox"/> Hold feeding if residual (amount of fluid in the abdomen prior to a feeding) is above 100 mg (milliliters).</p> <p><input type="checkbox"/> Monitor data as available.</p> <p><input type="checkbox"/> Monthly Weights.</p> <p><input type="checkbox"/> NPO (Nothing by mouth).</p> <p><input type="checkbox"/> Observe and report skin irritation at the tube site.</p> <p><input type="checkbox"/> Water flushes as ordered."</p> <p>Client A's ISP dated 12/10/13 and client A's 2013/2014 dysphagia care plan failed to include the 15 checks, what the staff were to be checking while doing the 15 minute checks, what the staff were to report and to whom the staff were to report.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 10/3/14 at 4 PM. During interview QIDP #1:</p> <p><input type="checkbox"/> QIDP #1 indicated client A was placed on 15 minute checks on 9/13/14 after his g-tube was dislodged on 9/12/14.</p> <p><input type="checkbox"/> QIDP #1 indicated the IDT believed client A pulled his g-tube out unintentionally while masturbating.</p> <p><input type="checkbox"/> QIDP #1 indicated client A's tube came out on 9/15/14 while client A was on 15 minute checks.</p> <p><input type="checkbox"/> QIDP #1 indicated the staff were to check client A every 15 minutes to make sure his g-tube was in place.</p>			

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W000331	<p>__ When QIDP #1 was asked did client A's ISP and/or care plans specify how the staff were to monitor client A to ensure client A did not accidentally pull his g-tube out, QIDP #1 indicated the 15 minute checks were a temporary intervention until client a could get in to see his gastroenterologist to have a Mickey button (another type of g-tube) inserted.</p> <p>__ When asked was client A to keep his hands above the blankets or under the blankets and were the staff to uncover the client when checking on him, QIDP #1 stated client A liked to be covered up "a lot" and the staff were to make sure client A was not unintentionally pulling on his G-tube.</p> <p>__ QIDP #1 indicated client A's ISP/care plans did not indicate how and/or what the staff were to monitor while conducting 15 minute checks for client A.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-35 (b)(1)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p>			
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	<p>Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility's nursing services failed to ensure:</p> <p>__ Client C was provided her built up boot to wear throughout the day.</p> <p>__ Nursing conducted and documented a thorough assessment of client C's g-tube (gastrostomy tube - a tube inserted through the abdomen that delivers nutrition directly to the stomach) site and surrounding abdominal skin.</p> <p>__ Nursing conducted and documented a thorough assessment of the ulceration on client C's right great toe.</p> <p>Findings include:</p> <p>During observations on the second floor west hallway of the facility on 10/3/14 between 1:30 PM to 2:30 PM client C sat reclined in her wheelchair in her bedroom. Client C was wearing ankle socks/footies. A soft formed boot lay on client C's bed. Client C's abdomen was exposed along with a portion of client C's g-tube. At 2:30 PM CNAs (Certified Nursing Assistants) #1 and #2 entered client C's bedroom and repositioned client C in her wheelchair. CNAs #1 and #2 were asked when client C was to wear the boot that was laying on client C's bed. CNA #1 stated, "I'm new. This is my first day with her." CNA #1 stated, "She</p>	W000331	<p>I. North Willow does provide nursing services in accordance with their needs. An IDT and inservice for Client C's use of the built up boot were completed. The use of the boot has been added to her client specific training and her care plan includes guidelines for wearing the boot. Client C's nursing assignment sheet has been reviewed and the use of the boot added. A safety plan has been developed to help protect Client C's toe from additional irritation to her right great toe. Client C's nurses have been trained on the need to document on the condition of the g-tube and site when administering nutrition and/or medications.</p> <p>II. This deficiency may impact all people residing in the facility who have feeding tubes.</p> <p>III. PD's will meet with nursing administration to identify people with recurrent health concerns (same issue more than once in 90 days such as skin irritation around a g-tube site) or on-going medical needs that require specific equipment (such as a brace or boot). For any such people identified, the QIDP will meet with the IDT to develop Safety Plans. Copies of safety plans will be maintained in the classrooms with copies of Client Specific Training for easy access by CNA staff. Staff will also be inserviced on any new safety plans developed. Nursing has also been retrained to document on the condition of the g-tube when</p>	11/12/2014

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	<p>should have it on at all times. I forgot to put it back on this morning after giving her a bath." CNA #1 and #2 repositioned client C by pulling her up in her chair and placing her chin strap on. This surveyor asked to see client C's g-tube site. CNA #1 lifted client C's top enough to expose the g-tube. Client C was noted to have a french catheter g-tube that extended approximately 10 to 12 inches from the client's abdomen. The area around the g-tube was dry, red and irritated with no drainage noted. CNA #2 stated, "I think it's been like that for awhile."</p> <p>The facility's reportable and investigative records were reviewed on 10/2/14 at 3 PM.</p> <p>__The investigative summary of 4/30/14 indicated on 4/30/14 client C was found in bed by the staff and the client's g-tube was pulled out and the balloon was still inflated. Client C was taken to the ER and the g-tube was replaced.</p> <p>__The investigative summary of 6/23/14 indicated on 6/23/14 while a continuous feed was in progress a CNA (Certified Nursing Assistant) reported client C's g-tube was out. The report indicated the dislodgment was not observed and the g-tube balloon was deflated.</p> <p>__The investigative summary of 7/16/14 indicated on 7/16/14 client C was observed with g-tube deflated and sent to</p>		<p>administering nutrition and/or medications including if there are any changes in the status of the tube. Nursing retraining also includes monitoring for the use of assigned protective equipment and documenting assessment of any wounds/injuries.</p> <p>IV. To help prevent reoccurrence, all staff will be trained to monitor and attend to all clients they encounter, whether or not as part of their assigned group. PD's will review and sign off on Safety Plans. As part of regular active treatment monitoring, QIDP's and PD's will check that copies of client specific training and safety plans are available in the classrooms. Nursing supervisors will review nursing notes regularly to monitor that documentation is complete and includes required information.</p>	

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	<p>the ER to have tube replaced. The summary indicated client C continues to be assessed by nursing.</p> <p>__The investigative summary of 8/27/14 indicated on 8/27/14 nursing found client C's g-tube dislodged while client C was sitting in her wheelchair in her bedroom. The summary indicated client C was taken to the ER and the g-tube was replaced. "Staff will be reminded to check on [client C's] g-tube placement when [client C] is awake or in bed due to [client C] moving in bed and possibility of tube getting under her and be (sic) tugged. They will also be reminded that during changing briefs, sheet and clothing needs to be pulled over the tube, since it is possible for [client C] to unintentionally tug at tube due to uncontrollable hand movements. Client (C) continues to be assessed by nursing each shift...."</p> <p>Client C's record was reviewed on 10/3/14 at 3:30 PM.</p> <p>Client C's IDT (Interdisciplinary Team) note of 5/30/14 indicated the team met to discuss [client C's] trip to the wound center on 5/29/14. [Client C] was noted with an open area on her right great toe on 5/17/14 and had been sent to the ER (Emergency Room) with a recommendation to have an appointment with the wound center for further</p>						

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	<p>evaluation.... An order for a build a boot was also obtained from her PCP (Primary Care Physician) to wear while she is up in her wheelchair and when in bed to help protect her toe."</p> <p>__ Client C's 5/1/14 IDT note indicated staff reported finding client C's g-tube out "at about 9:15 pm.... Nursing noted [client C] had her mickey button in her hand with the balloon still inflated. The g-tube stoma was pink and irritated with 4 main scratches around it. An order was obtained to send [client C] to [name of hospital] for g-tube replacement.... The team notes that [client C] does not have a history of pulling out her g-tube. It is not clear why she pulled the tube at this time. The team does not expect future episodes but will continue to monitor."</p> <p>__ Client C's 7/11/14 IDT note indicated on 6/23/14 staff reported to nursing that client C's tube was out. "[Client C] was sent to the ER for the g-tube to be replaced.... [Client C's] care plans remain appropriate at this time. Team will continue to monitor."</p> <p>__ Client C's 8/11/14 IDT indicated "On 7/16 (2014) staff found [client C's] g-tube with the bulb deflated.... [Client C's] care plans remain appropriate at this time. Team will continue to monitor."</p> <p>__ Client C's 10/2/14 IDT note indicated on 8/27/14 client C's tube was dislodged and client C was sent to the ER to have</p>						

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	<p>her g-tube replaced. The note indicated client C "will continue to be assessed by nursing each shift prior to feeding/meds.... Staff will continue to check [client C's g-tube placement when she is awake or in bed to ensure that the g-tube is not under her and be (sic) tugged. They will also continue to ensure that during changing briefs, sheets and clothing needs to be pulled over the tube since it is possible for [client C] to unintentionally tug at the tube due to uncontrolled hand movement."</p> <p>Client C's ISP dated 4/24/14 indicated "Dependent on tube feeding/inadequate oral intake due to: Dysphagia.... Check tube placement every feeding. Elevate HOB (head of bed) 30-45 degrees during and for 30-60 minutes after feeding. Enteral formula and feedings as ordered. Monitor for S/SX (Signs or Symptoms) of intolerance to TF (tube feeding):... Monitor lung sounds for respiratory complications.... NPO (Nothing by mouth). Observe and report skin irritation at the tube site. Water flushes as ordered...."</p> <p>Client C's nursing notes indicated, not all inclusive: __10/3/14 at 1:56 PM "G-tube patent, tolerated medication and water flushes. No distress noted."</p>			

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	<p>__10/2/14 at 7:47 PM "G-tube placement and patency checked.... G-tube site cleansed and tx (treatment) applied.... Dressing remains to great toe."</p> <p>__10/2/14 at 12:24 PM "...g-tube placement and patency checked.... site cleaned and tx applied."</p> <p>__10/1/14 at 10:29 PM "...g-tube placement and patency checked.... site cleaned and tx applied."</p> <p>__10/1/14 at 12:27 PM "...g-tube placement and patency checked.... site cleaned and tx applied."</p> <p>__9/30/14 at 7:56 PM "G-tube placement and patency checked.... G-tube site cleaned and tx applied.... Dressing remains to great toe."</p> <p>__9/30/14 at 9:45 AM "...g-tube placement and patency checked.... site cleaned and tx applied."</p> <p>__9/30/14 at 7 AM "Tolerating cont. (continuous) g-tube fdg (feeding) without s/s (signs or symptoms) of difficulty. G-tube in place, no residual noted."</p> <p>__9/29/14 at 9:24 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied. Dressing remains to great toe."</p> <p>__9/29/14 at 12:40 PM "...g-tube placement and patency checked.... site cleaned and tx applied."</p> <p>__9/29/14 at 7 AM "Tolerating cont. g-tube fdg without s/s of difficulty. G-tube in place, no residual noted."</p>			

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	<p>__9/28/14 at 9:31 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/28/14 at 1:08 PM "Client (C) taken off the Feeding pump as ordered.... site cleaned and tx applied."</p> <p>__9/27/14 at 10:07 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/27/14 at 1:47 PM "G-tube placement and patency checked.... G-tube site cleaned and tx applied."</p> <p>__9/26/14 at 10:27 PM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/25/14 at 9:50 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/25/14 at 10:47 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/24/14 at 7: 59 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/24/14 at 10:09 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/24/14 at 7 AM "Tolerating cont. g-tube fdg without s/s of difficulty. G-tube in place, no residual noted."</p>			

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	<p>__9/23/14 at 9:26 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/23/14 at 10:10 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/23/14 at 7 AM "Tolerating cont. g-tube fdg without s/s of difficulty. G-tube in place, no residual noted."</p> <p>__9/22/14 at 6:34 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/22/14 at 7:02 AM "Feeding tube placement verified.... Site around feeding tube cleansed."</p> <p>__9/21/14 at 6:35 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/21/14 at 9:41 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/21/14 at 5:39 AM "Feeding tube placement verified.... Site around feeding tube cleansed."</p> <p>__9/20/14 at 6:22 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/20/14 at 10:31 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p>			

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	<p>__9/20/14 at 7 AM "Tolerating cont. g-tube fdg without s/s of difficulty. G-tube in place, no residual noted."</p> <p>__9/19/14 at 9:27 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/18/14 at 9:35 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/18/14 at 12:33 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/18/14 at 5:53 AM "G/T (g-tube) patent and placement checked.... Tx to G/T site done."</p> <p>__9/17/14 at 9:10 PM "...g-tube placement verified... g-tube site cleansed, no redness or drainage noted..."</p> <p>__9/17/14 at 10:22 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/16/14 at 7:25 PM "G-tube placement and patency checked.... G-tube site cleansed and tx applied.... Dressing remains to great toe."</p> <p>__9/16/14 at 12:44 AM "...g-tube placement and patency checked... site cleaned and tx applied."</p> <p>__9/16/14 at 7:05 AM "Tolerating cont. g-tube fdg without s/s of difficulty. G-tube in place, no residual noted."</p> <p>9/16/14 at 7 AM "At 12:30 am, client (C)</p>			

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	<p>awake, crying out intermittently. Client c/o right great toe 'hurts.' Noted bandage clean, dry, intact on top aspect of right great toe; noted with area of redness outer aspect of bandage area...."</p> <p>Client C's 9/24/14 physician's orders indicated Nystatin Powder (used to treat fungal infections) two times a day to GI (g-tube site).</p> <p>Client C's Altered Skin Integrity due to ulceration of right great toe dated 5/30/14 indicated client C was to wear a "Build a Boot while in chair and bed" and to keep right great toe protected with barrier and light dressing.</p> <p>Client C's nursing notes failed to include a full assessment and documentation of client C's skin around her g-tube and the ulceration on her right great toe.</p> <p>Interview with RN #3 on 10/3/14 at 2 PM stated when assessing a client's g-tube the nurse "should" assess the skin around the g-tube and document any redness, irritation and/or drainage as well as the tubes patency, bowel sounds and/or abdominal distention.</p> <p>Interview with the D.O.N. on 10/3/14 at 3:45 PM indicated client C had a healing wound on her right great toe and the staff</p>			

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W000436	<p>were to ensure client C was wearing her padded boot on her right foot at all times except when in the shower. The D.O.N. stated the wound was small and "almost healed" and nursing staff were to continue to monitor and assess client C's right great toe and document their assessments in the nursing notes.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-17(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients (client C) the facility failed to ensure client C was provided a built up boot.</p> <p>Findings include:</p> <p>During observations on the second floor west hallway on 10/3/14 between 1:30 PM to 2:30 PM client C sat reclined in her wheelchair in her bedroom. Client C was wearing ankle socks/footies. A soft</p>	W000436	I. North Willow does furnish, maintain in good repair, and work with the people who live her to use and make informed choices about the use devices identified by the interdisciplinary team as needed by the client. An IDT and inservice for Client C's use of the built up boot were completed. The use of the boot has been added to her client specific training and her care plan includes guidelines for wearing the boot. Client C's nursing assignment sheet has been reviewed and the use of the	11/12/2014

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	<p>formed boot laid on client C's bed. At 2:30 PM CNAs (Certified Nursing Assistants) #1 and #2 entered client C's bedroom and repositioned client C in her wheelchair. CNAs #1 and #2 were asked when client C was to wear the boot that was laying on client C's bed. CNA #1 stated, "I'm new. This is my first day with her." CNA #1 stated, "She should have it on at all times. I forgot to put it on this morning after giving her a bath."</p> <p>Client C's record was reviewed on 10/3/14 at 3:30 PM.</p> <p>__ Client C's IDT (Interdisciplinary Team) note of 5/30/14 indicated "The team met to discuss [client C's] trip to the wound center on 5/29/14. [Client C] was noted with an open area on her right great toe on 5/17/14 and had been sent to the ER (Emergency Room) with a recommendation to have an appointment with the wound center for further evaluation.... An order for a build a boot was also obtained from her PCP (Primary Care Physician) to wear while she is up in her wheelchair and when in bed to help protect her toe."</p> <p>__ Client C's Altered Skin Integrity due to ulceration of right great toe dated 5/30/14 indicated client C was to wear a "Build a Boot while in chair and bed" and to keep right great toe protected with barrier and light dressing.</p>		<p>boot added. A safety plan has been developed to help protect Client C's toe from additional irritation to her right great toe.</p> <p>II. This deficiency may impact all people residing in the facility who use adaptive equipment.</p> <p>III. PD's will meet with nursing administration to identify people with recurrent health concerns (same issue more than once in 90 days such as skin irritation around a g-tube site) or on-going medical needs that require specific equipment (such as a brace or boot). For any such people identified, the QIDP will meet with the IDT to develop Safety Plans. Copies of safety plans will be maintained in the classrooms with copies of Client Specific Training for easy access by CNA staff. Staff will also be inserviced on any new safety plans developed. Nursing has been retrained to monitor for the use of assigned protective equipment.</p> <p>IV. To help prevent reoccurrence, facility staff, including nursing, will be trained to monitor and attend to all clients they encounter, whether or not as part of their assigned group. PD's will review and sign off on Safety Plans. As part of regular active treatment monitoring, QIDP's and PD's will check that copies of client specific training and safety plans are available in the classrooms.</p>				

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	<p>Interview with the D.O.N. on 10/3/14 at 3:45 PM indicated client C had a healing wound on her right great toe and the staff were to ensure client C wore her padded boot on her right foot at all times except when in the shower.</p> <p>This federal tag relates to complaint #IN00156483.</p> <p>3.1-39(a)</p>			