

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/17/2014
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NAME OF PROVIDER OR SUPPLIER  HIGHLAND NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9630 FIFTH ST HIGHLAND, IN 46322
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F000000	<p>This visit was for the Investigation of Complaint IN00145510.</p> <p>Complaint IN00145510-Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey date: March 17, 2014</p> <p>Facility number: 000367 Provider number: 155458 AIM number: 100289280</p> <p>Surveyor: Heather Tuttle, RN-TC</p> <p>Census bed type: SNF/NF 34 Total: 34</p> <p>Census payor type: Medicare: 11 Medicaid: 16 Other: 7 Total: 34</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	Quality review completed on March 21, 2014, by Janelyn Kulik, RN.			
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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to ensuring treatments for venous stasis ulcers were completed on time as ordered by the Physician for 1 of 1 residents reviewed for non pressure related skin conditions in the sample of 4. (Resident #C)</p> <p>Findings include:</p> <p>1. On 3/17/14 at 5:05 a.m., Resident #C was observed awake and in bed. At that time, CNA #1 removed the resident's sock. The resident was noted to have a kerlix bandage wrapped around part of her foot with a large amount of dried bloody drainage noted. The date on the bandage was 3/14/14.</p> <p>On 3/17/14 at 6:50 a.m., the resident was observed in bed laying on her back. At that time, LPN #1 removed the resident's sock and was going to</p>	F000309	<p>9</p> <p><b>1.What corrective action will be accomplished for those residents who are affected by the alleged deficient practice?</b> The treatment for Residents #c was completed on 3/17/2014.</p> <p><b>2.How will you identify other residents that may be affected by the alleged deficient practice?</b> All Residents who have a wound would have the potential to be affected by the alleged deficient practice. All Residents with wounds and dressing orders were audited on 3/18/2014 (attachment # 1) to ensure that all dressings were changed as ordered.</p> <p><b>3.What measures have been put in place or what systemic changes we will make to ensure that the practice does not reoccur?</b> The wound policy was revised on 4/1/2014 to include nurse's initials and dates on all dressings and wound treatments and orders for treatments on admission. (attachment #2) All Nurses inserviced on 3/18/2014 on wound policy and completion of</p>	04/05/2014
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	<p>perform a skin assessment. The LPN removed the kerlix bandage and the gauze sponges. The LPN also indicated at the time, the date on the dressing was 3/14/14. The resident's third and fourth toes were necrotic and black in color. There was a moderate amount of dried blood noted on the back of her foot. The LPN took a measurement of the wound which was 3.5 centimeters (cm) by 6 cm.</p> <p>The record for Resident #C was reviewed on 3/17/14 at 3:25 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, stroke, diabetes, acute renal failure, neuropathy, and coronary artery disease. The resident was admitted to the hospital on 3/3/14 and returned back to the facility on 3/14/14.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 1/15/14 indicated the resident had no pressure or stasis ulcers. The resident was dependent on staff for transfers and bed mobility.</p> <p>Review of the current plan of care dated 1/15/14 indicated the resident had the potential for impaired skin related to a history of ulcers and</p>		<p>treatment records and medication records. (See attachment #3)</p> <p><b>4. How will the corrective action be monitored to ensure the alleged deficient practice does not reoccur?</b> A wound care audit was developed. (attachment #4) Wound audits will be conducted weekly for two weeks then monthly on all residents with wounds to ensure the deficient practice does not reoccur. The Quality Assurance committee and Facility Administrator will oversee compliance. Completion date: April 5/2014</p>				

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	<p>immobility.</p> <p>Review of the Nursing Readmission Assessment dated 3/14/14 indicated the resident was readmitted to the facility with open areas to the third and fourth toes. The Nursing Admission sheet indicated the left foot third and fourth toes were necrotic.</p> <p>Review of the Wound Assessment Record indicated the resident was admitted with venous stasis ulcers on 3/14/14 with the measurements of 3.8 cm by 5.6 cm.</p> <p>Review of Physician Orders dated 3/15/14 indicated cleanse left foot third and fourth toes with normal saline and pat dry. Apply Sureprep to toes daily and cover with kerlix.</p> <p>Review of the Treatment Administration Record (TAR) indicated the treatment for the third and fourth toes was signed out on 3/15/14 as being completed. The treatment had not been signed out as being completed on 3/14 or 3/16/14.</p> <p>Interview with LPN #2 on 3/17/14 at 7:10 a.m., indicated the resident came back to the facility on Friday 3/14/14. She indicated she had</p>				

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	<p>worked on Saturday 3/15/14 also and does remember performing the treatment change for the resident.</p> <p>Interview with the Director of Nursing on 3/17/14 at 8:30 a.m., indicated the treatment should have been completed as ordered by the Physician.</p> <p>This Federal Tag relates to Complaint IN00145510</p> <p>3.1-37(a)</p>			
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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident who was admitted to the facility with pressure ulcers received the necessary treatment and services to prevent further breakdown related to obtaining treatment orders for pressure ulcers and for performing treatments as ordered by the Physician for 2 of 4 residents reviewed for pressure ulcers in the sample of 4. (Residents #C and #D)</p> <p>Findings include:</p> <p>1. On 3/17/14 at 5:05 a.m., Resident #C was observed awake and in bed. At that time, CNA #1 turned the resident onto her left side. The resident was noted to have an uncovered open area on her left inner buttock. The area was red in color</p>	F000314	<p><b>F314</b></p> <p><b>1.Whatcorrective action will be accomplished for those residents who are affected bythe alleged deficient practice?</b> A treatment order wasobtained for resident # c on 3/17/2014 and resident #d was obtained on 3/15/2014.</p> <p><b>2.How will you identify otherresidents that may be affected by the alleged deficient practice?</b> Allresidents with wounds have the potential to be affected by the allegeddeficient practice. An audit was completed for all residents with wounds toensure there was a treatment order on 3/18/2014. (attachment # 1)</p> <p><b>3.What measures have been put inplace or what systemic changes we will make to ensure that the practice doesnot reoccur?</b> The wound policy was revised to includeorders for wounds on admission.(attachment #2) All</p>	04/05/2014			

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	<p>and the surrounding skin was pink. There was a moderate amount of dried blood noted on the resident's incontinent brief. The gauze bandage was observed crinkled up and was sticking to the resident's upper thigh. The date on the bandage was 3/13/14.</p> <p>On 3/17/14 at 6:50 a.m., the resident was observed in bed laying on her back. At that time, CNA #2 assisted the resident onto to her left side. LPN #1 was also present to perform a skin assessment. The LPN indicated at the time, there was an open area on the resident's left inner buttocks and noted the dried blood on the incontinent brief. The LPN took a measurement of the pressure ulcer which was 1 centimeters (cm) by 0.5 cm, he indicated also at the time, the pressure ulcer was a Stage II.</p> <p>The record for Resident #C was reviewed on 3/17/14 at 3:25 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, stroke, diabetes, acute renal failure, neuropathy, and coronary artery disease. The resident was admitted to the hospital on 3/3/14 and returned back to the facility on 3/14/14.</p>		<p>nursing staff in serviced on 3/18/2014 on treatment orders, Treatment records and dressing changes on 3/18/2014.</p> <p><b>4.How will the corrective action bemonitored to ensure the alleged deficient practice does not reoccur?</b>A wound care audit was developed. (attachment 4) Wound audits will be conductedweekly for two weeks then monthly on all residents with wounds to ensure thedeficient practice does not reoccur. The Quality Assurance committee andFacility Administrator will oversee compliance. Completion date: April 5/2014</p>				

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	<p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 1/15/14 indicated the resident had no pressure or stasis ulcers. The resident was dependent on staff for transfers and bed mobility.</p> <p>Review of the current plan of care dated 1/15/14 indicated the resident had the potential for impaired skin related to a history of ulcers and immobility.</p> <p>Review of the Nursing Readmission Assessment dated 3/14/14 indicated the resident was readmitted to the facility with an open area to the coccyx. No description was available for review.</p> <p>Review of the Wound Assessment Record indicated the resident was admitted with a Stage II pressure ulcer on 3/14/14 to the coccyx. The area measured 0.8 cm by .4 cm.</p> <p>Review of Physician Orders dated 3/14-3/16/14 indicated there was no treatment ordered for the pressure ulcer.</p> <p>Review of the Treatment Administration Record (TAR) for the month of 3/2014 indicated there was</p>			
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	<p>no evidence of any documentation of a treatment being completed for the pressure ulcer on the coccyx or the left inner buttock.</p> <p>Interview with LPN #2 on 3/17/14 at 7:10 a.m., indicated she performed the reassessment of the resident on 3/14/14 when she came back from the hospital. She indicated there was no open area on the resident's left inner buttock at that time, but her coccyx area looked tender, so she kept the dressing in place from the hospital. She further indicated she wanted to make sure the resident did not break down, so she left it on for preventative measures. The LPN indicated she did not obtain a Physician's Order for any type of treatment or preventative measures for the resident's coccyx area.</p> <p>2. On 3/17/14 at 4:50 a.m., Resident #D was awake and in bed. At that time, CNA #2 removed the resident's heel protectors and socks to both his feet. There was a kerlix bandage noted to both of the feet with no dates on the bandages.</p> <p>On 3/17/14 at 6:35 a.m., LPN #1 was observed to perform a skin assessment for the resident's feet. He removed the resident's kerlix</p>			
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	<p>bandage to the left foot. At that time, there was open area noted on the resident's left heel. There was a moderate amount of brown dried drainage noted on the kerlix bandage. There was white slough noted to the area as well as pink granulation tissue. The LPN then removed the kerlix bandage to the right foot. There was a dried area noted to the resident's right heel. The area was red in color with no drainage.</p> <p>The record for Resident #D was reviewed on 3/17/14 at 11:30 a.m. The resident was admitted to the facility on 3/2/14 from the hospital. The resident's diagnoses included, but were not limited to, anemia, renal insufficiency, diabetes, high blood pressure, coronary artery disease, stroke and hyperlipidemia.</p> <p>Review of the Wound Assessment Record indicated on 3/2/14 the resident was admitted to the facility with a Stage III pressure ulcer to the left heel. The measurement was 4 centimeters (cm) by 2.5 cm. with 90% granulation tissue and 10% yellow slough tissue. Further review of the Wound Assessment Record indicated the resident had an open area to the right heel as well. It was also</p>						

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	<p>categorized as a Stage III and measured 1.5 cm by 0.5 cm with 100% granulation tissue.</p> <p>Review of Nursing Admission Assessment dated 3/2/14 indicated the resident had pressure sores to both of his heels.</p> <p>Review of Physician Orders dated 3/2/14 indicated there was no evidence a treatment order had been obtained for both of the pressure ulcers to the resident's heels.</p> <p>Further review of Physician Orders dated 3/5/14 indicated an order to cleanse the right heel with normal saline, and apply Sureprep and cover with Aquafoam dressing every other day. Another Physician Order dated 3/5/14 indicated an order to cleanse the left heel with normal saline and apply Bacitracin and cover with Aquafoam dressing every other day.</p> <p>Review of the Treatment Administration Record (TAR) for the month of 3/2014 indicated there was no evidence a treatment had been signed out on 3/2, 3/3, 3/4, and 3/5/14 for the both pressure ulcers on the resident's heels. The first time a treatment had been signed out as being completed was on 3/7/14.</p>			
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	<p>Interview with the Director of Nursing on 3/17/14 at 2:30 p.m., indicated the treatment order for both heels was not obtained until 3/5/14 (three days after the resident was admitted).</p> <p>This Federal Tag relates to Complaint IN00145510</p> <p>3.1-40(a)(2)</p>			
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