

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2015
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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00167998.</p> <p>Complaint IN00167998 - Substantiated, Federal/State deficiency related to the allegations is cited at F314.</p> <p>Survey dates: February 25, 26, 27, 2015 through March 2 and 3, 2015</p> <p>Facility Number: 000186 Provider Number: 155289 AIM Number: 100266300</p> <p>Survey Team: Tina Smith-Staats, RN, TC Karen Lewis, RN Ginger McNamee, RN Toni Maley, BSW Winter Hyde, RN (February 25, 26, 27, 2015)</p> <p>Census Bed Type: SNF/NF: 103 Total: 103</p> <p>Census Payor Type: Medicare: 20</p>	F 000		

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 SS=E Bldg. 00	<p>Medicaid: 64 Other: 19 Total: 103</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 6, 2015 by Randy Fry RN.</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to provide care and services in a manner to promote resident dignity regarding lengthy meal waits and feeding assistance for 6 of 6 residents reviewed for dignity (Residents #C, #39, #131, #68, #129 and #82).</p> <p>Findings include:</p> <p>1. During a 2/25/15, 11:34 a.m. to 12: 30 p.m., observation of lunch in the Lounge Dining Room the following was observed:</p>	F 241	<p>The facility is unable to correct the alleged deficient practice for residents #C, 39, 68, 82, 129 and 131. All residents have the potential to be affected by the alleged deficient practice. Meal times will be adjusted for those residents requiring assistance with the dining experience, therefore alleviating any lengthy waiting times. DON/Designee will revise the seating arrangement as needed and communicate any changes to the Dietary Department for tray distribution. Charge Nurses will be responsible to ensure that no resident requiring assistance with dining will arrive early creating</p>	04/02/2015			

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	<p>Dependent Resident #39 was seated in her broda chair at the table as if ready to dine at 11:34 a.m. (26 minutes prior to the scheduled meal time). Resident #39 slept in her broda from 11:34 a.m. until 12:06 p.m. when her meal was served (32 minutes seated at the table prior to the meal). Resident #39's meal was placed in front of her with her plates and cups uncovered. The staff then walked away and did not return for 2 minutes to feed the dependent resident.</p> <p>Dependent Resident #82 was seated in her broda chair at the table as if ready to dine at 11:34 a.m. (26 minutes prior to the scheduled meal time). Resident #82 was served her meal at 12:13 p.m. Her meal was uncovered and placed in front of her. The staff left the table and did not return to feed her until 12:18 p.m. (5 minutes with her meal in front of her and a total of 44 minutes seated at the table before she was assisted to eat).</p> <p>Dependent Resident #129 was seated in her wheel chair as if ready to dine at 11:34 a.m. (26 minutes before the scheduled meal time). Resident #129 was seated with her back towards everyone and every thing in the dining room and faced only her table mate. Resident #129 was served her meal at</p>		<p>extended waiting times before the meal is served. A member of management will observe the Therapeutic Dining room meals 3 times a week ongoing to ensure that no extended waiting times occur. Nursing will be in-serviced regarding the meal times and activity basket diversionary materials for the residents prior to their meal times by the DON/Designee/Activity Director. Meal times will be discussed monthly at QA Committee meetings for any issues identified during management observations ongoing.</p>		

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	<p>12:10 p.m. (36 minutes seated at the table prior to the meal).</p> <p>Dependent Resident #131 was seated in her wheel chair as if ready to dine at 11:37 a.m. (23 minutes before the scheduled meal times). Resident #131 was served her meal at 12:07 p.m. (30 minutes seated at the table before the meal was served). After her meal was served, the resident was cued to eat and Resident #131 began to feed herself.</p> <p>Dependent Resident #68 was seated in her broda chair at the dining room table as if ready to dine at 11:39 a.m. (21 minutes before the scheduled meal time). Resident #68 slept until her meal was served at 12:14 p.m. Her meal was placed before her and uncovered. The staff member then walked away. The staff member returned at 12:17 p.m., and began to feed the resident (3 minutes with food in front of her without assistance and a period of 38 minutes seated at the table before she was assisted to eat).</p> <p>Dependent Resident #C was seated in her broda chair as if ready to dine at 11:45 a.m. (15 minutes prior to the scheduled meal time). She slept in her broda chair until her meal was served at 12:09 p.m. (a period of 24 minutes from arrival to meal</p>			

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	<p>service).</p> <p>During the 2/25/15, per-meal wait, no activity or staff to resident socialization was provided. The TV was on at the far side of the room from where Residents #C, #39, #131, #68, #129 and #82 were seated. The room did not have diversionary materials available for resident use. The dependent residents did not converse with one another.</p> <p>During the 3/2/15, 11:24 to 12:35 p.m., lunch observation in the Lounge Dining Room the following was observed:</p> <p>Dependent Resident #82 was escorted into the room and seated at the table at 11:43 a.m. Resident #82 was served her meal and assisted to eat at 12:04 p.m. (a period of 23 minutes from arrival to meal service).</p> <p>Dependent Resident #C was escorted into the room and seated at her table at 11:44 a.m. Resident #C was served her meal at 12:05 p.m. (a period of 22 minutes from arrival to meal service).</p> <p>During the 3/2/15, per-meal wait no activity or staff to resident socialization was provided. The TV was on at the far side of the room from where Residents #C and #82 were seated. The room did</p>			

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	<p>not have diversionary materials available for resident use. The dependent residents did not converse with one another.</p> <p>During a 3/3/15, 7:50 a.m. to 8:30 a.m., observation of breakfast in the Lounge Dining Room the following was noted:</p> <p>Resident #39 was served her meal tray at 8:00 a.m. The uncovered plate and glasses were placed on the table in front of the dependent resident then the staff walked away. The staff did not return for a period of 3 minutes. At 8:03 a.m., CNA #12 began to feed Resident #39 and a resident who sat across the table from her. The CNA slid back and forth on a rolling stool from resident to resident. She would leave Resident #39 for periods of 1 to 2 minutes to feed the resident seated across the table. This practice continued throughout the entire meal.</p> <p>Resident #82 was served her meal at 8:01 a.m. The food and drinks were uncovered. The staff member left the area for 2 minutes before assisting the dependent resident to dine.</p> <p>Resident #129 sat in her wheelchair facing the table as if ready to dine from 7:50 a.m. to 8:14 a.m. (a period of 24 minutes) before her meal was served. At 8:01 a.m., Resident #129's table mate was</p>			

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	<p>served her meal. Resident #129 sat at the table for 13 minutes and watched her tablemate eat without any breakfast of her own. At 8:14 a.m. when Resident #129 was served her meal she began to eat and drink on her own with only periodic cues offered.</p> <p>Resident #68 was escorted into the dining room and seated at the table at 7:56 a.m. Resident #68's tablemate was served her meal and assisted to dine at 8:01 a.m. Resident #68 watched her tablemate eat for 10 minutes before her meal was served at 8:11 a.m.</p> <p>During the 3/3/15, pre-meal wait no activity or staff to resident socialization was provided. The TV was on at the far side of the room from where Residents #C, #39, #131, #68, #129 and #82 were seated. The room did not have diversionary materials available for resident use. The dependent residents did not converse with one another.</p> <p>2. During a 3/3/15, 8:37 a.m., interview, CNA #12 indicated it was difficult to feed residents who were seated on opposite sides of the table. She indicated this had been the breakfast seating for Resident #39 and another resident for the past 5 months. CNA #12 indicated staff were to escort dependent residents to the</p>			

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	<p>dining room 15 minutes or so before the scheduled meal time. She indicated she believed the Lounge Dining Room served breakfast at 7:30 a.m. (30 minutes prior to the posted time) and lunch at 11:30 a.m. (30 minutes prior to the posted time.) She indicated she would escort residents to the Lounge Dining Room for breakfast between 7:15 a.m. and 7:20 a.m. (40 to 45 minutes before the meal was scheduled).</p> <p>During a 3/3/15, 8:41 a.m., interview, CNA #7 indicated staff should escort residents to the dining room about 15 minutes before the meal was scheduled. She indicated she would assist residents to the Lounge Dining Room for breakfast between 7:30 a.m. and 7:45 a.m. (15 to 30 minutes before the meal was scheduled). CNA #7 also indicated she would escort residents to the Lounge Dining Room for lunch between 11:30 a.m. and 11:40 a.m. (20 to 30 minutes before meal time).</p> <p>During a 3/3/15, 9:14 a.m., interview, the Activity Director indicated residents with moderate to severe cognitive impairment should be offered activities which are shorter in length and modified to their cognitive abilities. She indicated there were no activities scheduled in the Lounge Dining Room before any of the</p>			

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	<p>meals. She indicated she had not asked staff to bring residents to the Lounge Dining Room early. The Activity Director indicated the activity department had worked to prepare individualized "busy boxes" or "memory boxes" for each resident for the 2014 Christmas season. She indicated each resident had a box in his/her room which could be used by staff and residents for each resident's leisure time pursuits.</p> <p>During a 3/31/15, 11:56 a.m. interview, the Social Services Director (SSD) indicated dependent residents should not sit for long periods of time without stimulation. The Social Services Director indicated the facility had been working to improve the dining process and make it a pleasurable experience. The SSD also indicated this was a new program and the facility was still working to make it effective.</p> <p>3. During a 3/3/15, 7:50 a.m., observation, a "Dining Room Meal Times" schedule was posted on the wall of the Lounge (assisted) Dining Room. The schedule indicated breakfast was served in the Lounge Dining Room at 8:00 a.m., and Lunch was served in the Lounge Dining Room at 12:00 p.m. This information was consistent with the information provided by the Director of</p>			

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	<p>Nursing at the time of entrance on 2/25/15.</p> <p>4. Resident #68's clinical record was reviewed on 3/02/2015 at 3:10 p.m., Resident #68's current diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety and delusional disorder.</p> <p>Resident #68 had a current, 2/18/15, quarterly, Minimum Data Set assessment (MDS) which indicated: the resident sometimes understood others, was sometimes understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #68 had a current, 2/18/15, "Activities Update Assessment" which indicated: the resident was confused to time, place and most people, the resident was unable to understand or follow directions, and the resident's attention</p>			

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	<p>span was poor.</p> <p>Resident #68 had a current, 2/18/15, care plan problem/need regarding difficulty in communication due to dementia. Approaches to this problem included, but were not limited to, the staff will anticipate the resident's needs.</p> <p>Resident #68 had a current, 2/18/15, care plan problem/need regarding the need for staff assistance for all activities of daily living. Approaches to this problem included, but were not limited to, "I need total assistance with all aspects of care."</p> <p>5. Resident #82's clinical record was reviewed on 3/02/2015 at 3:30 p.m. Resident #82's current diagnoses included, but were not limited to, dementia, Alzheimer's disease, anxiety, delusional disorder and depression.</p> <p>Resident #82 had a current, 2/22/15, quarterly, Minimum Data Set assessment (MDS) which indicated: the resident had unclear speech, sometimes understood others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, was totally dependent on staff assistance for mobility both on and off</p>			

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	<p>the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding depression and dementia. Approaches to this problem included, but were not limited to,"sing hymns with me I will usually join in."</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding chronic pain.</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding needing assistance with activities of daily living due to dementia.</p> <p>Resident #82 had a current, 2/20/15, "Social Service Update Assessment" which indicated: the resident had poor attention span, rarely attended group activities and only occasionally attempted to initiate conversation.</p> <p>6. Resident #39's clinical record was reviewed on 3/2/15 at 10:37 a.m. Resident #39's current diagnoses included, but were not limited to, Alzheimer's disease, generalized anxiety disorder, depression and dementia.</p> <p>Resident #39 had a current, 2/11/15,</p>			

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	<p>significant change, Minimum Data Set assessment (MDS) which indicated: the resident rarely or never understood, was rarely or never understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #39 had a current, 2/13/15, "Activities Update Assessment" which indicated: the resident appeared to have confusion to other people, place and time, had a very poor attention span, had very poor judgement, had limited communication, and was unable to make independent decisions.</p> <p>Resident #39 had a current, 2/19/15, care plan problem/need regarding a cognitive and communications deficient due to Alzheimer's disease. Approaches to this problem included, but were not limited to, individualized activities based on cognitive status and 1:1 (one to one) visits and sensory group.</p>			

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	<p>7. Resident #129's clinical record was reviewed on 3/03/2015 at 11:40 a.m. Resident #129's current diagnoses included, but were not limited to, multiple sclerosis, cognitive communication deficient, anorexia, and depression.</p> <p>Resident #129 had a current, 1/30/15, significant change, Minimum Data Set assessment (MDS) which indicated: the resident was moderately cognitively impaired and required cueing and assistance for decision making, required staff assistance for mobility both on and off the unit, and required extensive assistance from staff to eat.</p> <p>Resident #129 had a current, 1/29/15, Activities Update Assessment, which indicated: the resident was disoriented to place and time, had a fair attention span, and had delusions at times.</p> <p>8. Resident #C's clinical record was reviewed on 3/03/2015 at 11:05 a.m. Resident #C's current diagnoses included, but were not limited to, Alzheimer's disease, dementia, depression and anxiety.</p> <p>Resident #C had a current, 1/29/15, significant change, Minimum Data Set</p>			

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	<p>assessment (MDS) which indicated: the resident had impaired hearing, had unclear speech, sometimes understood others, was sometimes understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #C had a current, 2/20/15, "Activities Update Assessment" which indicated the resident had a poor attention span.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding the need for assistance with all activities of daily living. Approaches to this problem included, but were not limited to, the staff will feed this resident.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding long and short term memory loss and an expressive disorder.</p>			

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	<p>Resident #C had a current, 1/29/15, care plan problem/need regarding impaired hearing and frequent refusal to wear a hearing aide.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding the need for hospice services.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding anxiety and depression. Approaches to this problem included, but were not limited to, encourage participation in activities of choice.</p> <p>9. Resident #131's clinical record was reviewed on 2/27/15 at 9:49 a.m. Resident #131's current diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, and debility.</p> <p>Resident #131 had a current, 1/13/15, admission, Minimum Data Set assessment (MDS) which indicated: the resident was severely cognitively impaired and rarely or never made decisions, required staff assistance for mobility both on or off the unit and required staff cueing and/or assistance when eating.</p>			

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	<p>Resident #131 had a current, 1/7/15, "Initial Activity Assessment" which indicated: the resident was pleasantly confused, had a fair attention span, and had poor judgement.</p> <p>Resident #131 had a current, 1/13/15, care plan problem/need regarding a self care deficient and the need for assistance with activities of daily living.</p> <p>10. During a 3/3/15, 10:13 a.m. interview, the Social Services Director (SSD) indicated dependent residents could need staff assistance for stimulation and leisure time pursuits while in their rooms. The SSD also indicated that lack of stimulation for dependent residents could be both a dignity and quality of life issue. The SSD indicated activities for cognitively impaired residents should be short in length, 15 minutes or so, because most had impaired attentions spans due to their medical conditions. Lastly, the SSD indicated a radio or TV being on in a cognitively impaired resident's room did not always provide stimulation to the resident. Each resident needed resident specific stimulation in their environment.</p> <p>During a 3/3/15, 11:56 a.m., interview, the Activities Consultant, Activity Director and Social Services Director</p>			

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F 248 SS=E Bldg. 00	<p>indicated dependent residents should not sit for long periods of time without stimulation. All three agreed lack of stimulation could be a quality of life issue. A 8/1/14, revised copy of "Resident Rights" was provided by the Director of Nursing on 3/3/15 at 1:14 p.m. The "Resident Rights" indicated the residents have a right to a dignified existence. The "Resident Rights" indicated "...The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>3.1-3(t) 3.1-34(a)(7)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview and record review, the facility failed to ensure direct care staff provide assistance and services to dependent residents, who could not self initiate leisure time pursuits for 4 of 4 residents reviewed for</p>			F 248	Resident specific activity boxes for resident #C, #39, #68, and #82 were updated as needed. Staff were in-serviced on resident specific activity boxes and providing assistance with leisure time pursuits for residents. All dependent residents who could		04/02/2015

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	<p>activities (Resident #C, #39, #68 and #82).</p> <p>Findings include:</p> <p>1. During a 3/3/15, 9:14 a.m., interview, the Activity Director indicated the activity department had identified three cognitive levels for resident throughout the facility. The activity department had initiated activities at the three levels. Because not all activities would meet each resident's needs, residents needed personalized diversionary materials in their rooms. The activity department had worked to prepare individualized "busy boxes" or "memory boxes" for each resident for the 2014 Christmas season. She indicated each resident had a box in his/her room which could be used by the staff and residents for each resident's leisure time pursuits.</p> <p>During a 3/3/15, 10:13 a.m., interview, the Social Services Director (SSD) indicated dependent residents could need staff assistance for stimulation and leisure time pursuits while in their rooms. The SSD also indicated that lack of stimulation for dependent residents could be both a dignity and quality of life issue. The SSD indicated activities for cognitively impaired residents should be short in length, 15 minutes or so, because</p>		<p>not self initiate leisure time pursuits have the potential to be affected. Resident specific activity boxes were implemented/updated to ensure leisure time activities were available. Resident interest sheets were placed in rooms for direct care staff to identify leisure time pursuits. Direct care staff in-serviced regarding providing assistance and services to dependent residents who are unable to self initiate leisure time pursuits. Activity Director or designee will complete weekly rounds for twelve weeks then monthly for three months to ensure assistance and services are provided to dependent residents who are unable to self initiate leisure time pursuits. All findings will be reviewed in monthly Quality Assurance meetings.</p>	

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	<p>most had impaired attentions spans due to their medical conditions. Lastly, the SSD indicated a radio or TV being on in a cognitively impaired resident's room did not always provide stimulation to the resident. Each resident needed resident specific stimulation in their environment.</p> <p>During a 3/3/15, 11:56 a.m., interview, the Activities Consultant, Activity Director and Social Services Director (SSD) indicated dependent residents should not sit for long periods of time without stimulation. All three agreed lack of stimulation could be a quality of life issue.</p> <p>2. Resident #68 was observed in her room during the following dates and times:</p> <p>On 2/27/2015 at 9:37 a.m., Resident #68 was seated in her broda chair in her room. Her back was to the window. She was facing the divider curtain and door. She was asleep.</p> <p>On 3/2/15 at 9:28 a.m., Resident #68 was seated in her broda chair in her room. She was facing the window. The window blinds were closed. She was asleep.</p> <p>On 3/2/15 at 10:12 a.m., Resident #68 was seated in her broda chair in her</p>			

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	<p>room. She was facing the window. The window blinds were open. She was asleep.</p> <p>On 3/3/15 at 8:50 a.m., Resident #68 was seated in her broda chair in her room. Her back was to the window. She was facing the divider curtain and door. The curtain partially blocked her view of the hall. She was asleep.</p> <p>On 3/3/15 at 9:12 a.m., Resident #68 was seated in her broda chair in her room. Her back was to the window. She was facing the divider curtain and door. The curtain partially blocked her view of the hall. She was asleep.</p> <p>On 3/3/15 at 9:42 a.m., Resident #68 was seated in her broda chair in her room. Her back was to the window. She was facing the divider curtain and door. The curtain partially blocked her view of the hall. She was awake. A staff member was in the room and speaking to her about therapy.</p> <p>Resident #68's clinical record was reviewed on 3/02/2015 at 3:10 p.m. Resident #68's current diagnoses included, but were not limited to, Alzheimer's disease, depression, anxiety and delusional disorder.</p>			

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	<p>Resident #68 had a current, 2/18/15, quarterly, Minimum Data Set assessment (MDS) which indicated: the resident sometimes understood others, was sometimes understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #68 had a current, 2/18/15, "Activities Update Assessment" which indicated: the resident was confused to time, place and most people, the resident was unable to understand or follow directions, and the resident's attention span was poor.</p> <p>Resident #68 had a current, 2/18/15, care plan problem/need regarding difficulty in communication due to dementia. Approaches to this problem included, but were not limited to, the staff will anticipate the resident's needs.</p> <p>Resident #68 had a current, 2/18/15, care</p>			

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	<p>plan problem/need regarding the need for staff assistance for all activities of daily living. Approaches to this problem included, but were not limited to, "I need total assistance with all aspects of care."</p> <p>Resident #68 had a current, 2/18/15, care plan problem/need regarding a cognitive deficit related to Alzheimer's disease and delusions. Approaches to this problem included, but were not limited to, "I will have my activities individualized based on my cognitive abilities and preferences" and "my staff will visit me 1:1 [one to one] and also take me to sensory group."</p> <p>3. Resident #82 was observed in her room during the following dates and times:</p> <p>On 2/27/15 at 9:39 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was not on. The resident was asleep.</p> <p>On 2/27/15 at 10:25 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing</p>			

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	<p>the wall with the clock and the TV. The TV was not on. The resident was asleep.</p> <p>On 2/27/15 at 11:08 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was not on. The resident was greeted with a wave and waved back in return.</p> <p>On 3/2/15 at 9:31 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was on. The resident was asleep.</p> <p>On 3/2/15 at 10:14 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was on. The resident was asleep.</p> <p>On 3/2/15 at 11:11 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The</p>			

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	<p>TV was on. The resident was asleep.</p> <p>On 3/3/15 at 8:48 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was on. The resident was asleep.</p> <p>On 3/3/15 at 9:12 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was on. The resident was asleep.</p> <p>On 3/2/15 at 9:44 a.m., Resident #82 was seated in her broda chair. She was in her room. She was seated between the two beds and parallel to the beds. The window was to her right. She was facing the wall with the clock and the TV. The TV was on. The resident was asleep.</p> <p>Resident #82's clinical record was reviewed on 3/02/2015 at 3:30 p.m. Resident #82's current diagnoses included, but were not limited to, dementia, Alzheimer's disease, anxiety, delusional disorder and depression.</p> <p>Resident #82 had a current, 2/22/15,</p>						

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	<p>quarterly, Minimum Data Set assessment (MDS) which indicated: the resident had unclear speech, sometimes understood others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding depression and dementia. Approaches to this problem included, but were not limited to, "sing hymns with me I will usually join in."</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding chronic pain.</p> <p>Resident #82 had a current, 2/20/15, care plan problem/need regarding her overall mood being affected by anxiety and delusions. Approaches to this problem included, but were not limited to, "Encourage me to participate in activities, such as sensory group and/or music activities."</p> <p>Resident #82 had a current, 2/20/15, care</p>			

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	<p>plan problem/need regarding needing assistance with activities of daily living due to dementia.</p> <p>Resident #82 had a current, 2/20/15, "Social Service Update Assessment" which indicated: the resident had poor attention span, rarely attended group activities and only occasionally attempted to initiate conversation.</p> <p>4. Resident #39 was observed in her room during the following dates and times:</p> <p>On 2/27/15 at 8:47 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 2/27/15 at 9:40 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 2/27/15 at 10:25 a.m., Resident #39</p>			

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	<p>was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 2/27/15 at 11:08 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 3/2/15 at 9:32 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 3/2/15 at 10:14 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p>			

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	<p>On 3/2/15 at 11:10 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 3/3/15 at 8:49 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 3/3/15 at 9:13 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall decor and a TV. The TV was on. The resident was asleep.</p> <p>On 3/3/15 at 9:44 a.m., Resident #39 was seated in her broda chair in her room. The room was dark. The curtain between the two beds was partially drawn. Resident #39 sat with her back to the bed facing the wall that had wall</p>			

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	<p>decor and a TV. The TV was on. The resident was asleep.</p> <p>Resident #39's clinical record was reviewed on 3/2/15 at 10:37 a.m. Resident #39 current diagnoses included, but were not limited to, Alzheimer's disease, generalized anxiety disorder, depression and dementia.</p> <p>Resident #39 had a current, 2/11/15, significant change, Minimum Data Set assessment (MDS) which indicated: the resident rarely or never understood, was rarely or never understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #39 had a current, 2/13/15, "Activities Update Assessment" which indicated: the resident appeared to have confusion to other people, place and time, had a very poor attention span, had very poor judgement, had limited</p>			

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	<p>communication, and was unable to make independent decisions.</p> <p>Resident #39 had a current, 2/19/15, care plan problem/need regarding a cognitive and communications deficient due to Alzheimer's disease. Approaches to this problem included, but were not limited to, individualized activities based on cognitive status and 1:1 (one to one) visits and sensory group.</p> <p>Resident #39 had a current, 2/11/15, care plan problem/need regarding the need for hospice services.</p> <p>5. Resident #C was observed in her room during the following dates and times:</p> <p>On 2/27/15 at 8:43 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing to look out the door into the hallway. There was no form of audio or visual stimulation being provided in the room.</p> <p>On 2/27/15 at 9:36 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing to look out the door into the hallway. There was no form of audio or visual stimulation being provided in the room.</p> <p>On 3/2/15 at 9:11 a.m., Resident #C was</p>			

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	<p>seated in her broda chair. She was in her room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>On 3/2/15 at 9:28 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>On 3/2/15 at 10:11 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>On 3/2/15 at 11:08 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>On 3/2/15 at 11:25 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing her TV. The resident was awake. She did not appear to be watching TV. Her eyes did not move to track the activity on the screen. Her facility expression did not change. Her eyes appeared unfocused.</p> <p>On 3/3/15 at 8:51 a.m., Resident #C was seated in her broda chair. She was in her</p>			

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	<p>room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>On 3/3/15 at 9:41 a.m., Resident #C was seated in her broda chair. She was in her room. She was facing her TV. The resident was asleep. The TV was on and playing softly.</p> <p>Resident #C's clinical record was reviewed on 3/03/2015 at 11:05 a.m. Resident #C's current diagnoses included, but were not limited to, Alzheimer's disease, dementia, depression and anxiety.</p> <p>Resident #C had a current, 1/29/15, significant change, Minimum Data Set assessment (MDS) which indicated: the resident had impaired hearing, had unclear speech, sometimes understood others, was sometimes understood by others, could not complete a mental status interview because she rarely or never understood, was moderately cognitively impaired and required assistance and cueing for decision making, at times had difficulty focusing on her surroundings, at times had a decreased level of activity such as sluggishness or staring into space, stayed in one position, was totally dependent on staff assistance for mobility both on and</p>			

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	<p>off the unit and was totally dependent on staff assistance for eating.</p> <p>Resident #C had a current, 2/20/15, "Activities Update Assessment" which indicated the resident had a poor attention span,</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding the need for assistance with all activities of daily living. Approaches to this problem included, but were not limited to, the staff will feed this resident.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding long and short term memory loss and an expressive disorder.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding impaired hearing and frequent refusal to wear a hearing aide.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding the need for hospice services.</p> <p>Resident #C had a current, 1/29/15, care plan problem/need regarding anxiety and depression. Approaches to this problem included, but were not limited to, encourage participation in activities of</p>			

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	<p>choice.</p> <p>6. During a 3/3/15, 9:39 a.m., interview, CNA #8, indicated she had not been trained regarding memory boxes or busy boxes. She indicated she knew a few residents had memory boxes from their families. She indicated she had no resident specific instructions regarding leisure time pursuits and stimulation.</p> <p>During a 3/3/15, 9:45 a.m., interview, LPN #9 indicated each resident did receive a personalized box for their room at Christmas time. She indicated stimulation prevents boredom and benefits each residents well being.</p> <p>During a 3/3/15, 9:49 a.m., interview, CNA #12 indicated she was unaware of any box or specialized items in each residents room for stimulation during leisure times. She indicated she did not know anywhere she could look to find what stimulation each resident needed or desired when in their room.</p> <p>During a 3/3/15, 9:52 a.m., interview, CNA #13 indicated she did not know about any boxes or personalized items in each resident's room for stimulation during leisure times. She indicated she was unaware of any method to know individual resident's needs or desires</p>						

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F 314 SS=D Bldg. 00	<p>during leisure times. She did indicate one resident had a special apron that she could wear and manipulate for pleasure.</p> <p>A 8/1/14, revised copy of "Resident Rights" was provided by the Director of Nursing on 3/3/15 at 1:14 p.m. The "Resident Rights" indicated the residents have a right to a dignified existence. The "Resident Rights" indicated "...The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality...."</p> <p>3.1-33(a)</p> <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 provide care and services to promote the healing of pressure ulcers, and failed to provide</p>	F 314	The facility is unable to correct the alleged deficient practice for residents #C, D and B.All residents have the potential to be affected by the alleged deficient	04/02/2015

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	<p>interventions to prevent the development of pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. (Residents #C, #D, and #B)</p> <p>Findings include:</p> <p>1. The following observations for Resident #C were made on 2/27/15:</p> <p>At 8:43 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the hallway;</p> <p>At 8:49 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the doorway, and her eyes were open;</p> <p>At 9:36 a.m., the resident was sitting in a broda chair with the chair back upright and her legs raised approximately 25 degrees, in her room facing the hallway;</p> <p>At 9:53 a.m., the resident was sitting in a broda chair with back upright and her legs raised approximately 25 degrees, in her room facing the doorway;</p> <p>At 10:22 a.m., the resident was in her bed, resting on her back with a bowel movement odor noted in the room;</p>		<p>practice. Nursing will audit the care plans for all residents with any current pressure areas and/or the potential of developing a pressure area will be reviewed to ensure the appropriate interventions are in place. DON/Designee to review results of audit conducted. All residents in Broda chairs or residents with current skin issues will be toileted/checked and/or changed after the morning meal and placed back to bed after lunch. Rounds checklist will be utilized by the Unit Managers/Nurses each shift to ensure that repositioning is occurring. Rounds checklist will include placement of wheelchair cushions for all residents. DON/Designee to in-service nursing staff regarding turning and repositioning residents and pressure ulcer preventions. DON/Designee will review the rounds checklists each business day for any concerns. QA Committee to review the results of the audits monthly ongoing.</p>		

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	<p>And at 11: 07 a.m., the resident was in her bed, resting on her back.</p> <p>The following observations for Resident #C were made on 3/2/15:</p> <p>At 8:33 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the dining room;</p> <p>At 8:38 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the dining room;</p> <p>At 8:40 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television;</p> <p>At 9:28 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes closed;</p> <p>At 9:43 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, LPN #9 entered the room and rearranged the resident's blanket and left the room;</p>			

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	<p>At 10:00 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 10:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes closed;</p> <p>At 11:08 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes closed;</p> <p>At 11:14 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 11:25 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, with her eyes open;</p> <p>At 11:30 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in the activity room, no staff were</p>			

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	<p>present;</p> <p>At 12:28 p.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television;</p> <p>At 1:39 p.m., the resident was in bed, resting on her back, with her eyes closed;</p> <p>At 1:47 p.m., the resident was in bed, resting on her back, with her eyes closed;</p> <p>At 1:53 p.m., observed wound care for Resident #C;</p> <p>And at 2:58 p.m., the resident was in bed, resting on her back, with her eyes closed.</p> <p>The resident was not repositioned during any of the observations on 3/2/15 from 8:33 a.m. through 12:28 p.m.</p> <p>The following observations of Resident #C were made on 3/3/15:</p> <p>At 7:37 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room with a baby doll in her lap, her eyes were closed and the chair was angled toward the foot of the bed;</p> <p>At 8:40 a.m., the resident was sitting in a</p>			

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	<p>broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television with her eyes open;</p> <p>At 8:48 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 8:51 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes closed;</p> <p>At 9:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 9:35 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p> <p>At 9:41 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed;</p>			

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	<p>At 10:20 a.m., the resident was sitting in a broda chair with the back upright and the legs raised approximately 25 degrees, in her room facing the television, her eyes were closed and the hospice nurse entered the room;</p> <p>At 10:50 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room with her eyes closed;</p> <p>And at 11:11 a.m., the resident was sitting in a broda chair with the back upright and her legs raised approximately 25 degrees, in her room facing the television, and her eyes were closed.</p> <p>The resident was not repositioned during any of the observations on 3/3/15 from 7:37 a.m. through 11:11 a.m.</p> <p>The clinical record for Resident #C was reviewed on 3/2/15 at 1:20 p.m. Diagnoses for Resident #C included, but were not limited to, Alzheimer's disease, muscle weakness, and abnormal posture. Resident #C was admitted to hospice on 1/17/15.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 1/29/15, indicated Resident #C could not complete</p>			

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	<p>a mental status interview because she was rarely or never understood. The assessment indicated Resident #C had an altered level of consciousness which fluctuated (comes and goes, and changes in severity) and psychomotor retardation which fluctuated also. The assessment indicated Resident #C required total assistance from the staff for all turning and repositioning services. The assessment indicated the resident was at risk of developing pressure ulcers.</p> <p>An "Initial Pressure Ulcer Report", dated 2/16/15, indicated Resident #C had a stage 2 pressure ulcer, defined as "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough", on her left buttock. The area measured 1.8 centimeters (cm) by 2.0 cm with "wound edges well defined and attached."</p> <p>A "Pressure Ulcer Progress Report", dated 2/23/15, indicated Resident #C had a stage 2 pressure ulcer on her left buttock. The area measured 1.8 cm by 2.0 cm with "wound edges well defined and attached." A stage 2 pressure ulcer on her coccyx. The area measured 0.8 cm by 0.2 cm with "wound edges well defined and attached." An unstageable pressure ulcer, defined as "full tissue loss in which the base of the ulcer is covered</p>			

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	<p>by slough [yellow, tan, gray, green or brown] and/or eschar [tan, brown or black] in the wound bed", on her right buttock. The area measured 0.8 cm by 1.2 cm with "no open areas noted." One of the preventative devices checked as being used for the resident was "turning/positioning program."</p> <p>Resident #C had a health care plan focus of a stage 2 pressure ulcer on left buttock and coccyx, initiated on 2/16/15 and revised on 2/23/15. Interventions for this focus included, but were not limited to, turn and reposition every two hours and more frequently as needed, and toilet according to the toileting program.</p> <p>Resident #C had a health care plan focus of an unstageable pressure ulcer on right buttock, initiated on 2/23/15. The health care plan lacked any interventions related to turning and repositioning the resident.</p> <p>During an interview on 3/3/15 at 10:44 a.m., CNA #6 indicated she did not know why Resident #C was still in her chair and had not returned to bed after breakfast.</p> <p>During an interview on 3/3/15 at 10:54 a.m., CNA #7 indicated she works the day shift and her shift begins at 6:00 a.m. She indicated Resident #C is up in her</p>			

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	<p>chair when she arrives to work. CNA #7 indicated Resident #C should be transferred back to bed after breakfast. She indicated Resident #C requires the use of a Hoyer lift to be transferred and two staff are required to use the lift. CNA #7 indicated if a resident has skin issues with his or her bottom, then the resident should not be up in a chair for more than two hours at a time. CNA #7 indicated staffing for the facility is based on the number of residents and not the difficulty in the care for each resident. CNA #7 indicated it is sometimes difficult to get the residents back in bed or repositioned as they should be. CNA #7 indicated there are usually two CNAs and one nurse working on Hickory Hall and two CNAs and one nurse working on Redbud Court.</p> <p>During an interview on 3/3/15 at 11:20 a.m., CNA #8 indicated Resident #C requires total assistance and use of the Hoyer lift for transfers. CNA #8 indicated two staff are required when using the Hoyer lift. CNA #8 indicated if a resident has skin concerns with his or her bottom, the resident should only be up in a chair for "just a couple of hours."</p> <p>During an interview on 3/3/15 at 1:03 p.m., LPN #9 indicated Resident #C gets up in the morning between 5:00 a.m. and</p>			

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	<p>6:00 a.m. LPN #9 indicated Resident #C can be repositioned in her chair but should go back to bed after breakfast. LPN #9 indicated they try to get everything done for the residents. LPN #9 indicated Hickory Hall and Redbud Court need six staff but they are lucky when they have 5 staff. LPN #9 indicated the extra CNA is "split" between the two halls.</p> <p>During an interview on 3/3/15 at 1:10 p.m., LPN #10 indicated when there are five staff for Hickory Hall and Redbud Court "things go well", and tasks are able to be completed.</p> <p>During an interview on 3/3/15 at 1:58 p.m., Unit Manager #11 indicated Resident #C can be repositioned in her chair by tilting the chair back and adjusting the legs. She indicated she tries to check on all the residents in broda chairs after the weekday morning meeting. She indicated she thought the residents had been getting turned and repositioned as needed.</p> <p>2. Resident #B's clinical record was reviewed on 2/27/15 at 11:31 a.m. The resident's diagnoses included, but were not limited to, anxiety, depressive disorder, congestive heart failure, and chronic bronchitis.</p>				

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	<p>An Initial Pressure Ulcer report dated 1/28/15, indicated a pressure area, located on the left buttock, was not present upon admission. The pressure area was first noted on 1/28/15. The measurement of the pressure area located on the left buttock was 4.5 cm x 1.5 cm. The pressure area was staged as a stage II pressure ulcer with no drainage or odor. The periwound area was documented as normal in color. The documented treatment ordered was to cleanse with wound cleanser, apply skin prep to periwound skin, cover with Duoderm extra thin, change every 3 days and as needed.</p> <p>Resident #B had a skin care order dated 1/28/15. The order stated: "Skin care to upper buttocks: cleanse with wound cleanser or mild soap and water, pat dry. Apply Nystatin powder between upper cheeks of buttocks two times a day for irritated skin."</p> <p>Resident #B had an skin care order dated 1/28/15. The order stated: "Wound care left buttocks [sic]: cleanse wound with wound cleanser, apply skin prep to periwound edges, cover with Duoderm extra thin, change every 3 days and as needed."</p>			

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	<p>During an observation on 3/2/15 at 2:13 p.m., the Assistant Director of Nursing (ADON) entered the room of Resident #B and put on a pair of gloves and assembled the wound care supplies at the bedside. The ADON then assisted the resident in repositioning onto the right side and adjusted the resident's clothing and exposed the resident's buttocks. The ADON explained that Resident #B had two areas that would be receiving treatment. Resident #B had an order for Nystatin to be used on the skin between the left and right buttocks. She cleaned the area with wound cleanser and patted it dry with a 4 x 4 gauze. The ADON then sprinkled the Nystatin powder onto a new 4 x 4 gauze. She shook the powder over an opened soda pop can located on the bedside table. The ADON did not remove her gloves nor did she wash her hands. The ADON assessed the wound. The ADON went back to the treatment cart to retrieve more dressing supplies. She brought them back to the bedside, then removed her gloves and washed her hands. The ADON then put on a new pair of gloves. The wound was measured and the measurements were written on the back of the paper measuring tape, that had been used to measure the wound, with an ink pen she removed from her hair. The ADON then placed the ink pen back in her hair. The ADON then</p>			

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	<p>applied the new dressing to the wound area. The ADON then placed Nystatin back into the plastic bag while still wearing the gloves she wore while dressing the wound. The ADON then removed her gloves and washed her hands. She picked up the trash and dressing change supplies and took them back to the treatment cart. The trash was discarded in the trash container located on the side of the treatment cart and the supplies and Nystatin were placed inside the treatment cart.</p> <p>A current facility policy dated 6/20/12, titled "Clean Dressing Change" was provided by the Unit Manager #1 on 3/3/15 at 10:30 a.m., and indicated the following: "Purpose: 1. To protect the wound from contamination. 2. To absorb drainage. 3. To promote a healing environment. ...General Guidelines: 1. Bring all equipment to the bedside within easy reach. ...4. Perform hand hygiene and put on gloves. 5. Remove the soiled dressing and pull soiled gloves off over dressings and dispose of in moisture-proof bag. 6. Perform hand hygiene and put on clean gloves.</p>			

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	<p>7. Cleanse the wound with prescribed solution. The wound is cleaned from top to the bottom or with outward strokes from the least contaminated to the most contaminated. For irregular wounds, such as decubitus, clean from the center outward using circular strokes.</p> <p>8. Remove soiled gloves and Observe [sic] the overall appearance of the wound.</p> <p>...11. Dispose of trash and clean hands ..."</p> <p>A current facility policy dated 4/2012, titled "Hand Washing" was provided by the Unit Manager #1 on 3/3/15 at 10:30 a.m., and indicated the following: "Policy: To Ensure [sic] proper hand washing before and after procedures and/or resident care to prevent the spread of infection. ...When to Wash Hands (at a minimum): Before putting on and after taking off gloves. When reporting to work or going home. Before eating and drinking. Before and after using toilet. After sneezing, coughing, or blowing nose. After touching hair, face, clothing etc. After smoking cigarettes. Before and after each resident contact. After touching resident or handling his or her belongings.</p>			

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	<p>Whenever hands are visibly soiled. After contact with any body fluids. After handling any contaminated items (linens, soiled briefs, garbage, etc."3. Resident #D was observed on 3/2/15 at 9:47 a.m., up in a wheelchair being pushed by a CNA. The resident did not have a cushion in his wheelchair. He was sitting on a white folded incontinent pad.</p> <p>Resident #D was observed in activities on 3/2/15 at 10:58 a.m. He was sitting in his wheelchair on a white folded incontinent pad with no cushion.</p> <p>Resident #D was observed in his room on 3/2/15 at 11:33 a.m. He was sitting in his wheelchair with no cushion in the chair.</p> <p>Resident #D was observed in bed on 3/2/15 at 1:52 p.m. There was no wheelchair cushion observed in the room.</p> <p>An observation of the resident's treatment to the left buttock was made on 3/2/15 at 2:35 p.m., with the Assistant Director of Nursing and CNA #2 present. No cushion for the wheelchair was observed. CNA #2 indicated the resident was suppose to have a cushion in his wheelchair. The CNA indicated the wheelchair had been washed the night before and the cover to the cushion had probably been removed for cleaning. The</p>			

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	<p>CNA indicated the cushion cover needed to be air dried and it takes longer to dry thoroughly. The Assistant Director of Nursing indicated the resident should have a cushion in his wheelchair. She indicated extra cushions were available and she would have replaced the cushion if staff had informed her.</p> <p>Resident #D's clinical record was reviewed on 2/27/15 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dysphagia and cognitive deficits due to cerebrovascular disease, osteoarthritis, peripheral neuropathy and Stage II chronic kidney disease.</p> <p>The resident had a 2/22/15, physician's order to cleanse area to left buttock with dermal wound cleanser, apply aquacel ag [a topical wound medication], cover with duoderm thin, change dressing every other day and as needed till healed.</p> <p>The resident had a 1/2/15, quarterly Minimum Data Set assessment. The assessment indicated the resident required extensive one person physical assistance for bed mobility and transfers. The assessment indicated the resident was at risk for developing pressure ulcers.</p> <p>The resident had a 2/23/15, care plan</p>			

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	<p>focus for a suspected deep tissue injury on the left buttock related to extended pressure. An intervention for this problem was a cushion in the chair for pressure redistribution.</p> <p>A 2/22/15, "Initial Pressure Ulcer Report", indicated Resident #D had a 0.5 cm by 0.5 cm suspected deep tissue injury to the left buttock.</p> <p>4. The 10/10, revised "Wound Prevention Protocol" was provided on 3/3/15 at 2:30 p.m., by the RN Consultant. The purpose of the protocol was to: identify residents that were at high risk for developing pressure areas; to relieve or remove pressure to prevent tissue trauma; and to initiate nursing interventions along with medical orders to prevent tissue trauma. The protocol indicated chair bound residents at moderate and high risk for developing pressure areas were to be repositioned and encouraged to shift weight every hour. Staff were to assist with positioning as needed.</p> <p>This Federal tag relates to complaint IN00167998.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F 441 SS=D Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and</p>	F 441	The facility is unable to correct the alleged deficient practice for	04/02/2015			

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	<p>record review, the facility failed to ensure current standards of practice and facility policy were followed to ensure residents were protected from potential exposure to infection during wound care. This practice had the potential to affect one (Resident #B) of one residents observed for wound care in the Stage 2 sample of 4.</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 2/27/15 at 11:31 a.m. The Resident's diagnoses included, but were not limited to, anxiety, depressive disorder, congestive heart failure, and chronic bronchitis.</p> <p>An Initial Pressure Ulcer report dated 1/28/15, indicated a pressure area, located on the left buttock, was not present upon admission. The pressure area was first noted on 1/28/15. The measurement of the pressure area located on the left buttock was 4.5 cm x 1.5 cm. The pressure area was staged as a stage II pressure ulcer with no drainage or odor. The periwound area was documented as normal in color. The documented treatment ordered was to cleanse with wound cleanser, apply skin prep to periwound skin, cover with Duoderm extra thin, change every 3 days and as</p>		<p>resident #B.All residents have the potential to be affected by the alleged deficient practice.Nursing staff will be in-serviced on hand washing and Licensed only nursing will be in-serviced on proper dressing change procedures by the DON/Designee.Dressing change observations will be completed by the DON/Designee 3 times weekly for 1 month, 2 times weekly for 1 month, 1 time weekly thereafter.QA Committee will review the dressing change observations monthly until no continuing concerns are identified and with QA approval the observations will be suspended.</p>	

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	<p>needed.</p> <p>Resident #B had a skin care order dated 1/28/15. The order stated: "Skin care to upper buttocks: cleanse with wound cleanser or mild soap and water, pat dry. Apply Nystatin powder between upper cheeks of buttocks two times a day for irritated skin."</p> <p>Resident #B had a skin care order dated 1/28/15. The order stated: "Wound care left buttocks: cleanse wound with wound cleanser, apply skin prep to periwound edges, cover with Duoderm extra thin, change every 3 days and as needed."</p> <p>During an observation on 3/2/15 at 2:13 p.m., the Assistant Director of Nursing (ADON) entered the room of Resident #B and put on a pair of gloves and assembled the wound care supplies at the bedside. The ADON then assisted the resident in repositioning onto the right side and adjusted the resident's clothing and exposed the resident's buttocks. The ADON explained Resident #D had two areas that would be receiving treatment. Resident #B had an order for Nystatin to be used on the skin between the left and right buttocks. She cleaned the area with wound cleanser and patted it dry with a 4 x 4 gauze as ordered. The ADON then sprinkled the Nystatin powder onto a new</p>			

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	<p>4 x 4 gauze. She shook the powder over an opened soda pop can located on the bedside table. The ADON did not remove her gloves nor did she wash her hands. The ADON assessed the wound. The ADON went back to the treatment cart to retrieve more dressing supplies. She brought them back to the bedside, then removed her gloves and washed her hands. The ADON then put on a new pair of gloves. The wound was measured and the measurements were written on the back of the paper measuring tape, that was used to measure the wound, with an ink pen she removed from her hair. The ADON then placed the ink pen back in her hair. The ADON then applied the new dressing to the wound area. The ADON then placed Nystatin back into the plastic bag while still wearing the gloves she wore while dressing the wound. The ADON then removed her gloves and washed her hands. She picked up the trash and dressing change supplies and took them back to the treatment cart. The trash was discarded in the trash container located on the side of the treatment cart and the supplies and Nystatin were placed inside the treatment cart.</p> <p>During an interview on 3/2/15 at 2:00 p.m., the Assistant Director of Nursing indicated that she was also the wound care nurse.</p>				

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	<p>During an interview on 3/3/15 at 2:45 p.m., the Registered Nurse Consultant indicated the facility had no other policy related to clean dressing changes and hand washing. She did provide a blank audit form she indicated that was used by the Quality Assessment and Assurance Committee for monitoring hand washing after the last annual survey.</p> <p>A current facility policy dated 4/2012, titled "Hand Washing" was provided by the Unit Manager #1 on 3/3/15 at 10:30 a.m., and indicated the following: "Policy: To Ensure [sic] proper hand washing before and after procedures and/or resident care to prevent the spread of infection. ...When to Wash Hands (at a minimum): Before putting on and after taking off gloves. When reporting to work or going home. Before eating and drinking. Before and after using toilet. After sneezing, coughing, or blowing nose. After touching hair, face, clothing etc. After smoking cigarettes. Before and after each resident contact. After touching resident or handling his or her belongings. Whenever hands are visibly soiled. After contact with any body fluids.</p>			

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F 520 SS=D Bldg. 00	<p>After handling any contaminated items (linens, soiled briefs, garbage, etc."</p> <p>3.1-18(l)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility's Quality Assurance and Assessment (QAA & A) Committee failed to implement a plan of action to prevent the development of and promote the healing of pressure ulcers.</p> <p>This deficient practice impacted 3 of 4</p>	F 520	Facility is unable to correct the alleged deficient practice for residents #B, C and D.All residents have the potential to be affected by the alleged deficient practice. Nursing will audit the care plans for all residents with any current pressure areas and/or	04/02/2015

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	<p>residents reviewed for pressure ulcer(Residents #C, #D, and #B)</p> <p>Findings include:</p> <p>1. During an interview on 3/3/15 at 2:41 p.m., the Administrator indicated the QAA & A Committee reviewed, "Things from last year, we go over and over those...." He identified some improvements they had made such as hiring a different wound care nurse. The Administrator was unable to identify a current corrective action plan the facility had in place to prevent and heal pressure ulcers.</p> <p>2. The clinical record for Resident #C was reviewed on 3/2/15 at 1:20 p.m. Diagnoses for Resident #C included, but were not limited to, Alzheimer's disease, muscle weakness, and abnormal posture. Resident #C was admitted to hospice on 1/17/15.</p> <p>An "Initial Pressure Ulcer Report", dated 2/16/15, indicated Resident #C had a stage 2 pressure ulcer, defined as "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough", on her left buttock. The area measured 1.8 centimeters (cm) by 2.0 cm with "wound edges well defined and attached."</p>		<p>the potential of developing a pressure area will be reviewed to ensure the appropriate interventions are in place. DON/Designee to review results of the audit conducted. All residents in Broda chairs or residents with current skin issues will be toileted/checked and/or changed after the morning meal and placed back to bed after lunch. Rounds checklist will be utilized by the Unit Managers/Nurses each shift to ensure that repositioning is occurring. Rounds checklist will include placement of wheelchair cushions for all residents. DON/Designee to in-service nursing staff regarding turning and repositionin, cushion placement for residents. DON/Designee will review the rounds checklist each business day for any concerns identified during rounds. QA Committee will conduct reviews of the rounds checklist audits to identify any continuing or additional issues identified monthly ongoing.</p>				

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	<p>Resident #C had a health care plan focus of a stage 2 pressure ulcer on left buttock and coccyx, initiated on 2/16/15 and revised on 2/23/15. Interventions for this focus included, but were not limited to, turn and reposition every two hours and more frequently as needed, and toilet according to the toileting program.</p> <p>Resident #C was observed multiple times from 2/27/15 to 3/3/15, seated in a broda chair with the back upright and her legs raised approximately 25 degrees for extended periods of times. No repositioning occurred during these observations.</p> <p>3. Resident #B's clinical record was reviewed on 2/27/15 at 11:31 a.m. The resident's diagnoses included, but were not limited to, anxiety, depressive disorder, congestive heart failure, and chronic bronchitis.</p> <p>An Initial Pressure Ulcer report dated 1/28/15, indicated a pressure area, located on the left buttock, was not present upon admission. The pressure area was first noted on 1/28/15. The measurement of the pressure area located on the left buttock was 4.5 cm x 1.5 cm. The pressure area was staged as a stage II pressure ulcer with no drainage or odor.</p>			

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	<p>The periwound area was documented as normal in color. The documented treatment ordered was to cleanse with wound cleanser, apply skin prep to periwound skin, cover with Duoderm extra thin, change every 3 days and as needed.</p> <p>During an observation on 3/2/15 at 2:13 p.m., Resident #B received wound care. The wound care did not follow infection control protocol.</p> <p>4. Resident #D's clinical record was reviewed on 2/27/15 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dysphagia and cognitive deficits due to cerebrovascular disease, osteoarthritis, peripheral neuropathy and Stage II chronic kidney disease.</p> <p>A 2/22/15, "Initial Pressure Ulcer Report", indicated Resident #D had a 0.5 cm by 0.5 cm suspected deep tissue injury to the left buttock.</p> <p>Resident #D was observed multiple times in bed on 3/2/15 from 9:47 a.m. to 11:33 a.m. There was no wheelchair cushion observed in the room.</p> <p>An observation of the resident's treatment to the left buttock was made on 3/2/15 at 2:35 p.m., with the Assistant Director of</p>			

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	<p>Nursing and CNA #2 present. No cushion for the wheelchair was observed. CNA #2 indicated the resident was suppose to have a cushion in his wheelchair. The CNA indicated the wheelchair had been washed the night before and the cover to the cushion had probably been removed for cleaning. The CNA indicated the cushion cover needed to be air dried and it takes longer to dry thoroughly. The Assistant Director of Nursing indicated the resident should have a cushion in his wheelchair. She indicated extra cushions were available and she would have replaced the cushion if staff had informed her.</p> <p>The 10/10, revised "Wound Prevention Protocol" was provided on 3/3/15 at 2:30 p.m., by the RN Consultant. The purpose of the protocol was to: identify residents that were at high risk for developing pressure areas; to relieve or remove pressure to prevent tissue trauma; and to initiate nursing interventions along with medical orders to prevent tissue trauma. The protocol indicated chair bound residents at moderate and high risk for developing pressure areas were to be repositioned and encouraged to shift weight every hour. Staff were to assist with positioning as needed.</p> <p>During an interview on 3/3/15 at 2:45</p>			

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	p.m., the Registered Nurse Consultant indicated the facility had no other policy related to clean dressing changes and hand washing. She did provide a blank audit form she indicated was used by the Quality Assessment and Assurance Committee for monitoring hand washing after the last annual survey. 3.1-52(b)(2)				