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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155094 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/23/2013 |
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| NAME OF PROVIDER OR SUPPLIER ST MARY HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 CASON ST LAFAYETTE, IN 47904 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 19, 20, 21, 22, and 23, 2013</p> <p>Facility number: 000037 Provider number: 155094 AIM number: 100291350</p> <p>Survey team : Bobette Messman, RN, TC Rita Mullen, RN Maria Pantaleo, RN Michelle Carter, RN (August 19, 20, 21, and 22, 2013)</p> <p>Census bed type: SNF/NF: 55 SNF: 8 Total: 63</p> <p>Census payor type: Medicare: 8 Medicaid: 41 Other: 14 Total: 63</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by</p> | F000000 | <p>The submission of this plan of correction does not indicate an admission by St. Mary Healthcare Center of the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of St. Mary Healthcare Center. The campus maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. The plan of correction shall serve as a credible allegation of compliance with all Federal and State requirements governing the management of this campus. St. Mary Healthcare Center is requesting a face to face Informal Dispute Resolution for the scope and severity assignmnet of "G" to less severity for F314 which is included in this Plan of Correction.</p> | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | Tammy Alley RN on August 29, 2013. | | | | |

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| F000157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician of a pressure ulcer, upon a residents admission and failed to notify the physician when the area</p> | F000157 | WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #12 is discharged to | 09/20/2013 | | | |

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| | <p>worsened to a stage 3 pressure ulcer for 1 of 3 residents reviewed for physician notification of pressure ulcers. The resident was admitted with a reddened area that progressed to a stage 2 and 3 pressure ulcer. (Resident #12)</p> <p>Findings include:</p> <p>The record for Resident #12 was reviewed on 8/21/13 at 3:45 p.m.</p> <p>Diagnoses for Resident #12 included, but were not limited to, osteoarthritis, hyperlipidemia, sleep apnea, back pain, high blood pressure, anemia, gastroesophageal reflux disease, depression, and a history of deep vein thrombosis.</p> <p>A Nursing Admission Assessment document, dated 7/10/13, indicated red abdominal folds, present upon admission.</p> <p>A Skin Care Plan, dated 7/10/13, on the Nursing Admission Assessment document, indicated as an intervention, "prevent skin from touching skin".</p> <p>During an interview, on 8/20/13 at 5:00 p.m., the Director of Nursing (DON) indicated the red area was at</p> | | <p>home prior to survey. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: The Director of Health Services (DHS) will review all residents with pressure wounds to validate that documentation supports that the responsible party and physician have been notified in regards to the current status of wounds and/or if wounds have worsened. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: An inservice is scheduled September 16 for nurses and will include education on the following: Physician and family notification of worsening condition and Change in Condition forms which also includes proper notification. CORRECTIVE ACTION MONITORING: Per campus guidelines, the Nursing Leadership Team will review the 24 hour Report, Circumstance and Assessment Forms, Change in Condition Forms, and physician telephone orders in the daily clinical meeting 5 days per week. The review is to ensure that the responsible party and physician have been notified timely. The audits and observations will be conducted by the DHS or</p> | | |

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| | <p>her pants line, on her abdomen and said, "I don't believe there was an intervention implemented to prevent skin from touching skin."</p> <p>Physician assessment and progress notes, dated 7/10/13, exhibited no indication the abdomen was evaluated; there was no mentioning of redness to abdominal folds.</p> <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the location of a stage 2 pressure wound impairment was to the right abdominal fold. During an interview with the DON on 8/20/13, at 5:00 p.m., the DON indicated she was informed of Resident #12's skin impairment on 7/15/13.</p> <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the physician was notified of a Stage 2 pressure area to Resident #12's right abdominal fold on 7/16/13.</p> <p>Physician orders, dated 7/16/13, indicated the following, "Therahoney [a barrier cream] to right abdominal area, cover with optifoam, change every day."</p> | | designee 2 x per week for four weeks, and then monthly for five months. The results of the audit and observations will be reported, reviewed and monitored for compliance in the QAA Committee for a minimum of six months then random or as needed as recommended. | | | | |

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| | <p>Wound Tracking documents, for Resident #12, indicated the following measurments, to the right abdominal fold, pressure ulcer:</p> <p>7/16/13 Stage 3, 2.0 x 2.0 x 2.1 cm. (centimeters) 7/23/13 Stage 3, 1.2 x 1.2 x less than 0.1 cm. 7/30/13 Stage 3, 1.0 x 1.0 x less than 0.1 cm.</p> <p>A Resident First Conference note, dated 7/31/13, indicated Resident #12 had a Stage 3 pressure ulcer at the abdominal fold.</p> <p>The documentation provided failed to indicate the physician assessed the Stage 3 pressure area. During an interview with the DON, on 8/20/13 at 5:30 p.m., she indicated it is not typical for a resident with a Stage 3 pressure area to not be evaluated by a physician or a nurse practitioner. She indicated there were no notes to indicate any evaluation by a physician.</p> <p>3.1-5(a)(3)</p> | | | | |

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| F000279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to update a Care Plan for fall prevention for a resident with a history of falls for 1 of 4 residents reviewed for falls (Resident #56).</p> <p>Findings include:</p> <p>The clinical record of Resident #56 was reviewed on 8/19/13 at 1:30 p.m.</p> <p>A review of Fall Circumstance, assessment and intervention reports, dated 5/25/13 through 7/22/13,</p> | F000279 | WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The care plan for resident # 56 has been updated to reflect current needs. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents with the potential for falls have been identified and care plans have been updated to include interventions to prevent falls. MEASURES PUT IN PLACE OR | 09/20/2013 | |

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| | <p>indicated the resident had fallen four times, 5/25/13 at 11:50 a.m., 6/20/13 at 12:00 p.m., 7/8/13 at 9:00 p.m., and 7/22/13 at 7:10 p.m. Interventions were put in place for a self releasing seat belt and alarms.</p> <p>The Fall circumstance, assessment and intervention, dated 7/22/13, indicated "Resdient stated she got up and wanted to see if her call light was on...Resident is unable to maintain balance while standing or walking without assistance...Prevention up date: First one put to bed at noc [night]."</p> <p>A Care Plan for ADLS (Activities of Daily Living), dated 8/16/13, did not indicate Resident #56 was to be put to bed first at night. The Care Plan had not been updated to include the intervention of putting the resident to bed first at night.</p> <p>During an interview with the Director of Nursing, on 8/22/13 at 3:00 p.m., she indicated the Care Plan for ADLS had not been updated to include putting the resident to bed first at night.</p> <p>3.1-35(a)</p> | | <p>SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: All residents with falls have been reviewed to ensure that care plans reflect current interventions to prevent falls. The licensed nursing staff will be inserviced on September 16 in regards to campus fall guidelines and updating resident care plans to reflect current interventions. CORRECTIVE ACTION MONITORING: Per campus guidelines, the Nursing Leadership Team will review the 24 hour Report, Circumstance and Assessment forms, Change in Condition forms and physician telephone orders in the daily clinical meeting 5 days per week. The review is to ensure that the care plan has been intitiated and updated as necessary to reflect current interventions in fall prevention. The Daily Clinical Report will be completed to document the review of the above reports and forms. The Director of Health Services (DHS) or designee will conduct audits and observations 2 x per week for four weeks and then monthly for five months to ensure compliance. The results of the audit and observations will be reported, reviewed and monitored for compliance through the campus QAA Committee for a minimum of six months then random or as needed as recommended.</p> | | |

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| F000280 SS=D | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure a care plan conference was held with a residents family member for 1 of 1 resident reviewed for care plan meetings. (Resident #80)</p> <p>Findings include:</p> <p>The record for Resident #80 was reviewed on 8/21/13 at 9:15 a.m.</p> <p>Diagnoses for Resident #80, included, but were not limited to, progressive dementia with psychosis and depressed features, history of edema, and history of left femoral</p> | F000280 | <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #80 has care plan meeting re scheduled for September 18, at 10:30 a.m.</p> <p>HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents have the potential to be affected by the deficient practice. The campus has conducted an audit of all residents to ensure that care plan invitations have been sent to residents/and or responsible</p> | 09/20/2013 | | | |

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| | <p>neck fracture.</p> <p>During an interview, on 8/20/13, at 10:30 a.m., with Resident #80's family member, she indicated she was the person who would be contacted for resident care plan conferences. The family member indicated a care plan meeting was scheduled for June 20, 2013 and facility staff canceled the meeting on that day. She indicated the Social Services Director said they would reschedule. At the time of the interview, the care plan meeting was still not rescheduled.</p> <p>During an interview with the Director of Nursing (DON) on 8/21/13, at 9:00 a.m., she indicated resident care conferences were held every Wednesday and families were invited to attend. On 8/22/13 at 1:00 p.m., during an interview with the Executive Director (ED), she said post card invitations were sent to family members, in advance, to encourage family members to schedule a care plan meeting. The ED indicated the June 20, 2013 conferences were canceled for all residents, including Resident #80. She indicated Resident #80's care plan meeting had not been rescheduled, yet.</p> <p>The calendar schedules for June, July</p> | | <p>parties. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Social Service Director will conduct an audit of all care plans due for the month to ensure that all residents and/or responsible parties are invited. The Social Service Director will conduct the audit one time per month for the current month for six months and document results on a log. CORRECTIVE ACTION MONITORING: The results of the Care Plan Invitation audit and log will be reported monthly to the QAA Committee by the Social Service Director. The results of the audit will be reported, reviewed and monitored for compliance in the QAA Committee for a minimum of six months then random or as needed as recommended.</p> | | |

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| | <p>and August 2013 were reviewed, with the ED, on 8/22/13 at 1:05 p.m. All conferences canceled on June 20, 2013 were rescheduled, except for Resident #80. The ED indicated care plan conferences were expected to occur every 90 days.</p> <p>The ED indicated, on 8/22/13, at 1:10 p.m., the Resident Relations staff member tried to reschedule the care plan meeting with Resident #80's family member, but the dates available did not work for the family member. The staff member indicated she thought the family member would contact her to reschedule. The ED indicated documentation related to the latter conversation was not documented.</p> <p>3.1-35(d)(2)(B)</p> | | | |

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| F000282 SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to provide prevention interventions and follow care plans for pressure ulcer development for 2 of 3 residents reviewed for pressure ulcers. (Resident #12 & #48)</p> <p>Findings include:</p> <p>1. The record for Resident #12 was reviewed on 8/21/13 at 3:45 p.m.</p> <p>Diagnoses for Resident #12 included, but were not limited to, osteoarthritis, hyperlipidemia, sleep apnea, back pain, high blood pressure, anemia, gastroesophageal reflux disease, depression, and a history of deep vein thrombosis.</p> <p>A Nursing Admission Assessment document, dated 7/10/13, indicated red abdominal folds, present upon admission.</p> <p>A Skin Care Plan, dated 7/10/13, on the Nursing Admission Assessment document, indicated as an</p> | F000282 | <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:</p> <p>Resident #12 has been discharged to home. Resident # 48 care plan has been revised to reflect preventative interventions related to wounds. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents with wounds have been re-assessed to ensure that documentation reflects the current status and intervention are documented on the care plans. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Director of Health Services (DHS) or designee will be inservicing nurses on September 16, regarding wounds and wound documentation and will be re inserviced on care plans in prevention of skin impairment. CORRECTIVE ACTION MONITORING: Per campus guidelines, the Nursing</p> | 09/20/2013 | | | |

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| | <p>intervention, "prevent skin from touching skin".</p> <p>During an interview, on 8/20/13 at 5:00 p.m., the Director of Nursing (DON) indicated the red area was at her pants line, on her abdomen and said, "I don't believe there was an intervention implemented to prevent skin from touching skin."</p> <p>Physician assessment and progress notes, dated 7/10/13, exhibited no indication the abdomen was evaluated; there was no mentioning of redness to abdominal folds.</p> <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the location of a stage 2 pressure wound impairment was to the right abdominal fold. During an interview with the DON on 8/20/13, at 5:00 p.m., the DON indicated she was informed of Resident #12's skin impairment on 7/15/13.</p> <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the physician was notified of a Stage 2 pressure area to Resident #12's right abdominal fold on 7/16/13.</p> | | <p>Leadership Team will review the 24 hour report, Circumstance and Assessment Forms, Change in Condition Forms, and physician telephone orders in the daily clinical meeting 5 days a week. The review is to ensure that care plans have been initiated and updated as necessary to reflect the current status of wounds. The Director of Health Services (DHS) or designee will conduct audits and observations 2 x per week for four weeks, then monthly for five months to ensure compliance. The results of the audit and observation will be reported, reviewed and monitored for compliance through the campus QAA Committee for a minimum of six months then random or as needed as recommended.</p> | | |

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| | <p>Physician orders, dated 7/16/13, indicated the following, "Therahoney [a barrier cream] to right abdominal area, cover with optifoam, change every day."</p> <p>A Resident First Conference note, dated 7/31/13, indicated Resident #12 had a Stage 3 pressure ulcer at the abdominal fold.</p> <p>The documentation provided failed to indicate the physician assessed the Stage 3 pressure area. During an interview with the DON, on 8/20/13 at 5:30 p.m., she indicated it is not typical for a resident with a Stage 3 pressure area to not be evaluated by a physician or a nurse practitioner. She indicated there were no notes to indicate any evaluation by a physician.</p> <p>2. The clinical record of Resident #48 was reviewed on 8/21/13 at 1:30 p.m. Resident #48 was admitted to the facility on 5/17/13.</p> <p>An Initial Nursing Assessment, dated 5/17/13 (no time noted), indicated red pressure areas on the left and right buttocks. The Resident was resistive to the initial body assessment regarding skin issues.</p> | | | |

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| | <p>Admitting Physician orders, dated 5/17/13, included but were not limited to, Riley's buttocks cream for redness and a Prime Air Mattress with setting at 120 - 164 pounds.</p> <p>A Nursing note, dated 5/18/13 at 9:00 p.m., indicated "Resident is still resistive to skin assessment."</p> <p>A Nursing note, dated 5/20/13 at 1:00 a.m., indicated "Open area to left inner buttocks 1 (centimeter) x 0.5 x <0.1...Multiple layers of scar tissue around area et (and) on buttocks... this is a chronic issue (per hx [history]) ..."</p> <p>During an interview with the Director of Nursing, on 8/21/13 at 3:30 p.m. she indicated the air mattress over lay was placed on the bed 5/21/13. This was four days after the Resident was admitted to the facility.</p> <p>3.1-35(g)(2)</p> | | | | |

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| F000314 SS=G | <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 record review and interview, the facility failed to provide timely prevention interventions and treatments to pressure ulcers for 2 of 3 residents reviewed for pressure ulcers. The residents were admitted with reddened areas that progressed to Stage 2 and 3 pressure ulcers. (Resident #12 & #48)</p> <p>Findings include:</p> <p>1. The record for Resident #12 was reviewed on 8/21/13 at 3:45 p.m.</p> <p>Diagnoses for Resident #12 included, but were not limited to, osteoarthritis, hyperlipidemia, sleep apnea, back pain, high blood pressure, anemia, gastroesophageal reflux disease, depression, and a history of deep vein thrombosis.</p> | F000314 | The Annual Survey for St. Mary Healthcre Center was conducted on August 23, 2013. The campus received the 2567 on August 30, 2013. The facility was cited for F314 with a scope and severity assignment of "G". We are requesting an IDR for the scope and severity of this citation from "G" to less severity. While we do not dispute the resident has a wound in the abdominal area, we feel the facility acted appropriately in identifying, treating and mitigating risk of skin breakdown for this resident. Incorrect documentation is reflected in the statement of deficiencies. The surveyor incorrectly states the measurments of the wound. The 2567 portrays the wound as 2.0 x 2.0 by 2.1 cm. In three separate documents including the campus Wound Tracking Log, Weekly Pressure Ulcer Assessment and an internal electronic Key Stats document, the wound is measured as 2.0 x | 09/20/2013 | |

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| | <p>A Nursing Admission Assessment document, dated 7/10/13, indicated red abdominal folds, present upon admission.</p> <p>A Skin Care Plan, dated 7/10/13, on the Nursing Admission Assessment document, indicated as an intervention, "prevent skin from touching skin".</p> <p>During an interview, on 8/20/13 at 5:00 p.m., the Director of Nursing (DON) indicated the red area was at her pants line, on her abdomen and said, "I don't believe there was an intervention implemented to prevent skin from touching skin."</p> <p>Physician assessment and progress notes, dated 7/10/13, exhibited no indication the abdomen was evaluated; there was no mentioning of redness to abdominal folds.</p> <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the location of a stage 2 pressure wound impairment was to the right abdominal fold. During an interview with the DON on 8/20/13, at 5:00 p.m., the DON indicated she was informed of Resident #12's skin impairment on 7/15/13.</p> | | <p>2.0 x <0.1. The less than (<) sign was mistaken as a 2. The 2567 also states that the treatment, Therahoney, is a barrier cream which would indicate an inappropriate treatment for a Stage III wound. Our records support that Therahoney is a debriding and healing agent which would be an appropriate treatment for the identified wound. We believe the wound was caused by pressure from wearing pants that were too tight around the resident's waist causing an existing area to worsen into a pressure ulcer in the abdominal area. The resident was admitted with an excoriated area. We have listed a summary of information related to the wound of Resident # 12 from admission to discharge. July 10: Resident admitted to campus and assessment noted redness to abdominal fold. Physician and daughter notified of redness to area. New order obtained at the time of admission for antifungal powder every shift until healed. Treatment was implemented and signed as given. July 15: Open area noted to abdominal fold area. Skin Impairment Assessment and Circumstance form completed, physician notified and a new order for Therahoney, a debrider, was obtained. Measurements of the wound are documented as 0.9 x 0.8 and 0 cm depth with yellow slough noted by the nurse. July</p> | |

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| | <p>A document titled, Skin Impairment Circumstance, Assessment and Intervention, dated 7/15/13, indicated the physician was notified of a Stage 2 pressure area to Resident #12's right abdominal fold on 7/16/13.</p> <p>Physician orders, dated 7/16/13, indicated the following, "Therahoney to right abdominal area, cover with optifoam, change every day."</p> <p>Wound Tracking documents, for Resident #12, indicated the following measurements, to the right abdominal fold, pressure ulcer:</p> <p>7/16/13 Stage 3, 2.0 x 2.0 x less than 0.1 cm. (centimeters) 7/23/13 Stage 3, 1.2 x 1.2 x less than 0.1 cm. 7/30/13 Stage 3, 1.0 x 1.0 x less than 0.1 cm.</p> <p>A Resident First Conference note, dated 7/31/13, indicated Resident #12 had a Stage 3 pressure ulcer at the abdominal fold.</p> <p>The documentation provided failed to indicate the physician assessed the Stage 3 pressure area. During an interview with the DON, on 8/20/13 at 5:30 p.m., she indicated it is not</p> | | <p>16: Director of Health Services (DHS) assessed the wound, noted slough to be present and therefore staged the wound as Stage III. Physician and daughter were notified. Measurements of the wound are documented as 2.0 x 2.0 x less than .1cm with slough noted 50%. July 23: DHS documented measurements as 1.2 x 1.2 x less than .1. Area documented as red, with no slough noted. July 30: DHS documented measurements as 1.0 x 1.0 x less than .1 cm with 25% slough. August 5: Resident was discharged to home with physician order of Therahoney with dry dressing to right abdomen and change daily. We feel the facility acted appropriately in identifying, treating and mitigating further skin breakdown and respectfully request reconsideration of the scope and severity of this citation. WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #12 has been discharged to home. However the 2567 identified the measurements for the wound as 2.1 centimeters and should have been less than .1 centimeter in depth. This is incorrect on the 2567 based on the Wound Tracking Log, Pressure Ulcer Log, and Director of Health Services internal electronic</p> | | |

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| | typical for a resident with a Stage 3 pressure area to not be evaluated by a physician or a nurse practitioner. She indicated there were no notes to indicate any evaluation by a physician. | | document and wound tracking system. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents with pressure wounds have been re evaluated to ensure that the care plan and interventions reflect the residents current status. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Per Campus guidelines, the Nursing Leadership Team will review the 24 hour report, Circumstance and Assessment Form, Change in Condition Form and physician telephone orders, in the daily clinical meeting 5 days per week. The daily clinical review is to ensure that the care plan has been initiated and updated as necessary to reflect current interventions in regards to skin impairment. The Daily Clinical Report will be completed to document the review of the above stated reports and forms. CORRECTIVE ACTION MONITORING: The Director of Health Services (DHS) or designee will conduct audits and observations 2 x per week for four weeks and then monthly for five months. The results of the audit and observatons will be reported, reviewed and monitored for compliance in the QAA | | |

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| | <p>2. The clinical record of Resident #48 was reviewed on 8/21/13 at 1:30 p.m. Resident #48 was admitted to the facility on 5/17/13.</p> <p>An Initial Nursing Assessment, dated 5/17/13 (no time noted), indicated red pressure areas on the left and right buttocks. The Resident was resistive to the initial body assessment regarding skin issues.</p> <p>Admitting Physician orders, dated 5/17/13, included but were not limited to, Riley's buttocks cream for redness and a Prime Air Mattress with setting at 120 - 164 pounds.</p> <p>A Nursing note, dated 5/18/13 at 9:00 p.m., indicated "Resident is still resistive to skin assessment."</p> <p>A Nursing note, dated 5/20/13 at 1:00 a.m., indicated "Open area to left inner buttocks 1 (centimeter) x 0.5 x <0.1...Multiple layers of scar tissue around area et (and) on buttocks... this is a chronic issue (per hx [history]) ..."</p> <p>A Pressure Ulcer Assessment, dated 5/20/13, indicated a Stage II Pressure Ulcer on the left inner buttocks, 1 x</p> | | Committee for a minimum of six months and random or as needed as recommended. | |

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| | <p>0.5 x <0.1. Treatment was started to the area with cleansing and Therahoney. Measurements were as follows:</p> <p>5/21/13 1.0 x .3 x <0.1 (The Soffflex air overlay was placed on the bed)</p> <p>5/28/13 1.5 x 1.5 (A Roho cushion was placed in the wheelchair 5/30/13)</p> <p>6/4/13 1.3 x 1.6 x <0</p> <p>6/11/13 1.0 x 1.0 x <.1</p> <p>6/18/13 0.6 x 0.6</p> <p>6/25/13 healed</p> <p>A Pressure Ulcer Assessment, dated 5/26/13, indicated a Stage II Pressure Ulcer to the right inner buttocks, 2.6 x 1.6 x .1. Treatment was started with cleansing, Therahoney and optifoam. Measurements were as follows:</p> <p>5/29/13 1.5 x 2.0</p> <p>6/4/13 .5 x 3.4 x <1</p> <p>6/11/13 1.0 x 0.5 x <.1</p> <p>6/18 healed.</p> | | | | | | |

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| | <p>A Pressure Ulcer Assessment, dated 5/26/13, indicated a Stage II Pressure Ulcer on the coccyx, .2 x .2 x <0.1. Treatment was started with calzyme cream with each incontinence episode and every shift. Measurements were as follows:</p> <p>5/29/13 0.4 x 0.4 (Order changed to cleanse area, Threahoney and cover with a dressing)</p> <p>6/4/13 0.6 x 0.5 x <0.1</p> <p>6/11/13 0.1 x 0.1 x<0.1</p> <p>6/18/13 0.1 x 0.1</p> <p>6/25/13 healed</p> <p>During an interview with the Director of Nursing, on 8/21/13 at 3:30 p.m. she indicated the areas were not properly assessed when the resident was admitted on 5/17/13 and the air mattress was not placed on the bed until 5/21/13.</p> <p>3.1-40(a)(2)</p> | | | | | | |

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| F000323 SS=D | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure resident safety and proper positioning by failing to ensure foot pedals were in place for 1 of 1 resident reviewed for safety. (Resident #72)</p> <p>Findings include:</p> <p>The record for Resident #72 was reviewed on 8/21/13 at 10:40 a.m.</p> <p>Diagnoses for Resident #72 included, but were no limited to, dementia, Alzheimers disease, diabetes mellitus, muscle weakness, hyperlipidemia, anxiety, dementia with behaviors, history of prostatetic malignancy, and a history of multiple falls.</p> <p>During an observation at 9:45 a.m., on 8/21/13, of an activity in the Legacy dining room, Resident #72 was sitting in his high back wheelchair. His feet were dangling.</p> <p>Additionally, Resident was observed</p> | F000323 | <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY TEH DEFICIENT PRACTICE: Resident # 72 foot pedals were reapplied to the wheelchair on the day of survey. HOW OTHER RESIDETNS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents with foot pedals on wheelchairs have been assessed to ensure that foot pedals are in place as needed and ordered by the physician. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Nurses will be inserviced on September 16 regarding residents with foot pedals and the importance of having pedals available and present on the wheelchair. CORRECTIVE ACTION MONITORING: The Director of Health Services (DHS) or designee will conduct an audit and observation of residents with wheelchair pedals 2 x per week for four weeks, and monthly for</p> | 09/20/2013 |

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| | <p>in the above said position during observations at 10:05 a.m. and 10:15 a.m., on 8/21/13.</p> <p>During an interview with LPN #1, on 8/21/13, at 10:21 a.m., she indicated Resident #72 should have foot pedals on his wheelchair because he could not self propel himself and was a fall risk.</p> <p>3.1-45(a)(2)</p> | | <p>five months. The results of the audit and observation will be reported, reviewed and monitored for compliance through the QAA Committee for a minimum of six month then random or as needed as recommended.</p> | | |

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| F000371 SS=F | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure the cleanliness of the equipment and properly store food in the walk-in freezer for 1 of 1 kitchen observed for cleanliness. This deficit practice had the potential to affect 63 of 63 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen, on 8/19/13 at 7:25 a.m., with Cook #2 the following items were noted:</p> <ol style="list-style-type: none"> 1. A BBQ Grill top was found to have grease and chunks of hamburger. 2. Debris on a lower shelf of a work station next to the ice cream freezer. 3. The large can opener had dried tomato sauce on the blade. 4. Dust and grease behind the stove and ovens. | F000371 | <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: An inservice will be conducted on September 19, for all Food Service employees on proper procedures for food handling in regards to glove use, handwashing and contamination. The Inservice will also include proper cleaning and storage of dishes, utensils, and steam table pans. Employees identified will be counseled with teachable moments related to glove use, handwashing, and contamination. The dish machine and utensil items in question were promptly cleaned on August 12, 2014. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: All residents have the potential to be affected by the alleged practice. An inservice will be conducted for all Food Service employees on proper procedures for food handling in regard to glove use,</p> | 09/15/2013 | |

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| | <p>5. In the dishwashing room the vent over the dishwasher and a fan mounted on the wall had large amounts of dust that had collected on the blades and metal coverings.</p> <p>6. In the walk-in freezer a bag of shredded potatoes was found open and not dated.</p> <p>During an interview with Cook #2, on 8/19/13 at 7:45 a.m., she indicated the BBQ grill was used 8/18/13 and had not been cleaned from the night before, the can opener should have been cleaned after used, and the fan and vent in the dishwashing room was on a schedule to be cleaned but no one had done it yet.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> | | <p>handwashing and contamination. The Inservice will also include proper cleaning and storage of dishes, utensils and steam table pans. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: The Director of Food Service (DFS) or designee will document observations of food handling techniques by the line staff 2 x per week for four weeks then monthly for five months and take corrective action as needed. The observations will be documented on a log. The DFS or designee will make visual inspection of all dietary department sanitation 2 x per week then monthly for five months and document on the log.</p> <p>CORRECTIVE ACTION MONITORING: Results of the food handling and sanitation audits will be reported at least monthly to the QAA Committee by the DFS. The results of the audit will be reported, reviewed and monitored for compliance in the QAA Committee for a minimum of six months then random or as needed as recommended.</p> | | |

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| F000465 SS=B | <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure resident's rooms were maintained for a good repair for 7 of 35 residents reviewed for a homelike environment. (Rooms #201, #202, #203, & #207)</p> <p>Findings include:</p> <p>On 8/22/13 at 10:45 a.m., during an environmental tour with the Director of Plant Operations, observations were made. The following occupied rooms, #201, #202, #203, and #207, had chipped paint and several dents on the P-Tech wall units (air conditioning and heating wall units).</p> <p>During an interview on 8/22/13 at 10:50 a.m., the Director of Plant Operations indicated the 4 units needed repaired and painted.</p> <p>3.1-19(f)</p> | F000465 | <p>WHAT CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident Room #s 201, 202, 203, and 207 will be corrected for chip paint and dents on the P Tech heating and air condition units. HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN: The Director of Plant Operations (DPO) will inspect all P Tech heating and air condition units for dents and repair as needed. MEASURES PUT IN PLACE OR SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: Campus requests replacement of five P Tech heating and air condition units during its annual budget for replacement each year. The DPO will conduct audits and observations of the entire campus and schedule replacement of those units that need replaced most and repair those that are able to be repaired. CORRECTIVE ACTION MONITORING: The DPO will provide the results of the audit</p> | 09/20/2013 | | | |

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| | | | and observation to the the QAA Committee and update results of replacement and repair for a minimum of six months or as needed as recommended. | |