

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2014
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NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
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F000000	<p>This visit was for the Investigation of Complaint IN00148397.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey, the Residential Licensure Survey and the Investigation of Complaint IN00146512.</p> <p>Complaint IN00148397 - Substantiated. Federal/state deficiencies related to the allegations are cited at F279 and F314.</p> <p>Survey Dates: April 29 and 30, 2014, May 1, 2, 5, 7, and 8, 2014</p> <p>Facility number: 004075 Provider number: 155734 AIM number: 200491220</p> <p>Survey team: Jennifer Carr, RN, TC Julie Dover, RN Angela Halcomb, RN Brenda Buroker, RN (May 2, 7, and 8, 2014) Janelyn Kulik, RN (May 2, 2014) Rita Bittner, RN (May 5, 7, and 8, 2014) Tammy Forthofer, RN (May 5, 7, and 8, 2014)</p> <p>Census bed type:</p>	F000000	<p>Submission of this plan of correction is not an admission by Thornton Terrace Health Campus that the deficiencies alleged in this survey are accurate or depict the quality of services provided to the residents of this health care facility. This plan of correction is submitted timely in accordance with state and federal regulatory guidelines.</p> <p>This plan of correction is intended to serve as the health facility's credible allegation of compliance with state and federal regulatory requirements.</p>	

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

TITLE

(X6) DATE

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

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F000279 SS=D	<p>SNF: 17 SNF/NF: 22 Residential: 26 Total: 65</p> <p>Census payor type: Medicare: 20 Medicaid: 12 Other: 33 Total: 65</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 16, 2014, by Brenda Meredith, R.N.</p> <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</p>						

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	<p>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 develop a comprehensive care plan for a resident who was identified as being at high risk for pressure ulcers (Resident A) for 1 of 4 residents reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>1. The clinical record for Resident A was reviewed on 5/8/14 at 9:15 a.m. and indicated the resident was admitted to the facility in November 2013. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and shortness of breath.</p> <p>The clinical assessment, dated 11/5/13, indicated the resident was at risk of developing a pressure ulcer. The reason the resident was at risk was that he was noncompliant with turning.</p>	F000279	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #A was discharged to the hospital on 3/9/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents at risk for pressure ulcer development have the potential to be affected.</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All residents were reassessed utilizing the Assessment Review and Considerations form by the DON or ADON to verify that all residents at risk for development of pressure ulcers are properly identified and interventions are care planned with a completion date of 5/9/14.</p> <p>All new admissions will be reviewed within 24 hours to verify that</p>	06/06/2014

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	<p>The initial Minimum Data Set (MDS), dated 11/12/13, indicated the resident had no pressure ulcers, required extensive assistance for bed mobility, transfer and toileting. The assessment indicated the resident had a foley catheter and was occasionally incontinent of bowel. The assessment indicated the resident scored 10 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The initial MDS indicated the resident exhibited no behaviors or mood problems.</p> <p>There was no care plan related to the resident's risk of developing pressure ulcers. During an interview with the DON (Director of Nursing) on 5/8/14 at 2:21 p.m., she indicated that she looked in the care plan and there was nothing regarding the resident's high risk of developing pressure ulcers.</p> <p>This Federal tag relates to Complaint IN00148397.</p> <p>3.1-35(a)</p>		<p>potential risk factors for pressure ulcer development have been properly identified and care planned accordingly by the DON, ADON or Clinical Nursing team.</p> <p>The licensed nursing staff and IDT were in serviced from 5/19/14-5/22/14 regarding the development of comprehensive care plans with emphasis on pressure ulcer risks by the DON and ADON.</p> <p>The MDS coordinator was reeducated regarding the care planning process by the MDS administrative support staff on 5/27/14.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>All residents identified at risk for developing a pressure ulcer will be reviewed by the IDT in the daily 5 day per week clinical meeting, and weekly in the Clinically at Risk meeting.</p> <p>10% of facility census (approximately 6 residents) will be reviewed randomly by the DON or ADON to verify that potential risk factors for pressure ulcer development have been properly identified and interventions are care planned accordingly. The audit will be completed weekly x 12weeks then every other week for 12 weeks .</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,</p>	F000314	<p>Findings of the observations will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>	06/06/2014

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	<p>the facility failed to provide interventions to prevent the development of pressure ulcers in a resident admitted to the facility without pressure ulcers for 1 of 4 residents reviewed for pressure ulcers. The resident developed an unstageable pressure ulcer within three weeks of being admitted to the facility. (Resident A)</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 5/8/14 at 9:15 a.m. and indicated the resident had diagnoses of hypertension, diabetes mellitus, and shortness of breath. The resident was admitted to the facility in November 2013. The initial Minimum Data Set (MDS) assessment, dated 11/12/13, indicated the resident had no pressure ulcers, but was at risk for developing pressure ulcers. The MDS assessment indicated the resident needed the extensive assistance of two persons for bed mobility, transfer, dressing and toileting. The resident had a foley catheter and was occasionally incontinent of bowel. There was no plan of care developed to address the resident's risk of developing pressure ulcers.</p> <p>The quarterly MDS assessment, dated 1/17/14, indicated the resident had an</p>		<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #A was discharged to the hospital on 3/9/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All other residents have the potential to be affected .</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All residents were reassessed utilizing the Assessment Review and Considerations form by the DON or ADON to verify that all residents at risk for development of pressure ulcers are properly identified and interventions are care planned with a completion date of 5/9/14.</p> <p>All new admissions will be reviewed within 24 hours to verify that potential risk factors for pressure ulcer development have been properly identified and care planned accordingly by the DON, ADON or Clinical Nursing team.</p> <p>All licensed nursing staff were reeducated on the Pressure Prevention Guidelines and Wound Plan of Care Guidelines by the DON and ADON on 5/19/14-5/22/14.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p>				

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	<p>unstageable pressure ulcer (slough/eschar; suspected deep tissue injury in evolution) measuring 5 centimeters (cm) long, 3.5 cm wide and 0.3 cm deep.</p> <p>The Treatment Administration Record indicated the resident's skin was assessed weekly and on 11/26/13, the nurse signed that the assessment was completed and a "0" was written on the record to indicate there were no skin issues.</p> <p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 11/27/13, indicated the resident had an unstageable pressure ulcer on the right hip, measuring 3 cm long by 2.5 cm wide and less than 0.1 cm deep. The assessment indicated the physician and family were notified and treatment was initiated.</p> <p>The "Skin Impairment Circumstance, Assessment, and Intervention form, completed on 11/27/13, indicated the "res [resident] scoots around in bed & lays predominately on R [right] side. The prevention update was listed as "encourage resident to T & R [turn and reposition] q 2 [every 2 hours]."</p> <p>There was a "Pressure Ulcer Letter of Unavoidability", dated 12/1/13, with two marks indicating the "clinical conditions</p>		<p>10% of facility census (approximately 6 residents) will be reviewed randomly by the DON or ADON to verify that potential risk factors have been properly identified and interventions are care planned accordingly. The audit will be completed weekly x 12weeks then every other week for 12 weeks .</p> <p>All residents identified at risk for developing a pressure ulcer will be reviewed by the IDT in the daily 5 day per week clinical meeting, and weekly in the Clinically at Risk meeting. The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>	

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	<p>this resident exhibits that make the likelihood of this pressure ulcer unavoidable include, but are not limited to, resident immobility and: Pale skin and Noncompliance with care interventions, Turning and positioning." "Res only likes to lay on R [right] side."</p> <p>The resident's laboratory results, dated 11/3/13 indicated: Albumin 3.8 (3.7 - 4.8) Total Protein 6.6 (6.7 - 8.9)</p> <p>There was no plan of care to address the resident's desire to lay on his left side, nor that he was noncompliant with turning from admission until the wound was identified on 11/27/13.</p> <p>The DON (Director of Nursing) was unable to provide a policy and procedure regarding interventions for a resident identified as being at high risk for pressure ulcers when requested on 5/8/14 at 11:14 a.m.</p> <p>During an interview on 5/8/14 at 2:21 p.m., the DON indicated the resident was big in size and he liked to stay up in the wheel chair and not lie down. She was unable to explain why the resident was assessed on 11/26/13 as having no skin concerns and on 11/27/13 was found with an unstageable pressure ulcer. She was</p>			

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	<p>unable to find a plan of care to address the resident's high risk for developing pressure ulcers. There was no plan to educate the resident on the risks associated with not following a turning schedule.</p> <p>The resident developed a second pressure ulcer on the left hip. It was first noted on 12/31/13 as a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough.), measuring 7 cm long, 8 cm wide and 0.2 cm deep.</p> <p>The resident continued to have the wounds when discharged from the facility in March 2014. The right hip wound was a Stage 4 (full thickness of skin and subcutaneous tissue is lost exposing the muscle and/or bone) and measured 2 cm long, 2.4 cm wide and 1 cm deep. The left hip wound was assessed as a Stage 2, measuring 1 cm long, 1 cm wide and 1.5 cm deep.</p> <p>This Federal tag relates to Complaint #IN00148397.</p> <p>3.1-40(a)(1)</p>				