STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155271	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/31/2011
NAME OF PROVIDER OR SUPPLIER MILLER'S SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 8400 CLEARVISTA PL INDIANAPOLIS, IN46256	

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F0000	This visit was for Investigation of Complaint IN00095258. Complaint IN00095258 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309, F314, F315, F327. Survey dates: August 30 & 31, 2011. Facility Number: 000171 Provider Number: 155271 AIM Number: 100267050 Survey Team: Courtney Hamilton RN TC Christi Davidson RN Census bed type: SNF: 22 SNF/NF: 48 Total: 70 Census payor type: Medicare: 18 Medicaid: 44 Other: 8 Total: 70 Sample: 3 These deficiencies reflect state findings	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2. Quality review 9/07/11 by Suzanne Williams, RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a physician's order was followed for the recording of urine output in a resident who had just received a Foley catheter. This practice affected 1 of 3 residents reviewed for physician's orders in a sample of 3. (Resident A) Findings include: Resident A's record was reviewed on 08/31/11 at 8:15 A.M.. Diagnoses included but were not limited to TIAs (transient ischemic attacks), COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), anemia, rheumatoid arthritis, ORIF (open reduction internal fixation) left hip surgery. A physician's order dated 08/18/2011, indicated "...Anchor 14fr [french] 10 cc [cubic centimeter] Foley cath for large amounts of excoriation to peri area, abd, buttocks, & bil inner thighs...wound MD to eval and tx....."	F0282	F282- Services by a Qualified Persons/Per Care Plan The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F242 I. Resident A no longer resides within the facility. Resident A was the only resident affected by the deficient practice during the survey. II. All resident's with Foley Catheters with an order to document output have the potential to be affected by this deficient practice. An audit will be completed for all of these potential resident's to ensure the physicians order is being followed and documentation is in place per the order. III. All staff nursing staff will be inserviced on the policy for New Orders, Verbal/Telephone (Attachment A). and the policy titled Output Monitoring (Attachment B). IV. The corrective actions will be monitored by the DON or Designee by use of the Urinary Output Review, QA tool (Attachment C). This tool will be done 5 times a week for 8 weeks and weekly for 3 months and	09/22/2011

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	A physician's order dated 08/18/2011, indicated "Monitor urine output q [every] shift and record amount in poc [plan of care]." The record lacked documentation of Resident A's output. An interview with the Administrator on 08/31/2011 at 3:00 P.M., indicated there was no further documentation on Resident A's urine output. She indicated a urine sample was sent from the catheter but it was unknown how much of a sample was sent. A current facility policy titled, "New Orders - verbal/telephone" dated 07/2008 provided by the Administrator on 08/31/2011 at 5:00 P.M., indicated..."Purpose: to ensure physicians orders are transcribed correctly and carried out per plan...Transcribe new order...follow order through completion...." This federal tag relates to complaint IN00095258. 3.1-35(g)(2)		monthly for 6 months. The frequency will be reevaluated by the QA team at that time. V. All Systemic changes will be in place by 9/22/2011.	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed for a resident with an autoimmune disorder who developed a fungal infection with severe excoriation. This practice affected 1 of 3 residents reviewed for assessments in a sample of 3. (Resident A) Findings include: Resident A's record was reviewed on 08/31/11 at 8:15 A.M.. Diagnoses included, but were not limited to, TIAs (transient ischemic attacks), COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), anemia, rheumatoid arthritis, ORIF (open reduction internal fixation) left hip surgery. A current Minimum Data Set [MDS] dated 08/11/2011, indicated Resident A was cognitively intact, and was not experiencing any symptoms of depression. Resident required one person extensive assistance with dressing, toileting, and hygiene. Resident required a wheelchair for locomotion. The MDS indicated	F0309	Addendum Version An IDR has been submitted for this citation. F 309- Provide Care/Services for highest well being The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F309 I. Resident A no longer resides within the facility. Resident A was the only resident cited during the survey. II. All resident's have the potential to be affected by the cited deficiency. All current residents will have a comprehensive assessment completed to ensure accurate assessments are in place on all patients. III. All current residents will continue to have a Daily or Weekly Comprehensive assessment completed as required by the policy. All new residents will have a Comprehensive assessment completed upon admission. All staff will be inserviced on the policy for the Charting Procedure (attachment F). All nursing staff will return demonstrate the ability to complete and properly document the Comprehensive Assessments. IV. The corrective actions will be monitored by use the Assessment QA Tool, titled: Nursing Assessment Review	09/22/2011

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	Resident A was also continent of both bowel and bladder. Resident A was assessed to be at risk for developing pressure ulcers. A current medication administration record dated 08/01/2011, indicated resident was receiving Methotrexate [antineoplastic medication] 2.5 mg [milligrams] daily, Lasix [diuretic] 20 mg daily, and Hydrochlorothiazide [diuretic] 25 mg daily. There was an additional order to monitor for s/s (signs and symptoms) of infection q (every) shift. A nursing admission assessment dated 08/01/2011 at 14:42 hrs [hours] (2:42 P.M.), indicated Resident A was admitted to the facility on 07/31/2011. Resident was alert and oriented to self, situation, time, place with intermittent confusion. Resident had a recent fracture/repair of L (left) hip. Resident was not receiving any antibiotic therapy and had staples in place at the incision site. Resident A was rated as being ..."rarely moist... skin is usually dry, linen only requires changing at routine intervals...." Resident was "...always continent... bowel and bladder..." The resident indicated her pain level was ..."3-5 (mild to moderate)..." No other wounds were documented on the assessment.		(attachment G). This will be completed by the DON or Designee. This tool will be completed daily for 30 days, weekly for 4 weeks, monthly for 3 months and the frequency will be reevaluated and the need determined by the Quality Assurance Team at that time.V. All systemic changes and inservicing will be completed by Sept 22, 2011.	

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	A lab report dated 08/01/2011 indicated Resident A's WBC [white blood cell count] was 8.04. (Normal range: 3.98-10.04). An Occupational Therapy ADL assessment dated 08/01/2011, indicated resident required minimal assistance for a sponge bath of her upper body, maximum assistance for a sponge bath of her lower body, and maximum assistance for dressing both her lower body and toileting. A nursing assessment dated 08/05/2011 at 11:20 A.M., indicated resident had pain rated ..."5-7 (mod [moderate] - severe)...prn (as needed) hydrocodone [pain medication] given as needed...staples in place, clean and dry...." A nursing assessment dated 08/06/2011 at 11:06 A.M., indicated "...incision to L hip free of s/s (signs/symptoms) infection [sic]. drsg (dressing) CDI (clean, dry, intact)...." A nursing assessment dated 08/07/2011 at 13:50 hrs (1:50 P.M.), indicated Resident A's staples were in place with "...drainage present....small amount of blood drainage on upper hip dressing intact and changed. lower [sic] hip dressing clean, clear, dry and intact no drainage present. resident			

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	[sic] has no c/o [complaints of] pain at this time." A nursing assessment dated 08/08/2011 at 9:20 A.M., lacked documentation of a nursing assessment of the incision site. A nursing assessment dated 08/09/2011 at 10:11 A.M., indicated, "...L hip fx [fracture]. Dressing clean, dry intact...." A nursing assessment dated 08/10/2011 at 17:26 hrs (5:26 P.M.), indicated resident had pain "...L hip 8/10...gave 2 norco [pain medication] given at 7 A.M...." The record lacked documentation of a nursing assessment of the incision site. A nursing assessment dated 08/11/2011 at 17:08 hrs (5:08 P.M.), indicated Resident A had pain "...L hip 8/10...@ [at} 0730 [7:30 A.M.] gave 2 norco...staples in place...clean and dry...drsg intact L hip [sic]...." A nursing assessment dated 08/12/2011 at 16:17 hrs (4:17 P.M.), indicated resident had pain ..."L hip 8/10...gave 1 norco...staples intact L hip scant amt (amount) of serosanguineous drainage upper incision on old drsg...." A physicians order dated 08/12/2011, indicated "CBC [complete blood count]			

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	on 08/13/2011, [down arrow] (decrease) Norco to 1 tab PO Q6H PRN pain..." A physicians progress note dated 08/12/2011, indicated "...pt feels weak c (with) poor endurance...post-op pain: change Norco ...secondary to family's concern about number of meds..." A nursing assessment dated 08/13/2011 at 17:33 hrs (5:33 P.M.), indicated resident was not experiencing any pain, "...staples in place...drsg changed to L hip incisions. bruising [sic] noted to L hip upper incision. non [sic] tender to touch. no [sic] drainage present at this time. no [sic] warmth noted....." No other wounds were documented on the nursing assessment. A lab report dated 08/13/2011, indicated Resident A's WBC [white blood cell count] was 4.39 (Normal range: 3.98-10.04), Neutrophils were 83.4 (Normal range: 34.0-71.1). A nursing assessment dated 08/14/2011 at 14:45 hrs (2:45 P.M.), indicated resident was not experiencing any pain, "....drsg changed to L hip incision. Drsg CDI. Bruise noted to L hip upper incision. no [sic] warmth noted, no drainage present. denies [sic] pain. swelling [sic] noted around upper incision. MD notified...."			

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	A physicians order dated 08/14/2011, indicated "schedule appt with [surgeon] on Monday, 08/15/2011 at 8 A.M., for staple removal...draw culture on blood from L upper incision to thigh, draw CBC on 08/15/11 AM...." A nursing assessment dated 08/15/2011 at 14:47 hrs (2:47 P.M.), indicated resident was not having any pain, "... staples intact (L) hip small amt of brown drainage top incision with odor tx completed...." A lab report dated 08/15/2011, indicated Resident A's WBC was 2.96 (Normal range: 3.98-10.04), Lymphocytes [white blood cells] were 0.74 (Normal range: 1.18-3.74). A nursing assessment dated 08/16/2011 at 10:28 A.M., indicated Resident A had "...7/10 L hip pain...norco given @ 0900....tx (treatment) completed to surgical incision L hip top incision reddened scant amt of brown drainage on old drsg. staples [sic] intact....groin and buttock excoriated applied cream crm [sic] as ordered...." A transfer sheet dated 08/16/2011 at 13:45 hrs (1:45 P.M.), indicated Resident A was seen by her surgeon for a follow up appointment.			

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	A new skin alteration assessment dated 08/16/2011 at 14:36 hrs (2:36 P.M.), indicated resident had a new rash/excoriation. "...resident is excoriated/reddened multiple painful areas: peri area, abd (abdominal) fold, bilateral groin, inner thighs, and buttock. abd [sic] fold L 2.4 x 1.3 x 0.1 cm, mid abd fold 3.4 x 0.8 x 0.1 cm. excoriation [sic] bilateral groin, L 3.7 x 1.4 x 0.1 cm and R (right) 3.2 x 1.2 cm, R inner thigh 6.6 x 2.6 x 0.1 cm with moderate amt of bleeding and L inner thigh 3.7 x 2.6 x 0.1 cm with moderate amt. of bleeding. buttock [sic] 0.3 cm x 0.2 x 0.1 cm and 0.2 x 0.4 x 0.1 cm. areas [sic] cleansed with soap and water, and tx completed as ordered. new orders nystatin powder [antifungal powder] apply to reddened areas beneath breast, abd fold, and peri area bid [twice a day] and prn, diflucan [antifungal medication] 150 mg 1 tab PO [by mouth] dly [daily] x 3 days, sensicare [protective cream] apply to buttock q [every] shift & prn reddened buttock....notified MD...." A nursing infection assessment dated 08/16/2011 at 22:24 hrs (10:24 P.M.), indicated Resident A had "....a non productive dry cough, no change in usual urination, surgical wound infection...top left hip incision has small amount of blood drainage, swelling, redness to			

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	site...." A physicians order dated 08/16/2011, indicated Resident A to be started on Keflex [antibiotic] 500 mg PO Q 6 hours x 7 days...[checkmark] stool for C-diff [clostridium difficile], hold colace (stool softener), [checkmark] UA C&S [urinalysis culture and sensitivity]...Nystatin powder apply to reddened areas [down arrow] breast, abd fold, & peri areas BID & PRN. Diflucan 150 mg 1 tab PO dly x 3 days...Sensicare - apply to buttock q shift and PRN reddened buttock..." A physicians progress note dated 08/16/2011 indicated, "...therapy also noting [up arrow] confusion...." A lab report dated 08/16/2011, indicated Resident A had straw colored urine, with leukocytes and blood present in the urine. A nurses progress dated 08/16/2011, indicated "[doctors name] in to see [resident]...assessed res left hip incision, noted redness and swelling...noted increased confusion and c/o loose stools...." A nursing assessment dated 08/17/2011 at 10:45 A.M., indicated resident had "....pain left hip 7/10...norco given @			

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	0900 (9:00 A.M.)...abdomen soft and non distended..." Diarrhea was not indicated on the nursing assessment...Resident was documented to have surgical wound infection. "...L hip upper surgical site infected - tx completed scant amt of brown drainage on old drsg, no active drainage. area [sic] remains discolored...." Incision was documented as being, "...clean and dry..." "...Peri area, bilateral groin, and buttock remains excoriated tx [sic] completed. to bed after meals and therapy to allow areas to be open to air..." A lab report dated 08/17/2011 indicated Resident A was negative for C-Diff. A physicians order dated 08/17/2011, indicated "psych services to evaluate & treat as indicated...family requested eval." A psychological evaluation dated 08/17/2011, indicated "...psych eval due to suspected depression, drug seeking behavior..." Impressions included "...pt complained of sleep and appetite issue along with her depression...." A nursing infection assessment dated 08/18/2011 at 01:40 hrs (1:40 A.M.), indicated Resident A had "...fungal infection of skin or mucous membranes....surgical wound/incision infected....drainage to left hip dark brown			

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	and thick, covered with steril [sic] dressing... redness to left hip surgical site with hardness felt under the skin, light pressure causing draining...resident c/o pain to the left hip and area warm to touch...." A nursing assessment dated 08/18/2011 at 15:47 hrs (3:47 P.M.), indicated resident had pain in "...bilateral groin and L hip .. norco [given] pain 8/10..." The assessment indicated the resident had a Foley catheter inserted. Resident had "...regular BM [bowel movement] every 1-3 days...." No diarrhea was documented on assessment. "...L hip reddened upper surgical incision site infected - tx completed no active drainage. L lower hip incision reddened...." Resident also had "...peri area, bilateral groin, abdominal fold and buttocks remains excoriated tx completed. to [sic] bed after meals and therapy to allow areas to be open to air...." A groin and buttocks wound assessment dated 08/18/2011 at 18:43 hrs (6:43 P.M.), indicated Resident A's left and right groin folds and buttocks wounds were open. "....wound bed moist and bright red in color...exudates: candidiasis [fungus], red, weepy and tender area with pasty exudate...surgical incision: incision to left hip noted to be swollen and red in			

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	color - scattered erythematous (red) area around wound - some raw and weepy - consistent with tape allergy...pain assessment: resident complains of tenderness upon examination, res has pain medication PRN and is effective...treatment: wash area with Ketoconazole [anti fungal] 2% shampoo once dly for 6 weeks to affected areas. Apply Clotrimazole [antifungal] q AM x 7 days then begin BID. Lortisone [antifungal] sparingly Q hs [sic] [at bedtime] x 7 days....catheter placed 08/18/11 to assist in healing d/t [due to] resident is currently incontinent. Res currently on MVI [multivitamin supplement] daily...possible causative factors: fecal and urinary incontinence. loose stools...." An abdominal wound assessment dated 08/18/2011 at 18:55 hrs (6:55 P.M.), indicated Resident A's wound was open. "...wound bed: abdominal pannus [fold] with red, raw areas consistent with candidiasis...surrounding skin: erythema noted to surrounding skin...pain assessment: resident complains of tenderness upon examination, res has pain medication PRN and is effective...treatment: wash area with Ketoconazole 2% shampoo once dly for 6 weeks to affected areas. Apply Clotrimazole q AM x 7 days then begin			

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	BID. Lortisone sparingly Q hs [sic] x 7 days....catheter placed 08/18/11 to assist in healing d/t resident is currently incontinent. Res currently on MVI daily...possible causative factors: fecal and urinary incontinence. loose stools...." A wound physicians progress note dated 08/19/2011, indicated resident had "...fecal incontinence...Foley cath started today...abdominal pannus with red, raw areas...candidiasis. Back: normal...Groin/Buttock: candidiasis, red weepy and tender areas...with exudate...." A physicians order dated 08/18/2011, indicated "cleanse abd fold, buttocks et [and] bil [bilateral] groin area c Ketoconazole 2% shampoo dly [sic] x 6 weeks. Apply Clotrimazole to groin, abd fold et buttocks q AM x 7 days then BID... Anchor 14fr [french] 10 cc [cubic centimeter] Foley cath for large amounts of excoriation to peri area, abd, buttocks, & bil inner thighs...wound MD to eval and tx....." A physicians order dated 08/18/2011, indicated "Monitor urine output q shift and record amount in poc [plan of care]". The record lacked documentation of Resident A's output.			

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	A nursing infection assessment dated 08/19/2011 at 01:42 A.M., indicated Resident A had "...thick brown dark fluid draining from left hip incision and yeast to the peri area, Foley cath inserted on 08/18/2011 and draining dark amber urine into bedside bag..." The nursing notes also lacked documentation of Resident A's incontinence, increased confusion, diarrhea, and nose bleeds. A physicians order dated 08/19/2011, indicated "Send to ER @ [hospital] for eval and tx of profuse bleeding of mouth." A resident transfer form dated 08/19/2011 at 5:00 A.M., indicated Resident A transferred to hospital with "...bleeding from mouth bright red in color unable to determine origin...." Resident was noted to be continent of bowel and had an indwelling Foley catheter. Resident was noted to be at risk for skin breakdown. An emergency room report dated 08/19/2011 at 6:01 A.M., indicated Resident A went to the hospital after waking up with dry blood in her mouth. Resident also had a nose bleed in the emergency department. An emergency room treatment record			

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	dated 08/19/2011 indicated resident arrived at the emergency room with shortness of breath. Platelets were noted to be 13,000 (Normal value: 150-400). Residents heart rate was 109, BUN [blood urea nitrogen] levels were 57 (Normal value: 6-20) and creatinine [renal function test] was 1.4 (Normal value: 0.50-0.90). CBC indicated her WBC count was 500 (Normal value: 3.98-10.04). Sodium level was 129 (Normal value: 136-144). Her oropharynx was "...covered in blood..." Resident received 1 unit of platelets in the emergency department. Resident's Methotrexate was placed on hold on admission to the hospital. A history and physical from the hospital dated 08/19/2011 at 10:27 A.M., indicated Resident A was admitted to the hospital with diagnoses of pancytopenia [low blood count levels] with epistaxis [nose bleed], infectious disease "...clearly has a urinary tract infection...a questionable infection of the left hip at the surgical site, as well as pneumonia which is in the right middle lobe, diarrhea, acute renal failure, likely due to dehydration, hyponatremia and hypokalemia likely due to dehydration, bilateral groin and lower abdominal skin fold excoriation and fungal infection...." A consultation report from the hospital			

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	dated 08/19/2011 at 1:01 P.M., indicated residents family reported, "...since her discharge to [facility], she has been having diarrhea....now has a Foley...." Per note from physician, it is unknown if resident had any urinary problems, "...but no documented complaints of dysuria [difficulty urinating]..." noted from facility. A progress note from the hospital dated 08/19/2011 indicated Resident A had "...epistaxis x 1 week [up arrow], diarrhea x 2 weeks. C-Diff [clostridium difficile] negative per family..." A facility final discharge summary dated 08/24/2011 at 16:04 hrs (4:04 P.M.), indicated resident "...developed set backs due to hip incision infection, tx with atb [antibiotics]...CBC indicated that Hbg [hemoglobin] and Hct [hematocrit] were on the low side - hbg 9.9-10.7...she had yeast infection of abdominal folds...she became weaker and not performing in therapy as well...." The record lacked documentation of a care plan for Resident A's risk of immuno suppression related to the rheumatoid arthritis and Methotrexate use. The record lacked documentation of a of care plan for Resident A's risk for			

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	dehydration related to diuretic use, diarrhea, and large open weepy wounds. The record lacked documentation of a care plan for Resident A's incontinence. An interview with the 1st floor Unit Manager on 08/31/11 at 1:30 P.M., indicated she follows all wounds and she does random skin assessments on residents. She indicated the floor nurses do daily assessments on residents and that should include skin assessments. Those assessments should be documented on the computer. An interview with the 1st floor Unit Manager on 08/31/11 at 3:15 P.M., indicated Resident A did not have any wounds on admission to the facility. She indicated resident had some incontinence on admission but approximately a week into the admission, she noticed a decline in the resident's cognition and resident became incontinent of bowel and bladder. The Unit Manager also indicated resident also had several days of diarrhea prior to being transferred to the hospital and was checked for C-Diff. The Unit Manager indicated a staff nurse first noted the yeast on Sunday, August 14th but the wounds were not open. She indicated the new wounds were not brought to her attention until August 16th and the floor nurse who			

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	identified the alteration should have started a skin treatment and notified the Unit Manager or D.O.N. The Unit Manager indicated she noticed a red, raised incision site with a hematoma on the resident's hip. resident then had a follow up visit a few days later with the surgeon for staple removal. On August 18th, the yeast was noticed to be opening up while on rounds with the wound doctor. Wound was "...very moist, bloody". She also indicated resident did not have any pressure ulcers. Staff were assisting resident with ADL's [activities of daily living] with peri care and toileting. Resident was able to clean her upper body, perform oral care, and wash her hair but she did require cueing. An interview with the 1st floor Unit Manager on 08/31/11 at 4:15 P.M., indicated the physician was aware of Resident A's lab results. She indicated there was no discussion regarding the resident being on Methotrexate or being immunosuppressed. An interview with the DON on 08/31/11 at 4:30 PM indicated a bowel and bladder assessment are part of the admission assessment and would not be done again unless there was a change of condition. The DON indicated there was no further documentation on the resident's change in			

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	continence status after her admission to the facility. An interview with the Administrator on 08/31/11 at 3:00 P.M., indicated there was no further documentation on Resident A's urine output. She indicated a urine sample was sent from the catheter but it was unknown how much of a sample was sent. A current facility policy titled "Physician & Family Notification of Condition Changes" dated 03/2003 provided by the Administrator on 08/31/2011 at 5:00 P.M., indicated "...notify the physician of any change in condition that may or may not warrant a change in the treatment plan...remember faxing does not eliminate nursing responsibility of follow-up assessment and further reporting to the physician, if necessary...." A current facility policy titled "Charting Procedure" dated 11/2010 provided by the Administrator on 08/31/2011 at 5:00 P.M., indicated, "...any physical or emotional symptom or complaint will be documented in the progress notes. Any condition change will be documented in the progress notes...Daily charting will be completed ... to support skilled services provided by nursing...Weekly charting: to be completed on routine weekly basis...and documentation of a thorough			

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	head to toe skin assessment..." This federal tag relates to complaint IN00095258. 3.1-37(a)			
F0327 SS=D	The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to ensure a resident's hydration status was maintained after developing diarrhea, large seeping wounds and while taking diuretic medications. This practice affected 1 of 3 residents reviewed for hydration in a sample of 3. (Resident A) Findings include: Resident A's record was reviewed on 08/31/11 at 8:15 A.M.. Diagnoses included, but were not limited to, TIAs (transient ischemic attacks), COPD (chronic obstructive pulmonary disease), CAD (coronary artery disease), anemia, rheumatoid arthritis, ORIF (open reduction internal fixation) left hip surgery. A current medication administration	F0327	Addendum Version F 327-Sufficient Fluid to Maintain Hydration The facility respectfully submits the following plan of correction as credible allegation of compliance to the above mentioned regulation, prefix F 327 I. Resident A no longer resides within the facility. Resident A was the only resident cited during the survey. II. All resident's have the potential to be affected therefore all residents will be assessed by use of the Guidelines as listed in CMS's RAI Version of 3.0 for Dehydration/Fluid Maintenance (Attachment K) to ensure that if they are at risk, the proper inventions are in place. III. All staff will be inserviced on the policy for Hydration Management Program (Attachment L). and the use of the Guidelines as listed in CMS's RAI Version of 3.0 for Dehydration/Fluid Maintenance (Attachment K) The Unit	09/22/2011

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	record dated 08/01/2011, indicated resident was receiving Methotrexate [antineoplastic medication] 2.5 mg [milligrams] daily, Lasix [diuretic] 20 mg daily, Hydrochlorothiazide [diuretic] 25 mg daily. A nursing admission assessment dated 08/01/2011 at 14:42 hrs (2:42 P.M.), indicated Resident A was admitted to the facility on 07/31/2011. Resident was alert and oriented to self, situation, time, place with intermittent confusion. Resident had a recent fracture/repair of L (left) hip. Resident was not receiving any antibiotic therapy and had staples in place at the incision site. Resident A was rated as being ..."rarely moist... skin is usually dry, linen only requires changing at routine intervals...." Resident was "...always continent... bowel and bladder..." A lab report dated 08/01/2011 indicated, Resident A's sodium level was 133 (Normal value: 136-144) and her creatinine level was 0.96 (Normal value: 0.50-0.90). The record lacked documentation of a BMP (basic metabolic panel) being ordered for Resident A after 08/01/2011. A new skin alteration assessment dated 08/16/2011 at 14:36 hrs (2:36 P.M.),		Manager will Monitor the 24 hour condition report for changes in condition that would trigger a change in hydration . The Unit Managers will review/audit Fluid Intake daily to ensure proper intakes are occurring. IV. The corrective actions will be monitored by, the DON or Designee by use of the Hydration Review (Attachment M). This will be completed weekly for 8 weeks, monthly for 3 months, and will be reevaluated and determined as to the necessary frequency by the Quality Assurance Team at that time. V. All systemic changes and inservicing will be in place by September 22, 2011.	

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	indicated resident had a new rash/excoriation. "...resident is excoriated/reddened multiple painful areas: peri area, abd (abdominal) fold, bilateral groin, inner thighs, and buttock. abd [sic] fold L 2.4 x 1.3 x 0.1 cm, mid abd fold 3.4 x 0.8 x 0.1 cm. excoriation [sic] bilateral groin, L 3.7 x 1.4 x 0.1 cm and R (right) 3.2 x 1.2 cm, R inner thigh 6.6 x 2.6 x 0.1 cm with moderate amt of bleeding and L inner thigh 3.7 x 2.6 x 0.1 cm with moderate amt. of bleeding. buttock [sic] 0.3 cm x 0.2 x 0.1 cm and 0.2 x 0.4 x 0.1 cm..." A lab report dated 08/16/2011, indicated Resident A had straw colored urine, with leukocytes and blood present in the urine. A nurses progress dated 08/16/2011, indicated "[doctors name] in to see [resident]...assessed res left hip incision, noted redness and swelling...noted increased confusion and c/o loose stools...." A groin and buttocks wound assessment dated 08/18/2011 at 18:43 hrs (6:43 P.M.), indicated Resident A's left and right groin folds and buttocks wounds were open. "....wound bed moist and bright red in color...exudates: candidiasis [fungus], red, weepy and tender area with pasty exudate...surgical incision: incision			

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	to left hip noted to be swollen and red in color - scattered erythematous (red) area around wound - some raw and weepy..." An abdominal wound assessment dated 08/18/2011 at 18:55 hrs (6:55 P.M.), indicated Resident A's wound was open. "...wound bed: abdominal pannus [fold] with red, raw areas consistent with candidiasis..." A wound physicians progress note dated 08/19/2011, indicated resident had "...fecal incontinence...Foley cath started today...abdominal pannus with red, raw areas...candidiasis. Back: normal...Groin/Buttock: candidiasis, red weepy and tender areas...with exudate...." A physicians order dated 08/18/2011, indicated "Monitor urine output q shift and record amount in poc [plan of care]." The record lacked documentation of Resident A's output. A nursing infection assessment dated 08/19/2011 at 01:42 A.M., indicated Resident A had "...thick brown dark fluid draining from left hip incision and yeast to the peri area, Foley cath inserted on 08/18/2011 and draining dark amber urine into bedside bag..."			

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	A physicians order dated 08/19/2011, indicated "Send to ER @ [hospital] for eval and tx of profuse bleeding of mouth". A lab report dated 08/19/2011 indicated Resident A had straw colored urine. An emergency room treatment record dated 08/19/2011 indicated resident arrived at the emergency room with shortness of breath. Platelets were noted to be 13,000 (Normal value: 150-400). Residents heart rate was 109, BUN [blood urea nitrogen] levels were 57 (Normal value: 6-20) and creatinine [renal function test] was 1.4 (Normal value: 0.50-0.90). CBC indicated her WBC count was 500 (Normal value: 3.96-10.04). Sodium level was 129 (Normal value: 136-144). Her oropharynx was "...covered in blood..." Resident received 1 unit of platelets in the emergency department and an IV was started. A history and physical from the hospital dated 08/19/2011 at 10:27 A.M., indicated Resident A was admitted to the hospital with diagnoses of pancytopenia [low blood count levels] with epistaxis [nose bleed], infectious disease "...clearly has a urinary tract infection...a questionable infection of the left hip at the surgical site, as well as pneumonia which is in the right middle lobe, diarrhea, acute renal failure,			

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	likely due to dehydration, hyponatremia and hypokalemia likely due to dehydration, bilateral groin and lower abdominal skin fold excoriation and fungal infection...." A consultation report from the hospital dated 08/19/2011 at 1:01 P.M., indicated residents family reported, "...since her discharge to [facility], she has been having diarrhea...." A progress note from the hospital dated 08/19/2011 indicated Resident A had "...epistaxis x 1 week [up arrow], diarrhea x 2 weeks. C-Diff [clostridium difficile] negative per family..." A current care plan dated 08/19/2011 indicated the resident experienced "...bowel elimination alteration: diarrhea....Interventions: administer medications as ordered, encourage extra fluid, updated physician with changes....." The record lacked documentation of a of care plan for Resident A's risk for dehydration related to diuretic use, diarrhea, and large open weepy wounds. An interview with the 1st floor Unit Manager on 08/31/11 at 3:15 P.M., indicated the resident was coming to the dining room for meals and was			

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	consuming about 50% of her meals. Her fluid intake was described as "not bad.....The Unit Manager indicated on August 18th, she observed Resident A's wounds with the wound doctor and indicated the yeast was noticed to be opening up while on rounds with the wound doctor. Wound was "...very moist, bloody...." An interview with the Administrator on 08/31/11 at 3:00 P.M., indicated there was no further documentation on Resident A's urine output. She indicated a urine sample was sent from the catheter but it was unknown how much of a sample was sent. A current facility policy titled "Charting Procedure" dated 11/2010 provided by the Administrator on 08/31/2011 at 5:00 P.M., indicated, "...any physical or emotional symptom or complaint will be documented in the progress notes. Any condition change will be documented in the progress notes...Daily charting will be completed ... to support skilled services provided by nursing...Weekly charting: to be completed on routine weekly basis...and documentation of a thorough head to toe skin assessment..." This federal tag relates to complaint IN00095258.			

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	3.1-46(b)			