

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155138	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-INDIANAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2860 CHURCHMAN AVE INDIANAPOLIS, IN 46203
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 27, 28, 29, and 30, 2015, and May 1, and 4, 2015</p> <p>Facility number: 000063 Provider number: 155138 AIM number: 100266210</p> <p>Census bed type: SNF/NF: 83 Total: 83</p> <p>Census payor type: Medicare: 7 Medicaid: 70 Other: 6 Total: 83</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing,</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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	<p>neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of mistreatment was thoroughly investigated and immediately reported to the State survey and certifications agency</p>	F 225	The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:	06/03/2015

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	<p>for 1 of 2 residents reviewed for an allegation of mistreatment. (Resident #30)</p> <p>Findings include:</p> <p>During a Stage 1 interview with Resident #30 on 4/28/2015 at 10:58 a.m., the resident indicated some of the staff did not treat the residents with respect and dignity and would "talk mean" to the residents.</p> <p>The clinical record review, completed on 4/30/15 at 10:50 a.m., indicated Resident #30 had diagnoses including, but not limited to, dementia with delusional features.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 2/9/15, assessed the resident as having a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating mild cognitive impairment.</p> <p>During an interview with Registered Nurse (RN) #1 on 4/30/15 at 12:14 p.m., RN #1 provided a copy of a grievance filed on behalf of Resident #30 on 4/14/15, from a concern voiced at the Resident Counsel meeting. The notation on the form indicated the resident voiced a concern regarding a Certified Nursing Assistant (CNA), "biting her head off</p>		<p>The incident with R30 was immediately reported to the State and the investigation was initiated. Alert and oriented residents and staff were interviewed and none one had any issues. The results of the investigation unsubstantiated.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>No other residents interviewed by State or facility staff had any issues with staff.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Clinical Director of Indiana educated management staff of investigating and reporting.</p>		

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	<p>when she asks for help."</p> <p>During an interview with RN #1 and the Activity Director (AD) on 4/30/15 at 2:45 p.m., indicated the information was reported to RN #1 on 4/14/15, immediately after the meeting. RN #1 indicated the resident was then interviewed and denied all knowledge of the grievance information. RN #1 indicated the Administrator was contacted and informed of the allegation at which time the decision was made to resolve the grievance due to lack of information. RN #1 indicated the resident's care plan was updated on 4/23/15, to include the intervention of 2 care givers when providing care to the resident. The grievance form was signed by RN #1 on 4/23/15, and the Administrator on 4/25/15.</p> <p>During an interview with the Administrator and RN #1 on 4/30/15 at 3:11 p.m., the Administrator indicated the allegation was not reported to the State survey and certifications agency as the resident had denied all knowledge of the incident when interviewed. RN #1 indicated no other residents or staff were interviewed regarding the allegation.</p> <p>On 4/27/15 at 1:03 p.m., RN #1 provided</p>				<p>Facility staff will be educated on May 27, 2015 at all staff meeting.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Any concerns from a resident will be reviewed and Clinical Director will be contacted as needed and incident will be reported to State.</p> <p>Tracking record/audit form will be maintained in Nursing office to ensure any allegation is reported to State</p> <p>DNS/Designee will report findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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F 226 SS=D Bldg. 00	<p>the Reporting Alleged Abuse violation policy dated 1/15/15, and indicated the policy was the one currently used by the facility. The policy indicated, "...It is also the policy of this center to take appropriate steps to ensure all alleged violations of federal or state laws which involve mistreatment, ...(alleged violations) are reporting [sic] immediately to the executive director of the center...Such violations are also reported to State agencies in accordance with existing law. The center investigates each such alleged violation thoroughly and reports the result of all investigations...."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure implementation of written policies and procedures in that an allegation of mistreatment was not thoroughly investigated and immediately reported to</p>	F 226	The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:	06/03/2015

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	<p>the State survey and certifications agency for 1 of 2 residents reviewed for an allegation of mistreatment. (Resident #30)</p> <p>Findings include:</p> <p>During a Stage 1 interview with Resident #30 on 4/28/2015 at 10:58 a.m., the resident indicated some of the staff did not treat the residents with respect and dignity and would "talk mean" to the residents.</p> <p>The clinical record review, completed on 4/30/15 at 10:50 a.m., indicated Resident #30 had diagnoses including, but not limited to, dementia with delusional features.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 2/9/15, assessed the resident as having a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating mild cognitive impairment.</p> <p>During an interview with Registered Nurse (RN) #1 on 4/30/15 at 12:14 p.m., RN #1 provided a copy of a grievance filed on behalf of Resident #30 on 4/14/15, from a concern voiced at the Resident Counsel meeting. The notation on the form indicated the resident voiced a concern regarding a Certified Nursing</p>		<p>The incident with R30 was immediately reported to the State and the investigation was initiated. Alert and oriented residents and staff were interviewed and none one had any issues. The results of the investigation unsubstantiated.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>No other residents interviewed by State or facility staff had any issues with staff.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Clinical Director of Indiana educated management staff of investigating and reporting.</p>				

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	<p>Assistant (CNA), "biting her head off when she asks for help."</p> <p>During an interview with RN #1 and the Activity Director (AD) on 4/30/15 at 2:45 p.m., indicated the information was reported to RN #1 on 4/14/15, immediately after the meeting. RN #1 indicated the resident was then interviewed and denied all knowledge of the grievance information. RN #1 indicated the Administrator was contacted and informed of the allegation at which time the decision was made to resolve the grievance due to lack of information. RN #1 indicated the resident's care plan was updated on 4/23/15, to include the intervention of 2 care givers when providing care to the resident. The grievance form was signed by RN #1 on 4/23/15, and the Administrator on 4/25/15.</p> <p>During an interview with the Administrator and RN #1 on 4/30/15 at 3:11 p.m., the Administrator indicated the allegation was not reported to the State survey and certifications agency as the resident had denied all knowledge of the incident when interviewed. RN #1 indicated no other residents or staff were interviewed regarding the allegation.</p>		<p>Facility staff will be educated on May 27, 2015 at all staff meeting.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Any concerns from a resident will be reviewed and Clinical Director will be contacted as needed and incident will be reported to State.</p> <p>Tracking record/audit form will be maintained in Nursing office to ensure any allegation is reported to State</p> <p>DNS/Designee will report findings of any reportables to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>		

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F 279 SS=D Bldg. 00	<p>On 4/27/15 at 1:03 p.m., RN #1 provided the Reporting Alleged Abuse violation policy dated 1/15/15, and indicated the policy was the one currently used by the facility. The policy indicated, "...It is also the policy of this center to take appropriate steps to ensure all alleged violations of federal or state laws which involve mistreatment, ...(alleged violations) are reporting [sic] immediately to the executive director of the center...Such violations are also reported to State agencies in accordance with existing law. The center investigates each such alleged violation thoroughly and reports the result of all investigations...."</p> <p>3.1-28(a)</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 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,</p>			

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	<p>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 observation, interview, and record review, the facility failed to ensure a careplan was developed for a resident (Resident #81) with a contracture for 1 of 2 residents reviewed for range of motion services.</p> <p>Findings include:</p> <p>The clinical record of Resident #81 was reviewed on 04/30/2015 at 10:42 a.m. Diagnoses included, but were not limited to, paralysis affecting his right side and cerebrovascular hemorrhage (stroke).</p> <p>A review of Occupational Therapist Progress & Discharge Summary dated 08/15/2014, included the following discharge plan and instructions: "Resident is discharged to same SNF [skilled nursing facility] under restorative nursing care for UE ROM [upper extremity range of motion] exercises."</p> <p>A Quarterly Minimum Data Set (MDS) dated 12/26/2014, assessed Resident #81 as having an upper extremity impairment on one side and a Brief Interview for</p>	F 279	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R81's care plan was updated to reflect contracture to right hand.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Any resident with contractures had their care plans reviewed to ensure the contracture was noted.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not</p>	06/03/2015

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	<p>Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment.</p> <p>On 04/28/2015 at 1:00 p.m., Resident #81 was observed sitting in his wheelchair in his room. Resident #81 was observed with his arm laying in his lap with his wrist bent downward at approximately a 90 degree angle. Resident #81 indicated he could not stretch his wrist upward.</p> <p>During a Stage 1 staff interview on 04/28/2015 at 4:08 p.m., RN #14 indicated Resident #81 had a right upper extremity contracture (a condition of fixed high resistance to passive stretch of a muscle) did not receive range of motion services.</p> <p>A review of the current care plans on 04/30/2015 at 10:45 p.m., did not contain a careplan addressing range of motion services for Resident #81.</p> <p>During an interview on 04/30/2015 at 3:10 p.m., Occupational Therapist (OT) # 9 indicated the therapy discharge orders go to the MDS coordinator. Occupational Therapist #9 indicated the Minimum Data Set (MDS) Coordinator runs the restorative nursing services program.</p>		<p>recur are as follows:</p> <p>Therapy will report to DNS/Designee any resident noted to have a contracture to ensure a care plan is initiated.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Audit form will be maintained in Nursing office to ensure any resident with a contracture has a care plan and ROM if indicated.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions</p>				

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F 280 SS=D Bldg. 00	<p>During an interview on 05/01/2015 at 3:55 p.m., the MDS Coordinator indicated no residents were currently receiving restorative nursing services for range of motion.</p> <p>On 05/04/2015 at 4:30 p.m., the DON (Director of Nursing) was asked to provide a current careplan regarding care of Resident #81's contracture. No further information was provided by survey exit on 05/04/2015 at 6:45 p.m.</p> <p>3.1-35(a)</p> <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</p>			

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	<p>and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to update a care plan for a resident who no longer had an indwelling urinary catheter for 1 of 2 residents reviewed for urinary catheters. (Resident #29)</p> <p>Findings include:</p> <p>The clinical record review of Resident #29, completed on 5/4/2015 at 3:37 p.m., indicated the resident had diagnoses including, but not limited to, incomplete bladder emptying and an enlarged prostate.</p> <p>A Minimum Data Set (MDS) assessment completed on 2/9/15, assessed the resident as being incontinent of bowels and bladder (unable to control bowels or urine). The resident was assessed as having a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating no cognitive impairment.</p> <p>During a Stage 1 observation of Resident #29 on 4/28/15 at 10:22 a.m., the resident was in bed with an incontinent brief in place. The resident indicated he had difficulty controlling his urine and he relied on staff to assist with cleaning and changing his briefs.</p>	F 280	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R29's care plan was reviewed and updated to reflect current status</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Facility care plans will be audited to ensure that only residents with current catheters have corresponding care plans.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p>	06/03/2015

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	<p>A review of the recapitulation of physician's orders dated 5/4/15, lacked an order for an indwelling urinary catheter.</p> <p>A review of the care plans for Resident #29 indicated the resident had an alteration in elimination of bowel and bladder related to urinary retention. The start date for the care plan was 6/16/2011, and the care plan was revised on 12/16/2014. Interventions included, but were not limited to, change _____ (name indwelling) catheter, check catheter tubing for proper drainage and positioning, irrigate catheter as ordered, and to keep the drainage bag of the catheter below the level of the bladder at all times and off the floor.</p> <p>During an interview with Registered Nurse (RN) #1 on 5/4/2015 at 2:50 p.m., RN #1 indicated the resident did not currently have an indwelling urinary catheter and had not had one for quite some time. RN #1 indicated the care plan interventions regarding the indwelling catheter should have been discontinued when the catheter was removed.</p> <p>3.1-35(d)(2)(B)</p>		<p>Unit Managers/Charge nurses will report in clinical start up and changes in urinary appliances, care plan will reviewed and updated as needed.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Audit form will be maintained in Nursing office to ensure any resident with a catheter has a care plan that reflects usage.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 282 SS=D Bldg. 00	<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 ensure a resident's hemodialysis access site was assessed for signs and symptoms of infection as indicated by the written plan of care, for 1 of 1 resident who met the criteria for review of dialysis care. (Resident #33)</p> <p>Findings include:</p> <p>The clinical record of Resident #33 was reviewed on 5/1/15 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, renal insufficiency, which is a condition where the kidneys are unable to adequately filter waste products from the blood. The resident was admitted to the facility on 2/8/15, and discharged from the facility on 4/28/15.</p> <p>The resident was receiving hemodialysis treatments 3 times per week. Hemodialysis is a process of filtering</p>	F 282	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R33 was discharged 4/28/15.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All other facility residents that go to dialysis had orders reviewed and were corrected if needed.</p> <p>The measures put into place</p>	06/03/2015

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	<p>waste products from the blood using a machine. The machine is connected to the body through an access site. Resident #33's access site was a fistula in the right arm. A fistula is a surgically created connection between a vein and an artery, to which a dialysis machine is connected.</p> <p>A care plan for Resident #33, created on 2/26/15, and current through discharge from the facility on 4/28/15, indicated a focus of, "Alteration in Kidney Function Due to End Stage Renal disease...evidenced by hemodialysis." Interventions included, "Check access site daily fistula/graft/catheter - signs of infection (redness, hardness, swelling, pain, drainage, elevated temperature, body chills)."</p> <p>No information was found in the resident's record which indicated the fistula access site had been checked for daily for signs and symptoms of infection. On 5/4/15 at 8:55 a.m., R.N. #1 indicated the daily assessments for the access site would be found in nurses' progress notes.</p> <p>No information was found in the nurses' progress notes for March and April 2015, which indicated any daily assessments of Resident #33's fistula had been done.</p>		<p>and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Any new admission/readmission with dialysis will have orders reviewed in daily clinical stand up.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Audit form will be maintained in Nursing office to ensure any resident with dialysis has an assessment of the site as care planned.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 312 SS=D Bldg. 00	<p>3.1-35(g)2</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation and interview, the facility failed to ensure residents requiring assistance with personal hygiene and grooming had nail care provided for 2 of 3 residents reviewed for Activities of Daily Living (ADL) assistance. (Resident #30 and Resident #59)</p> <p>Findings include:</p> <p>1. The clinical record review, completed on 4/30/15 at 10:50 a.m., indicated Resident #30 had diagnoses including, but not limited to, dementia with delusional features.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 2/9/15, assessed the resident as having a Brief Interview for Mental Status (BIMS) of 11 out of 15, indicating mild cognitive impairment. The resident was assessed as requiring</p>			F 312	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R33 and R59 had nail care provided.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Audit of facility residents was completed and any resident needing nail care received care.</p> <p>The measures put into place</p>		06/03/2015

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	<p>extensive assistance of 1 staff person for personal hygiene, toileting, and dressing.</p> <p>During a Stage 1 observation of Resident #30 on 4/28/15 at 10:58 a.m., the resident's fingernails were noted to be long and have a brown substance under the nails. Nail polish was chipped or missing on all of the fingernails. Resident #30 indicated it had been, "quite some time" since a staff person had assisted with nail care and assistance was needed due to having 2 nails that had broken leaving jagged edges.</p> <p>During an observation of Resident #30 on 4/30/15 at 11:00 a.m., the fingernails of the resident were noted to be long with 2 nails broken with jagged edges. When asked about nail care, the resident indicated cleaning and filing was needed.</p> <p>During an interview with Certified Nursing Assistant (CNA) #15 on 4/30/15 at 11:10 a.m., CNA #15 indicated the resident required assistance and cueing of 1 staff person to perform ADL's and was usually agreeable to having staff assistance with bathing and dressing.</p> <p>2. The clinical record of Resident #59 was reviewed on 4/30/15 at 3:38 p.m. Diagnoses for the resident included, but</p>		<p>and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>DNS/ADNS/Unit Managers/Designee will audit residents coded as dependant for nail care 5 times a week for 5 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then weekly.</p> <p>Golden Ace rounds will now include checking their residents nail care and report to DNS/Designee.</p> <p>Nail care will be reviewed at all staff education meeting on May 27, 2015</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/ADNS/Unit Managers/Designee will audit</p>				

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	<p>were not limited to, depressive disorder, altered mental status, left eye impairment, and weakness.</p> <p>A quarterly Minimum Data Set assessment, dated 1/4/15, indicated the resident was moderately cognitively impaired and needed extensive assistance of 1 staff person for hygiene needs.</p> <p>A current care plan, initiated 11/8/13, indicated the resident had a physical functioning deficit related to self care due to, "left eye surgically removed, muscle weakness, chronic pain and poor memory..." Interventions included personal hygiene assistance.</p> <p>On 4/28/15 at 12:40 p.m., Resident #59's fingernails were observed to be long with dirt imbedded under each of the nails.</p> <p>On 5/5/15 at 9:00 a.m., the resident's fingernails, again, were observed to be long, with dirt imbedded under each of the nails.</p> <p>3.1-38(3)(E)</p>		<p>residents coded as dependant for nail care 5 times a week for 5 weeks, 3 times a week for 4 weeks, 2 times a week for 4 weeks and then weekly.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure continued use of an indwelling catheter was medically justified for 1 of 1 residents reviewed for indwelling catheter use. (Resident #27)</p> <p>Findings include:</p> <p>The clinical record review of Resident #27, completed on 5/4/15 at 9:41 a.m., indicated the resident had diagnoses including, but not limited to, diabetes and female stress incontinence.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed on 3/12/15, assessed the resident as having a Stage 3 pressure ulcer. A Stage 3 pressure ulcer is characterized by full thickness skin loss in an area caused by pressure.</p>	F 315	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R27 had catheter removed</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>All other facility residents that had catheters were reviewed to ensure that a medically justified diagnosis was present.</p>	06/03/2015	

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	<p>The resident had a current care plan with an original start date of 8/10/2011, which indicated the resident was at risk or had an actual pressure ulcer. An intervention added 4/16/14, indicated the resident had a indwelling urinary catheter to promote the healing of a Stage 4 pressure ulcer.</p> <p>The recapitulation of physician's orders dated 4/1/15, indicated the resident had a catheter related to urinary tract infection and female stress incontinence. The origination date of the catheter order was 1/13/2014.</p> <p>During an interview with Registered Nurse (RN) #1 on 5/4/15 at 11:53 a.m., RN #1 indicated the resident originally had a Stage 4 pressure ulcer on the coccyx (tailbone), which had healed to the current status of Stage 2. RN #1 indicated the resident had an indwelling urinary catheter placed when the pressure ulcer was a Stage 4 to promote the healing of the pressure ulcer. RN #1 indicated the resident no longer had a Stage 4 pressure ulcer and no longer had medical justification for the use of the indwelling catheter.</p> <p>During an observation of the pressure ulcer dressing change on 5/1/2015 at 4:38 p.m., Registered Nurse (RN) #14 indicated the pressure ulcer had been</p>		<p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Any admission/readmission resident with a catheter will have catheter use reviewed at clinical start up to ensure that usage is medically justified.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Residents with catheters will be audited 5 times a week for 4 weeks then 3 times a week for 4 weeks then weekly.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 318 SS=D Bldg. 00	<p>much larger and deeper at one time and now was almost healed. An indwelling catheter was observed with slightly cloudy yellow urine in the tubing.</p> <p>A physician's order clarifying the medical justification of the indwelling catheter was not found in the clinical record as of 5/4/15 at 3:30 p.m.</p> <p>3.1-41(a)(1)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure that a resident with a limited range of motion (Resident #81) received appropriate treatment to increase and/or to prevent further decrease of range of motion for 1 of 2 residents reviewed for range of motion services.</p> <p>Findings include:</p> <p>The clinical record of Resident #81 was reviewed on 04/30/2015 at 10:42 a.m. Diagnoses included, but were not limited</p>	F 318	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R81 was evaluate by OT and will receive skilled OT services 5 times a week for 4 weeks and then will be reevaluated. OT evaluating need for splint for right hand.</p>	06/03/2015

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	<p>to, paralysis affecting Resident #81's right side and cerebrovascular hemorrhage (stroke).</p> <p>On 04/28/2015 at 1:00 p.m., Resident #81 was observed sitting in his wheelchair in his room. Resident #81 was observed with his arm laying in his lap with his wrist bent downward at approximately a 90 degree angle. Resident #81 indicated he could not stretch his wrist upward.</p> <p>A review of Occupational Therapist Progress & Discharge Summary dated 08/15/2014, included the following discharge plan and instructions, "Resident is discharged to same SNF [skilled nursing facility] under restorative nursing care for UE ROM [upper extremity range of motion] exercises."</p> <p>A careplan for Resident #81, dated 3/26/2014 and updated on 12/29/2014, indicated physical functioning deficit related to self care impairment, mobility impairment, range of motion limitations due to debility with old cerebral vascular accident (stroke) and hemiplegia (paralysis). Interventions included, but were not limited to, bed mobility assistance, eating assistance, locomotion assistance, transfer assistance, and rehab therapy as ordered.</p>		<p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Residents with ROM limitations will be reviewed by MDSC in conjunction with therapy and appropriate Restorative programs will be written and implemented.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>The facility has hired a dedicated Restorative Aide who will oversee the Restorative program.</p> <p>When Therapy refers a resident for Restorative ROM they will give a written referral to MDSC, who will write and implement program on Care Tracker. Therapy will also report any</p>	

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	<p>Quarterly IDT (Interdisciplinary Team) Resident Review dated 12/29/2014, indicated Resident #81 had a functional limitation in range of motion impairment to one upper extremity.</p> <p>A review of the current recapitulation of physician's orders lacked an order for restorative nursing services for range of motion for the resident's right wrist.</p> <p>During an interview on 04/30/2015 at 3:10 p.m., Occupational Therapist (OT) #9, indicated therapy recommendations for restorative nursing go to the Minimum Data Set (MDS) Coordinator for implementation.</p> <p>During a review of certified nursing assistant documentation on 05/01/2015 at 11:20:04 a.m., no documentation for restorative nursing services for range of motion were found for Resident #81.</p> <p>During a review of nursing progress notes on 05/01/2015 at 11:29 a.m., no documentation was found for restorative nursing services for range of motion for Resident #81.</p> <p>During an interview on 05/01/2015 at 3:55 p.m., the MDS Coordinator indicated no residents were currently</p>		<p>referrals during Clinical Start Up.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit Restorative programs for compliance 5 times a week for 4 weeks, then 3 times for 4 weeks, then weekly.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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F 441 SS=D Bldg. 00	<p>receiving restorative nursing services for range of motion.</p> <p>On 05/04/2015 at 10:30 AM, RN #1 was asked about documentation for range of motion and information following the Quarterly IDT Review dated 12/29/2014, for Resident # 81. No further information was provided by survey exit on 05/04/2015 at 06:45 PM.</p> <p>3.1-42(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</p>			

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure precautions were initiated to prevent the spread of infection for a resident diagnosed with an active Clostridium difficile infection (Resident #39) and a resident diagnosed with an active methicillin resistant staphylococcus aureus infection (Resident #65).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #65 was reviewed on 4/30/15 at 9:17 a.m. Diagnoses for the resident included, but were not limited to, septic shock, presenile dementia, intestinovesical fistula, colostomy and a history of necrotizing fasciitis (a condition where a severe bacterial infection causes rapid and extensive tissue death).</p>	F 441	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R65 resides in a private room and no longer receives antibiotic and MRSA has been resolved and is off isolation.</p> <p>R39 did not have C-Diff at the time of the survey so isolation was not indicated at that time.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective</p>	06/03/2015

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	<p>A nurses's note on 4/2/2015, indicated the resident had a fever of 101.5 Fahrenheit, the physician was notified, and laboratory blood cultures were ordered. Laboratory results dated 4/6/15, for the blood cultures drawn 4/2/15, indicated Resident #65's blood samples were positive for methicillin resistant staphylococcus aureus (MRSA). MRSA infections are contagious and difficult to treat because they are resistant to most antibiotics.</p> <p>The resident had a large, open abdominal wound which was pouched and drained into a bag. The bag had to be emptied by the nursing staff. He used a urinal.</p> <p>He was receiving fingerstick blood sugar tests 4 times per day, and his vital signs and temperature were being checked every shift.</p> <p>On 5/4/15 at 8:45 a.m., the Director of Nursing (DON) indicated, we always use Standard Precautions. Standard Precautions are the minimum infection prevention practices and include good hand hygiene.</p> <p>"Precautions to Prevent the Spread of MRSA in Healthcare Settings" (September, 2014) was retrieved on 5/6/15 from the Centers of Disease</p>		<p>actions taken are as follows:</p> <p>Other residents being treated for C Diff and MRSA have been reviewed and placed in isolation.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p> <p>Licensed staff has been educated on infection control procedures.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/Designee will audit residents with residents receiving treatment for C-Diff and MRSA 5 times a week for 4 weeks, then 3 times a week for 4 weeks and then weekly to ensure appropriate isolation</p>	

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	<p>Control (CDC) website. Precautions included, "The components of contact precautions may be adapted for use in non-hospital healthcare facilities, especially if the patient has draining wounds, or difficulty controlling body fluids...Don gown upon entry into the room..."</p> <p>On 5/1/15 at 3:35 p.m., the DON provided a policy dated August, 2014, titled Multidrug-Resistant Organisms, and indicated it was the policy currently used by the facility. The policy indicated, "Staff will use Standard Precautions as the primary approach to preventing transmission of MDROs [multidrug resistant organisms]...Masks are not recommended...except...when there is a risk of splashing body fluids...The staff and practitioner will evaluate each individual known or suspected to have infection with a multidrug-resistant organism for...initiation of Contact Precautions...may implement or consider the following to determine the need for Contact Precautions...The individual's ability to contain infected...body fluids...Risks for transmission including uncontrolled secretions, draining wounds..."</p> <p>An observation on 4/28/15 at 12:26 p.m. indicated Resident #65 was not in</p>		<p>has been initiated.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>	

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	<p>isolation for contact precautions.</p> <p>On 4/28/15 at 12:26 p.m., Certified Nursing Assistant (CNA) #2 was observed entering the resident's room and emptying his urinal and abdominal wound drainage bag. The CNA was not wearing a gown to prevent the splashing of body fluids on her clothing.</p> <p>2. The clinical record of Resident #39 was reviewed on 4/30/15 at 11:33 a.m. Diagnoses for the resident included, but were not limited to, dementia and history of Clostridium difficile (C-diff). C-diff is a bacteria which can cause severe diarrhea, dehydration and inflammation of the colon. Older adults are especially at risk.</p> <p>"C. difficile Infection," July, 2013, was retrieved from the Mayo Clinic website on 5/6/15. It indicated, "c. difficile bacteria are passed in feces and spread to food, surfaces and objects when people who are infected don't wash their hands thoroughly. The bacteria produce spores that can persist in a room for weeks or months. If you touch a surface contaminated with C. difficile, you may then unknowingly swallow the bacteria."</p> <p>"Frequently Asked Questions about Clostridium Difficile for Healthcare</p>			

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	<p>Providers," March 2012, was retrieved from the Centers of Disease Control (CDC) website on May 6, 2014. The guidance included the need to use contact isolation precautions (wearing gowns and gloves) when entering the room of a resident with known or suspected C-diff.</p> <p>"FAQ's [frequently asked questions] about Clostridium difficile," September, 2012, was retrieved on 5/6/15 from the CDC website. Information included, " The elderly and people with certain medical problems have the greatest chance of getting C. diff. C. diff. spores can live outside the human body for a very long time and may be found on things in the environment such as bed linens...can spread from person to person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors...To prevent c. diff infections...Use Contact Precautions to prevent C. diff from spreading to other patients. Contact Precautions mean: Whenever possible, patients with C,diff will have a single room or share a room only with someone else who also has C. diff., Healthcare providers will put on gloves and wear a gown over their clothing while taking care of patients with C. diff."</p> <p>A quarterly Minimum Data Assessment,</p>			

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	<p>dated 1/6/15, indicated the Resident #39 was severely impaired in her ability to make decisions, frequently incontinent of bowel movements, and needed the extensive assistance of 2 staff members for toileting and personal hygiene.</p> <p>A current care plan for Resident #39, created on 8/12/13, indicated the resident had an alteration in elimination of bowel and bladder. Interventions included use of briefs and pads for incontinence protection.</p> <p>On 4/28/15 at 3:34 p.m., Resident #39's daughter indicated the resident was incontinent and, "has had bouts of C. diff. and smears her stool on the walls and bed linens."</p> <p>On 2/9/15 a physician's order indicated the resident was to have a stool specimen sent to the laboratory for analysis. On 2/12/15, laboratory results indicated the resident's stool was C. diff positive. An antibiotic was ordered to treat her C. diff.</p> <p>There was no indication in the resident's record she was placed on contact precautions.</p> <p>A brief clinical record review for Resident #39's roommate, currently, and when a stool was sent for analysis on</p>			

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	<p>2/6/15, and confirmed with C. diff bacteria on 2/9/15, indicated Resident #55 was also severely cognitively impaired. The clinical record indicated the resident was not currently positive for C diff.</p> <p>On 5/4/15 at 8:30 a.m., Certified Nursing Assistant #5 indicated Resident #39, "smears stool on the walls," and did not think the resident had ever been on contact isolation.</p> <p>On 5/4/15 at 8:40 a.m., Housekeeper #4 indicated she usually cleaned the rooms on the hall where Resident #39 resided, and always asked the nurse if there were any isolation rooms. The housekeeper indicated she had not had a C. diff room to clean in the last 3 months.</p> <p>On 5/4/15 at 8:41 a.m., the Housekeeping Supervisor indicated they used a special bleach preparation if a resident had C. diff., and did not remember using this solution for any rooms on the Resident #39's hall in the last 3 months.</p> <p>On 5/4/15 at 8:35 a.m., the Director of Nursing (DON) indicated, "We always use standard precautions. If the stool is contained, the resident would not need to be in contact isolation." The DON indicated she was not aware the Resident</p>			

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F 465 SS=D Bldg. 00	<p>#39 smeared stool on the walls and bed linens. The DON indicated she would talk to the Assistant Director of Nursing. No further information was provided by the end of the survey on 5/4/15 at 6:30 p.m.</p> <p>3.1-18(j)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT 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 maintain four (4) community wheel chairs in safe operating condition.</p> <p>Findings include:</p> <p>1) On 04/28/15 an observation of community wheel chair located in Resident Room 21. The right arm rest of the wheel chair was torn/frayed with the foam exposed.</p> <p>2) On 04/28/15 an observation of community wheel chair located in Resident Room 22. The right arm rest of the wheel chair was torn/frayed with the foam exposed.</p>	F 465	<p>All residents have the potential to be affected by this deficient practice. All resident's wheelchairs noted under this tag have been inspected and repairs were completed before surveyors exited. In addition all resident's wheelchairs have been inspected for damages with no additional findings. To ensure this deficient practice does not recur, all wheelchairs are scheduled to be inspected and repaired on a routine basis. Staff to be in serviced on reporting any damages to the Maintenance director or designee. ED/designee to review wheelchair repair/inspection schedule every business day, and inspect those wheelchairs that were scheduled to be repaired/inspected on the</p>	06/03/2015

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F 514 SS=D Bldg. 00	<p>3) On 05 /01/15 an observation of dark blue community wheel chair across room room 31 in the hallway near the vending machine with blue tag #90, had the back rest pulling away from the screws and was torn/frayed with padding exposed.</p> <p>4) On 5/1/15 an observation of black community wheel chair outside resident room 27 with both foot rests torn and padding exposed.</p> <p>5) On 5/4/15 at 11:00 a.m., at the end of the environment tour, the Maintenance Supervisor indicated the above mentioned wheel chairs were in need of repairs.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of</p>		<p>previous day. Additionally, wheelchair inspections have been added to each department managers daily room inspection list. Concerns will be addressed during the management team's daily stand up meeting. Inspections are to be completed every day x 30, then 3 x weekly for 30 days, and 2 x weekly thereafter. The results of these audits will be presented at QA&A for three months to track for any trends. If any trends are identified audits will continue based on QA&A recommendations. If no trending identified the will be reviewed on prn basis.</p>	

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	<p>care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to accurately document wound care for 1 of 2 residents reviewed for pressure ulcers. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record of Resident #14 was reviewed on 05/04/2015 at 11:00 a.m. Diagnoses included, but were not limited to, renal failure (kidney failure) and congestive heart failure.</p> <p>A physician's order dated 03/27/2015, indicated the physical therapy wound care to Resident #14's right trochanter area was to be discontinued.</p> <p>Physical therapist progress and discharge summary dated 03/27/2015, indicated, "...Discharge Plans & [and] Instructions: Nursing to continue to monitor wound area until full closure to endure no trauma and complication if infection...."</p> <p>Review of the medication administration record (MAR) for the month of April 2015, indicated the resident was to receive wound care to the right hip. The wound care orders included, "Foam</p>	F 514	<p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>R14 continues to have an ordered treatment by nursing to her right trochanter which continues to be a Stage IV by MDS definition.</p> <p>Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</p> <p>Other residents with pressure ulcers were reviewed to ensure appropriate departments were providing treatment.</p> <p>The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</p>	06/03/2015

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	<p>Dressing Bordered Pad [Wound dressings] Apply to R [right] Troch [trochanter] [hip] topically every day shift [6:00 a.m. to 2:00 p.m. or 6:00 a.m. to 6:00 p.m.] every Monday, Thursday for Wound Care Cleanse R Trach [sic] wound with NS [normal saline]; apply barrier cream to peri [around] wound, cover with foam drsg [dressing] and secure with tape on day shift on Mon [Monday] and Thurs [Thursday]." The order was documented as completed with initials on the medication administration review on April 6, 9, 20, 23, and April 27, 2015, even though the dressing order was discontinued on 03/27/2015.</p> <p>During an interview on 05/01/2015 at 03:30 p.m., Registered Nurse (RN) # 14 indicated the wound care to the right hip was currently completed by therapy on Mondays and Thursdays.</p> <p>During an interview on 05/04/2015 at 09:16 a.m., Physical Therapist (PT) #11, indicated Resident #14's right trochanter wound was healed as of 03/27/2015. PT #11 indicated the dressing changes had not been completed by therapy since 03/27/2015.</p> <p>A review of Wound Evaluation Flow Sheet provided by RN #1 on 05/04/2015 at 10:20 a.m., "...D...Surrounding</p>		<p>Licensed staff educated on who and when Therapy provides treatment and when nursing provides treatment.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>DNS/ADNS/Designee will audit residents with pressure areas 5 times a week then 3 times a week then weekly to ensure the appropriate department is treating the areas.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p>				

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	<p>Tissue... 2o. Additional notes: Resolving, completely closed. E. Comments 1. Current Treatment barrier cream Date Treatment Ordered 04/06/2015...6. Has the wound healed? 1. Yes...." The Wound Evaluation Flow Sheet was electronically signed by RN #1 with a date of 04/06/2015.</p> <p>An observation of Resident #14's right trochanter wound was completed on 05/04/2015 at 1:49 p.m., with Licensed Practical Nurse (LPN) #12 in Resident #14's room. No dressing in place. Area closed with thin scab over it.</p> <p>3.1-50(a)(2)</p>			