

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2012
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NAME OF PROVIDER OR SUPPLIER IRONWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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F0000	<p>This visit was for the Investigation of Complaints IN00109380, IN00110574, IN00111686, and IN00112436.</p> <p>Complaint IN 00109380-Substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F514.</p> <p>Complaint IN00110574-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00111686-Substantiated. Federal/state deficiencies related to the allegations are cited at F309.</p> <p>Complaint IN00112436-Substantiated. Federal/state deficiencies related to the allegations are cited at F314 and F282.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: August 6 & 7, 2012</p> <p>Facility number: 000042 Provider number: 155103 AIM number: 100291540</p> <p>Survey team: Janet Adams, RN, TC</p>	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusions set forth in the statement of deficiencies or any violation of regulations. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Revisit on or after August 31, 2012.	

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>Shannon Pietraszewski, RN</p> <p>Census bed type: SNF/NF: 148 Total: 148</p> <p>Census payor type: Medicare: 11 Medicaid: 112 Other: 25 Total: 148</p> <p>Sample: 13</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 12, 2012 by Bev Faulkner, RN</p>				

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F0250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review and interview, the facility failed to ensure interventions were initiated, implemented and residents were evaluated after resident to resident altercations for 4 of 4 residents reviewed for resident to resident altercations.</p> <p>(Residents #L, #M, #P, and #D)</p> <p>Findings include:</p> <p>1. Upon observation of Resident D on 8/6/12 at 5:00 p.m., Resident D was in his wheel chair across from the 500 nurses station, bumping into the back of another resident. Resident D utilized his right hand to the wheel trying to propel himself. The wheel chair was moving in a circular motion.</p> <p>Observation of Resident P on 8/6/12 at 5:15 p.m., Resident P was in his wheel chair across from the 400 nurses station. Resident P was observed propelling himself to the Ridgedale dining room at this time.</p> <p>The Facility Incident Reporting Forms</p>	F0250	<p>Residents' #L, #M, #P, and #D were evaluated by IDT (interdisciplinary team). Interventions were implemented and care plans for each resident was updated as necessary to reflect current status. All residents with behaviors and/or receiving medication and other interventions for behaviors will be reviewed by IDT. Care plans for each resident was updated as necessary. All staff will be in serviced on Facility Policy and Procedures: Mood and Behavior Program, Abuse Prevention and Reporting. Education will include facility CARES program which includes managing resident behaviors. Nursing and social services will be educated on documentation standards to ensure records are completed per policy regarding monitoring behaviors and follow up measures are in place. IDT will review all residents with behaviors 5 times per week, M-F to ensure appropriate measures are in place during DCR. All residents with behaviors and/or receiving other interventions, including medications for behavior management, will be reviewed monthly during Behavior</p>	08/31/2012			

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	<p>initiated on 6/12/12 at 9:10 a.m., indicated both Resident D and Resident P were in the Ridgedale dining room. CNA #3 witnessed Resident P "with an angry look on his face, holding onto Resident D's WC (wheel chair) and Resident D with a new abrasion on his right chin and a puffy lip with faint bruise."</p> <p>Resident D and Resident P were placed on every 15 minute checks over the next 72 hours. Both were separated and assessed. Preventative measures taken were for staff to take Resident D to Ridgedale dining room just prior to meal times, feed him immediately and then return him to the 500 unit. IDT (Interdisciplinary Team) met to review and update the care plan for Social services to be "made available" for any distress. Nursing was to continue to monitor Resident D and the physician to be notified for any changes.</p> <p>A follow up report, dated 6/15/12, indicated Resident D was going in circles when he accidentally bumped his wheelchair into Resident P and then grabbed the wheelchair. Resident P reached and struck Resident D on the right side of the face/cheek. Treatment was ordered for the abrasion on his chin. Resident D was to be escorted to the dining room and monitored. If Resident</p>		<p>Meeting. Recommendations by Behavior Review team will be implemented into each resident's plan of care as indicated. Trends identified will be reviewed and addressed by Quality Assurance (QA) committee monthly times 3 months and quarterly thereafter.</p>	

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	<p>D had a behavior, he was to be removed so it was not disturbing to the other residents who were dining.</p> <p>Resident D's record was reviewed on 8/6/12 at 11:55 a.m., and Resident D's diagnoses included but not were not limited to, dementia, stroke with left hemiparesis, and aphasia.</p> <p>Resident D's 24 hour Resident Flow Record was initiated on 6/16/12. The flow record indicated the 15 minute checks were initiated due to the resident to resident altercation. There were no flow records between 6/12/12 to 6/16/12.</p> <p>A Social Service note, dated 6/12/12 at 5:20 p.m., noted the resident to resident altercation. SW #2 indicated nursing would continue to monitor Resident D and he was unable to voice what occurred. There was no other documentation in the progress notes until 7/19/12.</p> <p>Upon interviewing the ADON on 8/6/12 at 4:00 p.m., she indicated there were no flow records regarding the 15 minute checks from 6/12/12 to 6/15/12 for Resident D.</p> <p>A second Facility Incident Reporting Form, dated 7/18/12, was reviewed. The</p>			

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	<p>form indicated on 7/18/12 at 9:00 p.m., Resident D was in his wheel chair in the hallway when Resident P reached over and took a hold of Resident D's throat area. CNA #4 observed and immediately separated the two residents.</p> <p>Resident D and Resident P were placed on every 15 minute checks for 72 hours and assessed. Orders were received for treatment to Resident D's abrasion to his neck. Preventive measure taken was staff to be educated in keeping both residents apart. Due to Resident P having a diagnoses of Bipolar, he was ordered to have a stat Depakote (a medication to treat behaviors) level drawn and possible psychiatry evaluation at VA (Veteran's Administration). Resident D was to remain on every 15 minute checks with Social Services to assess for any negative outcome nursing to monitor for any s/s (signs and symptoms) of infection from abrasion and to notify the physician and family immediately of any changes.</p> <p>A follow up report (undated) indicated Social Service was attempting to get Resident P to be seen by the VA for outpatient psychiatry appointment and the facility was waiting for confirmation. Social Services assessed both parties with no negative outcomes, stress or behaviors.</p>			

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	<p>Resident D's 24 hour Resident Flow Record was initiated on 7/18/12 at 9:00 p.m., for resident to resident incident. The Resident Flow records for 15 minute checks ended on 7/19/12 at 9:45 p.m.</p> <p>A social service note by SW #2 on 7/19/12 at 3:00 p.m., indicated the resident to resident altercation and Resident D smiled at her when asked if "someone choked him." The next Social Service note was 7/20/12 at 11:10 a.m., indicating the resident continues to be unable to recall the incident. No further documentation were indicated.</p> <p>Resident P's record was reviewed on 8/6/12 at 4:30 p.m. Resident P's diagnoses included, but not were not limited to, stroke with right hemiparesis, expressive aphasia, bipolar, post traumatic stress disorder, and schizophrenia.</p> <p>The Behavior Detail Report for Resident P indicated there were no behaviors logged for 6/12/12 or 7/18/12.</p> <p>Resident P's 24 hour Resident Flow Record of the first incident was initiated on 6/12/12 and indicated it was due to the resident to resident altercation. The 6/14/12 Flow Record was not found and the 6/20/12 Flow Record was incomplete.</p>				

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	<p>A Social Service note, dated 6/12/12 at 3:25 p.m., indicated the resident to resident altercation. Resident P was unable to recall the incident and indicated to SW #2 he was not upset with anyone or anything. SW #2 indicated Resident P will be monitored by nursing. On 6/13/12 at 1:10 p.m., SW #2 indicated Resident P is unable to recall the incident. There were no other documentation in the Progress notes until 7/19/12.</p> <p>Resident P's 24 hour Resident Flow Record of the second incident was initiated on 7/18/12 at 10:00 p.m., and indicated it was due to Resident P's behaviors. The Flow Record for the dates of 7/19/12, 7/20/12, 7/23/12, 7/24/12, 7/26/12, 7/28/12, 7/29/12, 7/31/12 were incomplete. There were no Flow Records for 7/15/12, 8/1/12, 8/3/12, 8/6/12, 8/7/12, and 8/8/12.</p> <p>Social Services Progress notes on 7/19/12 at 9:05 a.m., indicated SW #2 spoke with Resident P and he was not able to recall the incident. SW #2 left a message for the spouse for permission to send the resident for inpatient psychiatry services. At 2:47 p.m., SW #2 received permission from spouse for inpatient psychiatry services and a message was left with two individuals at the VA. On 7/20/12 at</p>			
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	<p>11:24 a.m., SW #2 received a call from an individual from the VA who indicated she was getting in contact with someone from a local clinic and to be expecting a call from them. There were lack of social service notes indicating if a call was received from the local clinic.</p> <p>An interview with the Director of Social Services indicated Resident P's wife made an appointment for the resident to be seen in outpatient clinic on 8/8/12.</p> <p>Upon interviewing SW #2 on 8/7/12 at 1:10 p.m., she indicated nursing initiates the 15 minute checks and stops the 15 minute checks. She indicated her role was to talk to the residents or nurse and look at the 24 hour sheets and the 15 minute checks. If the resident was non-verbal, she will look at documentation and/or 24 hours sheets as well as participate in the daily Stand-up (morning meetings). She indicated the Behavior Team ended around March or April of 2012.</p> <p>There were no other measures put to into place by Social Service Department for both Resident D and Resident P.</p> <p>2. On 8/7/12 at 7:55 a.m., Residents #M and #L were observed eating breakfast in</p>						

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	<p>the Ridgedale Dining Room. Resident #M was seated at a table with three other residents. Resident #M was facing the window. Resident #L was at another table in the dining room and he was facing the window. Residents #M and #L were not in view of each other.</p> <p>A Facility Incident Reporting Form completed on 7/8/12 indicated on 7/8/12 at 12:15 p.m., Resident #L reached over and took a piece of pie off Resident M's lunch tray. Resident #M then struck Resident #L in the cheek causing an abrasion and a small amount of bruising. Preventative interventions listed on the form indicated the residents were now to be at separate tables in the dining room and Resident #M was to be at a table where residents are not attempting to remove food off other residents trays. Further preventative measures to be taken were for the IDT (Interdisciplinary Team) to meet and review the plan of care for the residents related to the incident. The Final Report section indicated the two residents were immediately separated and an investigation was started. The resident were assigned to different tables in the dining room and staff were to continue to monitor both residents "very frequently."</p> <p>The record for Resident #M was reviewed on 8/7/12 at 10:40 a.m. The resident's</p>			

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	<p>diagnoses included, but were not limited to, MS (Multiple Sclerosis), lack of coordination, cognitive deficit, and mood disorder.</p> <p>The Social Service Progress Notes for Resident #M were reviewed. An entry made on 7/9/12 at 5:15 p.m., indicated Social Services met with the resident in regards to the resident to resident altercation which occurred on 7/8/12. The progress note indicated the resident ate his food and drank his drink so he punched him. The writer discussed the inappropriateness of the resident's behavior and he voiced understanding and stated he felt bad after it happened. The progress note also indicated that Resident #M would be added to the list for the Psychiatry services to see upon their next visit. The progress note did not indicate any other interventions that were to be put into place.</p> <p>24 Hour Resident Flow Records were in the resident's chart. No flow records were available for review for the dates for the dates of 7/8/12. A 24 Hour Resident Flow Record for 7/9/12 indicated the resident was on 15 minute checks related to a resident to resident altercation. The form listed the times (at 15 minute intervals) that the resident was to be checked. There was no documentation of</p>			

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	<p>the resident being checked between 2400 (12:00 a.m.) through 2145 (11:45 p.m.)</p> <p>A 24 Hour Resident Flow Record initiated on 7/10/12 indicated Resident #M was on 15 minute checks related to being involved in resident to resident altercation. On the 7/10/12 record, there was no documentation between 10:30 a.m. thru 1345 (1:45 p.m.)</p> <p>When interviewed on 8/7/12 at 1:10 p.m., the Social Service Director indicated Social Service does not participate in initiating or monitoring the 15 minute checks.</p> <p>When interviewed on 8/7/12 at 1:12 p.m., Social Worker #2 indicated Resident #M and #L were both placed on every 15 minute checks after the resident to resident altercation and Social Service is not involved in determining when the 15 minute checks are to discontinued.</p> <p>When interviewed on 8/7/12 at 12:40 p.m., LPN #4 indicated she was assigned to care for Resident #M on this day. The LPN indicated the resident was currently on 15 minute checks and the reason the resident is on 15 minute checks is for his safety because he frequently transfers himself out of bed or his wheelchair and</p>			

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	<p>on Saturday Resident #M was found on the floor. LPN #4 indicated she not aware of the resident having any physical alterations or behaviors towards other residents.</p> <p>When interviewed on 8/7/12 at 1:50 p.m., the Director of Nursing (DON) indicated she met with Social Services and the Nurse Consultant about a month ago regarding behavior management and psychotropic medications and were starting a weekly system audit to review behaviors. The DON indicated nursing staff should have known the reason Resident #M was on 15 minute checks.</p> <p>The record for Resident #L was reviewed on 8/7/12 at 11:50 a.m. The resident's diagnoses included, but were not limited to, dementia, closed head injury, anxiety, and a history of a right ankle fracture.</p> <p>The 7/12 Nurses' Notes were reviewed. An entry on 7/8/12 at 1:30 p.m., indicated the physician was notified of a the resident being involved in resident to resident altercation and some swelling was noted to the resident's cheek. An entry made on 7/8/12 at 8:00 p.m., indicated the 15 minute checks were in place for the resident due to the resident to resident altercation. An entry made on 7/11/12 at 1:50 p.m., indicated hourly</p>			

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	<p>checks were started.</p> <p>The Social Service Progress Notes were reviewed. An entry made on 7/9/12 indicated Social Service met with the resident in regards to the resident to resident altercation. The entry indicated the resident stated he knew someone beat him up but was unable to recall why and he was not afraid of the other resident who struck him. An entry made on 7/10/12 at 2:10 p.m., indicated the resident voiced no concerns in regard to the incident with the other resident. There were no other entries in the July Social Service notes regarding the frequent checks being changed from every 15 minutes to hourly.</p> <p>3.1-34(a)(1)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure services were provided by qualified persons related to a CNA removing a pressure ulcer dressing for 1 of 3 residents observed with pressure ulcer wound dressings in the sample of 13. (Resident #F) (CNA #1)</p> <p>Finding include:</p> <p>On 8/6/12 at 4:30 p.m., CNA's #1 and #2 were observed initiating incontinence care for Resident #F. The CNA's removed the resident's brief and turned the resident to her left side. CNA #2 held the resident on her side. The resident had a wound dressing in place to the coccyx area. There was a small smear of light brown bowel movement present. The CNA cleansed the area and then started to pull the wound dressing down and packing gauze was observed in the coccyx wound. When interviewed at this time, CNA #1 indicated she had to take the dressing off to be able to cleanse the area well.</p>	F0282	<p>CNA #1 was educated on facility of policy regarding licensed staff providing care related to treatments, including removal of dressings for pressure ulcers, and other services according to residents' plan of care. Licensed Nurse provided wound care to the resident per physicians order on 8/6/12. No negative outcomes were noted by this practice. All residents receiving wound care have the potential to be affected. All residents with current treatment orders will be reviewed to ensure care plans are reflective of current status. All staff will be educated on performing duties within scope of practice. Nursing staff will be in-service on wound prevention and management, to ensure residents receive wound care by appropriate discipline. Unit Manager (UM) or designee will perform random observations of nursing assistants providing care to residents with wounds weekly times 4 weeks, then monthly times 3 months. Immediate corrective action and/or education will be provided, up to and including disciplinary action. Results of observations will be reported to the Director of Nursing (DON) for review in</p>	08/31/2012			

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	<p>When interviewed upon entering the resident's room on 8/6/12 at 4:35 p.m., LPN #3 indicated the resident had a wound vac in place and it was removed earlier on the day shift due to the the wound vac not functioning and a dressing was then applied to the area. The LPN indicated to the CNA she should not remove the dressing when completing incontinence care.</p> <p>The record for Resident #F was reviewed on 8/6/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, left above the knee amputation, cerebral vascular accident (stroke), and high blood pressure.</p> <p>Review of the 8/12 Physician orders indicated there was an order for the resident to have have a wound vac to the coccyx and abdominal wounds. The wound vac to the areas was to be set at 125 mmg (measurement of suction).</p> <p>The Skin Grid-Pressure/Venous Insufficiency Ulcer report for the coccyx wound was reviewed. The following entries were made for the coccyx ulcer: 8/1/12- stage IV ulcer (a wound with full thickness tissue loss with bone, tendon, or muscle exposed), 7.3 cm (centimeters) x 6 cm x 3 cm, red color, serosanguineous drainage present, no</p>		<p>monthly QA. QA will identify and address any trends, including need for corrective action or continued monitoring. Addendum: UM or designee will perform random observations of nursing assistants providing care to residents on all 3 shifts to ensure all services are performed within their scope of practice. Monthly monitoring will continue times 5 months, with results reported to QA. Upon review of audits, QA will determine if further education and/or further monitoring is needed. Any identified non-compliance will result in immediate corrective action and one on one education, including progressive disciplinary action up to and including termination.</p>				

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	<p>odor, with 2 cm of tunneling/undermining present.</p> <p>8/4/12- stage IV ulcer, 7.4 cm x 6.2 cm, x 3.1 cm, red color, serosanguineous drainage present, no odor, with 2 cm of tunneling/undermining present.</p> <p>Review of the facility's "Position Description for a Nursing Assistant" did not include for CNA's to remove wound dressings. A Nursing Assistant Competencies checklist was signed by CNA #1 on 3/26/12. The checklist indicated the CNA was to perform tasks to assist residents within the job description.</p> <p>When interviewed on 8/6/12 at 5:00 p.m., the facility Nurse Consultant indicated the CNA should not have removed the dressing to the resident's coccyx wound.</p> <p>This federal tag relates to Complaint IN00112436.</p> <p>3.1-35(g)(2)</p>						

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on record review and interview, the facility failed to provide the necessary treatment and services to maintain the resident's highest practicable well being related to monitoring a resident after Emergency Room visits for bleeding from the groin for 1 of 3 closed records reviewed for change in condition in the sample of 13. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 8/7/12 at 11:00 a.m. The resident's diagnoses included, but were not limited to, sepsis (infection), high blood pressure, depression, anemia, and infected arterial grafts, right below the knee amputation, femoral popliteal bypass grafts, peripheral vascular disease, and a history of deep vein thrombosis (a blood clot).</p> <p>Review of a 7/4/12 Facility Incident Reporting Form indicated on 7/4/12 at</p>	F0309	<p>Closed record review. Resident C no longer resides at facility. An audit of all residents transferred to hospital and returned to facility in last 30 days will be reviewed to ensure appropriate measures are in place. Resident assessment and/or care plans will be updated to reflect current status. Licensed nurses will be in-serviced on facility policy and procedures: Episodic Documentation related to documentation of resident assessment, such as change in condition, resident care issues, until it is resolved. Education will include SBAR and INTERACT II (resident assessment/communication tools). IDT reviews all residents with change in condition, in DCR, 5 times per week to ensure appropriate measures are in place. UM or designee will audit residents who readmit to facility, including residents returning from extended (LOA) to ensure appropriate resident assessments are completed. Audits will be completed daily during DCR times 4 weeks, weekly times 4 weeks, then monthly times 3.</p>	08/31/2012	

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	<p>3:30 p.m., a Therapist entered the resident's room to take the resident to therapy. The resident was noted to be ashen in color with fluid under her left thigh/hip area. The Therapist called the resident by name with no response and then went to nursing to obtain assistance. Nurses immediately went to the resident and CPR (Cardio Pulmonary Resuscitation) was initiated. The form indicated the resident's dressing was checked by Nursing at 1:15 p.m. and the resident's dressing was dry and intact.</p> <p>A Physician/NP/PA Communication and Progress Note was completed on 7/1/12 at 4:00 a.m. The Progress Note was written by Nursing. The Note indicated the resident had copious amounts of bleeding from the left groin arterial graft site and pressure was held.</p> <p>A Physician/NP/PA Communication and Progress Note was completed on 7/2/12 at 12:25 a.m. The Progress Note was written by Nursing. The Note indicated she was having difficulty controlling bleeding from the resident's left groin and direct pressure was applied. The back page of the Progress Note indicated at 12:25 a.m., the resident was heard yelling out for help and when the CNA and the Nurse entered the room, the resident's bed and gown were covered in blood. Direct</p>		Results of audits will be reported to DON for review during monthly QA meeting. QA will identify and address any trends, including the need for corrective action or continued monitoring. Corrective action and/or education will be provided up to and including disciplinary action.				

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	<p>pressure was applied to the compression dressing and large amounts of blood started to flow from the bottom of the dressing and bright red spurts of blood were noted. 911 was called and arrived at 12:38 a.m., and EMS took over and the bleeding stopped at that time. The resident was then transported to the hospital.</p> <p>The 7/2012 Nurses' Notes were reviewed. An entry on 7/1/12 at 6:30 a.m., indicated the resident approached the Nurses' station at 3:50 a.m., and asked the Nurse how long it would be until she would get her morning medications. The entry indicated the Nurse told her the earliest she could get her medications would be at 4:00 a.m. The entry then indicated later the Nurse entered the resident's room and administered medications to the resident and then went into the bathroom to get water to flush the resident's gastrostomy tube and when the Nurse came out of the bathroom the resident stated "I don't know where this blood is coming from." The Nurse pulled back the covers and the resident's gown, abdomen, thigh, were covered in bright red blood. The Nurse called out for help from the other Nurse. A large amount of blood was noted in a pool to the left groin scar. Direct pressure was held and a third Nurse paged the Physician, called 911. EMS (ambulance</p>				

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	<p>services) arrived at 4:18 a.m. and transported the resident to the hospital.</p> <p>The next entry in the Nurses' Notes was made 7/1/12 at 7:02 a.m. This entry indicated the hospital was called by the Nurse and the Nurse was told they were not sure if the resident would be returning to the facility or be admitted to the hospital. There was no documentation of when the resident returned from the hospital emergency room after being sent to the Emergency Room at 4:18 a.m. There was no follow up assessment of the residents left groin site in the 7/1/12 Nurses' Notes.</p> <p>The next entry in the 7/12 Nurses' Notes was made on 7/2/12 at 3:20 p.m. This entry indicated the resident was told to remain on bed rest and was non compliant. The resident hopped on her scooter and proceeded to go outside to smoke and was told by the Nurse she was to stay in bed. The resident stated she needed to have a cigarette. The resident came back to the unit and her left groin site started bleeding. The Physician was notified. The next entry in the 7/2/12 Nurses' Notes was at 3:30 p.m. This entry indicated the resident had an appointment with the surgeon at 10:00 a.m. The next entry in the Nurses' Notes was made on 7/2/12 at 6:30 p.m., and this entry</p>			

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	<p>indicated the resident returned from an appointment with her attending Physician. There were no further entries in the 7/2/12 Nurses' Notes. There was no follow up documentation to indicate when the resident returned from the hospital. There was no further documentation of any assessment of the left groin after the resident returned from the hospital due to left groin bleeding.</p> <p>There were three entries made in the 7/3/12 Nurses' Notes. The first entry was made at 2:00 a.m. This entry indicated the dressing to the right groin remained intact with no active bleeding noted. The next entry was made at 3:30 p.m. This entry indicated the dressing to the left groin was dry and intact. The next entry was made at 10:00 p.m. This entry indicated there was no assessment of the dressing to the resident's left groin.</p> <p>The first entry in the 7/4/12 Nurses' Notes was made at 6:00 p.m. This entry indicated the resident was in bed and asked for pain medication at 1:50 p.m. The nurse went to the Nurses' station to give report and during that time the therapist came to the Nurses' station and stated Resident #C was sitting in a pool of blood. 911 was called and staff ran to the room and CPR was started and EMS arrived.</p>				

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	<p>Review of the 7/1/12 hospital Emergency Care Center Patient Discharge and Follow-Up Instructions indicated the resident's discharge diagnosis was left groin bleeding and the instructions were to return to the Emergency Room if the symptoms worsened. The instruction sheet was signed by the hospital staff at 0956 (9:56 a.m.).</p> <p>Review of the 7/2/12 hospital Emergency Care Center Patient Discharge and Follow-Up Instructions indicated the resident's discharge diagnosis was left groin hemorrhage and the instructions were to keep the wound bandaged for 48 hours and to remain on bed rest for 48 hours. The instruction sheet was signed by the hospital staff at 0912 (9:12 a.m.).</p> <p>When interviewed on 8/7/12 at 1:50 p.m., the Director of Nursing indicated she was aware of the 7/1/12 and the 7/2/12 incidents when the resident was sent out to the hospital for bleeding from the groin. The DON indicated she communicated with staff and felt they were monitoring the resident.</p> <p>This federal tag relates to Complaint IN00111686.</p> <p>3.1-37(a)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure treatment and services were rendered to promote healing and and prevention of pressure ulcers related to Prevalon boots not in place, a wound vac device not functioning, and lack of ongoing assessments of wound changes for 2 of 3 residents with pressure ulcers in the sample of 13 (Residents #F and #H)</p> <p>Findings include:</p> <p>1. During orientation tour on 8/6/12 at 4:15 a.m., Resident #F was observed in bed. The resident was awake. A wound vac machine (an device which provides suction to open wounds to promote healing) was observed on the mattress at the foot of the resident's bed. The wound vac machine was not on. Tubing was connected from the wound vac device to a</p>	F0314	Resident F was provided a new wound vac on 8/6/12. The Prevalon boot was placed on Resident Fs right foot on 8/6/12. Resident H was assessed by nursing to include measurement and description of all wounds. Documentation noted on clinical record and interventions in place per plan of care. An audit of all residents receiving wound care and residents with interventions, such as pressure relieving devices, was completed to ensure each resident has interventions in place, and that each intervention is included residents' plan of care and nursing assignment sheet to reflect current status. Nursing staff will be in serviced on facility policy and procedure regarding Wound Prevention and Treatment. In service training will include alternative wound therapy, in the event a wound vac machine is unavailable or inoperable, as ordered by physician. In service training will	08/31/2012	

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	<p>pressure ulcer on the resident's coccyx. There was no drainage observed in the tubing. A blue Prevalon boot (a soft boot to prevent pressure on the heels) was observed in the resident's bed. The boot was not on the resident's right foot.</p> <p>The record for Resident #F was reviewed on 8/6/12 at 11:00 a.m. The resident's diagnose included, but were not limited to, diabetes mellitus, left above the knee amputation, cerebral vascular accident (stroke), and high blood pressure.</p> <p>Review of the 8/12 Physician orders indicated there was an order for the resident to have a Prevalon boot to the right foot. The order was initially written on 6/8/12. There were also Physician orders for the resident to have a wound vac to the coccyx wound and the abdominal wall wound. The wound vac to the areas was to set at 125 mmg (measurement of suction).</p> <p>Review of the 7/20/12 Skin Integrity care plan indicated the resident was at high risk for the pressure ulcer development. Care plan interventions included to protect the elbow and heels and to provide treatment as ordered by the Physician.</p> <p>The Skin Grid-Pressure/Venous Insufficiency Ulcer report for the</p>		<p>also include ensuring appropriate interventions are in place for each resident. UM or designee will conduct rounds daily, M-F times 4 weeks, then weekly times 8 weeks, then monthly times 3. Observation of residents receiving wound care by wound vac will be made to ensure appliance is on per physician order. Corrective action and/or education will be made immediately, up to and including disciplinary action. Results of audits will be reported to DON for review in monthly QA meeting. QA committee will identify and address any trends, including determining if correction action and/or continued monitored is needed.</p>		

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	<p>abdominal and coccyx wounds were reviewed. The following entries were made for the coccyx ulcer:</p> <p>8/1/12- stage IV ulcer (a wound with full thickness tissue loss with bone, tendon, or muscle exposed), 7.3 cm (centimeters) x 6 cm x 3 cm, red color, serosanguineous drainage present, no odor, with 2 cm of tunneling/undermining present.</p> <p>8/4/12- stage IV ulcer, 7.4 cm x 6.2 cm, x 3.1cm, red color, serosanguineous drainage present, no odor, with 2 cm of tunneling/undermining present.</p> <p>The Skin Grid-Venous Insufficiency Ulcer report for the abdominal and coccyx wounds were reviewed. The following entries were made for the abdominal ulcer.</p> <p>8/1/12- stage III (a wound with full thickness loss), 3.9 cm x 7.5 cm x .3cm, red in color, no odor or drainage, and no tunneling or undermining.</p> <p>8/4/12- stage III , 1.7 cm x 8.8 cm x .1 cm, red in color, no odor or drainage, and no tunneling or undermining.</p> <p>When interviewed on 8/6/12 at 6:10 p.m., the Director of Nursing indicated the wound vac should have been on as ordered by the Physician.</p> <p>When interviewed on 8/7/12 at 1:50 p.m.,</p>			

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	<p>the Director of Nursing indicated the resident should have had the boot on as ordered by the Physician.</p> <p>2. On 8/6/12 at 8:00 a.m., Resident #H was observed in bed. There was a specialty low air loss mattress on the resident's bed.</p> <p>On 8/6/12 at 12:12 p.m., LPN #2 was observed rendering wound care to a pressure ulcer on Resident #H's left heel. There was an open area to the resident's left heel. The area was circular in shape and was approximately 2.5 cm (centimeters) x 2.5 cm. In the center of the wound there was dark brownish/black eschar area noted. This area measured approximately 1.5 x 1 cm. The rest of the wound bed was red in color.</p> <p>On 8/7/12 at 9:35 a.m., LPN #2 was observed rendering wound care to a pressure ulcer on the residents coccyx area. The wound was approximately 3 cm x 3 cm. There was an irregular shaped area of dark brown/blackish eschar in the center of the ulcer.</p> <p>The residents record was reviewed on 8/6/12 at 4:00 p.m. The resident was admitted to the facility on 7/18/12. The resident's diagnoses included, but were</p>			

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	<p>not limited to, diabetes, peripheral neuropathy, high blood pressure, and lumbar stenosis.</p> <p>The Skin Grid-Pressure/Venous Insufficiency Ulcer/Other report for the coccyx wound were reviewed. Entries were made as follows: 7/19/12- stage I (a wound with non blanchable redness of a localized area) pressure ulcer , measuring 2 cm x 2cm, red color, no drainage. 7/25/12- stage II, pressure ulcer (a wound with partial thickness loss of dermis) measuring 2 cm x 1cm x .1 cm, wound color red, no drainage or odor. 8/1/12- stage II, measuring 2 cm x 1 cm x .2 cm, no odor or drainage, red in color. The above entries were completed by Unit Manager #1.</p> <p>The Skin Grid-Pressure/Venous Insufficiency Ulcer/Other report for the left heel wound were reviewed. Entries were made as follows: 7/19/12- stage II pressure ulcer. measuring 3 cm x 4 cm x .1cm, red in color, no drainage, no odor. 8/1/12- stage III ulcer (ulcer with full thickness tissue loss, measuring 3 cm x 4 cm x 0.1 cm, red in color, no drainage or odor. The above entries were completed by Unit Manager #1.</p>			

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	<p>A care plan titled "Skin Integrity Assessment: Prevention and Treatment Plan of Care" was initiated on 7/20/12. The care plan indicated the resident had a stage II ulcers to the coccyx and the left heel. Care plan interventions included to monitor the wound weekly and prn (as needed.)</p> <p>The 7/12 and 8/12 Physician orders indicated there was an order written on 7/18/12 to cleanse the left heel wound with normal saline, apply Silvadene ointment and and cover the wound every shift. An order was written on 7/19 to discontinue the Silvadene (a medicated cream to treat pressure ulcers) to the left heel. An order was written on 7/20 to apply an Allevyn foam pad to the left heel and to change the Allevyn every day and as needed, initiate an air mattress and for the resident to have Prevalon boots. An order was written on 7/30/12 to cleanse the left heel with normal saline, apply Bacitracin (an antibiotic ointment) and an Allevyn foam dressing to the heel every shift. The first Physician order for a treatment to the coccyx wound was written on 7/24/12. This order was to cleanse the coccyx wound with normal saline, apply Santyl (a debriding ointment), and apply an Allevyn foam dressing to the wound every day. An</p>			

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	<p>order was written on 8/2/12 to discontinue the above Santyl treatment and to start to apply Santyl Metrogel to the coccyx wound after cleansing the wound with normal saline and cover the wound with an Allevyn dressing daily.</p> <p>The 7/12 and 8/12 Nursing Progress Notes were reviewed. There was no documentation of any assessment of the pressure ulcer to the resident's coccyx or left heel to indicate when the brownish/black eschar areas were first noted to the wounds.</p> <p>The 7/12 and 8/12 Nurses' Notes were reviewed. An entry made on 7/24/12 at 3:00 a.m., indicated an open area was found on the resident's coccyx and the wound measured 1 cm x 1 cm with .5 cm depth. An entry made on 7/24/12 at 2:00 p.m., indicated a small amount of serous sanguineous drainage was noted on the left heel dressing. There were no other assessments of the changes in the two pressure ulcers that were first identified on 7/19/12.</p> <p>When interviewed on 8/6/12 at 12:12 p.m., LPN #2 indicated there was eschar present on the resident's left heel wound. The LPN indicated the eschar was not present when she started doing treatments on the wound when the resident was first</p>						

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	<p>admitted.</p> <p>When interviewed on 8/7/12 at 9:35 a.m., LPN #2 indicated the darkened areas present on the resident's coccyx wound were not present when she first started doing treatments to the wound when the resident was first admitted.</p> <p>When interviewed on 8/7/12 at 11:00 a.m., Unit Manager #1 indicated she measures and assesses the resident's wound weekly and records the assessment and measurement on the Skin Grid sheet. The Unit Manager indicated she assessed the area this morning and the dark area observed on the wounds were not present on her last assessment of the wounds which she completed on 8/1/12. The Unit Manager indicated there was a change in the wounds and nursing staff should have been assessing the wound daily when treatments were done and the areas of brown/black tissue on the wound should have assessed and documented. The Unit Manager also noted the resident's Physician had observed the wounds on his visits and spoke with the resident's family and the family had requested palliative care and pain relief for the resident.</p> <p>This Federal tag relates to Complaint IN00112436.</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to provide adequate supervision related to use of the correct Hoyer pad for transferring and transferring a resident correctly as per his plan of care for 2 of 3 residents reviewed for falls in a sample of 13. (Residents E and K)</p> <p>Findings include:</p> <p>1. Resident K record was reviewed on 8/6/12 at 8:00 a.m. Resident K's diagnoses included, but were not limited to, sudural hematoma resulting for a cerebral vascular accident (stroke), and left tibial/fibula (leg) fracture after a fall on 7/10/12.</p> <p>While observing a dressing change on 8/6/12 at 8:20 p.m., Resident K was observed sitting in her wheelchair with her back to her bed. A Hoyer pad was observed on her dresser.</p> <p>Upon record review on 8/6/12 at 9:20 a.m., an IDT note on 6/14/12 at 3:00 p.m., indicated the resident had fallen.</p>	F0323	<p>Clinical record review and evaluation of Residents E and K were completed to ensure appropriate transfer and/or equipment was updated on each resident's plan of care and nursing assignment sheets. CNA #6 was educated on appropriate transfer technique per plan of care. An audit of all residents' at risk for falls will be reviewed to ensure appropriate transfers, interventions, and/or equipment is updated on each resident's plan of care and nursing assignment sheets to reflect current status. All staff will be in serviced on facility policy regarding Fall Prevention and Management, to prevent accidents and ensure residents are transferred according to their plan of care. Charge nurses will round each shift, to ensure fall interventions are in place. UM or designee will conduct rounds 5 times per week times 4, then weekly times 4, the monthly times 3. Rounds will include random observation of resident transfers and fall interventions. Corrective action will be made immediately, up to including disciplinary action if indicated. IDT will review all fall</p>	08/31/2012			

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	<p>During a transfer observation on 8/6/12 at 11:30 a.m., Resident K was in bed with a different Hoyer pad under her. CNA #2 and CNA#5 were in the room at this time and the CNA's indicated the resident had the wrong Hoyer pad when she got up this morning. CNA #5 indicated she did not get the resident up.</p> <p>2. Resident E's record was reviewed on 8/6/12 at 10:30 a.m. Resident E's diagnoses included, but were not limited to, seizure disorder secondary to a head injury, multiple falls and left hemiparesis.</p> <p>At Physical Therapy note on 7/24/12 recommended Resident E be a two person transfer for safety.</p> <p>A physician communication and Progress Note for 7/31/12 at 2:00 p.m., indicated the resident was lowered to the floor. CNA #6 indicated she was giving care to the resident when he told her he was a one person assist. CNA #6 attempted to transfer the resident and "his knees gave out", therefore, was lowered to the floor.</p> <p>A physician order, dated 7/31/12 (no time), indicated the resident was to be a two person transfer with no lift.</p> <p>A Fall/Injury Assessment Care Plan</p>		<p>incidents during DCR daily, M-F, to investigate and provide interventions. Results of audits and incidents will be reviewed monthly in QA. QA committee will identify and address any trends. QA will determine if corrective action or education is indicated.</p> <p>Addendum: UM or designee will perform random observations of nursing assistants providing care to residents on all 3 shifts to ensure fall interventions are in place, and staff are transferring residents according to their plan of care. Monthly monitoring will continue times 5 months, with results reported to QA. Upon review of audits, QA will determine if further education and/or further monitoring is needed. Any identified non-compliance will result in immediate corrective action and one on one education, including progressive disciplinary action up to and including termination.</p>				

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	<p>revised on 7/16/12, indicated interventions on 7/31/12 "Sit to stand per therapy DT (due to) fall", to be transferred with two assist, then a D/C (discontinue) the two assist. An ADL/Mobility Plan of Care on 7/16/12 indicated the resident will be transferred by sit to stand lift.</p> <p>The quarterly MDS (Minimum Data Set) Assessment on 7/15/12, indicated the resident was an extensive, two person physical assist.</p> <p>An interview with LPN #5 indicated the resident was a two person lift to stand and therapy had not written the order to change.</p> <p>An interview with Director of Nursing on 8/7/12 at 4:45 p.m., indicated the CNA assignment sheet indicated the resident was a two person assist.</p> <p>This federal tag relates to Complaint IN 00109380.</p> <p>3.1-45(a)(2)</p>				

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F0514 SS=A	<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 care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to showers being given for 2 of 7 residents reviewed for shower documentation in the sample of 13. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. The record for resident #G was reviewed on 8/6/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, schizophrenia, anxiety, diabetes, and constipation.</p> <p>Review of Bath Type Detail Report for 6/28/12 through 8/6/12 indicated the resident received showers on 6/29/12,</p>	F0514	<p>Clinical records and care plans for residents D and G were reviewed and updated to include interventions regarding showers. Shower schedules were verified for both residents.</p> <p>An audit of all residents shower records will be conducted to ensure documentation of showers is in place for each resident, including indication of refusals and interventions offered. Care plans and nursing assignment sheets will be updated to reflect current status. Nursing staff will be in-serviced on facility policy and procedure regarding documentation standards, to ensure resident clinical records are complete and accurate.</p> <p>UM or designee will audit shower records daily, M-F, times 4 weeks, then weekly times 4, then monthly times 3. Immediate corrective</p>	08/31/2012			

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	<p>7/10/12, 7/17/12, 7/24/12, and 8/3/12. The report indicated the resident refused bathing on 7/31/12 and received bed baths on 7/18/12, 7/23/12, and 7/25/12.</p> <p>When interviewed on 8/7/12 at 5:00 p.m., the DON indicated there was no further documentation of the resident receiving showers.</p> <p>2. Resident D's record was reviewed on 8/6/12 at 11:55 a.m., and Resident D's diagnoses included, but not were not limited to, dementia, stroke with left hemiparesis, and aphasia.</p> <p>On 8/7/12 at 4:30 p.m., the quarterly MDS (Minimum Data Set) Assessment, dated June 4, 2012, was reviewed. The MDS indicated the resident was totally dependent on staff for personal hygiene and bathing.</p> <p>During this time, there was no documentation of Resident D receiving a shower or bath on 5/26/12, 5/30/12, 6/2/12, 6/9/12, 6/13/12, 6/16/12, 6/23/12, 7/4/12, 7/11/12, 7/21/12, and 8/4/12.</p> <p>Interview with the Director of Nursing on 8/7/12 at 5:00 p.m., indicated there was no other documentation indicating the resident received showers on the listed</p>		<p>action and/or education will be provided, up to and including disciplinary action. UM will report results of audits to DON for review in monthly QA meeting. QA committee will identify and address any trends, including determining whether corrective action and/or continued monitoring is indicated.</p>				

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	<p>dates.</p> <p>This federal tag relates to Complaint IN 00109380</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				