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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/07/2014 |
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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 3, 4, 2014 and February 6 and 7, 2014</p> <p>Facility Number: 000186 Provider Number: 155289 AIM Number: 100266300</p> <p>Survey Team: Jason Mench, RN, TC Angela Selleck, RN Kim Davis, RN Julie Dover, RN Tina Smith-Staats, RN</p> <p>Census Bed Type: SNF/NF: 100 Total: 100</p> <p>Census Payor Type: Medicare: 19 Medicaid: 58 Other: 23 Total: 100</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 17, 2014 by Randy Fry</p> | F000000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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| | RN. | | | |

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| F000156 SS=B | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p> | | | | |

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| | <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p> | | | |

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| | <p>and how to receive refunds for previous payments covered by such benefits. Based on observation and interview, the facility failed to ensure the information to notify the Indiana State Department of Health (ISDH) complaint hotline of concerns was posted for 1 of 4 days observed. (2/6/2014)</p> <p>Findings include:</p> <p>On 2/6/14 at 1:30 p.m., during an interview with the Resident Council President she indicated the facility staff had not informed the residents of how to make complaints to the state concerning the care they receive.</p> <p>On 2/6/14 at 1:50 p.m., upon review of the signage the ISDH complaint 800 number was not observed posted.</p> <p>3.1-4(j)(3)</p> | F000156 | Resident Council President has been notified in writing how to make complaints to the state concerning resident care and the location of the information. 800 number has been posted. All other residents have the potential to be affected by the alleged deficient practice. Residing residents will be given the information and its location. Residents/responsible parties will be notified of the posted information on admission. Admission Coordinator will ensure that the information is provided upon admission. Information will also be addressed at each Resident Council and care plan meetings. Social Service to monitor information provided. Compliance to be reviewed at quarterly QA Committee Meetings ongoing. | 03/09/2014 | |

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| F000157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified immediately of an abnormal blood sugar reading of 20 mg/dl</p> | F000157 | The facility is unable to correct the alleged deficient practice for resident #109. All residents have the potential to be affected by the alleged deficient practice. Unit Managers/Designee to audit the | 03/09/2014 | | | |

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| | <p>(milligrams per deciliters for one of one resident reviewed for physician notification (Resident #109).</p> <p>Findings include:</p> <p>The clinical record of Resident #109 was reviewed on 2/6/14 at 2:00 p.m. The record indicated the resident's diagnoses included, but were not limited to, Diabetes. The record indicated, Resident #109's diabetes was treated with insulin injections daily.</p> <p>A nurse's note provided the following information. "Late Entry 1/4/2014, 1:10 a.m. The CNA [certified nursing assistant] on Chestnut called this nurse to assist with resident. Resident was sitting on toilet and kept repeating odd phrases. The resident was moved to her rolling walker and scratched her right shin as she began to lose her balance... Blood sugar 20. The resident was given emergency glucagon. At blood sugar 22, the resident was given orange juice. 0130 blood sugar came up to 42. 0140 blood sugar was 69 and the resident was fully alert to person, place, time, and situation."</p> <p>A nurse's note dated, 1/4/14 at 9:37</p> | | <p>medical record for all residents that are receiving blood sugar monitoring for the last 30 days to ensure no others have been affected by the alleged deficient practice. Physicians will be notified if applicable. DON to in-service Nursing staff regarding timely physician notification of abnormal blood sugars. Unit Managers to audit blood sugars, timely physician notification each business day to ensure that appropriate notifications are occurring and to be discussed daily in the Departmental morning meetings. DON will review the audits weekly for compliance. Results of audits will be reviewed during the QA Committee Meetings quarterly ongoing.</p> | | |

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| F000226 SS=D | <p>a.m., indicated the doctor was notified.</p> <p>Unit Manager #1 was interviewed on 2/7/14 at 10:25 a.m. The manager indicated, the physician was not notified of the 1:10 a.m. abnormal low blood sugar until eight hours later at 9:37 a.m.</p> <p>The facility policy entitled, "Administrative Physician Notification for Change in Condition" , revised on 9/2005, was presented by the Director of Nursing on 2/7/14 at 3:00 p.m. The policy indicated, "... 2. To ensure that medical care problems are communicated to the attending physician in a timely, efficient, and effective manner.... The following symptoms, signs and laboratory values should prompt immediate notification of the physician...2. Signs.... Blood sugar over 250 or under 60...".</p> <p>3.1-5(a)(2)</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.</p> | | | |
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| | <p>Based on interview and record review, the facility failed to ensure a contracted healthcare provider of Dialysis provided Abuse and Neglect training according to the Elder Justice Act for 1 of 1 residents reviewed for Dialysis (Resident #69).</p> <p>Findings include:</p> <p>During an Interview with the Administrator on 2/7/14 at 1:30 p.m., the Administrator indicated the Dialysis Center provided him with a Statement they emailed to him on 2/7/14 at 12:37 p.m.. The Administrator presented the email on 2/7/14 at 1:30 p.m., which indicated;</p> <p>"We do not train staff specific to the Elder Justice Act..."</p> <p>"...In just a quick review of the Elder Justice Act, I don't see that our staff would be covered, as we are not owners, operators, employees, managers, agents, or contractors in any LTC facility..."</p> <p>In the contract with the dialysis center, dated 9/29/09, provided by the DoN on 2/7/14 at 1:41 p.m., no information was covered pertaining to the dialysis center inservicing it's</p> | F000226 | No residents were identified during the survey as being affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice and have been given the required posting information and how to notify the state regarding any resident care issues. Administrator is working with the Dialysis Center to ensure compliance with the Elder Justice Act. All contracted agencies will be reviewed to ensure compliance with the Elder Justice Act. QA tool to be modified to address monitoring and compliance annually. | 03/09/2014 | | | |

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| F000241 SS=D | <p>employees on the prevention of abuse and neglect according to the Elder Justice Act.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review and interview the facility failed to ensure residents were cared for in a dignified manner regarding call light response for 3 of 3 residents interviewed for call light response, 1 of 4 families interviewed for call light response and 4 of 12 months call light response concerns were expressed in Resident Council Minutes. (Residents #47, 54 and 102)</p> <p>Findings include:</p> <p>During an interview with Resident #47 on 2/3/14 at 1:59 p.m., she indicated there was not enough staff to make sure she received the care and assistance without having to wait a long time. Resident #47 stated "tell us they are short of help</p> | F000241 | The facility is unable to correct the alleged deficient practice for residents #47, 54 and 102. All residents have the potential to be affected by the alleged deficient practice. Nursing staff to be in-serviced on appropriate call light response time by the DON/Designee. Call light response time monitoring will be conducted on all shifts daily ongoing. Results of call light response time monitoring will be reviewed at QA Committee Meetings quarterly ongoing. | 03/09/2014 | | | |

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| | <p>sometimes. Now and then. The weather has a lot to do with that."</p> <p>During an interview with Resident #54 on 2/3/14 at 1:32 p.m., she indicated there was not enough staff to make sure she received the care and assistance without having to wait a long time. Resident #54 stated "I think they could use more. Sometimes I have to wait a long time for them to answer the light and has had to wait up to 20 minutes for assistance." She indicated that it was worse on the weekends.</p> <p>During an interview with Resident #102 on 2/3/14 at 2:24 p.m., she indicated there was not enough staff to make sure she received the care and assistance without having to wait a long time. Resident #102 indicated long wait times on getting call lights answered.</p> <p>During a family interview of Resident 102 on 2/6/14 at 1:05 p.m., the family stated "there is not enough staffing to meet resident needs but it does not do any good to complain because they just yell at the staff that are there."</p> <p>During an interview with the Administrator on 2/6/14 at 2:21 p.m.,</p> | | | |

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| | <p>he stated "We have been scheduling a little heavier each year and I know that they look at the PPD (Patient Per Day) to help determine the scheduling.</p> <p>During an interview with the DoN (Director of Nursing) on 2/6/14 at 4:01 p.m., she stated "the scheduling was done according to the census on the unit and whenever we have 100 residents or more we are at full staff... We are based on our census. I would state to the residents we are staffed according to our census. If residents indicated that the facility needed more aides that probably was my response in resident council minutes that we are staffed according to our census."</p> <p>A review of Resident Council Minutes on 2/6/14 at 1:10 p.m. indicated the following:</p> <p>Resident Council Minutes on 5/28/13, indicated call light monitoring on hickory lane was completed. A complaint during Resident Council on 8/16/13 stated "more aides are needed to care for residents." Resident Council Minutes on 8/22/13 indicated the complaint was resolved. On 9/20/13,</p> | | | |

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| F000242 SS=D | <p>in response to the complaint on 8/16/13 the DoN indicated the "Facility is appropriately staffed for census." Resident Council Minutes on 11/21/13 indicated a complaint of long call lights especially after supper. On 12/9/13, in response to complaint the DoN instructed staff to be more observant.</p> <p>During an interview with the Administrator on 2/7/14 at 2:30 p.m., he indicated call light monitoring is performed by the weekend Nurse Manager on Saturdays and Sundays and times are tracked. This is an on going quality assurance check system.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure the resident's preferences for</p> | F000242 | The facility respectfully requests a review of the exhibits accompanying this plan of correction regarding the citation | 03/09/2014 | | | |

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| | <p>bathing and bedtime were followed for 1 of 3 family interviews. (Resident #148)</p> <p>Findings include:</p> <p>On 2/4/14 at 10:20 a.m., during an interview with Resident #148's husband, he indicated the resident doesn't get up or go to bed as she previously had, nor was her showering routine the same. He indicated prior to being placed in facility the resident took showers on a daily basis. He indicated he would be happy with every other day. The husband also indicated she spent more time in bed now.</p> <p>Resident #148's clinical record was reviewed on 2/6/14. The resident's diagnoses included, but were not limited to, cerebral vascular accident. The Minimum Data Set admission assessment, dated 12/25/13, indicated choosing a bed time was somewhat important and choosing between a shower, tub bath, bed bath and sponge bath was somewhat important to this resident.</p> <p>On 2/7/14 at 9:30 a.m., during an interview LPN #8 indicated Resident #148 received two showers per week and was given a bed bath in</p> | | <p>F242. Resident #148's husband was interviewed on 2-4-14 at 10:20 a.m. regarding the time the resident desires to get up, go to bed and bathing frequency. Resident #148's husband is extremely hard of hearing and slightly confused as the result of a stroke and the family is unsure he was able to comprehend the questions accurately. Resident #148's husband completed a choices for resident care form upon admission which identified the times she gets up, goes to bed and bathing frequency. Resident choice questions has been conducted for resident #148 with the Power of Attorney to review the choices. All residents have the potential to be affected by the alleged deficient practice. Resident choice questions will be reviewed for all residents to ensure their choices are being honored by the Unit Managers/Designee. All new admissions to the facility will be interviewed to determine their choices for care. At each care plan meeting the resident choices will be reviewed to ensure no changes are desired. QA tool to be used quarterly to monitor for compliance.</p> | | | | |

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| F000248 SS=D | <p>between as needed. She indicated a reclining shower chair was used for this resident. This resident would also alert staff when she would like to lie down in bed by waving her arm to get attention and would point to her bed.</p> <p>3.1-3(u)(3)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide ongoing activities in accordance with the interest of the resident for 1 of 3 residents reviewed for activities in a sample of 5. (Resident #148)</p> <p>Findings include:</p> <p>On 2/6/14 at 8:40 a.m., Resident #148 was observed with open eyes lying in bed with the head of bed at a less than 30 degree angle. The night stand was observed positioned next the bed behind her head out of the</p> | F000248 | <p>The survey results reflected alleged deficiencies in the areas of activities for a one day observation. No other days were observed for activity participation. Family is very satisfied with the Activity program that has been provided for resident #148. Activity Director has been working with the Therapy Department to continuously identify activities best suited to resident #148's functional and cognitive abilities. Activities staff have provided one to one visits, stop by visits and offered other activities based on resident #148's interest survey. The multiple contacts with resident #148, her family and therapy staff show the activities departments efforts to establish a</p> | 03/09/2014 |

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| | <p>resident's view. A dry erase board with a written date of 2/4/14, pictures of labeled family members, and a Bible were observed on this night stand. The room was quiet with no TV or radio on.</p> <p>On 2/6/14 at 9:54 a.m., Resident #148 was observed resting in bed with eyes closed, lights low, and room quiet.</p> <p>On 2/6/14 at 2:10 p.m., Resident #148 was observed sitting up in high back wheel chair right arm in splint. The TV was on "Brady Bunch", and the picture board for communication was on the over the bed table.</p> <p>On 2/6/14 at 2:40 p.m. Resident # 148 was observed resting in bed with eyes closed.</p> <p>On 2/6/14 at 2:45 p.m., during an Interview the Activities Director indicated 1 on 1 activities were attempted weekly for 20 minutes at a time. Reading the Bible, hand massages, assisting resident with puzzles and writing the alphabet on white board with her left hand were attempted; however, the resident would turn her head or pull her hand away. When activities staff would knock on the resident's door, Resident #148 would start shaking her head negatively, which were marked as a refusal. The Activities</p> | | <p>rapport with resident #148 and continually work to meet the activity needs. An Activity Interest Survey was completed for resident #148 with resident and family input. Activity staff 1:1's were increased to 3x's weekly and activity staff were informed of resident's interest based on Activity Interest Survey. A care plan meeting was held with resident's family on 2/19/14 and family provided information regarding resident's activity likes and dislikes. Activity staff reviewed the activity program currently being provided. Resident #148's care plan was reviewed and updated accordingly. All residents have the potential to be affected by the alleged deficient practice. Activity staff will review each resident's activity interest survey to ensure an ongoing program of activities is provided in accordance with their interests. Activity staff in-serviced regarding providing an activities program designed to meet the interests of each resident. Activity Director or Designee will review participation/ 1:1 records of three residents weekly for eight weeks then monthly to ensure activity needs and interests are met. All findings will be reviewed monthly in Quality Assurance meetings.</p> | | | | |

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| | <p>Director indicated a rapport had not been established with Resident #148.</p> <p>On 2/7/14 at 8:30 a.m., during an interview LPN #8 indicated Resident #148 smiled when her husband spoke Spanish to her. LPN #8 indicated the resident would attempt to speak and was able to shake her head to answer questions in a positive or negative response. This was an improvement to the blinking of her eyes to answer previous questions a few weeks ago.</p> <p>Resident #148's clinical record was reviewed on 2/6/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to, Cerebral Vascular accident.</p> <p>The Minimum Data Set (MDS) assessment, dated 12/25/13, indicated religious activities, reading the Bible, books and magazines as well as gospel music were very important to Resident #148.</p> <p>On 2/6/14 at 8:30 a.m., Resident #148's activity care plan indicated 1 on 1 visits for stimuli and companionship with topics related to past missionary life, spiritual topics and, gentle touch.</p> <p>The activity interest survey record,</p> | | | | |

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| | <p>dated 12/24/13, indicated Resident #148 liked reading the Bible, books, church services, Bible study, gospel music and visiting with friends and family.</p> <p>The activity initial assessment form, dated 12/25/13, indicated Resident #148 attended a local church as well as being a missionary. This form indicated the resident was unable to attend group activities at this time. One on one planned resident's "...activity preferences were unknown at this time."</p> <p>The resident's activity participation record indicated the following: On 1/30/14 Resident #148 did participate in pet therapy when an animal was brought to the resident's room. Resident #148 did not participate in any of the following activities.</p> <p>The scheduled activity calendar for 2/3/14 through 2/7/14 indicated the following: 2/3/14 at 9:30 a.m. Early Bird Exercise; 10:30 a.m. Bingo; 11:30 a.m. Sensory Smiles; 1:05 p.m. Up & At 'Em Exercise; 1:30 p.m. Ladies Outing - Let's Go Out To Eat. 2/4/14 at 9:30 a.m. Early Bird Exercise; 10:30 a.m. Olympic Crafts - Flags of the World &</p> | | | |

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|--------------------|--|---------------|---|----------------------|
| | <p>Torches; 11:30 a.m. Sensory Smiles; 1:00 p.m. Card Club; 1:05 p.m. Up & At 'Em Exercise; 2:00 p.m. Bible Study; 6:45 p.m. Games.</p> <p>2/5/14 at 9:30 a.m. Early Bird Exercise; 10:35 a.m. February IQ; 11:30 a.m. Sensory Smiles; 1:00 p.m. Card Club; 1:05 p.m. Up & At 'Em Exercise; 2:00 p.m. Music; 6:45 p.m. Choir Practice.</p> <p>2/6/14 at 9:30 a.m. Early Bird Exercise; 10:30 a.m. Olympic News & Discussion; 11:30 a.m. Sensory Smiles; 1:05 p.m. Up & At 'Em Exercise; 2:30 p.m. Worship Service; 3:15 p.m. Sweet Memories.</p> <p>2/7/14 at 9:30 a.m. Early Bird Exercise; 10:10 a.m. Manicure Mania; 11:00 a.m. Sensory Smiles; 1:05 p.m. Up & At 'Em Exercise; 1:30 p.m. Men's Outing - Let's Go Out to Eat; 6:30 p.m. Wii Sports - Let's Celebrate the Start of the Olympics</p> <p>3.1-33(a)</p> | | | |

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|--|--|---|---|----------------------|---|
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| F000280 SS=D | <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Pressure Ulcer Care Plan of 1 of 3 residents reviewed for pressure areas was updated to reflect a newly developed pressure sore when the new area developed (Resident #135).</p> <p>Findings include:</p> <p>The Initial Tour was conducted on 2/3/14, beginning at 9:00 a.m. During the tour, Resident #135 was observed in the recliner chair. The resident sat on a thick bath blanket. A pressure reducing cushion</p> | F000280 | Care plan has been updated for resident #135 to reflect the resident's desire to sleep in the recliner as well as the bed. It has also been updated to reflect the current pressure area and need for cushion when out of bed. All residents have the potential to be affected by the alleged deficient practice. An audit has been conducted for all dependent residents to ensure that a cushion is utilized while in a recliner or wheelchair and location of sleep desires have been care planned. Nursing staff will be in-serviced on the placement of a cushion for all residents in recliners or wheelchairs when out of bed by the DON/Designee. | 03/09/2014 | |

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| | <p>(RoHo) was on the resident's wheelchair.</p> <p>The resident was interviewed on 2/3/14 at 10:30 a.m. During the interview, Resident #135 indicated he sat in his recliner most of the day and slept in it most of the night.</p> <p>Certified Nursing Assistant (CNA) #2 was interviewed on 2/4/14 at 8:15 a.m. During the interview the CNA indicated Resident #135 was in the recliner every morning. She indicated she was not sure how long he did sleep in the bed.</p> <p>During an interview with LPN #3 on 2/4/14 at 10:00 a.m., the nurse indicated she thought Resident #135 slept in the bed half the night and recliner chair the last half of the night.</p> <p>The clinical record of Resident #135 was reviewed on 2/4/14 at 10:40 a.m. The record indicated the resident's diagnoses, included, but were not limited to, heart disease, kidney disease, edema, chronic back pain, sleep apnea, and arthritis.</p> <p>The Admission Skin Assessment, dated 12/18/13, indicated, Resident</p> | | <p>Rounds checklist will be utilized each day by DON/Designee to ensure cushion placement in recliners and wheelchairs. Rounds checklist audits will be reviewed during quarterly QA Committee meetings to ensure compliance. This will be ongoing.</p> | | |

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|--|--|---|---|--|--|---|--|
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| | <p>#135 had two pressure sores on admission to the facility. A Suspected Deep Tissue Injury (SDTI) on the coccyx and a Stage Two on the right gluteal fold.</p> <p>The current, Physician orders indicated the pressure sores were treated with a Aquacel foam dressing daily. Vitamin C and Zinc were also administered daily.</p> <p>A skin sheet dated 2/6/14 indicated the resident developed a Stage Two Pressure Area on the Left Gluteal Fold on 1/18/14.</p> <p>The Admission Minimum Data Set Assessment (MDS), dated 12/25/13, indicated the resident required staff assistance for transfers and ambulation. The MDS indicated the resident was continent of urine and bowel.</p> <p>The Care Plan, dated 12/26/13, indicated Resident #135 was at risk for pressure areas due to immobility and pain. The Care Plan interventions included, administration of pain medications, barrier cream, diet, pressure reducing mattress, toilet program, turn and reposition every two hours, and weekly skin assessments.</p> | | | | | | |

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| | <p>On 1/20/14, the Care Plan was updated to include, (Resident's name) was admitted with pressure ulcer to coccyx and right gluteal fold, history of pressure ulcer to coccyx. The Care Plan interventions were updated to include, medications for wound healing, administer and evaluate treatments, weekly wound assessments, family education, diet as ordered, report changes to the physician, and a pressure reducing mattress.</p> <p>The Care Plan did not include the newly developed area to the left gluteal fold a chair cushion, or the resident's routine of sleeping in the recliner.</p> <p>Resident #135 was observed in the recliner chair, with no RoHo cushion in place on the following dates and times:</p> <p>2/3/14 at 9:00 a.m. 2/3/14 at 10:30 a.m. 2/3/14 at 2:30 p.m. 2/3/14 at 4:00 pm 2/4/14 at 8:30 a.m. 2/4/14 at 11:00 am 2/4/14 at 1:15 p.m. 2/4/14 at 4:00 p.m. 2/6/14 at 8:45 a.m.</p> | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>2/6/14 at 4:10 p.m. 2/7/14 at 8:15 a.m. 2/7/14 at 10:00 a.m. 2/7/14 at 1:30 p.m.</p> <p>The Wound Nurse/Assistant Director of Nursing (ADoN) was interviewed on 2/7/14 at 9:20 a.m. The ADoN indicated she did not know how often or how long Resident #135 slept in the recliner at night and the information had not been added to the Care Plan. She indicated the RoHo cushion should be in the resident's recliner when he was sitting in that chair. The nurse indicated she did not monitor to ensure the resident's cushion was on the recliner and not in the wheelchair.</p> <p>The ADoN further indicated CNAs were instructed to report any loose dressings not covering the pressure area,soiled dressings,or missing dressings to the charge nurse when the CNA noted a dressing problem. The nurse indicated she did not monitor daily dressings. She did assess and complete a weekly report.</p> <p>The facility policy, "Wound Prevention and Treatment Protocol", dated 10/10, was presented by the</p> | | | |

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| F000309 SS=D | <p>Nurse Consultant on 2/7/14 at 9:00 a.m. The policy indicated, "... Effective pressure ulcer treatment plan should include: Management of tissue load.... Nursing management during daily rounds needs to observe and monitor that prevention interventions and care plan interventions are actually being done timely....".</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and record review, the facility failed to ensure one of seven residents reviewed for pain management was free of mouth pain from ill fitting dentures (Resident #109).</p> <p>Findings include:</p> <p>Resident was interviewed on 2/4/14 at 8:45 a.m. During the interview,</p> | F000309 | <p>Facility is unable to correct the alleged deficient practice for resident #109. Resident #109 has been seen by the Dentist on 2-18-14 with no recommendations. An oral and pain assessment has been updated to address any potential pain concerns. All other residents have the potential to be affected by the alleged deficient practice. An audit of all residents that have been seen by the Dentist in the last 60 days has been conducted</p> | 03/09/2014 |

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| | <p>the resident indicated she had mouth pain due new dentures. She indicated she had gotten the dentures in December from the facility dental company, but the dentist had not been back.</p> <p>The clinical record of Resident #109 was reviewed on 2/6/14 at 1:00 p.m. A nurse note dated 12/30/13 at 1:00 p.m., indicated the residents dentures were delivered that day, 12/30/13. The note did not include an assessment of the resident.</p> <p>No assessment was included regarding the resident's dentures in the nursing notes.</p> <p>The most current Pain Evaluation was dated, 10/23/13, prior to the dentures. The assessment did not include mouth pain.</p> <p>No Minimum Data Set Assessment had been completed after the new dentures were received on 12/30/13.</p> <p>The Care Plan dated 10/23/13, indicated Resident #109 had a potential for pain related to fracture, muscle spasms, and lumbago. The Care Plan interventions included, assessment, medications, diversional activities, encourage</p> | | <p>to ensure there are no outstanding dental issues. The audit will be reviewed by the DON. Nursing staff has been in-serviced regarding reviewing the dental forms following the dental visit fo any recommendations. When applicable should an oral procedure or replacement of dentures occur a pain and oral assessment will be completed. DON/Designee to review the Dental visit forms to ensure all recommendations have been addressed upon each visit quarterly or as needed visits. RN Consultant to review DON follow up of audits upon visits. QA Committee will review the audits to ensure compliance with Plan of Correction quarterly ongoing.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/07/2014 |
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| | <p>resident to ask for pain medicine, position change, and notify MD if pain medicine is not effective. The Care Plan did not include mouth/denture pain.</p> <p>During an interview with LPN #3 on 2/6/14 at 2:00 p.m., the nurse indicated she had not assessed the resident following the new denture procedure. She was unaware the resident's dentures did not fit properly.</p> <p>During an interview with LPN #4 at 2:05 p.m., on 2/6/14, the nurse indicated he had not assessed Resident #109 following the new denture procedure. He indicated he was unaware she was in pain.</p> <p>The Unit Manager #1 was interviewed on 2/6/14 at 2:20 p.m. The Manager indicated assessments had not been completed following the new denture procedure for Resident #109. The Nurse Manager indicated if an assessment had been completed, the facility would have been aware of the resident's pain.</p> <p>3.1-37(a)</p> | | | | |

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| F000314 SS=G | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to prevent the development of an unstageable pressure ulcer for Resident #64, and to provide services to promote healing of a pressure ulcer for 2 of 3 residents who met the criteria for pressure ulcers (Resident #64 and #135).</p> <p>Findings include:</p> <p>1. During an observation on 2/6/14 at 8:43 a.m., Resident #64 was seated in his high back wheelchair and was wearing brown leather slip-on shoes with white socks.</p> <p>During observation and interview with the DoN on 2/6/14 at 4:08 p.m., Resident #64 was laying in bed with no dressing to the left heel or heel protectors on. Resident #64 had a</p> | F000314 | Resident #135's care plan has been updated to include the area to the gluteal fold, chair cushion and his routine of sleeping in the recliner as well as the bed. The facility is unable to address the previous alleged deficient practice of cushion not in chair and the loose dressing. Resident #64 the facility is unable to correct the alleged deficient practice of no dressing to the heel or missing heel protectors. All residents have the potential to be affected by the alleged deficient practice. All Braden assessments have been reviewed for potential skin issues and addressed when applicable. Shift nursing rounds will be completed ensuring pressure ulcer prevention interventions are being adhered to each shift. Nursing staff will be in-serviced regarding pressure ulcer preventions and notification of the Charge Nurse if any dressings are loose or missing by the DON/Designee. QA Committee to | 03/09/2014 | |

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| | <p>wound to the inner side of his left heel with black eschar (thick leathery necrotic or devitalized tissue, frequently black or brown in color). The DoN indicated the wound to the left heel was the size of a quarter and she needed to check to see why the dressing to his left foot was not on.</p> <p>During an observation on 2/6/14 at 4:18 p.m., the Director of Nursing (DoN) stated to LPN #9, "Resident #64 is to have a treatment to his left heel and needs to be done please." LPN #9 indicated yes.</p> <p>During an observation on 2/7/14 at 8:37 a.m., Resident #64 was seated in his high back wheelchair and was wearing brown leather slip-on shoes with white socks. A blue heel protector was on the dresser beside his bed just inside the door.</p> <p>During observation and interview with LPN #6 on 2/7/14 at 8:41 a.m., Resident #64 was seated in his high back wheelchair and was wearing brown leather slip-on shoes with white socks with his feet rested on the foot rests. LPN #6 stated "Resident does not like to wear the floating boot while he is up in his wheelchair, it would be better if he</p> | | <p>review any concerns with Nursing round audits at quarterly QA meetings ongoing.</p> | | |

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| | <p>did wear it." LPN #6 asked Resident #64 if he would wear his floating boot. Resident #64 nodded his head up and down for yes. LPN #6 placed the heel protector on Resident #64's left foot. Resident #64 rested calmly with the blue heel protector boot on his left foot.</p> <p>During an observation and interview on 2/7/14 at 1:56 p.m., LPN #6 measured the wound to Resident# 64's left heel that was on the inner side of the left heel, circular in shape and was black in color. LPN #6 stated that the wound to left heel measured "2.5 centimeters in length and 2.5 centimeters in width." No depth was indicated.</p> <p>The clinical review for Resident #64 was reviewed on 2/6/14 at 10:35 a.m.</p> <p>Resident #64 had diagnoses which included, but not limited to, late effects Cerebrovascular disease, hemiplegia/hemiparesis due to Cerebrovascular disease, attention to gastrostomy, cognitive deficit, depressive disorder, hypertension, paralysis agitans, essential and other specified forms of tremor, chronic airway obstruction and dementia.</p> | | | | |

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| | <p>The current Physician orders dated 1/22/2014 indicated, " Apply skin prep to left heel and wrap with kerlex daily. Every day shift for wound float heels off of bed."</p> <p>A care plan problem for Resident #64 indicated, "...has a pressure ulcer present to left heel." Interventions related to the care plan problem indicated, "Administer treatments as ordered and assess for effectiveness, initiated 1/23/14."</p> <p>The review of the weekly skin documentation, dated 1/22/14, indicated an Unstageable (Unstageable; "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and /or eschar (tan, brown or black) in the ulcer bed.") pressure ulcer to the left heel with an onset date of 1/22/14 and not present on admission. The length was 2.5 centimeters by 2.5 centimeters width and no depth noted. The description indicated a "black eschar tissue, no drainage, no odor noted."</p> <p>The review of the weekly skin documentation, dated 1/27/14, indicated an Unstageable pressure</p> | | | | | | |

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| | <p>ulcer to the left heel. The length was 2.5 centimeters by 2.5 centimeters width and no depth noted. The description indicated "black eschar remains to left heel..."</p> <p>The review of the weekly skin documentation, dated 2/3/14, indicated an Unstageable pressure ulcer to the left heel. The length was 2.5 centimeters by 2.5 centimeters width and no depth noted. The wound progress description indicated "black eschar remains..." Treatment included "Apply skin prep to left heel and wrap with kerlex daily." "Preventative devices that resident is using this week include: foot/heel protectors, chair or w/c (wheelchair) cushion, skin barrier cream/oint etc..."</p> <p>During an interview with the DoN on 2/6/14 at 3:39 p.m., she stated that Resident #64 was to have heel protectors (float boots) when the resident was up in his wheelchair and to float his heels on a pillow when in bed... "With eschar you want to keep it dry and use skin prep to toughen up the skin a little bit and use gauze wrap to help protect it from the bed linens or slipper socks so it won't get knocked off..."</p> | | | | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>During an interview with the Wound Nurse on 2/7/14 at 9:36 a.m., she indicated it would benefit the Resident #64's wound to the left heel if the resident wore the heel protector while up in his wheelchair as well. She stated "the heel protector/boot would be more beneficial than his shoe or sock. Especially if the treatment is not on the wound then it could inhibit the healing process along with not having the heel protector on as well. I will definitely address that. It's a know better type of thing. The daily treatment to the left heel is to use skin prep and wrap with kerlex."</p> <p>2. The Initial Tour was conducted on 2/3/14, beginning at 9:00 a.m. During the tour, Resident #135 was conserved in the recliner chair. The resident sat on a thick bath blanket. A pressure reducing cushion (RoHo) was on the resident's wheelchair.</p> <p>The resident was interviewed on 2/3/14 at 10:30 a.m. During the interview, Resident #135 indicated he sat in his recliner most of the day and slept in it most of the night.</p> <p>Certified Nursing Assistant (CNA) #2 was interviewed on 2/4/14 at 8:15</p> | | | |

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|--------------------|---|---------------|---|----------------------|
| | <p>a.m. During the interview the CNA indicated Resident #135 was in the recliner every morning. She indicated she was not sure how long he did sleep in the bed.</p> <p>During an interview with LPN # 3 on 2/4/14 at 10:00 a.m., the nurse indicated she thought Resident #135 slept in the bed half the night and recliner chair the last half of the night.</p> <p>The clinical record of Resident #135 was reviewed on 2/4/14 at 10:40 a.m. The record indicated the resident's diagnoses, included, but were not limited to, heart disease, kidney disease, edema, chronic back pain, sleep apnea, and arthritis.</p> <p>The Admission Skin Assessment, dated 12/18/13, indicated, Resident #135 had two pressure sores on admission to the facility. A Suspected Deep Tissue Injury (SDTI) on the coccyx and a Stage Two on the right gluteal fold.</p> <p>The current, Physician orders indicated the pressure sores were treated with a Aquacel foam dressing daily. Vitamin C and Zinc were also administered daily.</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 |
|--|--|

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|--------------------|--|---------------|---|----------------------|
| | <p>A skin sheet dated 2/6/14 indicated the resident developed a Stage Two Pressure Area on the Left Gluteal Fold on 1/18/14.</p> <p>The Admission Minimum Data Set Assessment (MDS), dated 12/25/13, indicated the resident required staff assistance for transfers and ambulation. The MDS indicated the resident was continent of urine and bowel.</p> <p>The Care Plan, dated 12/26/13, indicated Resident #135 was at risk for pressure areas due to immobility and pain. The Care Plan interventions included, administration of pain medications, barrier cream, diet, pressure reducing mattress, toilet program, turn and reposition every two hours, and weekly skin assessments.</p> <p>On 1/20/14, the Care Plan was updated to include, (Resident's name) was admitted with pressure ulcer to coccyx and right gluteal fold, history of pressure ulcer to coccyx. The Care Plan interventions were updated to include, medications for wound healing, administer and evaluate treatments, weekly wound assessments, family education, diet</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 |
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|--------------------|---|---------------|---|----------------------|
| | <p>as ordered, report changes to the physician, and a pressure reducing mattress.</p> <p>The Care Plan did not include the newly developed area to the left gluteal fold, a chair cushion, or the resident's routine of sleeping in the recliner.</p> <p>The personal care of Resident # 135 was observed with CNA #2 on 2/3/14 at 1:45 p.m. The CNA assisted the resident to stand from the toilet. The foam dressing was observed. The dressing was loose in the middle, exposing the Stage two pressure ulcer on the resident's left gluteal fold. The area was observed to be red, open and dry.</p> <p>CNA #2 was interviewed on 2/4/14 at 8:15 a.m. The CNA indicated she noticed the dressing was loose on Resident #135's pressure sore when she helped him on 2/3/14 at 1:45 p.m. The CNA indicated she did not report the loose dressing to the nurse.</p> <p>Resident #135 was observed in the recliner chair, with no RoHo cushion on the following dates and times:</p> <p>2/3/14 at 9:00 a.m.</p> | | | |

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|--|--|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | | |
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| | <p>2/3/14 at 10:30 a.m. 2/3/14 at 2:30 p.m. 2/3/14 at 4:00 p.m. 2/4/14 at 8:30 a.m. 2/4/14 at 11:00 a.m. 2/4/14 at 1:15 p.m. 2/4/14 at 4:00 p.m. 2/6/14 at 8:45 a.m. 2/6/14 at 4:10 p.m. 2/7/14 at 8:15 a.m. 2/7/14 at 10:00 a.m. 2/7/14 at 1:30 p.m.</p> <p>The Wound Nurse/ADoN was interviewed on 2/7/14 at 9:20 a.m. The ADoN indicated she did not know how often or how long Resident #135 slept in the recliner at night and the information had not been added to the Care Plan. She indicated the RoHo cushion should be in the resident's recliner when he was sitting in the chair. The nurse indicated she did not monitor to ensure the resident's cushion was on the recliner and not in the wheelchair.</p> <p>The Wound nurse/ADoN further indicated CNAs were instructed to report any dressings that they observed loose/exposing the pressure sore, soiled, or missing to the charge nurse when the CNA noted a dressing problem. The</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | | |
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| F000328 SS=D | <p>nurse indicated she did not monitor daily dressings. She did assess and complete a weekly report.</p> <p>The facility policy, "Wound Prevention and Treatment Protocol", dated 10/10, was presented by the Nurse Consultant on 2/7/14 at 9:00 a.m. The policy indicated, "... Effective pressure ulcer treatment plan should include: Management of tissue load.... Nursing management during daily rounds needs to observe and monitor that prevention interventions and care plan interventions are actually being done timely....".</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to ensure aseptic technique was</p> | F000328 | The facility is unable to correct the alleged deficient practice for resident #56. Residents requiring Tracheotomy care have the | 03/09/2014 | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | | |
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| | <p>maintained during one of one observation of tracheostomy care/suctioning for one of one resident reviewed for tracheostomy care (Resident #56).</p> <p>Findings include:</p> <p>The clinical record of Resident #56 was reviewed on 2/6/14 at 1:30 p.m. The record indicated the resident's diagnoses include, but were not limited to, Cerebrovascular Disease, Hemiparesis, Respiratory Failure, Pneumonia, heart disease, and neoplasms of the Esophagus and Larynx.</p> <p>The current February 2014 Physician orders, included daily Tracheostomy care, breath sounds four times a day, and suctioning as needed.</p> <p>The Admission Minimum Data Set Assessment (MDS), dated 11/7/13, indicated Resident #56's cognition was intact with a BIMs(Brief Interview for Mental Status) score of 15. The MDS indicated the resident required staff assistance for all Activities of Daily Living and was occasionally incontinent of urine.</p> <p>Tracheostomy care was observed</p> | | <p>potential to be affected by the alleged deficient practice. No other Tracheotomy residents were present in the facility at the time of the survey process. Nursing staff to be in-serviced regarding Tracheotomy care by the DON/Designee and conducted annually thereafter. DON/Designee to conduct Tracheotomy care observations 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks. Random Tracheotomy care observations will continue ongoing 1 time a month ongoing determined by the QA Committee. QA Committee will review the audit observations and after the 12 week period if no concerns are identified the observation audits will continue randomly monthly thereafter ongoing.</p> | | | | |

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| | <p>on 2/7/14 at 9:30 a.m. with LPN #3. Upon entrance to the room, a urinal, one third full of urine, was observed on the bedside table with two bottles of undated sterile water and some of the resident's personal items. LPN #3 put the sterile supplies on the table next to the urinal. She took the urinal into the bathroom to empty. While in the bathroom, the LPN #3 washed her hands for ten seconds and donned gloves.</p> <p>Without cleaning the bedside table or putting down a clean barrier, LPN #3 opened her supplies on top of the area where the urinal had been. LPN #3 opened a new bottle of sterile water and poured some into the disposable carton supplied in the sterile tracheostomy kit.</p> <p>LPN #3 reached across the resident, turned on the suction machine and handed the suction tubing to the resident. The LPN #3 then cleaned around the tracheostomy site.</p> <p>With the gloves on, LPN #3 reached into her uniform pocket, pulled out a small device to check the resident's oxygen level and put it on the resident's finger. She continued to clean the tracheostomy site.</p> | | | |

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| | <p>LPN #3 opened the sterile glove package on the bedside table. She suctioned the tracheostomy, and cleaned the area with a Q-Tip from the tracheostomy kit on the bedside table, and checked the resident's oxygen saturations with the device on the resident's finger.</p> <p>LPN #3 removed her gloves, closed the sterile water container on the bedside table and washed her hands for nine seconds.</p> <p>LPN #3 then listened to the resident's lung sounds with her stethoscope, picked up a large syringe used for administering gastrostomy tube medications and the carton she had poured the sterile water into from the bedside table, and took it into the bathroom.</p> <p>LPN #3 took the oxygen saturation device off the resident's finger and put it back into her pocket, and gathered the remainder of supplies.</p> <p>LPN #3 indicated she did not know how long the two bottles of sterile water had been left on the bedside table since they were not dated. She discarded the bottles, leaving only the clean bottle she had brought in and put on the bedside table next to the urinal.</p> | | | |

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| | <p>The facility "Tracheostomy Suctioning" Policy, revised 7/2012, was presented by Unit Manager # 1 on 2/7/14 at 10:00 a.m.</p> <p>The policy indicated, "...PROCEDURE: The respiratory therapist/nurse will complete the following when suctioning a tracheostomy... A. Practice Standard Precautions.... E- Wash hands thoroughly..."</p> <p>The facility policy entitled "Handwashing", revised 4/2012, was presented by Unit Manager #1 on 2/7/14 at 10:00 a.m. The policy indicated, "...1- Wet hands with water. Leave water running. 2- Apply soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly and up to wrist for 20 seconds..."</p> <p>3.1-47(a)(4) 3.1-47(a)(5)</p> | | | | | | |

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| F000329 SS=D | <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the effectiveness of diuretics was monitored for 1 of five residents reviewed for unnecessary medications (Resident #135).</p> <p>Findings include:</p> <p>The clinical record of Resident #135 was reviewed on 2/4/14 at 10:40 a.m. The record indicated the resident's diagnoses, included, but</p> | F000329 | The tag alleges that the resident was not being monitored for the diuretic therapy. The facility along with the Primary Physician and Pharmacy Consultant feel that this was inappropriately cited. Treatment record for diuretics to include monitoring for any increase in chronic edema for resident #135 has been added. All other residents with a diagnosis of chronic edema have the potential to be affected by the alleged deficient practice. An audit for the last 30 days for residents with a diagnosis of chronic edema | 03/09/2014 | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | | |
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| | <p>were not limited to, heart disease, edema, kidney disease, chronic back pain, sleep apnea, and arthritis. The current February 2014 physician orders were reviewed. The orders included two diuretics, (water pills) for edema. Lasix was administered two times a day, 80 milligrams (mgs) in the morning and 40 mgs in the afternoon, and 5 mgs of Metolazone was administered on Monday, Wednesday and Friday mornings 1/2 hour before the Lasix.</p> <p>The physician orders included an order for weekly weights originally dated 1/9/14.</p> <p>There was no physician order for a planned weight loss.</p> <p>The January and February 2014 Medication Administration Record and Treatment Record did not include monitoring for edema or weight gain.</p> <p>The consultant Pharmacist review, dated 1/29/14, indicated no irregularities and no recommendations.</p> <p>A Nutrition at Risk (NAR) committee report dated 1/5/14, included a five pound weight gain in one week.</p> | | <p>will be conducted to ensure that no other resident has been affected by the alleged deficient practice. Treatment records will be updated to include monitoring of increased edema for those with the diagnosis. A diagnosis review will be conducted by the DON/Designee upon admission and any new diagnosis of chronic edema orders obtained. Diagnosis orders will be reviewed for new admissions and any new orders for existing residents in the Departmental morning meeting. QA Committee will review the morning meeting record to ensure the diagnoses are being discussed each day quarterly ongoing.</p> | | | | |

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| | <p>The last family physician progress note dated, 1/8/14, indicated the resident had edema.</p> <p>The Care Plan dated 12/26/13, included, "... Alteration in ADL [activities of daily living] r/t [related to] impaired mobility, edema X 4 extremities, pain, and weakness.". The Care Plan interventions included, "... Observe for/document/report to MD, PRN [as needed] any changes, any potential for improvement, reasons for self care deficit, expected course, declines in function...".</p> <p>The resident visited the cardiologist on 1/28/14. Included in the cardiologist report were home instructions. The instructions indicated to weigh at the same time everyday. Call the office if a three pound weight gain in two to three days was noted. Call the doctor if there was increased swelling in the legs.</p> <p>Further review of Resident #135's clinical record, indicated no daily monitoring of weight or edema.</p> <p>Unit Manager #1 was interviewed on 2/7/14 at 1:45 p.m. The Unit</p> | | | |

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| | <p>Manager indicated the Cardiology Home Instructions were added to Resident #135's clinical record in error. She indicated the resident is weighed only weekly. The Unit Manager further indicated the only monitoring of the resident's weight and edema is documented in the Weekly Skin Observations. She presented a Skin Observation form dated 2/4/14. The form indicated edema of the resident's hands and legs. There was no documentation of follow up with the family doctor or cardiologist in the clinical record.</p> <p>3.1-48(a)(3)</p> | | | |

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| F000334 SS=D | <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | | |
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| | <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on interview and record review, the facility failed to provide evidence of annual informed consents for the influenza vaccine for 3 of 5 residents reviewed. (Resident #48, Resident #68 and Resident #78).</p> <p>Findings include:</p> <p>1. The record review for Resident #48 on 2/7/14 at 9:00 a.m., indicated the most current consent for the pneumococcal and influenza vaccine was dated 9/15/09. The medical record indicated Resident</p> | F000334 | The facility has updated the immunization consents forms for residents #48, 68 and 78. The facility has conducted and audit of consent forms to ensure no other residents have been affected by the alleged deficient practice and consent forms will be signed with the correct verbiage if applicable. Consent forms with the verbiage annually will be utilized for all future admission to the facility. Medical Records Coordinator will review all signed consent forms to ensure the verbiage annually is contained in the form. DON/Designee to review the appropriate form when conducting admission chart | 03/09/2014 | | | |

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| NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953 | | |
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| | <p>#48 received the influenza vaccine on 10/8/13.</p> <p>2. The record review for Resident #68 on 2/7/14 at 8:24 a.m., indicated the most current consent for the pneumococcal and influenza vaccine was dated 6/1/09. The medical record indicated Resident #68 received the influenza vaccine on 10/7/13.</p> <p>3. The record review for Resident #78 on 2/7/14 at 8:53 a.m., indicated the most current consent for the pneumococcal and influenza vaccine was dated 8/27/12. The medical record indicated Resident #78 received the influenza vaccine on 10/7/13.</p> <p>5. During an interview on 2/7/14 at 9:33 a.m., with the Director of Nursing, the three different immunization consent forms in use were reviewed. One of the consent forms indicated the resident and or Power of Attorney/guardian were consenting for an annual vaccination. The Director of Nursing indicated that she sent new consents out annually to anyone who had refused the vaccine the previous year. She further indicated the consents were not obtained</p> | | <p>audits for new admissions. DON/Designee will audit the forms annually before administration of influenza vaccine for the correct verbiage. QA Committee will review the audits conducted by the DON prior to the administration of the flu vaccine annually.</p> | | |

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| F000412 SS=D | <p>annually.</p> <p>Review of the current undated immunization policy entitled "Policy for Influenza Vaccine of Residents", provided by the Director of Nursing on 2/7/14 at 9:33 a.m., included but was not limited to, the following:</p> <p>"...PROCEDURE... Obtain written, informed consent from resident; this should be included on admission..."</p> <p>3.1-18(b)(5)</p> <p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview and record review, the facility failed to assess a resident's dental needs and failed to ensure care was provided for 1 of 3 residents reviewed for dental care in a sample of 7.</p> | F000412 | The facility is unable to correct the alleged deficient practice for resident #125. Resident has been seen by the facility dentist on February of this year. Oral assessment has been updated. All other residents have the potential to be affected by the alleged | 03/09/2014 | |

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| | <p>(Resident #125)</p> <p>Findings include:</p> <p>On 2/3/14 at 2:30 p.m., during a resident interview, Resident #125 was observed removing his bottom dentures prior to the resident interview. Resident #125 indicated he would be better understood with the dentures out because they didn't fit well. He also indicated he had mouth pain and difficulty chewing. On 2/6/14 at 4:20 p.m., during an interview Resident #125 indicated he has had his dentures probably 50 years and they have been ill fitting for 4 years. He also indicated he had been at the facility for a year, and he and his daughter had notified staff.</p> <p>Resident #125's clinical record was reviewed on 2/6/14 at 9:45 a.m. The resident's diagnoses included, but were not limited to, hypertension, hyperlipidemia, arthritis and hip fracture. The significant change Minimum Data Set (MDS) assessment, dated 11/22/13, indicated the resident's height was 67 inches and weight was 132 pounds. The resident was not on a prescribed weight loss program. The resident required extensive assist of 1 person with his personal</p> | | <p>deficient practice. Oral assessments for the residents have been updated and any concerns will be addressed with the Dentist if applicable. Nursing staff will be in-serviced to promptly notify the Charge Nurse of any resident voicing dental issues by the DON/Designee. When a resident refuses a dental visit quarterly and has voiced a concern the Facility Prime Source Dental Scheduler will place the resident on a list to be seen for the next month. Facility Prime Source Scheduler will notify the Dentist of an as needed for the next month. A list of residents will be given to the DON as to who did or did not see the Dentist for the quarterly visit and the DON to follow up with the Dental Scheduler for potential resident placement on a list for the next month. QA Committee to review the resident list of resident refusals to ensure appropriate follow up is occurring quarterly ongoing.</p> | | |

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| | <p>hygiene. The admission MDS, dated 8/9/2013, indicated the resident's height was 67 inches and weight was 142 pounds with no information related to dentures and/or chewing problems.</p> <p>The nurse's notes indicated on 10/28/13 the resident refused a dental visit with no reason given. No other dental visit had been made. The nurses note on 1/3/14 at 2:29 p.m. indicated no chewing or swallowing problems noted.</p> <p>Resident #125's weights were as follows: 1/7/14 - 134; 12/12/13 - 133; 12/5/13 - 133; 12/3/13 - 133; 11/27/13 - 132; 11/21/13 - 132; 11/14/13 - 133; 11/7/13 - 132; 11/5/13 - 133; 10/24/13 - 143; 10/17/13 - 141; 10/10/13 - 142; 10/3/13 - 144.</p> <p>3.1-24(a)(1)</p> | | | | |

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| F000431 SS=E | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure treatments were labeled and, expired medications destroyed, and</p> | F000431 | The facility is unable to correct the alleged deficient practice. No residents were identified during the survey process. All residents have the potential to be affected | 03/09/2014 |

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| | <p>nutritional supplements were stored according to the manufacture's directions for two of two medication rooms and two of four treatment carts observed.</p> <p>Findings include:</p> <p>The Redbud Court/Hickory Lane Medication Room was observed on 2/7/14 beginning at 8:45 a.m., with LPN #5. The refrigerator temperature log on the outside of the refrigerator indicated the temperature was 42 degrees on 2/7/14. The thermometer on the inside of the refrigerator indicated a temperature of 24 degrees. No medications or supplements were found to be frozen in the refrigerator.</p> <p>On the bottom shelf of the refrigerator was a tray of 16, undated, thawed health shakes. The health shake label indicated;</p> <p>"... Storage and Handling. Store frozen. Thaw under refrigeration 40 degrees or below. After thawing,keep refrigerated. Use within 14 days of thawing. Date thawed _____".</p> <p>LPN #5 was interviewed on 2/7/14 at 8:50 am. LPN #5 indicated she was</p> | | <p>by the alleged deficient practice.Nursing staff/Dietary staff will be in-serviced regarding the storage and dating of health shakes when thawed. Dietary will date each health shake with the date it was removed from the freezer to thaw. Nursing staff in addition will be in-serviced regarding comingling of medications, the need to place treatments in a bag or keep in a separate compartment, properly labeled treatments and the disposal of expired medications. Unit Managers will audit treatment carts to ensure all items are stored appropriately, labeled, Nurse compliance with disposal of medications, refrigerator temperatures and dating of health shakes. This will be completed weekly ongoing. DON to review audits after completion weekly ongoing.QA Committee to review completed audits for any needed revision quarterly ongoing.</p> | | | | |

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| | <p>uncertain as to when all the shakes were put into the refrigerator.</p> <p>The Hickory Lane treatment cart was observed in the Medication Room. Three tubes of cream were commingled in one area of the cart. The used tubes were not separated by bags, boxes, or any other type of barrier. They had no resident name on any of the three tubes.</p> <p>The Hickory Lane medication cart was observed on 2/7/14 at 8:55 a.m. A plastic box was on top of the cart. The box contained three strawberry health shakes and one opened can of Ensure covered by a disposable glove.</p> <p>At 9:00 a.m. on 2/7/14, LPN #6 inserted a thermometer into one of the health shakes. The temperature of the shake registered 59 degrees.</p> <p>LPN #6 was interviewed on 2/7/14 at 9:00 a.m. LPN #6 indicated the shake was warm and had been on top of the medication cart since 7:30 a.m.</p> <p>The Dietary Manager (CDM) was interviewed on 2/7/14 at 2:30 p.m. The CDM indicated the nursing staff normally went to the kitchen to</p> | | | | |

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| | <p>request the health shakes as they were needed. The CDM indicated the health shakes were stored frozen in the kitchen, but were not dated when they were taken out of the freezer.</p> <p>The Chestnut Lane/Walnut Creek medication room was observed with QUAPI (Quality Assurance Performance Improvement) Nurse #7 on 2/7/14 at 10:25 a.m.</p> <p>Five vials of Lasix were observed in a bag, in a cupboard over the sink. According to the label on the outside of the bag, the medication expired on 2/1/14.</p> <p>QUAPI nurse #7 was interviewed on 2/7/14 at 10:26 a.m. She indicated the medication was pulled from the emergency drug kit by the pharmacy tech because it had expired. QUAPI nurse #7 indicated the medication should have been destroyed. QUAPI nurse #7 indicated she did not know why the medication was in the cupboard.</p> <p>The Walnut Creek treatment cart was observed with LPN #8 on 2/7/14 at 10:30 a.m. Two small bottles of powder, with two different resident names were observed in the same</p> | | | | |

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| | <p>open boxed area of the cart. Beside this small area was a larger area which contained eight tubes of cream. These used creams had no resident names on them and were not dated. In the same square area was one expired treatment with a discharged resident's name on it.</p> <p>LPN #8 was interviewed on 2/7/14 at 10:31 a.m. LPN #8 indicated that is how the treatments are stored in the carts. The nurse indicated the expired treatment should have been destroyed.</p> <p>The nurse consultant was interviewed on 2/7/14 at 1:45 p.m. The nurse consultant indicated the facility's consultant pharmacist had instructed the facility staff that treatments could be stored together if they were in separate baggies.</p> <p>3.1-25(m)(o)</p> | | | |

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| F000441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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 prevent the spread of infection, the facility must isolate the resident. (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. (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, interview, and record review, the facility failed</p> | F000441 | Facility is unable to correct the alleged deficient practice for | 03/09/2014 | | | |

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| | <p>to ensure hand washing was completed for 20 seconds by one of one nurse observed during one of one observation of tracheostomy/suction care for one of one resident reviewed for tracheostomy care (Resident #56) (LPN #3).</p> <p>Findings include:</p> <p>The clinical record of Resident #56 was reviewed on 2/6/14 at 1:30 p.m. The record indicated the resident's diagnoses included, but were not limited to, Cerebrovascular Disease, Hemiparesis, Respiratory Failure, Pneumonia, heart disease, and neoplasms of the Esophagus and Larynx.</p> <p>The current February 2014 Physician orders, included daily Tracheostomy care, breath sounds four times a day, and suctioning as needed.</p> <p>The Admission Minimum Data Set Assessment (MDS), dated 11/7/13, indicated Resident #56's cognition was in tact with a BIMs (Brief Interview for Mental Status) score of 15. The MDS indicated the resident required staff assistance for all Activities of Daily Living and was</p> | | <p>resident #56. Residents utilizing a tracheotomy have the potential to be affected by the alleged deficient practice. No other residents were residing in the building at the time of the alleged deficient practice. Nursing staff to be in-serviced regarding tracheotomy care, appropriate preparation of the surface to be used and proper hand washing technique by the DON/Designee and annually thereafter. DON/Designee to conduct tracheotomy care observations 3 times a week for 4 weeks, 2 times a week for 4 weeks, 1 time a week for 4 weeks. Random monthly tracheotomy care observations will continue monthly ongoing upon the QA review. QA Committee will review the audit observations after the 12 week period if no concerns are identified the observation audits will continue randomly each month depending on tracheotomy availability thereafter ongoing</p> | | |

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| | <p>occasionally incontinent of urine.</p> <p>Tracheostomy care was observed on 2/7/14 at 9:30 a.m. with LPN #3. Upon entrance to the room, a urinal, one third full of urine, was observed on the bedside table with two bottles of undated sterile water and some of the resident's personal items. LPN #3 put the sterile supplies on the table next to the urinal. She picked up the urinal, took it into the bathroom and emptied it. LPN #3 washed her hands for ten seconds in the bathroom sink and donned gloves.</p> <p>Without cleaning the bedside table or putting down a clean barrier, LPN #3 opened her supplies on top of the area where the urinal had sat. LPN #3 opened a new bottle of sterile water and poured some into the disposable carton supplied in the sterile tracheostomy kit.</p> <p>LPN #3 reached across the resident, turned on the suction machine and handed the suction tubing to the resident. LPN #3 then cleaned around the tracheostomy site.</p> <p>With the gloves on, LPN #3 reached into her uniform pocket, pulled out a small device to check the resident's</p> | | | | | | |

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| | <p>oxygen level and put it on his finger. She then continued to clean the tracheostomy site.</p> <p>LPN #3 then opened the sterile glove package laying on the bedside table. She suctioned the tracheostomy, and cleaned the area with a Q-Tip from the tracheostomy kit laying on the bedside table, and checked the resident's oxygen saturations with the device on the resident's finger.</p> <p>LPN #3 removed her gloves, closed the sterile water container on the bedside table walked into the bathroom, and washed her hands for nine seconds.</p> <p>LPN #3 then listened to the resident's lung sounds with her stethoscope, picked up a large syringe used for administering gastrostomy tube medications and the carton she had poured the sterile water into from the bedside table, and took it into the bathroom.</p> <p>LPN #3 took the oxygen saturation device off the resident's finger and put it back into her pocket, and gathered the remainder of supplies.</p> <p>LPN #3 indicated she did not know how long the two bottles of sterile</p> | | | | |

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| | <p>water had been left on the bedside table since they were not dated. She discarded the bottles, leaving only the clean bottle she had brought in and put on the bedside table next to the urinal.</p> <p>The facility "Tracheostomy Suctioning" Policy, revised 7/2012, was presented by Unit Manager #1 on 2/7/14 at 10:00 a.m. The policy indicated, PROCEDURE: The respiratory therapist/nurse will complete the following when suctioning a tracheostomy. A. Practice Standard Precautions.... E- Wash hands thoroughly...</p> <p>The facility policy entitled "Handwashing", revised 4/2012, was presented by Unit Manager #1 on 2/7/14 at 10:00 a.m. The policy indicated, "...1- Wet hands with water. Leave water running. 2- Apply soap. Using friction, rub hands together, cleaning under nails and between fingers thoroughly and up to wrist for 20 seconds..."</p> <p>3-1-18(l)</p> | | | | | | |