

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155531	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2014
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NAME OF PROVIDER OR SUPPLIER OAKBROOK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 850 ASH ST HUNTINGTON, IN 46750
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F000000	<p>This visit was for the Investigation of Complaint IN00158958.</p> <p>Complaint IN00158959 - Substantiated. Federal/State deficiency related to the allegation was cited at F314.</p> <p>Survey dates: November 13 and 14, 2014.</p> <p>Facility number: 000569 Provider number: 155531 AIM number: 10026766</p> <p>Survey team: Shelley Reed, RN TC</p> <p>Census bed type: SNF/NF: 30 Total : 30</p> <p>Census payor type: Medicare: 3 Medicaid: 23 Other: 4 Total: 30</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	
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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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F000314 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <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 interview and record review, the facility failed to ensure skin assessments were completed to prevent the development of a pressure sore for 2 of 4 residents reviewed for pressure sores. (Resident B and D)</p> <p>Findings Include:</p> <p>1. The clinical record of Resident (B) was reviewed on 11/13/14 at 10:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, end stage renal disease, dialysis, fracture of the tibia and fibula, diabetes mellitus and anemia.</p>	F000314	<p>F314</p> <p>1. Skin assessments are being completed on a weekly basis for Resident B and Resident D to allow the facility to provide necessary treatment and services to promote healing and prevent infection.</p> <p>2. All other residents are at risk for the alleged deficient practice. A head to toe skin assessment was initially completed and if areas were noted, the MD and POA were notified. Skin assessments are being completed on a routine weekly basis.</p> <p>3. The facility's policy for Skin Management has been reviewed and no changes are indicated at this time</p>	11/24/2014

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	<p>The facility document entitled, "Admission/Re-admission Resident Assessment", dated 8/22/14, indicated Resident (B) had multiple bruises on his right arm, a fistula on his left upper arm and partial amputation on his right foot. The note indicated the resident's skin was dry and warm.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 9/4/14, indicated Resident (B) was not at risk to develop pressure sores and did not currently have any pressure sores.</p> <p>The 5-day MDS assessment, dated 9/11/14, indicated Resident (B) was at risk to develop pressure sores and had 1-stage 2 and 2 unstageable pressure areas on admission. The largest area measured 2.1 cm [centimeters] x 2.4 cm.</p> <p>The facility documentation entitled, "Initial Pressure Ulcer Assessment", dated 9/5/14, indicated a 3.3 cm x 2.4 cm, unstageable pressure area to the back, right heel. The wound bed was dark brown-black with pale pink edges.</p> <p>Another "Initial Pressure Ulcer Assessment", dated 11/2/14, indicated a 4.0 cm x 2.5 cm x <[less than] 0.1 cm stage 2 pressure sore to the coccyx area.</p>		<p>(See Attachment A). The nursing staff have been re-educated on the policy with special focus on completing weekly skin assessments on all residents (See Attachment B). A weekly auditing tool has been implemented (See Attachment C).</p> <p>4. The DON or designee will complete the weekly auditing tool to ensure skin assessments have been completed on scheduled work days as follows: Weekly for 2 months, every other week for 2 months, then monthly thereafter on an ongoing basis. Should a problem be found, immediate corrective action will occur. Results of these reviews and any corrective action will be reviewed during the facility's quarterly QA meetings and the plan adjusted as indicated.</p>	

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	<p>The wound bed and edges were red in color.</p> <p>Review of a current care plan, dated 9/5/14 and updated 11/2/14, indicated Resident (B) had a problem with a pressure area to his left foot. The three wounds measured 1.4 cm x 0.3 cm, 3.3 cm x 2.4 cm and 1.4 cm x 1.2 cm. The interventions included, but were not limited to, "daily skin inspections by nursing assistant, head to toe skin assessments by licensed nurse weekly and PRN [when necessary]."</p> <p>Another care plan, dated 9/10/14 and updated 9/11/14, indicated Resident (B) was at risk for the development of pressure ulcers due to: incontinent of bowel and bladder, limited ROM [Range of Motion], dialysis and fracture of tibia/fibula with cast blind. The interventions included, but were not limited to, "head to toe skin assessment at least weekly by licensed nurse, staff to observe skin condition while providing care and notify the charge nurse of any skin problems for further assessment and possible MD [Medical Doctor] and responsible party notification."</p> <p>2. The clinical record for Resident (D) was reviewed on 11/14/14 at 8:45 a.m. The resident's diagnoses included, but</p>			

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	<p>were not limited to, anemia, hypertension, congestive heart failure, asthma and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, dated 7/30/14, indicated Resident (C) was at risk to develop pressure sores and did not currently have any pressure sores.</p> <p>The facility document entitled, "Initial Pressure Ulcer Assessment", dated 7/31/14, indicated Resident (D) had a 0.5 cm x 0.3 cm x 0.1 cm, stage 2 pressure sore on her coccyx. The wound bed was white with pink edges.</p> <p>Review of the "Weekly Skin Assessment" sheets, indicated no skin assessment was found for May 31, July 12 or July 26, 2014.</p> <p>Review of a current care plan, dated 6/25/14 and updated 11/12/14, indicated Resident (D) had a problem related to the risk of development of pressure ulcers due to physical limitation, neuropathy and urinary incontinence. The interventions included, but were not limited to, "head to toe skin assessments at least weekly by a licensed nurse, staff to observe skin condition while providing care and notify the charge nurse of any skin problems for further assessment and</p>			

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	<p>possible MD [Medical Doctor] and responsible party notification."</p> <p>3. During an interview on 11/13/14 at 9:30 a.m., the Director of Nursing (DON) indicated she had been in the facility approximately 3 weeks. She indicated the skin assessments were not being done routinely prior to her starting her position. She indicated, since starting, she had done a facility wide skin assessment on each resident. She indicated the previous wound nurse no longer worked at the facility.</p> <p>During an interview on 11/13/14 at 2:00 p.m., the Corporate Nurse indicated the 5-day MDS assessment for Resident (B) was wrong and the resident was not admitted with a pressure sore, but it developed while in the facility.</p> <p>During an interview on 11/14/14 at 9:30 a.m., the Director of Nursing (DON) indicated she could not find any additional skin assessments for August for Resident (B).</p> <p>3.1-40(a)(1)</p>			