

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
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F000000	<p>This survey was for the Investigation of Complaint IN00157720.</p> <p>Complaint IN00157720 - Substantiated. Federal/State deficiencies related to the allegations are cited F272, F279, F309, F314 and F323.</p> <p>Survey dates: October 15-16, 2014</p> <p>Facility number: 000124 Provider number: 155219 AIM number: 100266730</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 18 Medicaid: 68 Other: 10 Total: 96</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. <b>This facility requests a desk review for paper compliance for all.</b></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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F000272 SS=D	<p>Quality Review completed on October 24, 2014, by Brenda Meredith, R.N.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in</p>			

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	<p><b>assessment.</b></p> <p>Based on record review and interview, the facility failed to provide an accurate Admission assessment on a totally dependent resident who developed a Stage II pressure ulcer for 1 of 5 residents reviewed for assessments in a sample of 5. (Resident "D")</p> <p>Finding includes:</p> <p>During the initial tour, accompanied by the DNS (Director Nursing Services), on 10/15/14 between 9:00 a.m. and 9:30 a.m., Resident "D" was identified as having an open area on his (L) (Left) heel. The DNS indicated the area was thought to be present on admission and "missed" on the admission assessment. The area was further described as a large blister which had opened and continued to heal.</p> <p>The record of Resident "D" was reviewed on 10/15/14 at 11:00 a.m. Resident "D" was admitted to the facility, on 09/11/14, with diagnoses including but not limited to, CP (Cerebral Palsy), bradycardia (slow heart rate), chronic CO2 retention, diabetes, COPD (Chronic Obstructive Pulmonary Disease), and hypothermia (low body temperature).</p> <p>The Admission MDS assessment</p>	F000272	<p><b>F272:</b> It is the practice of this facility to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p><b>Affected Resident:</b> Resident D's physician was notified of area to left heel on 9/16/14 and treatment order was obtained. Area has since healed. A head to toe skin assessment has been completed to ensure no other areas were identified. <b>Resident's shaving the potential to be affected:</b> All residents have had a skin assessment completed to ensure identified areas have been assessed, documented a treatment in place and a care plan that addresses any skin issue.</p> <p><b>Systemic Changes:</b> Licensed nurses have been re-educated on facility Policy and Procedure as it relates to accurate completion of Nursing Admission Information, in addition licensed nurses have been re-educated on conducting resident skin assessments and identification of pressure ulcers. <b>Monitoring:</b> A Performance Improvement tool has been developed that will monitor accuracy of Nursing Admission Information, along with appropriate pressure ulcer identification PI tool will include skin assessment completed and validated by 2 nurses. UM/SDC/DON or</p>	11/15/2014			

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	<p>(Minimum Data Set: a tool to assist staff in planning care), dated 09/18/14, indicated Resident "D" was not cognitively intact and appropriate for interview, required extensive assistance of 2 or more for changing position in bed, toileting and hygiene. The resident was totally dependent and required 2 or more for wheelchair placement, dressing, and bathing. The resident had a G-tube (gastrostomy tube: tube inserted in abdomen to provide liquid nourishment/feedings.) and was incontinent of bowel and bladder.</p> <p>The "NURSING ADMISSION INFORMATION" form, dated 09/11/14 at 10:30 p.m., indicated Resident "D" was totally dependent for 1-2 staff for all care needs. The BRADEN Scale (for predicting pressure sore risk), indicated the resident was at moderate risk for developing skin issues and the skin evaluation for skin assessment noted the G-tube site insertion site. There was no documentation related to a heel wound.</p> <p>The "INTERIM PLAN OF CARE (Developed On Admission)", dated 09/11/14, indicated: "PROBLEM: Alteration in skin integrity: ...Potential" was checked. "GOAL(s): Will not develop skin breakdown...</p>		designee will review audit tools weekly. Results will be reviewed in PI Meeting monthly x 6 months to ensure compliance. Recommendations for further follow up and/or resolution will be made at end of the 6 months. <b>CompletedBy:</b> November 15, 2014	

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	<p>Skin assessment weekly Pressure reducing mattress... Incontinence care as needed T&amp;P [Turn &amp; Position] or reposition q [every] 2 hours Chair cushion to chair when OOB [Out Of Bed]..." were all checked as interventions. A choice area, "Heel floating device used" was not checked and no reference to a heel blister was noted.</p> <p>Review of NURSE'S NOTES did not refer to any skin issues, from 09/11/14 through 09/15/14.</p> <p>A NURSE'S NOTE indicated: "09/16/14 0720 [7:20 a.m.] Approx [approximately] 5:30 a.m. CNA notified this writer resident had an open area on his (L) [Left] heel. Upon entering room, resident was lying on his (L) side. (L) heel has an open area measurements 7 x 6 cm [centimeters]. Appears to be a blister that opened. Skin was peeled back red tissue min [minimum] amount of reddish/clear drainage noted. MD [Medical Doctor] notified left message on VM [Voice Mail] request order for tx [treatment] awaiting response...."</p> <p>A "Pressure Ulcer Care Plan" and a "PRESSURE ULCER RECORD [PUR]" was initiated on 09/16/14. The Pressure</p>			

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	<p>Ulcer Care Plan indicated: "Problem: Stage II [2] to left heel 2* [secondary] blister...." The PUR indicated the wound as a "STAGE II- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister."</p> <p>On 10/16/14, at 8:50 a.m., the Clinical Education Nurse provided a Policy &amp; Procedure, titled, "Resident Examination and Assessment: 2013," which indicated: "Purpose: The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan.</p> <p>Preparation: 1. Review the resident's admission assessment and/or preliminary care plan to assess for any special situations regarding the resident's care...</p> <p>Steps in the Procedure: ...h. Skin: (1) intactness; (2) moisture; (3) color; (4) texture; and (5) presence of bruises, pressure sores, redness, edema, rashes...."</p> <p>Reporting: ...2. Notify the physician of any abnormalities such as, but not limited to:...e. wounds or rashes on the resident's skin...."</p> <p>This Federal tag relates to Complaint</p>			

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F000279 SS=D	<p>IN00157720.</p> <p>3.1-31(c)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a care plan to address the usage of a specialty</p>	F000279	<b>F279:</b> It is the practice of this facility to use the results of an assessment to develop, review, and revise the resident's	11/15/2014

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	<p>mattress for 1 of 5 residents reviewed for care plans in a sample of 5. (Resident "E")</p> <p>Finding includes:</p> <p>The record for Resident "E" was reviewed on 10/16/14 at 12:50 p.m. Diagnoses included, but were not limited to, PVD (Peripheral Vascular Disease: impaired circulation), muscle weakness, abnormal posture, and dementia with delusions.</p> <p>The most recent MDS assessment (Minimum Data Set: a tool to assist staff in planning care), dated 10/08/14, indicated Resident "E" was not cognitive for interview and required extensive assist of 2 for transfers, locomotion, and balance.</p> <p>Resident "E" was observed lying in a low bed with the low air loss mattress on 10/15/14 at 10:50 a.m., and again, on 10/16/14 at 8:50 a.m. A fall mat was located next to the bed.</p> <p>The resident had been hospitalized, on 09/28/15, for treatment of a boil to her hip and discharged back to the ECF (Extended Care Facility) on 10/01/14. The ACF (Acute Care Facility: Hospital) History &amp; Physical, dated 09/29/14,</p>		<p>comprehensive plan of care. It is the practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet resident's medical, nursing, and mental and psychosocial need that is identified in the comprehensive assessment.</p> <p><b>Affected Resident:</b> Resident E's care plan was updated to reflect current status (Resident has since discharged) <b>Resident's shaving the potential to be affected:</b> Care Plan review has been completed for all residents with specialty mattresses and care plans updated as needed to address specialty mattresses, Certified Nursing Assistant care cards have been updated to include specialty mattresses.</p> <p><b>Systemic Changes:</b> Licensed Nurses and Certified Nursing assistants have been educated on the use of specialty mattresses. In addition licensed nurses have been re-educated on facility Policy and Procedure related to comprehensive Care Plans Monitoring: A Performance Improvement Tool has been developed that will monitor care plans, certified nursing assistant care plans and any education needed as it relates to specialty mattresses. UM/SDC/DON or designee will review audit tools weekly. Results will be reviewed in PI Meeting monthly x 6 months to ensure</p>		

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	<p>indicated, "Specialty bed to try to prevent further decubitus issues...." There was no indication when the speciality (air flow mattress) bed was initiated. The record indicated Resident "E" sustained 2 unwitnessed falls, 2 days apart, on 10/07/14 and 10/09/14.</p> <p>A "Comprehensive Care Plan" indicated: "Problem: 10/07/14 fall r/t air loss mattress. 0 [no] injury. Approach: 10/07/14 bolsters to bed. 10/09/14 Therapy to continue."</p> <p>There was no care plan to address the use of the speciality bed.</p> <p>The "Low air loss with alternating pressure: Operating Instruction," observed attached to the air mattress motor and attached by the mattress provider indicated, "...3. Place patient on mattress in a normal relaxed position...."</p> <p>On 10/15/14, at 10:00 a.m., the DNS was interviewed in regard to the 2 falls following the low air loss mattress placement on the bed of Resident "E." The DNS indicated the resident is believed to have moved herself towards the edge of the bed, resulting in the unwitnessed fall on 10/07/14. The DNS indicated the facility placed bolsters on the bed following the fall but despite the</p>		<p>compliance. Recommendations for further follow up and/or resolution will be made at end of the 6 months.</p> <p><b>Completed By:</b> November 15, 2014</p>	

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	<p>intervention, the resident apparently slid off between the mattress and bolsters on 10/09/14. The DNS indicated each time the bed was in the lowest position and the resident was found on the fall mat. The DNS indicated when a low air loss mattress is ordered, the mattress is delivered by the mattress company representative and the controls are set and reviewed with the nurse caring for the resident.</p> <p>LPN #3 was interviewed on 10/15/14 at 11:00 a.m., and indicated the resident was able to move herself about in bed and worked her way to the edge, resulting in the fall.</p> <p>LPN #6 was interviewed on 10/16/14 at 9:30 a.m., and indicated the resident appeared to have moved herself to the edge of the bed, resulting in the fall.</p> <p>Confidential interviews with 7 direct care staff members, throughout the survey, indicated they were aware of Resident "E" falling from the low bed on both occasions. The staff members interviewed indicated there had been no inservices on the low air loss mattress.</p> <p>The CNA task sheet (a form to cue CNA's on resident care needs), provided by the DNS on 10/15/14 at 10:00 a.m.,</p>			

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F000309 SS=D	<p>did not indicate the use or reference to the low air loss mattress.</p> <p>This Federal tag relates to Complaint IN00157720.</p> <p>3.1-35(e)</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, record review and interviews, the facility failed to accurately assess and and provide timely treatment for a resident with a history of boils for 1 of 5 residents reviewed for assessment. (Resident "E")</p> <p>Finding includes:</p>	F000309	<p><b>F309:</b> It is the practice of this facility that each resident receive and the facility to 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. <b>Affected Resident:</b> A Treatment order was obtained</p>	11/15/2014

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	<p>The record for Resident "E" was reviewed on 10/16/14 at 12:50 p.m. Diagnoses for Resident "E" included, but were not limited to, PVD (Peripheral Vascular Disease: impaired circulation), muscle weakness, abnormal posture, and dementia with delusions.</p> <p>The most recent MDS assessment (Minimum Data Set: a tool to assist staff in planning care), dated 10/08/14, indicated Resident "E" was not cognitive for interview and required extensive assist of 2 for transfers, locomotion, and balance.</p> <p>On 10/15/15, at 11:00 a.m., an interview with LPN #3 indicated the resident's dependence status had been the same since before the most recent MDS.</p> <p>Nurse's notes indicated Resident "E" had been diagnosed with boils in the past and antibiotic therapy initiated on the day of diagnosis. The notes indicated the areas had resolved without further complications.</p> <p>The Nurse's Notes indicated the following:</p> <p>"09/19/14 1600 [4:00 p.m.] UA [Urinalysis] + [positive] ...order obtained for macrobid [antibiotic used for Urinary</p>		<p>on 9/23/14 to affected area on left hip, A new order for Keflex was obtained on 9/26/14 to treat affected area on left hip (resident has since been discharged)</p> <p><b>Residents having the potential to be affected:</b> All residents have had a skin assessment completed to ensure identified areas have been assessed, documented a treatment in place and a care plan that addresses any skin issue</p> <p><b>Systemic Changes:</b> Licensed Nurses have been re-educated on facility Policy and Procedure as it relates to change of condition of a resident. In addition licensed nurses have been re-educated on facility Policy and Procedure related to completing skin assessments. <b>Monitoring:</b> A Performance Improvement tool has been developed that will monitor identification of change of condition, appropriate assessment and follow up for any identified skin issues. UM/SDC/DON or designee will review audit tools weekly. Results will be reviewed in PI Meeting x 6 months to ensure compliance. Recommendations for further follow up and/or resolution will be made at end of the 6 months. <b>Completed By:</b> November 15, 2014</p>				

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	<p>Tract Infections]...."</p> <p>"09/23/14 1940 CNAs were giving care a [before] evening meal et noted an area on her (L) hip, 9 X 9 red area. No S/S [Signs/Symptoms] of pain c [with] palpation. Dr. notified et duoderm to (L) hip. ^ [change] q 3 days et prn [as needed]...."</p> <p>"09/26/14 1800 [6:00 p.m.] New order Keflex [Antibiotic] 500 mg q8* X 2 weeks...."</p> <p>"09/28/14 1900 [7:00 p.m.] Abt [Antibiotic] UTI et boil on (L) hip. Greenish discharge noted at (L) hip site...order for eval et tx [treat] @ [at] [ACF: Acute Care Facility - hospital name]."</p> <p>"09/28/14 2330 [11:30 p.m. Received call from [ACF name] ER [Emergency Room]. Resident being admitted to hospital."</p> <p>Review of the ACF records, including but not limited to, ER record, History &amp; Physical, and Discharge Summary, indicated Resident "E" was admitted on 09/28/14. The Admission diagnosis was an abscessed boil to the (L) hip. The abscessed boil was I &amp; D'd (Incised &amp; Drained), dressed &amp; the resident was put</p>			

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F000314 SS=D	<p>on antibiotic therapy specific to the wound. Resident "E" was readmitted to the ECF (Extended Care Facility) on 10/01/14.</p> <p>A confidential interview, during the survey, indicated Resident "E" was on an antibiotic specific to UTI's and the resident's ACF stay could have been avoided had the resident received Keflex on the day the area was noted rather than 72 hours later.</p> <p>On 10/15/14, at 10:50 a.m., accompanied by LPN #3, the (L) hip area was observed after LPN #9 removed the dressing. The area was shallow cuplike, granulating well &amp; pink in appearance. The area appeared to be approximately 3 centimeters in diameter and no exudate was noted.</p> <p>This Federal tag relates to Complaint IN00157720.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p>				

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	<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 record review, interviews and observation, the facility failed to provide interventions upon admission for a totally dependent resident to prevent the development of a left heel blister which opened and resulted in a Stage II pressure area for 1 of 3 residents reviewed for pressure areas in a sample of 5. (Resident "D")</p> <p>Finding includes:</p> <p>During the initial tour, accompanied by the DNS (Director Nursing Services), on 10/15/14 between 9:00 a.m. and 9:30 a.m., Resident "D" was identified as having an open area on his (L) (Left) heel. The DNS indicated the area was thought to be present on admission and "missed" on the admission assessment. The area was further described as a large blister which had opened and continued to heal.</p> <p>The record of Resident "D" was reviewed</p>	F000314	<p><b>F314:</b> It is the practice of this facility to 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 are unavoidable;and the resident having pressure sores receives necessary treatment and services to promote healingprevent infection and prevent new sores from developing.</p> <p><b>AffectedResident:</b> ResidentD's physician was notified of area to left heel on 9/16/14 and treatment orderwas obtained. Area has sincehealed. A head to toe skin assessmenthas been completed to ensure no other areas were identified. <b>Residents having the potential to be affected:</b> Allresidents have had a skin assessment completed to ensure identified areas havebeen assessed, documented a treatment in place and a care plan that addressesany skin issue. <b>SystemicChanges:</b> Licensed nurseshave been re-educated on facility Policy and</p>	11/15/2014

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	<p>on 10/15/14 at 11:00 a.m. Resident "D" was admitted to the facility, on 09/11/14, with diagnoses including, but not limited to, CP (Cerebral Palsy), bradycardia (slow heart rate), chronic CO2 retention, diabetes, COPD (Chronic Obstructive Pulmonary Disease), and hypothermia (low body temperature).</p> <p>The Admission MDS assessment (Minimum Data Set: a tool to assist staff in planning care), dated 09/18/14, indicated Resident "D" was not appropriate for interview, required extensive assistance of 2 or more for changing position in bed, toileting and hygiene. The resident was totally dependent and required 2 or more for wheelchair placement, dressing, and bathing. The resident had a G-tube (gastrostomy tube: tube inserted in abdomen to provide liquid nourishment/feedings.) and was incontinent of bowel and bladder.</p> <p>The "NURSING ADMISSION INFORMATION" form, dated 09/11/14 at 10:30 p.m., indicated Resident "D" was totally dependent for 1-2 staff for all care needs. The BRADEN Scale (for predicting pressure sore risk), indicated the resident was at moderate risk for developing skin issues and the skin evaluation for skin assessment noted the</p>		<p>Procedure as it relates to accurate completion of Nursing Admission Information, in addition licensed nurses have been re-educated on conducting resident skin assessments and identification of pressure ulcers</p> <p><b>Monitoring:</b> A Performance Improvement tool has been developed that will monitor accuracy of Nursing Admission Information, along with appropriate pressure ulcer identification PI tool will include skin assessment completed and validated by 2 nurses. UM/SDC/DON or designee will review audit tools weekly. Results will be reviewed in PI Meeting x 6 months to ensure compliance. Recommendations for further follow up and/or resolution will be made at end of the 6 months.</p> <p><b>Completed By:</b> November 15, 2014</p>	

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	<p>G-tube site insertion site. There was no documentation related to a heel wound.</p> <p>The "INTERIM PLAN OF CARE (Developed On Admission)," dated 09/11/14, indicated: "PROBLEM: Alteration in skin integrity: ...Potential" was checked. "GOAL(s): Will not develop skin breakdown... Skin assessment weekly Pressure reducing mattress... Incontinence care as needed T&amp;P [Turn &amp; Position] or reposition q [every] 2 hours Chair cushion to chair when OOB [Out Of Bed]..." were all checked as interventions. A choice area, "Heel floating device used" was not checked and no reference to a heel blister was noted.</p> <p>The NURSE'S NOTES did not refer to any skin issues from 09/11/14 through 09/15/14.</p> <p>A NURSE'S NOTE indicated: "09/16/14 0720 [7:20 a.m.] Approx [approximately] 5:30 a.m. CNA notified this writer resident had an open area on his (L) [Left] heel. Upon entering room, resident was lying on his (L) side. (L) heel has an open area measurements 7 x 6 cm [centimeters]. Appears to be a blister</p>			

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	<p>that opened. Skin was peeled back red tissue min [minimum] amount of reddish/clear drainage noted. MD [Medical Doctor] notified left message on VM [Voice Mail] request order for tx [treatment] awaiting response...."</p> <p>A "Pressure Ulcer Care Plan" and a "PRESSURE ULCER RECORD [PUR]" was initiated on 09/16/14. The Pressure Ulcer Care Plan indicated: "Problem: Stage II [2] to left heel 2* [secondary] blister...." The PUR indicated the wound as a "STAGE II- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister." The PUR indicated the measurement, at the time, as 9.0 L [Length] X 9.0 W [Width] X 0 D [Depth], no exudate, and "WOUND BED: Dark pink/red tissue" and "SURROUNDING SKIN: Edema". "PROGRESS NOTE: Heels developed area-non filled fluid blister c [with] skin intact - appears that resid [resident] rest heels on foot board. Area skin prep &amp; wrapped c Kerlix [soft dressing wrap]."</p> <p>A Physician's order indicated: "09/17/14 1. Cleanse lt [left] heel c [with] NS [Normal Saline]. Pat dry and apply skin prep to are q [every] sif. Wrap c Kerlix. 2. Flat heels while in bed."</p>			

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	<p>On 10/16/14, at 10:25 a.m., accompanied by the DNS and the Unit Manager, the resident's (L) heel dressing was removed and the area observed. The open area appeared to be approximately 1 cm in diameter with a small amount of red/pink serosanguinous drainage. The surrounding heel area was noted to be deep red to slightly dusky in appearance. Interview with the Unit Manager, at the time, indicated the resident did wear shoes on both feet prior to the discovery of the blister.</p> <p>On 10/16/14, at 8:50 a.m., the Clinical Education Nurse provided a Policy &amp; Procedure, titled, "Resident Examination and Assessment: 2013," which indicated: "Purpose: The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan.</p> <p>Preparation: 1. Review the resident's admission assessment and/or preliminary care plan to assess for any special situations regarding the resident's care...</p> <p>Steps in the Procedure: ...h. Skin: (1) intactness; (2) moisture; (3) color; (4) texture; and (5) presence of bruises, pressure sores, redness, edema, rashes...."</p>			

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F000323 SS=D	<p>Reporting: ...2. Notify the physician of any abnormalities such as, but not limited to:...e. wounds or rashes on the resident's skin...."</p> <p>This Federal tag relates to Complaint IN00157720.</p> <p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interviews, the facility failed to ensure a dependent resident was safely positioned in a speciality bed which resulted in 2 unwitnessed falls (Resident "E") and a resident who required supervision and the assistance of 2 during toileting which resulted in a fall (Resident "F") for 2 of 3 residents reviewed with a history of falls in a sample of 5.</p> <p>Findings include:</p> <p>1. The record for Resident "E" was</p>	F000323	<p><b>F323:</b> It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. <b>Affected Residents:</b> Resident E's care plan was updated to reflect current status (resident has been discharged from facility) Resident F's care plan and certified nursing aide care card has been updated to reflect current status <b>Residents having the potential to be affected:</b> All resident fall</p>	11/15/2014

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	<p>reviewed on 10/16/14 at 12:50 p.m. Diagnoses for Resident "E" included, but were not limited to, PVD (Peripheral Vascular Disease: impaired circulation), muscle weakness, abnormal posture, and dementia with delusions.</p> <p>The most recent MDS assessment (Minimum Data Set: a tool to assist staff in planning care), dated 10/08/14, indicated Resident "E" was not cognitive for interview and required extensive assist of 2 for transfers, locomotion, and balance.</p> <p>Resident "E" was observed lying in a low bed with the low air loss mattress on 10/15/14 at 10:50 a.m., and again, on 10/16/14 at 8:50 a.m. A fall mat was located next to the bed.</p> <p>The resident had been hospitalized, on 09/28/14, for treatment of a boil to her hip and discharged back to the ECF (Extended Care Facility) on 10/01/14. Review of the ACF (Acute Care Facility: Hospital) History &amp; Physical, dated 09/29/14, indicated, "Specialty bed to try to prevent further decubitus issues..." There was no indication when the speciality (air flow mattress) bed was initiated.</p> <p>The record indicated Resident "E"</p>		<p>care plans have been reviewed and updated as needed to reflect resident's current status, along with certified nursing aide care cards <b>Systemic Changes:</b> Nursing staff have been re-educated on facility Policy and Procedure as it relates to accident prevention, with a focus on fall prevention <b>Monitoring:</b> A Performance Improvement Tool has been developed that will monitor compliance with fall prevention and care plan implementation. UM/SDC/DON or designee will review audit tools weekly. Results will be reviewed in PI Meeting monthly x 6 months to ensure compliance. Recommendations for further follow up and/or resolution will be made at end of the 6 months.</p> <p><b>Completed By:</b> November 15, 2014</p>	

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	<p>sustained 2 unwitnessed falls, 2 days apart, on 10/07/14 and 10/09/14.</p> <p>Review of the fall investigations indicated: Fall #1:</p> <p>"Category: Fall -Fall Without Injury...10/07/14 10:00 AM...Indicated Locations: Resident's Room Detailed Description: Describe the fall. Include any injury or suspected injury and what patient was doing prior to fall: RESIDENT WAS NOTED TO BE ON RIGHT SIDE LEANING BACK, AGAINST SIDE OF BED. PILLOW, PAD ALARM, AND SHEETS WERE UNDERNEATH RESIDENT....</p> <p>List interventions in place at the time of the fall: CALL LIGHT IN PLACE, BED IN LOW POSITION, ALARM IN PLACE AND FUNCTIONING...</p> <p>Document the implemented interventions: BOLSTERS TO LOW AIR LOSS MATTRESS... Contributing Factors: History of Falls/Confused/Poor Balance...</p> <p>Care Plans: Care Plan Reviewed</p> <p>Summary of findings from staff member interviews: res. [resident] on an air</p>			

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	<p>mattress. res got to close to the edge, the air mattress gave way and the resident slid out of bed onto the floor. sheet, alarm and pillow remained under the resident....</p> <p>Summary of findings from the resident interview: res. stated she did not know what happened....</p> <p>Overall summary of investigative findings and conclusions: res. slid out of bed r/t [related/to] air mattress. Bolsters to be placed....</p> <p>What actions were implemented for any other residents that might be identified at risk? 100% audit of air mattress to ensure they all have bolsters placed.</p> <p>What education/competencies were provided to staff to address any issues? n/a [not/applicable]</p> <p>What process or policy and procedure changes were made to address any issues? n/a</p> <p>Describe the identified/ongoing QA/PI [Quality Assurance/Performance Improvement] plan? n/a"</p> <p>Fall #2: "Category: Fall... Date and Time: 10/09/14 2:35 p.m....Indicated Locations: Resident's room Detailed Description: Describe the fall...: resident found sitting on mat on floor with bed alarm behind her. personal alarm attached and functional. resident</p>			

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	<p>assessed for injuries. no apparent injuries. rom [range of motion] wnl [within normal limits]. neurochecks initiated....</p> <p>List interventions in place at the time of the fall: bed alarm, personal alarm, fall mat, bolster....</p> <p>Document the implemented interventions: occupational therapy for repositioning...</p> <p>Contributing factors: History of Falls/Lower Extremity Weakness/Poor Safety Awareness...</p> <p>Predisposing factor: No predisposing factors indicated...</p> <p>Nursing Interventions: Were any new nursing interventions implemented? Yes Document the implemented interventions: occupational therapy for repositioning.... Care Plans: Care Plan Revised..."</p> <p>A "Comprehensive Care Plan" indicated:</p> <p>"Problem: 10/07/14 fall r/t air loss mattress. 0 [no] injury. Approach: 10/07/14 bolsters to bed. 10/09/14 Therapy to continue."</p> <p>There was no care plan to address the use</p>			

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	<p>of the speciality bed. Review of the "Low air loss with alternating pressure: Operating Instructions," observed attached to the air mattress motor and attached by the mattress provider indicated, "...3. Place patient on mattress in a normal relaxed position...."</p> <p>On 10/15/14 at 10:00 a.m., the DNS was interviewed in regard to the 2 falls following the low air loss mattress placement on the bed of Resident "E." The DNS indicated the resident is believed to have moved herself towards the edge of the bed, resulting in the unwitnessed fall on 10/07/14. The DNS indicated the facility placed bolsters on the bed following the fall but despite the intervention, the resident apparently slid off between the mattress and bolsters on 10/09/14. The DNS indicated each time the bed was in the lowest position and the resident was found on the fall mat. The DNS indicated when a low air loss mattress is ordered, the mattress is delivered by the mattress company representative and the controls are set and reviewed with the nurse caring for the resident.</p> <p>LPN #3 was interviewed, on 10/15/14 at 11:00 a.m., and indicated the resident was able to move herself to about in bed and worked her way to the edge, resulting</p>			

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	<p>in the fall.</p> <p>LPN #6 was interviewed, on 10/16/14 at 9:30 a.m., and indicated the resident appeared to have moved herself to the edge of the bed, resulting in the fall.</p> <p>Confidential interviews with 7 direct care staff members, throughout the survey, indicated they were aware of Resident "E" falling from the low bed on both occasions. The staff members interviewed indicated there had been no inservices on the low air loss mattress.</p> <p>B. The record of Resident "F" was reviewed on 10/15/14 at 1:45 p.m. Diagnoses included, but were not limited to, diabetes, osteoarthritis, psychosis, delusional disorder, CHF (Congestive Heart Failure), and Stage III CKD (Chronic Kidney Disease).</p> <p>The most recent MDS (Minimum Data Set - a tool to assist staff in planning care), dated 08/07/14, indicated Resident "F" was confused at times and required extensive assistance of 2 for transfers, ambulation and toileting needs.</p> <p>The record indicated Resident "F" sustained a fall on 09/16/14.</p> <p>The fall investigation indicated:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2014
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	<p>Category: Fall Date and Time: 9/16/14 11:54 AM... Indicated Locations: Bathroom</p> <p>Detailed Description. Describe the fall. Include any injury or suspected injury and what patient was doing prior to fall: resident fell from w/c wheel/chair] to floor.</p> <p>Event Description, occurrence or assessment investigative notes: resident was lowered to the floor the proper way with a CNA and a gait belt used....</p> <p>Fall specific information: Extremities/join [sic] deformity: Yes Location and description of deformity: bilateral and contractures... Was supervision provided: requires one assist for all transfers...</p> <p>Nursing Interventions:.... Were there any interventions in place at the time of the fall? Yes Document the implemented interventions: maintenance to fix left w/c lock/brake..."</p> <p>"Comprehensive Care Plans" indicated: Problem: 11/26/13 Resident has ADL [Activities Daily Living: dressing, bathing, toileting, etc] Deficit. Approach: 03/27/14 assist II [2] to transfer...."</p>			

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	<p>The CNA task sheet (a form to cue staff on resident needs), provided by the DNS on 10/15/14 at 10:00 a.m., indicated Resident "F" was an "Assist x 2".</p> <p>On 10/16/14, at 8:45 a.m., the Staff Educator provided a copy of a Policy &amp; Procedure, titled, "Falls At-A-Glance: 04/10/12" and indicated: "Policy: It is the intent of this facility to provide residents with assistance and supervision in an effort to minimize the risk of falls and fall related injuries...</p> <p>Procedure: ...2....The care plan will be reviewed following each fall, quarterly, annually, and with each significant change. Interventions are to be revised as indicated by the assessment...</p> <p>...4. DON [Director Of Nursing] or designee initiates Fall Review Tracking &amp; Incident/Accident tracking form. a. Review fall and care plan during clinical meeting daily for minimum of 3 days. b. Continue Root Cause Analysis...."</p> <p>This Federal tag relates to Complaint IN00157720.</p> <p>3.1-45(a)(2)</p>			