

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/14/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN 46360
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F0000	<p>This visit was for the Investigation of Complaint IN00109456.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00109456 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309, F314 & F323.</p> <p>Survey dates: June 4, 5, 6, 7, 8, 9, 11, 12, 13 and 14, 2012</p> <p>Facility number: 000236 Provider number: 155344 AIM number: 100287700</p> <p>Survey team: Kathleen (Kitty) Vargas, RN-TC (June 4, 5, 6, 7, 8, 11, 13 & 14, 2012) Lara Richards RN (June 4 & 5, 2012) Heather Tuttle, RN (June 4, 5, 6, 7, 8, 9, 11, 13 & 14, 2012) Janlyn Kulik, RN (June 12, 2012)</p> <p>Census bed type: SNF/NF 92</p>	F0000	<p>This provider wishes this Plan of Correction to be considered our credible allegation of compliance. Preparation and or execution of this Plan of Correction does not constitute admission of agreement of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared and or executed solely because it is required by the provision of Federal and State laws.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Total 92</p> <p>Census payor type: Medicare 22 Medicaid 56 Other 14 Total 92</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/21/12 by Suzanne Williams, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident's plan of care was followed as written related to the use of call lights, and for non pressure related skin conditions for 1 of 4 residents reviewed for accidents of the 6 who met the criteria for accidents and for 1 of 3 residents reviewed for non pressures related skin conditions of the 7 who met the criteria for non pressure related skin conditions and for 1 of 2 residents reviewed for activities of daily living of the 2 who met the criteria for activities of daily living. (Residents #J & #H)</p> <p>Findings include:</p> <p>1. On 6/5/2012 at 9:42 a.m., Resident #H was observed in bed. The resident was observed with blue bruises to her right upper arm above the elbow.</p> <p>On 6/6/12 at 10:47 a.m., Resident #H was observed up in her wheelchair in her room, sitting in front of her television. The resident's call light</p>	F0282	<p>1.Residents H and J call lights was replaced with in her reach on 6/13/12. Resident H bruises are being monitored weekly on the weekly plan sheets. The MD and families were notified on 6/13/12.</p> <p>2.other residents call lights were checked for proper placement by the DON/designee on- 6/14/12-- Any call lights not in reach has been placed in proper position. Residents' skin sheets were reviewed for weekly documentation of abnormal skin issues by- DON/Designee-on-6/19/12. Any skin checks not in compliance were corrected by the nursing staff on 6/19/12.</p> <p>3.Management (SS, Activities, Nursing, PT , BOM, Dietary, Housekeeping, Maintenance, MDS) is to conduct resident call light rounds daily M – F on all three shifts,4 times a week, then 3 times weekly for 4 weeks then 2 times a week for 4 weeks then weekly there after. Nursing Staff was in-serviced on 6/18/12 on the following resident Care Plans by the DON. Management (SS, Activities, Nursing, PT , BOM, Dietary, Housekeeping, Maintenance, MDS)in-serviced on 6/20/12 on</p>	07/14/2012			

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	<p>was observed laying on the bed behind her and completely out of reach, about 4 feet away from her. There were blue/green bruises noted to her upper right arm above elbow.</p> <p>On 6/7/12 at 9:47 a.m., the resident was observed in bed, her legs were dangling over the side of the bed as she was attempting to get out of the bed by herself. The resident's upper body was still in the bed. The resident was indicating she wanted to get out of the bed and kept stating "help." The resident's call light was observed on the bed side table which was located at the foot of the bed completely out of reach for the resident to turn it on. A CNA was summoned and came into the room and stated, "I will fix her up and then tell her aide." At that time, the call light out of the resident's was also pointed out to the CNA. There were blue/green bruises noted to the resident's upper right arm above her elbow.</p> <p>On 6/8/12 at 9:15 a.m., the resident was observed in bed. At that time, there were blue/green bruises noted to the right upper arm.</p> <p>On 6/11/12 at 11:00 a.m., the resident was observed in a</p>		<p>conducting rounds .by the DON . Nursing staff was inserviced on skin care documentation on 6/18/12 by the DON. Skin sheets will be monitored weekly by the DON/designee for 12 weeks then two times a month for three months.</p> <p>Assessment of the rounds will be conducted and presented to PI monthly for nine months</p> <p>The indicator will be reviewed at the monthly performance improvement meeting monthly until 95% compliance is reached.</p>		

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	<p>wheelchair in her room. There were faded bruises observed to her right upper arm.</p> <p>On 6/13/12 at 3:50 p.m., the resident was observed sitting in a wheelchair in front of the television. The resident's call light was located on her bed which was behind the resident about four feet. The call light was out of immediate reach for the resident to use. The resident indicated she had to use the bathroom. At that time, CNA #2 was called into the resident's room. The CNA was questioned regarding the placement of the call light and indicated "Oh." The CNA then indicated, the resident usually turns herself around in the wheelchair to reach the call light.</p> <p>The record for Resident #H was reviewed on 6/13/12 at 9:43 a.m. The resident's diagnoses included, but were not limited to, stroke with hemiplegia, congestive heart failure, high blood pressure, dysphagia, anxiety, and depression.</p> <p>Review of the 5/2/12 plan of care, indicated the resident was at risk for falls due to cannot stand by herself and needed help transferring to and from the bed. The nursing approaches were to have the staff</p>						

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	<p>remind me to use my call light for assists and to keep my personal items close to me so I do not reach for them and fall out of my chair.</p> <p>Review of the plan of care, dated 5/2/12, indicated the resident was at risk for skin breakdown because of decreased mobility, receives aspirin, and incontinence. The nursing approaches were check the resident's skin daily with care, and observe for bruising, blood in stool and bleeding gums, and document changes.</p> <p>Review of Nursing Progress Notes, dated 5/31-6/13/12, indicated there was no evidence of any documentation regarding bruising to the right upper arm.</p> <p>Interview with CNA #3 on 6/13/12 at 11:10 a.m., indicated the resident's call light was always to be in reach after getting them up and placing them in their wheelchair.</p> <p>Interview with the Staff Development Nurse on 6/13/12 at 11:11 a.m., indicated the CNAs and nursing staff were supposed to make sure the call lights were within reach for the residents before leaving the room. The Staff Development Nurse further indicated Resident #H was capable of</p>			

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	<p>turning on her call light for help.</p> <p>2. Resident #J was observed on 6/7/12 at 10:28 a.m. She was in bed, lying on her left side. She stated, "I need help and I can not find my button to ask for help." The resident's call light was observed behind the resident's bed. The resident could not reach the call light to request help.</p> <p>The record for Resident #J was reviewed on 6/11/12 at 9:07 a.m. The resident had diagnoses that included, but were not limited to, diabetes, hypertension, and clostridium difficile infection (an infection of the intestines that causes loose, frequent stools).</p> <p>The significant change Minimum Data Set (MDS) assessment, with an assessment reference date of 5/31/12, was reviewed. It indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. It also indicated the resident required extensive assistance of staff for bed mobility, transfers, dressing and toileting. It indicated she was frequently incontinent of urine and bowel.</p> <p>There was a Care Plan, dated 6/7/12, that indicated:</p>				

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	<p>I need extensive assist by the staff to complete bed mobility, transfers, dressing hygiene, walking, locomotion, toileting and bathing Goal: I will participate in therapies, I will complete as much of my own care as I am able and I will need staff to complete the tasks that I cannot do -I will participate in Occupational Therapy and Physical Therapy -I need all my necessary supplies and equipment set up within easy reach -I need enough time to complete the tasks -I need the staff to complete all the tasks that I cannot do</p> <p>Interview with CNA #1, on 6/11/12 at 1:29 p.m., indicated the resident was capable of using the call light and did use the call light to request assistance with care when she needed it. He indicated the resident's call light should have been within the resident's reach.</p> <p>Interview with the Administrator on 6/14/12 at 9:30 a.m., indicated the resident's call lights were expected to be placed within the resident's reach.</p> <p>This Federal tag relates to Complaint IN00109456.</p> <p>3.1-35(g)(2)</p>						

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 interview, the facility failed to ensure the necessary treatment and services were maintained related to the assessment and monitoring of bruises and shingles for 2 of 3 residents reviewed for non pressure related skin conditions of the 7 who met the criteria for non pressure related skin conditions and for 1 of 2 residents reviewed for infections related to shingles. (Resident's #G, #H, and #J)</p> <p>Findings include:</p> <p>1. On 6/05/2012 at 9:42 a.m., Resident #H was observed in bed. The resident was observed with blue bruises to her right upper arm above the elbow.</p> <p>On 6/6/12 at 10:47 a.m., Resident #H was observed up in her wheelchair in her room, sitting in front of her television. There were blue/green</p>	F0309	<p>1. Resident #G shingles have resolved. Resident #H bruises were documented and physician and family were notified on 6/13/12. Resident #J had been discharged and returned new bruises were documented, and physician and family were notified.</p> <p>2. Audits of resident treatment sheets were conducted on 6/18/12 by the DON/designee. All residents with current skin issues had the nurse practitioner and or physician re notified of skin issues. Those skin assessments that were not monitored weekly have been corrected as of 6/18/12 by staff. Residents on anticoagulents will have a head to toe assessment completed by--DON/designee by 7/14/12 and any issues identified and addressed by 7/14/12</p> <p>3. Treatment sheets will be monitored weekly, by the DON/designee to ensure residents weekly skin assessments are current. Nursing Staff were Inservice on 6/18/12 on quality of care issues related to monitoring abnormal</p>	07/14/2012			

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	<p>bruises noted to her upper right arm above elbow.</p> <p>On 6/7/12 at 9:47 a.m., the resident was observed in bed, her legs were dangling over the side of the bed as she was attempting to get out of the bed by herself. There were blue/green bruises noted to the resident's upper right arm above her elbow.</p> <p>On 6/8/12 at 9:15 a.m., the resident was observed in bed. At that time, there were blue/green bruises noted to the right upper arm.</p> <p>On 6/11/12 at 11:00 a.m., the resident was observed in a wheelchair in her room. There were faded bruises observed to her right upper arm.</p> <p>On 6/13/12 at 11:04 a.m., LPN #2 was asked to perform a skin assessment for the resident. At that time, the resident was observed with yellow/brown bruises to the right upper arm. The LPN indicated she was unaware of any bruising the resident had to her arms and she did not know about them. The LPN indicated it was the facility's policy to identify bruising, document, measure and assess them and transcribe the</p>		<p>skin issues (shingles, rashes, bruises) An anticoagulant inservice will be conducted by 7/14/12 by the DON/desiginee for nursing staff.</p> <p>4. Treatment sheets will be monitored weekly to ensure skin assessments are updated weekly. Results of the audits will be presented to PI monthly. The indicator will be reviewed at the monthly performance improvement for six months meeting monthly until 95% compliance is reached.</p> <p>5. Date certain July 14 th 2012.</p>		

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	<p>information on a non pressure ulcer sheet.</p> <p>The record for Resident #H was reviewed on 6/13/12 at 9:43 a.m. The resident's diagnoses included, but were not limited to, stroke with hemiplegia, congestive heart failure, high blood pressure, dysphagia, anxiety, and depression.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment, dated 4/30/12, indicated the resident was usually understood, and understands, with a BIMS score of 7, which indicated severe cognitive impairment. The resident needed extensive assistance with one to two person assist with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene.</p> <p>Review of the plan of care, dated 5/2/12, indicated the resident was at risk for skin breakdown because of decreased mobility, receives aspirin, and incontinence. The nursing approaches were check the resident's skin daily with care, and observe for bruising, blood in stool and bleeding gums, and document changes.</p> <p>Review of Nursing Progress Notes, dated 5/31-6/13/12, indicated there</p>			

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	<p>was no evidence of any documentation regarding bruising to the right upper arm.</p> <p>Review of the non pressure ulcer sheets, indicated there were no sheets completed for bruising to the right upper arm.</p> <p>Review of the 6/5 and 6/12/12 shower sheets, indicated there was old bruises noted but none were indicated on the resident's right upper arm.</p> <p>Interview with the Staff Development Nurse on 6/13/12 at 11:30 a.m., indicated staff were to measure, assess and document all bruises on the non pressure forms and monitor them weekly until they were gone.</p> <p>2. Resident #J was observed on 6/5/12 at 10:28 a.m. There was a large bruise, 3 inches in size, on her right arm and a bruise that was 2 inches in size on her right wrist.</p> <p>The resident was observed on 6/7/12 at 12:30 p.m., the bruises an her right wrist and right arm were still noted. Interview with the resident at that time indicated she was taking a blood thinner and it caused bruises.</p>			

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	<p>The record for Resident #J was reviewed on 6/11/12 at 9:07 a.m. The resident had diagnoses that included, but were not limited to, diabetes, hypertension, and atrial fibrillation (an abnormal heart rhythm).</p> <p>The resident was admitted to the facility on 4/14/12. Review of the April 2012, May 2012 and June 2012 Medication Administration Records, indicated the resident received coumadin (an anticoagulant medication to thin the blood and reduce the risk of blood clots) routinely.</p> <p>The significant change Minimum Data Set (MDS) assessment, with an assessment reference date of 5/31/12, was reviewed. It indicated the resident received anticoagulant medications.</p> <p>There was a Care plan, dated 6/7/12, that indicated: I am at risk for complications because I use coumadin Goal:I will not have any complications -the nurse will monitor my labs -the nurse will give me my coumadin like the doctor ordered -the staff observe me for bruising, blood in stool, bleeding gums, etc -the nurse will observe me for s/s of</p>						

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	<p>adverse reactions (hematuria, nausea, vomiting -the nurse will notify the doctor of any complications</p> <p>The Non-Pressure Skin Condition Records were reviewed. There was a Non-Pressure Skin Condition Record dated 6/1/12 that indicated the resident had a bruise on her right inner wrist that measured 3.3 cm (centimeters) x 4.1 cm. There were no further assessments and measurements after 6/1/12.</p> <p>There was a Non-Pressure Skin Condition Record dated 6/1/12 that indicated the resident had a bruise on her left lateral elbow that measured 3.4 cm x 3 cm, there were no further assessments and measurements after 6/1/12.</p> <p>There was a Non-Pressure Skin Condition Record dated 6/1/12 that indicated the resident had a bruise on her right upper arm that measured 3.4 cm x 4.2 cm, there were no further assessments and measurements after 6/1/12.</p> <p>There was a Non-Pressure Skin Condition Record dated 6/1/12 that indicated the resident had a bruise on her right lateral elbow that measured</p>						

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	<p>5 cm x 5.6 cm. There were no further assessments and measurements after 6/1/12.</p> <p>Interview with the Staff Development Nurse on 6/11/12 at 1:50 p.m., indicated bruises were to be assessed and measured weekly and that assessment was to be documented on the Non-Pressure Skin Condition Record.</p> <p>Interview with the Assistant Director of Nursing on 6/11/12 at 2:04 p.m., indicated bruises were to be assessed, measured and documented weekly on the Non-Pressure Skin Condition Record.</p> <p>3. The record for Resident #G was reviewed on 6/13/12 at 11:28 a.m. The resident had diagnoses that included, but were not limited to chronic kidney disease, hearing loss and blindness.</p> <p>There was a Physician/NP (Nurse Practitioner) Communication and Progress Note form, dated 4/6/12, that indicated, "Rash observed by CNA during shower. Resident reports they itch (sic). No open areas. Rash to left lateral thigh and left lateral trunk comprised of varying sized macular measuring .5 cm x .5 largest</p>			

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	<p>to .1 x .1 cm the smallest [sic]." A Physician's order, dated 4/6/12, indicated, "Moisturizing lotion to affected area on left lateral buttock and left lateral trunk at H.S. (hour of sleep) and prn (as needed for complaint of itching."</p> <p>There was a Nurse's Note, dated 4/18/12 at 4:15 p.m. that indicated, "New order Valtrex (a medication used to treat shingles)1000 milligrams twice daily for 5 days . . . res (resident) reported to nurse on duty with c/o (complaint) of pain and discomfort to right side upon investigation and MD (physician) examining, it was found to be shingles (an inflammatory skin condition producing painful blisters along the nerve tracks) res has pain at site POA (Power of Attorney) informed MD aware."</p> <p>There was a Non-Pressure Skin Condition Record that indicated the resident had a rash that was first observed on 5/10/12.</p> <p>There was no Non-Pressure Skin Condition Records for the rash that was noted on 4/6/12 on the resident's left lateral trunk and left lateral thigh.</p> <p>There was no Non-Pressure Skin</p>						

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	<p>Condition Record dated for 4/18/12 when the MD identified that the resident's body rash as shingles.</p> <p>Interview with the Staff Development Nurse on 6/12/12 at 2:35 p.m., indicated there should have been Non-Pressure Skin Condition Records completed for the resident on 4/6/12 and 4/18/12 when the rash was observed.</p> <p>The policy titled "Post-Admission Weekly Skin Assessments" that was undated, was provided by the Director of Nursing on 6/13/12. She indicated the policy was current.</p> <p>The policy indicated: The Weekly Pressure Ulcer Status Record and the Non-Pressure Skin Condition Record are used for weekly assessment of existing wounds.</p> <p>Non-Pressure Skin Condition Record: On a weekly basis, an in-depth assessment is performed and recorded on the Non-Pressure Skin Condition Record in the resident's medical record.</p> <p>Weekly Non-pressure ulcer Tracking Report: Each resident's non-pressure ulcer description is listed on the Weekly</p>			

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	<p>Non-Pressure Ulcer Tracking Report.</p> <p>Review of a blank Non-Pressure Ulcer Status Record indicated the condition type was to be recorded as surgical, non-surgical, skin tear, abrasion, bruise, venous ulcer or arterial ulcer. The date, site, size in cm, depth, drainage, odor, color, tunneling, appearance of the wound, response to treatment and nurses signature dietary and MD notification, presence or absence of pain and the nurses' signature were all to be documented weekly.</p> <p>This Federal tag relates to Complaint IN00109456.</p> <p>3.1-37(a)</p>			

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview, the facility failed to perform a complete assessment of an acquired stage II pressure ulcer (a partial thickness loss of dermis presenting as a shallow open ulcer) for 1 of 4 residents reviewed for pressure ulcers of the 5 residents who met the criteria for pressure ulcers. (Resident #B)</p> <p>Findings include:</p> <p>The closed record for Resident #B was reviewed on 6/8/12 at 2:53 p.m. The resident had diagnoses that included, but were not limited to, heart failure, peripheral vascular disease and hypertension.</p> <p>The admission Minimum Data Set (MDS) assessment, with a reference date of 2/18/12, indicated the resident was at risk of developing pressure</p>	F0314	<p>1. Resident B pressure ulcer was documented by the Nurse practitioner. Nurse practitioner assessed area and wrote progress notes on wound on 5/2/12. The residents' caregiver was also notified of new wound 5/2/12. Resident has since discharged from facility.</p> <p>2. other residents with new pressure ulcers were assessed for proper documentation that includes measurements by the DON/designee on 6/22/12.</p> <p>3. Pressure ulcers and abnormal skin issues will be documented on the 24hour-report sheet for notification to the managers. Nurse manager will audit the treatment sheets weekly for initial measurements and weekly updates. Nursing Staff Inservice on 6/18/12 to</p>	07/14/2012			

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	<p>ulcers.</p> <p>A Braden Scale for predicting pressure sore risk was completed on 4/28/12. The results indicated the resident's score was 18, which indicated she was at risk for developing pressure ulcers.</p> <p>There was a Care Plan, dated 2/24/12, that indicated: I am at risk for skin breakdown, I am frequently incontinent of bowel and bladder. I have decreased mobility, I have just had a right great toe amputated and I have cellulitis of my right foot. I have dx (diagnosis) of pvd (peripheral vascular disease) -I will not have any skin breakdown -the staff check my skin daily during care -the nurse assess my skin weekly -the staff apply lotion and creams as needed -the staff help me turn every 2 hours -I have a pressure reducing mattress and a cushion in my w/c -the staff clean me after incontinent episodes -I receive supplements</p> <p>There was a Physician Order, dated 5/2/12 at 10:07 a.m., that indicated, "Stage II pressure ulcer coccyx, cleanse coccyx ulcer site with ns</p>		<p>ensure new pressure ulcers are measured and placed on a pressure ulcer sheet by the DON. Nursing staff were inserviced by on how pressure ulcers are measured and placed on the sheets as well as what assessments need to be documented by DON on 6/18/12.</p> <p>4. Treatment sheets will be monitored weekly to ensure skin assessments are initiated and are updated weekly. Results of audits will be presented to PI monthly. The indicator will be reviewed at the monthly performance improvement for six months meeting monthly until 95% compliance is reached.</p>				

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	<p>(normal saline) apply Duoderm (a dressing) q (every) 3 days and prn (as needed) for soiling."</p> <p>The Nurse's Notes, dated 5/2/12, were reviewed. There was an entry at 10:15 a.m., that indicated, "received new order from NP (Nurse Practitioner), POA (Power of Attorney) educated." There was no assessment or measurements of the stage II pressure ulcer to the resident's coccyx noted in the Nurse's Notes.</p> <p>Review of the record indicated there was no Weekly Pressure Ulcer Status Record, dated 5/2/12, for the resident.</p> <p>The Weekly Skin Integrity Data Collection sheet indicated there were, "no new areas" on 5/4/12 and on 4/27/12.</p> <p>On 6/13/12 at 9:26 a.m., interview with the Director of Nursing (DoN) indicated there was no assessment of the stage II pressure ulcer that was noted on 5/2/12, by the nursing staff. She indicated there was no Pressure Ulcer Status Record completed when the stage II pressure ulcer was first noted on 5/2/12. She indicated the width, length, depth, color, odor, drainage, and appearance was not</p>			

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	<p>assessed when the wound was first noted. She indicated a complete assessment of the pressure ulcer was to have been completed and documented on the Pressure Ulcer Status Record on 5/2/12, when the treatment was obtained for the stage II pressure ulcer. She indicated the facility policy was not followed,</p> <p>The policy titled Post-Admission Weekly Skin Assessments, that was undated, was provided by the DoN on 6/13/12. She indicated the policy was current. The policy indicated:</p> <p>A complete assessment is essential to an effective pressure ulcer prevention and treatment program. A comprehensive individual evaluation helps the facility to identify the resident at risk for developing pressure ulcers, the level and nature of risks, and the presence of pressure ulcer.</p> <p>The Weekly Pressure Ulcer Status Record and the Non-pressure Skin Condition Record are used for weekly assessment of existing wounds.</p> <p>Review of a Weekly Pressure Ulcer Status Record indicated the pressure ulcer was to be assessed as follows; Date first observed, location, stage,</p>			

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	<p>surface area length x width x depth, granulation, drainage, odor, color, tunneling, appearance of the wound, assessment of pain, dietary and MD notification and the nurses' signature.</p> <p>This Federal tag relates to Complaint IN00109456.</p> <p>3.1-40(a)(2)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident was free from accidents related to ensuring call lights were in reach for a resident with a history of falls for 1 of 4 residents reviewed for accidents of the 6 who met the criteria for accidents. (Resident #H)</p> <p>Findings include:</p> <p>On 6/6/12 at 10:47 a.m., Resident #H was observed up in her wheelchair in her room, sitting in front of her television. The resident's call light was observed laying on the bed behind her and completely out of reach, about 4 feet away from her.</p> <p>On 6/7/12 at 9:47 a.m., the resident was observed in bed, her legs were dangling over the side of the bed as she was attempting to get out of the bed by herself. The resident's upper body was still in the bed. The resident was indicating she wanted to get out of the bed and kept stating</p>	F0323	<p>F 323 Free of Accidents</p> <p>1. Resident H call light was replaced within her reaches on 6/14/12. Resident is able to propel herself in wheelchair and reach her call light.</p> <p>2. other residents call lights were checked for placement. Any call lights not in reach were placed in proper position on 6/14/12 by the DON/designee.</p> <p>3. Management, SS, Activities, Nursing, PT, BOM, Dietary, Housekeeping, Maintenance, (MDS))to conduct resident rounds daily Monday-Friday, on all shifts for 4 weeks, then 3x week x 4 weeks, then 2x week x 4 weeks, then weekly thereafter. Staff was Inservice on the 6/18/12 in putting call lights in reach</p> <p>4. The audit of resident rounds will be conducted and presented to PI monthly. for 9 months The indicator will be reviewed at the monthly performance improvement meeting monthly until 95% compliance is reached.</p> <p>(</p>	07/14/2012

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	<p>"help." The resident's call light was observed on the bed side table which was located at the foot of the bed completely out of reach for the resident to turn it on. A CNA was summoned and came into the room and stated, "I will fix her up and then tell her aide." At that time, the call light out of the resident's reach was also pointed out to the CNA.</p> <p>On 6/13/12 at 3:50 p.m., the resident was observed sitting in a wheelchair in front of the television. The resident's call light was located on her bed which was behind the resident about four feet. The call light was out of immediate reach for the resident to use. The resident indicated she had to use the bathroom. At that time, CNA #2 was called into the resident's room. The CNA was questioned regarding the placement of the call light and indicated "Oh." The CNA then indicated, the resident usually turns herself around in the wheelchair to reach the call light.</p> <p>The record for Resident #H was reviewed on 6/13/12 at 9:43 a.m. The resident's diagnoses included, but were not limited to, stroke with hemiplegia, congestive heart failure, high blood pressure, dysphagia, anxiety, and depression.</p>						

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	<p>Review of the significant change Minimum Data Set (MDS) assessment, dated 4/30/12, indicated the resident was usually understood, and understands, with a BIMS score of 7, which indicated severe cognitive impairment. The resident needed extensive assistance with one to two person assist with bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. The resident had no falls since the last assessment.</p> <p>Review of the 5/2/12 plan of care, indicated the resident was at risk for falls due to cannot stand by herself and needed help transferring to and from the bed. The nursing approaches were to have the staff remind me to use my call light for assists and to keep my personal items close to me so I do not reach for them and fall out of my chair.</p> <p>Review of the fall risk assessments, dated 4/23/12 and 5/9/12, indicated a score 16 which meant the resident was a high fall risk.</p> <p>Review of the falls reduction checklist, dated 4/23/12, indicated the resident has a low bed, a pain assessment was completed and the</p>			

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	<p>medications were reviewed with pharmacy.</p> <p>Review of Nurses Notes, dated 5/9/12 at 12:30 p.m., indicated the CNA yelled out to come to the resident's room. The resident was found on the floor in a sitting position sitting directly and leaning against the wheelchair and foot rest. The resident was trying to propel herself in the wheelchair in her room and slipped and slid down to the floor.</p> <p>Review of the incident follow up and recommendation form, dated 5/9/12, indicated a dycem (a nonskid pad) was added to the resident's wheelchair.</p> <p>Interview with CNA #3 on 6/13/12 at 11:10 a.m., indicated the resident's call light was always to be in reach after getting them up and placing them in their wheelchair.</p> <p>Interview with the Staff Development Nurse on 6/13/12 at 11:11 a.m., indicated the CNAs and nursing staff were supposed to make sure the call lights were within reach for the residents before leaving the room. The Staff Development Nurse further indicated Resident #H was capable of turning on her call light for help.</p>			

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