

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/16/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F0000	<p>This visit was for Investigation of Complaints IN00113221, IN00113740, IN00114064.</p> <p>Complaints: IN00113221 Substantiated Federal/State deficiencies related to the allegations are cited at F166, F282, F514.</p> <p>IN00113740 Substantiated Federal/State deficiencies related to the allegations are cited at F157, F282, F309</p> <p>IN00114064 Substantiated Federal/State deficiencies related to the allegations are cited at F157, F282, F309</p> <p>Unrelated deficiencies cited</p> <p>Survey dates: August 13, 15, & 16, 2012</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey Team: Mary Jane G. Fischer, RN</p> <p>Census bed type: SNF/NF: 116 Total: 116</p>	F0000		

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>Census payor type: Medicare: 20 Medicaid: 87 Other: 9 Total: 116</p> <p>Sample: 7 Supplemental sample: 2</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 23, 2012 by Bev Faulkner, RN</p>			
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F0157 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 observation, record review and interview, the facility failed to ensure the physician was notified of changes in wound status or omissions of wound treatment for 2 of 3 residents reviewed for</p>	F0157	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of	09/15/2012			

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	<p>wound care treatment in the sample of 7. [Resident's "B" and "G"].</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-15-12 at 9:20 a.m. Diagnoses included but were not limited to status post muscle flap closure of decubitus - multiple wounds to sacrum, hip and feet, multiple sclerosis, quadriplegic, asthma, and depression. These diagnoses remained current at the time of the record review. The record also indicated the resident received care at a local wound care clinic.</p> <p>Physician orders, dated 04-17-12, instructed the nursing staff to change the resident's dressings in addition to the wound V.A.C. [vascular assisted closure] every Monday - Wednesday - Friday.</p> <p>The record indicated the resident was diagnosed with a deep vein thrombosis on 08-06-12 and received physician orders for Lovenox [a blood thinner] 100 mg [milligrams] subQ [subcutaneously] every 12 hours and Coumadin [an anticoagulant] 4 mg daily.</p> <p>The resident was seen and evaluated by the local wound clinic physician on 08-14-12 at which time the resident's</p>		<p>deficiencies. This plan of correction is prepared and/or executed solely because required. F 157 Notify of Changes (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue#1 Orders for Resident #B were transcribed. Pharmacy was notified of new orders. MD/family was notified of orders not transcribed and medication not available. Issue#2 Wound MD was notified of Resident #G not having the wound vac in place on 8-16-12 and declined placing wound vac at that time. Resident #G no longer resides in the facility. Issue #3 and #4 Active licensed staff on duty was educated on physician /family notification and change of condition. (b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility audit was conducted to identify current residents that have a wound vac and/or change in their wound. Any identified areas were reported to the MD. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Licensed nursing staff was educated regarding MD/Family notification with change of condition. Licensed</p>				

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	<p>wounds were debrided and silver nitrate [a medication to impede bleeding] applied.</p> <p>Interview on 08-15-12 at 3:00 p.m., Licensed Nurse employee #4 [the facility Wound Care Nurse] indicated when the resident returned from the wound care physician visit on 08-14-12, the physician orders for wound care included instructions to "clean with saline - [apply] Santyl [a medication to aid in debridement] and continue the wound V.A.C. on Monday - Wednesday - Friday," had not been "taken off or transcribed" and therefore the "Santyl had not been ordered from the pharmacy and the treatment had not been started on the day the resident returned" from the physician visit. The Licensed Nurse indicated she would need to call the physician and inform him the order had not been completed and would need to request a new order to "hold the Santyl until it comes from the pharmacy."</p> <p>Observation on 08-15-12 at 3:05 p.m., with Licensed Nurse employee #4 in attendance, the resident was turned to the right side to view the wounds to bilateral ischium's and sacrum. Three thick white pads had been placed and taped to cover the resident's wounds. Licensed Nurse employee #4 removed the dressings and</p>		<p>staff was educated to document on the 24 hour report any change with wound and wound orders for follow up and discussion at morning meeting. The wound nurse/unit manager will monitor orders, 24 hour report, and transcription 5 days weekly to ensure accurate and timely documentation and notification when necessary have been made to help ensure continued compliance. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: DNS/Designee will review 24 hour report to identify any changes with wound and wound orders 5 days weekly during morning clinical meeting, any identified issues will result in review of Residents clinical record to assure documentation of MD/Family notification this will be an ongoing plan of correction. The ED will report results at the next QA/PI meeting and monthly for 3 months then will have quarterly monitoring by the DNS/Designee to maintain compliance. (e) Date of compliance: 9-15-12</p>		

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	<p>remarked that the wounds have continued to bleed despite the physician intervention of silver nitrate. The Licensed Nurse indicated she could not perform the dressing change as ordered but would need to contact the physician a "second time" due to the continued bleeding from all three wounds.</p> <p>The nurses notes, dated 08-15-12 at 4:45 p.m., indicated the following: "... noted increased bleeding secondary to DVT [deep vein thrombosis] to right calf. Currently on Lovenox 100 mg BID and Coumadin 4 mg daily. N.O. [new order] received, Prisma [a medication in the treatment of open areas] daily and as needed."</p> <p>Observation on 08-16-12 at 12:15 p.m., with Licensed Nurse employee #4 in attendance, the resident was turned to the right side to view the areas to bilateral ischium's and sacrum. After the resident was turned the Licensed Nurse indicated the dressing which were currently on the resident were "not the dressings" she placed "yesterday afternoon." "They must have had to change the dressing on the evening shift due to bleeding because these are not my dressings. [Resident] is still bleeding so I'll have to call over there again [the wound center] and ask the Doctor what he wants us to do. Either he</p>						

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	<p>will need to cauterize it or we'll have to get order for therapy to do it. I wish the nurses would have told me."</p> <p>The nurses notes lacked documentation of ongoing bleeding of the resident's wounds, the need to change the original dressing as applied by Licensed Nurse employee #4 or the nursing staff informed the resident's physician of the ongoing bleeding to the wounds or need for potential intervention.</p> <p>The resident also had physician orders, originally dated 08-02-12, to "Hold the Wound V.A.C. [vascular assisted closure] for one week. Resumption of care was noted as 08-09-12. The record lacked documentation the resident received the needed therapy/treatment to the surgical wounds from the original date of 08-09-12 through 08-15-12.</p> <p>During interview on 08-16-12 at 9:40 a.m., Licensed Nurse employee #4 verified the resident did not receive the treatment and the physician had not been notified of the lack of treatment and implementation of the Wound V.A.C. as ordered.</p> <p>2. The record for Resident "G" was reviewed on 08-16-12 at 11:10 a.m. Diagnoses included but were not limited</p>						

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	<p>to, history of sacral decubitus stage 4 [full tissue thickness loss with exposed bone, tendon or muscle] with osteomyelitis, severe protein caloric malnutrition, and a history of deep vein thrombosis. These diagnoses remained current at the time of the record review.</p> <p>The resident was recently re-admitted to the facility after ongoing treatment to the sacral wound at a local area hospital. The resident returned to the facility on 07-26-12 with orders which included the resident to be seen and evaluated by the "in-house" contracted wound care staff.</p> <p>The resident was seen and evaluated on 08-01-12 at which time the physician's "Diagnosis/Plan" included the continued implementation of "NPWT [negative pressure wound therapy]." The physician note indicated "awaiting NPWT approval from [name of payor source] with noted improvement."</p> <p>Interview on 08-16-12 at 11:45 a.m., Licensed Nurse employee #4 indicated "[a specific payor source] denied the use of the wound V.A.C., so then I completed another form [a different payor source], the doctor signed it and we submitted the form for the use of the equipment. We received the approval for the use and received delivery of the equipment on</p>						

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	<p>08-13-12."</p> <p>The resident was again seen by the "in-house" contracted wound care staff on 08-15-12. The record lacked documentation or communication the nursing staff had with the physician in which he was aware the resident had been approved through a different payor source for the use of the equipment in the treatment of the wound on 08-13-12.</p> <p>Observation on 08-16-12 at 12:05 p.m., the resident was lying in bed. The resident did not have the physician ordered wound V.A.C. therapy as ordered.</p> <p>3. Review of facility policy on 08-15-12 at 9:05 a.m., provided by the Director of Nurses, titled "Notifications," and dated as 10-03-07 indicated the following:</p> <p>"POLICY [bold type] - Staff informs the resident, consults with their attending physician and notifies the resident's surrogates when: Treatment needs to be altered significantly"</p> <p>4. Review of facility policy on 08-15-12 at 9:05 a.m., provided by the Director of Nurses, titled "Condition Change of a Resident," and dated as 10-31-06,</p>			

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	<p>indicated the following:</p> <p>"RATIONALE [bold type] Resident change of condition is identified for proper treatment implementation. The physician is informed of resident events and/or changed in resident's condition."</p> <p>"DEFINITIONS [bold type] Immediate Notification [underscored] - the physician should be informed at the time the event occurs either directly or by pages. Significant Change - a decline or improvement in a resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease - related clinical interventions, is "self limiting," impacts more than one area of the resident's health status; and requires interdisciplinary review and/or revision of the care plan."</p> <p>This Federal tag relates to Complaint IN00113740 and IN00114064.</p> <p>3.1-5(a)(3)</p>				

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure the prompt resolution of grievances when a resident/family member conveyed a concern of missing clothes to staff members the facility failed to seek a resolution and keep the resident/family member informed of the resolution for 1 of 3 residents reviewed for grievances in a sample of 7 and 1 of 2 supplemental sampled residents reviewed. [Residents "A" and "H"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 08-15-12 at 9:20 a.m. The resident had been admitted to the facility on 04-17-2007 and expired on 06-20-12.</p> <p>The resident progress notes, dated 06-19-12, indicated the concerned family member spoke with facility staff regarding the loss of resident clothing. "Writer also dealt with laundry concerning resident clothes. They are washed and getting distributed this afternoon. Will continued to monitor as</p>	F0166	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F-166 Grievances</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>Issue#1 Resident's # A no longer resides at the facility. Issue#2 Resident #H grievance regarding missing clothing was transcribed and noted as resolved. Offered Resident reimbursement of property missing. The facility staff was re-educated on the facility standard and guidelines for the grievance reporting process. The Social Service Director was re-educated on the facility standards for grievance resolution and follow-up to determine resident satisfaction.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Residents</p>	09/15/2012			

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	<p>needed."</p> <p>Interview on 08-16-12 at 10:00 a.m., the Social Service Director indicated "Yes there was a problem with clothes and it all seemed to happened right before [resident] died. We never did find all the clothes and what was left the family donated except for one blue suit. The family wanted to make a stuffed animal out of it for remembrance."</p> <p>2. Review of complaint and grievance documentation on 08-15-12 at 9:05 a.m., included a complaint/grievance dated 06-21-12 by Resident "H". The "issues" included the following: "Res. [Resident] stating missing clothes - gray stretch sweat pants, multiple striped colored blouse, dark blue jeans [size noted], leopard [sic] print t-shirt, light blue blue jeans [size noted], heavy brown sweater and which jacket coat." The form had been completed and dated 06-21-12, by the Activity Director.</p> <p>The section of the form noted as "department referred to" and "for completion by the Executive Director and resolution date" was blank.</p> <p>During the exit conference on 08-13-12 at 1:00 p.m., the Director of Nurses was questioned about the lack of resolution to</p>		<p>who are cognitively intact were interviewed to determine if any grievances had been reported to facility staff without resolution, any identified issues were corrected at that time. Those residents that are considered "non-interviewable" had their responsible party contacted to determine if there are any unresolved concerns. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: . The facility staff will be re-educated on the grievances reporting process. The Social Service Director will meet 2 times monthly with the Resident Council to ensure concerns are brought to the Administrator for investigating, reporting, resolution, and follow-up in a timely manner. The Facility Management Team will review all event reports, grievances, and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, and follow-up with any grievances in a timely manner. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The Director of Social Services will randomly interview 5 residents weekly for the next 4 weeks then monthly thereafter, to determine if residents have</p>				

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	<p>this grievance since 06-21-12. The Director of Nurses indicated she was unaware of the grievance and would need to investigate.</p> <p>On 08-15-12 at 9:05 a.m., the Director of Nurses provided a copy of the original complaint/grievance" with a "department response" which indicated the following: "Follow up with [name of resident]. [Resident] stated this happen <sic> when 1st admitted but wants SS [social services] to be able to order from catalog or [name of another shopping service]. [Resident] wants to wait instead of money replaced. Housekeeping cont. [continues] to look for clothes ongoing."</p> <p>Interview on 08-16-12 at 10:00 a.m., the Social Service Director indicated "I'm not going to lie to you, there have been so many management changes we dropped the ball."</p> <p>Review of the facility policy on 08-15-12 at 9:35 a.m., provided by the Director of Nurses, titled "Complaints/Grievances," and dated 10-31-10 indicated the following:</p> <p>"Rationale [bold type] After receiving a complaint/grievance, the center actively seeks a resolution and keeps the resident and/or family members/responsible party</p>		<p>voiced grievances that were not reported timely to the management of the facility. If any of these 5 resident's are non-interviewable, then the responsible party will be contacted. Review of these audits will be reported at the monthly QA/PI meeting for 3 months then monitored quarterly with System reviews. (e) Date of compliance: 9-15-12</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>appropriately apprised of progress toward resolution."</p> <p>"Procedure [bold type] - 1. Acknowledge and document the complaint/grievance, 2. Forward the form to Executive Director/Designee, 3. Record the date, resident/family name, and issues or concern on the center complaints/grievance log, 4. Assign the appropriate Department Head to investigate, 5. Investigate to validate the complaint/grievance, 6 Notify resident and/or family/responsible party of progress within three (3) days of initial complaint/grievance, 7. Determine a resolution, 8. Notify the resident or family member/responsible party of the resolution. Record notification of <sic> the Complaint/Grievance Log. 9. Record the date resolved and resolution on the center, 10. Sign and date the Complaint/Grievance form and Complaint/Grievance Log."</p> <p>Interview on 08-16-12 at 12:00 p.m., Resident "H" indicated "It seemed like my closet had been plucked clean. I didn't know if someone was mad at me or what. They [in reference to clothing] were here and then they were gone. Some of the things were given to me as gifts."</p> <p>This Federal tag relates to Complaint</p>						

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	IN00113221. 3.1-7(a)(2)				

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F0282 SS=E	<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 physician orders and resident plans of care were followed for 1 of 3 residents reviewed for wounds resulting in Resident ["B"] not receiving wound therapy as ordered, which resulted in the increase of a surgical wound.</p> <p>In addition the facility failed to ensure physician orders and/or plans of care were followed related to settings on an air mattress or receiving ordered nutritional supplements for 3 of 7 sampled residents. [Residents "B", "G", "C" and "E"].</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-15-12 at 9:20 a.m. Diagnoses included but were not limited to, status post muscle flap closure of decubitus - multiple wounds to sacrum, hip and feet, multiple sclerosis, quadriplegic, asthma, and depression. These diagnoses remained current at the time of the record review. The record also indicated the resident received cared at a local wound care clinic.</p>	F0282	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 282 Services by Qualified Staff (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>ISSUE 1: Resident #B orders were clarified and careplan was updated. ISSUE 2: Resident #G's mattress was set to the appropriate setting. Resident #G no longer resides at the facility. ISSUE#3 MD of Resident #C was notified of not receiving nourishment. Current staff on that shift was educated on the importance of nourishments and correct documentation of nourishments. ISSUE#4 Staff member responsible for caring for Resident #E was educated on the importance of nourishments and the correct documentation of nourishments. Ice cream was served to Resident. (b) How</p>	09/15/2012			

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	<p>The resident's current plan of care, dated 06-05-12, indicated the resident had "alteration in skin integrity - surgical wounds to left ischium, right ischium and sacral areas." Interventions to the plan of care included "Report any drainage to MD [Medical Doctor] or increase s/s [signs and symptoms] of infection, treatment as ordered, NPWT [negative pressure wound therapy - a device which removed infectious material or other fluids from the wound]."</p> <p>Physician orders from the wound care clinic, dated 07-10-12, instructed the nursing staff to clean the resident's wounds with saline and apply Santyl [a medication to aid in the debridement of a wound] and continue with the wound V.A.C.</p> <p>A subsequent physician order, dated 08-02-12, indicated "Hold the Wound V.A.C. [vascular assisted closure] for one week." Resumption of care was noted on the treatment administration record as "08-09-12."</p> <p>The record lacked documentation the resident received the needed therapy/treatment for seven days to the surgical wounds from 08-09-12 through 08-15-12.</p>		<p>you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident that receives additional supplements could have been affected. Audit was completed with other Residents that receive supplements . (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Nursing staff have been educated on: · Following MD orders, · Documenting bed settings on the MAR/TAR · The importance of serving nourishments and the correct documentation of consuming.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The UM/designee will conduct a random weekly audit of at least 5 residents per week x 4 weeks then every 2 weeks for the next 2 months - to ensure that each resident's plan of care is being followed as order by their attending physician with a focus on supplements, wound treatments and bed settings. The findings from these audits will be reviewed at the facility QA/PI meeting monthly for 3 months, and then quarterly monitoring by the DNS when completing the facility system</p>				

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	<p>Review of the Facility "Non-Pressure Ulcer Weekly Log," on 08-13-12 at 12:00 p.m., and dated 07-25-12, indicated the following measurements in regard to the resident's surgical wounds.</p> <p>1.) left ischium 3.0 cm [centimeters] by 2.7 by 0.1 cm. 2.) right ischium 4.5 cm by 3.0 cm by 2.2 cm. 3.) sacrum/coccyx 3.0 cm by 3.0 cm by 0.1 cm.</p> <p>Review of the Facility "Non-Pressure Ulcer Weekly Log," on 08-13-12 at 12:00 p.m., and dated 08-10-12, indicated the following measurements in regard to the resident's surgical wounds:</p> <p>1.) left ischium 2.5 cm [centimeters] by 2.0 by 0.1 cm. 2.) right ischium 5.0 cm by 3.0 cm by 0.9 cm. 3.) sacrum/coccyx 4.0 cm by 3.7 cm by 0.3 cm.</p> <p>The resident was evaluated by the physician at the local wound care clinic on 08-14-12 and documented the wounds measurements as follows prior to debridement:</p> <p>1.) left ischium 4.0 cm by 2.0 cm by 0.2</p>		reviews. (e) Date of compliance: 9-15-12				

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	<p>cm.</p> <p>2.) right ischium 5.5 cm by 3.7 cm. by 0.4 cm.</p> <p>3.) sacrum/coccyx 3.8 cm by 2.5 cm by 0.3 cm.</p> <p>During interview on 08-16-12 at 9:40 a.m., Licensed Nurse employee #4 [the facility Wound Care Nurse] verified the resident did not receive the resumption of treatment which included Wound V.A.C. therapy as ordered.</p> <p>In addition, review of the wound care clinic "physician orders/patient instructions," dated 05-08-12, instructed the nursing staff of a change to the treatment. The original physician orders dated 04-17-12 instructed the nursing staff to clean the wounds with acetic acid prior to application of the dressings and wound V.A.C. The 05-08-12 physician orders now instructed the nursing staff to "clean with saline, apply Santyl and continue with the wound V.A.C."</p> <p>Review of the July 2012 and August 2012 Treatment Administration Records continued to instruct the nursing staff to use "acetic acid" to clean the wounds prior to application of dressings and the wound V.A.C.</p> <p>Interview on 08-15-12 at 3:00 p.m., the</p>			

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	<p>Licensed Nurse employee #4 indicated when the resident returned from the wound care physician visit on 08-14-12, the physician orders for wound care included instructions to "clean with saline - [apply] Santyl and continue the wound V.A.C. on Monday - Wednesday - Friday," had not been "taken off or transcribed" and therefore the "Santyl had not been ordered from the pharmacy and the treatment had not been started on the day the resident returned" from the physician visit. The Licensed Nurse indicated she would need to call the physician and inform him the order had not been completed and would need to request a new order to "hold the Santyl until it comes from the pharmacy."</p> <p>The Licensed Nurse employee #4 indicated she was unaware of the change in the physician orders from acetic acid to saline.</p> <p>2. The record for Resident "G" was reviewed on 08-16-12 at 11:10 a.m. Diagnoses included but were not limited to, history of sacral decubitus Stage 4 [full tissue thickness loss with exposed bone, tendon or muscle] with osteomyelitis, severe protein caloric malnutrition, and a history of deep vein thrombosis. These diagnoses remained current at the time of the record review.</p>						

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	<p>The resident was recently re-admitted to the facility after ongoing treatment to the sacral wound at a local area hospital. The resident returned to the facility on 07-26-12 with orders which included the resident to be seen and evaluated by the "in-house" contracted wound care staff.</p> <p>Review of the resident's plan of care, dated 07-27-12, indicated the resident had "alteration in skin integrity." "Interventions" to this plan of care included "treatment as ordered, low air loss mattress pressure reducing mattress."</p> <p>Observation on 08-16-12 at 12:05 p.m., the resident was observed on a "low air loss mattress [a special mattress to off load pressure points for a resident who had been determined at risk of skin breakdown]." During this observation, licensed nurse employee #10 was interviewed in regard to the appropriate setting for this specialty mattress. The licensed nurse indicated she was unaware of what the setting were supposed to be, but thought the control device came "pre-set." During this observation, the controls were set at "float - normal pressure" and "comfort level - 3."</p> <p>Review of the "Low Air Loss Mattress Guidelines," manufacturer's specifications</p>						

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	<p>on 08-16-12 at 12:30 p.m., indicated "FYI - All mattress [sic] are set to the patients therapeutic level for their weight. DO NOT ADJUST THE MATTRESS SETTINGS." "Patient's weights - in lbs. < [less than] 100 lbs. set at "4", < 150 lbs. set at "4 or 5," < 190 lbs. set at "5 or 6."</p> <p>During interview on 08-16-12 at 12:35 p.m. the Director of Nurses indicated the "resident weighed 162.3 lbs." and the mattress was set "incorrectly." Based on the resident's weight the adjustment should have been at least on "4 or higher."</p> <p>3. The record for Resident "C" was reviewed on 08-15-12 at 10:25 a.m. Diagnoses included but were not limited to Dementia, hypertension, depressive disorder and anemia. The resident had physician orders for a regular mechanical soft diet and a subsequent physician order ,dated 04-`16-12, for a "house shake supplement two times daily at 10:00 a.m. and 3:00 p.m. between meals, document % [percentage] of consumption."</p> <p>The resident's current plan of care indicated the resident received 4 ounces of house shake at 10:0 a.m. and 3:00 p.m. Interventions to this plan of care included "assist resident at meals as needed, supplement as ordered."</p>			

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	<p>The resident had changed rooms due to a family request on 08-13-12.</p> <p>Observation on 08-15-12 at 11:00 a.m., in the resident's original room, on a counter surface was a supplement with the resident's name. The glass was dated "08-13-12 10:00 a.m." and was full and appeared untouched.</p> <p>Observation in the resident's current room on 08-15-12 at 11:25 a.m., and again at 12:50 p.m. was the resident's 10:00 a.m. supplement. The glass was untouched and dated "08-15-12 10:00 a.m."</p> <p>The Medical Nutrition Therapy Review, dated 07-13-12, indicated the quarterly review was completed with no nutritional concerns at this time. Receives 4 ounces supplement twice daily. Will continue to monitor meal consumption and supplement acceptance."</p> <p>Review of the Medication Record for August 2012, which contained information related to the resident's consumption of the house shake was blank for the percentage of consumption on 08-13-12 at 10:00 a.m., and the area for documentation of consumption on 08-15-12 indicated the resident "consumed 100 %," as initialed by the staff nurse.</p>						

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	<p>4. The record for Resident "E" was reviewed on 08-15-12 at 10:55 a.m. Diagnoses included but were not limited to, subarachnoid hemorrhage, anemia, cerebral vascular accident and hypertension.</p> <p>The resident had physician orders for double portions and fortified foods - serve ice cream with lunch and dinner - whole milk with meals pureed, regular liquids in dining room with supervision. In addition the resident received a physician ordered "supplement," originally dated 04-12-12, and followed by "120 ml [milliliters] of water - give by mouth two times daily at 10:00 a.m. and HS [bedtime] Document % consumed."</p> <p>The resident's current plan of care, dated 06-27-12, indicated the resident had dysphagia. A subsequent plan of care, dated 07-09-12, indicated the resident received regular large portions of fortified foods with ice cream at lunch and dinner, whole milk at meals, house shake at meals and the supplement at 10:00 a.m. and HS [bedtime]. Interventions to this plan of care included diet as ordered, provide supplement as ordered."</p> <p>Observation on 08-15-12 at 11:22 a.m., the resident was seated in the Activity</p>			

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	<p>Room. A small container had been placed at the nurses station, in which there were the 10 a.m. resident supplements. A staff member picked up the supplement for resident "E" and took it to the resident's room. Observation at 10:30 a.m., the resident was not in the room but was seated in the Activity Room.</p> <p>Observation on 08-16-12 at 11:20 a.m., the resident's supplement was observed on the resident's nightstand included the resident's name and was dated "08-15-12 HS." The container was full and untouched.</p> <p>Review of the August 2012 Medication Record, where a notation was made in regard to the percentage of the supplement and water consumed was initialed by the nurse on on 08-15-12 for 10:00 a.m. "100 %." The section dated 08-14-12 and again on 08-15-12 for 9:00 p.m. was blank.</p> <p>Observation on 08-15-12 at 1:05 p.m., the resident was observed seated in the assist dining room. The resident's tray did not include the ice cream as ordered.</p> <p>The Dietary notation, dated 06-18-12, indicated "appears to be meeting nutritional needs. Will continue plan of</p>						

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	<p>care. Monitor consumption."</p> <p>This Federal tag relates to IN00113221, IN00113740 and IN00114064.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=G	<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 services to a resident with surgical wounds, in that when a resident had specific physician orders the nursing staff failed to implement the physician orders which resulted in a deterioration of the surgical area for 1 of 3 residents reviewed for wounds and the use of a wound V.A.C. [vascular assisted closure] in a sample of 7. [Resident "B"].</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-15-12 at 9:20 a.m. Diagnoses included but were not limited to, status post muscle flap closure of decubitus - multiple wounds to sacrum, hip and feet, multiple sclerosis, quadriplegic, asthma, and depression. These diagnoses remained current at the time of the record review. The record also indicated the resident received care at a local wound care clinic.</p>	F0309	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 309 – Provide Care/Services (a) What corrective action will be accomplished for those residents found to have been affected by this practice:</p> <ul style="list-style-type: none"> · Medication error form has been completed for Resident #B · MD and family have been notified · Licensed nurse who was identified responsible for this has been educated on the responsibility regarding obtaining written orders for changes in medication regimen and appropriately disciplined. <p>(B)How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken:</p> <ul style="list-style-type: none"> · Audit was completed to identify any 	09/15/2012			

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	<p>The resident's current plan of care, dated 06-05-12, indicated the resident had "alteration in skin integrity - surgical wounds to left ischium, right ischium and sacral areas." Interventions to the plan of care included "Report any drainage to MD [Medical Doctor] or increase s/s [signs and symptoms] of infection, treatment as ordered, NPWT [negative pressure wound therapy - a device which removed infectious material or other fluids from the wound]."</p> <p>Physician orders from the wound care clinic, dated 07-10-12, instructed the nursing staff to clean the resident's wounds with saline and apply Santyl [a medication to aid in the debridement of a wound] and continue with the wound V.A.C.</p> <p>The record indicated the resident was sent to a local area hospital on 07-31-12 due to a change in mental status.</p> <p>Review of the Emergency Room Report, dated 07-31-12, indicated the resident had "severe decubitus ulcer on [resident] back. Forensic nurse was called to evaluate the patient's wound care, decubitus condition. Pictures were taken and Adult Protective Agency was consulted. The hospital Nursing Assessment, dated 07-31-12, indicated</p>		<p>other resident(s), that are on NWPT to determine if MD has provided changes in orders (C) What measures will be put into place or what systemic changes will you make to ensure that the practice does not reoccur: Education was completed with the licensed nurses regarding the following: · the responsibility of accuracy when taking/transcribing physician orders to the TAR. · the responsibility regarding obtaining written orders for changes in medication regimen before any discontinuation of a med/treatment. (d) How will the corrective actions be monitored to ensure the practice will not reoccur, what quality measures will be put into place: The DNS/designee will conduct a weekly review of at least 5 residents x 4 weeks then every 2 weeks thereafter for two month, to ensure that: · medications that have been discontinued have a corresponding MD order, · accuracy of transcription of new orders to the TAR. The findings will be reviewed at the next QA/PI meeting then monthly for 3 months and then quarterly by the DNS when completing systems review. Date of compliance: 9-15-12</p>				

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	<p>"buttocks/coccyx wound vac disconnected when left ECF [extended care facility], dressing to coccyx not fully intact, smell noted - serous and bloody drainage noted at different areas of wound - forensic [name of forensic nurse] took pics. [pictures]. Forensic nurse notified [name of physician] of pt's [patient's] wound issues and concern over smell of coccyx decub. [decubitus]."</p> <p>Interview on 08-13-12 at 9:00 a.m., the hospital forensic nurse indicated "there was a clear adhesive dressing all over [resident] buttocks and redness everywhere. The pictures show there was slimy and icky drainage under the dressing and the secretions had a foul odor."</p> <p>The hospital record indicated the resident received an antibiotic Cipro 400 mg [milligrams] IV [intravenous] while at the hospital.</p> <p>The hospital record indicated the resident returned to the facility with a diagnosis of change in mental status, urinary tract infection and decubitus ulcers. The resident had physician orders to continue with an oral antibiotic Cipro 500 mg for 10 additional days due to the urinary tract infection.</p>			

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	<p>Review of the Facility "Weekly Non Pressure Skin Condition Report," on 08-13-12 at 12:00 p.m. and dated 05-30-12, indicated the following measurements:</p> <p>1.) left ischium 5.6 cm by 2.2 cm by 0.1 cm. 2.) right ischium 4.0 cm [centimeters] by 1.0 cm by 3,6 cm 3.) sacrum/coccyx 9.5 cm by 2.5 cm by 1.5 cm.</p> <p>The 06-27-12 measurements noted on the "Weekly Non Pressure Skin Condition Report," indicated:</p> <p>1.) left ischium 3.5 cm by 2.7 cm by 0.1 cm. 2.) right ischium 6.7 cm by 4.0 cm by 3.0 cm. 3.) sacrum/coccyx 3.8 cm by 3.0 cm by 0.1 cm</p> <p>The 07-25-12 "Weekly Non Pressure Skin Condition Report indicated the following measurements in regard to the resident's surgical wounds:</p> <p>1.) left ischium 3.0 cm [centimeters] by 2.7 by 0.1 cm. 2.) right ischium 4.5 cm by 3.0 cm by 2.2 cm. 3.) sacrum/coccyx 3.0 cm by 3.0 cm by</p>						

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	<p>0.1 cm.</p> <p>Further review of the facility record indicated the physician at the wound care clinic instructed the nursing staff on 08-02-12 to "Hold the Wound V.A.C. [vascular assisted closure] for one week."</p> <p>Resumption of care was noted on the treatment administration record as "08-09-12." During interview on 08-15-12 at 2:00 p.m., Licensed Nurse employee #4 indicated "at times the doctor will give the resident a 'vacation' from wound V.A.C. just like they do with some medications."</p> <p>The record lacked documentation the resident received the needed therapy/treatment for seven days to the surgical wounds from 08-09-12 through 08-15-12.</p> <p>Review of the Facility "Non-Pressure Ulcer Weekly Log," on 08-13-12 at 12:00 p.m., and dated 08-10-12, included the following measurements in regard to the resident's surgical wounds:</p> <ol style="list-style-type: none"> 1.) left ischium 2.5 cm [centimeters] by 2.0 by 0.1 cm. 2.) right ischium 5.0 cm by 3.0 cm by 0.9 cm. 3.) sacrum/coccyx 4.0 cm by 3.7 cm by 						

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	<p>0.3 cm.</p> <p>The record indicated the resident was diagnosed with a deep vein thrombosis on 08-06-12 and received physician orders for Lovenox [a blood thinner] 100 mg [milligrams] subQ [subcutaneously] every 12 hours and Coumadin [an anticoagulant] 4 mg daily and subsequently seen and evaluated by the physician at the local wound care clinic on 08-14-12.</p> <p>Prior to debridement the wounds measured as follows:</p> <ol style="list-style-type: none"> 1.) left ischium 4.0 cm by 2.0 cm by 0.2 cm. 2.) right ischium 5.5 cm by 3.7 cm. by 0.4 cm. 3.) sacrum/coccyx 3.8 cm by 2.5 cm by 0.3 cm. <p>The record indicated that the resident showed improvement in the surgical wounds until which time the nursing staff failed to re-institute the physician orders of wound V.A.C. therapy on 08-09-12.</p> <p>Observation on 08-15-12 at 3:05 p.m., with Licensed Nurse employee #4 [the Facility Wound Care Nurse] in attendance the resident was turned to the right side to view the wounds to bilateral ischium's</p>				

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	<p>and sacrum. Three thick white pads had been placed and taped to cover the resident's wounds. Licensed Nurse employee #4 removed the dressings and remarked that the wounds have continued to bleed despite the physician intervention of silver nitrate. The Licensed Nurse indicated she could not perform the dressing change as ordered but would need to contact the physician due to the continued bleeding from all three wounds.</p> <p>During interview on 08-16-12 at 9:40 a.m., Licensed Nurse employee #4 verified the resident did not receive the resumption of treatment which included Wound V.A.C. therapy as ordered on 08-09-12.</p> <p>In addition, review of the wound care clinic "physician orders/patient instructions," dated 05-08-12, instructed the nursing staff of a change to the treatment. The original physician orders, dated 04-17-12, instructed the nursing staff to clean the wounds with acetic acid prior to application of the dressings and wound V.A.C. The 05-08-12 physician orders now instructed the nursing staff to "clean with saline, apply Santyl and continue with the wound V.A.C."</p> <p>Review of the July 2012 and August 2012 Treatment Administration Records</p>				

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	<p>continued to instruct the nursing staff to use "acetic acid" to clean the wounds prior to application of dressings and the wound V.A.C.</p> <p>Interview on 08-15-12 at 3:00 p.m., the Licensed Nurse employee #4 [the facility Wound Care Nurse] indicated when the resident returned from the wound care physician visit on 08-14-12, the physician orders for wound care included instructions to "clean with saline - [apply] Santyl and continue the wound V.A.C. on Monday - Wednesday - Friday," had not been "taken off or transcribed" and therefore the "Santyl had not been ordered from the pharmacy and the treatment had not been started on the day the resident returned" from the physician visit. The Licensed Nurse indicated she would need to call the physician and inform him the order had not been completed and would need to request a new order to "hold the Santyl until it comes from the pharmacy."</p> <p>Review of the facility policy on 08-16-12 at 8:30 a.m., provided by the Director of Nurses, titled "Negative Pressure Wound Therapy," dated 04-28-10, indicated the following:</p> <p>"RATIONALE [bold type] Residents are selected per criteria for the provision of Negative Pressure Wound Therapy</p>						

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	<p>(NPWT) which removes infectious material or other fluids from the wound under the influence of continuous and/or intermittent sub-atmospheric pressure to promote wound healing. NPWT may be implemented on chronic wounds that have failed to proceed through normal stages of healing and have filed with standard care for treatment."</p> <p>"15.) Clean wound with solution as ordered by physician."</p> <p>This Federal tag relates to IN00113740 and IN00114064.</p> <p>3.1-37(a)</p>						

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident received treatment and services to aid in the healing of pressure ulcers in that when the facility obtained approval for the use of special equipment in the treatment of a pressure ulcer, the nursing staff failed to inform the physician the equipment was available for use and implementation for 1 of 2 resident sampled for pressure ulcers and the use of a wound V.A.C. [vascular assisted closure] in a sample of 7. [Resident "G"].</p> <p>Findings include:</p> <p>The record for Resident "G" was reviewed on 08-16-12 at 11:10 a.m. Diagnoses included but were not limited to, history of sacral decubitus Stage 4 [full tissue thickness loss with exposed bone, tendon or muscle] with</p>	F0314	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F 314 Pressure Areas</p> <p>(a)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>Resident #G no longer resides in the facility</p> <p>Licensed staff was educated on the facility's wound care program standard and guideline with a focus placed on management of tissue loads through positioning and bed settings.</p> <p>(b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p>	09/15/2012			

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	<p>osteomyelitis, severe protein caloric malnutrition, and a history of deep vein thrombosis. These diagnoses remained current at the time of the record review.</p> <p>The resident was recently re-admitted to the facility after ongoing treatment to the sacral wound at a local area hospital. The resident returned to the facility on 07-26-12 with orders which included the resident to be seen and evaluated by the "in-house" contracted wound care staff.</p> <p>Review of the resident's plan of care, dated 07-27-12, indicated the resident had "alteration in skin integrity." "Interventions" to this plan of care included "treatment as ordered, low air loss mattress pressure reducing mattress."</p> <p>The resident was seen and evaluated on 08-01-12 at which time the physician's "Diagnosis/Plan" included the continued implementation of "NPWT [negative pressure wound therapy]." The physician indicated "awaiting NPWT approval from [name of payor source] with noted improvement."</p> <p>Interview on 08-16-12 Licensed Nurse employee #4 indicated "[a specific payor source] denied the use of the wound V.A.C., so then I completed another form [a different payor source], the doctor</p>		<p>A facility wide "Skin Sweep" was completed on the active residents in-house to identify those residents with pressure ulcers and to assure that pressure ulcers were correctly measured; appropriate treatments were implemented, and documented accordingly. Care plans reviewed and revised as needed. Bed settings were also audited for correct settings. Physician was notified of any areas identified and appropriate orders obtained.</p> <p>(c)What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Nursing Staff which includes C.N.A's have been educated on the components of F314 regarding prevention of pressure areas and pressure reducing measures with a focus on turning and repositioning, off loading tissue management, incontinent care, and reporting to the charge nurse any change in a resident's condition. Additionally licensed nurses were educated on the facility's wound care program with a focus on those residents assessed to be at high risk for skin breakdown. Licensed staff will be provided on-going educational training regarding wound care and treatment. UM/Wound nurse/Designee will observe turning and repositioning as well as identifying that pressure relieving devices are in place during daily facility rounds including bed settings.</p> <p>(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The DNS/Wound nurse and/or</p>				

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	<p>signed it and we submitted the form for the use of the equipment. We received the approval for the use and received delivery of the equipment on 08-13-12."</p> <p>The resident was again seen by the "in-house" contracted wound care staff on 08-15-12. The record lacked documentation or communication the nursing staff had with the physician in which he was aware the resident had been approved through a different payor source for the use of the equipment in the treatment of the wound on 08-13-12.</p> <p>Observation on 08-16-12 at 12:05 p.m., the resident was observed lying in bed. The resident did not have the physician ordered wound V.A.C. therapy as ordered.</p> <p>In addition on 08-16-12 at 12:05 p.m., the resident was observed on a "low air loss mattress [a special mattress to off load pressure points for a resident who had been determined at risk of skin breakdown]." During this observation, licensed nurse employee #10 was interviewed in regard to the appropriate setting for this specialty mattress. The licensed nurse indicated she was unaware of what the setting "were supposed to be," but thought the control device came "pre-set." During this observation, the</p>		<p>Designee will observe one dressing change weekly, and will randomly inspect two wounds a week to review measurement, treatment, and prevention methods. DNS/wound nurse will monitor pressure relieving devices and timing of turning and repositioning during daily facility rounds, including random rounds on evening and night shifts. Any issues identified will be immediately addressed and a report of these findings will be presented at the next QA/PI Meeting and for 4 weeks thereafter, then Quarterly by DNS with systems reviews.</p> <p>(e)Date of compliance: 9-15-12</p>		

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	<p>controls were set at "float - normal pressure" and "comfort level - 3."</p> <p>Review of the "Low Air Loss Mattress Guidelines," manufacturer's specifications on 08-16-12 at 12:30 p.m., indicated "FYI - All mattress [sic] are set to the patient's therapeutic level for their weight. DO NOT ADJUST THE MATTRESS SETTINGS." "Patient's weights - in lbs. < [less than] 100 lbs. set at "4", < 150 lbs. set at "4 or 5," < 190 lbs. set at "5 or higher."</p> <p>During interview on 08-16-12 at 12:35 p.m., the Director of Nurses indicated the "resident weighed 162.3 lbs." and the mattress was set "incorrectly." Based on the resident's weight the adjustment should have been at least on "4."</p> <p>3.1-40(a)(2)</p>						

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F0366 SS=D	<p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>Based on record review and interview, the facility failed to ensure a resident was provided a substitute/alternate meal, in that when a resident elected to have the alternate meal served at dinner time, the facility failed to provide the resident preference for 1 of 1 supplemental sampled resident's in regard to meal satisfaction in a supplemental sample of 2. [Resident "I"].</p> <p>Findings include:</p> <p>Interview on 08-15-12 at 1:00 p.m., Resident "I" indicated displeasure with the meal service from the previous evening meal [08-14-12].</p> <p>Review of the "Dinner Menu" for Tuesday 08-14-12 indicated the "Main Entree" included triple cheese pizza, tossed salad, and pineapple upside down cake," with the "Alternate" of "meatballs with gravy, mashed potatoes, zucchini coins and fruit cup."</p> <p>The resident indicated [resident] notified the staff for the "alternate" to be served</p>			F0366	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F – 366 Substitutes of Similar Nutritive Value (A)What corrective action(s) will be accomplished for those residents found to have been affected: Resident #I was reevaluated by the Food and Nutrition Department for likes and dislikes and proper documentation on the dietary card. The facility food and nutrition staff was educated on the importance of validating any likes and dislikes on the residents dietary card and honoring resident wishes, including food substitutions. Facility nursing staff was educated on the importance of reviewing the residents dietary card prior to service to ensure the residents dislikes are not served and if dislikes are served they were educated on getting replacements. (B)How will you</p>		09/15/2012

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	<p>for the dinner meal. The resident indicated [resident] was informed everyone [emphatic] would need to be served first and then [resident] would receive the alternate meal.</p> <p>The resident indicated a wait of "over one hour" when [resident] "wheeled" self back in the direction of the kitchen only to be told the "chef had already left and the kitchen was closed." "They asked me if I wanted a sandwich and I said 'no' because I wanted the meatball dinner. I went to bed hungry that night."</p> <p>Interview on 08-16-12 at 10:20 a.m., the Dietary Supervisor indicated she investigated the resident's concern after she had been notified of the resident's complaint conveyed to this surveyor on 08-15-12. The Dietary Supervisor indicated the resident stated the "exact" same thing and was told [resident] would have to wait until everyone else was served. "I talked with my cook and she remembered the request but she said she told the staff member to let her complete the trays already on the tray line [5 or 6 trays] that had already been started and then she would make the tray for the resident. She said a tray was made but never given to [name of resident]. I was told they asked if they could make [resident] a sandwich and [resident] said</p>		<p>identify other residents having potential to be affected and what corrective action will be taken: Residents with special diets and/or specific food preferences had the potential to be affected. Residents who are interviewable were interviewed to determine if they had any concerns regarding their meals and dislikes being served. Family/interested party will be contacted for Residents that are non interviewable to determine if they had any concerns regarding the meals and dislikes being served.</p> <p>(C)What measures will be put into place or what systemic changes will be made to ensure this will not recur: An in-service will be provided to the Dietary Manager, Dietary Staff and those who serve resident meals regarding honoring resident food preferences and substitutions. The facility dietary staff was educated on the importance of validating any likes and dislikes on the residents dietary card and honoring resident wishes. Facility nursing staff was educated on the importance of reviewing the residents dietary card prior to service to ensure the residents dislikes are not served and on meal replacements if Resident does not like/want what has been served. the facility administrator will review resident council concerns when voiced in order to</p>		

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	'no.' 3.1-21(a)(4)		resolve any concerns timely. (D)How the corrective action(s) will be monitored to ensure the practice will not recur: The RD and/or Dietary Manager or designee will audit a minimum of ten resident meal trays three times per week for four weeks and then weekly to ensure special diets, dislikes, and substitutes are honored. The Administrator or designee will randomly interview 5 residents weekly to determine if residents have voiced concerns regarding food dislikes being served. The findings will be reported to the Administrator and monthly to the QA/PI and quarterly by RD/designee when completing systems reviews (E) Date of Compliance: 9-15-12		

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident's record was complete and readily accessible for 3 of 7 sampled residents. [Resident's "A", "B" and "G"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 08-13-12 at 12:50 p.m. The resident's record indicated the resident received Hospice services. The resident expired on 06-20-12. The record identified as the "most current record" contained Hospice notations dated 08-2011.</p> <p>Interview on 08-15-12 at 1:15 p.m., the Medical Record staff member indicated she was unsure why the "old notes were</p>	F0514	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 514 Clinical Records (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Issue#1 Resident #A was taken from a closed file. Hospice notes have been integrated into Resident charts Issue#2 Resident #B Inventory sheet was updated Staff on duty was reeducated on the importance of documenting food consumption. Issue#3 Resident #G Inventory sheet was updated</p>	09/15/2012			

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	<p>in the chart" and not the current records. "I'll have to go look for them. I don't know why they're not in here like they're supposed to be."</p> <p>Interview on 08-15-12 at 1:00 p.m., the Director of Nurses indicated she was unaware of the location of the most current Hospice notes. At 2:30 p.m., the Director of Nurses indicated the Hospice notes were "found in a separate binder but were supposed to be part of the most current clinical record."</p> <p>2. The record for Resident "B" was reviewed on 08-15-12 at 9:20 a.m. The record indicated the resident had been admitted to the facility on 09-23-11. Observation on 08-15-12 at 3:00 p.m., the resident had an abundant amount of personal possessions in room. Review of the "Inventory of Personal Effects," dated 09-29-11 indicated the resident had 1 purse, 1 set of reading glasses, 2 watches, 1 stuffed animal and 10 puzzles. After the resident's items were "re-inventoried" on 08-16-12, the resident had 2 pages of personal effects, with 54 items identified some of which included perfumes, planters, hygiene products, 10 carat gold earrings, various clothing, books, puzzles, eyewear and a cellular phone.</p> <p>In addition the resident had a diagnosis of</p>		<p>Resident #G no longer resides in the facility . (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>. An audit was conducted of residents receiving hospice for accurate/available documentation. Inventory sheets for current Residents have been updated (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Nursing staff will be educated on standards and guidelines, and professional standards of practices for maintaining clinical record documentation of inventory sheets and hospice documentation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Medical Records/designee will audit 3 times weekly for the next 4 weeks and then weekly x4 weeks then quarterly thereafter for hospice documentation and updated inventory sheets This plan of correction will be discussed and reviewed at the next monthly QA/PI meeting for 3 months then quarterly by DNS when completing systems review (e) Date of compliance: 9-15-12</p>				

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	<p>protein malnutrition and had physician orders for a regular diet. The Medical Nutrition Therapy Review, dated 05-29-12, indicated the need to "monitor weight, and meal intake."</p> <p>Review of the "Individual Resident Meal Intake Record for August 2012 lacked documentation for breakfast and lunch on August 1, 2, 3, 4, 5, 6, 7, 8, 9, 13, and 14. The Dinner meal consumption lacked documentation on August 1 and 2, 2012.</p> <p>3. The record for Resident "G" was reviewed on 08-16-12 at 11:10 a.m. The resident was recently re-admitted to the facility on 07-26-12. Review of the "Inventory of Personal Effects" was blank. The form was signed by a Certified Nurses Aide and witnessed by another staff member. Observation on 08-16-12, the closet door for the resident was opened. Clothing was observed in this closet. During interview on 08-16-12, the Director of Nurses indicated when she saw the Inventory Sheet had not been completed but signed by a staff member, she instructed the staff on 08-16-12 to go to the resident's room and inventory the resident's personal belongings.</p> <p>Instructions at the top of the "Inventory of Personal Effects" sheet indicated the</p>				

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	<p>following:</p> <p>"Upon admission, identify the resident's personal belongings by indicating quantity of those items listed. Use the space allowed to write in additional items as necessary. Update as necessary throughout the resident's stay by using the space provided."</p> <p>Review of the facility policy on 08-16-12 at 9:30 a.m., titled "Documentation of Residents Health Status, Needs and Services," and dated 10-31-09 indicated the following:</p> <p>"RATIONALE [bold type] The resident's medical record is a continuing account of the resident's health status and needs, the treatments delivered, results of diagnostic tests and the resident's response to treatment."</p> <p>"PROCEDURE [bold type] 4. Documentation in a resident's medical record should be accurate, organized and complete."</p> <p>Review of the facility Admission packet on 08-13-12 at 12:00 p.m. indicated the following:</p> <p>"Personal Belongings - we take an inventory of a patient's personal items</p>			

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	<p>upon admission to the center."</p> <p>Review of facility policy on 08-16-12 at 9:45 a.m., provided by the Director of Nurses, titled "Resident Personal Belongings," and dated 04-28-09 indicated the following:</p> <p>"RATIONALE - Each resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing as space permits, unless to do so would infringe upon the right or health and safety of other resident's."</p> <p>"PROCEDURE - 6. Complete a personal belongings inventory sheet upon admission. Update as needed with personal belongings added throughout the resident's stay and/or removed from the center."</p> <p>This Federal tag relates to IN00113221.</p> <p>3.1-50(a)(1) 3.1-50(a)(3) 3.1-50(a)(4)</p>				