

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155662	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2013
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NAME OF PROVIDER OR SUPPLIER NURSING CARE AT HARTSFIELD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 503 OTIS R BOWEN DR MUNSTER, IN 46321
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F000000	<p>This visit was for the Investigation of Complaint IN00121273.</p> <p>Complaint IN00121273-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F312.</p> <p>Survey date: March 12, 2013</p> <p>Facility number: 010758 Provider number: 155662 AIM number: 200229550</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF: 78 SNF/NF 16 Total: 94</p> <p>Census payor type: Medicare: 27 Medicaid: 9 Other: 58 Total: 94</p> <p>Sample: 6</p> <p>This deficiency reflects state findings</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 17, 2013, by Janelyn Kulik, RN.</p>			

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F000282 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 follow the resident's plan of care related to providing incontinence care for 2 of 3 residents reviewed for being at risk for alterations in skin integrity in the sample of 5. (Residents #C and #D) (CNA's #1, #2, #3, and #5) (LPN #1 and ADON)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 3/12/13 at 5:45 a.m., Resident #C was observed sitting in a high back wheelchair in her room. The resident was dressed in a pair of pants and a shirt. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 7:30 a.m., the resident was observed sitting in the wheelchair in her room. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 8:55 a.m., CNA #1 was observed pushing the resident down the hallway in her wheelchair. The</p>	F000282	<p>1. Corrections from previous timeframes cannot be made. Resident's C & D were assessed and both residents were totally dependant for toileting and transfers. Resident C had a treatment for excoriation/moisture associated dermatitis and an open area was identified on her left buttock. Resident D was assessed and also had a treatment in place due to total incontinence for moisture associated dermatitis/excoriation, however, no open areas were noted to the skin. Both residents were removed from the early am get up list. 2. A list of residents based upon census on 3-12-13 was developed to identify residents totally dependant for transfers, their level of continence and their risk for skin breakdown. The list of residents was analyzed for clinical links and care plans are being revised to reflect the current plan of care. The nurse aide assignment records are also being modified to provide direction toward each individuals plan of care. Focused modifications are in relation to skin care, turning and/or repositioning and incontinence care/toileting. Get up list was</p>	04/11/2013			

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	<p>CNA placed the resident in the hallway across from the Nurses' Station.</p> <p>On 3/12/13 at 10:52 a.m., the resident was observed sitting in the wheelchair in her room. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 11:45 a.m., the resident was observed sitting in the wheelchair in the hallway across from the Nurses' Station.</p> <p>On 3/12/13 at 12:15 p.m., the resident was observed sitting in the wheelchair in the Dining Room for lunch. The resident remained in the wheelchair in the Dining Room until 1:20 p.m.</p> <p>On 3/12/13 at 1:20 p.m., CNA #3 pushed the resident from the Dining Room to her room in the wheelchair. CNA #2 followed the resident into the room. CNA #2 and CNA #3 then began to transfer the resident into her bed using the Hoyer Lift (a mechanical lift used to transfer residents). The CNA's removed the resident's brief. The brief was wet with urine and stool. A small superficial open area was observed on the resident's left mid inner buttock area. The open area measured</p>		<p>revised 3-28-13.3.C.N.A.'s involved on the day of the survey were re-educated initially on 3-13-13 by ADON. Nurses and C.N.A.'s will be informed regarding the modifications made of the resident care plans and nurse aide assignment sheets on April 4, 2013 and April 5, 2013. The nursing management team will continue to provide direction and support to our nursing staff through on-going monitoring of adherence to the plan of care. The policy entitled "Incontinency Management Program" will be reviewed with the nurses and C.N.A.'s at the time of the in-service. Staff found non-compliant following formal education will receive discipline per facility protocol.4.An audit tool was implemented entitled "Resident Round" attached # 1, which will be utilized to assure compliance to residents plan of care for moisture management, transfers and repositioning. The charge nurse/designee will observe at least 2 residents per shift per day 3 X a week for 6 weeks. Observations will include a sample of dependant residents requiring staff assist for turning/repositioning and/or incontinence management according to established schedule. Charge nurses every shift will be responsible for making rounds on all residents on each shift to assure compliance with plan of</p>		

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	<p>approximately .5 cm (centimeters) x .5 cm and was red in color. There was no drainage or odor from the area. The CNA's applied a clean brief at this time.</p> <p>On 3/12/13 at 1:40 a.m., the ADON (Assistant Director of Nursing) and LPN #1 entered the resident's room to assess the resident's skin. The resident was asked what was sore and she replied "My butt." The ADON indicated the area on the left buttock was open. LPN #1 indicated she was not aware of the open area until this time.</p> <p>When interviewed on 3/12/13 at 1:30 p.m.,CNA #2 indicated she was assigned to care for the resident on the day shift. The CNA indicated she began work at 6:00 a.m. and the resident was dressed and up in the wheelchair at the start of her shift this morning. The CNA indicated the last time she laid the resident in her bed to change her was at approximately 11:15 a.m. or 11:30 a.m. The CNA indicated she did not transfer the resident into the bed to check or change her between 6:00 a.m. and 11:15 a.m. CNA #2 indicated she did recall taking the resident into the Shower Room at approximately 7:30 a.m. and checked her brief while she</p>		<p>care for moisture management for dependant residents. Random audits will be done daily by the Nurse Manager/designee during rounds for 6 months to assure compliance with the incontinence management plan. Results of the audit observations will be brought to QA Committee meeting quarterly for review and/or recommendations.5.DON responsible for compliance. April 11, 2013</p>		

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	<p>was in the chair. The CNA indicated she did not get the resident out of the wheelchair at this time.</p> <p>The record for Resident #C was reviewed on 3/12/13 at 8:00 a.m. The resident's diagnoses included, but were not limited to, seizure disorder, dementia, depression, high blood pressure, and atrial fibrillation (an irregular heart rhythm).</p> <p>A care plan initiated on 2/11/13 indicated the resident was at risk for skin break down related to limitations in bed mobility and being incontinent of bowel and bladder. Care plan interventions included for staff to check the resident for incontinence every two hours and provide pericare after each incontinent episode.</p> <p>Review of the 3/2013 Physician Order Statement indicated there was an order for the resident to be up in the wheelchair with the use of a mechanical lift.</p> <p>A "Bowel/Bladder/Incontinence Assessment " was completed on 2/11/13. The assessment indicated the resident had multiple daily episodes of urinary incontinence. The assessment also indicated the</p>						

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	<p>resident was incontinent of bowel and bladder and wore briefs. The assessment also indicated staff were to check the resident for incontinence every two hours and provide pericare.</p> <p>Review of the 2/12/13 Minimum Data Set (MDS) annual full assessment indicated the resident required extensive assistance from staff members for bathing, hygiene, and toileting. The assessment also indicated the resident was always incontinent of bowel and bladder. The assessment also indicated the resident did not reject care.</p> <p>2. On 3/12/13 at 7:30 a.m., Resident #D was observed sitting in a gerichair in the Dining Room. The resident's eyes were closed. The resident was dressed in pants and a shirt. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 9:05 a.m., 10:50 a.m., 11:45 a.m., 12:05 p.m., and 12:37 p.m. the resident was observed in a geri chair in a semi reclined position in her room. There were no staff members or visitors in the room at the above times.</p> <p>On 3/12/13 at 12:50 p.m., a staff member pushed the resident into the</p>				

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	<p>Dining Room. The resident was not checked for incontinence prior to being taken out of her room. The resident remained in the chair in the Dining Room until 1:15 p.m. At 1:15 p.m., CNA #5 pushed the resident's chair into her room from the Dining Room. The CNA left the resident in the chair and did not check the resident for incontinence at this time.</p> <p>On 3/12/13 at 1:35 p.m., CNA #1 entered the resident's room with CNA #4. The CNA's transferred the resident into her bed using the Hoyer lift and changed the resident's brief. The resident's brief was wet with urine.</p> <p>When interviewed on 3/12/13 at 1:35 p.m., CNA #1 indicated she was assigned to care for the resident. The CNA indicated the resident was up in the chair when she started her shift at 6:00 a.m. The CNA indicated another CNA helped her transfer the resident into bed and changed the resident at approximately 11:00 a.m. The CNA indicated she did not change the resident between 6:00 a.m. and 11:00 a.m. The CNA indicated she did not transfer the resident from the gerichair to the bed to check the resident for incontinence between 6:00 a.m. and 11:00 a.m. as the</p>						

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	<p>resident was in the chair during this time.</p> <p>The record for Resident #D was reviewed on 3/12/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, dementia, glaucoma, and a history of a urinary tract infection.</p> <p>A care plan initiated on 7/25/12 indicated the resident was at risk for skin breakdown related to limitations in bed mobility and incontinence of bowel and bladder. The care plan was last updated on 1/15/13. Care plan interventions included for staff to check the resident for incontinence every two hours and to assist the resident in turning and repositioning.</p> <p>The 3/2013 Physician Order Statement indicated there was an order for the resident to be up as tolerated using a mechanical lift and assistance of two staff members.</p> <p>The 7/20/12 "Bowel/Bladder/Incontinence Assessment" was reviewed. The assessment was last re-evaluated on 1/15/13. The assessment indicated the resident was incontinent of bowel and bladder. The assessment also indicated the resident was to be</p>			

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	<p>checked for incontinence every two hours and staff were to provide incontinence care.</p> <p>The 1/15/13 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of staff for transfers and toileting. The assessment also indicated the resident was always incontinent of bowel and bladder.</p> <p>When interviewed on 3/12/13 at 2:00 p.m., the Director of Nursing indicated if resident's were dependent on staff for transfers using the Hoyer lift the staff should use the lift to place the in bed to check and change for incontinence.</p> <p>This federal tag relates to Complaint IN00121273.</p> <p>3.1-35(g)(1)</p>			

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure incontinence care was provided for dependent residents as per the resident's plan of care for 2 of 4 residents reviewed for activities of daily living in the sample of 5. (Residents #C and #D) (CNA's #1, #2, #3, and #5) (LPN #1 and ADON)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 3/12/13 at 5:45 a.m., Resident #C was observed sitting in a high back wheelchair in her room. The resident was dressed in a pair of pants and a shirt. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 7:30 a.m., the resident was observed sitting in the wheelchair in her room. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 8:55 a.m., CNA #1 was observed pushing the resident down</p>	F000312	<p>1. Corrections from previous timeframes cannot be made. Residents C & D were assessed and are both dependant for toileting and transfers. Resident C has an order Calmoseptine Cream q shift applied to Stage II on left buttocks. Resident D had an order to apply Calmoseptine Cream to bilateral buttocks q shift due to fragile skin. 2.A list of residents requiring incontinence care was developed based upon the census on 3-12-13. The resident care plans are being reviewed and revised to reflect the current plan of care. The nurse aide assignment sheets are also being modified to provide direction toward each residents plan of care in regard to incontinence management.3.C.N.A.'s involved with residents C & D care were re-educated following survey on 3-13-13 by ADON. Nurses and C.N.A. meetings will be scheduled on April 4, 2013 and April 5, 2013 to inform of the modifications to the nurse aide assignment sheets and resident care plans. The policy entitled "Incontinence Management Program" will be reviewed at the</p>	04/11/2013			

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	<p>the hallway in her wheelchair. The CNA placed the resident in the hallway across from the Nurses' Station.</p> <p>On 3/12/13 at 10:52 a.m., the resident was observed sitting in the wheelchair in her room. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 11:45 a.m., the resident was observed sitting in the wheelchair in the hallway across from the Nurses' Station.</p> <p>On 3/12/13 at 12:15 p.m., the resident was observed sitting in the wheelchair in the Dining Room for lunch. The resident remained in the wheelchair in the Dining Room until 1:20 p.m.</p> <p>On 3/12/13 at 1:20 p.m., CNA #3 pushed the resident from the Dining Room to her room in the wheelchair. CNA #2 followed the resident into the room. CNA #2 and CNA #3 then began to transfer the resident into her bed using the Hoyer Lift (a mechanical lift used to transfer residents). The CNA's removed the resident's brief. The brief was wet with urine and stool. A small superficial open area was observed on the resident's left mid inner buttock</p>		<p>time of the meeting and questions answered. The charge nurses/designee will be responsible for monitoring compliance with the incontinence management program. Staff found non-compliant following formal education will receive discipline per facility protocol. 4.An audit tool entitled "Resident Rounds" will be implemented and utilized by the charge nurses and nursing management to assure compliance. The Charge nurse/designee will observe at least 2 different residents per shift per day 3X a week for 6 weeks. Observations will include a sample of residents dependant for incontinenace care and turning and/or repositioning according to an established schedule. The results/compliance of the audit completion will be evaluated by the QA nurse/designee weekly for 6 weeks to determine the need to contunue audits or change the frequency of audits to ensure the deficient practice will not recur. Charge nurses every shift will be responsible for making rounds on all residents on each shift to assure compliance with resident plan of care for moisture management on dependant residents. Random audits will be done daily by the Nurse Manager/designee during rounds for 6 months to assure that incontinence care is provided per</p>				

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	<p>area. The open area measured approximately .5 cm (centimeters) x .5 cm and was red in color. There was no drainage or odor from the area. The CNA's applied a clean brief at this time.</p> <p>On 3/12/13 at 1:40 a.m., the ADON (Assistant Director of Nursing) and LPN #1 entered the resident's room to assess the resident's skin. The resident was asked what was sore and she replied "My butt." The ADON indicated the area on the left buttock was open. LPN #1 indicated she was not aware of the open area until this time.</p> <p>When interviewed on 3/12/13 at 1:30 p.m., CNA #2 indicated she was assigned to care for the resident on the day shift. The CNA indicated she began work at 6:00 a.m. and the resident was dressed and up in the wheelchair at the start of her shift this morning. The CNA indicated the last time she lay the resident into her bed to change her was at approximately 11:15 a.m. or 11:30 a.m. The CNA indicated she did not transfer the resident into the bed to check or change her between 6:00 a.m. and 11:15 a.m. CNA #2 indicated she did recall taking the resident into the Shower Room at approximately 7:30</p>		<p>plan of care. Results of the audits will be brought to QA committee quarterly for review and recommendations. 5.DON responsible for compliance. April 11, 2013.</p>		

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	<p>a.m. and checked her brief while she was in the chair. The CNA indicated she did not get the resident out of the wheelchair at this time.</p> <p>The record for Resident #C was reviewed on 3/12/13 at 8:00 a.m. The resident's diagnoses included, but were not limited to, seizure disorder, dementia, depression, high blood pressure, and atrial fibrillation (an irregular heart rhythm).</p> <p>A care plan initiated on 2/11/13 indicated the resident was at risk for skin break down related to limitations in bed mobility and being incontinent of bowel and bladder. Care plan interventions included for staff to check the resident for incontinence every two hours and provide pericare after each incontinent episode.</p> <p>Review of the 3/2013 Physician Order Statement indicated there was an order for the resident to be up in the wheelchair with the use of a mechanical lift.</p> <p>A "Bowel/Bladder/Incontinence Assessment " was completed on 2/11/13. The assessment indicated the resident had multiple daily episodes of urinary incontinence.</p>						

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	<p>The assessment also indicated the resident was incontinent of bowel and bladder and wore briefs. The assessment also indicated staff were to check the resident for incontinence every two hours and provide pericare.</p> <p>Review of the 2/11/13 Braden Scale for predicting pressure ulcer risk indicated the resident's mobility was very limited and her skin was often moist. The Braden Scale also indicated the resident was at high risk for developing pressure ulcers.</p> <p>Review of the 2/12/13 Minimum Data Set (MDS) annual full assessment indicated the resident required extensive assistance from staff members for bathing, hygiene, and toileting. The assessment also indicated the resident was always incontinent of bowel and bladder. The assessment also indicated the resident did not reject care.</p> <p>2. On 3/12/13 at 7:30 a.m., Resident #D was observed sitting in a gerichair in the Dining Room. The resident's eyes were closed. The resident was dressed in pants and a shirt. The resident was not receiving care at this time.</p> <p>On 3/12/13 at 9:05 a.m., 10:50 a.m.,</p>			

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	<p>11:45 a.m., 12:05 p.m., and 12:37 p.m. the resident was observed in a geri chair in a semi reclined position in her room. There were no staff members or visitors in the room at the above times.</p> <p>On 3/12/13 at 12:50 p.m., a staff member pushed the resident into the Dining Room. The resident was not checked for incontinence prior to being taken out of her room. The resident remained in the chair in the Dining Room until 1:15 p.m. At 1:15 p.m., CNA #5 pushed the resident's chair into her room from the Dining Room. The CNA left the resident in the chair and did not check the resident for incontinence at this time.</p> <p>On 3/12/13 at 1:35 p.m., CNA #1 entered the resident's room with CNA #4. The CNA's transferred the resident into her bed using the Hoyer lift and changed the resident's brief. The resident's brief was wet with urine.</p> <p>When interviewed on 3/12/13 at 1:35 p.m., CNA #1 indicated she was assigned to care for the resident. The CNA indicated the resident was up in the chair when she started her shift at 6:00 a.m. The CNA indicated another CNA helped her transfer the resident</p>						

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	<p>into bed and changed the resident approximately around 11:00 a.m. The CNA indicated she did not change the resident between 6:00 a.m. and 11:00 a.m. The CNA indicated she did not transfer the resident for the gerichair to the bed to check the resident for incontinence between 6:00 a.m. and 11:00 a.m. as the resident was in the chair during this time.</p> <p>The record for Resident #D was reviewed on 3/12/13 at 8:50 a.m. The resident's diagnoses included, but were not limited to, Alzheimer disease, dementia, glaucoma, and a history of a urinary tract infection.</p> <p>A care plan initiated on 7/25/12 indicated the resident was at risk for skin breakdown related to limitations in bed mobility and incontinence of bowel and bladder. The care plan was last updated on 1/15/13. Care plan interventions included for staff to check the resident for incontinence every two hours and to assist the resident in turning and repositioning.</p> <p>The 3/2013 Physician Order Statement indicated there was an order for the resident to be up as tolerated using a mechanical lift and assistance of two staff members.</p>			

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	<p>The 7/20/12 "Bowel/Bladder/Incontinence Assessment" was reviewed. The assessment was last re-evaluated on 1/15/13. The assessment indicated the resident was incontinent of bowel and bladder. The assessment also indicated the resident was to be checked for incontinence every two hours and staff were to provide incontinence care.</p> <p>The 1/15/13 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of staff for transfers and toileting. The assessment also indicated the resident was always incontinent of bowel and bladder.</p> <p>When interviewed on 3/12/13 at 2:00 p.m., the Director of Nursing indicated if resident's were dependent on staff for transfers using the Hoyer lift the staff should use the lift to place the in bed to check and change for incontinence.</p> <p>This federal tag relates to Complaint IN00121273.</p> <p>3.1-38(a)(2)(C)</p>				

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