

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/06/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189119.</p> <p>Complaint IN00189119 - Substantiated Federal/State deficiencies related to the allegations are cited at F157, F278, F314, F353, F371, and F514.</p> <p>Survey dates: January 4, 5, and 6, 2016</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Census bed type: SNF/NF: 124 Total: 124</p> <p>Census payor type: Medicare: 14 Medicaid: 92 Other: 18 Total: 124</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on January</p>	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our record of compliance effective February 5, 2016 for the survey completed January 6, 2016.	

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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F 0157 SS=D Bldg. 00	<p>7, 2016.</p> <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>			

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	<p>Based on interview and record review, the facility failed to notify a family member of a resident's arm swelling, bruising, and complaints of pain, and of a new physician's order for x-rays, for 1 of 4 residents reviewed for family notification, in a sample of 11. Resident B</p> <p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed on 1/4/16 at 1:30 P.M.</p> <p>Nurse's Notes, dated 11/20/15 at 2:30 P.M., indicated, "...Resident left forearm appears to be slightly swollen, at L [left] wrist down to hand (left) bruising appearing to appear. Res [resident] c/o [complains of] pain at touch. X Ray ordered by NP [Nurse Practitioner] [Name] of Left forearm et [and] wrist. Awaiting results."</p> <p>A Physician's order, dated 11/20/15, indicated, "Xray of Left forearm and Left wrist to rule out injury...Family has been notified of the above treatment change [blank]. Date notified [blank]."</p> <p>On 1/5/16 at 11:25 A.M., during an interview with the Director of Nursing (DON), she indicated she was aware that</p>	F 0157	<p>F 157</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: This resident now resides in another long term carefacility.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: No other residents were identified with this deficientpractice.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Staff will be educated on family notification anddocumentation of new physician orders.</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: This deficient practice will be monitored with a "FamilyNotification Tool" that will be presented to the Quality Assurance Team monthlyx 3, then if no problems noted will be monitored quarterly x 3.</p>	02/05/2016

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	<p>Resident B's family was not notified of the resident's arm concerns or order for an xray, and that it had been addressed.</p> <p>On 1/5/16 at 11:40 A.M., during an interview with Resident B's responsible party, she indicated she was unaware of the resident's arm condition and order for xray until 2 days after it was found, when the facility sent the resident to the emergency room for evaluation.</p> <p>On 1/5/16 at 12:10 P.M., the DON provided the current facility policy, "Change in a Resident's Condition," dated 2003. The policy included: "Interpretation & Implementation: 1. The Charge Nurse/Nurse Supervisor will notify the resident, his/her physician, his/her legal representative(s), and/or his/her interested family members, when there is:...b. a change in the resident's condition, c. A need to alter treatment significant [sic]...."</p> <p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-5(a)(2)</p>		<p>By what date the systemic changes will be completed: 2/5/2016</p>	

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F 0278	483.20(g) - (j)			

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SS=D Bldg. 00	<p>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to accurately assess 2 pressure ulcers, by staging the ulcers incorrectly on the Minimum Data Set (MDS) Assessment, for 1 of 4 residents reviewed for accurate MDS assessments, in a sample of 11. Resident B</p>	F 0278	<p>F 278</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: The Resident now resides in another long term care facility.</p> <p>How otherresidents having the</p>	02/05/2016

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	<p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 1/4/16 at 1:30 P.M. The resident was admitted to the facility on 9/24/15.</p> <p>A hospital note, dated 9/22/15, indicated: "Postoperative Diagnosis: 1. Left ischial tuberosity stage 4 pressure ulcer. 2. Right heel stage 4 pressure ulcer...Left ischial tuberosity pressure ulcer measures 3.0 x 2.4 x 0.8 cm [centimeters]...20% black, 60% bright red and 20% yellow in the base. This involves bone...The right heel ulcer measures 0.7 x 0.7 x 0.3 cm...This involves bone...."</p> <p>An admission MDS assessment, dated 10/1/15, indicated, "Skin Conditions: Report based on highest stage of existing ulcer(s) at its worst/ do not 'reverse' stage...Current Number of Unhealed Pressure Ulcers at Each Stage: 1- Number of Stage 1 pressure ulcers. A. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence... B. 1 -Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough...0 - Stage 3...0-Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar [black tissue] may be</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All Residents with Pressure ulcers will have their MDS's reviewed for accurate staging.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Educate licensed nursing staff on proper staging of wounds/pressure areas. A New MDS Coordinator was hired who has experience in information gathering and assessments.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Residents with pressure ulcers will have their MDS's reviewed for proper pressure ulcer staging and will be reported on the "MDS Pressure Ulcer Staging Tool" and reported to the Quality Assurance Team monthly x 3 and if there are no problems will be reported quarterly x 3.</p> <p>By what date the systemic changes will be completed: 2/5/2016</p>		

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	<p>present...Often includes undermining and tunneling...Most Severe Tissue Type for Any Pressure Ulcer: 2 - Granulation tissue - pink or red tissue with shiny, moist, granular appearance...."</p> <p>On 1/5/16 at 11:25 A.M., during an interview with the Director of Nursing, she indicated the staff member who completed Resident's B MDS assessment was no longer working on MDS assessments.</p> <p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-31(a)</p>			

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F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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			

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	<p>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, interview, and record review, the facility failed to ensure interventions were implemented and care plans updated regarding skin breakdown; failed to update the physician of a pressure ulcer; failed to assess pressure ulcers at least weekly; failed to document and assess the reopening of an ulcer; failed to perform treatments as ordered, and failed to arrange transportation to a wound clinic for pressure ulcer care. This resulted in a Stage 3 pressure area on the resident's coccyx, and the redevelopment of a resident's back pressure ulcer, without a documented assessment or treatment order (Resident D), and the increase in size of a resident's Stage 4 pressure area (Resident B). This affected 2 of 4 residents reviewed with pressure areas, in a sample of 11. Resident D and B</p> <p>Findings include:</p> <p>1. On 1/4/16 at 9:25 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident D had open areas to her coccyx and buttocks.</p> <p>The clinical record of Resident D was</p>	F 0314	<p>F 314 What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident B now resides in another long term care facility. Resident D's area was assessed, a treatment was ordered, the careplan was updated, the family was notified, and the area was healed on 1/11/2016. How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: Skin assessments were completed for other residents and no other areas were noted. What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur: Staff education on the proper procedures to follow when new pressure areas are identified. How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place: This will be managed by an audit tool " Newly Identified Pressure Areas" which will</p>	02/05/2016

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	<p>reviewed on 1/5/16 at 11:15 A.M.</p> <p>A care plan, initially dated 2/24/15 and with a goal target date of 8/2/15, indicated: "Focus: Skin breakdown, potential for related to: decreased mobility, weakness and Peripheral Neuropathy which has affected resident's BLE's [bilateral lower extremities] and is progressing. Resident requires assistance from staff for all transfers...Interventions: Notify family/physician of any new areas of skin breakdown...Treatments as ordered...."</p> <p>A care plan regarding current skin breakdown was not found in the clinical record.</p> <p>A Minimum Data Set (MDS) assessment, dated 10/27/15, indicated Resident D was moderately impaired in cognitive skills for daily decision-making, required extensive assistance of two+ staff for bed mobility and transfer, and had no pressure ulcers.</p> <p>A Physician's order, dated 11/10/15, indicated, "Cleanse area on back [with] NS [normal saline]. Apply "Stimulen Powder" to wound bed. Cover [with] foam dressing QD [every day] et [and] prn [as needed] x 2 weeks then re-eval [re-evaluate]."</p>		<p>monitor if proper procedures are followed when a new pressure area is identified. This will be presented to the Quality Assurance Team monthly x 3and then if no problems quarterly x 3.</p> <p>By what date the systemic changes will be completed: 2/5/2016</p>	

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	<p>Nurse's Notes did not document the area on the Resident's back.</p> <p>Nurse's Notes included the following notations:</p> <p>11/11/15 at 3:00 P.M.: "This nurse went to [change] drsg [dressing] on back, when this nurse observed open areas on buttocks. Coccyx open area measures 1.2 x .4, Stage II. [Right] buttock open area measuring 4 cm x 1.5. [Left] buttock there are 3 separate [sic] small areas measuring .5 x .7, .5 x .5, et [and] .4 x .1. Hydrogel applied to all et covered [with] foam drsgs...."</p> <p>11/19/15 at 2:30 P.M.: "N.O. [new order] rec'd [sic] to dc [discontinue] all prev. [previous] wound tx [treatment] to coccyx and buttocks. N.O rec'd... Will continue to monitor."</p> <p>12/26/15 untimed: "Tx done to bilat [bilateral] buttocks/coccyx areas. Appears to be healing well...."</p> <p>Documentation indicated the 12/26/15 note was the most recent notation in the Nurse's Notes.</p> <p>A Physician's note, dated 12/30/15, indicated, "D/C current tx: Begin - Apply</p>			

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	<p>hydrogel impregnated gauze to area on coccyx. Apply hydrogel paste to areas on buttocks. Cover [with] Mepilex sacral. D/C when healed. [Change] daily."</p> <p>On 1/5/16 at 10:00 A.M., a skin assessment was requested. RN # 1 assisted the resident to turn. A dressing was observed over the coccyx/buttocks area. When RN # 1 removed the dressing, the buttocks area appeared red and excoriated. An open ulcer, with a yellowish center, was observed on the coccyx. 2 superficial areas were observed on the right buttocks area.</p> <p>On 1/5/16 at 12:10 P.M., skin assessment documentation was requested. RN # 1 indicated she was the staff who was to complete the documentation, "but it's probably not up to date." RN # 1 indicated she tried to measure the pressure ulcers weekly, but did not always transfer the information onto the correct forms. RN # 1 provided Resident D's "Weekly Pressure Ulcer" records at that time.</p> <p>The Weekly Pressure Ulcer records indicated the following:</p> <p>Description of Stages: Stage 1: Intact skin with non-blancheable redness...Stage 2: Partial thickness loss of dermis</p>			

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	<p>presenting as a shallow open ulcer with a red or pink wound bed, without slough...Stage 3: Full thickness loss...Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed...Unstageable: Slough and/or eschar (black tissue): Known but not stageable due to coverage of wound bed by slough and/or eschar...."</p> <p>Date of Onset: Left blank. Site/Location: coccyx. Date 11/11, Stage II. Size in cm (Length x Width) 1.2 x .4. Exudate [drainage] Scant. Wound bed pink, Surrounding skin color pink...Preventive Measures/Progress: Turned q [every] 2 hours. Pressure Relieving Interventions, cushions et mattress. Is resident experiencing pain related to wound? Yes.</p> <p>Date: 11/19, Stage II. Size 1 x 0.5, Depth <0.1...Tx [changed]...."</p> <p>Documentation regarding the coccyx pressure ulcer after 11/19/15 was not found.</p> <p>Date of onset: 11-10-15. Site/Location: mid center back. Date 11/10, Stage III. Size 1 x 0.3, Depth 0.1, Exudate scant, Wound bed yellow, Surrounding skin color pink...Response to Treatment/Comments: Stimulen powder</p>			

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	<p>[with] foam dressing daily...."</p> <p>Date 11/19, Stage II, Size 1 x 0.5, Depth <0.1, Exudate Scant... Wound Bed pink...."</p> <p>Documentation regarding the back pressure ulcer after 11/19/15 was not found.</p> <p>Date of onset: Left blank. Site/Location: Right buttock. Date 11/11, Stage [Left blank]. Size 4 x 1.5, Depth [none], Exudate bleeding, Wound bed yellow, Surrounding skin color pink...Response to Treatment/Comments: Hydrogel et foam change daily et PRN...."</p> <p>Documentation regarding the right buttock pressure ulcer after 11/11/15 was not found.</p> <p>Documentation regarding the left buttock pressure ulcers was not found.</p> <p>On 1/5/16 at 2:50 P.M., another skin assessment was requested. LPN #1 indicated he was unsure if the resident had an area on her back. LPN # 1 and LPN # 2 assisted the resident. An undated duoderm dressing was observed on the resident's lower mid back. LPN # 1 removed the dressing, and a pressure area was observed, with bleeding from the</p>			

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	<p>area .</p> <p>LPN # 2 indicated at that time that she would check the resident's treatment record to determine what treatment the resident would receive. The resident's treatment record, dated January 2016, was observed at that time to have no treatment listed for the resident's back open area. LPN # 2 indicated she was aware of the resident having a treatment order for her back the previous month.</p> <p>On 1/5/16 at 3:05 P.M., during an interview with the DON, she indicated she was unaware the resident had an open area on her back. She indicated the area had healed on 12/23/15, and must have reopened. She indicated RN # 1 was responsible for completing the pressure ulcer assessments weekly She indicated the most recent measurements she had received, dated 12/29/15, included: Coccyx: 2 x 1.5 x .2, Right buttock, 1 x 0.5 x .1, and Right buttock, 2 x 2.</p> <p>On 1/6/16 at 1:30 P.M., an additional skin assessment was requested. LPN # 1 assisted the resident, and measured the resident's back pressure ulcer as 1.5 x .3 x <.1 cm. The wound bed was red, without surrounding redness. LPN # 1 indicated he had only been working on that unit for approximately 2 weeks, and</p>			

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	<p>was unsure of the etiology of the area.</p> <p>2. The closed clinical record of Resident B was reviewed on 1/4/16 at 1:30 P.M. Diagnoses included, but were not limited to, coronary artery disease, peripheral vascular disease, paraplegia, and dementia.</p> <p>An admission MDS assessment, dated 10/1/15, indicated the resident had a short term and long term memory problem, and was totally dependent on two + staff for bed mobility and transfer. The MDS assessment indicated the resident had 2 unhealed pressure ulcers.</p> <p>A care plan, dated 9/24/15 and with a goal target date of 12/23/15, indicated: "Focus, Resident has skin impairment - Admit with chronic decubitus [sic] ulcers to bilateral heels and coccyx areas. Resident does see wound care clinic and [name of physician] for treatment plan to these areas. Interventions: Administer treatments as ordered. Assist with appts [appointments] to wound care clinic [name] as ordered...Use [name] for transfer to [name] wound ctr [center]."</p> <p>Wound Care Center notes, dated 11/19/15, indicated, "...Wound measurements: Left ischial tuberosity - 2.9 x 2.0 x 0.7, Right heel - 5.0 x 3.2 x</p>			

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	<p>0.3."</p> <p>Wound Care Center notes, dated 12/3/15, indicated, "...11-19-15 [Culture and Sensitivity] [positive] Proteus Mirabilis. 1) Nursing bandage change to Right heel Stage 4 pressure ulcer...daily [and] prn. 2) Left ischial tuberosity Stage 4 pressure ulcer...daily [and] prn. Follow up appt. Dec 10, 2015. Measurements: Left ischial tuberosity:- 4 x 3.2 x 0.6, Right heel - 7.2 x 4.7 x 0.3. Rocephin [an antibiotic]...x 14 days addition!"</p> <p>Wound Care Center notes, dated 12/10/15, indicated, "[Left] ischial tuberosity - irrigate wound [with] 20 cc NS [normal saline], skin prep peri wound, barrier cream peri, algidex ag wet gauze, foam q [every] day...[Right] heel stage 4 pressure - irrigate [with] 20 cc NS, barrier cream peri, algidex ag wet gauze, ABD pad, roll gauze q day...Measurements: [Left] ischial - 5.0 x 2.5 x 0.5, [Right] heel - 4.0 x 5.0 x 0.2. F/U [follow up] appt. Dec 17th @ 3:00 pm."</p> <p>Nurse's Notes, dated 12/12/15 at 3:00 P.M., indicated, "Treatment done."</p> <p>The next notation in the Nurse's Notes, dated 12/22/15 at 1:15 P.M., indicated the resident was transferred to another</p>			

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	<p>facility.</p> <p>Nurse's Notes did not document the resident attended an appointment on 12/17/15.</p> <p>A Medication Administration Record (MAR), dated December 2015, indicated the resident received the prescribed daily treatment to either her coccyx or her heel on 12/5, 12/6, 12/8, and 12/18/15. The remaining dates were not initialed as completed.</p> <p>On 1/5/16 at 10:30 A.M., during an interview with the DON and Administrator, the DON indicated Resident B did not go to the Wound Care Center on 12/17/15. The DON indicated no staff had set up an appointment with the ambulance service, and another service was contacted but refused to transport the resident due to payment concerns. The DON indicated as far as she knew, the resident did not go to her wound care center appointment after 12/17 and was discharged on 12/22/15.</p> <p>On 1/5/16 at 11:40 A.M., during an interview with the responsible family member for Resident B, she indicated she had visited the resident on 12/13/15, and the resident's dressings were dated 12/11/15. The family member indicated</p>			

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	<p>nursing staff had informed her they "couldn't get everything done." The family member indicated the resident was unable to go to her wound care appointment on 12/17/15, due to the facility not setting up transportation. She indicated the appointment was not rescheduled on 12/18 or 12/19, and she decided to transfer the resident on 12/22/15.</p> <p>On 1/5/16 at 3:05 P.M., during an interview with the DON, she indicated the unit manager was to have filled out weekly pressure ulcer assessments for Resident B, but that "they probably were not done." She indicated she did not have any documentation of weekly pressure ulcer assessments for Resident B.</p> <p>On 1/5/16 at 3:45 P.M., the DON provided the current facility policy on Pressure Ulcer monitoring, dated 3/09. The policy included: "Purpose: To record on a weekly basis (at a minimum) a complete pressure ulcer description, the response to treatment, and notification of family, doctor, and dietary...Complete this form WEEKLY on every resident with an identified Stage I, II, III, IV, or unstageable pressure ulcer...."</p> <p>On 1/6/16 at 11:30 A.M., the DON provided the current facility policy on</p>			

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	<p>Skin Management, dated November 2014. The policy included: "Residents admitted with skin impairments will have: Appropriate interventions implemented to promote healing. A Physician's order for treatment; Wound location and characteristics documented in the Nurse's Notes...In addition, the following forms are completed and placed with the resident's Treatment Record:...Weekly Pressure Ulcer Record...Wounds are tracked as acquired (developed in-house or admitted with) and are assessed and documented on the Weekly Pressure Ulcer Record...A Physician's Order will be written to monitor each ulcer...The Nurse will assure treatments, interventions, Care Plan, and the appropriate skin documentation records are initiated in a timely manner...Pressure ulcers are measured and staged weekly...."</p> <p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-40(a)(2)</p>			

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p>			

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	<p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to ensure sufficient staffing was available to answer call lights timely, give showers, toilet residents, reposition residents, and transfer residents to and from their beds, for 1 of 4 units in the facility (unit E/F) and the potential to affect 38 residents residing on this unit. Residents A, G, H, I, B, J, K</p> <p>Findings include:</p> <p>1. On 1/4/16 at 11:15 A.M., during an interview with Resident A, he indicated, "There's not enough help." He indicated he had to wait for his call light to be answered timely; he indicated it was always at least 15 minutes or longer before staff responded. Resident A indicated, "There's only 1 person on eves, and they expect her to do it all. The staff is mad as h--l." Resident A indicated he often had to wait to go to the bathroom and receive personal care.</p>	F 0353	<p>F 353</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:</p> <p>The Administratorand DON continue to make daily rounds and talking with Residents about anyconcerns. All meals are assigned to department heads to assist with passing ofmeals and nursing supervisors to assist with meals if needed. Shower times havebeen reviewed for appropriate times with each resident on E and F Unit</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:</p> <p>All Residents have the potential to be affected. Staffingwill be monitored every shift. Recruitment of new staff will continue. Two hourrounds on each unit to make sure care is being provided. Showers to bemonitored daily.</p>	02/05/2016

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	<p>2. On 1/5/16 at 10:55 A.M., during an interview with Resident G, he indicated, "There's not enough staff." He indicated, "It takes awhile for call lights to be answered." Resident G indicated he frequently did not receive his showers, and had gone 2 weeks without a shower.</p> <p>3. On 1/5/16 at 3:10 P.M., during an interview with Resident I, he indicated he received 1 shower a week. He indicated, "I heard you were supposed to receive 2 showers a week." He indicated he required assistance with cutting his meat, and frequently did not receive assistance.</p> <p>4. On 1/5/16 at 3:45 P.M., during an interview with Resident H, she indicated she frequently had to "wait awhile for them to answer call light." She indicated, "I have to pee so bad and just can't hold it." Resident H indicated she usually received 1 shower a week.</p> <p>5. On 1/5/6 at 11:40 A.M., during an interview with a family member of a recently discharged resident, Resident B, she indicated the resident appeared to never have her hair washed. She indicated nursing staff had informed her they didn't have time to change the resident's dressing. She indicated she found the resident laying in a urine soaked bed.</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Two hour rounds will be completed on each unit to make sure care is being completed. Staff will be educated on completion of showers and on getting residents to the dining room for meals if desired by the resident. Staff will be educated on answering call lights timely. We will offer residents on E and F a weekly meeting to voice concerns to Administration. We continue to monitor staffing every shift. We will continue to recruit new staff as available. This company has been and will continue to offer sign on and referral bonuses. Staff are paid bonuses for picking up extra shifts. Nursing Administration will continue to pick up shifts as needed to meet the staffing needs. We will also offer to pay for C.N.A classes up front for selected individuals who have a passion for long term care. Signs will be posted on the property for "Help Wanted". On-Line Postings will continue for long term care providers. Searches for Resumes on-line will continue.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>	

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	<p>6. During a confidential interview with Staff A, he/she indicated, "We can't give the residents proper care." Staff A indicated, "We can't get everyone up and toileted. We can't get the showers done."</p> <p>During a confidential interview with Staff B, he/she indicated, "It's hard to get it all done." Staff B indicated, "We do what we can." Staff B indicated he/she made it a priority to feed residents, but that it make take a long time. Staff B indicated he/she would leave residents in bed, because it would take too much time to get residents up and down from bed. Staff B indicated he/she could not get the showers done.</p> <p>7.. On 1/4/16 at 10:15 A.M., during an interview with the local ombudsman, she indicated she had received several calls from concerned staff and family members complaining about the lack of staff on the EF unit. She indicated staff were complaining about working 17 and 19 hours without a break, and informed her that residents were not getting "decub care, or being fed." She indicated family members were complaining of residents "reeking of urine."</p> <p>8. On 1/4/16 at 3:45 P.M., the Administrator provided Resident Council</p>		<p>The results of the two hour round sheets will bemonitored for turning and repositioning and incontinence care, the ADL sheetswill be monitored for Shower completion and meal consumption, a call lightaudit tool will be used to monitor call lights times, Notes will be takenduring Resident meetings, Staffing will be monitored every shift, HR willmonitor turnover rates and new hires and all will be reported to the QualityAssurance team monthly x3 and then will be re-evaluated for continued monthlymonitoring or will be moved to Quarterly x3.</p> <p>By what date thesystemic changes will be completed: 2/5/2016</p>	

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	<p>minutes. The minutes included:</p> <p>10/28/15: "[Resident J] stated, 'at 1:30 A.M. he talked to the nurse and needed to be turned to opposite side.' The nurse told him, 'She would be right back' and did not return."</p> <p>12/30/15: "[Resident K] says 'She sits too long in dining room before meals.'</p> <p>9. On 1/4/16 at 12:00 P.M., the Administrator provided current CNA assignment sheets. The sheets for EF unit indicated:</p> <p>There were 20 residents on E hall: 5 residents required the assistance of 1 staff for transfer/mobility; 6 residents required the assistance of 2 staff; and 7 residents required a hooyer (mechanical lift) or stand-up lift. 12 residents were incontinent; 16 residents were on a "check/change" schedule; and 1 resident was on a "toileting plan." 11 residents were to be "turned and repositioned."</p> <p>There were 18 residents on F hall: 4 residents required the assistance of 1 staff for transfer/mobility; 5 residents required the assistance of 2 staff; and 7 residents required a hooyer (mechanical lift) or stand-up lift. 9 residents were incontinent; and 15 residents were on a</p>			

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	<p>"check/change" schedule. 10 residents were to be "turned and repositioned" and 4 residents were to be "asked" if they wanted to be turned and repositioned.</p> <p>On 1/4/16 at 3:15 P.M., during an interview with the Staff Scheduler, she indicated that on the EF unit she attempted to schedule 2 nurses and 3 CNAs on day shift, 2 nurses and 2 CNAs on evening shift, and 1 nurse and 1 CNA on night shift. She indicated if staff called in, the nurse working would attempt to find a replacement. She indicated the staffing was based on census, but "also if we had ample staff, I would think we would have at least 2 CNAs on night shift."</p> <p>On 1/5/16 at 9:15 A.M., during an interview with the Director of Nursing (DON), she indicated she was aware of staffing concerns. She indicated the facility did utilize agency staff.</p> <p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-17(a)</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F 0371 SS=D Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident refrigerators were monitored for</p>	F 0371	<p>F 371</p> <p>What Correctiveaction(s) will be accomplished for those residents</p>	02/05/2016

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	<p>correct temperatures, for 3 of 3 resident refrigerators reviewed, in a sample of 11 residents. Residents A, E, and F</p> <p>Findings include:</p> <p>1. On 1/4/16 at 11:15 A.M., Resident A was observed to have a refrigerator in his room. A temperature log was taped on the side. The log indicated: November/December 2015, and was filled out on 8 days in November and 4 days on December with the notation "40 degrees." The refrigerator was opened, and no thermometer was observed.</p> <p>On 1/5/16 at 12:00 P.M., Resident A's refrigerator was observed to have a new temperature log, dated January 2016. The log was filled out from 1/1-1/5 with the notation "40 degrees." When the refrigerator was opened, there was no thermometer.</p> <p>At that time, Housekeeping Staff # 1 was interviewed. She indicated she put the new log on Resident A's refrigerator. She indicated she just realized it did not have a thermometer.</p> <p>2. On 1/5/16 at 10:15 A.M., a refrigerator was observed in Resident E's room. A temperature log was not observed near the refrigerator. A thermometer was not</p>		<p>found to have been affected by the deficient practice: A thermometer and log was placed on the refrigerators immediately.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All Resident with refrigerators have the potential to be affected. All Residents with Refrigerators were observed and if they did not have a thermometer or a log one was placed immediately.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff education will be completed to ensure that staff are monitoring for logs sheets and thermometers and that they replace any missing or defective item.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Personal Refrigerators will be monitored once a week x 4 for placement of the Thermometer and log sheet. Then if no problems are noted we will monitor monthly. The results of the Audit tool "Refrigerator thermometer and log"</p>	

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	<p>observed inside the refrigerator.</p> <p>3. On 1/5/16 at 10:20 A.M., a refrigerator was observed in Resident F's room. A temperature log was not observed near the refrigerator. A thermometer was not found inside the refrigerator.</p> <p>At that time, the Unit Manager was interviewed regarding temperature logs for resident refrigerators. She indicated she was unaware of temperature logs for resident refrigerators.</p> <p>On 1/5/16 at 12:20 P.M., during an interview with the Housekeeping Supervisor, she indicated housekeeping staff were to check the refrigerators daily, and all should have thermometer's. She indicated staff had removed the temperature logs for Resident E and F the previous day, and had not replaced them.</p> <p>On 1/5/16 at 12:10 P.M., the Administrator provided the current facility policy on "In Room Refrigerators," dated 11/09. The policy included: "Temperatures will be taken daily by housekeeping and will be 41 or below. If above 41 housekeeping will notify the charge nurse who will inturn [sic] put refrigator [sic] out of order until maintance [sic] can check it when he receives a work order to do so...."</p>		<p>will be reported monthly to the Quality Assurance Team.</p> <p>By what date the systemic changes will be completed: 2/5/2016</p>	

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F 0514 SS=D	<p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.75(l)(1) RES</p>			

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Bldg. 00	<p>RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>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 interview and record review, the facility failed to ensure documentation was complete regarding administration of medications and ointments, for 1 of 4 residents reviewed for complete documentation, in a sample of 11. Resident B</p> <p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed on 1/4/16 at 1:30 P.M.</p> <p>The resident's Medication Administration Record (MAR), dated December 1-21 2015, indicated the following:</p> <p>Aspirin EC 81 mg tablet Take 1 tablet by mouth daily: Not initialed as given on</p>	F 0514	<p>F 514</p> <p>What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: Resident B no longer resides at this Facility.</p> <p>How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken: All Residents have the potential to be affected by thisdeficient practice. All Medication Administration records and TreatmentAdministration records will be reviewed.</p> <p>What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not</p>	02/05/2016

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	<p>12/12, 12/15, 12/16.</p> <p>Cyanocobalamin (Vitamin B 12), Inject Intramuscularly once a month: Scheduled to be given on 12/13/15. It was not initialed as given.</p> <p>Rivastigmine, Apply new patch every morning Dx [diagnosis]: Memory enhancer: Not initialed as given 12/12, 12/13, and 12/18.</p> <p>Synthroid 200 mcg, Take 1 tablet by mouth daily: Not initialed as given 12/12, 12/15, and 12/16.</p> <p>Gabapentin 300 mg, Take 1 capsule by mouth twice a day, Dx: Neuropathy: Initialed as given only 1 time a day on 12/1, 12/2, 12/4, 12/5, 12/6, 12/15, 12/18, 12/19, and 12/20. Not initialed as given on 12/3, 12/12, and 12/16.</p> <p>Fentanyl patch (for pain control) 12.5 mcg qod [every other day]: Initialed as given on 12/6, 12/14, and 12/17.</p> <p>Lotrisone Cream apply to buttocks twice daily: Not initialed as given 12/11, 12/12, 12/13, 12/14, 12/15, 12/16, and 12/20.</p> <p>On 1/5/16 at 9:15 A.M., during an interview with the Director of Nursing, she indicated the Unit Manager was to</p>		<p>recur: All Nurses will be educated on proper administration of medications and treatments and the documentation thereof.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A Medication and Treatment Administration Audit tool will be completed monthly x 3 and if the issue is resolved it will be completed quarterly. All results will be reported to the Quality Assurance Team.</p> <p>By what date the systemic changes will be completed: 2/5/2016</p>		

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	<p>have been checking documentation, and had not been doing it.</p> <p>On 1/5/16 at 12:10 P.M., the Director of Nursing provided the current facility policy "Documentation of Medication Administration," dated April 2007. The policy included: "The facility shall maintain a medication administration record to document all medications administered. A Nurse or Certified Medication Aide (where applicable) shall document all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication must be documented immediately after (never before) it is given...."</p> <p>This Federal tag relates to Complaint IN00189119.</p> <p>3.1-50(a)(1)</p>			

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