

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2013
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NAME OF PROVIDER OR SUPPLIER SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaints IN00131445 and IN00131970 and IN00133446.</p> <p>Complaints: IN00131445 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F312, F314 and F323.</p> <p>IN00131970 Substantiated. Federal/State deficiency related to the allegation is cited at F368.</p> <p>IN00133446 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F309.</p> <p>Survey dates: July 26, 29, 31, 2013 and August 1, 2013</p> <p>Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 15 SNF/NF: 102</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after August 26, 2013.</p>	

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

TITLE

(X6) DATE

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

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	<p>Total: 117</p> <p>Census Payor Type: Medicare: 21 Medicaid: 88 Other: 8 Total: 117</p> <p>Sample: 22</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on August 7, 2013.</p>				

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F000157 SS=E	<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 resident families and physicians were notified for possible intervention for 4 of 9 residents</p>	F000157	F157 Notify of changes (injury/decline/room, etc) It is the practice of this provider to immediately inform the resident, consult with the resident's physician, and if known, notify the	08/26/2013			

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	<p>reviewed for notification in a sample of 22. (Residents "D", "G", "N" and "K").</p> <p>Findings include:</p> <p>1. The record for resident "D" was reviewed on 07-26-13 at 11:30 a.m. Diagnoses included, but were not limited to, chronic pain, diabetes mellitus, Alzheimer dementia, anemia, depressive disorder, peripheral vascular disease and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, originally dated 10-20-11, indicated the resident was at risk for skin breakdown due to peripheral vascular disease, anemia, a history of traumatic amputation, osteomyelitis and cardiac conditions and a history of skin breakdown. Interventions to this plan of care included "assess and document skin condition weekly and as needed. Notify MD [medical doctor] of abnormal findings."</p> <p>Review of the resident record indicated the following: "Event: 07-19-13 at 11:23 p.m. burst blister on left second toe - new area. [measurement] 1.0 cm [centimeters]</p>		<p>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; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <ul style="list-style-type: none"> · Resident D no longer resides at the facility · Resident G: was evaluated by physician and clarified that he wanted aspirin therapy continued · Resident N: Physician was notified that resident did not receive Cipro as ordered. Physician stated "If resident has taken it for 5 days then it's ok". · Resident K: been notified and orders have been clarified. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · Residents with a change of condition have the potential to be affected by the alleged deficient practice. · Licensed staff will be educated on the Change of Condition Policy by August 26, 2013 by the DNS/designee. · Residents are reviewed for change of condition in the 		

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	<p>by 1.0 cm by 0.1 cm, pink with no drainage and no odor. Bacitracin covered with gauze covering."</p> <p>"Progress note: 07-20-13 at 11:01 p.m. blister to 2nd left toe assessed this shift. Reddish appearance, no pain or discomfort noted related to bursted blister."</p> <p>"Progress note: 07-21-13 at 9:53 p.m. Pt. [patient] left toe continues to be red in color."</p> <p>"Progress note: 07-22-13 at 8:11 a.m. blister on left second toe is weeping clear fluid. Resident complains of discomfort when dressing area. Will continue to monitor."</p> <p>"Observation report: 07-22-13 at 11:37 p.m. - burst blister on left second toe - small open area on burst blister. Pain at site. Mild intensity. Resident makes facial expressions [i.e. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth]."</p> <p>"Progress note: 07-24-13 at 12:27 a.m. [family member] here and claimed that she was not informed of the blister on 2nd toe of left foot. Examined toe and found toe condition</p>		<p>morning interdisciplinary team meeting to review for resident change of condition, family, and physician notification.</p> <p>· DNS/designee reviews the physician orders and The Facility Activity Report in the Interdisciplinary Team Meeting for documentation to support that physician/family have been notified. · The Nurse Manager on call is notified of acute change in condition on the weekend and holiday to verify that family and physician are notified.</p> <p>· DNS/Executive Director is notified as necessary. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Residents Change of condition is reviewed in the morning interdisciplinary team meeting for resident change of condition and for physician and family/responsible party notification. · DNS/designee reviews the physician orders and Facility Activity Report in the Interdisciplinary Team Meeting for documentation to support that physician and family/responsible party have been notified. · The Nurse Manager on call is notified of acute change in condition on the weekend and holiday to ensure that family and physician will be notified. · Licensed staff will be educated on the Change of Condition Policy, by August 26, 2013 by the Director of Nursing</p>		

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	<p>was much deteriorated since initial assessment on 07-19-[13]. Called MD and ADNS [assistant director of nurses] and given resident new treatment ordered with Xenaderm to wound, cover with gauze and wrap with Kerlix. Tramadol HCL [a narcotic analgesic] 50 mg [milligrams] - 2 tablets three times a day for pain. MD requested Podiatry consult ASAP [as soon as possible]. SS [social service] given request."</p> <p>"Progress note: 07-24-13 8:39 a.m. [family member] in to visit at breakfast and voiced concern pertaining to wound to left foot. Alternate nurse redressed wound this morning and states she noted that the toe was swollen with yellow drainage."</p> <p>"Observation report: 07-24-13 at 2:59 p.m. Currently experiencing pain and has had pain in the last 5 days. The pain made it hard to sleep and limited activities. The resident described the pain as 'frequent, heavy and severe during the changing of the dressing on the toe.'"</p> <p>A review of the hospital record on 07-26-13 at 8:10 a.m., indicated the concerned family member made a determination to take the resident to the local area hospital emergency</p>		<p>Services/designee.</p> <ul style="list-style-type: none"> · Noncompliance with the facility policy and procedures may result in employee education and /or disciplinary action up to and including termination. · DNS/Designee to monitor compliance for physician/family notification. 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 Change of Condition CQI tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter. · If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. · Data will be submitted to the CQI Committee for review and follow up. <p>Compliance date: August 26, 2013</p>		

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	<p>room. A review of the emergency room physician documentation, dated 07-24-13 at 9:50 a.m., indicated the resident was "brought by medics secondary to 7 days of foot ulcer. [family member] saw her last night and noted increased foot pain. Unknown duration. RN [Register Nurse] said stated Monday as a blister. Cleaned wound and dressed." "Physical Examination - left foot second toe, ulcerated with necrotic tissue, warm foot to touch, not able to palpate pulse." "The left second toe edematous and erythematous locally. On the left second toe ulcer located at the IPJ [interpharangeal joint] is macerated, is dorsal and measures 1.2 cm by 2.0 cm with exposed bone which appears to be the head of the proximal phalanx. There is also an ulcer noted on the lateral side of the second toe of the left foot."</p> <p>"Impression/Assessment: left second toe infection - podiatry consulted and can operate on toe on 07-29-[13]."</p> <p>The hospital podiatry exam, dated 07-24-13 at 11:30 a.m., indicated the "patient presents with left 2nd ulcer. patient's daughter states she was told it started as a blister on Monday 22nd, 2013. Left second toe is edematous and erythematous with</p>			

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	<p>the ulcer located at IPJ [interphalangeal joint] is macerated. Bone is exposed, head of the proximal phalanx. Ulcer size is dorsally 1.2 cm by 2.0 cm with probing to the bone. Also ulcer noted on lateral side of the second toe.</p> <p>During an interview on 07-28-13 at 12:35 p.m., a concerned family member indicated when she arrived at the facility, "tears were streaming down [resident's] face. She needed something for the pain. I was upset because no one notified me. Even though [resident] had the pressure ulcer they kept trying to put her shoes back on her. I talked to [name of licensed nurse #11] and told him I wanted to see how bad the area was. When I took off her sock I couldn't believe what I saw. She is a diabetic and I know what that can mean. I talked to the DON [Director of Nurses] and told her I had a major concern. She said she would be up to the room but she never came. I told them to call 911."</p> <p>The Director of Nurses indicated she received a "typed" statement from the licensed nurse [#11]. "I found it under my office door when I got here this morning."</p>						

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	<p>Review of the typed statement by Registered Nurse #11 on 07-29-13 at 11:00 a.m., indicated the licensed nurse independently performed a treatment on a resident without a physician order/intervention on two occasions.</p> <p>The typed note as follows: "On Friday July 19, 2013 I was the charge nurse for the second floor, Team Three, which included [name of resident "D"]. At 10:30 p.m., one of the night aides informed me that the resident had a sore on the second toe of her left foot. Upon assessment of the toe, I determined that there was a blister that had ruptured. The opening of the blister was red in color and there was evidence of some drainage, but there was no foul odor present. The blister was treated with Bacitracin and covered with gauze. I communicated with the night nurses, taking over Team Three, that this event had been started on the computer and that the doctor, DNS [Director of Nursing Services] to inform her of the situation. I contacted the MD through the answering service, but there was no response by the end of my shift. Before I left, I stressed to BOTH night nurses the importance of communicating the patient's change</p>						

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	<p>in status to her [family member] after the MD had been contacted the next morning before the end of their shift."</p> <p>The licensed nurse indicated he was not scheduled to work the following weekend and returned to work on Monday July 22, 2013.</p> <p>"When I returned to work for my shift on Monday, July 22, 2013, the nurse giving me report for Team Three stated that the patient's dressing had been changed on the affected toe and no further description was provided. The shift proceeded; the dressing on the patient's toe was observed and nothing was observed as remarkable at that time."</p> <p>"On Tuesday July 23, 2013, after the patient had been put to bed, her [family member] arrived for a visit. I was in the middle of the evening med. [medication] pass and was preparing to start the normal patient treatments (including changing the patient's toe dressing) when the patient's [family member] came to me and stated that her mother had complained of pain in her affected foot. When the [family member] saw the dressing on her mother's toe, she stated that she had not been informed that there had been a change in the situation and</p>						

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	that this dressing was needed. When the patient's [family member] informed me that she had not been notified, I was very upset...the patient's [family member] was understandably irate and stated that she should have been contacted at any time such a discovery was made. I agreed with her and proceeded to change the dressing on the patient's foot. The dressings, which had loosened, were covered with dark, foul smelling drainage. The sore on the toe was now fully opened to the point that bone and sinew were exposed. I assessed this to be an emergency situation. I applied Xenaderm and a gauze dressing to the toe and wrapped the entire foot with a Kerlix bandage. I then contacted the MD through his answering service, stating that I had an emergency. When the MD returned the call, I described the wound to him, how I had dressed it and told him that the resident was in a great deal of pain. The MD ordered paid [sic] medication based on what was immediately available on site, agreed with the treatment I had performed and also ordered a Podiatry consult which I communicated to Social Services. Shortly after that the Floor Supervisor called and I informed her of the						

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	<p>situation. She called the ADNS [assistant director of nursing services], who then called to speak with me about the resident. She agreed with the treatment and said that the resident's shoe should not be put on the affected foot. Upon returning to the resident, I administered the prescribed pain medication. The [family member] seemed upset but stated that she was going home and would return early the next morning."</p> <p>The licensed nurse #11, failed to immediately inform the resident's physician for intervention, related to the blister. In addition, the licensed nurse failed to again alert the physician for intervention and treatment, and independently provided a treatment to this dependent resident.</p> <p>2. The record for resident "G" was reviewed on 07-29-13 at 8:10 a.m. Diagnoses included, but were not limited to, multiple sclerosis, peripheral neuropathy, diabetes mellitus, hypertension, cerebral vascular accident and a history of falls. These diagnoses remained current at the time of the record review.</p>						

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	<p>During an interview on 07-29-13 at 8:00 a.m., the Director of Nurses indicated the resident had been improperly transferred on 07-26-13, by Certified Nurses Aide #13, in which the resident fell to the floor and sustained a head injury. The Director of Nurses indicated the resident was sent to the hospital for evaluation.</p> <p>A review of the facility Event Report, dated 07-26-13 indicated the resident was being "toileted in the shower room and further indicated that when the CNA responded to her call light the resident told the CNA she needed to be toileted and would need the help from another staff member to transfer and CNA state 'No I can do it, while attempting to transfer resident from toilet to w/c [wheelchair] resident became weak and CNA was unable to stop her fall.'" The event report indicated the resident had a hematoma to the right side of forehead which measured 10.5 centimeters by 4.5 centimeters. Hematoma observed to right side of forehead et [and] resident c/o [complained of] headache."</p> <p>The notation section dated 07-26-13 at 6:10 p.m., indicated the resident was "observed becoming lethargic and expressing a need to go to sleep.</p>				

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	<p>Family at bedside. MD [medical doctor] notified et n.o. [new order] received to send to ER [emergency room] for eval [evaluation] and treat. [treatment]."</p> <p>Review of the hospital record, dated 07-26-13, indicated the following:</p> <p>"The patient presents with fall while being helped with transfer to chair and then fell with nurse assistant, hit anterior head and also right foot and ankle pain, no LOC [loss of consciousness], no neck pain, no chest pain, no blood thinners. The course/duration of symptoms is constant. The character of symptoms is pain. The degree at onset was moderate. Right anterior forehead swelling. Radiology Impression: osteoporosis: No dislocation. There appears to be a step-off in the subcapital region of the second metatarsal bone. This findings is suspicious for acute fracture. Please correlate clinically."</p> <p>"Exam: CT [cat scan] of the head without contrast - Impression: Right frontal scalp soft tissue swelling/hematoma."</p> <p>Further review of the hospital record instructed the resident that she "had a head injury. HOME CARE: Do not</p>				

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	<p>take aspirin after a head injury."</p> <p>Review of the resident's Medication Administration Record for July 2013 indicated the resident had original physician orders, dated 08-11-11, for "Aspirin 81 mg [milligrams] by mouth once daily." The administration record indicated the nursing staff gave the resident the aspirin on 07-27-13 and again on 07-28-13.</p> <p>The record lacked physician notification for instruction as to whether the resident should continued the aspirin therapy.</p> <p>3. The record for Resident "N" was reviewed 07-31-13 at 9:10 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, peripheral vascular disease, hypertension and osteoarthritis. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 06-10-13 for a urinalysis with a culture and sensitivity due to pain during urination.</p> <p>A subsequent notation indicated the resident received physician orders on 06-24-13 for Cipro (an antibiotic) 250</p>			

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	<p>mg (milligrams) by mouth two times a day for 10 days for a urinary tract infection.</p> <p>In addition, the physician instructed the nursing staff on 07-01-13 for a urinalysis with a culture and sensitivity after the completion of the antibiotic.</p> <p>A review of the resident's medication administration record for June 2013 and July 2013, indicated the nursing staff failed to administer the antibiotic as ordered, and only provided the medication thru July 1, 2013, even though the notation on the medication record for July 2013 instructed the nursing staff to continue the treatment thru 07-03-13.</p> <p>Review of the urinalysis, collected on 07-02-13 indicated the resident's urine remained cloudy, with few bacteria, and 3+ for leukocytes.</p> <p>The record lacked documentation the physician had been notified the resident had not completed the antibiotic treatment as ordered.</p> <p>4. The record for resident "K" was reviewed on 07-29-13 at 2:00 p.m. Diagnoses included, but were not limited to, cellulites/abscess, congestive heart failure, renal failure,</p>				

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	<p>hypertension and pain. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had impaired skin integrity to the right lower leg as "blisters, weeping skin and 3+ edema." A review of the resident's plan of care, dated 07-19-13 instructed the nursing staff to "assess wound weekly documenting measurements and description, notify MD [medical doctor] of worsening or no change in wound or for signs of infection, treatment as ordered."</p> <p>The "event report" dated 07-19-13 indicated the area to the right lower extremity upper measured 0.9 cm (centimeters) by 0.5 cm by < (less than) 0.1 cm.</p> <p>A review of the physician orders, dated 07-19-13 instructed the nursing staff to "cover fluid filled blisters to RLE [right lower extremity - shin] with dry dressing daily until resolved.</p> <p>The resident progress note, dated 07-26-13 at 10:50 a.m. indicated the right lower extremity presents as "2 dried blisters, no drainage, no s/sx [signs or symptoms] of infection, no pain, areas open to air, noted to have</p>						

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	<p>3+ edema to bilateral lower extremities."</p> <p>During interview on 07-29-13 at 2:00 p.m., the Director of Nurses confirmed the blisters had "burst" but the nursing staff had not contacted the physician to update about the change in the resident's right lower extremity for possible additional intervention.</p> <p>During the daily exit conference on 07-29-13 at 3:15 p.m., the Director of Nurses indicated the physician was notified and would be at the facility that evening.</p> <p>A record review on 07-31-13 at 10:00 a.m., indicated a physician order dated 07-29-13 for "Bacitracin ointment to open wounds/blisters topically BID [two times a day], cover with gauze and change two times a day, Ted hose BLE [bilateral lower extremity - indication: edema. Discontinue the dry drsg [dressing] to right lower extremity from 07-19-13."</p> <p>The record lacked timely notification of the physician for possible interventions.</p> <p>5. Review of facility policy on 07-26-13 at 1:30 p.m., titled "Resident</p>				

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	<p>Change of Condition," dated as "revised 03-10," indicated the following:</p> <p>"POLICY [bold type] It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party and that appropriate, timely and effective intervention occurs."</p> <p>"2. Acute Medical Change - a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in charge will notify the physician. b. If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical Director for medical intervention. c. The responsible party will be notified that there has been a change in the resident's condition and what seeps are being taken."</p> <p>This Federal tag relates to Complaints IN00131445 and IN00133446.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>						

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F000282 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 record review the facility failed to follow physician orders or resident care plans for 7 of 22 sampled residents. (Residents "D", "N", "K", "E", "A", "G" and "B").</p> <p>Findings include:</p> <p>1. The record for resident "D" was reviewed on 07-26-13 at 11:30 a.m. Diagnoses included, but were not limited to, chronic pain, diabetes mellitus, Alzheimer dementia, anemia, depressive disorder, peripheral vascular disease and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, originally dated 10-20-11, indicated the resident was at risk for skin breakdown due to peripheral vascular disease, anemia, a history of traumatic amputation, osteomyelitis and cardiac conditions and a history of skin breakdown. Interventions to this plan of care included "assess and document skin condition weekly and</p>	F000282	<p>F282</p> <p>Comprehensive Care Plans</p> <p>This provider ensures the services provided or arranged by the facility is provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident D no longer resides at the facility · Resident N: Physician was notified that resident did not receive Cipro as ordered. Physician stated "If resident has taken it for 5 days then it's ok". · Resident K: did not like knee high Ted hose and has physician's order for thigh high TED hose. TED hose are applied per physician's order. · Resident E: Shower schedule has been changed. Resident receives incontinent care per plan of care. Resident was assessed with no pain and no impaired skin integrity. · Resident A: Pressure wound has resolved. Physician's orders were clarified and resident 	08/26/2013
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	<p>as needed. Notify MD [medical doctor] of abnormal findings."</p> <p>Review of the resident record indicated the following: "Event: 07-19-13 at 11:23 p.m. burst blister on left second toe - new area. [measurement] 1.0 cm [centimeters] by 1.0 cm by 0.1 cm, pink with no drainage and no odor. Bacitracin covered with gauze covering."</p> <p>"Progress note: 07-20-13 at 11:01 p.m. blister to 2nd left toe assessed this shift. Reddish appearance, no pain or discomfort noted related to bursted blister."</p> <p>"Progress note: 07-21-13 at 9:53 p.m. Pt. [patient] left toe continues to be red in color."</p> <p>"Progress note: 07-22-13 at 8:11 a.m. blister on left second toe is weeping clear fluid. Resident complains of discomfort when dressing area. Will continue to monitor."</p> <p>"Observation report: 07-22-13 at 11:37 p.m. - burst blister on left second toe - small open area on burst blister. Pain at site. Mild intensity. Resident makes facial expressions [i.e. grimaces, winces, wrinkled</p>		<p>receives calmoseptine as ordered by physician as preventative treatment. · Resident G: Has new physician's order to discontinue 2person assist and initiate sit to stand lift. Care plan and resident care sheets have been updated. · Resident B: has low bed and mat on the floor per plan of care. Resident Care Sheet has been updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All Residents have the potential to be affected by the alleged deficient practice. · Licensed staff will be educated on licensed nurse rounds policy, change of condition,physician orders, accurate reading of physician's orders and transcription to the MAR/TAR, following resident care/ CNA assignment sheets, development,implementation, review and maintenance of care plans, and Nursing scope of practice by August 26, 2013 by DNS/designee. · The Facility Activity report and physician orders and are reviewed in the morning interdisciplinary team meeting to ensure services are provided per physician's orders and plan of care and care plans are updated. · DNS/designee reviews the physician orders and The Facility Activity Report to ensure services are provided per plan of care. · The Charge Nurse</p>				

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	<p>forehead, furrowed brow, clenched teeth]."</p> <p>"Progress note: 07-24-13 at 12:27 a.m. [family member] here and claimed that she was not informed of the blister or 2nd toe on left foot. Examined toe and found toe condition was much deteriorated since initial assessment on 07-19-[13]. Called MD and ADNS [assistant director of nurses] and given resident new treatment ordered with Xenaderm to wound, cover with gauze and wrap with Kerlix. Tramadol HCL [a narcotic analgesic] 50 mg [milligrams] - 2 tablets three times a day for pain. MD requested Podiatry consult ASAP [as soon as possible]. SS [social service] given request."</p> <p>"Progress note: 07-24-13 8:39 a.m. [family member] in to visit at breakfast and voiced concern pertaining to wound to left foot. Alternate nurse redressed wound this morning and states she noted that the toe was swollen with yellow drainage."</p> <p>"Observation report: 07-24-13 at 2:59 p.m. Currently experiencing pain and has had pain in the last 5 days. The pain made it hard to sleep and limited activities. The resident described the pain as 'frequent, heavy and severe</p>		<p>reviews the physician orders and the Facility Activity Report to ensure that services are provided per plan of care on the weekends. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Licensed staff will be educated on licensed nurse rounds policy, change of condition, physician orders, accurate reading of physician's orders and transcription to the MAR/TAR, following resident care/ CNA assignment sheets, development, implementation, review and maintenance of care plans, and Nursing scope of practice by August 26, 2013 by DNS/designee. · All copies of physician orders will be checked for transcription errors and care plan review by Nurse Managers during clinical meeting. · The Charge Nurse reviews the physician orders and The Facility Activity Report to ensure that services are provided per plan of care on the weekends. · Weekly audits of MAR's/TAR's will be completed by Nurse Managers to ensure that treatments and medications are administered per physician's order. · The IDT will review the physician orders at the clinical meeting. The IDT determines if further interventions or changes to the plan of care is necessary. · Nurse rounds checklist will be completed by the</p>				

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	<p>during the changing of the dressing on the toe."</p> <p>A review of the hospital record on 07-26-13 at 8:10 a.m., indicated the concerned family member made a determination to take the resident to the local area hospital emergency room. A review of the emergency room physician documentation, dated 07-24-13 at 9:50 a.m., indicated the resident was "brought by medics secondary to 7 days of foot ulcer. [family member] saw her last night and noted increased foot pain. Unknown duration. RN [Register Nurse] said stated Monday as a blister. Cleaned wound and dressed." "Physical Examination - left foot second toe, ulcerated with necrotic tissue, warm foot to touch, not able to palpate pulse." "The left second toe edematous and erythematous locally. On the left second toe ulcer located at the IPJ [interpharngal joint] is macerated, is dorsal and measures 1.2 cm by 2.0 cm with exposed bone which appears to be the head of the proximal phalanx. There is also an ulcer noted on the lateral side of the second toe of the left foot."</p> <p>"Impression/Assessment: left second toe infection - podiatry consulted and can operate on toe on 07-29-[13]."</p>		<p>charge nurses every shift to ensure care is provided per physician's orders, plan of care, and resident care/ CNA assignment sheets. · Staff who are noncompliant may be re-educated and /or receive disciplinary action up to and including termination. · Director of Nursing/designee is to monitor for compliance. 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 Resident Care Rounds CQI and Care Plan updating CQI will be utilized weekly x 4, and monthlyx2, quarterly thereafter. · The CQI committee will review the data collected. If a 95%threshold is not achieved, an action plan will be developed. Compliance date: August 26, 2013</p>		

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	<p>The hospital podiatry exam, dated 07-24-13 at 11:30 a.m., indicated the "patient presents with left 2nd ulcer. patient's daughter states she was told it started as a blister on Monday 22nd, 2013. Left second toe is edematous and erythematous with the ulcer located at IPJ [interphalangeal joint] is macerated. Bone is exposed, head of the proximal phalanx. Ulcer size is dorsally 1.2 cm by 2.0 cm with probing to the bone. Also ulcer noted on lateral side of the second toe.</p> <p>During an interview on 07-28-13 at 12:35 p.m., a concerned family member indicated when she arrived at the facility, "tears were streaming down [resident's] face. She needed something for the pain. I was upset because no one notified me. Even though [resident] had the pressure ulcer they kept trying to put her shoes back on her. I talked to [name of licensed nurse #11] and told him I wanted to see how bad the area was. When I took off her sock I couldn't believe what I saw. She is a diabetic and I know what that can mean. I talked to the DON [Director of Nurses] and told her I had a major concern. She said she would be up to the room but she never came. I told them to</p>			

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	<p>call 911."</p> <p>The Director of Nurses indicated she received a "typed" statement from the licensed nurse [#11]. "I found it under my office door when I got here this morning."</p> <p>Review of the typed statement by Registered Nurse #11 on 07-29-13 at 11:00 a.m., indicated the licensed nurse independently performed a treatment on a resident without a physician order/intervention on two occasions.</p> <p>"On Friday July 19, 2013 I was the charge nurse for the second floor, Team Three, which included [name of resident "D"]. At 10:30 p.m., one of the night aides informed me that the resident had a sore on the second toe of her left foot. Upon assessment of the toe, I determined that there was a blister that had ruptured. The opening of the blister was red in color and there was evidence of some drainage, but there was no foul odor present. The blister was treated with Bacitracin and covered with gauze. I communicated with the night nurses taking over Team Three that this event had been started on the computer and that the doctor, DNS [Director of Nursing Services] to</p>				

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	<p>inform her of the situation. I contacted the MD through the answering service, but there was no response by the end of my shift. Before I left, I stressed to BOTH night nurses the importance of communicating the patient's change in status to her [family member] after the MD had been contacted the next morning before the end of their shift."</p> <p>The licensed nurse indicated he was not scheduled to work the following weekend and returned to work on Monday July 22, 2013.</p> <p>"When I returned to work for my shift on Monday, July 22, 2013, the nurse giving me report for Team Three stated that the patient's dressing had been changed on the affected toe and no further description was provided. The shift proceeded; the dressing on the patient's toe was observed and nothing was observed as remarkable at that time."</p> <p>"On Tuesday July 23, 2013, after the patient had been put to bed, her [family member] arrived for a visit. I was in the middle of the evening med. [medication] pass and was preparing to start the normal patient treatments (including changing the patient's toe dressing) when the patient's [family</p>						

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	<p>member] came to me and stated that her mother had complained of pain in her affected foot. When the [family member] saw the dressing on her mother's toe, she stated that she had not been informed that there had been a change in the situation and that this dressing was needed. When the patient's [family member] informed me that she had not been notified, I was very upset...the patient's [family member] was understandably irate and stated that she should have been contacted at any time such a discovery was made. I agreed with her and proceeded to change the dressing on the patient's foot. The dressings, which had loosened, were covered with dark, foul smelling drainage. The sore on the toe was now fully opened to the point that bone and sinew were exposed. I assessed this to be an emergency situation. I applied Xenaderm and a gauze dressing to the toe and wrapped the entire foot with a Kerlix bandage. I then contacted the MD through his answering service, stating that I had an emergency. When the MD returned the call, I described the wound to him, how I had dressed it and told him that the resident was in a great deal of pain. The MD ordered paid [sic] medication based on what</p>						

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	<p>was immediately available on site, agreed with the treatment I had performed and also ordered a Podiatry consult which I communicated to Social Services. Shortly after that the Floor Supervisor called and I informed her of the situation . She called the ADNS [assistant director of nursing services], who then called to speak with me about the resident. She agreed with the treatment and said that the resident's shoe should not be put on the affected foot. Upon returning to the resident, I administered the prescribed pain medication. The [family member] seemed upset but stated that she was going home and would return early the next morning."</p> <p>The licensed nurse #11, failed to follow the resident's plan of care in regard to the notification of the physician for abnormal findings.</p> <p>2. The record for Resident "N" was reviewed 07-31-13 at 9:10 a.m. Diagnoses included, but were not limited to, dementia with behaviors, glaucoma, peripheral vascular disease, hypertension and osteoarthritis. These diagnoses remained current at the time of the record review.</p>						

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	<p>The resident had physician orders, dated 06-10-13 for a urinalysis with a culture and sensitivity due to pain during urination.</p> <p>A subsequent notation indicated the resident received physician orders on 06-24-13 for Cipro (an antibiotic) 250 mg (milligrams) by mouth two times a day for 10 days for a urinary trace infection.</p> <p>In addition, the physician instructed the nursing staff on 07-01-13 for a urinalysis with a culture and sensitivity after the completion of the antibiotic.</p> <p>A review of the resident's medication administration record for June 2013 and July 2013, indicated the nursing staff failed to administer the antibiotic as ordered, and only provided the medication thru July 1, 2013, even though the notation on the medication record for July 2013 instructed the nursing staff to continue the treatment thru 07-03-13.</p> <p>3. The record for resident "K" was reviewed on 07-29-13 at 2:00 p.m. Diagnoses included, but were not limited to, cellulites/abscess, congestive heart failure, renal failure, hypertension and pain. These</p>				

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	<p>diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had impaired skin integrity to the right lower leg as "blisters, weeping skin and 3+ edema." A review of the resident's plan of care, dated 07-19-13 instructed the nursing staff to "assess wound weekly documenting measurements and description, notify MD [medical doctor] of worsening or no change in wound or for signs of infection, treatment as ordered."</p> <p>The "event report" dated 07-19-13 indicated the area to the right lower extremity upper measured 0.9 cm (centimeters) by 0.5 cm by < (less than) 0.1 cm.</p> <p>A review of the physician orders, dated 07-19-13 instructed the nursing staff to "cover fluid filled blisters to RLE [right lower extremity - shin] with dry dressing daily until resolved."</p> <p>The resident progress note, dated 07-26-13 at 10:50 a.m. indicated the right lower extremity presents as "2 dried blisters, no drainage, no s/sx [signs or symptoms] of infection, no pain, areas open to air, noted to have 3+ edema to bilateral lower</p>				

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	<p>extremities."</p> <p>During interview on 07-29-13 at 2:00 p.m., the Director of Nurses confirmed the blisters had "burst" but the nursing staff had not contacted the physician to provide an update on the resident's right lower extremity.</p> <p>During the daily exit conference on 07-29-13 at 3:15 p.m., the Director of Nurses indicated the physician was notified and would be at the facility that evening.</p> <p>A record review on 07-31-13 at 10:00 a.m., indicated a physician order dated 07-29-13 for "Bacitracin ointment to open wounds/blisters topically BID [two times a day], cover with gauze and change two times a day, Ted hose BLE [bilateral lower extremity - indication: edema. Discontinue the dry drsg [dressing] to right lower extremity from 07-19-13."</p> <p>During an observation on 07-31-13 at 12:00 p.m., the resident did not have the physician ordered treatment of the TED hose as indicated.</p> <p>4. The record for resident "E" was reviewed on 07-26-13 at 1:20 p.m. Diagnoses included, but were not limited to, debility, pain, hypertension</p>				

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	<p>and pain. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's current plan of care, dated 06-04-13, indicated the resident had "impaired skin integrity due to IAD [incontinence associated dermatitis] to the sacrum and a subsequent plans of care, dated 08-13-12 and 05-17-11, which identified the resident with a "self care deficit" and "incontinence related to history of urinary tract infections and impaired mobility." Interventions to these plans of care which were not followed included the following: "assess for pain and treat as ordered, incontinent care as needed, assist resident with eating as needed, and check every tow hours of incontinence."</p> <p>During an observation on 07-26-13 10:15 a.m., with the second floor Unit Manager in attendance, a pungent urine odor was obvious in the hallway in the vicinity of the resident's room.</p> <p>A request was made to check this resident for incontinence, and the Unit Manager indicated she could tell the resident was "wet." A second request was made to check the resident.</p>						

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	<p>Upon entrance to the resident's room, the urine odor was very strong. The resident was in bed, with her breakfast tray still present on the overbed table. As the Unit Manager removed the overbed table, the resident's bedspread was covered with a red liquid. The Unit Manager indicated, "Oh it looks like she spilt her juice." As the Unit Manager removed the bedspread, the sheet, resident's gown, and quilted underpad all had the spillage from the red liquid as the liquid had seeped through the linens and gown. The resident said, "I'm cold." The Unit Manager indicated the resident was cold because she was not only wet from the red liquid, but also because she had urinated.</p> <p>A request was made to turn the resident. As the Unit Manager turned the resident the two quilted under pads as well as the bed linens and gown were saturated with urine, which extended from the resident's waist level to her knees.</p> <p>During this observation, the Unit Manager identified a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) pressure ulcer on the resident's right</p>						

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	<p>buttocks. As the Unit Manager pulled on the resident's right hip area, the resident stated "Oh that hurts."</p> <p>A certified nurses aide entered the resident's room and indicated that even though this resident was part of her assignment, she hadn't been in to see the resident "until just now, because [name of another Certified Nurses Aid] was suppose to give her, her shower this morning. I guess she has been sitting here all this time."</p> <p>5. The record for resident "A" was reviewed on 07-26-13 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer disease and dementia. These diagnoses remained current at the time of the record review. During the initial tour of the facility on 07-26-13 at 10:00 a.m., the Unit Manager identified this resident as "dependent upon staff" for care.</p> <p>A review of the resident's current plan of care, and originally dated 02-09-11, indicated the resident was at risk for pressure ulcers related to dependence upon staff for bed mobility and incontinence of bowel and bladder. Interventions included "treatment as ordered."</p> <p>The record indicated the resident had</p>						

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	<p>a physician order, dated 07-27-13 for a treatment - "Calmoseptine" to the left buttocks every shift and as needed for soilage."</p> <p>A review of the "event report" dated 07-27-13 at 6:22 p.m., indicated the resident had a "new area - a Stage 2 on the left buttocks which measured 1.1 cm by 0.3 cm by < [less than] 0.1 cm."</p> <p>During an observation on 07-29-13 at 10:30 a.m., the resident was observed lying on the right side while in bed. A request was made to CNA # 12 to observe the resident's buttocks. The CNA informed the resident of the need to turn her and check "her bottom." The CNA pulled back the sheet, and then turned the resident. The resident was observed with her slacks pulled down to her knees and during this observation, the physician ordered treatment was not present on the resident's coccyx or left hip area. The resident's coccyx was bright red in color.</p> <p>6. The record for resident "G" was reviewed on 07-29-13 at 8:10 a.m. Diagnoses included, but were not limited to, multiple sclerosis, peripheral neuropathy, diabetes mellitus, hypertension, cerebral</p>				

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	<p>vascular accident and a history of falls. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's current plan of care, originally dated 08-13-12, indicated the resident had "self care deficit related to decreased cognition, weakness, multiple sclerosis, neoplasm of the meringues, history of CVA [cerebral vascular accident] and required 2 staff assist with transfers."</p> <p>Review of the facility Resident Care Sheets, on 07-26-13 at 11:30 a.m., indicated the nursing staff were educated in the need for the resident transfer of 2 staff members.</p> <p>During an interview on 07-29-13 at 8:00 a.m., the Director of Nurses indicated the resident had been improperly transferred on 07-26-13, by Certified Nurses Aide #13, in which the resident fell to the floor and sustained a head injury. The Director of Nurses indicated the resident was sent to the hospital for evaluation.</p> <p>A review of the facility Event Report, dated 07-26-13 indicated the resident was being "toileted in the shower room and further indicated that when the CNA responded to her call light</p>				

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	<p>the resident told the CNA she needed to be toileted and would need the help from another staff member to transfer and CNA stated, 'No I can do it, while attempting to transfer resident from toilet to w/c [wheelchair] resident became weak and CNA was unable to stop her fall.' The event report indicated the resident had a hematoma to the right side of forehead which measured 10.5 centimeters by 4.5 centimeters." The "notation" section indicated "This writer summoned to shower room per activities staff. Upon entering room, resident was observed sitting on bottom on floor in front of the toilet. Resident was fully clothed with shoes and LLE [left lower extremity] brace, however pants and brief were pulled down. Resident stated that she had been using the toilet and when finished she put on the call light for assistance. when the CNA entered the room, resident states that she told the CNA she would need another staff member to assist with the transfer. The CNA stated, 'no I can do it' and attempted to transfer resident by herself. During the transfer resident became weak and CNA was unable to stop her fall Hematoma observed to right side of forehead et [and] resident c/o [complained of] headache."</p>			

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	<p>During an observation on 07-29-13 at 8:15 a.m., the resident was seated in the main dining room, waiting for breakfast. The resident's right forehead was observed with a circular bruised area, which spanned from the eyebrow area to the scalp. The resident wore a boot type device to the right ankle/foot. When interviewed, about the pain associated with the head injury or her ankle, the resident slightly touched her right forehead and indicated her head still hurt from the fall, as well as her ankle. "they told me, my ankle is just sprained but it hurts more than that."</p> <p>7. The record for resident "B" was reviewed on 07-26-13 at 1:07 p.m. Diagnoses included, but were not limited to, chronic pain, ischemic heart disease, alzheimer disease, dementia and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's current plan of care, originally dated 08-11-11 indicated the resident was a "fall risk." Interventions to this plan of care included "start date: 08-11-11 provide appropriate assistive devices such as low bed, mats on floor," and an</p>				

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	<p>updated approach "start date 05-20-13 floor mat at bedside."</p> <p>A review of the progress notes, dated 06-19-13 at 12:04 a.m., indicated "pts [patients] son came in and found pt on floor LPN [licensed practical nurse] and CNA [certified nurses aide] put pt back to bed. Assessment done, no injuries noted."</p> <p>A subsequent notation dated 06-19-13 at 12:03 p.m., indicated IDT [interdisciplinary team] Fall Review: 06-18-13 approx. [approximately] 11:00 p.m. un-witnessed fall, res. [resident] was found on floor by [family member]. Nurse was notify [sic] by son. New interventions: low bed, mat on floor. low air loss mattress."</p> <p>Although the "approach" to the plan of care included a low bed and a mat on the floor, the intervention was not in place at the time the resident was found by the family member.</p> <p>This Federal tag relates to Complaints IN00131445 and IN00133446.</p> <p>3.1-35(g)(2)</p>						

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F000309 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 a dependent resident received proper care and services, in that when a resident had a blister, the nursing staff (registered nurse #11) failed to inform the physician for immediate intervention, and made a determination to treat the affect area without a physician order. When the blistered area ruptured, and continued to deteriorate, the licensed nurse (#11) again made the determination for a treatment without a physician order.</p> <p>This deficient practice occurred over a 6 day period and resulted in the resident being admitted to the local area hospital, and required traumatic amputation of a toe for 1 of 3 residents reviewed for ulcers in a sample of 22. (Resident D).</p> <p>Findings include:</p> <p>The record for resident "D" was reviewed on 07-26-13 at 11:30 a.m.</p>	F000309	<p>F 309 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 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident D: No longer resides at this facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents that have actual skin impairment have the potential to be affected by the alleged deficient practice · Facility skin sweep will be conducted by August 26, 2013. – Skin Sweep to be done by 9/7.All impairments in skin integrity will be evaluated by a Licensed Nurse</p>	08/26/2013	

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	<p>Diagnoses included, but were not limited to, chronic pain, diabetes mellitus, Alzheimer dementia, anemia, depressive disorder, peripheral vascular disease and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's Annual History and Physical Examination, dated 06-03-13, indicated the resident had "no rash, no pressure ulcers."</p> <p>A review of the resident's Minimum Data Set Assessment, dated 06-13-13, indicated the resident was dependent on the nursing staff for transfers, bed mobility, dressing and hygiene. In addition, the assessment indicated the resident was "at risk" for pressure ulcers, but did not have a pressure ulcer at the time of the assessment and further indicated the resident had no foot problems.</p> <p>The resident's current plan of care, originally dated 10-20-11, indicated the resident was at risk for skin breakdown due to peripheral vascular disease, anemia, a history of traumatic amputation, osteomyelitis and cardiac conditions and a history of skin breakdown. Interventions to this plan of care included "assess and</p>		<p>and reported to Physician for appropriate treatment and interventions · Licensed Nurses will be educated by August 26, 2013 by the DNS/Designee on Skin Management Program , Change of Condition policy, and physician/family notification. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Licensed Nurse swill be educated by August 26, 2013 by the DNS/ designee on Skin Management Program, Change of Condition policy, and physician/family notification. · The Interdisciplinary Team will review all new admissions, re-admissions, physician orders and Facility Activity Report to identify residents with actual skin impairment for evaluation, intervention and monitoring. · Skin sweeps will be held monthly and DNS/designee will ensure that appropriate evaluation, interventions and monitoring occur. · Physician will be promptly notified of all impairment in skin integrity to ensure that appropriate,timely, and effective intervention occurs. · Charge nurse will call DNS/designee with all impairment in skin integrity on all shifts to ensure that intervention is initiated per physician's order. · Residents with wound/potential of wounds will be monitored by</p>				

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	<p>document skin condition weekly and as needed. Notify MD [medical doctor] of abnormal findings."</p> <p>Review of the resident record indicated the following: "Event: 07-19-13 at 11:23 p.m. burst blister on left second toe - new area. [measurement] 1.0 cm [centimeters] by 1.0 cm by 0.1 cm, pink with no drainage and no odor. Bacitracin covered with gauze covering."</p> <p>"Progress note: 07-20-13 at 11:01 p.m. blister to 2nd left toe assessed this shift. Reddish appearance, no pain or discomfort noted related to bursted blister."</p> <p>"Progress note: 07-21-13 at 9:53 p.m. Pt. [patient] left toe continues to be red in color."</p> <p>"Progress note: 07-22-13 at 8:11 a.m. blister on left second toe is weeping clear fluid. Resident complains of discomfort when dressing area. Will continue to monitor."</p> <p>"Observation report: 07-22-13 at 11:37 p.m. - burst blister on left second toe - small open area on burst blister. Pain at site. Mild intensity. Resident makes facial expressions</p>		<p>wound nurse/designee weekly to ensure physician orders and care plans are followed.</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> <p>· Skin Management Program and Change of Condition CQI tool will be completed weekly x 4 weeks, monthly x 2months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance Compliance date: August 26, 2013</p>		

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	<p>[i.e. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth]."</p> <p>"Progress note: 07-24-13 at 12:27 a.m. [family member] here and claimed that she was not informed of the blister or 2nd toe on left foot. Examined toe and found toe condition was much deteriorated since initial assessment on 07-19-[13]. Called MD and ADNS [assistant director of nurses] and given resident new treatment ordered with Xenaderm to wound, cover with gauze and wrap with Kerlix. Tramadol HCL [a narcotic analgesic] 50 mg [milligrams] - 2 tablets three times a day for pain. MD requested Podiatry consult ASAP [as soon as possible]. SS [social service] given request."</p> <p>"Progress note: 07-24-13 8:39 a.m. [family member] in to visit at breakfast and voiced concern pertaining to wound to left foot. Alternate nurse redressed wound this morning and states she noted that the toe was swollen with yellow drainage."</p> <p>"Observation report: 07-24-13 at 2:59 p.m. Currently experiencing pain and has had pain in the last 5 days. The pain made it hard to sleep and limited activities. The resident described the</p>			

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	<p>pain as 'frequent, heavy and severe during the changing of the dressing on the toe.'"</p> <p>The resident's record indicated scheduled pain medication, original physician order dated 07-27-12 for Tramadol [a narcotic analgesic] 50 mg [milligrams, three times a day," but lacked any further intervention to control the resident's pain."</p> <p>A review of the hospital record on 07-26-13 at 8:10 a.m., indicated the concerned family member attempted to have the resident seen by a local Podiatrist, but was unable to have the area assessed immediately, and made the determination to take the resident to the local area hospital emergency room. A review of the emergency room physician documentation, dated 07-24-13 at 9:50 a.m., indicated the resident was "brought by medics secondary to 7 days of foot ulcer. [family member] saw her last night and noted increased foot pain. Unknown duration. RN [Register Nurse] said stated Monday as a blister. Cleaned wound and dressed." "Physical Examination - left foot second toe, ulcerated with necrotic tissue, warm foot to touch, not able to palpate pulse." "The left second toe</p>			

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	<p>edematous and erythematous locally. On the left second toe ulcer located at the IPJ is macerated, is dorsal and measures 1.2 cm by 2.0 cm with exposed bone which appears to be the head of the proximal phalanx. There is also an ulcer noted on the lateral side of the second toe of the left foot."</p> <p>The hospital History and Physical, dated 07-24-13 at 1530 [3:30 p.m.] indicated the "left second toe with ulcer on toe on IPJ [interpharangeal joint] with yellow slough - oriented to self only."</p> <p>"Impression/Assessment: left second toe infection - podiatry consulted and can operate on toe on 07-29-[13]."</p> <p>The hospital podiatry exam, dated 07-24-13 at 11:30 a.m., indicated the "patient presents with left 2nd ulcer. patient's daughter states she was told it started as a blister on Monday 22nd, 2013. Left second toe is edematous and erythematous with the ulcer located at IPJ [interphalangeal joint] is macerated. Bone is exposed, head of the proximal phalanx. Ulcer size is dorsally 1.2 cm by 2.0 cm with probing to the bone. Also ulcer noted on lateral side of the second toe.</p>			

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	<p>On 07-26-13 at 8:45 a.m., the hospital Podiatrist was at the resident's bedside and indicated the ulceration was the result of "pressure." During observation on 07-26-13 at 8:45 a.m., the resident was observed lying in bed. The hospital RN removed the dressing to the area and as she removed the dressing a pungent odor permeated the air. The nurse indicated the ulceration was located over the "knuckle." A thick yellow serosanguinous drainage was observed between the great toe and second toe. The nurse also identified an additional ulcerated area on the side of the second two and between the great toe and second toe."</p> <p>Further interview on 07-26-13 at 8:45 a.m., with the Medical Student in attendance with the Podiatrist, indicated she was present when the resident arrived at the emergency room. "We took pictures of her foot when she arrived in ER [emergency room]. The area was wet and macerated when she came in. There didn't seem to be an acute infection but there is a sinus tract that runs along the toe and is part of the opened area."</p> <p>During an interview on 07-28-13 at</p>				

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	<p>12:35 p.m., a concerned family member indicated when she arrived at the facility, "tears were streaming down [resident's] face. She needed something for the pain. I was upset because no one notified me. Even though [resident] had the pressure ulcer they kept trying to put her shoes back on her. I talked to [name of licensed nurse #11] and told him I wanted to see how bad the area was. When I took off her sock I couldn't believe what I saw. She is a diabetic and I know what that can mean. I talked to the DON [Director of Nurses] and told her I had a major concern. She said she would be up to the room but she never came. I told them to call 911."</p> <p>Interview on 07-26-13 at 1:00 p.m., the Director of Nurses indicated she had notified Registered Nurse #11 to come to the facility for counseling regarding the situation and Resident "D."</p> <p>On 07-29-13 at 9:00 a.m., the Director of Nurses indicated the licensed nurse failed to come to the facility as indicated on 07-26-13, but was allowed to work the weekend.</p> <p>The Director of Nurses indicated she received a "typed" statement from the</p>						

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	<p>licensed nurse. "I found it under my office door when I got here this morning."</p> <p>Review of the typed statement by Registered Nurse #11 on 07-29-13 at 11:00 a.m., indicated the following.</p> <p>"On Friday July 19, 2013 I was the charge nurse for the second floor, Team Three, which included [name of resident "D"]. At 10:30 p.m., one of the night aides informed me that the resident had a sore on the second toe of her left foot. Upon assessment of the toe, I determined that there was a blister that had ruptured. The opening of the blister was red in color and there was evidence of some drainage, but there was no foul odor present. The blister was treated with Bacitracin and covered with gauze. I communicated with the night nurses taking over Team Three that this event had been started on the computer and that the doctor, DNS [Director of Nursing Services] to inform her of the situation. I contacted the MD through the answering service, but there was no response by the end of my shift. Before I left, I stressed to BOTH night nurses the importance of communicating the patient's change in status to her [family member] after</p>			

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	<p>the MD had been contacted the next morning before the end of their shift."</p> <p>The licensed nurse indicated he was not scheduled to work the following weekend and returned to work on Monday July 22, 2013.</p> <p>"When I returned to work for my shift on Monday, July 22, 2013, the nurse giving me report for Team Three stated that the patient's dressing had been changed on the affected toe and no further description was provided. The shift proceeded; the dressing on the patient's toe was observed and nothing was observed as remarkable at that time."</p> <p>"On Tuesday July 23, 2013, after the patient had been put to bed, her [family member] arrived for a visit. I was in the middle of the evening med. [medication] pass and was preparing to start the normal patient treatments (including changing the patient's toe dressing) when the patient's [family member] came to me and stated that her mother had complained of pain in her affected foot. When the [family member] saw the dressing on her mother's toe, she stated that she had not been informed that there had been a change in the situation and that this dressing was needed. When</p>				

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	<p>the patient's [family member] informed me that she had not been notified, I was very upset...the patient's [family member] was understandably irate and stated that she should have been contacted at any time such a discovery was made. I agreed with her and proceeded to change the dressing on the patient's foot. The dressings, which had loosened, were covered with dark, foul smelling drainage. The sore on the toe was now fully opened to the point that bone and sinew were exposed. I assessed this to be an emergency situation. I applied Xenaderm and a gauze dressing to the toe and wrapped the entire foot with a Kerlix bandage. I then contacted the MD through his answering service, stating that I had an emergency. When the MD returned the call, I described the wound to him, how I had dressed it and told him that the resident was in a great deal of pain. The MD ordered paid [sic] medication based on what was immediately available on site, agreed with the treatment I had performed and also ordered a Podiatry consult which I communicated to Social Services. Shortly after that the Floor Supervisor called and I informed her of the situation . She called the ADNS</p>			

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	<p>[assistant director of nursing services], who then called to speak with me about the resident. She agreed with the treatment and said that the resident's shoe should not be put on the affected foot. Upon returning to the resident, I administered the prescribed pain medication. The [family member] seemed upset but stated that she was going home and would return early the next morning."</p> <p>Interview on 07-29-13, at 1:00 p.m., the Director of Nurses indicated she had no documentation to indicated when the blister first appeared, and did not have any "shower sheets," which would have included a description of the resident's skin condition, that would have alerted the nursing staff of the affected area.</p> <p>The licensed nurse #11, failed to immediately inform the resident's physician for intervention, related to the blister. In addition, the licensed nurse failed to again alert the physician for intervention and treatment, and independently provided a treatment to this dependent resident.</p> <p>From 07-19-13 through 07-24-13, at least four shifts of nurses, had</p>				

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	<p>contact with the resident and continued to provide a treatment to a resident without a physicians order related to the use of Bacitracin ointment and a dressing.</p> <p>This Federal tag relates to Complaint IN00133446.</p> <p>3.1-37(a)</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 a dependent resident received appropriate incontinent care in that when a resident who was identified as dependent upon staff for nursing care, the facility failed to ensure this resident received proper pericare for 1 of 5 residents reviewed in a sample of 22. (Resident "E").</p> <p>Findings include:</p> <p>1. The record for resident "E" was reviewed on 07-26-13 at 1:20 p.m. Diagnoses included, but were not limited to, debility, pain, hypertension and pain. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set Assessment, dated 05-13-13, indicated the resident required extensive assistance with bed mobility, toileting and hygiene. In addition the assessment indicated the resident was always incontinent of</p>	F000312	<p>F312 ADL care provided for dependent residents A resident who is unable to carry our activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>What corrective action(s) will be accomplished for those residents found to have been</p>	08/26/2013			

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	<p>bowel and bladder and at risk for pressure ulcers.</p> <p>A review of the resident's current plan of care, dated 06-04-13, indicated the resident had "impaired skin integrity due to IAD [incontinence associated dermatitis] to the sacrum and a subsequent plan of care, dated 08-13-12, which identified the resident with self care deficit.</p> <p>During an observation on 07-26-13 10:15 a.m., with the second floor Unit Manager in attendance, a pungent urine odor was obvious in the hallway in the vicinity of the resident's room.</p> <p>A request was made to check this resident for incontinence, and the Unit Manager indicated she could tell the resident was "wet." A second request was made to check the resident.</p> <p>Upon entrance to the resident's room, the urine odor was very strong. The resident was in bed, with her breakfast tray still present on the overbed table. As the Unit Manager removed the overbed table, the resident's bedspread was covered with a red liquid. The Unit Manager indicated, "Oh it looks like she spilt her juice." As the Unit Manager removed the bedspread, the sheet,</p>		<p>affected by the deficient practice? · Resident E: was monitored for signs and symptoms of urinary tract infection and is asymptomatic. Resident receives proper pericare. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents dependent for incontinent care have the potential to be effected by the alleged deficient practice · A skin sweep has been conducted by DNS/designee to ensure all interventions are in place to promote healing, prevent infection and prevent new sores from developing · Nursing staff will be educated on incontinence care and pericare by August 26, 2013 by the Director of Nursing Services/Designee to monitor for compliance. · All nursing staff will be skills validated on perineal care by the Staff Development Coordinator/designee by August 26, 2013. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff will be re-educated on incontinence and pericare by August 26, 2013 by the Staff Development – · All nursing staff will be skills validated on perineal care by the Staff Development</p>				

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	<p>resident's gown, and quilted underpad all had the spillage from the red liquid, as the liquid had seeped all the way through the linens and gown. The resident said, "I'm cold." The Unit Manager indicated the resident was cold because she was not only wet from the red liquid, but also because she had urinated.</p> <p>A request was made to turn the resident. As the Unit Manager turned the resident the two quilted under pads as well as the bed linens and gown were saturated with urine, which extended from the resident's waist level to her knees.</p> <p>During this observation, the Unit Manager identified a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) pressure ulcer on the resident's right buttocks. As the Unit Manager pulled on the resident's right hip area, the resident stated "Oh that hurts."</p> <p>A certified nurses aide entered the resident's room and indicated that even though this resident was part of her assignment, she hadn't been in to see the resident "until just now, because [name of another Certified Nurses Aid] was suppose to give her,</p>		<p>Coordinator/designee by August 26, 2013 Noncompliance with the facility policy and procedures may result in employee education and /or disciplinary action. · A Nurse rounds sheet will be completed each shift by charge nurses to ensure residents are receiving proper incontinence and perineal care. · Director of Nursing Services/designee will monitor for compliance. 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 Resident Care Rounds CQI tool will be utilized weekly x 4, monthly x 2, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed. Completion Date: August 26, 2013</p>		

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	<p>her shower this morning. I guess she has been sitting here all this time."</p> <p>During this observation, the Unit Manager indicated she would provide pericare to the resident. The Unit Manager instructed the resident she would be "right back" and exited the resident room. Upon return to the resident room, the Unit Manager had a bath towel in her hands. The Unit Manager donned gloves and proceeded to the sink, turned on the water and wetted one end of the towel with soap and water. The Unit Manager returned to the resident's bedside and pulled down the bed sheet and pulled up the resident's gown. The Unit Manager took the wetted/soaped towel and washed across the resident's upper thighs and then across the pericare and then took the other end of the towel and patted the resident dry. The Unit Manager then instructed the resident of the need to turn and while the Unit Manager pushed on the resident's buttocks, the resident reached for a metal bar which had been secured to the wall. As the resident remained turned, the Unit Manager washed across the resident's buttocks and then patted the areas dry.</p> <p>Review of the facility Skills Validation</p>						

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	<p>Check list on 07-26-13 at 1:30 p.m., titled PERINEAL CARE, and dated 03-2012, indicated the following:</p> <p>"Procedure - Wash hands and put on gloves. Assist resident to supine position and drape resident as needed. Fill wash basin with warm water and have resident check temperature. Assist resident to spread legs and lift knees if possible. Wet and soap folded wash cloth. Females: Separate labia and wash urethral area first. Wash between and outside labia in downward strokes. Alternate from side to side - wipe from front to back and from center of perineum outward. Use a clean area of the wash cloth with each wipe. Do not rewipe area unless using a clean area of the wash cloth. Change wash cloth as needed. Gently pat area dry in same direction as when washing. Clean anal area from front to back, using a clean area of wash cloth with each wipe. Change water in basin. With a clean wash cloth, rinse area, thoroughly in the same direction as when washing. Gently pat area dry in same direction as when washing."</p> <p>This Federal tag relates to Complaint IN00131445.</p>			

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	3.1-38(a)(3)(A)			

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F000314 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 dependent residents were identified with pressure areas and received treatment as indicated by the physician to prevent additional deterioration of a pressure ulcer for 3 of 10 residents reviewed for wound care in a sample of 22 (Residents "E", "D" and "A").</p> <p>Findings include:</p> <p>1. The record for resident "E" was reviewed on 07-26-13 at 1:20 p.m. Diagnoses included, but were not limited to, debility, pain, hypertension and pain. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set Assessment, dated</p>	F000314	<p>F 314 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 unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident E: Has had a skin assessment and skin is intact. Care plan has been updated for preventative measures. · Resident D: No longer resides in the facility. · Resident A: Pressure wound has resolved. Physician's orders were clarified and resident</p>	08/26/2013

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	<p>05-13-13, indicated the resident required extensive assistance with bed mobility, toileting and hygiene. In addition the assessment indicated the resident was always incontinent of bowel and bladder and at risk for pressure ulcers.</p> <p>A review of the resident's current plan of care, dated 06-04-13, indicated the resident had "impaired skin integrity due to IAD [incontinence associated dermatitis] to the sacrum and a subsequent plan of care, dated 08-13-12, which identified the resident with self care deficit.</p> <p>During an observation on 07-26-13 10:15 a.m., with the second floor Unit Manager in attendance, a pungent urine odor was obvious in the hallway in the vicinity of the resident's room.</p> <p>A request was made to check this resident for incontinence, and the Unit Manager indicated she could tell the resident was "wet." A second request was made to check the resident.</p> <p>Upon entrance to the resident's room, the urine odor was very strong. The resident was in bed, with her breakfast tray still present on the overbed table. As the Unit Manager removed the overbed table, the</p>		<p>receives calmoseptine as ordered by physician as preventative treatment.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be effected by the alleged deficient practice · Facility skin sweep will be conducted by August 26, 2013 by Nurse Management Team to ensure all interventions are in place to promote healing per physician's order, all skin conditions are identified, and physician is notified and plan of care is developed · Nursing staff will be in-serviced on Skin Management Program by the Director of Nursing Services/Designee designee by August 26, 2013 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Nursing staff will be in-serviced on Skin Management Program by the Director of Nursing/Designee designee by August 26, 2013 · Skin sweeps will be conducted by Nurse Management Team monthly. · All residents will have a skin assessment done weekly by the charge nurse. · Medical Records Director of designee will complete a weekly audit to ensure that skin assessments have been done per schedule. 				

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	<p>resident's bedspread was covered with a red liquid. The Unit Manager indicated, "Oh it looks like she spilt her juice." As the Unit Manager removed the bedspread, the sheet, resident's gown, and quilted underpad all had the spillage from the red liquid. The liquid had seeped all the way through the linens and gown. The resident said, "I'm cold." The Unit Manager indicated the resident was cold because she was not only wet from the red liquid, but also because she had urinated.</p> <p>A request was made to turn the resident. As the Unit Manager turned the resident the two quilted under pads as well as the bed linens and gown were saturated with urine, which extended from the resident's waist level to her knees.</p> <p>During this observation, the Unit Manager identified a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) pressure ulcer on the resident's right buttocks. As the Unit Manager pulled on the resident's right hip area, the resident stated "Oh that hurts."</p> <p>A certified nurses aide entered the resident's room and indicated that</p>		<ul style="list-style-type: none"> · Director of Nursing/Designee will monitor physician orders regarding pressure ulcers to ensure physician orders are followed by conducting rounds on all shifts. 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 Skin Management Program CQI tool will be utilized weekly x 4 weeks, monthly x 2 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director · If 95% a threshold is not achieved, an action plan will be developed to ensure compliance 		

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	<p>even though this resident was part of her assignment, she hadn't been in to see the resident "until just now, because [name of another Certified Nurses Aid] was suppose to give her, her shower this morning. I guess she has been sitting here all this time."</p> <p>At 11:25 a.m., the Unit Manager indicated the Stage 2 pressure ulcer measured 0.4 cm (centimeters) by 0.5 cm by 0.1 cm.</p> <p>2. The record for resident "D" was reviewed on 07-26-13 at 11:30 a.m. Diagnoses included, but were not limited to, chronic pain, diabetes mellitus, Alzheimer dementia, anemia, depressive disorder, peripheral vascular disease and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's Annual History and Physical Examination, dated 06-03-13, indicated the resident had "no rash, no pressure ulcers."</p> <p>A review of the resident's Minimum Data Set Assessment, dated 06-13-13, indicated the resident required extensive assistance by the nursing staff for transfers, bed mobility, dressing and hygiene. In</p>			

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	<p>addition, the assessment indicated the resident was "at risk" for pressure ulcers, but did not have a pressure ulcer at the time of the assessment. In addition the resident was incontinent of bowel and bladder.</p> <p>The resident's current plan of care, originally dated 10-20-11, indicated the resident was at risk for skin breakdown due to peripheral vascular disease, anemia, a history of traumatic amputation, osteomyelitis and cardiac conditions and a history of skin breakdown. Interventions to this plan of care included "assess and document skin condition weekly and as needed. Notify MD [medical doctor] of abnormal findings."</p> <p>A review of the hospital record on 07-26-13 at 8:10 a.m., indicated the resident was referred to the hospital "wound/skin evaluation" team, on 07-24-13 at 16:22 a.m. due to an observed pressure ulcer on the resident's sacral area. The documentation indicated the resident had a "Stage 1 [a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues], sacral pressure ulcer - and assessed as a healed sacral pressure ulcer with</p>				

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	<p>no pigmented skin and pinpoint superficially denuded site within the healed area that appears to have been caused by friction." Treatment interventions included a "mepilex foam dressing with border over the sacral pressure ulcer, with turn/tilt at least every 2 hours and pressure relief from bilateral heels and a waffle static air mattress."</p> <p>During an observation on 07-26-13 at 8:10 a.m., the resident was observed in bed. The hospital nurse was at the resident's bedside and indicated the resident had been admitted through the emergency room. "She was admitted with a Stage 1 pressure ulcer." During this observation the registered nurse removed the physician ordered dressing. The resident's coccyx was pink with slight reddened areas. The area was not opened.</p> <p>3. The record for resident "A" was reviewed on 07-26-13 at 11:00 a.m. Diagnoses included, but were not limited to, Alzheimer disease and dementia. These diagnoses remained current at the time of the record review. During the initial tour of the facility on 07-26-13 at 10:00 a.m., the Unit Manager identified this resident as "dependent upon staff" for care.</p>						

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	<p>A review of the resident's Minimum Data Set Assessment, dated 07-18-13 indicated the resident required extensive assistance with bed mobility, transfer, dressing, hygiene, and toileting. In addition the assessment indicated the resident was always incontinent of bowel and bladder and at risk for pressure ulcers.</p> <p>A review of the resident's current plan of care, and originally dated 02-09-11, indicated the resident was at risk for pressure ulcers related to dependence upon staff for bed mobility and incontinence of bowel and bladder. Interventions included "treatment as ordered."</p> <p>The record indicated the resident had a physician order, dated 07-27-13 for a treatment - "Calmoseptine" to the left buttocks every shift and as needed for soilage."</p> <p>A review of the "event report" dated 07-27-13 at 6:22 p.m., indicated the resident had a "new area - a Stage 2 on the left buttocks which measured 1.1 cm by 0.3 cm by < [less than] 0.1 cm."</p> <p>During an observation on 07-29-13 at</p>				

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	<p>10:30 a.m., the resident was observed lying on the right side while in bed. A request was made to CNA # 12 to observe the resident's buttocks. The CNA informed the resident of the need to turn her and check "her bottom." The CNA pulled back the sheet, and then turned the resident. The resident was observed with her slacks pulled down to her knees and during this observation, the physician ordered treatment was not present on the resident's coccyx or left hip area. The resident's coccyx was bright red in color.</p> <p>This Federal tag relates to Complaint IN00131445.</p> <p>3.1-40(a)(2)</p>				

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a dependent resident received care and services to prevent a fall with injury in that when a resident required toileting, the nursing staff failed to follow the resident's plan of care and request the assistance of another staff member in the transfer from the wheelchair to the commode. The CNA improperly transferred the resident independently, which resulted in the resident being dropped onto the floor and sustained significant bruising to her head and injury to the foot/ankle. This deficient practice effected 2 of 3 residents reviewed for falls in a sample of 22. (Resident "G" and "B").</p> <p>Findings include:</p> <p>1. The record for resident "G" was reviewed on 07-29-13 at 8:10 a.m. Diagnoses included, but were not limited to, multiple sclerosis, peripheral neuropathy, diabetes mellitus, hypertension, cerebral</p>	F000323	<p>F323 Free of accident hazards/Supervision/Devices</p> <p>It is the practice of this provider to ensure the resident's environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident G: Has new physician's order to discontinue 2person assist and initiate sit to stand lift. Care plan and resident care sheets have been updated. · Resident B: has low bed and mat on the floor per plan of care. Resident Care Sheet has been updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the</p>	08/26/2013
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	<p>vascular accident and a history of falls. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 06-01-13 indicated the resident required extensive assistance with two staff members when toileting. Further review of the Assessment indicated the resident was unable to balance herself without the assistance of staff members in regard to moving from a seated to a standing position, moving on and off toilet, and surface to surface transfers.</p> <p>A review of the resident's current plan of care, originally dated 08-13-12, indicated the resident had "self care deficit related to decreased cognition, weakness, multiple sclerosis, neoplasm of the meringues, history of CVA [cerebral vascular accident] and required 2 staff assist with transfers."</p> <p>Review of the facility Resident Care Sheets, on 07-26-13 at 11:30 a.m., indicated the nursing staff were educated in the need for the resident transfer of 2 staff members.</p> <p>During an interview on 07-29-13 at 8:00 a.m., the Director of Nurses</p>		<p>potential to be affected by the alleged deficient practice.</p> <p>· Nursing Staff have been educated on the fall management program, fall care plans interventions, levels of assist with transfers, and Resident Care Sheets by Director of Nursing/designee by August26, 2013 · Customer Care Representatives or licensed nurses are to make rounds on all shifts to verify that that fall interventions are in place per plan of care, resident need/CNA assignment sheet, and levels of assist with transfers are being followed What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · Nursing Staff have been educated on the fall management program, fall care plans interventions, levels of assist with transfers, and Resident Care Sheets by Director of Nursing/designee by August26, 2013 · Customer Care Representatives or licensed nurses are to make rounds on all shifts to verify that that fall interventions are in place per plan of care and levels of assist with transfers are being followed · All residents at risk for falls will be reviewed quarterly and significant change to ensure appropriate/interventions are in place by the IDT team. · During review of falls, the IDT will</p>	

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	<p>indicated the resident had been improperly transferred on 07-26-13, by Certified Nurses Aide #13, in which the resident fell to the floor and sustained a head injury. The Director of Nurses indicated the resident was sent to the hospital for evaluation.</p> <p>A review of the facility Event Report, dated 07-26-13 indicated the resident was being "toileted in the shower room and further indicated that when the CNA responded to her call light the resident told the CNA she needed to be toileted and would need the help from another staff member to transfer and CNA stated 'No I can do it, while attempting to transfer resident from toilet to w/c [wheelchair] resident became weak and CNA was unable to stop her fall.' The event report indicated the resident had a hematoma to the right side of forehead which measured 10.5 centimeters by 4.5 centimeters. The "notation" section indicated This writer summoned to shower room per activities staff. Upon entering room, resident was observed sitting on bottom on floor in front of the toilet. Resident was fully clothed with shoes and LLE [left lower extremity] brace, however pants and brief were pulled down. Resident stated that she had been using the toilet and when</p>		<p>physically investigate the resident's room to determine root cause of fall. Fall interventions will be implemented based on root cause. · Staff who are non compliant may be re-educated and /or receive disciplinary action up to and including termination. · Director of Nursing/Designee will monitor for compliance. 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? · The falls management CQI tool will be utilized weekly x 4, monthly x 2, quarterly thereafter. · The CQI committee will review the data. If a 95% threshold is not achieved, an action plan will be developed. · Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination.</p>				

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	<p>finished she put on the call light for assistance. When the CNA entered the room, resident states that she told the CNA she would need another staff member to assist with the transfer. The CNA stated, 'no I can do it' and attempted to transfer resident by herself. During the transfer resident became weak and CNA was unable to stop her fall Hematoma observed to right side of forehead et [and] resident c/o [complained of] headache."</p> <p>The notation section dated 07-26-13 at 6:10 p.m., indicated the resident was "observed becoming lethargic and expressing a need to go to sleep. Family at bedside. MD [medical doctor] notified et [and] n.o. [new order] received to send to ER [emergency room] for eval [evaluation] and treat. [treatment]."</p> <p>Review of the hospital record, dated 07-26-13, indicated the following:</p> <p>"The patient presents with fall while being helped with transfer to chair and then fell with nurse assistant, hit anterior head and also right foot and ankle pain, no LOC [loss of consciousness], no neck pain, no chest pain, no blood thinners. The course/duration of symptoms is</p>			

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	<p>constant. The character of symptoms is pain. The degree at onset was moderate. Right anterior forehead swelling. Radiology Impression: osteoporosis: No dislocation. There appears to be a step-off in the subcapital region of the second metatarsal bone. This findings is suspicious for acute fracture. Please correlate clinically."</p> <p>"Exam: CT [cat scan] of the head without contrast - Impression: Right frontal scalp soft tissue swelling/hematoma."</p> <p>During an observation on 07-29-13 at 8:15 a.m., the resident was seated in the main dining room, waiting for breakfast. The resident's right forehead was observed with a circular bruised area, which spanned from the eyebrow area to the scalp. The resident wore a boot type device to the right ankle/foot. When interviewed, about the pain associated with the head injury or ankle, the resident slightly touched her right forehead and indicated her head still hurt from the fall, as well as her ankle. "they told me, my ankle is just sprained but it hurts more than that."</p> <p>2. The record for resident "B" was reviewed on 07-26-13 at 1:07 p.m.</p>						

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	<p>Diagnoses included, but were not limited to, chronic pain, ischemic heart disease, alzheimer disease, dementia and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment dated 06-12-13 indicated the resident required extensive assistance with bed mobility. The resident's current plan of care, originally dated 08-11-11 indicated the resident was a "fall risk." Interventions to this plan of care included "start date: 08-11-11 provide appropriate assistive devices such as low bed, mats on floor," and an updated approach "start date 05-20-13 floor mat at bedside."</p> <p>A review of the progress notes, dated 06-19-13 at 12:04 a.m., indicated "pts [patients] son came in and found pt on floor LPN [licensed practical nurse] and CNA [certified nurses aide] put pt back to bed. assessment done, no injuries noted."</p> <p>A subsequent notation dated 06-19-13 at 12:03 p.m., indicated IDT [interdisciplinary team] Fall Review: 06-18-13 approx. [approximately] 11:00 p.m. un-witnessed fall, res. [resident] was found on floor by</p>			

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	<p>[family member]. Nurse was notify [sic] by son. New interventions: low bed, mat on floor. low air loss mattress."</p> <p>Although the "approach" to the plan of care already included a low bed and a mat on the floor, the intervention was not in place at the time the resident was found by the family member.</p> <p>This Federal tag relates to Complaint IN00131445.</p> <p>3.1-45(a)(2)</p>				

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F000368 SS=E	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>Based on observation, record review and interview, the facility failed to ensure resident's were offered bedtime snacks for 9 of 9 residents reviewed for bedtime snacks on the Memory Care Unit in a sample of 22. (Resident's "M", "P", "I", "H", "O", "N", "J", "Q" and "L")</p> <p>Findings include:</p> <p>1. The record for resident "M" was reviewed on 07-31-13 at 8:45 a.m. The resident received a regular diet. At the time of admission, 05-24-13, the resident had physician orders for "offer bedtime snack." The order</p>	F000368	<p>F368</p> <p>Frequency of meals/Snacks at bedtime</p> <p>It is the practice of the facility to Ensure each resident receives and the facility provides at least three meals daily, at regular times comparable to normal meal times in the community. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Resident M: Is offered a snack at bedtime daily.</p>	08/26/2013
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	<p>prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. During an interview on 07-31-13 at 1:00 p.m., the resident indicated he had not been offered a snack at bedtime. "I just eat the food they give me for breakfast, lunch and dinner. Before I came here I would walk to the store and get me something to have before I went to bed." Further review of the Medication Administration Record for June 2013, indicated "S" for 6 of 9 evening snacks, and for July 2013 "S" for 25 of 30 evening snacks.</p> <p>2. The record for resident "P" was reviewed on 07-31-13 at 3:00 p.m. The resident had physician orders for a regular diet. In addition the resident had physician orders, dated 08-12-10, for bedtime snacks. The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. Review of the July 2013 medication administration record indicated the resident was "S" [sleeping] 23 evenings. However the record also lacked documentation on 4 evenings, and at the time of the record review, the evening snack for 07-31-13 had already been documented. During an observation on 07-31-13 at 2:50 p.m. with the regional dietician in</p>		<ul style="list-style-type: none"> · Resident P: Is offered a snack at bedtime daily. · Resident I: Is offered a snack at bedtime daily. · Resident H: Is offered a snack at bedtime daily. · Resident O: Is offered a snack at bedtime daily. · Resident N: Is offered a snack at bedtime daily. · Resident J: Is offered a snack at bedtime daily. · Resident K: Is offered a snack at bedtime daily. · Resident L: Is offered a snack at bedtime daily. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</p> <ul style="list-style-type: none"> ·All residents who receive oral diets have the potential to be affected by the alleged deficient practice. ·All nursing and dietary staff will be in-services on the Bedtime Snack Policy by the Director of Nursing/designee by August 26, 2013. ·The facility will put in place a system to ensure that resident's receiving an oral diet are offered a bedtime snack by Executive Director by August 26, 2013. ·The system for bedtime snacks will include dietary providing portable carts for each unit with appropriate snacks and fluids for all diet orders daily. Nursing will offer all residents a bedtime snack prior to being placed in bed. Dietary will stock each unit with appropriate snacks for all diet orders. 				

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	<p>attendance, the "locked" refrigerator was opened, and the resident's peanut butter and jelly sandwich, dated 07-30-13 and identified as the evening snack was located on the wire refrigerator rack.</p> <p>3. The record for resident "I" was reviewed on 07-31-13 at 11:30 a.m. The resident had physician orders for a regular fortified diet. In addition the resident had physician orders dated 10-17-11 for "Offer bedtime snack." The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. A review of the resident's Minimum Data Set assessment, dated 06-26-13 indicated it was "somewhat important" to have snacks available between meals.</p> <p>A review of the May 2013 medication administration record indicated the resident was "S" on 28 of 31 evenings and the June 2013 medication administration record indicated "S" for 28 of 30 evenings.</p> <p>4. The record for resident "H" was reviewed on 07-31-13 at 12:21 p.m. The resident had physician orders for a regular diet. In addition the resident had physician order, dated 05-30-11 for "offer bedtime snack." The order prompted the nursing staff to</p>		<p>What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.</p> <ul style="list-style-type: none"> ·All nursing and dietary staff will be in-services on the Bedtime Snack Policy by the Director of Nursing/designee by August 26, 2013. ·The facility will put in place a system to ensure that resident's receiving an oral diet are offered a bedtime snack daily by Executive Director by August 26, 2013. ·The system for bedtime snacks will include dietary providing portable carts for each unit with appropriate snacks and fluids for all diet orders daily. Nursing will offer all residents a bedtime snack during prior to bedtime. Dietary will stock each unit with appropriate snacks for all diet orders. Charge nurse will ensure bedtime snacks are offered and distributed timely everyday. ·Weekly audits of MARs/TARs will be completed by the nurse managers to ensure that resident's receiving oral diets are offered a bedtime snack daily. <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> <ul style="list-style-type: none"> ·An HS snack CQI tool will be utilized weekly x 4, monthly x 2, 				

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	<p>document "A" = accepted, "R" = refused and "S" = sleeping.</p> <p>A review of the May 2013 medication administration record indicated the resident was "S" for 28 of 31 evenings, and the June 2013 medication administration record indicated the resident was "S" for 27 of 30 evenings. The resident's minimum data set assessment, dated 07-05-13 indicated "very important" for snacks available between meals.</p> <p>5. The record for resident "O" was reviewed on 07-31-13 at 9:25 a.m. The resident had physician orders for a regular diet. In addition, the resident had physician orders dated 10-12-11 for "offer bedtime snack." The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping.</p> <p>A review of the May 2013 medication administration record indicated "S" for 29 of 31 evenings, and June 2013 medication administration record "S" for 29 of 30 evenings. The record lacked documentation on 06-15-13.</p> <p>6. The record for resident "N" was reviewed on 07-31-13 at 9:10 a.m. The resident had physician orders for a regular diet. In addition the resident had physician orders, dated 05-27-13 to "offer bedtime snack." The order</p>		<p>and quarterly thereafter.</p> <p>The CQI committee will review the data collected. If a 95% threshold is not achieved, an action plan will be developed.</p> <p>Completion date: August 26, 2013</p>		

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	<p>prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. A review of the June 2013 medication administration record indicated "S" for 29 of 30 evenings with one date without documentation, and the July 2013 medication administration record indicated "S" for 28 of 30 days with two dates without documentation.</p> <p>7. The record for resident "J" was reviewed on 07-31-13 at 8:50 a.m. The resident had physician orders for a regular diet. In addition the resident had a physician order, dated 11-16-12 to "offer bedtime snack." The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. A review of the resident's May 2013 medication administration record indicated "S" for 31 of 31 evenings, June 2013 for 28 of 30 evenings, with evening without documentation, and the July 2013 medication administration record indicated "S" for 25 of 30 evenings.</p> <p>8. The record for resident "Q" was reviewed on 07-31-13 at 2:00 p.m. The resident had physician order for a diet with potassium restrictions. In addition the resident had physician</p>						

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	<p>orders at the time of admission, 07-16-13 to "offer bedtime snack." The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. Review of the July 2013 medication administration record indicated "S" for 12 of the available 13 evenings available for a bedtime snack.</p> <p>9. The record for resident "L" was reviewed on 07-31-13 at 8:30 a.m. The resident had physician orders for a pureed diet. In addition the resident had physician orders, dated 03-18-11 to "offer bedtime snack." The order prompted the nursing staff to document "A" = accepted, "R" = refused and "S" = sleeping. A review of the May 2013 medication administration record indicated "S" for 31 of 31 evenings, and the June 2013 medication administration record indicated "S" for 28 of 30 evenings with one date lacking documentation.</p> <p>A review of the census sheet which indicated the residents by room number indicated there were 32 residents who resided on the Memory Care Unit.</p> <p>During interview on 07-31-13 at 8:45 a.m., the Unit Manager indicated the bedtime snacks "come to the Unit</p>						

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	<p>around 7:30 p.m."</p> <p>During interview on 07-31-13 at 10:30 a.m., the Dietary Manager indicated the bedtime snacks are already on the unit, and they are "locked up. We want food fresh and available when they ask for it." When further interviewed the obligation of the staff to "offer" the bedtime snacks to the residents on the Memory Care unit, the Dietary Manager indicated, "yes they're suppose to offer."</p> <p>The facility did not have a system to ensure the resident's were "offered" the bedtime snack.</p> <p>This Federal tag relates to Complaint IN00131970.</p> <p>3.1-21(e)</p>				