

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155511	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2011
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NAME OF PROVIDER OR SUPPLIER TERRE HAUTE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 830 S 6TH ST TERRE HAUTE, IN47807
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 12, 13, 14, 15, 16, and 19, 2011</p> <p>Facility number: 000446 Provider number: 155511 AIM number: 100288720</p> <p>Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN Debra Skinner RN</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 7 Medicaid: 21 Other: 5 Total: 33</p> <p>Sample Stage 2: 30</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/21/11</p>	F0000		

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

TITLE

(X6) DATE

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

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F0157 SS=D	<p>Cathy Emswiller RN</p> <p>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, interview and record review, the facility failed to promptly notify the physician of a new pressure ulcer for 1 of 2 Stage 2 sampled residents reviewed with</p>	F0157	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared	01/18/2012

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	<p>pressure sores. [Resident #4]</p> <p>Finding includes:</p> <p>On, 12/12/11 at 2:52 p.m., the Minimum Data Set [MDS] coordinator was interviewed. The staff member indicated Resident #4 did not have any pressure areas.</p> <p>On, 12/15/11 at 9:54 a.m., Resident #4 was observed in bed. With CNA's #4 and #6 the resident was observed to have an open, slit area on the coccyx. The CNA's indicated the area was new.</p> <p>On, 12/16/11 at 11:15 a.m., with the DON, Resident #4 was observed with the opened slit area and two open round areas on the buttocks. No treatment was observed on the areas. The DON indicated she was not aware of the areas.</p> <p>Resident #4's clinical record was reviewed on, 12/19/11 at 9:56 a.m. A physician's order was noted dated, 12/16/11, for "Cleanse open areas on buttocks and coccyx with normal saline apply hydrocolloid change every three days and prn [as needed]. Documentation of the physician being notified of the new pressure ulcer prior to 12/16/11 was not noted.</p>		<p>and/or executed solely because required.</p> <p>F 157 Notify of Changes</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident # 4: The MD/Family was notified of new pressure ulcer, orders received for treatment, care plan updated, on 12-16-11.</p> <p>CN A 's # 4 and # 6 identified having provided care for Resident # 4 on 12/15/11 and not reporting the newly identified open area(s), were re-educated by a teachable moment on reporting skin issues to the licensed nurse at time of observation.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility skin audit was conducted on 12/17/11, to assess current residents for any unidentified pressure ulcer/ skin issues requiring treatment and proper MD/family notification.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: The nursing staff (including direct care-givers) was re-educated regarding reporting of any identified pressure ulcer/skin issues to the licensed nurse and the MD/Family notification of any identified pressure ulcers/open skin areas requiring</p>		

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	<p>LPN #2 was interviewed on, 12/16/11 at 11:50 a.m. The LPN indicated if a resident has an open area identified by the CNA's the CNA's are to report to the nurse on duty. The nurse then is to assess. If the wound nurse is on duty she is to assess the area and notify the physician.</p> <p>The resident's plan of care addressed the problem of at risk for developing a pressure ulcer related to Braden Scale score of 13, decreased mobility, incontinence, terminal illness, Huntington's Chorea, and was dated 7/24/11. Approaches included, but were not limited to, report changes in skin status to physician, Notify nurse immediately of any new areas of skin breakdown, ...noted during bathing or daily care ..."</p> <p>A facility policy titled "Acute Condition Changes, [no date], provided by the Administrator on 12/19/11 at 12:00 p.m. included, but was not limited to, "When Do You Need To Call the MD? ...2. Change in Resident Condition ...c. Changes in skin condition (pressure, stasis, skin tears) ..."</p> <p>3.1-5(a)(3)</p>		<p>treatment.</p> <p>The nursing staff will place any identified pressure ulcer / skin issue on the 24 hour report with time of MD/Family notification and treatment for pressure ulcer/ skin issue. This will be discussed at the next morning meeting and to ensure that the plan of care has been updated to reflect these changes.</p> <p>(d)How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: DNS /Designee will complete random skin checks on 5 residents weekly in conjunction to weekly skin checks to ensure that any/all new skins issues have been addressed timely. Along with this will be the review of the 24 hour report to identify any pressure ulcers/skin issues, check for MD/Family notification, and for new treatment orders. The above plan focus will continue for 4 weeks then bi-weekly x's two months, Report of the audits will be presented to the Risk Management/QA Meeting to ensure compliance remains and that it is recommended that oversight monitoring will be done quarterly by the RDCO when system review is completed which includes MD/Family notification of newly identified ulcers.</p> <p>Date of compliance: 1/18/12</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2012

FORM APPROVED

OMB NO. 0938-0391

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F0159 SS=B	<p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;</p>				

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	<p>and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to provide access to resident funds during weekend hours for 3 of 3 Stage 2 residents identified as facility handling personal funds (Resident #13, Resident #24, Resident #4)</p> <p>Findings include:</p> <p>1. Review on 12/19/11 at 12:30 p.m., of a document entitled "Resident Trust Fund Authorization" and dated 9/19/06, failed to address the availability of resident funds during the weekend hours. At the time of provision of this document, the Administrator identified Resident #13, #24, #4 as residents for whom the facility handled personal funds.</p> <p>On 12/19/11 at 12:41 p.m., the Administrator indicated there was no money contained in the lock box in the medication room which the Administrator had understood contained money (\$50-100) for residents to request as resident funds on weekends. The Administrator indicated there were no signs or</p>	F0159	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F 159 FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>-</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>ISSUE # 1, # 3 and # 4: Written notice of how to obtain resident funds during the weekend was provided to residents #4, 13 and 24. The lock box is now maintained with funds for access during weekends. If at any time additional money is requested/needed the NHA/BOM will be contacted to obtain these funds from the safe.</p> <p>ISSUE # 2: Family members who were not aware that the funds could be obtained on the weekend where provide written information that explained the process.</p> <p>-</p>	01/18/2012	

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	documentation posted anywhere in the facility to inform residents when they could request money from the business office at any time.		<p>(b) How will you identify other residents having potential to be affected by the same practice and what corrective action will be take:</p> <p>Resident's with which the facility handles funds had the potential to be affected. Written notices of how to obtain resident funds during the weekend was given to those residents residing in the facility and mailed to those who have a responsible party listed for management of their trust fund.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>The Business Office manager was educated on the Resident Trust Fund Standard and Guideline, Resident Trust Fund Policy and Procedure, and the State/Federal regulations for personal funds management by the Administrator on 12/29/11 to ensure that proper guidelines are followed on availability.</p> <p>The BOM will have the responsibility of placing funds in the locked box located in the med room each Friday by close of business or earlier if d/t a holiday. The BOM will reconcile the ending balances on the next routine scheduled work day. In the BOM's absence this responsibility will revert to NHA.</p> <p>Staff has been educated on the location of the lock boxed - as to who can have access to this lock box and how to properly complete the withdrawal forms for requested money from resident's current funds.</p> <p>(d) How the corrective</p>		

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	<p>2. On 12/13/11 at 9:57 a.m. Resident #4's family member was interviewed. The family member indicated the facility managed the resident's personal funds. The family member indicated he was not aware of getting funds on the weekends, but knew they needed to be obtained by Friday.</p> <p>3. On 12/13/11 at 2:45 p.m. Resident #24 was interviewed. The resident indicated the facility managed her personal funds and was not able to receive funds on the weekends.</p> <p>4. Interview of Resident #13 on</p>		<p>actions(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>- Administrator and/or designee will monitor availability of funds weekly x 4 weeks on Fridays then bi weekly the next two months to ensure that the funds have been placed as per standard and to review if the amount is adequate. The Administrator will report these findings to the Risk management/QA Committee monthly until substantial compliance is achieved and the committee recommends monitoring by the RFA, (regional field analysis) to maintain compliance when completing facility quarterly financial reviews.</p> <p>(e) Date of compliance: 01/18/2012</p>		

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	<p>12/13/11 at 2:10 p.m. indicated the facility handled funds for him. The resident indicated the business hours to obtain money was Monday through Friday. Resident #13 indicated he would obtain money needed for over the weekend on Fridays.</p> <p>3.1-6(f)(1)</p>				

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F0164 SS=D	<p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and interview, the facility failed to ensure personal privacy for 1 of 4 resident observed receiving care in a stage 2 sample of 30 in that during care the resident's privacy curtain did not totally enclose the resident's bed. (Resident #34)</p> <p>Findings include:</p> <p>During observation on 12/15/11 at</p>	F0164	<p>F-164 Privacy and Confidentiality</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p>	01/18/2012

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	<p>11:45 a.m. CNAs #1 and #4 provided incontinence care to Resident #34. The privacy curtain at end of bed was not long enough and a large space was left open allowing full view if the door to the resident's room was open. During the care two staff people knocked and open the door while the resident was receiving care.</p> <p>During interview on 12/16/11 at 9:45 a.m. the DON (Director of Nursing) indicated the resident's privacy curtain would not completely enclose around the end of the bed. The facility policy titled "Long Term Care Resident Rights in Indiana" was received on 12/19/11 at 3:14 p.m. from the Administrator. The policy indicated the resident had a right to "privacy in their room during bathing, medical treatment and personal care" And "Residents have a right to privacy and confidentiality. We do not discuss their information with others; we knock and wait for permission before entering their room."</p> <p>3.1-3(p)(4) 3.1-3(p)(5)</p>		<p>Teachable moment was presented to CN A # 1 and # 4, caring for resident #34 on Resident Rights with focus on use of privacy curtains while performing resident care.</p> <p>The privacy curtain at the end of the bed for resident # 34 has been replaced with one that is longer that will prevent any view of the resident and protect their privacy if the door to the room is opened.</p> <p>Staff on duty during the day shift on 12/15/11 were re-educated regarding the importance of waiting for permission to enter a room after knocking on a door.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Active residents in the facility being cared for on 11/15/11 had the potential to be affected. Facility review was performed and no other residents were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Facility staff have been re-educated on the components of this regulation with focus on Residents Right to Privacy - regarding the importance of waiting for permission to enter a room after knocking on a door and ensuring that privacy curtains are long enough to prevent any view of the resident and protect their privacy if the door to the room is opened.</p> <p>This training will be present during orientation and annually during employee educational fair.</p>	

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F0241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review the facility failed to promote care and maintain an environment that enhanced each	F0241	<p>All new staff will receive education on Resident Rights upon orientation and at least annually.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>DNS or designee will randomly observe 5 direct care staff 5 x's per week including all shifts and weekends for the next 4 weeks and then 3 x's week for the following two months to ensure Resident Right to Privacy is respected. The maintenance/housekeeping supervisor will round weekly for one month then bi-weekly for the next two months to ensure that privacy curtains are long enough to prevent any view of the resident and protect their privacy if the door to the room is opened. Any concerns will be addressed immediately and findings will be reported at the next QA/RM meeting to determine if compliance has been achieved and the committee recommends monitor to maintain compliance by the RDCO and Regional Director of Plant OPS when completing their quarterly systems reviews.</p> <p>(e) Date of compliance: 1/18/12</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions</p>	01/18/2012	

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	<p>resident's dignity for 7 of 29 residents observed in a stage 2 sample of 30 in that signs containing personal information were posted residents' rooms and/or staff were observed to enter resident rooms without knocking. (Resident # 7, Resident #30, Resident #34, Resident #4, Resident # 24, Resident #29, Resident # 21)</p> <p>Findings include:</p> <p>1. On 12/13/11 at 10:40 a.m., CNA #1 , CNA #6 and LPN # 5 were observed to enter Resident # 7's room without knocking prior to entering. The resident's door was observed to be closed and an interview by surveyor was being completed. The resident was observed to be aphasic with the ability to answer yes/no questions.</p> <p>Review of the resident's clinical record on 12/19/11 at 9 a.m. indicated nursing notes dated 12/16/11 in weekly summary of the resident identified as alert and oriented to time, person and place with the ability to make needs known with non-verbal communication.</p>		<p>set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F-241 Dignity and Respect of Individuality</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>ISSUE #1: CN A's # 1 was given a "Friendly warning" for failure to knock on a closed door violating Resident's # 7's room privacy. C NA # 6 and LPN # 5 given teachable moments for not knocking on a closed door prior to entering Resident # 7's room – resulting in violating care area and privacy.</p> <p>ISSUE # 2, # 3, # 4, # 5, # 6: Posted signs containing personal information were removed from the following resident rooms and/or doors: Resident #34, #30, # 21, # 8, and # 4 .this information was either discarded or relocated in a more private place. Care plans and/or care cares were updated to reflect these changes.</p> <p>ISSUE # 7: Due to the importance of the information to be communicated to caregivers for resident # 24 – a red arm band has been placed on</p>		

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			<p>the right arm to alert that no BP or blood draws to be taken from this arm. Care plan and/or care card has been updated to reflect these changes. This will also be noted on any future lab requisitions.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Active Residents in the facility being cared for during the survey process had the potential to be affected. Facility review to identify presence of any signage with personal information was completed 12-29-11. All signage has been removed per standard and/or relocated in a place that will not impede on their dignity.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Facility staff has been re-educated regarding Resident Right to Privacy included but not limited to: <ul style="list-style-type: none"> · to not having posted signage with personal information in a location that could be viewed by others, · Staff to knock on resident doors prior to entering their room/care area. </p>		

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			<ul style="list-style-type: none"> · To refer to administration staff for medical alert needs and how to accomplish these with respect to dignity. · Staff will receive education on Resident Rights upon orientation and at least annually. . · This will also be reviewed during resident and family council. · Letters will be posted in the next billing cycle to inform responsible parties of this citation along with the plan of correction and ask for their co-operation in refraining from any postings. <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: DNS or designee will randomly observe 5 direct care staff 5 x's per week for next 4 weeks then weekly for 2 months - including all shifts and weekends, to ensure Resident Right to Privacy is respected and no signage containing personal information is present in a place that would violate these rights. Room rounds will be completed twice a week for the next 4 weeks – then weekly for the next two months - to ensure no signage has been posted that could infringe on the resident's privacy and/or dignity. The Facility Risk Manager will report results at the next QA/Risk Management meeting and</p>		

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	<p>2. On 12/13/11, at 3 p.m. signs were observed above the head of Resident #34's bed which indicated "Must keep HOB 45 degrees up per nurse" And a sign on the resident's closet door indicating "please remember to put boots on in bed at noc float heels at all times."</p> <p>The sign above the resident's bed and on the closet door were noted again on 9/16/11, at 9:45 a.m.</p> <p>3. On 12/13/11 at 3 p.m., signs were observed on the outside of Resident #30's closet door that indicated the resident needed splints, with picture instructions on how to apply the splints.</p> <p>Resident #30's clinical record was reviewed on 12/15/11 at 11:30 p.m.</p>		<p>monthly thereafter until compliance has been achieved and the committee recommends quarterly monitoring by the RDCO when completing facility system review which includes review Quality of Life to maintain compliance.</p> <p>(a) Date of compliance: 1/18/12</p>		

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	<p>A physician's order was noted, dated 10/3/11, indicating the resident was to "donn" right contracture boot at HS [hours sleep] as tolerated effective 9/26/11.</p> <p>4. During initial tour 12/12/11 at 11:10 a.m., Resident # 21's door was observed to have signs on door. One sign indicated "Family will do laundry" and the other sign indicated "Clear throat before knocking on door so Ann will hear you". Resident #21 was observed to be very hard of hearing.</p> <p>Record review on 12/19/11 at 11 a.m., indicated the resident had, but was not limited to, the diagnoses of dementia with psychosis, legally blind and hard of hearing.</p> <p>5. During interview of Resident #8 on, 12/12/11 at 1:39 p.m. eight by 10 inch photographs were observed posted on the interior of the resident's room of braces applied to Resident #29, the resident's roommate, with the roommate's name labeled on the pictures.</p> <p>On 12/15/11 at 9:45 a.m. with the Corporate RN, the signs were again observed on the door. The signs were labeled with the resident's name and "Bilateral Dynaflex knee splints" and "Hip abductor."</p>				

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	<p>6. On 12/16/11 at 11:15 a.m. Resident #4 was observed receiving care. Eight by 10 inch photographs of the resident's legs with splints applied were observed posted on the interior of the room door.</p> <p>7. On 12/13/11 at 2:45 p.m. Resident #24 was interviewed. Signs were observed posted above the hand sink just inside the door to the room, and within view of the hallway of "No Needle Sticks in R [right] arm or BPs [blood pressure]" A sign was observed posted on the wall above the head of the resident's bed was noted of No needle sticks in right arm!!!! Please!"</p> <p>The signs were observed during observation of setting up dialysis on, 12/16/11 at 3:00 p.m., and were observed on 12/19/11 at 2:00 p.m.</p> <p>Review of the facility policy titled "Long Term Care Resident Rights in Indiana" on 12/19/11 at 3:14 p.m. from the Administrator indicated the resident had a right to "privacy in their room during bathing, medical treatment and personal care". And "Residents have a right to privacy and confidentiality. We do not discuss their information with others; we knock and wait for permission before</p>				

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F0314 SS=D	<p>entering their room."</p> <p>3.1-3(t)</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, interview and record review, the facility failed to provide necessary treatment to promote healing and prevent healing of pressure sores for 1 of 2 Stage 2 sampled residents with pressure sores. [Resident #4]</p> <p>Finding includes:</p> <p>On 12/12/11 at 2:52 p.m. the Minimum Data Set [MDS] coordinator was interviewed. The staff member indicated Resident #4 did not have any pressure areas.</p> <p>On 12/15/11 at 9:54 a.m. Resident #4 was observed in bed. With CNA's #4 and #6 the resident was observed to have an open, slit area on the coccyx. The CNA's indicated the area was new.</p>	F0314	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.</p> <p><u>F-314 Treatment/SVCS to Prevent/Heal Pressure Sores</u></p> <p>(a) What corrective action will be accomplished for those residents found to have been affected by this practice:</p> <p>The MD/Family was notified regarding resident #4's new pressure ulcer. Physician's orders were received and implemented for treatment, and the care plan was updated on 12/16/11.</p> <p>LPN # 5 and CNA #'s 4 and 6 received teachable moments regarding the facility's standard and guideline on wound care.</p> <p>(b) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken:</p>	01/18/2012	

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	<p>On 12/16/11 at 11:15 a.m., with the DON, Resident #4 was observed with the opened slit area and two open round areas on the buttocks. No treatment was observed on the areas. The DON indicated she was not aware of the areas.</p> <p>Resident #4's clinical record was reviewed on 12/19/11 at 9:56 a.m. A physician's order was noted dated 12/16/11 for "Cleanse open areas on buttocks and coccyx with normal saline apply hydrocolloid change every three days and prn [as needed].</p> <p>On 12/16/11 at 1:54 p.m., LPN #5, responsible for measuring and assessing pressure areas, provided a document titled "Wound Progress Record." Documentation of the resident's open areas was noted of discovery date 12/16/11. Documentation identified the areas as pressure and measurements were noted of: left upper coccyx area 0.7 cm [centimeters] by 0.3 cm.; coccyx slit: 1.2 cm by 0.3 cm.; and right buttock area 1.3 cm by 0.5 cm. Staging of the areas and measurements of depth was not documented.</p> <p>On 12/19/11 at 10: 15 a.m., LPN #5</p>		<p>A facility skin audit was conducted on 12/17/11, to identify any current Residents with unidentified pressure ulcer/skin issues requiring treatment and no other areas were identified. .</p> <p>(c) What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur:</p> <p>The Nursing staff was re-educated by the DNS/Designee on the facility's standard and guideline for Wound Care standards of Practice. Licensed nurses will assess residents skin during the scheduled shower/bathing assessment at least two times weekly.</p> <p>(d) How will the corrective action(s) be monitored to ensure the practice will not recur, what quality measures will be put into place?</p> <p>DNS and/or Designee will monitor the skin assessments to ensure the effectiveness of these actions, including:</p> <ul style="list-style-type: none"> · Randomly inspect at least 5 residents' skin weekly to ensure skin assessment is completed with accuracy per the facility's standard and guideline. RDCO will review residents wound /skin care quarterly during Facility quarterly Systems Review. · Findings of the weekly skin assessments will be reported at the monthly QA/Risk Management meeting until such time substantial compliance has been met. <p>(e) Date of compliance: 1/18/12</p>	
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	<p>was interviewed. The LPN indicated it was her understanding that shearing areas are not considered pressure and are not staged.</p> <p>A facility policy and procedure titled "Wound Care Standards of Practice," provided by the DON on 12/15/11 at 12:41 p.m., included, but was not limited to, "Pressure Ulcer Definition. A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. ...Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. ..." The DON was interviewed on 12/16/11 at 12:00 p.m. and indicated shearing should be considered as pressure.</p> <p>On 12/19/11 at 10:27 a.m. LPN #5 updated the wound progress record to include staging the pressure areas as Stage II with depth measurements on all three areas of 0.1 cm.</p> <p>LPN #2 was interviewed on 12/16/11 at 11:50 a.m. The LPN indicated if a resident has an open area identified by the CNA's the CNA's are to report to the nurse on duty. The nurse then is to assess. If the wound nurse is on</p>			

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	<p>duty she is to assess the area and notify the physician.</p> <p>The most recent Minimum Data Set [MDS] assessment dated 10/19/11 coded the resident as requiring total assistance of two for bed mobility, and transfers; total assistance with activities of daily living non-ambulatory and always incontinent of bowel. Utilized a Foley catheter.</p> <p>The resident's plan of care which addressed the problem of at risk for developing a pressure ulcer related to Braden Scale score of 13, decreased mobility, incontinence, terminal illness, Huntington's Chorea, dated 7/24/11. Approaches included, but were not limited to, report changes in skin status to physician, Notify nurse immediately of any new areas of skin breakdown, ...noted during bathing or daily care ..."</p> <p>3.1-40(a)(2) 3.1-40(a)(3)</p>			

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F0315 SS=D	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based observation and record review, for 1 of 2 Stage 2 residents reviewed for urinary catheter the facility failed to provide services to prevent urinary tract infections. [Resident #4.]</p> <p>Finding includes:</p> <p>On, 12/15/11 at 9:58 a.m., Resident #4 was observed in bed on a speciality air flow mattress with built in side bolsters, with an indwelling Foley catheter. The catheter tubing was observed draped up over the bolster and then down to the drainage bag hanging on the bed frame. With CNA's #4 and #6 present, the catheter tubing was observed not to be secured to the resident's thigh with a strap on the resident's left thigh, intended to secure the catheter and prevent irritation to the urethra.</p> <p>On, 12/15/11 at 2:00 p.m., Resident #4 was observed in bed. A side rail and bolster were observed in the</p>	F0315	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F315 UTI – Catheters -Bladder</p> <p>A) What corrective actions will be accomplished for those residents found to have been affected by the practice?</p> <p>Resident # 4 catheter tubing is currently maintained in proper positioning free of kinks and coiled on bed to prevent back flow of urine into the bladder. The catheter tubing is connected to a leg strap to prevent irritation to the urethra. ABT for UTI has been completed.</p> <p>CNAs # 4 and # 6 have been issued Teachable Moments regarding the placement (keep drainage bag below level of the</p>	01/18/2012			

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	<p>raised position. The Foley catheter tubing was observed going up over the side rail and down into the drainage bag attached to the bed frame.</p> <p>On, 12/16/11 at 11:15 a.m., the resident was observed in bed and the Foley catheter tubing was draped up and over bolster and siderails. Yellow urine with sediment was observed in the tubing.</p> <p>On, 12/16/11 at 2:00 p.m., the resident was observed in bed with the Foley catheter tubing draped up over the bolster.</p> <p>Resident #4's clinical record was reviewed on 12/15/11 at 3:30 p.m. A urinalysis report was noted dated, 12/4/11, documented the urine appearance was brown, cloudy, with 4 plus WBC [white blood cell] Esterase positive Nitrites. No culture on chart.</p> <p>A nurse's note, dated 12/4/11 at 9:30 a.m. was noted of T [temperature] 101.8 [degrees Fahrenheit], tea colored urine in f/c [Foley catheter]. MD [Medical doctor] notified, labs ordered started on IV [intravenous] NS [normal saline] 80 cc/hr [cubic centimeters per hour] for 48 hrs. [hours]. Cipro [antibiotic] 500 mg</p>		<p>bladder) and interventions used for catheter tubing, such as a leg strap.</p> <p>B) How will the facility identify other residents having the potential to be affected by the same practices? Audit completed for residents with current indwelling catheters to assure proper management of tubing of the indwelling catheter.</p> <p>C) What measures will be put into place to ensure the practice does not recur? Nursing and direct care giver staff were re-educated on the following: Standard and guideline F315 for Urinary Incontinence Program. This addressed the care of indwelling catheters – location of drainage bags and how to secure tubing.</p> <p>D) How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? DNS/Designee will review 24 hour report during daily morning clinical meeting to identify any orders and placement of indwelling catheter and care plan initiated. This will be an ongoing for compliance. DNS/Designee will also conduct random review of the residents</p>		

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F0323 SS=D	<p>[milligrams] gt [gastrostomy tube] and 400 mg [milligrams] IV q [every] 12 hours times 10 days. PIV [peripheral IV] started." A note later on 12/4/11 indicated the IV infiltrated, the physician was notified, and changed the gt order to be given for 14 days for urinary tract infection.</p> <p>A facility policy titled Catheter Care, revised 6/18/08, provided by the Administrator on 12/19/11 at 11:30 a.m. included, but was not limited to, "Ensure catheter tubing is secure with leg strap, and ensure catheter tubing is free of kinks and coiled neatly on bed."</p> <p>A plan of care, dated 7/24/11 which addressed use of urinary catheter included, but was not limited to, Keep catheter tubing free of kinks. Keep drainage bag below level of bladder. Prevent tension on urinary meatus from catheter.</p> <p>3.1-41(a)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>		<p>weekly for the next 4 weeks then bi-monthly for the next two months to visually check catheter placement and how the tubing is secured. Any issues identified will be immediately correct and staff re-educated.</p> <p>Report of the above findings will be reviewed at the next Risk management/QA meeting to determine if compliance has been met and the committee recommends oversight by the RDCO when completing Quarter Systems review which includes catheters.</p> <p>E) Date of correction: 1/18/12</p>		

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	<p>Based on observation, interview, and record review, the facility failed to ensure safety for 2 of 2 Stage 2 residents observed in sample transferred with a mechanical lift in accordance with manufacturer's directions. [Resident #4 and #34]</p> <p>Findings include:</p> <p>1. On 12/15/11 at 9:54 a.m. CNA's #4 and #6 were observed to transfer Resident #4 from a Broda chair to bed with an Invacare Reliant 600 mechanical lift. The base of the lift was closed after raising the resident from the chair and transferring to the air flow bed. The resident was positioned perpendicular to the mast during the transfer was waist high during the transfer and elevated higher to clear the side rail and bolsters present on the air mattress. With the base of the lift closed the resident was lowered into bed.</p> <p>2. On 12/16/11 at 11:15 a.m. CNA's #4 and #6 were observed to transfer Resident #4 from a Broda chair to air flow bed with the Invacare Reliant 600 lift. The resident was at waist height during the transfer and was raised higher to clear the bolsters applied to the air mattress and partially raised side rail before being lowered into</p>	F0323	<p>F-323 Accident Prevention</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>ISSUE # 1 & # 2: Teachable moment presented to CNA's #4 and #6, caring for resident #4 regarding appropriate transfer techniques using mechanical lift while transferring from chair to air flow bed making sure the base of the lift are in maximum open position (not closed) during transfer and also what to do with side bolsters on a bed during transfer.</p> <p>ISSUE # 3: Teachable moment presented to CNA # 1 and CNA # 4 caring for resident #34 regarding the appropriate transfer techniques using the mechanical lift, to transfer from bed to Geri-chair – making sure the lift legs are in maximum open position (not closed) and to check under the bed that the area is clear of any obstructions, (such as any cords) which might cause the resident in the sling to swing sideways back and forth.</p> <p>ISSUE #4: Teachable moment presented to LPN #5 and CNA # 6 - caring for resident # 8 regarding the appropriate transfer techniques using the mechanical lift, making sure the lift legs are in maximum open position (not closed) when transferring from bed to lounge chair and that resident is in alignment during the transfer and placement in the</p>	01/18/2012	

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	<p>bed.</p> <p>Manufacturer's information for the air mattress being utilized for the resident, provided by the DON on 12/15/11 at 12:05 p.m. included, but was not limited to, "Slide Bolster The iQ Slide bolsters always function as a centering divide. ...The iQ Slide bolsters can be easily adjusted by sliding the foam cylinders out of the open-ended mattress cover to create an open area for patient transfers."</p> <p>Resident #4's clinical record was reviewed on 12/19/11 at 9:56 a.m. An Minimum Data Set [MDS] assessment dated 10/19/11 coded the resident as total assistance of two for transfers.</p>		<p>chair.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Resident who requires assistance to transfer using a mechanical lift had the potential to be affected. Facility wide inspection of all residents who require mechanical lifts was completed to ensure manufacturers guidelines and facility policy followed. No other residents were found to be affected.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Direct care staff were re-educated on the standard and guideline of the use of mechanical lifts, including but not limited to:</p> <ul style="list-style-type: none"> - Resident is faced toward operator, - In proper alignment - catheter positioning - proper base of mechanical lift.is in maximum open position - check under the bed before transfer that area is clear of any obstructions - Assure that resident is in proper alignment when placed in the chair(s). - Transfers using mechanical lift will be observed by the assigned charge nurse on duty for CNA competency with random checks monthly. - New staff will be instructed on facility standard and guidelines and will perform return demonstration on use of mechanical lift for competency. - This will be re-inserviced during 		

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	3. On 12/15/11 11:45 a.m., CNA #'s 1 and 4 transferred resident #34 from the bed to a geri-chair, utilizing an Invacare Reliant 600 lift. CNA #1 pulled the lift from under the bed, while the resident was in the sling. As the lift was being pulled out, the sling holding the resident started swinging sideways back and forth. While lifting the resident up from the bed with the lift, and transferring the resident to a geri-chair, the legs of the lift was		annual employee competency training. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The DNS or designee will observe/audit mechanical lift transfers 5x's per week (to include all shifts and weekends) for 1 month and then 3x's a week (once on each shift) for 2 months, to observe for proper technique. These audits will be reported at the next monthly QA/RM meeting and monthly until substantial compliance is maintained and the committee recommend quarterly monitor by the RDCO to maintain compliance. (e) Date of compliance: 1-18-12		

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	<p>closed.</p> <p>During interview of CNA #1 on 12/15/11 at 11:50 a.m., the CNA indicated the lift rolled over a cord, causing the sling to move back and forth.</p> <p>During review of resident #8's clinical record, on 12/16/11 at 11:15 a.m., a quarterly assessment, dated 10/5/11, indicated the resident required extensive assist with transfers.</p> <p>4. On 12/14/11 at 10:45 a.m. CNA #6 and LPN #5 transferred resident #8 from the bed to a lounge chair utilizing an Invacare reliant 600 lift.</p> <p>The staff was observed to lift the resident from the bed with the legs of the lift closed, and to transport the resident from the bed to the lounge chair with the legs of the lift closed.</p> <p>During the transfer the resident was observed not positioned correctly in the lift pad. One of the resident's legs were higher than the other and the resident's body was positioned slightly crooked with the resident's head towards the right. The resident was facing sideways, to the operator of the lift, during the transfer.</p>				

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	<p>During interview of resident #8 on 12/15/11 at 12:20 p.m., the resident was observed sitting in a lounge chair. The resident indicated the staff didn't get her positioned correctly in the chair when placed in the chair with the lift. The resident was observed to be sitting in the lounge Chair in her room, slightly misaligned.</p> <p>During review of the facility policy titled "Reliant 600 Heavy-Duty Power Lift with Power Base" received from the DON (Director of Nursing) on 12/15/11 at 2:12 p.m., the following documentation was noted;</p> <p>"When moving the patient lift away from the bed, turn the patient so that he/she faces assistant operating the patient lift."</p> <p>"The legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed,</p>			

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	<p>return the legs of the lift to the maximum open position and lock the shifter handle immediately".</p> <p>"Before positioning the legs of the patient lift under a bed, make sure that the area is clear of any obstructions".</p> <p>3.1-45(a)(1)</p>				

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F0356 SS=B	<p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to prominently display the nurse staffing data with correct date and/or in a readable format for 1 of 1 nurse staffing data displayed in the facility. This had the potential to affect all 33 residents.</p>	F0356	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F 356 Nurse Staffing: BIPA</p>	01/18/2012	

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	<p>Findings include:</p> <p>1. On 12/12/11 at 1 p.m. the nurse staffing data was observed to be displayed on the front door. The staffing documentation was completed horizontally; however, the staffing data was posted vertically. The nurse staffing data posted was dated 12/6/11.</p> <p>Interview of the Administrator on 12/12/11 at 3:24 p.m. indicated the corporate office mandated the nurse staffing data be posted on the front door.</p> <p>2. On 12/13/11, and 12/14/11 at and on 12/15/11 at 9:30 a.m., the nurse staffing data was observed to be displayed on the front door vertically with the documentation horizontally.</p> <p>3. On 12/16/11 at 9 a.m., the nurse staffing data was observed to again be posted vertically with the documentation completed horizontally.</p> <p>4. Review of documentation provided by the Administrator on 12/19/11 at 12:05 p.m. indicated "...Posting of information: data must be displayed in a clear and readable format..."</p>		<p>Posting</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <ul style="list-style-type: none"> • Issue # 1, 2, 3 and 4: The required staffing sheet was posted horizontally, displayed horizontally in a clear and readable format with the current date at the front entry. • The required data (BIPA staffing sheet) that was posted in the front lobby area for 12/12/11 but had a 12/6/11 date – was replaced once identified with correct information for that day. • A second copy will be posted by the side door for those family members who use this as their main entry to the facility. • Also posted at the nurses station is the break down of each of the shift, the licensed nurses and CNAs as to their room assignment. This will be updated at the beginning of each shift so that visitors/family members etc.; know who is caring for each room yet protecting their privacy. <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: The facility has determined individuals that wanted to view the posted staffing data had the potential to be affected.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <ul style="list-style-type: none"> • The facility administration team has been reeducated/re-inserviced to the standard of posting the required BIPA information referred to above under immediate actions. • The facility administration team 		

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	3.1-13(i)(4)		<p>has been re-inserviced/reeducated that staffing data must be stored and readily available for review upon request. This information will be kept by the facility for 18-months.</p> <ul style="list-style-type: none"> · NHA and/or DNS along with the HR director will review the BIPA staffing form prior to posting. · Manager on duty/charge nurse for the weekends will assure BIPA staffing form is posted. <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <ul style="list-style-type: none"> · The monitoring of this will be a joint effort between the NHA/DNS/Weekend MOD who will when making their rounds observe that the posting of the BIPA staffing form is current, and the room assignment for licensed nurses and CNAs have been update for the current shift. · Any issues identified or adjustments will be immediately corrected. Review of these findings will be presented to the next Risk Management/QA Committee Meeting to determine if compliance has been achieved and can be maintained by quarterly oversight by the RDCO when completing facility systems review which addresses this posting. <p>(e) Date of compliance: 1/18/12</p>		