

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/05/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825
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F000000	<p>This visit was for the Investigation of Complaint IN00160064.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00160064 Substantiated. Federal/ State deficiencies related to the allegations are cited at F157, F309, and F314.</p> <p>Survey dates: December 1, 2, 3, 4, and 5, 2014</p> <p>Facility number: 000459 Provider number: 155567 AIM number: 100289700</p> <p>Survey team: Rick Blain, RN, TC Tim Long, RN Carol Miller, RN Diane Nilson, RN Christine Fodrea, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 52 Total: 56</p> <p>Census payor type:</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000157 SS=D	<p>Medicare: 4 Medicaid: 44 Other: 8 Total: 56</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 12, 2014 by Randy Fry RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as</p>				

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	<p>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 interview and record review, the facility failed to notify the physician for 1 of 3 residents reviewed for physician notification after a change in condition in a sample of 9. (Resident #K)</p> <p>Findings include:</p> <p>Resident #K's record was reviewed 12-4-2014 at 10:31 AM. Resident #K's diagnoses included, but were not limited to: renal failure, diabetes, anemia, depression, high blood pressure, mitral valve disorder, heart block, and peripheral vascular disease.</p> <p>A Review of Nursing Notes indicated the following: notes dated 11-11 through 11-14-2014 indicated Resident #K was alert and oriented x 3, not confused, or febrile. There were no nursing notes</p>	F000157	Resident # K is no longer in the facility. The facility will review current resident documentation since 12/1/14 to ensure MD/RP notifications were made as appropriate. Licensed staff have been re-educated on completing MD/RP notification. Each week, a change-of condition audit will be completed by the Health Information Manager, or designee to monitor compliance with timely physician notification. Each week, the Director of Nursing or designee will be responsible for monitoring change-of condition audits and coordinating compliance with physician notification as indicated. The Director of Nursing / Designee will be responsible for identifying patterns of noncompliance and reporting issues to the monthly QA&A committee for 6 months then quarterly thereafter for problem analysis and continued monitoring as	01/04/2015

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	<p>dated 11-15 and 11-16 available for review. The Nursing Notes dated 11-17 indicated Resident #K had a fall. There was no note on 11-17 to indicate if Resident #K had a change in cognitive status. Nursing Notes dated 11-18 and 11-19-2014 indicated Resident #K was now only oriented x 2, but there was no assessment of the reason for the change in cognition on either note. Additionally, neither note indicated the physician nor the family had been notified about the change in cognition. On 11-20-2014 at 8:30 AM, the notes indicated Resident #K was now oriented only to self, was lethargic, and skin was now a grayish tan. There was no further assessment noted in the Nursing notes.</p> <p>A review of the SBAR- change of condition form, indicated the facility had received a call from the dialysis unit at 8 AM. The phone call indicated Resident #K was being sent to the hospital due to low blood pressure and change of level of consciousness. The note further indicated the Nurse Practitioner had been notified at 8:30 AM.</p> <p>In an interview on 12-4-2014 at 2:35 PM, RN Consultant #3 indicated the physician is to be called whenever there is a change in the cognition or condition of the resident.</p>		indicated.Face to Face is requested for this tag.Repeat tag	

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F000309 SS=D	<p>This Federal tag relates to Complaint IN00160064.</p> <p>3.1-5(a)(2)</p> <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, interview, and record review, the facility failed to assess changes in condition for 3 of 9 residents reviewed with changes in condition in a sample of 9. (Resident #P, Resident # K, and Resident #O).</p> <p>Findings include:</p> <p>1. Resident #K's record was reviewed 12-4-2014 at 10:31 AM. Resident #K's diagnoses included, but were not limited to: renal failure, diabetes, anemia, depression, high blood pressure, mitral</p>	F000309	Resident #K and #O are no longer in the Facility. Resident #P was interviewed on 12/2/14 stating he was not having any pain. The facility will review current resident documentation since 12/1/14 for changes of condition related to non-pressure skin conditions, pain, and cognitive status for appropriate follow up. Any issues identified will be addressed as appropriate. Licensed staff were re-educated on assessment and documentation of changes of condition for pain, non-pressure skin conditions, and cognitive status. Each week, a change-of condition audit will be completed	01/04/2015

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	<p>valve disorder, heart block, and peripheral vascular disease.</p> <p>A review of Nursing Notes indicated the following: The notes dated 11-11 through 11-14-2014 indicated Resident #K was alert and oriented x 3, there was no indication Resident #K was confused, or febrile. There were no nursing notes available for review for the dates 11-15 and 11-16. Notes dated 11-17 indicated Resident #K had a fall. There was no note on 11-17 to indicate if Resident #K had a change in cognitive status. Nursing Notes dated 11-18 and 11-19-2014 indicated Resident #K was now only oriented x 2. There was no assessment of the reason for the change in orientation on either note. On 11-20-2014 at 8:30 AM, the notes indicated Resident #K was now oriented only to self, was lethargic, and skin was now a grayish tan. There was no further assessment to determine the cause of the change in condition noted in the Nursing notes.</p> <p>A review of the SBAR- change of condition form dated 11-20-2014, indicated the facility had received a call from the dialysis unit at 8 AM. The phone call indicated Resident #K was being sent to the hospital due to low blood pressure and a change of level of consciousness.</p>		<p>by the Health Information Manager, or designee to monitor compliance with change of condition related to pain, non-pressure skin condition and cognitive status. Each week, the Director of Nursing or designee will be responsible for monitoring change-of condition audits and coordinating compliance with physician notification as indicated. The Director of Nursing / Designee will be responsible for identifying patterns of noncompliance and reporting issues to the monthly QA&A committee for 6 months then quarterly there after for problem analysis and continued monitoring as indicated. Face to Face is requested for this tag. Repeat tag</p>				

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	<p>A review of hospital emergency room records dated 11-20-2014 indicated Resident #K was being admitted to the hospital with urinary tract infection, hypotension, and end stage renal disease.</p> <p>In an interview on 12-4-2014 at 1:57 PM, Nurse Consultant #3 indicated whenever a resident had a condition change, the resident should be assessed, and a change of condition form completed.</p> <p>A current policy titled Managing Change of Condition dated October 2011 provided by RN Consultant #3 indicated under the title "Objective" "to provide treatment and services to address changes in accordance with resident needs" The policy further indicated to "select and complete each section of the appropriate Change of Condition form".</p> <p>2. Resident #P's record was reviewed 12-3-2014 at 10:34 AM. Resident #P's diagnoses included, but were not limited to, dementia, personality disorder, hypothyroidism, dermatophytosis of the scrotal and perianal areas, scrotal varices, psychosis and osteoarthritis.</p> <p>Physician orders dated 11-25-2014 indicated Resident #P was prescribed Ibuprofen 600 Milligrams (mg) every 6</p>			

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	<p>hours as needed for pain, and Lotrimin 2% lotion to be applied to the scrotal area twice daily.</p> <p>During an observation on 12/02/2014 at 1:12 PM, Resident #P was observed to be shaking the right leg side to side and fidgeting in the wheelchair. Resident #P denied pain, but stated his leg and bottom didn't feel right.</p> <p>A review of the Nursing Assessment dated 11-25-2014, indicated Resident #P had pain in the left shoulder that was being managed with current medications, however, the assessment did not include pain in the perineal area.</p> <p>A review of the Pain Assessment/ Evaluation dated 11-25-2014 indicated Resident #P had a pain level of 6, but his pain was being adequately managed with the current medication. The form indicated Resident #P's pain was located in the left shoulder, but did not indicate there was any other area of pain.</p> <p>A review of Resident #P's Treatment Administration Record dated November 2014 and December 2014 indicated Lotrimin treatments were being administered as ordered to the perineal area.</p>						

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	<p>In an interview on 12-3-2014 at 11:41 AM, Resident #P indicated the cream ordered was being applied to the perineal area twice a day.</p> <p>A review of Resident #P's Medication Administration Record indicated Resident #P was not experiencing pain, and no as needed pain medication had been given.</p> <p>In an interview on 12-3-2014 at 1:09 PM, LPN #1 indicated if a resident is having signs of pain, the pain level and location should be assessed, and a pain medication should be given.</p> <p>3. Resident #O's record was reviewed 12-3-2014 at 8:50 AM. Resident #O's diagnoses included, but were not limited to, morbid obesity, High blood pressure, lymphedema, Asthma, atrial fib and flutter.</p> <p>A review of Physician Orders dated 7-14-2014 indicated no treatments were ordered for open areas.</p> <p>A review of Resident #O's nursing admission assessment dated 7-14-2014 did not indicate any open areas were present.</p> <p>A review of an SBAR (Change of</p>			

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	<p>Condition form) dated 7-24-2014 indicated 2 new wounds were identified on the back of Resident #O's right leg. The first area measured 1 cm x 0.8 cm x 0.1 cm. There was no indication of the location of the area. The second area measured 0.5 cm x 0.5 cm x 0.1 cm. There was no description of the location of the area. The back of the form indicated the Nurse Practitioner and family had been notified. The notes further indicated the areas were red in color with scant drainage, but there was no further descriptions of the areas.</p> <p>A review of an IDT - Post Occurrence Review dated 7-25-2014 indicated Resident #O had 2 open areas. The documentation indicated Resident #O's open areas were from rubbing on the sheet.</p> <p>A skin integrity care plan dated 7-25-2014 indicated Resident #O had open areas due to friction. The care plan had interventions of: keep area clean and dry, monitor for signs, and symptoms of infection, monitor for drainage and odor and apply treatment as ordered. There was no intervention to address prevention of friction.</p> <p>Review of Resident #O's Treatment Administration Records dated August,</p>			

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	<p>September, and October 2014 indicated his legs were wrapped with ace wraps beginning 8-18-2014 due to severe leg edema.</p> <p>A review of Treatment Administration Records dated July, August, September, and October, 2014 indicated Resident #O received treatment of hydrocolloid gel and optifoam to his lower legs every 3 days as ordered until discharge.</p> <p>A review of Resident #O's Braden scales completed 7-15,22,and 29; and 8-5 indicated Resident #O had been scored as high risk for pressure areas.</p> <p>A review of Non-pressure area skin reports indicated the following: Area #1 was measured 7-26-2014, the area was identified as being on Resident #O's right calf near the knee, and measured 1 cm x 0.8 cm x 0.1 cm. The area was described as red, and without drainage. Area #1 was measured again on 8-2-2014 and was described as improved, and pink with no drainage, and measured 0.8 cm x 0.5 cm x 0.1 cm. there was no further documentation on the form to indicate the area had healed, or was being monitored. Area #2 was located on the back of the right calf proximal to the knee and located towards the middle of the calf. The area was identified as being</p>			

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F000314 SS=G	<p>somewhat red, with no drainage, and measured 0.5 cm x 0.5 cm x 0.1 cm. There was no further documentation on the form to indicate the area had been healed or monitored.</p> <p>A review of Nurse Practitioner progress notes dated 8-29-2014 indicated Resident #O's skin changes were due to lymphedema. There was no mention if the areas were healed or remained open.</p> <p>In an interview on 12-3-2014 at 1:42 PM, LPN #1 indicated wounds were supposed to be measured weekly but, because the nurse's were so busy, they were unable to measure wounds very consistently.</p> <p>This Federal tag realties to complaint IN00160064.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure</p>				

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	<p>sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to assess and monitor residents for changes in skin integrity for 2 of 3 residents reviewed for pressure ulcers in a sample of 9 residents (Resident #N and Resident #O). This failure to assess and monitor skin integrity changes resulted in 1 resident's pressure areas increasing in stage from superficial to unstageable.</p> <p>Findings include:</p> <p>1. Resident #N's record was reviewed 12-5-2014 at 9:33 AM. Resident # N's diagnoses included, but were not limited to, cellulitis, morbid obesity, diabetes, high blood pressure, restless leg syndrome, lung disease, and lymphedema.</p> <p>A physician's order dated 9-18-2014 indicated Resident #N had wounds on the right upper thigh on admission. The orders additionally indicated to maintain a Foley catheter for wound healing.</p> <p>Physician Progress notes dated 9-18-2014 indicated Resident #N had pressure ulcers on the right upper thigh measuring</p>	F000314	Resident #N or #O are no longer residents in the facility. All other Pressure wounds were re-measured and skin sheets updated on 12/5/14. Nursing staff have been re-educated on proper procedures for completing assessments and measurements in accordance with policy. Each week the DON/Designee will complete a skin monitoring tool to monitor compliance with timely skin measurements. The Director of Nursing / Designee will be responsible for identifying patterns of noncompliance and reporting issues to the monthly QA&A committee for 6 months then quarterly thereafter for problem analysis and continued monitoring as indicated. Face to Face is requested on this tag. Repeat tag	01/04/2015			

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	<p>7.4 cm x 1.6 cm x less than (<) 0.1 cm and 3 cm x 0.8 cm x < 0.1 cm. The note further indicated the areas were superficial, and had a pink wound base.</p> <p>A review of Resident #N's care plans included a potential for pressure ulcer development, interventions included medication administration, lotion to skin, bath per schedule, encourage fluid intake and meal intake, encourage to reposition self, evaluate skin weekly, labs as ordered, pressure reducing cushion in wheel chair and on mattress. An additional care plan for stasis ulcers was initiated an 10-10-2014. The interventions were to document location and characteristics of wounds, medicate as ordered, and document signs of infection.</p> <p>An SBAR #1 dated 11-13-2014 indicated Resident #N had an area on right inner thigh of undetermined depth, due to yellow slough in the wound bed, measuring 7.4 cm x 1.6 cm. There was not a description of the location of the area. The document further indicated there was no drainage to the area, and the wound edges were pink.</p> <p>A review of SBAR #2 indicated there was a second area to the right inner thigh measuring 3 cm x 0.8 cm of</p>			

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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>undetermined depth due to yellow slough in the wound bed. There was not a description of the location of the area. The document further indicated there was no drainage to the area, and the wound edges were pink.</p> <p>A review of Resident #N's wound tracking indicated there was no wound tracking available for review to indicated the locations, size, or progress of the left upper thigh wounds between 9-18-2014 and 11-13-2014.</p> <p>A review of Pressure ulcer evaluation record dated 11-13-2014 indicated there was a right thigh wound proximal to the thigh/ torso fold, about the middle of the thigh. This wound was described as unstageable due to slough in the wound bed. and measured 7.4 cm x 1.6 cm. There was no depth noted on the document.</p> <p>A review of Pressure ulcer evaluation record dated 11-13-2014 indicated there was a right thigh wound proximal to the thigh/ torso fold, close to the inner part of the leg. This wound was described as unstageable due to slough in the wound bed. and measured 3 cm x 0.8 cm. There was no depth noted on the document.</p> <p>A review of Resident #N's Nurses Notes</p>						

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	<p>indicated there were no descriptions of the open areas, or measurements, or characteristics of the open areas between the initial admission assessment on 9-18-2014 on the wound reports dated 11-13-2014.</p> <p>In an interview on 12-5-2014 at 11:24 AM, LPN #1 indicated she had measured the wounds on 11-13-2014 and although the true depth was obscured by the slough in the wounds, the measured depth was 0.1 cm. When asked why this measurement had not been documented, LPN #1 indicated she had been instructed to leave the measurement off the document because of the underlying slough.</p> <p>A current policy titled Skin Integrity Standard dated June 2010 provided by RN Consultant #3 on 12-5-2014 at 9:35 AM indicated "weekly head to toe assessment of all residents by the Licensed nurse with narrative documentation of findings. Narrative findings will include; description of skin turgor, color, and any skin related issue."</p> <p>This Federal tag relates to Complaint IN00160064.</p> <p>3.1-40(a)(1)</p>			

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

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