STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00200579. Complaint IN00200579-Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F314, F323 and F425. Unrelated deficiencies are cited. Survey date: May 31 and June 1 and 2, 2016 Facility number: 000192 Provider number: 155295 AIM number: 100291120 Census bed type: SNF/NF: 66 Total: 66 Census by payor source: Medicare: 7 Medicaid: 52 Other: 7 Total: 66 Sample: 7 These deficiencies reflect State findings	F 0000	**The Statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all State and Federal regulations, the facility has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on May 8, 2016.		**date or dates indicated.**	
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow written physician orders for a pressure wound evaluation and treatment for 1 of 7 residents reviewed for physician orders (Resident B). Finding includes: Resident B's record was reviewed on 05/31/2016 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, hypertension, Diabetes Mellitus type 2, muscle weakness and abnormalities of gait and coordination. A physician order, dated 05/18/2016 at 10:46 a.m., indicated "Calazime [a cream to treat wounds that absorbs light drainage] to area on buttock once daily x [times] 10 days then reeval [sic]."	F 0282	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Resident "B" had the pressure wound re-evaluated by the Director of Nursing on 6/7/2016 following the residents physician orders. Resident "B" was found to have no adverse affects from the alleged deficient practice. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents who have pressure wound evaluation and treatment orders have the potential to be affected by this alleged deficiency. Any residents found to have the potential to be affected by this deficient practice were re-evaluated and treated according to physician orders by	06/14/2016

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	During an interview on 06/01/2016 at 4:22 p.m., the DON (Director of Nursing) indicated no re-evaluation of the resident's wound was performed on 05/28/2016 as ordered by the physician on 05/18/2016. During an interview on 06/02/2016 at 11:10 a.m., the DON indicated if a new order was given for a treatment to the same area, the initial order should be discontinued. Additionally, she indicated it was "standard practice" to place the original order on hold to revert back to when a timed order was given and re-evaluation was performed. She indicated the nurses would "know" to go back to the original order. She indicated the Treatment Administration Record lacked a physicians written order to place the original order on hold. This Federal tag relates to Complaint IN00200579. 3.1-35(g)(2)		the Director of Nursing. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Licensed nursing staff were re-educated on June 14, 2016 on following physician orders. Orders have been audited by the Director of Nursing to ensure wound evaluations and treatments have been completed. There were no negative findings. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · The Director of Nursing or designee will audit new orders 2 days a week x 12 weeks, then weekly for 3 months and then randomly in the electronic medical record to ensure the orders have been written properly, and evaluations and treatments have been completed per physicians order. Audits will be reviewed in QAPI meeting monthly for 6 months. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated following facility policy.	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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	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. Based on interview and record review, the facility failed to ensure a resident with a diagnosis of dementia with behavioral disturbances who was prescribed an antianxiety medication had her needs assessed and non-pharmaceutical interventions were tried prior to the antianxiety medication being administered every time for 1 of 1 resident being reviewed for a resident with a diagnosis of dementia receiving an antianxiety medication (Resident D). Finding includes: On 5/31/16 at 2:10 p.m., Resident D was observed laying in a low bed on her right side with a pillow behind her back sleeping. On 6/1/16 at 9:15 a.m., the resident was sitting in her broda chair in the hallway in front of the nurses station. She was sitting quietly eating a sucker. On 6/1/16 at 9:42 a.m., LPN #1 and LPN #2 was observed changing the resident's right heel pressure ulcer dressing.	F 0309	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Resident "D" was assessed on 6/2/2016 by the Director of Nursing to ensure she is offered non-pharmaceutical interventions prior to administering an antianxiety medication. The physician was notified, medication changes have been made, and	06/14/2016

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	Throughout the dressing change the resident yelled out "Please don't. No don't please stop." She would say "Oh." While LPN #1 was measuring the depth of the wound, then immediately applied the Santyl (a debriding medication) the resident yelled out "Oh, Oh, Oh." "No she shouldn't have." "No honey." She was crying "Oh please come here and help me." "I got to get out of here." She placed her hand to her mouth with her four fingers over her lips and brought her hand to and from her mouth while repeating in a high pitched sound "Oh, Oh, Oh." While LPN #2 was placing her non-skid sock on her left foot over the bulky dressing she was yelling out "Oh please don't do that." After the two nurses was completely finished with the dressing change the resident indicated "Make her leave me alone." She was grabbing for a hand while indicating "Thank you, Thank you." The resident had facial grimacing during the dressing change. LPN #1 indicated during the dressing change the resident had been medicated with routine scheduled Hydrocodone at 8:00 a.m. LPN #2 indicated when she was yelling out the staff would comfort her and continue care when able. LPN #1 indicated the resident would yell out whether she was getting her dressing changed or not. She indicated this was a "behavior" for her.		non-pharmaceutical interventions were clarified. There were no adverse effects from this alleged deficient practice. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents with a dementia diagnosis and who have orders for antianxiety medications have the potential to be affected by this alleged deficient practice. Non-pharmaceutical	

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	On 6/1/16 at 11:10 a.m., Resident D was sitting in the hallway in her broda chair in front of the dining room sitting quietly. Resident D's record was reviewed on 6/1/16 at 1:00 p.m. Diagnoses included, but were not limited to, low back pain, generalized anxiety disorder and dementia with behavioral disturbance. The resident's Electronic Medication Administration Record (EMAR) dated March, April and May 2016, included, but was not limited to, the following order: 10/16/15--Lorazepam tablet (an antianxiety medication) one milligram by mouth every six hours as needed for agitation related to generalized anxiety disorder. The Progress notes with these dates and times indicated Lorazepam was given without non-pharmaceutical interventions being tried prior to these doses being administered: 3/8/16 at 6:57 a.m.--"LORAZEPAM 1 MG [milligrams] TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER." 4/13/16 at 7:46 a.m.--"LORAZEPAM 1		interventions were clarified and implemented for those residents. All residents who have a diagnosis of dementia, and receive psychotropic or antianxiety medications were audited on June 7th by the Director of Nursing for non-pharmaceutical interventions. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed Nursing staff were re-educated on	

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	MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER easily agitated." 5/4/16 at 7:51 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER repeated yelling out." 5/11/16 at 8:00 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER easily agitated." 5/15/16 at 6:55 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER." 5/19/16 at 9:27 p.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER increased anxiety." 5/30/16 at 9:58 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER."		June 14, 2016 by the Director of Staff Development about assessing, documenting and utilizing non pharmaceutical interventions prior to the administration of antianxiety medications. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · The Director of Nursing or designee will audit PRN interventions through the electronic medical	

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	5/30/16 at 5:38 p.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER increased anxiety, yelling out, restless." The resident's record lacked assessment of needs or non-pharmaceutical interventions documented prior to giving the above doses of Lorazepam. On 6/1/16 at 1:45 p.m., the resident was observed sitting in front of the dining room in her broda chair with a sucker and was looking around. She would talk to people occasionally when a person walked by her chair. No yelling out was observed. On 6/2/16 at 8:45 a.m., the resident was observed sitting in her broda chair in the middle of the dining room exit door. She was sitting there quietly watching people as they walked down the hallway. On 6/2/16 at 9:40 a.m., further documentation regarding assessing the resident's needs and trying non-pharmaceutical interventions prior to medicating the resident with Lorazepam was requested from the DON (Director of Nursing).		record 2 days a week for 12 weeks, and twice a month for 3 months, and randomly thereafter. Audits will be reviewed in QAPI meeting monthly for 6 months. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated per company policy.	

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	On 6/2/16 at 2:10 p.m., the resident was in her room in bed sleeping. During an interview on 6/1/16 at 10:30 a.m., the DON indicated Resident D had "these behaviors" (yelling out "Oh, Oh, Oh", tapping her four fingers back and forth on her lips making a high pitched sound and telling people to stop touching her when no one is even touching her) whether or not you were provided care for her. She indicated the yelling she was doing during the dressing change was some of her "behaviors" because she had been medicated for pain one hour and 42 minutes prior to the dressing change. She indicated it did not matter if she was being cared for or sitting by herself out in the hallway, she yelled out whether anyone was touching her or not. During an interview on 6/2/16 at 11:24 a.m., the DON indicated she did not find any further documentation regarding assessment of needs or non-pharmaceutical interventions the facility tried prior to the nurses administering Lorazepam to Resident D. 3.1-37(a)			

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F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure appropriate wound assessments were performed for 3 of 3 residents who developed pressure ulcers (Residents C, D and B), failed to follow pressure ulcer prevention interventions to prevent worsening of pressure ulcers for 2 of 3 residents reviewed for pressure ulcers (Residents D and B) and failed to implement a preventative intervention to prevent the development of a pressure ulcer for 1 of 3 residents who developed a pressure ulcer (Resident C). Resident C's right heel pressure ulcer progressed from a Suspected Deep Tissue Injury (Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceeded by tissue that was painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissues.)	F 0314	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Residents "D" and "B" were re-assessed by the Director of Nursing on 6/2/2016 for pressure ulcer prevention interventions and were found to have no new or worsening	06/14/2016

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	to an Unstageable ulcer (Full thickness tissue loss in, which the base of the ulcer was covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) with bone being probed in the center of the wound upon examination. Findings include: 1. Resident C's record was reviewed on 5/31/16 at 3:03 p.m. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur, history of falling and chronic pain. The resident's Electronic Medication Administration Record (EMAR) dated May 2016, included, but was not limited to, the following order: 5/4/16--Cleanse the right heel ulcer with saline, then apply Silver Alginate (An antimicrobial dressing used to prevent a wound infection and it absorbed wound drainage and kept the wound bed moist). Cover the right heel ulcer with a heel foam dressing (a dressing specifically designed to fit the heel and typically used on pressure ulcers), then secure with kerlix wrap (a guaze type wrapping used to secure the dressing in place). Change the wound dressing daily. The resident's Admission MDS		pressure wounds. Resident "D" was provided a new Roho cushion on 6/2/2016. There were no adverse affects from this alleged deficient practice. Resident "C" no longer resides at this facility. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents with pressure ulcers who have the potential to develop pressure areas have the potential to be	

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	(Minimum Data Set) assessment dated 3/25/16, indicated he was 76 inches (6 feet 4 inches) tall and 321 pounds. Prior to the resident developing a pressure ulcer to his right heel his record did not indicate he had a specialty bed for his height or weight or any special equipment to accommodate his height. A "Wound Assessment-V2" report dated 3/22/16, indicated the resident acquired a pressure ulcer to the right heel on 3/22/16. The original stage was a SDTI (Suspected Deep Tissue Injury). The highest stage was SDTI. The wound bed was dry and was an intact fluid filled blister. The ulcer measured 2.0 x 5.0 x 0 cm (centimeters). The periwound had slight redness. The report indicated this was the first observation of the ulcer. A "Wound Assessment-V2" report dated 3/30/16, indicated the resident acquired a pressure ulcer to the right heel on 3/22/16. The original stage was a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister.) The highest stage was a SDTI. The wound bed had epithelial (pink) tissue present and was moist. The blister was broken and the skin was macerated (a softening or		affected by this alleged deficient practice. Those residents at risk have been reviewed and interventions are in place. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · On June 14th 2016, nursing staff were re-educated by the Director of Staff Development on Skin integrity and prevention of pressure ulcers, appropriate wound assessments and pressure ulcer	

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	breaking down of tissue from constant dampness, which can be caused by exposure to anything wet (e.g.) perspiration, urine, wound exudate). The ulcer measured 8.0 x 10.5 x 0 cm. Special equipment or preventative measures put into place was an low air loss mattress and a bed extension was requested. A progress note dated 4/5/16 at 3:03 p.m., indicated the resident was found in bed without his heels floated. The resident had a right heel pressure ulcer with a 6.0 cm circumference of blue/black skin on bottom of his heel, which had a 2.0 x 1.5 cm area that was black. There was no open area noted in the blue/black area. The wound was draining a small amount of serosanguineous fluid from the skin under the busted blister. A "Documents Review Report" from (Name of Hospital) dated 4/18/16, indicated the resident had a right heel pressure wound with 100% black yellow color. The wound measured 4.0 x 6.0 cm. The wound was unstageable in the ulcer bed. There was moderate amount of serosanguineous drainage and the periwound had erytherma (redness). Additional comments indicated the resident's unstageable pressure ulcer was		interventions. Residents that present with pressure ulcers have been re-evaluated for correct staging, measurements and treatments by the Director of Nursing. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · The director of nursing or designee will assess each pressure wound weekly for updated measurement, staging and correct treatment	

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	covered in yellow, black slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist and light in color; may be stringy). A "Hospital Procedure Note" from (Name of Hospital) dated 4/23/16, indicated the resident had a right heel decubitus and he had a debridement and irrigation of the right heel decubitus. He had wet eschar (thick, leathery necrotic or divitalized tissue, frequently black or brown in color) in the middle. The wound was debrided (dead tissue removed) and irrigated (flushed dead tissue from the wound) and he had a silver VAC dressing (Negative Pressure wound therapy) (helped promote healing of a wound at the cellular level) (had antimicrobial actions to help reduce infections to the wound) applied after the debridement of the wound. An "Admission Nursing Assessment v3" dated 4/30/16, indicated the resident had a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle was not exposed. Slough may be present, but did not obscure the depth of tissue loss. May include undermining and tunneling) pressure ulcer to his right heel. The ulcer measured 6.0 x 5.2 x 0.1 cm.		and preventative interventions. The Director of Nursing or designee will audit weekly for new treatments or wounds through the electronic medical record for 6 months. Audits will be reviewed in QAPI meeting monthly for 6 months. Non compliance will be addressed through re-education and progressive disciplinary actions as indicated per company policy.	

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	A progress note dated 5/3/16 at 11:27 a.m., indicated the wound on the resident's right heel measured 6.0 x 5.2 cm. The wound bed was red beefy tissue and had serosanguineous drainage on the dressing. A "Wound Healing Clinic Consult" from (Name of Hospital) dated 5/11/16, indicated the resident had a right heel ulceration. He developed the right heel ulceration secondary to being immobile in bed. He came to the clinic that day with no offloading of his right heel and indicated he had not been wearing his multi-Podus boot. He had a history of diabetes and peripheral vascular disease. The ulcer measured 4.5 x 6.5 x 0.4 cm with a wound bed mixed with 80% fibrotic, yellowish, brownish tissue and 20% granular with some capillary bud formation. The ulceration probed to the bone in the center of the wound. An "Admission Nursing Assessment v3" dated 5/23/16, indicated the resident had a right heel wound. A Progress note dated 5/23/16, indicated the resident refused to allow staff to remove the right heel dressing to assess the wound. Any additional wound assessments for			

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	the right heel pressure ulcer were requested from the Director of Nursing (DON) on 6/2/16 at 11:00 a.m. Any additional wound assessments, other than the wound assessments already received were requested on 6/2/16 at 3:27 p.m. By the end of the exit conference on 6/2/16, there was no additional wound assessments provided. During an interview on 6/2/16 at 3:27 p.m., the DON indicated the resident had a trapeze bar, which he was able to use to help reposition himself in the bed. She indicated he was 6 foot 4 inches tall and the bed he was in was too short for him and he would raise the head of his bed, then he would slide towards the foot of the bed. She indicated the resident was, so tall that his feet was flat against the end of the bed when he was laying in bed. She indicated the bed extension was not placed on the foot of the bed until after the resident developed the pressure ulcer to his right heel. She indicated he did not have multipodus boots to wear until he went to the Wound Clinic and they gave him a pair to wear. 2. On 5/31/16 at 2:10 p.m., Resident D was observed laying in a low bed on her			

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	right side with a pillow behind her back Her right heel was laying on the Genesis III alternating pressure pump mattress (a mattress with a pump that produced airflow with a 5 minute cycle time to alternate the pressure) with her left leg laying on top of her right leg and her left heel was laying on top of her right heel. The resident had blue non-skid socks on her feet. On 5/31/16 at 2:30 p.m., the resident's right heel was observed on the mattress with her left heel laying on top of her right heel with the MDS (Minimum Data Set) Coordinator in attendance. The resident had blue non-skid socks on her feet. The MDS Coordinator indicated when asked about the resident's heels needing to be floated the resident was on a low air loss mattress and covered her feet back up with the blankets and left the room. On 6/1/16 at 9:15 a.m., the resident was sitting in her broda chair in the hallway in front of the nurses station. She had blue non-skid socks on her feet laying on the footrest of the broda chair. On 6/1/16 at 9:42 a.m., LPN #1 and LPN #2 was observed changing the resident's right heel pressure ulcer dressing. The resident had a pressure ulcer to her right			

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	inner heel the size of a dime. The wound was a Stage II. The wound bed was 25% red and 75% pink tissue. LPN #1 indicated the wound was an UTD (Unable to determine). She indicated the facility was not allowed to "downstage" a wound. She measured the wound as 1.0 x 1.0 cm. After being asked what the depth measurement was, LPN #1 measured the depth of the wound as 0.1 cm. LPN #2 placed the residents blue non-skid socks back on her feet, which was laying on the broda chair footrest and took her into the hallway. During an interview on 6/1/16 at 9:59 a.m., LPN #1 indicated the wound assessments were performed weekly on one of the resident's shower days, by whoever the nurse was that had the resident that particular day. She indicated the facility no longer had a wound nurse. She indicated the DON "overseen" all the wound measurements after the wounds were measured weekly. On 6/1/16 at 11:10 a.m., Resident D was sitting in the hallway in her broda chair in front of the dining room with blue non-skid socks to her feet laying on the footrest of the broda chair. Resident D's record was reviewed on 6/1/16 at 1:00 p.m. Diagnoses included,			

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	but were not limited to, low back pain, generalized anxiety disorder and dementia with behavioral disturbance. Electronic Medication Administration Records (EMAR's) dated March, April, May and June 2016, included, but was not limited to, the following order: 3/14/16--Off load heels while in bed. None of the signature boxes on the EMAR's for this order for these time periods had initials in the boxes to indicate the resident's heels were offloaded while she was in bed. "Wound Assessments-V2" for the following dates indicated the following regarding Resident D's acquired left heel pressure ulcer: 2/29/16--The date acquired was 2/28/16. The location was the left heel. The original stage was SDTI and the highest stage was SDTI. The wound bed had epithelial tissue and was dry. It measured 1.0 x 3.5 x 0 cm. This was the first observation of the wound. Special equipment foam heel pads. 3/7/16--The acquired date was 2/28/16. The location was the left heel. The original stage was SDTI and the highest stage was a Stage II. The report indicated the Stage at the highest level could not be down-staged (the stage of the wound			

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	could not be changed to a lesser stage) as the wound healed. The wound bed had epithelial tissue and was dry. The wound was a blood tinged fluid filled blister. The wound measured 1.0 x 3.5 x 0 cm. The wound was unchanged. Special equipment foam heel cushions. 3/14/16--The acquired date was 2/29/16. The location was the left inner heel. The original stage was Stage II and the highest stage was a Stage II. The wound was a blood tinged fluid filled blister. The wound measured 2.0 x 2.8 x 0 cm. The wound was worsening. 3/21/16--The acquired date was 2/27/16. The location was the left proximal heel. The original stage was Stage II and the highest stage was a Stage II. The wound bed had epithelial tissue and was dry. The wound had dry skin covering the area from the old blister. The wound measured 1.5 x 2.5 x 0 cm. The wound was improving. Changes to treatment was to discontinue the foam heel pads and keep the purple foam booties on at all times except to shower. 3/30/16--The acquired date was 2/27/16. The location was the left heel. The original stage was SDTI and the highest stage was a Stage II. The wound bed had 25% necrotic tissue present and was dry.			

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	The wound measured 4.0 x 3.0 x 0 cm. The wound was worsening. Treatment change was to request a Physical Therapist to evaluate the wound for a possible treatment change. 4/6/16--The acquired date was 2/27/16. The location was the left heel. The original stage was SDTI and the highest stage was a SDTI. The wound bed had 50% necrotic tissue present and was dry. The wound measured 4.0 x 3.0 x 0 cm. The wound was unchanged. 4/11/16--The acquired date was 2/27/16. The location was the left heel. The original stage was Stage II and the highest stage was a Stage II. The wound bed was dry. The wound was a dried blister dark brown in color. The wound measured 4.0 x 3.0 x 0 cm. The wound was unchanged. 4/20/16--The acquired date was 2/27/16. The location was the left heel. The original stage was SDTI and the highest stage was a SDTI. The wound bed was not assessed. The wound measured 4.5 x 2.0 x 0 cm. The wound was unchanged. Treatment: Continue with the Vitamin A and D ointment and heel foam and offload the heels. 5/7/16--The acquired date was 2/27/16.			

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	The location was the left heel. The original stage was SDTI and the highest stage was a SDTI. The wound bed was not assessed. The wound measured 4.5 x 2.0 x 0 cm. The wound was unchanged. Treatment: Continue with the Vitamin A and D ointment and heel foam and offload the heels. 5/14/16--The acquired date was 2/28/16. The location was the left heel. The original stage was SDTI and the highest stage was a Stage II. The wound bed was epithelial tissue and moist. There was a scant amount of serosanguineous (thin, watery and pink in color) drainage. The wound measured 4.5 x 3.5 x 0 cm. The periwound was macerated. The wound was improving. Treatment: Calazime ointment (a ointment to treat wounds that absorbed light drainage). 5/24/16--The acquired date was 5/1/16. The location was the right heel. The original stage was UTD (Unable to determine) (Until enough slough or eschar was removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined. Stable dry, adherent, intact without erythema or fluctuance) eschar on the heels served as the body's natural [biological] cover and should not be removed) and the highest stage was a UTD. The wound bed had			

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	30% slough tissue present. The wound measured 3.5 x 2.5 x 0 cm. There was a scant amount of serosanguineous amount of drainage. The wound was improving. A progress note dated 6/1/16 at 10:19 a.m., indicated the left heel ulcer measured 1.0 x 1.0 x 0.1 cm. The record lacked the stage and wound bed assessment. The 5/19/16 "Wound Assessment V-2" was requested from the DON on 6/2/16 at 9:40 a.m. By the end of the exit conference on 6/2/16, the 5/19/16, wound assessment was not provided. During an interview on 5/31/16 at 10:00 a.m., the DON indicated she documented the right heel instead of the left heel as the pressure ulcer on the 5/24/16 wound assessment report and she also documented 5/1/16 instead of 2/27/16, as the acquired date for the left heel pressure ulcer. During an interview on 6/1/16 at 11:30 a.m., the DON indicated the facility's wound assessment forms indicated the nurses were not allowed to "upstage" a wound, so once a wound was a UTD it was always a UTD or a SDTI it had to			

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	always be a SDTI. She indicated the wound could be a healing UTD or healing SDTI. During an interview on 6/2/16 at 9:40 a.m., the DON indicated Resident D did not have her purple heel booties (protectors) placed on her until lunchtime on 6/1/16 and she should have them on at all times except to shower. She indicated the resident's left and right heel wound documentation was all the same. She indicated the right heel wound was a fluid filled blister, which went away, then was a dry callous. She indicated the facility nurses were not staging the wounds accurately. She indicated the offload heel order was an FYI (for your information) for the nurses like an order such as; May go LOA (leave of absence) with medications. She indicated there was no documentation to indicate the heels had been offloaded. She indicated she was the person who followed the progress of the wounds, since the wound nurse left. During an interview on 6/2/16 at 11:24 a.m.,, the DON indicated Physical Therapy did not assess the resident for the 3/30/16 recommendation for a treatment change for her left heel wound. She indicated she was not evaluated for a treatment change after the pressure ulcer			

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	got worse. 3. Resident B's record was reviewed on 05/31/2016 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, hypertension, Diabetes Mellitus type 2, muscle weakness and abnormalities of gait and coordination. A physician order, dated 05/18/2016 at 10:46 a.m., indicated, "Calazime [a cream to treat wounds that absorbs light drainage] to area on buttock once daily x [times] 10 days then reeval [sic]." A Care Plan dated, 01/06/2016, indicated "Focus. Potential for pressure ulcer development r/t [related to] two assist, Impaired mobility, Cognitive deficits...Interventions...Pressure reducing cushion in wheelchair...." A document titled, " Wound Assessment-V 2", dated 05/04/2016, indicated "...B...1. Location: right buttock. 2 a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: Acquired. Date acquired: 05/04/2016, 3 a. Type: Pressure. 4. PRESSURE ULCER STAGE...4 a. Original 1...4 b. Highest: 1...8. WOUND MEASUREMENTS, 8 a. 1.0 cm 8 b. 1.2 cm 8 c. 0.1 cm...."			

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	A document titled, "Skin Inspection Assessment", dated 05/05/2016, indicated "...6. Identify any new skin issues:..Site...Right buttock, Type: Pressure...Stage 3...." A document titled, "Clinical Interdisciplinary Assessment-V 2", dated 05/10/2016, indicated "...B. SKIN: Skin Conditions 1. Skin intact...." A document titled, "Wound Assessment-V 2", dated 05/18/2016, indicated " "...B...1. Location: right buttock. 2 a. Indicate whether this site was acquired during the residents stay or whether it was present on admission: Acquired. Date acquired: 05/18/2016, 3 a. Type: Pressure. 4. PRESSURE ULCER STAGE...4 a. Original 1...4 b. Highest: 1...8. WOUND MEASUREMENTS, 8 a. 2.0 cm 8 b. 1 cm 8 c. 0.1 cm...." A document titled, "Skin Inspection Assessment", dated 05/19/2016-05/26/2016, indicated "...6. Identify any new skin issues:..Site...Right buttock, Type: Pressure...Stage 3...." A Treatment Administration Record dated, May 2016, lacked signatures for dates 05/18/2016-05/28/2016 for the			

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	following: "Calazime to area on buttock once daily x 10 days then reeval [sic]." A document from the electronic charting system labeled "[Name of Resident], Task: Pressure Redistribution Device", dated 05/31/2016, indicated "...Was the pressure reducing device placed on the chair while the resident was in it?...."Day, Evening and Night shift had placed a check mark in the "yes" column to indicate the pressure relieving device was present for dates 05/18/2016 through 05/31/2016, with the exception of three night shifts on the dates 05/20/2016, 05/25/2016 and 05/26/2016. On those three night shifts there was a check mark placed in the "Not Applicable" column. The document lacked any information regarding if the device was inflated on those dates checked "yes". On 05/31/2016 at 2:13 p.m., the resident was observed sitting in his room in a recliner with the foot rest elevated. He was frequently shifting in his seat, exhibited facial grimacing and tugged at the back of his slacks. The Roho cushion (a pressure relieving device) beneath the resident was flat and the chair alarm pad was positioned beneath the cushion. At that time, CNA #8 was asked to assist the resident.			

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	On 06/01/2016 at 08:55 a.m., CNA #6 and CNA #7 were observed standing Resident B. The resident's slacks and brief were removed, exposing his buttocks. A small amount of brown stool was noted on the brief. LPN #2 removed the dressing to the right buttock and cleansed the right buttock wound with a saline dampened gauze sponge. The center of the wound was open with a beefy red center. The peri wound was pale, macerated (softening or breaking down of tissue from constant dampness, which can be caused by exposure to anything we (e.g.) perspiration, urine, wound exudate) and approximately the size of a quarter. CNA #6 wiped the residents buttocks in an upward manner, over the open wound. LPN #2 cleansed the resident's wound once more with a saline dampened gauze sponge. LPN #2 applied Calazime to the wound with a cotton tipped applicator and covered the wound with a foam dressing. The resident was cooperative with the dressing change. At that time, LPN #2 indicated she had previously assessed the wound to be a Stage 1. She indicated she "guessed" she did not stage it very well and did not have "time" to stage the wound properly due to the resident's history of combativeness. She indicated the wound was a "1 or 2". LPN #1 indicated "you got him on a good day",			

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	and indicated the resident often "hollers out" and "fights" with treatments. At that time, LPN #2, CNA #6 and CNA #7 nodded in agreement. During an interview, on 5/31/2016 at 2:40 p.m., the DON (Director of Nursing) indicated the CNA's should verify and document the placement and inflation of the Roho cushion every shift. She indicated if the cushion was found deflated, she would "hope" the CNA's would notify her or "somebody" to fix it. During an interview on 5/31/2016 at 2:50 p.m., OT (Occupational Therapist) #9 indicated the Roho removed from the resident's room had a hole in it and he was unable to determine if the cushion could be used again. During an interview on 06/01/2016 at 8:50 a.m., LPN #2 indicated she had performed the dressing change to the right buttock the previous day and the wound was a stage 1. During an interview on 06/01/2016 at 4:22 p.m., the DON indicated no reassessment was performed for the resident's wound as ordered by the physician on 5/18/2016 after the Calazime treatment was completed on 05/28/2016.			

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	During an interview on 06/02/2016 at 10:40 a.m., the resident's family member indicated when she visited last week, she found the resident sitting on the Roho cushion in the recliner and it was completely flat. She indicated she had taken the cushion to a staff member and told them it may have a "hole in it". She indicated the staff member reinflated the cushion and gave it back to the resident. During an interview on 06/02/2016 at 11:10 a.m., the DON indicated if a new order was given for a treatment to the same area, the initial order should be discontinued. Additionally, she indicated it was "standard practice" to place the original order on hold, then revert back to it when a timed order was completed. She indicated the nurses would "know" to go back to the original order. She indicated the Treatment Administration Record lacked a written order to place the original order on hold. A current policy titled, "[name of company] SKIN INTEGRITY STANDARD" dated April 2015, provided by the DON on 06/01/2016, at 2:00 p.m., indicated, "...If skin integrity issues are identified post-admission the following documented information is required:..1. Wound Specifics: a.			

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	Location of wound-as specifically as possible b. Size of the wound including length, width and depth in centimeters...d. Description of the wound bed: Presence of necrotic tissue [death of skin tissue] identified as eschar [thick, leathery necrotic or devitalized tissue, frequently black in color] or slough [Necrotic or avascular tissue in the process of separating from healthy tissue]. Color...Moist or dry...i. Stages of Pressure: Stage 1-Nonblanchable Erythema [abnormal redness of the tissues that does not blanch to pressure]. Stage 2-Partial Thickness Skin Loss. Stage 3-Full Thickness Skin Loss...5. Care plan up-dated to reflect current status of the wound,, treatment plan, turning and positioning program, and additional interventions to promote healing." This Federal tag relates to Complaint IN00200579. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0323 SS=D	483.25(h) FREE OF ACCIDENT			

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Bldg. 00	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 interview, observation, and record review, the facility failed to follow through with post fall interventions to prevent another potential fall for 2 of 3 residents reviewed for accidents (Resident C and E), failed to ensure a safe transfer method was performed to prevent a potential accident hazard for 2 of 2 transfers observed (Resident B) and failed to monitor a safety device for proper function for 1 of 3 residents reviewed for proper functioning safety devices (Resident B). Findings include: 1. Resident C's record was reviewed on 5/31/16 at 3:03 p.m. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur, history of falling and chronic pain. A "Fall Risk Assessment" dated 3/18/16, indicated his fall risk score was 60, which indicated he was at high risk for falls. The Morse Fall Scoring indicated: High Risk: 45 or higher Moderate Risk: 25-44 Low Risk: 0-24	F 0323	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Resident "E" was assessed on 6/2/2016 by the Director of Nursing to ensure all post fall interventions were in place, and all were found to be in-place. The table in resident "E" room was removed on 6/2/2016. Resident "B" was assessed on 6/2/2016 for proper transfer methods, and	06/14/2016

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	The resident had a Care Plan dated 3/20/16, which addressed the problem he had a self-care deficit and needed extensive assistance with ADL's (Activities of Daily Living) related to right hip replacement. The interventions included, but were not limited to, "...3/20/16--Transfer: One person physical assistance required...Toilet Use-One person physical assist required...." The resident had a Care Plan dated 3/20/16, which addressed the problem he was at risk for falls related to deconditioning and gait and balance problems. The interventions included, but were not limited to, "...3/20/16--Follow facility fall protocol, Pt [Physical Therapy] evaluate and treat as ordered or PRN [as needed]...." The Admission MDS (Minimum Data Set) assessment, dated 3/25/16, indicated the resident's BIMS (Brief Interview for Mental Status) was 15, which indicated his mental status was cognitively intact. An "IDT Post-Occurrence Assessment" report, dated 4/11/16, indicated the resident had a recent fall. The contributing factors indicated the resident had a fall on 4/8/16, his knees gave out		to ensure the monitoring safety device was functioning properly. The alarm was reactivated on 6/2/2016 and working properly. The residents in question were found to have no adverse effects from this alleged deficient practice. Resident "C" no longer resides at this facility. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents who are at risk for falls and	

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	when he was transferring with Physical Therapy to the toilet. Physical Therapy was to address the use of a knee brace with the Orthopedic Physician. He had a history of falls in the last 30 days. There were no injuries. Safety devices in place at the time of the fall were a pressure alarm, chair and bed alarm. IDT recommendations were to not leave the resident alone in the bathroom and therapy was to follow up with the Orthopedic Physician regarding the knee brace. A "PT Daily Treatment Note," dated 4/8/16, indicated "Pt attempting toilet transfer with CGA [Contact Guard Assist] when R [right] knee 'gave out' and pt [patient] fell to floor...Discussed with pt benefits of knee support." A "PT Daily Treatment Note," dated 4/9/16, indicated "Patient is recommended knee brace as he fell yesterday due to buckling of his R knee. His knee measured and the right kind of brace is suggested for him. Patient also trained on safe transfers." A "Z SBAR [Situation, Background, Assessment and Response]-Fall report of Incident w [with]/3 day post fall" report, dated 4/8/16, indicated on 4/8/16 at 2:14 p.m., the resident had a witnessed fall by		or need assist in transferring have the potential to be affected by this alleged deficient practice. All identified residents were reviewed by the Director of Nursing on 6/2/2016 for proper safety devices and fall interventions. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Nursing staff and Therapy staff were re-educated on June 14, 2016 by the Director of Staff	

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	PTA #5 while in the bathroom from the toilet while standing. The resident was getting off the toilet. The possible contributing factors was sliding or positioning issue. The resident indicated he lost his balance. The nurse was called to the resident's room by therapy and the resident was laying in front of the toilet. He had a bruise on his right shin below his knee. During an interview on 6/2/16 at 3:50 p.m., the Rehab Director indicated she was part of the IDT (Interdisciplinary Team), which recommended the intervention for the knee brace to prevent a potential fall, but as of current, he did not have a knee brace. 2. On 5/31/16 at 2:40 p.m., Resident E was observed sitting in her wheelchair in the hallway in front of the nurses station. She had a reddish color surrounding her left eye with a Band-Aid above her left eyebrow. Surrounding her left eye was swollen. She had purple colored bruising on the left side of her chin. She had a night stand at the head of the bed approximately 2 feet from the bed and a night stand at the foot of her bed with a TV sitting on it. Resident E's record review was completed on 6/1/16 at 10:00 a.m.		Development about safe transfers and the facility policy on the use of gait belts and follow through of post fall interventions. Proper functioning of alarms was audited by the Director of Nursing on 6/2/2016 to ensure proper placement and function. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · Director of Nursing or designee will conduct post occurrence IDT	

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	Diagnoses included, but were not limited to, dementia with behavioral disturbance, psychotic disorder with delusions, and major depressive disorder. The resident's "Fall Risk Assessment" dated 10/29/16, indicated the score was a 65, which indicated she was a high risk for falls. The Morse Fall Scoring was as follows: High Risk: 45 or higher Moderate Risk: 25-44 Low Risk: 0-24 A "Z SBAR-Fall Report of Incident w/3 day post fall" report dated 3/19/16, indicated the resident had an unwitnessed fall on 3/19/16 at 7:57 p.m., the resident was ambulating by her self in her room. The staff was unable to determine what the resident was attempting to do when she fell. A contributing factor was the resident was restless and anxious. She did not turn on her call light. She was unable to communicate what happened. She had an external head injury to the occipital area of her head. The resident's alarm sounded and the staff rushed into her room to find her lying on the floor on her back in the middle of her room between her bed and her roommate's bed with a "goose egg" knot on the back of her head, which was approximately 6 cm (centimeters) in diameter. She was sent		reviews to ensure post fall interventions are in place after each fall for 6 months. Director of nursing or designee will observe 2 transfers a week for 12 weeks, and randomly thereafter to monitor safe transfers utilizing gait belts. Alarms will be monitored for placement and function through the electronic medical record by the Director of Nursing or designee 2 times a week for 12 weeks, and weekly thereafter for 3 months. Audits will be reviewed in QAPI meeting monthly for 6 months	

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	to the ER for evaluation and treatment. An "IDT Post-Occurrence Assessment-V 2," report dated 3/21/16, indicated the resident had a recent fall. She had a diagnosis of dementia and was unaware of her safety needs. Potential interventions were restorative program referrals for a dining restoration program. She had a history of falls in the last 30 days. The alarm sounded from her room and the staff found her lying on her floor in the middle of the room with a knot on the back of her head. An IDT recommendation to prevent recurrence was the resident was to walk to and from the dining room for all meals by the nursing staff. A "SBAR-Fall Report of Incident w/3 day post fall 8 hr [hour]" report, dated 5/29/16, indicated the resident had a witnessed fall in her room from her bed while trying to self transfer. The staff was unable to determine what the resident was doing at the time of the fall. The resident was unable to communicate what occurred. She had a laceration and was sent to the ER for evaluation and treatment. The resident was witnessed falling from her bed and striking her face on a bedside table and landing prone (face down) on the floor.		· Non compliance will be addressed through re-education and progressive disciplinary actions as indicated per facility policy.	

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	An "IDT Post-Occurrence Assessment-V 2," report dated 5/31/16, indicated the resident had a recent fall from her bed on 5/29/16. She had a history of falls within the last 60 days. She rolled out of bed. The IDT recommendations indicated to place a mat at the bedside and place the bedside table at the foot of the bed. On 6/1/16 at 9:28 a.m., the resident was observed sitting in her wheelchair in the hallway in front of the nurses station. She had a wine and yellow colored bruising surrounding her left eye. She had swelling surrounding her left eye. She had 3 sutures above her left eyebrow. She had purple colored bruising on the left side of her chin extending down onto left side of her neck. On 6/1/16 at 3:05 p.m., with the DON in attendance a nightstand was observed at the head and foot of the bed. The DON indicated she was not sure what the new intervention was for the resident's last fall. During an interview on 6/1/16 at 3:10 p.m., the MDS (Minimum Data Set) Coordinator indicated LPN #11 completed the last fall report and the new interventions were for a mat to be placed at the bedside and the nightstand at the head of the bed to be placed at the foot of			

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	the bed. She indicated housekeeping must have misunderstood and thought another nightstand was to be placed at the foot of the bed and given her an extra nightstand. She indicated she would call the Housekeeping Supervisor and find out what happened. During an interview on 6/1/16 at 3:17 p.m., the MDS Coordinator indicated the Housekeeping Supervisor indicated she took out the bedside table the resident had in her room because she thought the nursing staff wanted that table removed. The MDS Coordinator indicated the Housekeeping Supervisor removed the wrong table and the nightstand should have been removed. During an interview on 6/2/16 at 10:45 a.m., the resident's family member indicated Resident E had not ambulated in six to eight months. During an interview on 6/2/16 at 10:50 a.m., LPN #1 indicated the CNA's perform the Walk to Dine program and one of them could pull a resident's PCC (Point Click Care) (a computer program) profile up on their IPOD (portable digital media player). During an interview on 6/2/16 at 10:55 a.m., CNA #12 indicated Resident E did			

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	not have a Walk to Dine Program. She was observed looking at the resident's information on the IPOD. She indicated at that time, if the resident had a Walk to Dine Program, she would have a "running man" on her PCC profile, so the CNA's would know to walk her to the dining room and she did not have the "running man" on her profile. 3. Resident B's record was reviewed on 05/31/2016 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, hypertension, Diabetes Mellitus type 2, muscle weakness and abnormalities of gait and coordination. A document titled "Fall Risk Assessment," dated 05/04/2016, indicated the resident received a total fall risk score of 55 on the "Morse Fall Scoring" scale. The scoring results range indicated a high risk was a score of 45 and higher. A document titled "SBAR [Situation, Background, Assessment, Response]-Fall Report of Incident w [with]/3 day post fall 8hr [hour]," dated 04/17/2017, indicated the resident incurred a fall on 04/17/2016 at approximately 19:00 [7:00 p.m.] " S. Situation...2. The patient...had an a. Un-Witnessed or Suspected Fall...3. From:..d. Chair or wheelchair...4. Which occurred from a. Self ambulation...5. In/On the:..b.			

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	resident Room...6. The patient was attempting to:..d. Unable to determine...B. Background. 1. Possible Contributing factors...c. Equipment failure...2. Additional Circumstances...b. Alarm failure or device removal...A. Assessment 1. Subjective or resident states: a. Unable to communicate what occurred...2. Mental status. a. Alert. 2 a. Oriented to: a. Person...4. Injury Assessment/Body Inspection...h. External head injury or trauma...4 a. Location. 3 large goose eggs on back of head...6. Briefly describe the nature of the occurrence...Writer walked by res room and found resident lying on back on the floor in his room. Res unable to tell writer what happened. Stated his head hurt. Writer found 3 goose eggs on back of head...Alarm was not sounding when writer found res [resident] on floor. Unable to determine how long he had been on floor...6. Other Relevant Information/ Nurses Progress Notes: Res alarm was not sounding when res was found on floor....: 53. Signs of Injury:..b. Bruising...54. Describe any injuries: bruising to back of head...." A document titled "IDT [Interdisciplinary Team] Post-Occurrence Assessment-V 2" dated 04/18/2016, indicated "...13. Enter contributing factors if applicable: Extensive assist with ADL's [Activities			

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	of Daily Living], incont [incontinent] B&B [bowel and bladder], difficulty with following directions...C. Safety Risk...2. History of falls. 2 a. Days: 1) 30...12. Review: Bruising noted to back of head, no open areas noted...D. Safety Devices...7. Pressure alarm. 8. Chair alarm. 9. Bed alarm...13. Describe factors contributing to device use: Cont [continent] with current alarms. Alarm was not sounding when staff found resident on floor...22. Review: Continue with current alarms... IDT Notes/Recommendation/Targeted Plan to Prevent Recurrence: 1. Notes/Recommendations/Plans: IDT reviewed documentation from fall...Staff to ensure alarms are turned on and working per order...." The Medication and Treatment Administration Records, dated April 2016 and May 2016, lacked documentation of chair alarm or bed alarm monitoring. A Care Plan, dated 01/06/2016, indicated "Focus. The resident is at risk for falls r/t [related to] Deconditioning, Gait/balance problems...Interventions...The resident uses chair/bed electronic alarm. Ensure the device is in place as needed." On 05/31/2016, the following			

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	observations were made: At 2:13 p.m., Resident B was sitting in his room in a recliner with the foot rest elevated. He frequently shifted in his seat, was grimacing and tugged at the back of his slacks. The Roho cushion (a pressure relieving device) beneath the resident was flat and the chair alarm pad was positioned beneath the cushion. At that time, CNA #8 entered the room to assist the resident. At 2:25 p.m., OT (Occupational Therapist) #9, CNA #8 and the MDS (Minimum Data Set) Coordinator entered the room. OT #9 stood to the resident's right and placed one of his arms under the resident's arm and grabbed the back of the resident's slacks and brief with his other hand and CNA #8 stood to the resident's left and placed one of her arms under the resident's left arm and grabbed the back of the resident's slacks and brief with her other hand. The MDS Coordinator stood in front of the resident with his walker and attempted to hold the resident's hands as OT #9 and CNA #8 attempted to pull the resident to a standing position. The resident resisted and his knees buckled. He kicked out the walker from in front of him and went toward the floor with his bottom. His bottom was even with the foot rest on his			

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	recliner. OT #9 removed the deflated Roho cushion. OT #9 and CNA #5 assisted the resident back into his chair by his arms and slacks. At 2:27 p.m., OT #9 brought a new Roho cushion to the resident's room. He and CNA #8 stood to the right and left side of the resident. The OT positioned the walker in front of the resident and asked him to stand. The resident stood up and OT #9 placed the new Roho cushion and chair alarm in the resident's recliner. During an interview on 05/31/2016 at 10:45 a.m., the DON (Director of Nursing) indicated it was the facility policy to use a gait belt with all transfers. During an interview on 05/31/2016 at 4:15 p.m., Physical Therapist #10 indicated transfers of all residents who were unsteady would require a gait belt and 1 to 2 persons as well, depending on the resident and staff assisting. During an interview on 06/01/2016 at 9:30 a.m., the DON indicated no chair or bed alarm checks were in place for the resident. During an interview, on 06/02/2016 at 11:30 a.m., the DON indicated there was			

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	no staff monitoring documentation in place to verify the presence of and proper working order of chair and bed alarms for the resident. A current policy titled, "Transfer Activities" dated 2006, provided by the DON on 06/01/2016 at 4:20 p.m., indicated "...PURPOSE. To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES...Ability to stand and bear weight. Loss of balance...EQUIPMENT...Transfer belt...Procedure...1. Obtain assistance of another individual if necessary for safe transfer...5. Apply transfer belt...10. Hold the transfer belt from underneath ...." A current policy titled, "Gait belt, Use of" dated 2008, provided by the DON on 06/01/2016 at 4:20 p.m., indicated "...Policy. It is the policy of this facility that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer. Purpose. To help control and balance resident during assisted transfer or ambulation...Equipment. Gait belt. Procedure. 1. Apply gait belt to resident waist unless otherwise indicated. Tighten to fit snuggly with the buckle at the side. 5. After the resident is standing, the belt			

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	assists in stabilizing, turning and walking the resident...." A current policy titled, "Falls Management" dated October 2010, provided by the DON on 06/01/2016 at 4:20 p.m., indicated "...Purpose. To evaluate risk factors and provide interventions to minimize risk, injury and occurrences...Equipment. Fall Prevention Equipment may include, but is not limited to: Alarms, sensor mats, transfer poles, floor pads, non-skid mats, hand rails, grab bars, trapeze, adaptive equipment, transfer lifts etc...FALL PREVENTION PROCEDURE...2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries...." This Federal tag relates to Complaint IN00200579 3.1-45(a)(1) 3.1-45(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive			

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	dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to try non-pharmaceutical interventions prior to administering an antianxiety medication each time it was given for 1 of 1 residents reviewed for administration of antianxiety medications (Resident D). Finding includes: Resident D's record was reviewed on 6/1/16 at 1:00 p.m. Diagnoses included, but were not limited to, low back pain, generalized anxiety disorder and dementia with behavioral disturbance. The resident's Electronic Medication Administration Record (EMAR) dated	F 0329	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Resident "D" was assessed on 6/2/16 by the Director of Nursing to ensure she is offered non-pharmaceutical	06/14/2016

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	March, April and May 2016, included, but was not limited to, the following order: 10/16/15--Lorazepam tablet (an antianxiety medication) one milligram by mouth every six hours as needed for agitation related to generalized anxiety disorder. The Progress notes with these dates and times indicated Lorazepam was given without non-pharmaceutical interventions being tried prior to the dose being administered: 3/8/16 at 6:57 a.m.--"LORAZEPAM 1 MG [milligrams] TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER." 4/13/16 at 7:46 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER easily agitated." 5/4/16 at 7:51 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER repeated yelling out." 5/11/16 at 8:00 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6		interventions prior to administering an antianxiety medication. The physician was notified, medication changes have been made, and non-pharmaceutical interventions were clarified. This resident was found to have no adverse effects from the alleged deficient practice. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents who have orders for	

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	hours as needed for agitated related to GENERALIZED ANXIETY DISORDER easily agitated." 5/15/16 at 6:55 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER." 5/19/16 at 9:27 p.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER increased anxiety." 5/30/16 at 9:58 a.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER." 5/30/16 at 5:38 p.m.--"LORAZEPAM 1 MG TABLET Give 1 mg orally every 6 hours as needed for agitated related to GENERALIZED ANXIETY DISORDER increased anxiety, yelling out, restless." The resident's record lacked non-pharmaceutical interventions documented prior to giving the above doses of Lorazepam.		antianxiety medications have the potential to be affected by this alleged deficient practice. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Residents who have psychotropic or antianxiety medications have been audited for non-pharmaceutical interventions. Licensed Nursing staff were re-educated on June 14, 2016 by the Director of Staff	

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	On 6/2/16 at 9:40 a.m., further documentation regarding trying non-pharmaceutical interventions prior to medicating the resident with Lorazepam was requested from the DON. During an interview on 6/2/16 at 11:24 a.m., the Director of Nursing indicated she did not find any further documentation regarding non-pharmaceutical interventions the facility tried prior to the nurses administering Lorazepam to Resident D. 3.1-48(a)(4)		Development about assessing, documenting and utilizing non pharmaceutical interventions prior to the administration of antianxiety medication. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · The director of nursing or designee will audit assessments through the electronic medical record 2 times per week for 12 weeks and twice a month for	

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			3 months, and randomly thereafter. Audits will be reviewed in QAPI meeting monthly for 6 months. · Non compliance will be addressed through re-education and progressive disciplinary actions as indicated per company policy.	
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure pain medication was available for 1 of 7 residents reviewed for medication availability (Resident D). Finding includes: Resident D's record was reviewed on 6/1/16 at 1:00 p.m. Diagnoses included, but were not limited to, low back pain, generalized anxiety disorder and dementia with behavioral disturbance. The resident's Electronic Medication Administration Record (EMAR) dated April 2016, included, but was not limited, to the following order: 2/4/16--Norco (Hydrocodone/Acetaminophen) Tablet (a narcotic pain medication) 5-325 mg (milligrams) Give one tablet by mouth three times a day for prophylactic related to low back pain. The resident's EMAR, dated April 2016, indicated the following dates and times of Resident D's Norco had a number 9 above the nurses initials in the ordered time box: 4/17/16 at 9:00 a.m.	F 0425	· **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice;** · Resident "D" was assessed by the Director of Nursing on 6/2/2016 and was found to have no adverse effects from this alleged deficient practice. · **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken;** · Residents who receive medications have the potential to be affected by the alleged deficient practice. An audit of medication carts was conducted on 6/6/2016 to ensure all medications were available. Any discrepancies were rectified. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** · Licensed nurses were re-educated June 14, 2016 on ordering medications. Any medication requiring a written prescription will be called to the doctor 7 days in advance to ensure there is a prescription written and the medications have arrived on time. Nurses have been educated on writing in the "Pharmacy log" any medication	06/14/2016

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	4/17/16 at 1:00 p.m. 4/17/16 at 5:00 p.m. 4/18/16 at 1:00 p.m. 4/18/16 at 5:00 p.m. 4/19/16 at 9:00 a.m. 4/19/16 at 1:00 p.m. 4/19/16 at 5:00 p.m. The resident's EMAR, dated April 2016, indicated a number 9 under the "Chart Codes" indicated "Other/See Progress Notes". The EMAR, dated April 2016, indicated the resident's 4/18/16 at 9:00 a.m., dose of Norco had a checkmark above the nurses initials in the ordered time box. These Progress Notes indicated the following: 4/17/16 at 8:20 a.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN need new script." 4/17/16 at 12:11 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN on order." 4/17/16 at 4:46 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN Not in stock. MD		that has not arrived with-in the contracted time. The nurse writing in the “Pharmacy log” is to also notify the Director of Nursing or her designee when medications are unavailable. · **How corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** · The director of nursing will audit the medication administration audit report on the electronic medical record 2 times a week for 12 weeks, and weekly thereafter for 3 months to ensure the medications are arriving in a timely manor. Director of Nursing or designee will contact the pharmacy representative with any and all concerns to ensure medications are arriving in a timely manor. Audits will be reviewed in QAPI meeting monthly for 6 months. Non compliance will be addressed through re-education and progressive disciplinary actions as indicated per facility policy.	

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	on call would not write script." 4/18/16 at 12:33 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN MD notified for script." 4/18/16 at 5:33 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN on order." 4/19/16 at 9:13 a.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN medication availability issue. [Name of Pharmacy] needs script. LM [Left Message] with MD." 4/19/16 at 12:08 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN Awaiting script-left message with MD." 4/19/16 at 4:41 p.m.--"Norco Tablet 5-325 MG Give 1 tablet by mouth three times a day for PROPHYLACTIC related to LOW BACK PAIN on order." A "Controlled Substances Record," dated 3/17/16, indicated 90			

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	Hydrocodone/Acetaminophen 5-325 mg tablets were received on 3/18/16. The last dose of tablets on this medication card were given to Resident D on 4/16/16 at 5:00 p.m. A "Controlled Substances Record," dated 4/19/16, indicated the first dose of Hydrocodone/Acetaminophen 5/325 mg tablet given to the resident was 4/20/16 at 8:00 a.m. A "Shipment Summary," dated 6/2/16, indicated Resident D's Hydrocodone/Acetaminophen 5-325 mg tablets were delivered to the facility on 4/20/16 at 3:52 a.m. Resident D missed a total of nine doses of scheduled routine doses of Norco pain medication. A Narcotic EDK (Emergency Drug Kit) list of medications updated on 5/30/16, indicated the facility had Hydrocodone/Acetaminophen 5-325 mg available to administer as emergency doses. A Medication Ordering Policy and Procedure was requested from the Director of Nursing (DON) on 6/2/16 at 11:24 a.m.			

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	At the time of the exit conference on 6/2/16, there was no further information provided regarding a policy and procedure for ordering medications. During an interview on 6/2/16 at 9:40 a.m., the DON indicated she did not know the resident went three days without her Norcos. She indicated the nurses caring for the resident those days probably did not get the Norcos out of the EDK to administer to the resident because the Physician had to be called, then the Pharmacy had to be called by the Physician to give the Pharmacy the order for the medication. She indicated the Pharmacy had to call the facility to give the nurse an authorization number to get the narcotic out of the EDK. She indicated "it's a long drawn out process," so that was why she probably did not get the Norcos from the EDK. During an interview on 6/2/16 at 11:24 a.m., the DON indicated a checkmark on the EMAR indicated the medication had been administered. She indicated LPN #1 indicated she had checked the box on 4/18/16 at 9:00 a.m., as the Norco being given in error as there were no Norcos available for the resident. The DON indicated there were no Norcos available in the medication cart for Resident D. She indicated Pharmacist #4 from (Name			

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	of Company) indicated on 3/17/16, a 30 day supply of Norcos were sent to the facility to cover the resident until 4/16/16. There was no remaining pain pills after that medication fill. A continuation letter was automatically generated to the Physician who should have ordered the Norcos after the 3/17/16, fill was sent to the facility. The DON indicated when the nurses ran out, they called the Pharmacy to get a refill and there was no active script on file. The DON indicated the nurses were to pull the strip off the medication card a "couple" days before the resident ran out of medication and re-ordered the medication, so the resident did not run out of medication. LPN #1 and RN #3 contacted the on call Physician, who was not this resident's Physician over the weekend, who refused to write a script for the pain medication. The DON indicated on Monday the resident's Physician was called and he wrote the script for her pain medication and it was sent out. She indicated when the facility cannot get something for a resident from a Physician the resident needed, the facility would contact the Medical Director. She indicated Resident D's Physician was also the Medical Director and the DON thought he was not called because he might have been in Florida during that time, but she was not sure.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLINTON HOUSE HEALTH AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041

(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
	This Federal tag relates to Complaint IN00200579. 3.1-25(a)			