

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155508	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/02/2016
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NAME OF PROVIDER OR SUPPLIER  TRANSCENDENT HEALTHCARE OF BOONVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 725 S SECOND ST BOONVILLE, IN 47601
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00191412.</p> <p>Survey dates: January 26, 27, 28, 29, and February 1 and 2, 2016</p> <p>Facility number: 000451 Provider number: 155508 AIM number: 1000266240</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor type: Medicare: 16 Medicaid: 54 Other: 6 Total: 76</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on February 10, 2016.</p>	F 0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective March 3, 2016 to the state findings of the Recertification and State Licensure survey conducted on January 26, 27, 28, 29 and February 1 and 2, 2016.</p>	
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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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F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was maintained during care and dining, for 3 of 6 survey days. (Resident H, Resident J, Resident #74, Resident K, Resident 21, Resident #57, Resident #52, Resident #2, Resident #32, Resident #83, Resident #93, Resident #77, Confidential Family Interview)</p> <p>Findings include:</p> <p>1. On 1/26/16 at 11:55 A.M., residents on the secured/Alzheimer's unit were seated for the noon meal which included Resident #74 who was seated at the first large dining room table that seated 6 residents. On 1/26/16 at 12:05 P.M., on the secured unit of the facility, the noon meal was delivered. Residents were</p>	F 0241	<p>F - 241</p> <p>1.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #74 is now receiving their meal tray at the same time that all other tablemates are being served.</p> <p>2.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #93 is now receiving supervision and assistance with her meals to maintain or</p>	03/03/2016

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	<p>seated at 2 large dining room tables and at individual or 2 person small dining room tables. Two CNA's prepared the noon meal family style and served the residents. On 1/26/16 at 12:23 P.M., CNA #18 served the first plate to a resident at the 1st large dining room table where Resident #74 was sitting. At 12:30 P.M., 5 of the 6 residents at the 1st large dining room table had received their plates and were eating. Staff stopped serving at the first large table and began serving 2 residents at one of the smaller tables. Resident #74 had not received her plate. Resident #74 voiced, "I didn't get any." At 12:33 P.M., Resident #74 voiced, "Everyone has eaten and I never got anything!" No staff responded to Resident #74's verbalizations. CNA #18 returned to the first large dining room table and served Resident #74 her plate at 12:34 P.M. A male resident sitting at the table beside Resident #74 had finished his plate and left the table by 12:34 P.M.</p> <p>On 2/2/16 at 1:50 P.M., the Director of Nursing was made aware of the noon meal observation on 1/26/16 in regard to Resident #74 not being served with the rest of her table. The DON and Unit Manager agreed residents at a table should all be served together. The DON also indicated at that time the secured unit had only been serving family style</p>		<p>enhance the resident's dignity and respect in full recognition of their individuality.</p> <p>3.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #83 is now being transferred in her wheel chair from one location to another only after the staff member has identified themselves to the resident and explained the task they are about to perform, such as moving the resident from one location to another.</p> <p>4.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident J now has their Foley catheter drainage bag covered at all times.</p> <p>5.) The corrective action taken for those residents found to have been affected by the deficient practice is that the</p>	

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	<p>for a couple of weeks.</p> <p>A facility policy (dated 10/5/15) entitled, "Family Style Dining" was reviewed on 2/2/16 at 11:40 A.M. The policy included but was not limited to, "...1.b. The prepared food items will be served in accordance with the acceptable standards of practice."</p> <p>2. During a random observation on 1/26/16 at 1:10 P.M., A CNA was observed setting a plate of food on the dining room table in front of Resident #93. The CNA was then observed placing a spoon in Resident #93's hand. Resident #93 began eating her mashed potatoes and ground meat with the wrong end of the spoon. After attempting to feed her self with the wrong end of the spoon, Resident #93 then began to feed herself with her hands, scooping up her mashed potatoes and ground meat. At 1:20 P.M., Resident #93 pulled her plate into her lap and continued to try to feed herself. At 1:25 P.M., CNA #21 approached Resident #93 and said "Let me help you." CNA #21 removed the plate from Resident #93's lap and started to feed Resident #93 the food that remained on the plate.</p> <p>3. During a random observation on 1/27/16 at 9:10 A.M., Resident #83 was</p>		<p>resident identified as resident # 21 is now being acknowledged by all staff members who approach her during meal service. In addition the resident's meal is not being interrupted by other staff members. The resident is receiving extensive assistance with their meals without interruption.</p> <p>6.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #52 is spoken to in an appropriate tone of voice by all staff members and is being transported in their wheel chair in a forward motion only. Staff members identified as housekeeper # 5 and LPN #15 has been re-in-serviced on tone of voice and proper wheel chair transports.</p> <p>7.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #</p>		

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	<p>observed sitting in a wheelchair at a table near the wall in the West Unit dining room with his/her head hanging down. CNA #4 was observed to transport Resident #83 in the wheelchair to another table near the medication carts in the dining room without warning. Resident #83 was observed to raise his/her head and CNA #4 stated, "Oh, I didn't know you were awake." CNA #4 was then observed to exit the dining room. CNA #4 was observed to return to the dining room at 9:20 A.M., and transport Resident #83 from the West Unit dining room to his/her room without speaking.</p> <p>4. On 1/27/16 at 11:56 A.M. and 12:06 P.M., Resident J was observed in the dining room sitting in a wheelchair with an uncovered catheter drainage bag hanging under the wheel chair. Amber colored urine was visible through the bag.</p> <p>On 1/28/16 at 2:32 P.M., Resident J was observed sitting on the porch in a wheelchair with an uncovered catheter drainage bag hanging under the wheelchair. Amber colored urine was visible through the bag.</p> <p>On 1/29/16 at 10:24 P.M., Resident J was observed sitting in a wheelchair in the dining room with a catheter drainage bag</p>		<p>32 is now receiving their meal tray and receiving assistance with their meal at the same time that other nearby residents are being served.</p> <p>8.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 2 is now being taken to their room following each meal to ensure the cleanliness of their clothing and to check and change for any incontinence.</p> <p>9.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident H is now free of facial hair and is receiving ADLs which include the removal of facial hair. The care plan has also been up-dated to reflect the resident's ADL needs and interventions.</p> <p>10.) The corrective action taken for those residents found to have been affected by the deficient practice is that</p>	

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	<p>hanging under the wheelchair. Amber colored urine was visible through the bag.</p> <p>On 2/1/16 at 9:04 A.M., Resident J was observed sitting in the West hall in a wheelchair with an uncovered catheter drainage bag under the wheelchair. Amber colored urine was visible through the bag.</p> <p>During an interview on 2/2/16 at 3:45 P.M., the Director of Nursing indicated it was the facility's policy to cover a resident's catheter drainage bag.</p> <p>5. During a random observation 1/27/16 at 12:30 P.M., Resident #21 was observed sitting in the main dining room eating lunch. The DON (Director of Nursing) was observed, at that time, sitting next to Resident #21, talking to and assisting with the meal. The RNC [Regulatory Nurse Consultant] was observed to approach the table of Resident #21 at 12:33 P.M. and speak to the DON without acknowledging Resident #21. The RNC was observed at 12:34 P.M. to sit in a chair at the table and continue the discussion with the DON. The RNC and the DON were observed through 12:40 P.M. to continue the discussion and not acknowledge Resident #21.</p>		<p>although nospecific resident was identified during the survey, the concern that wasbrought to the facility's attention was that a resident had requested to returnto bed prior to lunch and the residents request had not been accommodated. All staff has been re-inserviced onaccommodating the residents' personal requests as part of the mandatory dignityin-service.</p> <p>11.) The corrective actiontaken for those residents found to have been affected by the deficient practiceis that the residentidentified as resident #77 has since been discharged from the facility.</p> <p>12.) The corrective action taken for those residentsfound to have been affected by the deficient practice is that the information related to the residentidentified as resident K on the whiteboard in public review at the West Unithas had the information removed. Resident information is no longer placed on this dry</p>	

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	<p>During a dining observation on 1/28/16 at 12:40 P.M., LPN #10 was observed sitting at a dining room table assisting Resident #21 to eat. At 12:44 P.M., QMA #10 and CNA #6 were observed to approach LPN #10 and start a conversation. LPN #10 stopped feeding Resident #21 and turned her back to her while QMA #10 and CNA #6 were observed to be talking amongst themselves while standing over Resident #21's chair. At 12:52 P.M., LPN #10 returned to assisting Resident #21 with her meal.</p> <p>The clinical record for Resident #21 was reviewed on 2/2/16 at 9:00 A.M., diagnoses included but were not limited to dementia. A quarterly MDS (Minimum Data Set) assessment dated 10/24/15 for Resident #21 indicated she had a BIMS (Brief Interview for Mental Status) score of 3 indicating she was severely cognitively impaired. The MDS further indicated Resident #21 required extensive assistance of one person for assistance with eating.</p> <p>6. During a random observation on 1/27/16 at 12:50 P.M. Resident #52 was observed to enter the hallway in a wheelchair and ask Housekeeper #5 to put him/her to bed. Housekeeper #5</p>		<p>erase board.</p> <p>13.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 57 is now receiving all care and services in the privacy of their room. The Audiologist has been advised that upon future visits to the facility that all care/treatments are to be provided in the privacy of the resident's room.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that the facility has reviewed their policies on resident dignity and meal service to ensure that the policies include practices that maintain or enhance each resident's dignity and respect in full recognition of each resident's individuality.</i></p> <p>The measures that have been put into place to ensure that the deficient practice does</p>	

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	<p>indicated, at that time, she would get someone to help Resident #52 and was observed to approach the nursing station. Resident #52 was observed to have his/her back turned to Housekeeper #5 and propel the wheelchair back into the room. Housekeeper #5 was then observed to walk towards Resident #52 and speak. Resident #52 was observed to not respond and continue to propels his/her into the room. Housekeeper #5 was observed to shout, "[name of Resident #52], look at me, look at me, [name of Resident #52]" in a loud, raucous voice.</p> <p>During a random observation on 2/2/16 at 8:20 A.M., Resident #52 was observed propelling self to her room. She indicated at that time she was going "home".</p> <p>On 2/2/15 at 8:35 A.M., LPN #15 was observed to be pulling resident #52 backward through the open entryway in between the main dining room and the restorative dining room. Resident #32 was observed to be making loud grunting noises.</p> <p>The clinical record for Resident #52 was reviewed on 2/2/16 at 9:10 A.M., diagnoses included, but were not limited to, dementia, glaucoma, and major depressive disorder. A quarterly MDS</p>		<p>not recur is that a mandatory in-service has been conducted for all staff members on the facility's policies as it relates to all aspects of dignity and respect of our residents.</p> <p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that the facility policies on resident dignity and respect are being followed by all staff members. This tool will be completed by the Social Services Director and/or their designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meetings to determine if any additional action is warranted.</i></p>	

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	<p>dated 12/11/15 for Resident #52 indicated she had a BIMS score of 7 indicating she is severely cogently impaired and required extensive assistance of one person for eating</p> <p>During an interview with UM #1 on 2/2/15 at 1:36 P.M., she indicated residents should not be transported backward in their wheelchairs. She indicated she had educated LPN #15 prior to him leaving for the day.</p> <p>7. During a dining observation on 1/28/16 at 12:50 P.M., all trays in the dining room had been served except for two tables in the back. During this observation Resident #32 was observed to be sitting at her table without a tray and looking at the tray of a resident sitting at the table next to her. Resident #32 began to cry out and reach for the tray on the table to her left side. When she was unable to reach it she began to cry. No staff intervention was observed until 12:59 P.M. At that time during an interview QMA #10 indicated, the dining room service was complete and the residents in the remaining two tables were "feeders" and would be served when the restorative residents were served.</p> <p>The clinical record for Resident #32 was</p>			

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	<p>reviewed on 2/2/16 at 10:10 A.M., diagnoses included, but were not limited to dementia. A Quarterly MDS dated 11/14/15 for Resident #32 indicated a BIMS score of 3 which indicated she was severely cognitively impaired</p> <p>8. During an observation 1/28/16 at 2:10 P.M., Resident #2 was observed sitting up in a wheel chair in the restorative dining room. Resident #2 was observed to have his eyes closed and head bowed and a large amount of food debris was observed to be sitting in his lap. His pants appeared to have a wet spot on the upper inside pant leg near his thigh area.</p> <p>During an observation on 1/28/16 at 3:30 P.M., Resident #2 was observed to be sitting in the same spot in the restorative dining room. Resident #2 was observed to still have food debris in his lap and a baseball sized wet spot was observed on the upper inside thigh area. At that time the Director of Nursing (DON), Unit Manager #5 (UM), and LPN #3 were observed to be sitting at the nursing desk talking amongst themselves.</p> <p>During an observation of care for Resident #2 on 1/28/16 at 3:35 P.M., CNA #10 indicated Resident #2 usually told them when he needed to go to the restroom. CNA #10 indicated the last</p>			

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	<p>time Resident #2 had been toileted was prior to lunch. During the observation Resident #2's brief and pants were observed to be wet.</p> <p>The clinical record for Resident #2 was reviewed on 2/1/16 at 10:15 A.M., diagnoses included, but were not limited to delusional disorder, anxiety and atrial fibrillation. A Quarterly MDS dated 11/13/15 for Resident # 2 indicated he had a BIMS score of 1 indicating he had severe cognitive impairment. The MDS further indicated Resident #2 required extensive assistance of two or more persons for transferring and total dependence on 2 or more staff members for toileting and was always incontinent of bowel and bladder.</p> <p>9. On 2/1/16 at 8:55 A.M., Resident H was observed sitting in the main dining room of the facility. Facial hair observed on her chin and jaw areas.</p> <p>On 2/1/16 at 1:00 P.M., Resident H observed sitting in lobby area of facility with facial hair noted on chin and jaw areas.</p> <p>On 2/2/16 at 7:40 A.M., Resident H was observed sitting in the lobby area with facial hair approximately 1/4 inch noted on chin and jaw areas.</p>			

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	<p>The clinical record for Resident H was reviewed on 2/2/16 at 10:00 A.M.</p> <p>On 2/2/16 at 11:10 A.M., during interview with the Director of Nursing (DON), she indicated she would expect grooming of female facial hair unless the resident refused. The DON was made aware of Resident H's facial hair. The DON was also made aware Resident H's current care plan did not address activities of daily living (ADL's) except dental/ oral care. The care plan and the clinical record did not address the refusal of care and documentation was lacking that Resident H had refused care.</p> <p>On 2/2/16 at 11:30 A.M., a facility policy (dated 2010) entitled, "Shaving the Resident." The policy included but was not limited to, "...Reporting 1. Notify the supervisor if the resident refuses the procedure..."</p> <p>On 2/2/16 at 12:13 P.M., the DON indicated Resident H would be shaved.</p> <p>10. On 2/2/16 at 1:50 P.M., the Director of Nursing (DON) was made aware of a dignity concern voiced by an anonymous family member during the survey. The family member voiced that a resident had wanted to go to bed before lunch approximately a month ago and a CNA</p>			

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	<p>had not assisted the resident back to bed. The DON at that time agreed the concern voiced was a problem.</p> <p>11. On 2/2/16 at 1:50 P.M., the Director of Nursing (DON) was made aware of Resident #77 on the secured unit sitting in the dining room on 2/1/16 at 9:07 A.M. Resident #77 had no shoes on and was wearing one sock and the other foot bare. Feet were placed on the floor. On 2/1/16 at 9:50 A.M., Resident #77 was observed walking in the hall on the secured unit with his left foot bare and a sock on the right foot. The DON agreed at that time to the dignity concern.</p> <p>12. During a random observation on 2/2/16 at 8:20 A.M., on the West unit a whiteboard in public view contained the message "stool needed x 2 [room # of Resident K]"</p> <p>During an observation of the West unit on 2/2/16 at 1:30 P.M., a whiteboard in public view contained the message "stool needed x 1 [room # of Resident K].</p> <p>The clinical record for Resident K was reviewed on 2/2/16 at 2:44 P.M., diagnosis included, but were not limited to, diabetes, and chronic pain. A quarterly MDS dated 12/17/15 for Resident K indicated he had a BIMS score of 15,</p>			

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	<p>indicating he was cognitively intact.</p> <p>During an interview with UM #1 on 2/2/16 at 1:36 P.M., she indicated the whiteboard was supposed to be for staff names. She further indicated from time to time the board would be used to communicate between staff. UM #1 indicated the message written on the whiteboard was for staff so they would know Resident K needed a stool samples and the night shift had forgotten to erase it. UM #1 indicated care related information should not be publicly posted.</p> <p>13. During a random observation on 2/2/16 at 3:00 P.M., Resident #57 was observed to be sitting in a wheelchair in the facility main dining room. During the observation an Audiologist (doctor specializing in hearing) was observed to be seated on her left side. The Audiologist was observed to have a large syringe with clear liquid sitting on the table and a small stick like item. Resident #57 was observed to be holding her left ear. At this time during an interview with the Medical Records nurse she indicated she was unsure what procedure was being performed on Resident #57. She further indicated she would locate the documentation form the visit.</p>			

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	<p>An "Audiology Exam Form" dated 2/2/16 was provided indicating Resident #57 was seen by the Audiologist on that day. The form continued indicating the Audiologist had attempted to remove excessive wax from Resident #57's ear during the visit.</p> <p>The clinical record for Resident #57 was reviewed on 2/2/16 at 3:05 P.M., diagnoses included but were not limited to, heart failure. A quarterly MDS dated 12/17/16 for Resident # 57 indicated she had a BIMS score of 3, indicating she is severely cognitively impaired.</p> <p>A policy titled "Meal Service" dated 10/5/15 was provided by the facility on 2/2/16 at 1:30 P.M. it included, but was not limited to, "Residents shall be served their meals in accordance with dignity...Nursing staff...will serve residents trays and will help residents who require assistance with eating...Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity..."</p> <p>A policy titled "Quality of Life--Dignity" dated 2009, was provided by the facility on 2/2/16 at 1:30 P.M. It included, but was not limited to, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity,</p>			

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F 0282 SS=D Bldg. 00	<p>respect and individuality...'Treated with dignity' means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth...Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not 'labeling' or referring to the resident by his or her room number, diagnosis, or care needs...signs indicating the resident's clinical status or care needs shall not be openly posted...Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as need by...Helping the resident to keep urinary catheter bags covered...promptly responding to residents request for toileting assistance..."</p> <p>3.1-3(t)</p> <p>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 interview and record review, the facility failed to ensure physician's orders were followed regarding</p>	F 0282	<p>F - 282</p> <p>The corrective action taken for</p>	03/03/2016

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	<p>Coumadin dosage per the resident's physician's protocol for 1 of 1 resident reviewed for unnecessary medication. (Resident #15)</p> <p>Findings include:</p> <p>On 1/28/16 at 10:11 A.M., Resident #15 was observed in bed with no distress noted.</p> <p>On 1/28/16 at 10:30 A.M., Resident #15's clinical record was reviewed. Resident #15 had been admitted to the facility on 5/21/15. Her diagnoses included but was not limited to, anemia, recurrent DVT's (deep vein thrombosis), and a pacemaker.</p> <p>Resident #15's current January 2015 physician's orders included but was not limited to,</p> <p>"... *ANTICOAGULANT PROTOCOL* 10/20/15</p> <p>[Resident #15's physician's name],</p> <p>COUMADIN SLIDING SCALE 10/20/15 INR [International Normalized Ratio] 1.5 GIVE 7.5 MG [milligrams] INR 1.5-2.0 GIVE 5 MG INR 2.0-3.0 GIVE 2.5 MG</p>		<p>those residents found to have been affected by the deficient practice isthat the residentidentified as resident # 15 is now receiving the correct Coumadin dose inaccordance with the physician's orders. All changes in Coumadin therapy are now being obtained through theCoumadin clinic to ensure that there is no confusion in protocol.</p> <p><i>The corrective action taken for the other residentshaving the potential to be affected by the same deficient practice is that a housewide audit has been conducted on all residentsreceiving Coumadin therapy. Allresidents are receiving their correct Coumadin dosages in accordance with theirphysician's orders.</i></p> <p>The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has adopted a newpractice that upon review of all Coumadin related orders the Unit</p>		

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	<p>IF INR &gt; 3.0 OR BLEEDING 10/20/15 HOLD AND REPEAT IN THREE DAYS WEEKLY PT/ INR UNLESS OTHERWISE DIRECTED</p> <p>EVERY SHIFT 10/20/15</p> <p>COUMADIN SLIDING SCALE 10/20/15 INR &gt;1.5=5 MG COUMADIN 1.5-2.5=5 MG 2.6-3.2=2.5 MG</p> <p>IF INR OVER 3.2 OR PT 10/20/15 BLEEDS-HOL [hold] COUMADIN &amp; REPEAT PT/INR X 3 DAYS OTHERWISE PT/INR QID DAYS..."</p> <p>A physician's telephone order dated 1/8/16 indicated, "Levaquin [antibiotic] 500 mg i [one] QD xs [times] 7 days-URI [upper respiratory infection]."</p> <p>A physician's telephone order dated 1/10/16 indicated, "Cipro [antibiotic] 500 mg i BID [twice daily] x 7 days."</p> <p>A nursing progress note dated 1/11/16 at 17:53 (5:53 P.M.) indicated, "We are suppose to call Ohio Valley Heart Care at (phone number listed) if resident is put on antibiotics or steroids. We are to hold Coumadin starting for 5 days. On</p>		<p>Managers are responsible for auditing the MARs daily Monday through Friday to ensure that the Coumadin orders have been transcribed accurately and to ensure proper dosages are being administered.</p> <p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the transcription of and administration of Coumadin therapy. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted</i></p>	

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	<p>the 15th we are to give 2 mg of Coumadin and on the 16th go back to regular dose of 4 mg. PT/INR on the 20th. I wrote an order and added this to the MAR (medication administration record)."</p> <p>The January 2016 Medication Administration Record (MAR) included, but was not limited to, an order, Coumadin 4 mg take 1 tablet daily at 5:00 P.M. Handwritten above the dosage documentation indicated, "give 2 mg on the 15th &amp; start regular on 16 th." The MAR documentation indicated Coumadin 4 mg had been administered the 1st-10th and had been held on the 11th, 12th, 13th, and 14th, and then 4 mg administered the 15th - 20th. Documentation was lacking of the Coumadin 2 mg being administered on the 15th.</p> <p>A lab report dated 1/20/16 indicated a PT (Prothrombin time) of 20.8 seconds and a INR (International Normalized Ratio) of 3.1 with normal range of 2.5 - 3.5. Documentation handwritten on the lab report indicated the resident was currently on Coumadin (anticoagulant medication) 4 mg every day. A handwritten note on the lab report indicated, "Order rec'd [received] per Coumadin clinic cont. [continue] 4 mg Q [every] D [day] repeat PT/INR 2/4/16..."</p>			

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	<p>A physician's telephone order dated 1/21/16 indicated, "Continue Coumadin 4 mg daily. Repeat PT/ INR 2 wks (2/4/16)."</p> <p>On 1/29/16 at 10:35 A.M., LPN #5 (Resident #15's nurse) was interviewed regarding Coumadin protocol . LPN #5 during interview at that time indicated Resident #15's physician has Coumadin sliding scale orders. Review of Resident #15's January physician orders at that time indicated 2 Coumadin protocols with different sliding scale doses. She indicated it was unclear which protocol to use. LPN#5 indicated she thought she would use the first protocol listed on the MAR page and call Resident #15's physician if the INR was over 3.0. Reviewed with LPN #5 the 1/20/16 lab results with the Coumadin order from the heart clinic and the telephone order of 1/11/16 to call clinic if resident on antibiotics and steroids. LPN #5 was also made aware the January MAR indicated the last dose of the Levaquin (antibiotic) had been given on 1/17/16 and the last dose of Cipro (antibiotic) on 1/13/16. LPN #5 indicated it was unclear in regard to the correct protocol to use.</p> <p>On 1/29/16 at 11:15 A.M., the Director of Nursing (DON) was interviewed</p>			

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	<p>regarding Resident #15's Coumadin protocol. The DON indicated 2 physician's at the facility had their own Coumadin protocols. The DON indicated she thought the second protocol sliding scale listed on Resident #15's orders were the other physician's (not Resident #15's physician) Coumadin sliding scale protocol. The DON indicated staff should follow the Coumadin protocol unless the physician changes the protocol.</p> <p>A physician's order dated 1/29/16 at 11:30 A.M., indicated, to discontinue Resident #15's physicians sliding scale for Coumadin and to contact the heart clinic for all Coumadin results and orders. The order also indicated to contact the heart clinic when Resident #15 on antibiotics.</p> <p>On 1/29/16 at 11:35 A.M., the DON indicated she had checked with staff nurses at the facility and indicated nurses routinely call the heart clinic regarding PT/INR results for Coumadin orders. The DON also indicated she had called Resident #15's physician and received an order to follow the heart clinic's recommendations.</p> <p>On 2/2/16 at 10:30 A.M., during interview with the DON, the DON</p>			

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F 0309 SS=D Bldg. 00	<p>indicated the facility had no procedure or policy regarding Coumadin protocol or administration. The DON also indicated she had not received documentation from pharmacy to indicate that 2 mg of Coumadin had been given on 1/15/16.</p> <p>3.1-35(g)(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 ensure the fistula sites of a resident receiving hemodialysis were assessed and monitored for 1 of 1 resident reviewed receiving hemodialysis. (Resident #105)</p> <p>Findings include:</p> <p>On 1/28/16 at 9:30 A.M., Resident #105 was observed sitting in her wheelchair in the main dining room. No distress noted.</p>	F 0309	F – 309  The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #105 is now having their fistula assessed each shift in accordance with acceptable standards of practice. The resident also has documentation on the clinical record related to the fistula sites as well as has physician's	03/03/2016			

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	<p>On 1/28/16 at 11:45 A.M., Resident #105's clinical record was reviewed. Resident #105 had been admitted to the facility on 1/19/16. Diagnoses included but not limited to, absence of right leg below knee amputation, type 2 diabetes mellitus, heart failure, end stage renal disease, dependence on renal dialysis, and presence of cardiac pacemaker. Resident #105's current care plan dated 1/26/16 addressed the problems of at risk for falls and skin impairment.</p> <p>The admission nursing assessment dated 1/19/16 lacked documentation of a fistula site. The admission nursing assessment indicated Resident #105 was alert and oriented x 3. The admission physician orders dated 1/19/16, and current physician orders lacked orders for hemodialysis. Nursing notes from 1/19/16 to 1/28/16 lacked documentation regarding hemodialysis fistula sites, or the assessment and monitoring of fistula sites. The January Medication Administration Record (MAR) and the January Administration Record (TAR) lacked documentation of the hemodialysis fistula sites or the assessment and monitoring of the hemodialysis sites.</p> <p>On 1/28/16 at 1:32 P.M., the West Unit Manager Nurse was interviewed</p>		<p>orders for their routine hemodialysis.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been conducted to ensure that all residents who receive dialysis have documentation to support that their fistulas are assessed each shift. The audit also included validation of documented descriptions of the condition of the fistulas as well as current physician's orders.</i></p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses on the facility's policy related to the care and monitoring of the residents with a hemodialysis fistula.</p> <p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented</i></p>	

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	<p>regarding the assessment and monitoring of the dialysis fistula site. The West Unit Manager indicated at that time Resident #105 has 2 fistulas. The West Unit Manager indicated Resident #105 has a fistula on each arm and the bruit could be noted at each fistula but only one of the fistulas was active. The Unit Manager also indicated Resident #105 goes to dialysis three times a week and staff nurses should be checking the bruit of the fistula every shift.</p> <p>On 1/28/16 at 2:00 P.M., the Director of Nursing (DON) was made aware of documentation lacking regarding the hemodialysis fistula sites, assessment or monitoring of sites since admission.</p> <p>On 1/28/16 at 2:40 P.M., the DON indicated documentation was lacking in the clinical record for physician orders for dialysis or the assessment or monitoring of the fistula sites.</p> <p>On 1/28/16 at 2:42 P.M., the DON indicated nursing staff need to be assessing and monitoring the hemodialysis fistulas.</p> <p>On 1/28/16 at 2:52 P.M., the DON provided a facility policy (undated) entitled, "Hemodialysis Access Care." The policy included but was not limited</p>		<p>to monitor the documentation of those residents with a hemodialysis fistula. The tool includes monitoring of documented assessments of the fistula each shift as well as documentation on the nursing assessment of the condition of the fistula and that current dialysis orders are present on the clinical record. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</p>	

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F 0314 SS=G Bldg. 00	<p>to, "...4. d. Check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care and at least every shift..."</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 sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a dependent resident admitted without pressure ulcers and a dependent resident admitted with pressure ulcers was provided effective interventions and care to prevent the development of a Stage 3 pressure ulcers on the coccyx, stage 2</p>	F 0314	<p>F - 314</p> <p>1.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #76 has had an up-dated Braden scale completed. The</p>	03/03/2016	

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	<p>pressure ulcer on the left heel, and an unstageable pressure ulcer on the right foot (Resident #76) and 2 suspected deep tissue injuries on the right foot (Resident #62) for 2 of 3 residents who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #76 experiencing one stage 3 pressure ulcer, one stage 2 pressure ulcer, and Resident #62 experiencing 2 suspected deep tissue injuries. (Resident #76, Resident #62)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation on 1/29/16 at 8:30 A.M., Resident #76 was observed in bed wearing socks on both feet. The left foot was in direct contact with the mattress and a Multi Podus Boot was on the right foot.</li> </ol> <p>The following observations were made on 1/29/16 at 8:56 A.M., 9:05 A.M., 9:43 A.M., 10:58 A.M.: Resident #76 was observed sitting in a wheelchair with both feet on the floor. Resident #76 was wearing socks, but no Multi Podus Boot was observed on Resident #76's right foot. Resident #76's Multi Podus Boot was observed to be sitting on top of the dresser, in the room, during all the observations on 1/29/16.</p>		<p>plan of care has been reviewed and up-date to include appropriate interventions for the treatment of pressure ulcers. The CNA assignment sheets have also been up-dated to include interventions for the treatment of the resident's pressure ulcers as well as the location of the pressure ulcers. The resident is continuing to be seen by a physician who is a wound specialist. Hospice services have also provided additional orders related to pain management for the resident.</p> <p>2.) The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident # 62 is now receiving care and services in accordance with their plan of care related to the care and treatment of pressure ulcers as well as all other activities of daily living per the request of the resident's legal guardian. The resident is also continuing to be seen by a physician who is a wound specialist.</p>	

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	<p>On 1/29/16 at 11:35 A.M., Resident #76 was observed on the East hall sitting in a wheelchair without the Multi Podus Boot on the right foot. Resident #76 was observed to be attempting to propel the wheelchair with her Left and Right heel.</p> <p>The following observations were made on 2/1/16 at 9:13 A.M., 10:38 A.M., and 11:02 A.M. Resident #76 was observed sitting in her reclining chair with both feet elevated. A Multi Podus Boot was observed on the resident's right foot. There was no pressure relieving cushion on the seat of the recliner.</p> <p>During an observation on 2/1/16 at 11:10 A.M., Resident #76 was lying in a recliner with her eyes closed. Resident #76 yelled out and moaned in pain as CNA #13 and the Wound Care Nurse (WCN) adjusted the recliner to an upright position and assisted the resident with a transfer to the bedside. CNA #13 indicated it took two people to transfer Resident #76. At that time, there was no pressure relieving cushion on the recliner seat. The WCN stepped into the resident's bathroom to wash her hands. CNA #13 grasped under Resident #76's knees with her right arm and behind the resident's back with her left arm and pivoted the resident from a sitting position to a lying position on the</p>		<p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been conducted for all residents related to their level of risk for the development of pressure wounds. All residents' care plans have been reviewed and up-dated to ensure that all appropriate interventions are in place to address the residents' skin needs. The CNA assignment sheets have been up-date to include interventions for the prevention and/or treatment of pressure wounds. The CNA assignment sheets have also been up-dated to include the location of any pressure wounds. All pressure wounds are assessed weekly with thorough assessment of each wound documented in the clinical record.</i></p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory</p>	

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	<p>mattress. Resident #76 cried out in pain. The WCN removed the dressing from Resident #76's coccyx and observed the wound. The WCN indicated the wound looked different compared to the last time she viewed it. The WCN indicated the depth of the wound had increased. The WCN cleaned the coccyx wound and indicated she would stage the pressure area as a Stage 3, but that the area had been caused by friction. The width of the wound was 2.3 cm length x 2.5 cm x depth 1.0 cm. There was a slight odor present. Tunneling of 1.4 cm at the 1:00 position, 1.2 cm at the 3:00 position, 0.5 at the 6:00 position, 1.0 at the 9:00 position. The wound bed was 80% white and 20% red.</p> <p>During an observation on 2/2/16 at 2:15 P.M., Resident #76's was lying on the bed. Resident #76's left foot was observed lying on the mattress (not floated or elevated) and the Multi Podus Boot was not on the right foot. The Multi Podus Boot was observed lying in the wheelchair. Resident #76 was moaning and saying her left foot hurt. The WCN removed the resident's sock and a new pressure ulcer was discovered on the left heel measuring length 5.3 cm x width 5 cm x depth 0. The blister was intact.</p> <p>The right foot had a new blister on the</p>		<p>in-service has been provided for all nursing staff of the prevention and treatment of pressurewounds. The in-service also included a focus on each nursing members' responsibility to ensure that the residents' skin preventions were in place in accordance with each residents' individualized plan of care. In addition the in-service included specific instructions on the proper application of Multi-podus boots.</p> <p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to monitor the care and services provided to each resident at skin risk to ensure the residents are receiving the necessary interventions in the prevention and treatment of pressure wounds. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three</i></p>	

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	<p>heel measuring 2.3 cm x 3.5 cm. The blister was fluid filled. At that time the WCN was made aware that on 1/29/16, Resident #76 had been observed in the wheelchair with both feet on the floor without wearing the Multi Podus Boot on the right foot, and the left foot had not been floated for pressure relief while in bed. Additionally, the WCN was informed that there was no pressure relief cushion on the resident's recliner. The Wound Care Nurse indicated more instruction was needed for the CNA's in regard to pressure relief interventions.</p> <p>The clinical record of Resident #76 was reviewed on 2/1/16 at 1:30 P.M. The clinical record indicated Resident #76 was admitted to the facility on 10/3/15 and diagnoses included, but were not limited to, fracture of upper end left humerus, diabetes, dementia, muscle weakness.</p> <p>The "ADMISSION NURSING ASSESSMENT" dated 10/3/15 indicated Resident #76 had no skin conditions upon admission to the facility.</p> <p>The "BRADEN PRESSURE ULCER RISK" assessments dated 10/3/15 and 12/10/15, documented a total score of 20 which indicated Resident #76 was not at risk to develop a pressure ulcer.</p>		<p>weeks, then monthly for three months and then quarterly for threequarters. The outcome of this tool willbe reviewed at the facility Quality Assurance meeting to determine if anyadditional action is warranted.</p>		

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	<p>During an interview on 1/29/16 at 10:50 A.M., the Director of Nursing (DON) indicated all residents in the facility were considered at risk to develop pressure ulcers.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 10/10/15, indicated Resident #76 experienced severe cognitive impairment, was totally dependent for bed mobility, and was not at risk for developing pressure ulcers.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 12/28/16, indicated Resident #76 was totally dependent for bed mobility, had developed an unstageable pressure ulcer, but was not at risk for developing pressure ulcers.</p> <p>The Current Physician's Orders dated 1/1/15 through 1/31/15 indicated the following:                      "...Multi Podus Boot only off at hygiene"                      Dated 12/22/15                      "...NUTRITIONAL SUPPLEMENT 90 ML BY MOUTH THREE TIMES DAILY" Dated 10/22/15.                      "TURN AND REPOSITION EVERY 2 HOURS PER BRADEN SCORE" Dated 10/3/15</p> <p>The "MEDICATION ADMINISTRATION RECORD" dated</p>			

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	<p>2/16, read as follows: Anasept wound cleanser to coccyx, Apply silver gel to wound bed, pack with gauze, Cover with dry drsg [dressing] change 3 x [times] /week (M W F) and PRN (as needed) soiled" Dated 2/1/16.</p> <p>The Laboratory Cumulative Report dated 12/16/15 indicated Resident #76's lab values (blood levels) were as follows: Total protein was low at 5.1 g/dl [grams per deciliter]. The normal range for protein is 6.5 - 8.1 g/dl. Albumin was low at 2.4 g/dl. The normal range for albumin is 3.5 - 5.0 g/dl.</p> <p>The "DIETARY CONSULTANTS, INC, NUTRITIONAL ASSESSMENT" form dated 11/13/15 indicated Resident #76 experienced an unintentional weight loss and a house supplement had recently been added to Resident #76's diet three times a day.</p> <p>The "CNA Assignment Sheet" was provided by LPN #7 on 1/26/16 at 10:00 A.M. and a copy of the CNA assignment sheet was provided by the DON on 2/2/16 at 3:23 P.M. The CNA assignment sheets lacked documentation of the following documentation: wound locations, intervention with respect to the wounds, and direction for the Multi</p>			

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	<p>Podus Boot application and removal.</p> <p>The "Progress Notes" dated 12/22/15 indicated Resident #76 had a Deep Tissue Injury (DTI) on the right heel. The Physician's Order dated 12/22/15 read as follows: "Multipodus boot only off for hygiene." Measurements and wound appearance for the DTI were requested but not provided by the (WCN) Wound Care Nurse.</p> <p>The "Pressure Ulcer Treatment" policy provided by the DON on 1/29/16 at 9:55 A.M., read as follows: "...Suspected Deep Tissue Injury (Definition): purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear...The area may be preceded by tissue that is painful..."</p> <p>The "Progress Notes" dated 1/19/16, read as follows: "...Dr. [Physician's name] at bedside for eval...The superficial eschar on her right heel was removed bluntly. Two smaller areas of eschar remain. We will continue to treat with pressure relieving boots...Resident family stated that she was complaining of her bottom. She slides in her wheelchair...Coccyx - 2.5 x [by] 1.7 x 0.2 cm [centimeters] 80%yellow, 20% black. This is friction..."</p>			

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	<p>The "Progress Notes" dated 1/28/16, read as follows: "...Coccyx - 2.5 x 1.7 x 2 cm 80% grey, 20% black. Moderate amount of seropurulent drainage noted. Slight odor. Wound believed to be friction...MD notified...No new orders at this time."</p> <p>The "Progress Notes" dated 1/29/16, read as follows: "...Dressing change to wound on coccyx. Grey, thick drainage noted. .5 cm depth noted. Wound has foul odor. Resident c/o [complained of] pain during procedure..."</p> <p>The "Progress Notes" dated 2/1/16, read as follows: "...Resident has wound on coccyx. Originally thought to be caused from friction. Wound is now - 2.3 cm x 2.5 cm x 1.0 cm. Wound is irregular in shape. Moderate amount of purulent drainage. Slight odor present. Tunneling of 1.4 cm @ [at] 0100, 1.2 cm @ 0300, 0.5 @ 0600, 0.7 @0900, 1.0 cm between 0900 - 1200. Wound bed is 80 % white and 20% red. Resident c/o pain with touch..."</p> <p>The "Pressure Ulcer Treatment" policy provided by the DON on 1/29/16 at 9:55 A.M., read as follows: "...Stage 3 Pressure Ulcer (Definition): Full thickness tissue loss...Slough may be present but does not obscure the depth of</p>			

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	<p>tissue loss. May include undermining or tunneling...</p> <p>Stage 4 Pressure Ulcer (Definition): Full thickness tissue loss with exposed bone. often includes undermining and tunneling."</p> <p>The "Progress Notes" dated 2/2/16, at 3:20 P.M., documented a new area on the left heel and read as follows: "...Left heel has fluid filled blister measures approximately 5.3 cm x 5 cm x 0. Blister is intact. MD notified..."</p> <p>"Right heel also has small new area appears to be blister. Blister has small amount of fluid present. Blister measures approximately 2.3 cm x 3.5 cm. No drainage noted..."</p> <p>The Care Plan dated 12/2/15 was provided by the DON 1/29/16 at 10:15 A.M., and it read as follows: "Focus: ...Resident has potential impairment to skin integrity...Goal...The resident will maintain or develop clean and intact skin by review date...Educate family/caregivers of causative factors and measure to prevent skin injury...follow facility protocols for treatment of injury...Identify/document potential causative factors and eliminate/resolve where possible...Use a draw sheet of lifting device to move resident..."</p> <p>Documentation was lacking with respect</p>			

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	<p>to wearing the Multi Podus Boot at all times except for hygiene, floating feet at all times when in bed, and turning and repositioning resident every 2 hours.</p> <p>During an interview on 2/1/16 at 12:02 P.M., CNA #13 indicated the CNA assignment sheet was used as a guide for the care of each resident. CNA #13 indicated the CNA assignment sheet needed to be accurate, especially if a CNA was not familiar with the resident's needs.</p> <p>During an interview on 2/2/16 2:10 P.M., CNA #13 indicated she had put Resident #76 to bed and had taken the Multi Podus Boot off the right foot to "let it rest." CNA #13 indicated she was not sure if the boot should only be worn at night or if it should be worn during the day as well.</p> <p>The "Prevention of Pressure Ulcers" policy was provided by the DON on 1/29/16 at 9:55 A.M., and read as follows: "...3. a. Change position at least every 2 hours: b. Use foam, gel, air cushion as indicated to relieve pressure...4. When repositioning, reduce friction and shear by lifting (using appropriate lifting technique and equipment) rather than dragging..."</p>			

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	<p>During an interview on 2/2/16 at 3:45 P.M., the DON indicated the CNA assignment sheets needed to be updated more often and that pressure relieving measures needed to be communicated to all staff.</p> <p>2. During an interview with Unit Manager #5 on 1/27/16 at 8:45 A.M., she indicated Resident #62 had been admitted with stage 3 and 4 pressure ulcers.</p> <p>On 1/28/16 at 9:40 A.M., Resident #62 was observed to be lying in bed, on his back in no apparent distress. Resident #62 was observed to be wearing Multi-Podus Boots to both his feet with a gauze dressing underneath of them.</p> <p>During an observation of care on 1/29/16 at 10:55 A.M., CNA #6 and CNA #3 were observed assisting Resident #62 out of bed. At that time Resident #62 was observed to lying on his back in bed. When Resident #62 was rolled to the side a large amount of brown drainage was observed on the sheet under him. At that time Resident #62 refused to allow the CNA 's to change pants or do any hygiene. At that time during an interview Resident #62 indicated he did not want to stay in bed any longer since he had been asking to get up since 6 A.M. CNA #6 indicated at that time she did not know</p>			

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	<p>what to do when Resident #62 was refusing care and she and CNA #3 were observed to continue getting Resident #62 up in the wheel chair.</p> <p>During an interview with UM #2 on 1/29/16 at 11:10 A.M., was interviewed in regards to the care of Resident #62. UM #2 indicated Resident #62 often refused care. She further indicated Resident #62 had recently stayed up in his wheel chair for 6 days. UM #2 indicated she was aware Resident #62 had a guardian and indicated the guardian had stated to do care necessary to care for the resident however, she indicated they did not want to go against Resident #62's wishes.</p> <p>The clinical record for Resident #62 was reviewed on 1/28/16 at 10:10 A.M., diagnoses included, but were no limited to quadriplegia (paralysis of all limbs), depression, and stage 4 pressure ulcer.</p> <p>A complete guardianship order dated 8/20/15 was observed in chart and notarized.</p> <p>The Nurses notes were reviewed and included, but were not limited to, a nurses note dated 1/17/16 at 6 P.M, included, but were not limited to, " ...Stage 4 ulcer to [sign for right] buttock</p>			

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	<p>...Stage 2 ulcers to bilateral [both] heels..."</p> <p>The Nursing notes included, but were not limited to: A Social Service note dated 1/19/16 at 9:45 A.M., "SSD and Unit Manager called father, who is guardian, to discuss resident's constant refusal of care. Guardian stated that he has tried to let resident make decisions on his own, but if it is going to go against him receiving the appropriate care, then resident will no longer make decisions. Father stated he is guardian for a reason and wants staff to provide care, regardless of resident's refusal. Father stated to call him with any issues and he would be happy to speak with resident and staff. Father stated he wanted his son taken care of, even if resident has given up, that is why he has a guardian...Phone numbers were verified and father was informed that he would be contacted as needed. Father stated whatever we needed, he will try to help in anyway [sic] possible..."</p> <p>A nursing note dated 1/20/16 at 2:32 P.M., "res [resident] did not go to bed last night. Slept in w/c. Night shift reports several attempts to go to bed and res refused. Res has refused...and all attempts to lay down in bed for wound care also refused x3 hygiene care..."</p>			

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	<p>A nursing note dated 1/20/16 at 7:06 P.M., Resident refused dinner...Resident refused to lay in bed but opted to stay in W/C [wheel chair]. Resident educated on the importance of laying on air mattress...Resident still refused... Will continue to monitor..."</p> <p>A nursing note dated 1/22/16 at 7:22 P.M., "Resident stayed in w/c all shift. This nurse offered to assist resident into bed to relieve pressure on wounds. Resident refused..."</p> <p>A nursing note dated 1/22/16 at 11:28 P.M., "...continues to refuse to go to bed has been up in chair approx...32 hours..."</p> <p>A nursing note dated 1/23/16 at 1:19 P.M., "...Continues to refuse to go to bed has been in chair 5 days. Refuses all adl [activities of daily living] care unable to verbally redirect ..."</p> <p>A nursing note dated 1/25/16 6:25 A.M."...Resid. [sic] Continues to refuse to go to bed has been up in chair 6 days has refused all treatments showers in room now in w/c with clothes he has had on for day that are dirty and sweat and stool but refuses to be changed covered up with heavy blanket it is quite warm in room and resid. [Resident] Is sweating..."</p>			

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	<p>A nursing note dated 1/25/16 at 7:22 P.M., "Res cont [sic] [continues] to refuse care. Refused both meals today. At 1500 Reached [sic] father/guardian. He stated to give res shower and to put res to bed to do necessary tx [treatment] to wounds. Stated staff to give res care necessary for his health and welfare. Res showered and tx completed as ordered..."</p> <p>A "BRADEN PRESSURE ULCER RISK" assessment dated 7/17/15 indicated Resident #62 was at high risk to develop pressure.</p> <p>The care plans included, but were not limited to, "The resident has quadriplegia r/t [related to] Spinal injury (initiated 7/29/15)...interventions include, but were not limited to Assist with ADL's and locomotion as required, discuss with resident/and family any concerns, fears, issues regarding diagnosis or treatment..."</p> <p>A care plan for actual impairment related to quadriplegia (initiated 7/29/15) included, "...alternating flow air mattress, follow facility protocol for treatment of injury...Identify/document potential causative factors and eliminate/resolve where possible..."</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 12/30/16 indicated</p>			

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	<p>Resident #62 had a BIMS score (Brief Interview for Mental Status score) of 14 indicating Resident #62 was cognitively intact. The MDS further indicated Resident #62 had no behavioral concerns and was totally dependent on 2 or more staff members for bed mobility, transfers, personal hygiene and bathing.</p> <p>The facility provided wound care documentation for the wound on the right foot included, but was not limited to the following:</p> <p>On 7/17/15 Resident #62 was admitted to the facility with a Stage 4 pressure ulcer measuring 9 cm [centimeters] x [by] 6 cm x 0.3 cm, with a red wound bed with slough in the middle to the Right heel. The interventions put into place where to turn and reposition the resident every 2 hours, air mattress, float heels. The treatment was to clean wound with wound cleanser and apply hydrogel silver and cover with an ABD pad, and wrap with kerlix [wound dressing] daily.</p> <p>On 7/23/15 Resident #62's Stage 4 pressure ulcer to right heel, measuring 9 cm x 8 cm x &lt; [less than] 0.1 cm. The wound bed was dry with eschar. Current treatment was to clean the wound with wound cleanser and apply santyl [a debridement medication] to eschar cover</p>			

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	<p>with dry dressing every 2 days.</p> <p>On 10/19/15 the pressure ulcer was assessed as a Suspected Deep Tissue Injury (SDT) to the right heel measuring 1.8 cm x 1.8 cm x 1.4 cm, with moderate amount of clear/purulent drainage, pink wound bed, slight odor and no infection present. No changes to the treatments were made.</p> <p>On 11/3/15 the pressure ulcer was assessed as a SDT measuring 6 cm x 6 cm x &lt; 0.1 cm, no drainage, wound bed black, no infection present. The treatment ordered was wound cleanser anasept gel, and cover with gauze.</p> <p>On 12/1/16 the pressure ulcer was assessed as a SDT to right heel measuring 4 cm x 2.4 cm x 0.1 cm with a moderate amount of drainage and black wound bed. No change to treatment.</p> <p>On 12/8/15 the pressure ulcer was assessed as 2 separate areas on the right heel. Pressure ulcer # (number) 1 was a SDT measuring 3cm x 1.8 cm x 0.4 cm with a scant amount of bloody drainage and red wound bed. Pressure ulcer #2 was assessed as a SDT to the right heel measuring 1 cm x 0.8 cm with no depth and a small amount of bloody drainage and red wound bed.</p>			

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	<p>On 12/14/15 pressure ulcer #1 was assessed to be a SDI to right heel measuring 2.7cm x 1.3 cm x 0.2 cm, with a small amount of bloody drainage and red wound bed. Pressure ulcer #2 was assessed as being a SDT to right heel measuring 1 cm x 0.4 cm x 0 cm with a scant amount of clear drainage and pink wound bed. No change in the treatment was made.</p> <p>On 12/21/15 pressure ulcer #1 was assessed as being closed and pressure ulcer #2 was measured as being assessed as being 2 cm x 1 cm x 2 cm with a scant amount of bloody drainage and beefy red wound bed.(size increase)</p> <p>No documentation of wound measurements was provided from 12/22/15 to 1/10/16.</p> <p>On 1/11/15 pressure ulcer #2 on Resident #62's right heel was assessed as being a SDT measuring 7.2 cm x 6.2 cm x 0.2 cm with moderate amount of bloody/clear drainage and a wound bed containing 50% [percent] black eschar.</p> <p>On 1/25/16 pressure ulcer #2 to was measured at 6.5 cm x 6.8 cm x 0.2 cm. Documentation of the characteristics of the wound bed was lacking.</p>			

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	<p>The facility provided wound care documentation for the left heel which included, but was not limited to the following:</p> <p>On 7/17/15 Resident #62 was assessed as having an unstageable pressure ulcer to his left heel measuring 3.5 x 3.5 cm presenting as a fluid filled blister, with a red black wound bed and no drainage. The treatments put into place were to skin prep area every shift.</p> <p>On 7/23/15 the pressure ulcer to Resident #62's left heel was measured as a 4cm x 4cm fluid filled blister with black wound bed. There were no changes to the treatment.</p> <p>On 7/29/15 the pressure ulcer to Resident #62's left heel was measured the same and Multi Podus Boots were added to the preventive measures.</p> <p>On 8/18/15 the pressure ulcer was assessed as being an unstageable area measuring 1.8 cm x 2 cm x &lt; 1 cm with scant amount of drainage and black eschar in the wound bed. The treatment was changed to santyl ointment to black eschar every other day.</p> <p>On 11/3/15 the pressure ulcer to Resident</p>			

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	<p>#62's left heel was assessed as being a suspected deep tissue injury measuring 8 cm x 4 cm x 0.4 cm with a black wound bed, the treatment had been changed to clean with wound cleanser and cover with antisept gel, cover with gauze.</p> <p>On 11/9/15 the pressure ulcer to Resident #62's left heel was assessed as being 3 separate areas. Pressure ulcer #1 was assessed as being a SDT measuring 2 cm x 1.8 cm x 0.2 cm with a black/yellow/pink wound bed and scant drainage. The treatment for pressure ulcer #1 was clean with wound cleanser, apply antisept gel and cover with dry dressing, pressure ulcer #2 was assessed as a SDT measuring 1.4 cm x 1.6 cm x 0.4 cm with a "beefy red" wound bed a small amount of clear/purulent drainage. The treatment was the same. Pressure ulcer #3 was assessed as Stage 2 pressure area measuring 2.1 cm x 1 cm x 0.2 cm with no drainage and a pink wound bed. The treatment was ordered as clean with wound cleanser, apply antisept gel and cover with dry dressing.</p> <p>On 11/23/15 pressure ulcer#1 was assessed as being a SDT measuring 2 cm x 1.6 cm x 0.2 cm, with a 25% black wound bed and small amount of clear/purulent drainage. No changes were made to the treatment of pressure</p>			

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	<p>ulcer #1. Pressure ulcer #2 was assessed as being a SDT measuring 0.6 cm x 0.6 cm x 0.2 cm with a red wound bed and a small amount of clear/purulent drainage. No changes were made to the treatment of pressure ulcer #2. Pressure ulcer #3 was assessed as being a stage 2 pressure area measuring 3 cm x 0.8 cm x &gt; (greater than) 0.1 cm with no drainage, and a wound bed that was black. No change was made to the treatment of pressure ulcer #3.</p> <p>On 12/14/15 pressure ulcer #1 was assessed as being a SDT measuring 0.5 cm x 0.7 cm with no depth and a pink wound bed draining a small amount of bloody drainage. There was no change to the treatment of pressure ulcer #1. Pressure ulcer #2 was assessed as being a closed. Pressure ulcer #3 was assessed as being a stage 2 pressure ulcer measuring 4 cm by 0.7 cm with no depth, and a black wound bed. No change to the treatment of pressure ulcer #3 was made.</p> <p>On 12/21/15 area #1 was assessed being a SDT measuring 0.7 cm x 0.5 cm x 0 cm with a pink, yellow wound bed, and a small amount of drainage. No changes to the treatment of pressure ulcer #1 were made.</p> <p>Pressure ulcer #3 was assessed as being a stage 2 measuring 4 cm x 0.8 cm x &gt;0.1</p>			

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	<p>cm depth. No changes were made to the treatment of pressure ulcer #3.</p> <p>No documentation of wound measurements was provided from 12/22/15 to 1/10/16.</p> <p>The nurses' notes indicated on 1/11/16 the two wounds had become one and the areas to Resident #62's left heel as assessed as being a SDT measuring 5.8 cm x 4.2 cm x 0.2 cm with a wound bed containing 25% black eschar and a moderate amount of bloody drainage. No treatment changes were done.</p> <p>During an observation of wound care on 1/28/16 at 10:45 A.M., Resident #62 was observed lying supine in bed, with bilateral Multi Podus Boots in place. The boots were removed by the Wound care nurse (WCN) and dressing removed from the right foot. During this observation the WCN indicated Resident #62 had a new area to the lateral planter area of his foot. She indicated the area was a fluid filled blister measuring 2.5 cm x 2.4 cm. The WCN indicated the area was red/purple like and around the wound appeared to be bruised. The wound care nurse further indicated another "friction based" area to the resident's anterior ankle measuring 1 cm x 3 cm with no depth with a bruising surrounding the wound area. The WCN</p>			

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	<p>indicated the areas were caused by friction and not pressure, she further indicated this was from the residents feet sliding around in his Multi Podus Boots. At the same time the left heel was observed with the WCN. She assessed the wound to Resident #62's left heel as having being a suspected deep tissue injury measuring 7.5 cm by 3.5 cm with a wound bed containing 90% black eschar and 10% red tissue. The WCN indicated the suspected deep tissue injury was caused from the boots sliding around too much.</p> <p>During an interview with the Wound Care Nurse on 2/2/16 at 8:45 A.M., she indicated Resident #62 was admitted on 7/17/15 with a unstageable fluid filled blister to his left heel measuring 3.5 cm x 3.5 cm and a stage 3 pressure ulcer to his right heel measuring 9 cm by 6 cm with a depth of 0.3 cm. She indicated the wounds had progressed and shown signs of healing. The Wound Care Nurse indicated the discrepancy in the measurements were due to, new instructions on how to measure wounds, different people measuring the wounds, and the resident's refusal to allow staff to do care. She indicated she was aware that Resident #62's guardian had stated to do "everything necessary" to heal the wounds despite the resident's refusal</p>			

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F 0315 SS=D Bldg. 00	<p>however staff were scared to make him lay down, or do treatments. She further indicated the new areas found on Resident #62's right foot were friction based from the Multi Podus Boots rubbing and not pressure. The wound care nurse indicated the facility was going to order new Multi Podus Boots for Resident #62.</p> <p>3.1-40(a)(1)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident admitted with a urinary catheter had the supporting diagnosis for the continued use of the catheter and the resident had been assessed for for</p>	F 0315	F - 315  The corrective action taken for those residents found to have been affected by the deficient practice is that the resident identified as resident #	03/03/2016

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	<p>continued need of a urinary catheter upon admission 1 of 3 residents who met the criteria review of urinary catheterization. (Resident #103)</p> <p>Findings include:</p> <p>Resident #103 was observed on 1/29/16 at 8:45 A.M. Resident #103 was observed lying in bed with eyes closed. A urinary catheter bag was observed to attached to the left side of Resident #103's bed with amber urine in the bag.</p> <p>The clinical record for Resident #103 was reviewed on 1/29/16 at 8:56 A.M., the diagnoses included, but were not limited to dementia, migraines, and macular degeneration and urinary retention.</p> <p>The clinical record further indicated Resident #103 was admitted on 1/9/16 with a urinary catheter in place. The nurses notes were reviewed and documentation was lacking the continued use of the urinary catheter had been assessed or the physician had be consulted in regards to continued use of a urinary catheter.</p> <p>A history and physical dated 11/5/16 from local hospital included, but was not limited to urinary retention.</p>				<p>103 has had their Foley catheter removed perphysician's orders.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of all residents currently utilizing a Foley catheter to ensure that there is medical justification for each Foley catheter currently in place. No other residents were identified.</i></p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all licensed nurses on the facility policy related to Catheter justification including a review of their responsibility to assess the resident to ensure that there is medical justification for the continued use of the Foley catheter and/or documentation to support that the physician has been consulted in regards to the continued use of a urinary catheter.</p>		

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	<p>The care plans included, but were not limited to, a care plan for indwelling urinary catheter initiated 1/21/16. The interventions included, but were not limited to monitor and document intake and output as per facility policy.</p> <p>A Physician's progress note dated 12/4/15 from a urologist (physician specializing in urinary function) included, but was not limited to, "...At the present time, they are doing intermittent catheterization every 4 hours to empty bladder...He is certainly not a surgical candidate at the present time and I think the intermittent catheterization is the best that we can do presently. I would not leave the catheter in him..."</p> <p>During an interview with Unit Manager (UM) #2 on 1/29/16 at 1:15 P.M., she indicated resident #103 was admitted with a catheter for urinary retention. She indicated at this time she had not completed an assessment for continued use of the urinary catheter. She further indicated she indicated Resident #103 was going to be seen by an urologist and she had just received an order for the urinary catheter to stay in place until the visit. UM #2 indicated she would locate and provide documentation to support use of the urinary catheter and appointment for follow up.</p>		<p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that each resident utilizing a urinary catheter has documented supportive medical justification in the clinical record and that there is also documentation to reflect that the resident has been assessed and/or physician consulted for the continued need of the use of a urinary catheter. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</i></p>		

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	<p>During an interview with UM #2 was interviewed on 2/1/16 at 10:15 A.M., she indicated Resident #103 had an appointment for follow up with a urologist on 3/24/16. She indicated she had been instructed to call the urologist on 1/29/16 and ask for his/her recommendations on continued use of the urinary catheter. She indicated at that time the urologist had indicated the urinary catheter could be discontinued. She indicated the facility had not attempted to reduce the use of the urinary catheter and no documentation could be provided to indicate the urologist or the resident's physician had been consulted regarding medical necessity for the continued use of the urinary catheter. She indicated the urinary catheter had been discontinued on 1/29/16 and Resident #103 had been voiding with no difficulty.</p> <p>An order dated 1/29/16 included, but was not limited to, "...Attending Physician [name of resident physician]...D/C [discontinue] Foley [urinary catheter]..."</p> <p>During an interview on 2/1/16 at 10:19 A.M., the Director of Nursing Services indicated Resident #103 had been admitted with a urinary catheter for urinary retention. She indicated</p>			

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	<p>documentation was lacking a physician had been consulted regarding the continued use of the urinary catheter. The DNS indicated documentation was lacking the facility had assessed the resident for medical justification or made an attempt to remove the catheter prior to being questioned. She further indicated on 1/29/16 the urologist had been called and had indicated the catheter could be removed and the resident monitored for retention.</p> <p>A policy titled "Catheter Justification" dated 11/12/15 was provided by the DNS on 1/29/16 at 10:14 A.M. It included, but was not limited to, "Foley catheters will only be utilized when there is medical justification which has been documented by the physician or diagnostic tests support the medical need for the device ...Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by: Documented post void residual volume in range over 200 milliliters. Inability to manage the retention/incontinence with intermittent catheterization ..."</p> <p>3.1-41(a)(1)</p>			

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F 0353 SS=E Bldg. 00	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff was available to provide services on 1 of 3 nursing units. (West Unit, Confidential Family Interview, Resident G, Resident L, Resident J, Resident H, Resident Z, Resident K)</p> <p>Findings include:</p>	F 0353	F – 353  The corrective action taken for those residents found to have been affected by the deficient practice is that the facility has reviewed the needs of all residents on the West Unit, as the identity of those residents mentioned in the survey is confidential. The facility has	03/03/2016

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	<p>1. During a confidential family interview on 1/26/16 at 3:52 P.M., the interviewee indicated the facility did not have enough staff.</p> <p>2. During an interview on 1/27/16 at 8:30 A.M. Resident #G indicated he/she had requested to get out of bed at 6:00 A.M. that morning and was still waiting. Resident G further indicated the facility was short on help.</p> <p>3. During a random observation on 1/27/16 at 9:00 A.M., Resident L was observed propelling through the West unit dining room towards the hallway in a wheelchair and stated, "Oh, help me, it hurts!" At that time, LPN #15 and the WCN (Wound Care Nurse) were observed standing at medication carts in the West Unit dining room, the DON (Director of Nursing) and UM (Unit Manager) #1 were observed standing at the nursing station. Housekeeper #5 was observed to approach Resident L and state, "...what do you need..." During an interview, at that time, Resident L stated, "I need to go to the bathroom" and Housekeeper #5 then stated, "I will get someone". Housekeeper #5 was then observed to walk past the nursing station, LPN #15, the WCN, the DON, the UM #1 and enter a resident room. Resident L</p>		<p>reviewed its staffing patterns to ensure that the staffing patterns meets or exceeds the needs of the residents. Each resident on the West Unit is now receiving the necessary care and services to meet their individualized needs in a timely manner.</p> <p>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that since all residents on the West Unit have the potential to be affected by this deficient practice, the facility has reviewed the needs of all residents on the West Unit. The facility has reviewed its staffing patterns to ensure that the staffing patterns meets or exceeds the needs of the residents. Each resident on the West Unit is now receiving the necessary care and services to meet their individualized needs in a timely manner.</p> <p>The measures that have been put into place to ensure that the deficient practice does not recur is that a mandatory</p>	

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	<p>was then observed to enter a resident room and was observed to moan and stated, "Oh hurry up!". The AD (Activity Director) was then observed, at that time, to approach Resident L and stated, "what do you need?" Resident L stated, "My bladder is full, it hurts so bad!" The AD was observed to exit the resident room and stated, "I am going to get some help" CNA #2 was observed to enter the room at 9:20 A.M. and transport Resident L to the bathroom.</p> <p>4. During an interview on 1/27/16 at 10:45 A.M., Resident J indicated sometimes he/she rings the call light and no staff comes to assist him/her.</p> <p>5. During an interview on 1/27/16 at 11:00 A.M. Resident H indicated the facility was frequently short of staff during the night.</p> <p>6. The CNA assignment sheets provided by the DON on 1/27/16 at 2:00 P.M., indicated the following:</p> <p>West Hall: (Total of 36 residents): Required assist of staff for transfers: 36 residents Require assist of 2 staff for transfer: 18 residents At risk to experience a fall: 15 residents Required mechanical lift for transfer: 4</p>		<p>in-service has been provided for all staff on their responsibility to ensure that each resident receives the necessary care and services to meet their individualized needs in a timely manner.</p> <p><i>The corrective action taken to monitor to assure compliance is that a Quality Assurance tool has been developed and implemented to ensure that each resident is receiving the necessary care and services by facility staff in a timely manner. This tool will include observation of staff providing care in addition to resident interviews. This tool will be completed by the Director of Nursing and/or her designee daily for one week, then weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted.</i></p>	

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	<p>residents Required staff assistance for ADL (Activity of Daily Living) care: 36 residents Incontinent of bladder and/or scheduled toileting plan: 15 residents</p> <p>7. During an interview 1/28/16 at 10:30 A.M. the MDS (Minimum Data Set) Coordinator indicated the West Unit census was 36. The MDS Coordinator further indicated the following: Required assist of staff for transfers: 28 residents At risk to experience a fall: 24 residents Experienced cognitive impairment: 21 residents Experienced pressure related skin impairment: 4 residents At risk to experience pressure related skin impairment: 36 residents</p> <p>8. During an interview on 1/28/16 at 10:50 A.M., the DON indicated the nursing staff on the West unit nursing staff typically worked 12 hour shifts. The DON further indicated the West unit was usually staffed with 2 nurses with 3 CNA's on the first shift and 1 nurse with 3 CNA's on the second shift. The DON then indicated the unit managers don't have set hours, but are usually on the unit by 8:00 A.M. The DON then provided the daily staffing schedules as worked</p>			

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	<p>from 1/1/16 through 1/27/16. The schedules indicated the following:</p> <p>West Unit:</p> <p>1/10/16: 6:00 A.M. to 9:00 A.M.-1 RN/LPN and 1:00 P.M. to 6:00 P.M.-1 RN/LPN</p> <p>1/11/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 2:00 P.M. to 6:00 P.M.-1 CNA, and 12:00 A.M. to 6:00 A.M.-2 CNA's</p> <p>1/12/16: 2:00 P.M. to 8:00 P.M.- 2 CNA's, 8:00 P.M. to 2:00 A.M.-1 CNA, and 2:00 A.M. to 6:00 A.M.-2 CNA's</p> <p>1/13/16: 6:00 P.M. to 6:00 A. M.-2 CNA's</p> <p>1/15/16: 10:00 P.M. to 6:00 A.M.-2 CNA</p> <p>1/16/16: 2:00 P.M. to 6:00 P.M.-1 LPN and 9:00 P.M. to 6:00 A.M.-2 CNA's</p>			

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	1/18/16: 6:00 P.M. to 6:00 A.M.-2 CNA's			
	1/20/16: 10:00 P.M. to 6:00 A.M.-2 CNA's			
	1/21/16: 6:00 A.M. to 8:00 A.M.-2 CNA's and 6:00 P.M. to 6:00 A. M.- 2 CNA's			
	1/22/16: 12:00 A.M. to 6:00 A.M.-1 CNA			
	1/23/16: 6:00 A.M. to 8:00 A.M.-1 CNA and 8:00 P.M. to 6:00 A.M.-2 CNA's			
	1/24/16: 6:00 A.M. to 8:00 A.M.-1 CNA			
	1/25/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 2:00 P.M. to 4:00 P.M.-2 CNA's, 4:00 P.M. to 6:00 P.M.-1 CNA, and 6:00 P.M. to 6:00 A. M.-2 CNA's			
	1/26/16: 6:00 A.M. to 8:00 A.M.-1 QMA, 6:00 A.M. to 8:30 A.M.-1			

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	<p>CNA 6:00 P.M. to 10:00 P.M.- The staffing sheet lacked any documentation to indicate a nurse was assigned, 6:00 P.M. to 6:00 A. M.- 2 CNA's</p> <p>1/27/16: 2:00 P.M. to 6:00 P.M.-1 LPN and 2 CNA's 6:00 P.M. to 8:00 P.M.-1 LPN. 8:00 P.M. to 10:00 P.M.-The staffing sheet lacked any documentation to indicate a nurse was assigned. 6:00 P.M. to 6:00 A.M.-1 CNA</p> <p>9. During a random observation on 2/1/16 at 2:35 P.M. Resident Z was observed sitting in a wheelchair, at a table in the main dining room, moaning. During an interview, at that time, Resident Z indicated he/she needed assistance to go the bathroom. QMA #10 was then alerted to the request of Resident Z. QMA #10 was observed to transfer Resident Z from the main dining room to the West dining room and speak to CNA #16. QMA #10 was then observed to exit the West Unit dining room. CNA #16 was then observed to place Resident Z at a dining room table, near the nursing station, and exit the West Unit dining room. CNA #16 was observed to not speak to any other staff</p>			

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	<p>member before exiting the West Unit dining room. Resident Z was observed from 2/1/16 at 2:37 P.M. through 2:55 P.M. waving at passing staff, moaning, and stating, "please, please". During that time, the UM #1 was observed sitting at the nursing station and the DON was observed standing at the nursing station. On 2/1/16 at 2:55 P.M., the WCN was observed to alert CNA #6 to Resident Z's request and CNA #6 was observed to transfer Resident Z to the bathroom.</p> <p>10. During an interview on 2/1/16 at 2:44 P.M., UM #1 indicated the West Unit current census was 34. UM #1 further indicated the following: Required assist of staff for transfers: 17 residents Required mechanical lift for transfer: 2 residents Required assist of two staff for bed mobility: 4-5 residents At risk to experience a fall: 14 residents Experienced cognitive impairment: 28 residents Required staff assistance for ADL care: 34 residents Incontinent of bladder and/or scheduled toileting plan: 34 residents At risk to experience pressure related skin impairment: 34 residents</p> <p>11. The Resident Council minutes from</p>			

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	<p>November 2015 through January 2016 were reviewed on 2/2/16 at 10:00 A.M. and indicated the following, "...November 2015...they get to [Resident K] too late to roll...bed down...December 2015...they are a little shorthanded sometimes..."</p> <p>12. On 2/2/16 at 2:30 P.M., the HFA (Health Facilities Administrator) indicated all staff should be assisting residents and it should be the usual practice of the facility to ensure staffing was sufficient to meet the needs of the residents.</p> <p>The Policy and Procedure for Staffing provided by the HFA on 2/2/16 at 2:50 P.M. indicated, "...Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide...resident care services...Our facility publicly posts the daily staffing patterns each day to reflect the specific numbers of licensed and unlicensed staff that are available to provide direct patient care on each shift..."</p> <p>3.1-17(a) 3.1-17(b)</p>			

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F 0356 SS=E Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staffing information was posted on a daily basis, for 3 of 5 days the staffing posting was reviewed.</p>	F 0356	<p>F – 356</p> <p>The corrective action taken for those residents found to have been affected by the deficient practice is that all residents</p>	03/03/2016

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	<p>Findings include:</p> <p>The posting for daily staffing was observed on 1/26/16 at 9:00 A.M. to be dated 1/13/16.</p> <p>The posting for daily staffing was observed on 1/27/16 at 2:00 P.M. to be dated 1/26/16. During an interview, at that time, the HFA indicated the DON was responsible to post and update the staffing posting daily.</p> <p>The posting for daily staffing was observed on 1/28/16 at 8:30 A.M. to be dated 1/26/16. During an interview, at that time, the HFA indicated there was no specific policy and procedure for posting the daily staffing information, but it was usual facility practice to follow the regulations.</p> <p>3.1-13(a)</p>		<p>havethe potential to be affected by this deficient practice. Nursing administration is now posting thedaily staffing patterns each day which includes the facility name, currentdate, total number and the actual hours worked for registered nurses, licensedpractical nurses and certified nursing assistants as well as the current dailycensus.</p> <p>The corrective action takenfor the other residents having the potential to be affected by the samedeficient practice is thatall residents have the potential to be affected by this deficient practice. Nursing administration is now posting thedaily staffing patterns each day which includes the facility name, currentdate, total number and the actual hours worked for registered nurses, licensedpractical nurses and certified nursing assistants as well as the current dailycensus.</p> <p>The measures that have beenput into place to ensure that the deficient practice does not recur is that the facility has</p>		

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(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>conducted amandatory in-service for the Director of Nursing and Unit managers on thefacility practice of daily staff postings in accordance with the Federalregulations.</p> <p><i>The corrective action taken to monitor to assurecompliance is that a QualityAssurance tool has been developed and implemented to ensure that the requireddaily staff posting is in place daily in accordance with the Federalregulation. This tool will be completedby the Executive Director and/or his designee daily for one week, then weeklyfor three weeks, then monthly for three months and then quarterly for thre-quarters. The outcome of this tool willbe reviewed at the facility Quality Assurance meeting to determine if anyadditional action is warranted.</i></p>	