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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155389 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/01/2015 |
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| F 0000<br><br>Bldg. 00     | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 24, 25, 26, 29, 30 &amp; July 1, 2015.</p> <p>Facility number: 000473<br/>Provider number: 155389<br/>AIM number: 100290410</p> <p>Census bed type:<br/>SNF/NF: 53<br/>Total: 53</p> <p>Census payor type:<br/>Medicare: 11<br/>Medicaid: 30<br/>Other: 12<br/>Total: 53</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> | F 0000        | <b>Facility is requesting paper compliance for all deficiencies in this POC.</b>                                |                      |
| F 0279<br>SS=D<br>Bldg. 00 | <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS<br/>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive</p>  |               |   |                      |

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

TITLE

(X6) DATE

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

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|                    | <p>care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to create a care plan for diabetes mellitus for 1 of 5 residents reviewed for unnecessary medication. (Resident #74)</p> <p>Findings include:</p> <p>The clinical record for Resident #74 was reviewed on 7/1/15 at 11:30 a.m. The diagnosis for Resident #74 included, but were not limited to, diabetes mellitus.</p> <p>A physician order, dated 8/19/14, indicated Resident #74's blood glucose needed to be checked and recorded at 11:00 a.m. and 9:00 p.m. Staff would need to call doctor if blood sugar is below 70 or above 350.</p> <p>A physician order, dated 4/27/15,</p> | F 0279        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Resident #74 has a care plan that addresses diabetes mellitus. The care plan addresses how the condition is managed and when the doctor is to be notified regarding blood sugar levels. Residents who have diabetes mellitus as a diagnosis have the potential to be affected by this finding. An audit of all residents' medical records was conducted to identify those with diabetes mellitus. Their care plans were reviewed and updated to include how their diabetes mellitus is being managed and when the doctor is to be notified regarding their blood sugar levels. The DON/Designee will review all new admissions as well as all orders received to ensure that diabetic residents have a care plan in</p> | 07/31/2015           |

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|                    | <p>indicated Resident #74 to be given Metformin 500 mg by mouth twice daily.</p> <p>A physician order, dated 6/23/15, indicated Resident #74 to be given Novolin 70/30 6 units subcutaneously before breakfast.</p> <p>Resident #74's clinical record did not include a care plan for diabetes mellitus.</p> <p>An interview was conducted with the Assistant Director of Nursing on 7/1/15 at 12:31 p.m. She could not locate a care plan regarding diabetes mellitus and Resident #74 should have one.</p> <p>The facility care plan policy was provided by the Administrator on 7/1/15 at 9:05 a.m. It indicated the following: "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs, and strengths that will identify how the interdisciplinary team will provide care...Procedure: This is completed in the PCC (facility database) care plan section and/or hard section of the record....For each problem, need or strength a resident-centered goal is developed. Whenever possible the goal should be measurable (i.e., walk from nurses station to room by the next review of care plan)....Staff approaches are to be</p> |               | <p>place that addresses their diabetes and is current. This monitoring will be ongoing as part of the daily CQI (Quality Assurance) meetings. The DON/Designee will monitor all care plans of the residents who have diabetes as a diagnosis once weekly until 4 consecutive weeks of zero negative findings are achieved. Afterwards, random weekly monitoring will occur for a period of at least 6 months. Then, random monitoring will continue ongoing. Additionally, at the regularly scheduled Care Plan meetings, all care plans of diabetic residents will be reviewed for accuracy and completeness. This will be ongoing. At an inservice held 7/22/15, the nursing staff was re-educated on the necessity of having a current and accurate care plan in place to address diabetes for those residents who have diabetes as a diagnosis. The care plan will indicate how the condition is managed and when the doctor is to be notified regarding blood sugar levels. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as needed. At the monthly Quality Assurance meetings, the results of the monitoring of the care plans will be reviewed. Any concerns will have been addressed as discovered.</p> |                      |

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| F 0280<br>SS=E<br>Bldg. 00 | <p>developed for each problem/strength need. When possible, more than one discipline per approach is to be documented on the care plan or all disciplines are responsible for that approach"...</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2)<br/>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to revise/update a dental care plan, a dialysis care plan, an at risk for skin integrity issues care plan, a pressure ulcer care plan, an at risk for falls care plan, and a self care deficit care plan for 4 of</p> | F 0280        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Residents #27, #30, #59 and #51 have all had their care plans reviewed and updated. All of these care plans address the areas of focus for comprehensive</p> | 07/31/2015           |

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|                    | <p>13 residents reviewed for care plans. (Resident #27, #30, #59 &amp; #51)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #51 was reviewed on 6/26/15 at 9:30 a.m. The diagnoses for Resident #51 included, but were not limited to, edentulous.</p> <p>An observation of Resident #51 was made on 6/26/15 at 9:45 a.m. She had no teeth or dentures in her mouth.</p> <p>An interview was conducted with Resident #51 on 6/26/15 at 9:43 a.m. She indicated she had dentures, but they didn't fit, so she didn't wear them.</p> <p>An interview was conducted with Resident #51 on 6/29/15 at 12:03 p.m. She was not wearing her dentures at this time, and indicated her dentures were "just made weird."</p> <p>An observation of Resident #51 was made on 6/30/15 at 10:04 a.m. She was not wearing her dentures. She indicated she had not worn them in months, since she realized they didn't fit."</p> <p>An observation of Resident #51 was made on 6/30/15 at 12:17 p.m. She was eating lunch in her room without her</p> |               | <p>care of these residents with appropriate interventions and measureable goals. This includes but is not limited to any concerns with dental/denture issues, dialysis, skin issues and/or pressure ulcers and fall risk. The facility has policies and procedures to address these concerns including a policy on managing and caring for residents who receive dialysis. Residents who reside in the facility require comprehensive care plans, so all residents in the facility have the potential to be affected by this finding. The DON/Designee will review 10 care plans weekly to ensure that the care plans are comprehensive, timely and accurate. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 care plans will be monitored weekly for a period of not less than 6 months. Care plans will continue to be monitored at their regularly scheduled times ongoing. Any concerns discovered during the monitoring will be immediately corrected. At an inservice held 7/22/15, the IDT Team and the nursing staff were re-educated as to the care plan process and the policy on care planning as well as the explanation in the federal guidelines for care planning requirements. Any staff who fail to comply with their role requirement in the care plan</p> |                      |

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|                    | <p>dentures.</p> <p>The 6/17/15 IDT (Interdisciplinary Team) note indicated Resident #51's care plans were reviewed.</p> <p>None of Resident #51's care plans indicated her preference not to wear her dentures, including her dental care plan.</p> <p>An interview was conducted with the SSD (Social Services Director) on 6/30/15 at 9:50 a.m. She indicated she was unaware Resident #51 did not wear her dentures. She indicated, if Resident #51 did not wear her dentures, it would be her or the MDS Coordinator's responsibility to update the care plan to reflect this.</p> <p>2. The clinical record for Resident #27 was reviewed on 6/26/15 at 2:45 p.m. The diagnoses for Resident #27 included, but were not limited to, end stage renal disease and renal dialysis status.</p> <p>A Physician's Order, dated 4/29/15, indicated to check left arm every shift for thrill and bruit (sounds made at dialysis access site).</p> <p>Readmission Physician's Orders, dated 6/7/15, did not indicate an order to check Resident 27's dialysis access site for thrill or bruit.</p> |               | <p>process will be further educated and/or progressively disciplined as indicated. At the daily CQI meetings, needed additions or changes in the care plans will be discussed based on the CQI meeting discussion as well as any new orders received.</p> <p>Additionally, all care plan monitoring will be reviewed at the monthly Quality Assurance meetings. Any patterns will be addressed by an Action Plan written by the QA committee. The plan will be reviewed by the Administrator weekly until resolution is achieved.</p> |                      |

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|                    | <p>Resident #27's Dialysis Care Plan, no date but remained current at time of review, did not include an intervention to check the bruit/thrill every day/shift.</p> <p>The MDS Coordinator indicated, on 6/29/15 at 3:03 p.m., the dialysis care plan should follow what the Physician's Orders are and what the facility policy says.</p> <p>The Administrator indicated on 6/30/15 at 2:55 p.m., the facility did not have a policy on how to care for dialysis residents or their dialysis access sites. The Administrator further indicated the facility will get an order to monitor Resident #27's dialysis access site daily/shift, so that it will be consistently done.</p> <p>3a. The clinical record for Resident #30 was reviewed on 6/29/15 at 2:45 p.m. The diagnoses for Resident #30 included, but were not limited to, end stage renal disease, vascular dementia, and hand contractures.</p> <p>A Physician's Order, dated 4/7/15, indicated to discontinue use of palm protectors due to skin integrity issues.</p> <p>A Potential for Skin Breakdown care</p> |               |   |                      |

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|                    | <p>plan, no date but remained current at time of review, indicated an intervention for palm protectors at all times to both hands, except for bathing, meals, and completing transfers.</p> <p>3b. A Physician's Order for Resident #30, dated 6/23/15, indicated an order for granulex (wound medication) to wound bed on the right hand with medi-honey (wound dressing/medication) cut to size of wound bed and wrap kerlix (dressing) loosely around hand every day. The order also indicated to discontinue all previous wound care orders to right hand wound.</p> <p>A Skin Assessment, dated 6/2/15, indicated the pressure ulcer to the left hand had healed.</p> <p>A Pressure Ulcer Care Plan, no date but remained current at time of review, indicated to apply granulex to left hand wound daily and to apply vaseline to each hand daily.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 7/1/15 at 12:50 p.m., the ADON indicated the Potential for Skin Breakdown Care Plan and the Pressure Ulcer Care Plan should've been revised to reflect the current orders for Resident #30.</p> |               |   |                      |

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|  | <p>4a. The clinical record for Resident #59 was reviewed on 6/30/15 at 11:45 a.m. The diagnoses for Resident #59 included, but were not limited to, malignant neoplasm of intrahepatic bile ducts, unspecified debility, and diabetes mellitus.</p> <p>A Self Care Deficit Care Plan indicated interventions of Occupational Therapy (OT) for self care training with compensatory strategies and assistive device training to be provided 5-7 times a week and Physical Therapy (PT) to be provided 5-7 times a week for strength exercise and gait training. These interventions were dated 3/31/15.</p> <p>During an interview with Resident #59, on 6/30/15 at 11:20 a.m., Resident #59 indicated she was no longer in therapy but was in a restorative program.</p> <p>A Referral to Nursing form, dated 6/10/15, indicated Resident #59 was discharged from PT/OT and to provide bilateral upper extremities exercises with a 1 pound weight for 2 sets of 20 reps, all planes. The form also indicated to assist with ambulation with a rolling walker/wheelchair for 200 feet in the hallway for 3 times a day.</p> |  |  |  |
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| F 0309<br>SS=D<br>Bldg. 00                                      | <p>4b. An At Risk for Falls Care Plan for Resident #59 indicated interventions of Occupational Therapy for self care training with assistive device training and balance/coordination training to be provided 5-7 times a week and Physical Therapy to be provided 5-7 times a week for strength exercise, gait training, and safety and fall risk reduction. These interventions were dated 3/31/15.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 7/1/15 at 9:52 a.m., the ADON indicated the self care deficit and at risk for falls care plans should have been revised to remove the PT/OT participation interventions and to include the restorative exercises listed above as interventions.</p> <p>A policy titled, Care Plans, dated 2/2/15, was received from the Administrator at 9:05 a.m., on 7/1/15. The policy indicated, "...All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition...."</p> <p>3.1-35(d)(2)(B)</p> <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>Each resident must receive and the facility</p> |   |   |   |  |   |  |

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|                    | <p>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 interview, and record review, the facility failed to monitor a resident's dialysis access site daily for 1 of 1 resident reviewed for dialysis. (Resident #27)</p> <p>Findings include:</p> <p>The clinical record for Resident #27 was reviewed on 6/26/15 at 2:45 p.m. The diagnoses for Resident #27 included, but were not limited to, end stage renal disease and renal dialysis status.</p> <p>A Physician's Order, dated 4/29/15, indicated to check left arm every shift for thrill and bruit (sounds made at dialysis access site).</p> <p>Readmission Physician's Orders, dated 6/7/15, did not indicate an order to check Resident #27's dialysis access site for thrill or bruit.</p> <p>During an interview with RN #2, on 6/29/15 at 11:15 a.m., RN #2 indicated a Resident that has a dialysis access site, should have their site checked daily for the bruit and thrill. RN #2 further</p> | F 0309        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Resident #27 has a current and comprehensive care plan which addresses their care as related to receiving dialysis as well as care of the access site. This is in accordance with the facility's policy on dialysis care for residents who receive dialysis. All necessary orders are in place and being followed. Any resident who receives dialysis has the potential to be affected by this finding. The DON/Designee will monitor any new admissions who receive dialysis to be sure that a comprehensive care plan is in place as well as any necessary related orders. Further, daily at the CQI meetings as orders are reviewed, any pertaining to dialysis will be integrated into the care plan. The DON/Designee will monitor all residents who receive dialysis 3 days weekly to see that the access site is being properly monitored and that the care plan interventions are being implemented. Additionally, that proper documentation is completed. The monitoring will continue until 4 consecutive weeks of zero negative findings</p> | 07/31/2015           |

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|                    | <p>indicated there should be an order to monitor/observe the site daily and the observation should be marked on the medication administration record (MAR).</p> <p>On 6/29/15 at 12:20 p.m., Resident #27 indicated staff does not consistently look at her dialysis access site every day.</p> <p>A 14-day MDS (minimum data set) assessment, dated 6/21/15, indicated the BIMS (brief interview of mental status) of Resident #27 was 15, which was indicative of no cognitive impairment.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 6/29/15 at 2:50 p.m., the ADON indicated dialysis access site observation/monitoring was a nursing measure and there does not need to be an order to check the site daily/every shift. The ADON further indicated Nursing should document in the Resident's Progress Notes when the dialysis access site was observed and follow what the Resident care plan says regarding site observation/monitoring.</p> <p>Resident #27's dialysis care plan did not include an intervention to check the bruit/thrill every day/shift.</p> <p>A review of the Progress Notes for</p> |               | <p>are achieved. Afterwards, random weekly monitoring will occur for at least 6 months to ensure ongoing compliance. Then random monitoring will continue. Any concerns will be addressed as found. At an inservice held 7/22/15, for nursing staff, all points of the policy related to residents who receive dialysis were reviewed including care of the access site. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings, results of the monitoring will be reviewed for any patterns, however, any concerns will have been corrected upon discovery.</p> |                      |

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| F 0329<br>SS=D<br>Bldg. 00 | <p>Resident #27 indicated the dialysis access sites was checked on the following days since readmission to the facility on 6/7/15, 6/21/15, 6/20/15, 6/19/15, 6/17/15, 6/16/15, 6/14/15, 6/13/15, 6/12/15, 6/11/15, 6/10/15, 6/9/15.</p> <p>The Administrator indicated on 6/30/15 at 2:55 p.m., the facility did not have a policy on how to care for dialysis residents or their dialysis access sites. The Administrator further indicated the facility will get an order to monitor Resident #27's dialysis access site daily/shift, so that it will be consistently done.</p> <p>3.1-37(a)</p> <p>483.25(l)<br/>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br/>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to</p> |               |   |                      |

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|                    | <p>treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a resident was assessed for the nature or intensity of her pain prior to administration, non-pharmacological interventions were tried prior to administration, and for the effectiveness of the medication after the administrations of PRN (as needed) medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #51)</p> <p>Findings include</p> <p>The clinical record for Resident #51 was reviewed on 6/30/15 at 2:00 p.m. The diagnoses for Resident #51 included, but were not limited to: neuropathy, restless leg syndrome, and headaches.</p> <p>The potential for alteration in comfort care plan, with a target goal date of 9/8/15, indicated an intervention was to monitor for effectiveness of pain medications.</p> <p>The June, 2015 Physician's Orders for Resident #51 indicated two 325 mg</p> | F 0329        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Resident #51 has a comprehensive care plan related to pain and pain management. Prior to receiving "prn" (as needed) pain medication, Resident #51 is assessed for intensity of pain.</p> <p>Non-pharmacological Interventions which are attempted to relieve the pain are documented. After any dose of "prn" pain medication is administered, the effectiveness of it and of any other intervention to relieve pain will be documented. Any resident who experiences episodes of pain and receives prn pain medication has the potential to be affected by this finding. A "look back" audit was conducted to identify targeted residents who have chronic or occasional pain with the focus on those who receive prn pain meds. These residents had their records reviewed to be sure they had a current (within 30 days) pain assessment as well as an individualized care plan for their pain management. The DON/Designee will monitor the</p> | 07/31/2015           |

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|                    | <p>tablets of acetaminophen to be taken every 6 hours as needed for pain.</p> <p>The June, 2015 MAR (medication administration record) indicated Resident #51 was administered as needed acetaminophen on the following dates: 6/2/15, 6/5/15, 6/8/15, 6/9/15, 6/20/15, 6/21/15, 6/22/15, 6/23/15, 6/24/15, 6/27/15, 6/28/15, and 6/29/15.</p> <p>The reason for the above administrations, the intensity of the pain prior to the administrations, the non-medicinal pain management interventions tried prior to the administrations, and the effectiveness of the above administrations were not found in the clinical record.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) on 7/1/15 at 10:03 a.m. She indicated nursing staff should be assessing Resident #51 for the reason she wants the medication and whether it was effective afterwards. She indicated this information should have been documented in the nurses notes or on the back of the MAR. She indicated she could not find any verification assessments were done for Resident #51's June, 2015 prn acetaminophen administrations.</p> |               | <p>administration of prn pain meds on 5 residents who receive prn pain meds 3 days weekly to see that: a.) Pain was assessed prior to pain med administration b.) Any non-pharmacological intervention and its effectiveness is documented c.) Any prn med given is documented, as well as the effectiveness This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, random monitoring will continue weekly for at least 6 months to ensure ongoing compliance. Then random monitoring will be ongoing. Any concerns will be addressed as found. At an inservice held 7/22/15, for the nursing staff, the facility's policy on Pain Management was reviewed with the emphasis on assessment, non-pharmacological interventions and their effectiveness, pain med administration and its effectiveness as well as all related required documentation. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. At the monthly QA meetings the results of the monitoring will be reviewed. Any patterns will be addressed. An Action Plan will be written by the QA committee as necessary. The Administrator will monitor the Action Plan weekly until</p> |                      |

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| F 0441<br>SS=D<br>Bldg. 00 | <p>An interview was conducted with Resident #51 on 7/1/15 at 10:27 a.m. She indicated nursing would "sometimes" assess her for the effectiveness of the acetaminophen after administration. She indicated, "If it's a bad headache, they come back and ask. If it's not, they don't."</p> <p>The Pain Assessment and Management policy was provided by the ADON on 7/1/15 at 10:03 a.m. It indicated, "2) Non-medication pain management interventions must be considered prior to the administration of medication. 3) Residents who receive a PRN pain medication will be assessed for the effectiveness. 4) Document the results of the PRN pain medication on the back of the MAR and contact the physician if needed."</p> <p>3.1-48(a)(6)</p> <p>483.65<br/>INFECTION CONTROL, PREVENT SPREAD, LINENS<br/>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program<br/>The facility must establish an Infection Control Program under which it -</p> |               | resolution. However, all concerns will be addressed as found.   |                      |

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|                    | <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens<br/>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to utilize infection control practices during a wound dressing change for 1 of 3 resident's reviewed for pressure ulcers. (Resident #22)</p> <p>Findings include:</p> <p>The clinical record for Resident #22 was reviewed on 6/29/15 at 8:30 a.m. The diagnosis for Resident #22 included, but</p> | F 0441        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Resident #22 has their dressing changed using the proper technique as related to infection control practices. Hand hygiene and appropriate donning and discarding of gloves as well as establishing the appropriate "clean" field is being done.</p> <p>Residents who receive dressing changes have the potential to be affected by this finding. The</p> | 07/31/2015           |

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|                    | <p>were not limited to, left hip joint replacement.</p> <p>A physician order dated, 6/11/15, indicated Resident #22's treatment order for her sacral wound was the following: Clean the open area with normal saline and apply santyl to the wound bed. Then pack loosely with calcium alginate the open area and cover with a dry dressing. The wound dressing is to be changed every day and as needed for soilage.</p> <p>An observation was made on 6/29/15 at 1:07 p.m., of a wound dressing change. LPN #1 entered Resident #22's room and placed the wound dressing supplies on the right side of the resident's bedside table. The left side of the bedside table was stacked with books and papers. LPN #1 was not observed cleaning the bedside table prior to placing the wound dressing supplies on it. LPN #1 then washed her hands and donned a pair of gloves. LPN #1 assisted Resident #22 on her side and grabbed her urinary catheter bag and placed it on the bed. She then picked up a trash bag off the floor and placed it on the resident's bed. LPN #1 then removed Resident #22's old dressing, and immediately began cleaning the resident's open area. LPN #1 was not observed washing her hands or replacing her gloves prior to cleaning the resident's</p> |               | <p>DON/Designee will observe/monitor 3 dressing changes 3 days weekly to ensure that proper technique is being performed. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Afterwards, random weekly monitoring will occur for at least 6 months to ensure ongoing compliance. Then random monitoring will continue ongoing. Any concerns with technique will be corrected immediately, prior to any breach in technique being committed. At an inservice held 7/22/15, for the nursing staff, clean and sterile dressing techniques was reviewed. This included establishing the proper "field," hand hygiene, and appropriate glove donning and discarding. All nurses have given a successful return demonstration on proper dressing changes. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as indicated. The monitoring results of the dressing changes will be reviewed at the monthly QA meetings. This will be to identify any patterns. However, any concerns will have been identified and corrected as observed.</p> |                      |

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|                    | <p>open area. After cleansing the open area, LPN #1 then applied santyl into the open area and packed the wound using her gloved hand. At this time, she placed gauze on the open area and covered with tape. LPN #1 at this time removed her gloves and washed her hands.</p> <p>An interview was conducted on 6/29/15 at 1:17 p.m. with LPN #1. She indicated she should have changed her gloves after she removed the old dressing.</p> <p>An interview was conducted with the Assistant Director of Nursing on 7/1/15 at 10:00 a.m. She indicated LPN #1 should have changed her gloves after she removed the old dressing.</p> <p>A policy titled, "Dressing Change: Nonsterile (clean) and Sterile (aseptic)" was provided by the Assisted Director of Nursing on 6/30/15 at 10:32 a.m.<br/>"Purpose: Dressing changes are performed according to physician's orders<br/>Non-sterile (clean) dressing changes are appropriate for select wounds such as skin tears or ulcers. Sterile (aseptic) dressing changes are appropriate for surgical wounds and burns as order by physician ...Procedure: ...8. Apply latex free non-sterile gloves 9. Remove soiled dressing and discard in trash bag 10.</p> |               |   |                      |

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| F 0502<br>SS=D<br>Bldg. 00 | <p>Assess wound according to current practice guide 11. Remove latex free non-sterile gloves and discard in trash bag 12. Perform hand hygiene 13. Establish clean field by covering bedside table with paper towels or clean towel ...14. Apply ...latex free non-sterile gloves for non-sterile dressing 15. Cleanse wound per physician ' s order 16. Remove gloves and perform hand hygiene 17. Apply ... latex free non-sterile gloves for non-sterile dressing 18. Apply dressings and secure per physician ' s orders ..."</p> <p>3.1-18(I)</p> <p>483.75(j)(1)<br/>ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interview and record review, the facility failed to ensure lab draws were performed as ordered for 1 of 1 residents reviewed for Pre Admission Screening and Resident Review (Resident #111).</p> <p>Findings include:</p> <p>The clinical record for Resident #111 was reviewed on 6/30/15 at 11:45 a.m. The diagnoses for Resident #111 included,</p> | F 0502        | <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p> <p>Resident #111 has had their TIBC lab test done. Resident #111 receives all ordered labs timely. Their lab results are reported and logged and orders are obtained as indicated. Residents who reside in the facility and who have lab tests ordered have the potential to be affected by this finding. An audit was done to create a targeted list of residents</p> | 07/31/2015           |

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|                    | <p>but were not limited to, bladder cancer, chronic kidney disease and mental retardation.</p> <p>A Physician's Order, dated 6/18/15 at 4:25 p.m., indicated an order for a TIBC (total iron binding capacity-lab to determine amount of iron in blood) lab draw in the a.m.</p> <p>A TIBC lab was not located in the clinical record.</p> <p>During an interview with the Assistant Director of Nursing (ADON), on 7/1/15 at 9:35 a.m., the ADON indicated the lab was ordered but was not drawn by the lab company. She further indicated the lab was drawn the previous evening since the lab was not drawn as originally ordered and the facility maintained a lab tracking form for Residents to ensure labs were drawn as ordered.</p> <p>A lab tracking form was received from the ADON, on 7/1/15 at 10:25 a.m. The lab tracking form for Resident #111 indicated the TIBC was pending on 6/19/15.</p> <p>The ADON indicated, on 7/1/15 at 10:25 a.m., she was unsure why the lab tracking form indicated pending when the lab was not drawn and there was not a</p> |               | <p>who have lab orders. These orders were reviewed to see that they are properly entered on the schedule to be done as well as being placed on the lab tracking log. The DON/Designee will monitor all labs 3 days weekly for timeliness and completion including reporting as indicated. This monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Then, monitoring will occur weekly for a period of at least 6 months to ensure ongoing compliance. Then random monitoring will continue ongoing.</p> <p>At an inservice held 7/22/15, for nurses, the policy on the lab process was reviewed. This included steps from receiving an order until the test results are obtained and the tracking/logging/reporting are completed. Any staff who fail to comply with the points of the inservice will be further educated and/or progressively disciplined as necessary. At the monthly QA meetings, the lab monitoring results will be discussed and reviewed for patterns. However, any concerns will have been addressed as discovered.</p> |                      |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>155389 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____  |                            | X3) DATE SURVEY<br>COMPLETED<br>07/01/2015 |
| NAME OF PROVIDER OR SUPPLIER<br><br>WESTPARK A WATERS COMMUNITY |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1316 N TIBBS AVE<br>INDIANAPOLIS, IN 46222                                      |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
|   | confirmation from the lab company that<br>the TIBC was pending.<br><br>3.1-49(a)   |  |  |                            |  |