STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN47172	

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F0000	This visit was for the Investigation of Complaint IN00101837. This visit resulted in a partially-extended survey - Immediate Jeopardy. Complaint IN00101837 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F224, F225, F226, F280, F281, F282, F309, F314 and F323. Unrelated deficiency cited. Survey dates: January 5 and 6, 2012 Extended survey dates: January 9, 10, and 11, 2012 Facility Number: 010613 Provider Number: 155659 AIM Number: 200221040 Survey Team:. Gloria J. Reisert MSW/TC (1/5, 1/6, 1/9, and 1/10/2012) Avona Connell RN Donna Groan RN Dorothy Navetta RN (1/9 and 1/10/2012) Census Bed Type: SNF: 21 SNF/NF: 82 Total: 103	F0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

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

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	Census Payor Type: Medicare: 47 Medicaid: 39 Other: 17 Total: 103 Sample: 10 Supplemental Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 1/18/12 by Suzanne Williams, RN			

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F0157 SS=G	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. A. Based on record review and interview, the facility to contact a resident's physician and/or the Medical Director, when a resident complained of headache and vomited following a fall with head injury, for 1 of 1 resident reviewed with a head injury from a fall who subsequently died, in a sample of 10. (Resident B)	F0157	It is the policy of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.Resident B expired.	01/30/2012

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	B. Based on record review and interview, the facility failed to notify the physician when blood glucose readings fell below or above physician-set parameters, for 2 of 2 residents reviewed for blood glucose monitoring in a sample of 10 residents. (Residents E and I) Findings include: A.1. The clinical record for Resident B was reviewed on 1/5/12 at 12:55 p.m. The resident's diagnoses included, but were not limited to, metastatic colon cancer, anxiety, COPD (chronic obstructive lung disease) and immobility syndrome. The admission Minimum Data Set (MDS) assessment dated 11/21/11, indicated the resident was cognitively intact and had a fall since admission. Resident Progress Notes included, but were not limited to: 11/16/11 at 9:30 a.m. "This nurse called to pt (patient) room by CNA (certified nursing assistant) pt found sitting on bathroom (sic). Pt A &O (alert & oriented) x 3. No c/o (complaints of) pain or discomfort voiced. When asked what happened pt stating she was standing to transfer to bathroom and was trying to move raised toilet seat over to toilet when she lost her balance & fell. Denies hitting		Resident I no longer resides at the facility. The physician for resident E has been notified of all blood glucose readings that fell below or above the set parameters. Resident E continues with routine blood sugar monitoring and set parameters for physician notification. All residents with a change in condition have the potential to be affected. Nursing Administration will review the 24 Hr report logs on each unit daily to identify residents who have experienced changes requiring notification of physicians and/or responsible party. Licensed staff will be in serviced regarding notification of physicians and/or responsible party whenever a change in resident status has occurred and on Blood Glucose Monitoring (attachment A and B). Education for all new employees will occur at the time of orientation. Nursing Management will review the 24 Hr report logs on each unit daily to identify residents who have experienced changes requiring notification of physicians/responsible party. They will review the residents' records and ensure appropriate follow-up, notification of physician and responsible party, and documentation. Nursing management will sign the 24 HR report log indicating the completion of the audit.Results of the 24 HR report log audits will be reviewed in the IDT morning	

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	head. Skin intact. V/S (vital/signs) stable. Neuro checks initiated. Pt educated to ask for assist when transferring voiced understanding. will cont. (continue) to monitor." 11/24/11 at 11:30 p.m. "CNA answered call light, pt's roommate (sic) was helping pt. by alerting staff that res. rolled out of bed onto floor. Pt laying on L (left) side on floor, pt was seen to be calm, not in any distress skin normal tones, dry, warm to touch. VS (Vital Signs): 119/57 (blood pressure), 76 (pulse), 91% on RA (oxygen saturation on room air), 24 bpm (breaths per minute). No visible injuries, pt able to perform AROM (active range of motion) to all extremities, pat able to move to sitting position unassisted. Nurse & CNA assisted pt to standing position without difficulty no c/o pain. Sitting VS on edge of bed: 114/53, 72, 98.0, 24, 90 %. Notified DNS (Director of Nursing Service), MD & family, no adverse reactions." 11/25/11 at 2:50 a.m. "Pt c/o headache, pt has a small "goose egg" to L (left) side of head, palpated hard to touch, pt states does not hurt when nurse touches, pt emesis 20 ml (milliliters) of clear brown liquid. Gave pt po (by mouth) Tylenol 650 mg PRN (as needed) d/t (due to) Lortab 10/500 not available, pharmacy		meeting 5 times a week for 3 months. Results of the audits will be reviewed monthly at the PI Meeting, where action plans will be developed if indicated until 100% compliance is achieved.The DNS or designee will be responsible to ensure this standard has been met.	

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	sending. Gave pt PRN Zofran for nausea, have a call out to MD. Notified DNS to changes. Will continue to monitor." Documentation was lacking the physician was called again and/or the Medical Director notified. 11/25/11 at 4:10 a.m. "This writer went into check on pt, pt unresponsive, pupils fixed, called in another RN, ox sat 94% on 2 L (liters), 140/59, 79, 30 bpm, called 911 and sent pt to [named hospital] ER (emergency room) for evaluation & treatment, notified DNS & family of transfer. RN stayed with pt until EMS (emergency medical service) arrived." 11/25/11 at 4:30 a.m. "EMS arrived and transported pt to hospital via stretcher...." 11/25/11 at 6:20 p.m. "Res. son, [named] came to facility to pick up Res. belongings and spoke with DNS stating his mother had expired at [different named hospital] ER today." On 1/5/12 at 2:32 p.m., the interim DNS (Director of Nursing Services) indicated RN #1 assessed Resident B at 2:50 a.m., noted the hematoma, and called the MD and DNS. The DNS indicated the RN should have sent her out or called the Medical Director. The DNS indicated the doctor did not call back, the DNS directed			

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	RN #1 to monitor the resident. B.1. Review of the clinical record for Resident #E on 1/5/2012 at 1:45 p.m., indicated the resident had diagnoses which included, but were not limited to, paraplegia, diabetes mellitus, chronic obstructive pulmonary disease, and generalized pain. On 7/18/2011, the physician gave an order for blood glucose monitoring before every meal and at bedtime with sliding scale insulin and indicated he was to be notified if it fell below 60 or above 500. Review of the November 2011 Diabetic Monitoring Flow Sheet indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 11/2 = 1100 [11:00 a.m.] - critical high - 11/3 = 2000 [8:00 p.m.] - 49 - 11/4 = 1600 [4:00 p.m.] - high - 11/8 = 1115 [11:15 a.m.] - high - 11/9 = 1100 - 42 - 11/18 = 2000 - high - 11/22 = 1600 - high -11/24 = 2000 - high - 11/27 = 0600 [6:00 a.m.] - 58 - 11/29 = 1100 - 58 - 11/30 = 0600 - 59 Review of the December 2011 Diabetic Monitoring Flow Sheet indicated the			

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	resident had blood glucose readings which fell outside the set parameters which required physician notification: - 12/4 = 0600 - 27 - 12/7 = 1600 - high - 12/17 = 1100 - 48 Review of the nursing notes between 11/1 and 12/31/2011 lacked documentation of the physician having been notified when the blood glucose levels fell outside the physician set parameters. B.2. Review of the clinical record for Resident #I on 1/6/2012 at 11:50 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus, hypertension and gastroesophageal reflux disease. On 8/31/2011, the physician gave an order for blood glucose monitoring to be done before meals and at bedtime with sliding scale insulin to be administered based on readings and was to be notified if the blood glucose readings fell below 60 or above 500. Review of the October 2011 Diabetic Monitoring Flow Record indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 10/1 = 2000 - high			

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	- 10/2 = 1600 - 58 - 10/25 = 1100 - 48 Review of the November 2011 Diabetic Monitoring Flow Record indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 11/4 = 2000 - high - 11/12 = 1130 - high - 11/16 = 1600 - high - 11/18 = 0945 [9:45 a.m.] - high - 11/23 = 1100 - 58 - 11/25 = 1100 - high - 11/27 = 0600 [6:00 a.m.] - 40 - 11/28 = 0600 - high " = 2000 - high - 11/30 = 1100 - high " = 1900 [7:00 p.m.] - high Review of the nursing notes between 10/1 and 11/30/2011 lacked documentation of the physician having been notified when the blood glucose levels fell outside the physician set parameters. When queried about what to do if blood glucose readings fell outside set parameters, interviews with LPNs [licensed practical nurse] #3, 4 and 5 on 1/6/2012 between 4:35 p.m. and 4:45 p.m., indicated the following: - LPN #5 - "Would call physician is the blood sugars were below 60 or above 500.			

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	- LPN #4 - "Would call the doctor if the blood sugars were above 500 after I re-checked it." - LPN #3 - "If blood sugar was low, I would give orange juice and then re-check it in 15-30 minutes. If it was very high, call the physician." On 1/5/2012 at 4:50 p.m., the District Director of Clinical Operations presented a copy of the facility's current policy and procedure on "Condition Change of a Resident." Review of this policy at this time indicated: "...Definition: IMMEDIATE NOTIFICATION - the physician should be informed at the time the event occurs either directly or by pager...The nurse should not hesitate to contact the physician at any time for a problem that in their judgement requires immediate medical attention...Procedure:...5. Notify the physician of the clinical problems. If the attending is not available, notify the alternate physician on call then Medical Director...11. Monitor and reassess resident's condition and response to the interventions until stable or until emergency personnel arrives and takes over care for transfer to acute care..." This Federal tag is related to Complaint IN00101837.			

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	3.1-5(a)(1) 3.1-5(a)(2)			
F0224 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure residents were not neglected while a staff member visited another resident for personal reasons for 1 of 3 residents reviewed for abuse/neglect in a sample 10. (Resident E) Findings include: On 1/5/12 at 10:20 a.m., the Administrator provided a reportable event for Resident A and E which occurred on 11/19/11. Details of the incident included, but were not limited to, "Details of Incident: (Resident E) reported on 11/19/11 between 10 p.m. and 6 a.m. (LPN #1) gave his roommate, (Resident A), oral sex." On 1/5/12 at 9:15 a.m., when queried, the Administrator indicated the allegation was reported to the State on November 23, 2011. He indicated he had looked at the allegation as "poor conduct." He "looked	F0224	It is the policy of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.Resident A no longer resides at the facility. Resident E has had no adverse effects. LPN #1 was termed on November 22, 2011. Written Performance Improvement was completed with the ED and former DNS.□Residents residing on 200 and 300 halls had the potential to be affected. The Social Services Director and the SS assistant conducted individual resident interviews to determine other possible neglect issues. The ED investigated any identified concerns and assured individualized follow through.The Staff Development Coordinator will in-service the staff on neglect (see attachment C). The Staff Development Coordinator will include information on neglect in the orientation of new personnel. The Social Services Director, or	01/30/2012

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	at the allegation as a nurse made a poor decision. The allegation was reported to a nurse, who called me on Saturday, 11/19/11...(Resident A's) roommate wanted to talk with me. I wasn't looking at it as abuse. The nurse was allowed to work during this time, but put on a different hall. The nurse was termed on Tuesday, November 22, 2011." On 1/5/12 at 4:21 p.m., in interview with Resident E, he indicated "they (Resident A and LPN #1) had been joking around all week with each other and I didn't think anything of it, but that night she asked him if there was anything she could do for him & he told her 'Yes.' He then went into the bathroom, came out, pulled his curtains completely around the bed and she came back in and they went at it. I could hear everything they were doing. I knew something was up as in the month we've been roommates, he never once pulled those curtains. I told ([named] Administrator) and ([named] DNS) the next morning and they said they needed to check into things. ([Named] DNS) gave me her number and said call if anything else was a concern. I did not immediately report it to staff after it happened as you know how things get around. I was not afraid, just made me uncomfortable and didn't want her around me. The next night the nurse worked again and was		her designee, will conduct quarterly interviews to determine areas of neglect and report any indication of neglect to the ED. The Administrator will fully investigate reports of neglect and provide individualized follow through. The ED will review grievances as they are received to identify, investigate and provide individualized follow through for any indications of neglect.The ED and DNS will monitor through observation of resident care, individual resident and family interviews, and review of grievances/concerns, monthly for three months, then at least quarterly, to assure resident needs are not neglected. Results will be addressed monthly in PI meeting, where action plans will be developed if indicated, until 100% is achieved in reporting.The Executive Director or designee will be responsible to ensure this standard has been met.	

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	in/out of the room three times during the night, and in the dark I could hear them. She said one time to ([name] roommate) to just say she was giving him his pills but in the dark. Come on, I know better. I told ([name] Administrator) and ([named] DNS) the next morning that the nurse worked his hall & was in/out of the room several times. ([Named] Administrator) told me that was not right and she should not have been there. I guess they talked with her as she is no longer here. ([Named] roommate, Resident A) and I had it out about this. The nurse denied the behavior, but [Resident A] admitted it and took full responsibility for his actions. I was just uncomfortable especially when she came back in the next night to work our hall. She was in two consecutive nights before no more. I feel safe, secure, good roommate now. She just made me feel uncomfortable that's all. OK now." On 1/5/12 at 4:55 p.m., in interview with the interim Director of Nursing Services, she indicated it (the alleged abuse) would have occurred 11/18/11 through a.m. of 11/19/11 on the 10 - 6 shift. She did not know "she went back into the room second night." At this time, the Administrator indicated "She (LPN#1) visited (Resident A) several times the next night as a visitor. Yes, it was inappropriate for her to go into room. We			

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	were told the next day - Sunday about her coming in & termed her on Monday." The personnel file reviewed indicated the LPN's employment was terminated on Tuesday, November 22, 2011. On 1/6/12 at 8:35 a.m., the Administrator provided the Timecard for LPN #1 which indicated the following: Friday, 11/18/11: In 9:55 PM Out 3:15 AM (11/19/11) In 3:45 AM Out 6:22 AM ; Saturday 11/19/11: In 9:53 PM Out 3:21 AM In 3:51 AM Out 6:01 AM; Sunday 11/20/11: In 9:55 PM Out 1:30 AM In 1:56 AM Out 6:19 AM On 1/5/12 at 10 a.m., the IDNS provided the Daily Assignment Sheets for November 18, 19, 20 which included, but was not limited to: Friday November 18 LPN #1 was assigned to the 200 Hall where Resident A resided. There were 31 residents on the Hall; Saturday, November 19, LPN #1 was assigned to the 300 Hall with 34 residents residing on the hall and on November 20, LPN #1 was assigned to the 200 Hall where Resident A and 29 other residents resided. During an interview with Social Worker #1 on 1/6/2012 at 9:00 a.m., she indicated she was not aware of the incident between the residents and the LPN until on 11/23/2011 - 5 days later - when the			

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	former DNS spoke with Resident #E and she was told to interview other residents. She indicated the Administrator and the former DNS handled everything. This federal tag relates to Complaint IN00101837. 3.1-27(a)(3) 3.1-28(a)			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an alleged incident of abuse was reported immediately and the perpetrator suspended during the investigation for 1	F0225	It is the policy of this facility to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident	01/30/2012

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	of 3 reportable incidents involving 2 residents reviewed in the sample of 10. (Resident A, E) Findings include: On 1/5/12 at 10:20 a.m., the Administrator provided a reportable event for Resident A and E which occurred on 11/19/11. Details of the incident included, but were not limited to, "Details of Incident: (Resident E) reported on 11/19/11 between 10 p.m. and 6 a.m. (LPN #1) gave his roommate, (Resident A), oral sex." On 1/5/12 at 9:15 a.m., when queried, the Administrator indicated the allegation was reported to the State on November 23, 2011. He indicated he had looked at the allegation as "poor conduct." He "looked at the allegation as a nurse made a poor decision. The allegation was reported to a nurse, who called me on Saturday, 11/19/11...(Resident A's) roommate wanted to talk with me. I wasn't looking at it as abuse. The nurse was allowed to work during this time, but put on a different hall. The nurse was termed on Tuesday, November 22, 2011." On 1/5/12 at 4:21 p.m., in interview with Resident E, he indicated "they (Resident A and LPN #1) had been joking around all		property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).Resident A no longer resides at the facility. Resident E has had no adverse effects. LPN #1 was termed on November 22, 2011. Written Performance Improvement was completed with the ED and former DNS.□The Administrator will request the assistance of the Director of Nursing, SSD or their designees to assist with investigations of alleged abuse of residents. Together with the information they gather and any other information gained during the investigation a determination will be made as to the validity of the alleged abuse and implementation of policies and procedures to include: protection of resident(s) involved in allegation; Suspension of staff as indicated, reporting of allegation to state in accordance with federal and state requirements; completion of investigation and follow-up actions.□Education has been provided to staff on what is abuse, reporting of abuse, protecting residents during an investigation and conducting of an investigation of abuse allegations (see attachment D). □The investigation worksheet for Alleged Abuse, Neglect and Exploitation will be initiated at the	

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	week with each other and I didn't think anything of it, but that night she asked him if there was anything she could do for him & he told her 'Yes.' He then went into the bathroom, came out, pulled his curtains completely around the bed and she came back in and they went at it. I could hear everything they were doing. I knew something was up as in the month we've been roommates, he never once pulled those curtains. I told ([named] Administrator) and ([named] DNS) the next morning and they said they needed to check into things. ([Named] DNS) gave me her number and said call if anything else was a concern. I did not immediately report it to staff after it happened as you know how things get around. I was not afraid, just made me uncomfortable and didn't want her around me. The next night the nurse worked again and was in/out of the room three times during the night, and in the dark I could hear them. She said one time to ([name] roommate) to just say she was giving him his pills but in the dark. Come on, I know better. I told ([name] Administrator) and ([named] DNS) the next morning that the nurse worked his hall & was in/out of the room several times. ([Named] Administrator) told me that was not right and she should not have been there. I guess they talked with her as she is no longer here. ([Named] roommate, Resident A) and I		time of the alleged abuse to monitor for compliance. Recommendations will be reviewed monthly for the next three months, then quarterly at the Performance Improvement meeting with subsequent plan of correction developed and implemented as necessary. The Executive Director or designee will be responsible to ensure this standard has been met.	

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	had it out about this. The nurse denied the behavior, but [Resident A] admitted it and took full responsibility for his actions. I was just uncomfortable especially when she came back in the next night to work our hall. She was in two consecutive nights before no more. I feel safe, secure, good roommate now. She just made me feel uncomfortable that's all. OK now." On 1/5/12 at 4:55 p.m., in interview with the interim Director of Nursing Services, she indicated it (the alleged abuse) would have occurred 11/18/11 through a.m. of 11/19/11 on the 10 - 6 shift. She did not know "she went back into the room second night." At this time, the Administrator indicated "She (LPN#1) visited (Resident A) several times the next night as a visitor. Yes, it was inappropriate for her to go into room. We were told the next day - Sunday about her coming in & termed her on Monday." The personnel file reviewed indicated the LPN's employment was terminated on Tuesday, November 22, 2011. On 1/6/12 at 8:35 a.m., the Administrator provided the Timecard for LPN #1 which indicated the following: Friday, 11/18/11: In 9:55 PM Out 3:15 AM (11/19/11) In 3:45 AM Out 6:22 AM ; Saturday 11/19/11: In 9:53 PM Out 3:21 AM In 3:51 AM Out 6:01 AM; Sunday			

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	11/20/11: In 9:55 PM Out 1:30 AM In 1:56 AM Out 6:19 AM On 1/5/12 at 10 a.m., the IDNS provided the Daily Assignment Sheets for November 18, 19, 20 which included, but was not limited to: Friday November 18 LPN #1 was assigned to the 200 Hall where Resident A resided. There were 31 residents on the Hall; Saturday, November 19, LPN #1 was assigned to the 300 Hall with 34 residents residing on the hall and on November 20, LPN #1 was assigned to the 200 Hall where Resident A and 29 other residents resided. This federal tag relates to Complaint IN00101837. 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the policy and procedure was followed for reporting and investigating an allegation of abuse/neglect by a nurse, for 1 of 3 incidents involving 2 residents reviewed	F0226	It is the policy of this facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.The event has been fully	01/30/2012

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	in a sample of 10. (Residents A, E) Findings include: On 1/5/12 at 10:20 a.m., the Administrator provided a reportable event for Resident A and E which occurred on 11/19/11. Details of the incident included, but were not limited to, "Details of Incident: (Resident E) reported on 11/19/11 between 10 p.m. and 6 a.m. (LPN #1) gave his roommate, (Resident A), oral sex." On 1/5/12 at 9:15 a.m., when queried, the Administrator indicated the allegation was reported to the State on November 23, 2011. He indicated he had looked at the allegation as "poor conduct." He "looked at the allegation as a nurse made a poor decision. The allegation was reported to a nurse, who called me on Saturday, 11/19/11...(Resident A's) roommate wanted to talk with me. I wasn't looking at it as abuse. The nurse was allowed to work during this time, but put on a different hall. The nurse was termed on Tuesday, November 22, 2011." On 1/5/12 at 4:21 p.m., in interview with Resident E, he indicated "they (Resident A and LPN #1) had been joking around all week with each other and I didn't think anything of it, but that night she asked		investigated. Resident E received follow up services with SS and nursing and there was no adverse effect. Resident A denied adverse effect and completed therapy at the facility prior to discharge home on 11/23/11. LPN #1 was termed on November 22, 2011. Written Performance Improvement was completed with the ED and former DNS.The Administrator will request the assistance of the Director of Nursing, SSD or their designees to assist with investigations of alleged abuse of residents. Together with the information they gather and any other information gained during the investigation a determination will be made as to the validity of the alleged abuse and implementation of policies and procedures to include: protection of resident(s) involved in allegation; Suspension of staff as indicated, reporting of allegation to state in accordance with federal and state requirements; completion of investigation and follow-up actions.□Education has been provided to staff on what is abuse, reporting of abuse, protecting residents during an investigation and conducting of an investigation of abuse allegations (see attachment D). Injuries of unknown origin and allegations of abuse will be reviewed through the morning report process to ensure that the investigation and reporting	

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	him if there was anything she could do for him & he told her 'Yes.' He then went into the bathroom, came out, pulled his curtains completely around the bed and she came back in and they went at it. I could hear everything they were doing. I knew something was up as in the month we've been roommates, he never once pulled those curtains. I told ([named] Administrator) and ([named] DNS) the next morning and they said they needed to check into things. ([Named] DNS) gave me her number and said call if anything else was a concern. I did not immediately report it to staff after it happened as you know how things get around. I was not afraid, just made me uncomfortable and didn't want her around me. The next night the nurse worked again and was in/out of the room three times during the night, and in the dark I could hear them. She said one time to ([name] roommate) to just say she was giving him his pills but in the dark. Come on, I know better. I told ([name] Administrator) and ([named] DNS) the next morning that the nurse worked his hall & was in/out of the room several times. ([Named] Administrator) told me that was not right and she should not have been there. I guess they talked with her as she is no longer here. ([Named] roommate, Resident A) and I had it out about this. The nurse denied the behavior, but [Resident A] admitted it		process are completed and appropriate interventions have been implemented.□□The investigation worksheet for Alleged Abuse, Neglect and Exploitation will be initiated at the time of the alleged abuse to monitor for compliance. Recommendations will be reviewed monthly for the next three months, then quarterly at the Performance Improvement meeting with subsequent plan of correction developed and implemented as necessary, until100% compliance with reporting events are achieved.The Executive Director or designee will be responsible to ensure this standard has been met.	

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	and took full responsibility for his actions. I was just uncomfortable especially when she came back in the next night to work our hall. She was in two consecutive nights before no more. I feel safe, secure, good roommate now. She just made me feel uncomfortable that's all. OK now." On 1/5/12 at 4:55 p.m., in interview with the interim Director of Nursing Services, she indicated it (the alleged abuse) would have occurred 11/18/11 through a.m. of 11/19/11 on the 10 - 6 shift. She did not know "she went back into the room second night." At this time, the Administrator indicated "She (LPN#1) visited (Resident A) several times the next night as a visitor. Yes, it was inappropriate for her to go into room. We were told the next day - Sunday about her coming in & termed her on Monday." The personnel file reviewed indicated the LPN's employment was terminated on Tuesday, November 22, 2011. On 1/6/12 at 8:35 a.m., the Administrator provided the Timecard for LPN #1 which indicated the following: Friday, 11/18/11: In 9:55 PM Out 3:15 AM (11/19/11) In 3:45 AM Out 6:22 AM ; Saturday 11/19/11: In 9:53 PM Out 3:21 AM In 3:51 AM Out 6:01 AM; Sunday 11/20/11: In 9:55 PM Out 1:30 AM In 1:56 AM Out 6:19 AM			

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	On 1/5/12 at 10 a.m., the IDNS provided the Daily Assignment Sheets for November 18, 19, 20 which included, but was not limited to: Friday November 18 LPN #1 was assigned to the 200 Hall where Resident A resided. There were 31 residents on the Hall; Saturday, November 19, LPN #1 was assigned to the 300 Hall with 34 residents residing on the hall and on November 20, LPN #1 was assigned to the 200 Hall where Resident A and 29 other residents resided. On 1/5/12 at 9:25 a.m., the Administrator provided the policy and procedure for "Responding to and Investigating an Abuse Allegation" dated revised 07/22/10, which included, but was not limited to, the following: "Rationale: An employee, a visitor, or another resident can commit resident abuse. Alleged abuse committed by an employee or visitor is covered under this procedure... Procedure: Alleged Sexual Abuse: 1. Appoint someone to stay with resident for protection and comfort. 2. Preserve all physical evidence of assault pending investigation....For All Abuse Allegations: 1. Begin an internal investigation. 2. Immediately report the allegations to the Director of Operations, DDCO (District Director Corporate Operations), Regional Vice President,			

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	Human Resources, and legal counsel. 3. Call the police, if required by law and follow their instructions if there is an alleged: a. Physical abuse, b. Sexual abuse, or c. Theft of resident property. 4. Report the alleged abuse to the appropriate state agencies in accordance with state law. 5. Determine root cause(s) of the event. 6. Plan and implement corrective action. a. Address security issues immediately. b. Seek referral to a psychologist, ombudsman or other appropriate counseling/advocacy agent, as needed for the resident...For All Types of Abuse: 1. Follow the state's regulatory agency reporting requirements for the investigation's findings...5. If allegations against an employee are substantiated, a. Terminate employment, b. Send appropriate notification to the certification/licensure board, and c. Document in the employee's file that they are no longer eligible for re-hire and have been reported to their respective licensure and/or certification board...Documentation Guidelines: 1. Record the resident's physical and psychosocial status and actions taken by clinical personnel in the resident's medical record. 2. Update care plan interventions to address the resident's event outcomes and future risks. 3. Record notification to appropriate state agencies on forms provided by the legal department. 4.			

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	Record notification to police and outcomes of police investigation if applicable." This federal tag relates to Complaint IN00101837. 3.1-28(a)			
F0241 SS=B	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to ensure the residents' dignity was maintained when the residents who ate their meals on their units were served breakfast on styrofoam plates. This affected 65 of 102 residents being served breakfast on 4 of 4 units. Findings include: On 1/10/2012 at 7:40 a.m., upon entrance into the north activity room, it was observed that residents were being served breakfast on styrofoam plates. Upon further investigation down the 400 hall, residents were also being served breakfast on styrofoam plates in their rooms. On 1/10/2012 at 8:00 a.m., it was observed that a senior breakfast was	F0241	It is the policy of this facility to 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 this or her individuality.Sixty-five residents were served breakfast on Styrofoam plates, 3 of the 65 residents did not like the Styrofoam plates. All residents had the opportunity to eat in the main dining room at the Senior Breakfast where flatware was served. The SSD and nursing management identified through individual interviews those residents who feel they were not treated in a manner that maintains or enhances their dignity and their care plans have been updated to reflect their preference for not using Styrofoam plates at meals. In the event that Styrofoam plates need	01/30/2012

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	served for the outside community in the main dining room and they were being served on regular plates. Residents were allowed to attend breakfast in the main dining room if they chose, and five residents were observed to be present. On 1/10/2012 at 8:10 a.m., in an interview with the Dietary Manager #1, she indicated the residents were served on styrofoam plates because it would take too long to wash the plates. A piece for the dishwasher was missing and had been ordered, and they could only wash one tray of plates at a time. On 1/10/2012 at 8:15 a.m., in an interview with the Chef #1, he indicated he didn't think of "that" (how it affected dignity), but that he understands now and "it won't happen again." 3.1-3(t)		to be utilized for meal service, the ED will be notified for accurate implementation of Basic Resident Meal Service and the use of Styrofoam plates. The ED provided Morrison's contracted food services with written communication regarding Policy and Procedures for Basic Resident Meal Service (see attachment E). The Activity Director, or her designee, will poll residents each month at the Resident Council meeting as to whether they are being treated with dignity and respect and will report any complaints to the ED for follow through. The Social Services Director, or her designee, will conduct individual resident interviews quarterly to ascertain if the residents are being treated with respect and dignity and report any complaints to the ED for follow through. Results will be addressed monthly in PI meeting, where action plans will be developed if indicated,and 100% compliance is achieved.The Executive Director of designee will be responsible to ensure this standard has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
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F0280 SS=D	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. 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. Based on record review and interview, the facility failed to ensure the care plan was updated for 1 of 4 residents in a sample of 10 residents who was admitted with no pressure areas, and developed areas on the bilateral heels (Resident #A), failed to update the care plan with new interventions for a resident reviewed with falls for 1 of 2 residents reviewed for falls in a supplemental sample of 3 (Resident #L), and failed to update the care plan for changes in Code Status (whether to use life-saving measures) and discharge planning for 1 of 2 residents in a sample of 10 residents reviewed for comfort care (Resident #G). Findings include:	F0280	It is the policy of this facility develop comprehensive care plans 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.Resident A no longer resides in the facility. Resident G expired. Resident L has care plan updated and implemented for interventions to	01/30/2012

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	1. The clinical record for Resident #A was reviewed on 1/5/12 at 10:35 a.m. The resident's diagnoses included, but were not limited to right fractured acetabular (hip) open reduction and diabetes mellitus. The resident was admitted to the facility on 10/20/11. The admission assessment Minimum Data Set (MDS) dated 10/27/2011, included, but was not limited to: the resident was cognitively intact and was at risk for developing pressure ulcers, The Interim Plan of Care, which was not dated, indicated: "Skin Integrity Wound Care R (right) hip incision on admission; Problem: Risk for Skin Impairment; Goal: Pt (patient) will experience no breakdown x 40 days; Approach: 1. Weekly skin assessments; 2. Preventative Care; 3. Notify MD of any changes." A Comprehensive Care Plan Report dated 10/27/11, indicated: "Problem 12. Skin/tissue integrity impaired potential," with a hand written note on 11/1 "NS R heel (nonstageable area on right heel); Goal 1. 10/27/11 incision heal w/o (without) s/s (signs/symptoms) infection, skin remain free of breakdown; Est (estimated) Date 1/24/12; Approach: 1. 10/27/11 Pressure reduction bed and w/c		prevent falls.All residents with pressure ulcers, at risk for pressure ulcers, at risk for a fall or that have had a fall, and residents with a change in code status and discharge plans have the potential to be affected. The DNS and IDT will review the residents' care plans to ensure they are current and complete with accuracy for specific needs related to pressure ulcer interventions, interventions to reduce risk of accidents, Code status and discharge plans. The care plan will be re-evaluated and modified quarterly with assessments and as necesssary to reflect changes in care, service and treatment. The IDT will review the care plan with resident change in care, service and treatment Q am for accuracy in completion x 3 months. All findings will be reviewed in monthly PI meeting for 100% compliance.The DNS or designee will be responsible to ensure this standard has been met.	

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	(wheelchair); staff assist to T/P (turn/position) Q (every) 2 hours in bed; txs (treatments) as MD orders; Monitor skin for changes; Weekly skin assessments; Monitor incision for s/s infection thru healing 11/4 Dr. [name] wound specialist to eval (evaluate) and tx (treat)." A "Physician Telephone Order" dated 11/10/11 1510 (3:10 p.m.), indicated, "1. D/C (discontinue) skin prep to R heel 2. Aquaphor to R heel/foot BID (twice a day) 3. Elevate R heel off of bed 4. Shoe to R foot only with PT [physical therapy] (ok to wear splint at all time)." Documentation was lacking of the care plan being updated on 11/10/11 to include the skin treatment ordered by the MD. 2. The clinical record for Resident L was reviewed on 1/6/12 at 1:25 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, congestive heart failure and dementia with behaviors. The resident was admitted to the facility on 8/9/11 and readmitted on 12/28/11. The Quarterly Minimum Data Set dated 11/5/2011, included, but was not limited to: the resident was cognitively intact and had no falls since admission or the prior assessment. The Resident Progress Notes dated			

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	12/18/2011, included, but were not limited to: 12/18/11 6 a.m. "Pt (patient) found on floor in front of bed by CNA (Certified Nursing Assistant). Pt refused to stay sitting and raised herself up to bed. Refused to let me get BP (blood pressure) and vitals. Pt then threw can of Nepro (supplement) at me and was making threatening comments that she would kill me. After this she began to throw fruit and other things in her reach. Tried again for Vitals and BP was 170/90 HR (heart rate)105. Pt would not allow for an O2 (oxygen) (sic). Left room to call DON (Director of Nursing) and aide yelled for me again. Found pt throwing her potted plants at the window. Unable to reach DON at this time, call NP (Nurse Practitioner) and sent pt. to [named hospital]. Left message with family to call facility. EMS (Emergency Medical Service) arrived to pick up pt. and she cont. (continued) with threatening comments and gestures. Took pt blood sugar was 278..." 12/18/11 10:00 a.m. "Res returned to facility [named hospital] ER (emergency room) called with report stating Res was DX (diagnosed) with UTI (urinary tract infection) low potassium level no injury noted from fall x-rays (-) [negative] for Fx (fracture). Res alert with some confusion			

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	noted neuro checks initiated Vitals WNL (within normal limits) PERL (pupils equal react to light) moves extremities without difficulty no c/o pain. Requires ext. (extensive) assist of i with transfers & ADL's (Activities of Daily Living). Spoke with Res son made aware of Res' return to facility...." 12/18/11 11:00 a.m. "This nurse called to Res room found sitting in floor by bed near heating unit. C/o Bil. (bilateral) hip and lower back pain. Res left on floor as found with staff remaining @ side. NP aware order to send to [named hospital] for eval EMS notified Res BP -160/78 p - 92 R - 20 T - 98.9 Blood Sugar 217. Res alert able to recall her name, place, this nurses name, year but disoriented stating she got out of bed to get the "Bomb" by the heater explained to Res. the item was her water bottle. Res states "I know but it's a bomb it's gonna blow us all up. I know what's going on here they're making a movie and I'm gonna blow it up." Unable to reorientate (sic) Res EMS transferred Res to stretcher remains confused...." The Post Fall Evaluations dated 12/18/11 for 6:00 a.m. and 11:00 a.m. were reviewed by the IDT (Interdisciplinary Team) on 12/19/11 with no new Intervention Recommendations.			

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	The Comprehensive Care Plan dated 8/18/2011, reviewed with the clinical record, included, but was not limited to: "Problem 8: 11/7/11 Potential for falls/injury related to immobility, weakness and psychoactive med use; Goal 3/7/12 1. Falls risk related injuries will be minimized; Hand Written: 8/31/11 Fall - Preventive Mattress; 12/18/11 fall - found on floor @ 0600 @ bedside sent to hosp. for eval & treat." There were no new interventions documented. "12/18/11 @ 1100 Fall found on floor @ bedside - neuro checks sent to hosp for eval & treat." No new interventions were documented on the care plan. On 1/6/12 in interview with the Central Supply Director, he indicated he was responsible for updating the CNA assignment sheets with the interventions which would be added to the care plan. 3. Review of the clinical record for Resident #G on 1/5/2012 at 10:35 a.m., indicated the resident had diagnoses which included, but were not limited to: weakness, hypertension, status post dehydration, and arteriosclerotic cardiac disease. Review of the nursing notes indicated on 12/22/2011, the resident was sent to the			

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	hospital with altered mental status, slurred speech for two days and trouble swallowing. She returned on 12/29/2011. On 12/30/2011, the family decided that the resident would not want to be a Full Code anymore and requested she be made a DNR [Do Not Resuscitate]. The discharge plan was also changed and the resident would be on comfort measures only remaining in the facility. Review of the care plans included, but were not limited to: "Discharge Is Anticipated" and "Resident Is A Full Code", both with an effective date of 11/21/2011. Documentation was lacking of the care plans being updated to reflect the current status of the resident's code and discharge status. During an interview with LPN #5 on 1/6/2012 at 4:35 p.m., she indicated the MDS [Minimum Data Set] Coordinator does the updates to the care plans. In an interview with the MDS coordinator on 1/6/2012 at 4:50 p.m., she indicated any nurse or staff can update a care plan at any time. On 1/5/2012 at 2:15 p.m., LPN #6 presented a copy of the facility's current policy and procedure on "Comprehensive			

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	Plan of Care." Review of this policy at this time included, but was not limited to: "Rationale:...The care plan is re-evaluated and modified: As necessary to reflect changes in care, service and treatment;...and, With significant change of condition assessment...Procedure:...25. Update the care plan during the course of care delivery to reflect:...c. New Problems (resultant of change of condition or resident event); or d. Modified interventions (resultant of change of condition or resident event)...Documentation Guidelines: 1. Care Plan identifies: a. Resident centered problems/needs/strengths; b. related diagnosis and conditions...." This Federal tag is related to Complaint IN00101837. 3.1-35(d)(1) 3.1-35(d)(2)(B) 3.1-35(e)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to provide services which met professional standards of care by a nurse in that inappropriate interpersonal behavior occurred during provision of	F0281	It is the policy of this facility to provide or arrange for services that meet professional standards of quality.Resident E received follow up services with SS and nursing and there was no adverse	01/30/2012

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	care to 1 of 10 residents reviewed for quality of care in a sample of 10 residents. (Resident A) Finding includes: On 1/5/12 at 10:20 a.m., the Administrator provided a reportable event for Resident A and E which occurred on 11/19/11. Details of the incident included, but were not limited to, "Details of Incident: (Resident E) reported on 11/19/11 between 10 p.m. and 6 a.m. (LPN #1) gave his roommate, (Resident A), oral sex." On 1/5/12 at 9:15 a.m., when queried, the Administrator indicated he had looked at the allegation as "poor conduct." He "looked at the allegation as a nurse made a poor decision. The allegation was reported to a nurse, who called me on Saturday, 11/19/11...(Resident A's) roommate wanted to talk with me...The nurse was allowed to work during this time, but put on a different hall...." On 1/5/12 at 4:21 p.m., in interview with Resident E, he indicated "they (Resident A and LPN #1) had been joking around all week with each other and I didn't think anything of it, but that night she asked him if there was anything she could do for him & he told her 'Yes.' He then went		effect. Resident A denied adverse effect and completed therapy at the facility prior to discharge home on 11/23/11. LPN #1 was termed on November 22, 2011 and investigation of inappropriate behavior reported to the ISDH, APS, Indiana Board of Nursing and Attorney General's Office.□Residents residing on 200 and 300 halls had the potential to be affected. The Social Services Director and the SS assistant conducted individual resident interviews to determine other possible care issues. The ED investigated any identified concerns and assured individualized follow through.□The SDC/designee conducted an in-service with the licensed staff on meeting professional standards with an emphasis on Code of Conduct (see attachment G). The ED and DNS will monitor through observation of resident care, individual resident and family interviews, staff meetings, and review of grievances/concerns, monthly for three months, then at least quarterly, to assure resident are provided care that meets professional standards. Results will be addressed monthly in PI meeting, where action plans will be developed if indicated, until 100% compliance achieved.The Executive Director of designee will be responsible to ensure this standard has been met.	

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	into the bathroom, came out, pulled his curtains completely around the bed and she came back in and they went at it. I could hear everything they were doing. I knew something was up as in the month we've been roommates, he never once pulled those curtains. I told ([named] Administrator) and ([named] DNS) the next morning and they said they needed to check into things. ([Named] DNS) gave me her number and said call if anything else was a concern. I did not immediately report it to staff after it happened as you know how things get around. I was not afraid, just made me uncomfortable and didn't want her around me. The next night the nurse worked again and was in/out of the room three times during the night, and in the dark I could hear them. She said one time to ([name] roommate) to just say she was giving him his pills but in the dark. Come on, I know better. I told ([name] Administrator) and ([named] DNS) the next morning that the nurse worked his hall & was in/out of the room several times. ([Named] Administrator) told me that was not right and she should not have been there. I guess they talked with her as she is no longer here. ([Named] roommate, Resident A) and I had it out about this. The nurse denied the behavior, but [Resident A] admitted it and took full responsibility for his actions. I was just uncomfortable especially when			

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	she came back in the next night to work our hall. She was in two consecutive nights before no more. I feel safe, secure, good roommate now. She just made me feel uncomfortable that's all. OK now." On 1/5/12 at 4:55 p.m., in interview with the interim Director of Nursing Services, she indicated she did not know "she went back into the room second night." At this time, the Administrator indicated "She (LPN#1) visited (Resident A) several times the next night as a visitor. Yes, it was inappropriate for her to go into room. We were told the next day - Sunday about her coming in & termed her on Monday." The personnel file reviewed indicated the LPN's employment was terminated on Tuesday, November 22, 2011. Review of the time clock record presented by the Staffing Coordinator on 1/6/2012 at 2:00 p.m., indicated the LPN worked 11/18, 11/19, and 11/20 before being terminated on 11/22/2011. Review of the Indiana State Board of Nursing, A Compilation of the Indiana Code and Indiana Administrative Code, 2009 Edition, indicated the following in the section titled "Licensed Practical Nursing, Unprofessional Conduct.": "1. Using unsafe judgement, technical skills or inappropriate interpersonal behaviors			

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	in providing care." Review of the facility's Employee Handbook on 1/6/2012 at 3:45 p.m. provided by the Medical Records Clerk, included the following section: "...Code of Conduct: [facility name] requires all employees to perform their job responsibilities in an ethical manner and in accordance with applicable laws. To that end, [facility's] Risk Management and Compliance Program is designed to promote the ethical and legal conduct of all employees at all levels. When you begin employment at [facility], you will be asked to review and sign [facility's] Code of Conduct as a commitment that you will conduct all aspects of your job in an ethical and legal manner. You also will be required to participate in Compliance Program training and review the Code of Conduct annually...all employees are subject to the requirements of the Code of Conduct. [Facility's] Code of Conduct describes the Company's expectations, standards and requirements in its relationships with patients, residents, employees, shareholders, customers and contractors and the communities in which we work. [Facility] requires all employees to comply with all laws and regulations that govern our operations as a healthcare provider, employer and publicly (sic) held company."			

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	Review of LPN #1's personnel file on 1/6/2012 at 11:00 a.m., included a "Disciplinary Action Record" dated 11/22/2011 completed by the former DoN which indicated: "Reason for Disciplinary Action - It was noted or said that employee had unprofessional behaviors/talk toward a patient."..."Has this concern been previously discussed with employee - Yes - on handbook." Review of the LPN's signed Job Description as presented by the Staffing Coordinator on 1/9/2012 at 9:15 a.m., dated 3/30/2011 included, but was not limited to: "...Service Excellence Requirements:..Displays responsibility by taking ownership of quality care...Demonstrates commitment to interpersonal excellence through...a professional attitude..." This Federal tag is related to Complaint IN00101837. 3.1-35(g)(1)			
F0282 SS=D	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 record review and interview, the facility failed to follow the physician's	F0282	It is the policy of this facility to provide or arrange for services to be provided by qualified persons	01/30/2012

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	orders for reporting blood glucose levels which fell above or below the physician-set parameters, for 2 of 2 residents reviewed for blood glucose monitoring in a sample of 10 residents. (Residents #E and I) Findings include: 1. Review of the clinical record for Resident #E on 1/5/2012 at 1:45 p.m., indicated the resident had diagnoses which included, but were not limited to: paraplegia, diabetes mellitus, chronic obstructive pulmonary disease, and generalized pain. On 7/18/2011, the physician gave an order for blood glucose monitoring before every meal and at bedtime with sliding scale insulin and indicated he was to be notified if it fell below 60 or above 500. Review of the November 2011 Diabetic Monitoring Flow Sheet indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 11/2 = 1100 [11:00 a.m.] - critical high - 11/3 = 2000 [8:00 p.m.] - 49 - 11/4 = 1600 [4:00 p.m.] - high - 11/8 = 1115 [11:15 a.m.] - high - 11/9 = 1100 - 42 - 11/18 = 2000 - high		in accordance with each resident's written plan of care.Resident I no longer resides at the facility. The physician for resident E has been notified of all blood glucose readings that fell below or above the set parameters. Resident E continues with routine blood glucose monitoring and set parameters for physician notification. All residents with set parameters for physician notification for Blood Glucose Monitoring have the potential to be affected. All residents with Blood Glucose monitoring have been reviewed and physicians notified of any readings requiring physician notification. The SDC/designee has completed in servicing for all licensed nurses on Blood Glucose Monitoring with emphasis on notifying the physician for readings outside set parameters (see attachment B).The DNS/designee will audit the Blood Glucose Monitoring Record five times a week for notification of Blood Glucose readings requiring physician notification for one month, then three times a week for a month and then once a week for a month. The results of the audit will be discussed at the PI meeting on a monthly basis until 100% compliance has been achieved.The DNS or designee will be responsible to ensure this standard has been met.	

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	- 11/22 = 1600 - high -11/24 = 2000 - high - 11/27 = 0600 [6:00 a.m.] - 58 - 11/29 = 1100 - 58 - 11/30 = 0600 - 59 Review of the December 2011 Diabetic Monitoring Flow Sheet indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 12/4 = 0600 - 27 - 12/7 = 1600 - high - 12/17 = 1100 - 48 2. Review of the clinical record for Resident #I on 1/6/2012 at 11:50 a.m., indicated the resident had diagnoses which included, but were not limited to: diabetes mellitus, hypertension and gastroesophageal reflux disease. On 8/31/2011, the physician gave an order for blood glucose monitoring to be done before meals and at bedtime with sliding scale insulin to be administered based on readings and was to be notified if the blood glucose readings fell below 60 or above 500. Review of the October 2011 Diabetic Monitoring Flow Record indicated the resident had blood glucose readings which fell outside the set parameters which			

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	required physician notification: - 10/1 = 2000 - high - 10/2 = 1600 - 58 - 10/25 = 1100 - 48 Review of the November 2011 Diabetic Monitoring Flow Record indicated the resident had blood glucose readings which fell outside the set parameters which required physician notification: - 11/4 = 2000 - high - 11/12 = 1130 - high - 11/16 = 1600 - high - 11/18 = 0945 [9:45 a.m.] - high - 11/23 = 1100 - 58 - 11/25 = 1100 - high - 11/27 = 0600 [6:00 a.m.] - 40 - 11/28 = 0600 - high " = 2000 - high - 11/30 = 1100 - high " = 1900 [7:00 p.m.] - high When queried about what to do if blood glucose readings fell outside set parameters, interviews with LPNs [licensed practical nurse] #3, 4 and 5 on 1/6/2012 between 4:35 p.m. and 4:45 p.m., indicated the following: - LPN #5 - "Would call physician is the blood sugars were below 60 or above 500. - LPN #4 - "Would call the doctor if the blood sugars were above 500 after I re-checked it." - LPN #3 - "If blood sugar was low, I			

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	would give orange juice and then re-check it in 15-30 minutes. If it was very high, call the physician." On 1/6/2012 at 10:15 a.m., the District Director of Clinical Operations presented a copy of the facility's current policy and procedure on "Blood Glucose Monitoring. " Review of this policy at this time included, but was not limited to: "...27....If the physician has established blood sugar parameters, follow physician's orders..." This Federal tag is related to Complaint IN00101837. 3.1-35(g)(2)			
F0314 SS=J	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure a resident at risk for pressure ulcers and admitted with no skin breakdown received assessments and care to prevent pressure ulcers, resulting in stage 4 pressure ulcers to the heels (Resident C) for 1 of 4 residents reviewed for pressure ulcers in	F0314	It is the policy of this facility to 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	01/30/2012

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	the sample of 10, and a Stage 3 ulcer to the back (Resident M) for 1 of 1 resident reviewed for pressure ulcers in the supplemental sample of 3. In addition to the residents in immediate jeopardy, the facility failed to provide assessment and care to prevent the development of Stage 2 pressure ulcers for 2 of 4 residents reviewed for pressure ulcers in the sample of 10. (Resident A, H) The immediate jeopardy began on 12/26/11 when nursing found a Stage IV pressure ulcer after the resident complained of pain to his heels and the family requested nursing look at his heels. The Administrator and Director of Corporate Operations acting as Interim Director of Nursing Services were notified on 1/09/12 at 11:25 a.m. The immediate jeopardy was removed on 1/10/12 at 9 a.m., but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. The clinical record for Resident C was reviewed on 01/05/2011 at 1:10 p.m. The resident's diagnoses included, but were not limited to, fracture of right humerus (upper arm), hypertension (high blood		infection and prevent new sores from developing.Resident M and resident C have stage 3 and stage 4 pressure ulcers. Resident A completed therapy and was discharged home on 11/23/11. Resident H has a stage 2 pressure ulcer. Resident M, H and C have individualized interventions in place to reduce underlying risk factors and prevent further pressure ulcers. Wound MD is consulting and appropriate treatments implemented. Family members for resident M, H and C have been notified of skin breakdown. Pressure ulcers are assessed weekly including measurements and effectiveness of treatments and interventions. Skin assessment were completed for all residents on 01/10/12. All findings were addressed immediately with MD for treatment orders or pressure ulcer prevention devices. All residents have an updated Braden scale completed to identify residents at risk. RD reviewed and documented on any residents with newly identified pressure areas and those residents identified to be at risk for pressure. All changes will be communicated to staff on the C.N.A. assignment sheets and IDT morning meeting and updated on the care plan. Education started on 01/09/2011 at 1330 and has been completed with all Licensed	

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	pressure), Alzheimer's and depression. The resident was admitted to the facility on 12/04/11 from a hospital. The Transfer Form accompanying the resident upon admission, under the section for wounds and pressure ulcer was blank. The Minimum Data Set (MDS) assessment, completed on 12/13/11, indicated the resident was at risk for developing pressure ulcers. Section V of "Care Area Assessment (CAA) Summary #16 Pressure Ulcer" indicated the "Location and Date of CAA Information" was the H & P (history and physical), TAR (treatment administration record) and ADL (activities of daily living) tracker. The Late Loss ADL Flow Sheet for the month of December 2011 indicated the resident required total assistance of one person physical assist in bed mobility, transfers and toilet use. The history and physical from the hospital indicated, "Extremities: The patient has difficulty in moving his legs, which has been present for some time but worse since fall..." The Patient Nursing Evaluation completed on 12/4/2011, indicated the resident had "yellow bruising across chest, right groin, purple bruising--skin tear right		Nurses and C.N.As on Policies and Procedures related to Prevention and Management of Pressure Ulcers (see attachment H). Monitoring for completion of Weekly skin assessments, admission skin assessments, Braden scales, Performance of treatments, implementation of care plan will be daily for 14 days, then weekly x 6 weeks, then on going in a weekly IDT meeting for Residents with pressure and at high risk for pressure. All findings will be reviewed in monthly PI and revised per the PI committee recommendations.The DNS or designee will be responsible to ensue this standard has been met.	

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	elbow approximately 4 (centimeters) ...buttocks intact." No issues with skin impairment of the heels was noted. Admission orders, dated 12/04/11 and signed by the physician, included to apply skin prep to bilateral heels daily at hour of sleep. The Medication Record used to document treatments was initialed as this treatment being completed on all dates in December with the exception of the 18th, 20th, 21st, and 26th. A care plan dated 12/13/11, indicated the following: "Skin/tissue Integrity Impaired: Potential" Goal: "Will have skin intact" Approach: "Turn & reposition every 2 hours while in bed" "Use positioning and pressure relieving device bed and w/c (wheel chair)" "Report any red or open areas" "Skin checklist per facility policy" Additional problem on 12/26/11 "Stage IV (four) to Lt & Rt (left and right) heels. Approach: 12/16/11 "Proderm every shift, elevate heels off bed" 12/29/11 "Float heels, no shoes, slipper socks to ambulate." Resident Progress Notes dated 12/26/11 at 15:30 (3:30 p.m.) indicated "Assessment of bilateral feet per family request secondary res. c/o (complaints of) hurting			

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	areas found on bilateral heels R (right) 4 x 3.3 centimeters L (left) 1 x 1 centimeters necrotic, soft. Supervisor (name) notified of findings recommend for (name of wound doctor) to eval.(evaluate) on Thursday, N.O. (new order) written for proderm to bil (bilateral) heels." Resident Progress Notes dated 12/27/11 at 07:00 a.m. indicated "This nurse assessed res. bil (bilateral) heels this am. Lt (left) heel measure 1 x 1 x 0.70. Appears to have firm black eschar on outer aspects of heel. No redness to surrounding skin. Heel is soft. Rt. (right) heel measures 4 x 4.5 x 0.70. Surrounding skin immediate edges reddened, blanches to touch. Small amount of drainage noted to rt. heel, no odor. Heels up on pills (pillows). Upon assessment res had quick facial grimace during palpation. In quired (sic) if res would take prn (as needed) pain med, res stated he did not feel it was necessary. Assessment reported to floor nurse to monitor pain. Order for (name of doctor) to eval. and tx (evaluate and treat), will continue with proderm to heels. (up arrow) to indicated heels off mattress, while abed. Careplan updated to reflect areas et current interventions with skin and pain." On 12/29/11, the resident was seen by a wound care service, with the following			

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	documented on the evaluation sheet: "...s/p (status post) fall on 12/1 - R (right) humerus fx (fracture) and wrist. Pt. with increased confusion, decreased mobility. Non stageable/developed B (bilateral) heel decubs." "Pain my feet hurt" Plan: "Pressure relief, no shoes, Betadine daily to ea. (each) wound and cover with dry drsg (dressing). Heels up." During observation with LPN #2, on 01/06/12 at 5:52 a.m., the resident was observed to have slipper socks on in bed and the HeelZup elevating cushion was touching the bed foot board. The resident's heels were touching the mattress without benefit of a pressure relief device. On 01/06/12, the instruction sheet for the HeelZup cushion was provided by the facility at 10:10 a.m. The instruction sheet indicated to "Gently raise both legs of the patient and place the HeelZup cushion under the legs with both heels fully suspended." "For more leg elevation or to enhance patient comfort you may place a pillow on top of the HeelZup cushion. The raised borders will hold the pillow in place, preventing lateral movement. Always inspect for skin integrity every two hours." On 01/05/12 the wound care physician			

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	documented "Plan: Continue pressure relief and daily betadine. Will likely debride R (right) heel soon." On 01/09/12 at 8:57 a.m., during observation of the treatment provided to the resident's heels, the left heel had a dark area approximately 0.5 centimeters in the center of the heel. The resident indicated the area was tender. The left heel had a black area approximately 2.8 centimeters in circumference with the black area loosening on the inner aspect. 2. The clinical record for Resident M was reviewed on 1/9/12 at 11:40 a.m. The resident's diagnoses included, but were not limited to, depression, hypertension, venous thrombosis/embolism, and acute respiratory failure. The resident was admitted to the facility on 12/23/11. The admission assessment Minimum Data Set (MDS) dated 12/30/2011, included, but was not limited to: The resident was cognitively intact, required extensive assistance from two people for bed mobility, and under skin condition - was at risk of developing pressure ulcers, "...has one or more unhealed pressure ulcer(s) at Stage 1 or higher; 1 Stage 3 pressure ulcer... most severe tissue type for any pressure ulcer slough - yellow or white tissue that adheres to the ulcer bed			

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	in strings or thick clumps, or is mucinous." The resident's Interim Plan of Care, which was not dated, included, but was not limited to: "5. Skin Integrity Pressure Ulcer (left blank)." The Nutritional Needs Care Plan, dated 12/29/11, included, but was not limited to: "Increased demands for nutrients due to wounds to abdomen x 2 and back Stage III monitor wound status." The most recent Comprehensive Care Plan Report dated 1/5/2012, included, but was not limited to: "Problem #8 Skin/tissue integrity impaired; Potential risk r/t (related to) mobility and Stage 3 on back; Goal; Will have no new skin breakdown with healing of pressure wound on back and healing of abdominal surgical sites x 90 days; Approach 1. Turn & reposition Q 2 hrs and prn. 2. 1/5/2012 Pressure reduction mattress on bed and cushion in w/c; 3. 1/5/2012 Report any red or open areas; 4. 1/5/2012 Skin checks per facility policy; 5. 1/5/2012 Treatments as ordered 6. 1/5/2012 Wound care to follow (named doctor)." The resident's Weekly Skin Check Sheet included, but was not limited to: "12/23/11 2+ pitting edema bilateral feet"			

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	and "12/30/11 No new skin impairments noted." The resident's Weekly Pressure Ulcer BWAT (Bates-Jensen Wound Assessment Tool) Report dated 12/29/11, indicated the resident had a Stage III Pressure Ulcer. The December 2011 Treatment Record included, but was not limited to: Pressure Reduction mattress every day, Pressure Reduction cushion every day, both ordered 12/23/11. A Wound Care Initial Evaluation dated 12/29/11, included, but was not limited to: Wound #2 Back Stage III 2.9 x 3.0 x 0.1 sm. (small) serous exudate; No granulation; Yellow Necrosis; Diagnosis: Post - op abd wounds, back decub ... Santyl (debridement agent for treating decubitus ulcers) daily to back wound." On 1/9/12 at 1:40 p.m., on entrance to resident M's room, there was no answer to the knock on the door. The resident was not in the room at this time. The Medical Records Director was walking down the hall. She was queried as to what type of mattress was on the bed. She indicated it was a regular low air flow mattress. At 1:45 p.m., the resident was observed in the physical therapy department. When			

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	queried, the resident indicated there was a cushion in her wheelchair, in which she was seated, and she was taking therapy as she was wanting to go home. On 1/9/12 at 1:45 p.m., the Medical Records Director provided a copy of the current CNA (Certified Nursing Assistant) Assignment Sheet for 1/9/2012 which lacked any reference to the pressure ulcer and need for a cushion in the resident's wheelchair. On 1/9/12 at 4 p.m., the IDON provided a Wound Consult Note dated 1/9/12, which indicated, " Resident (named) has a large post-op abdominal wound and a smaller gluteal decub secondary to pressure from her wound vac tubing. She is mobile and able to perform pressure relief without assistance. The vac tubing has been repositioned so that it is no longer a concern and her wound should heal without complication with local wound care and a pressure relief mattress. An air mattress is not needed with a wound of this type on a patient with adequate mobility." This consult was faxed to the facility on 1/9/12 at 3:42 p.m. During interview on 1/9/12 at 4 p.m., the IDON indicated Resident M did not require any additional pressure relieving devices. During observation on 1/10/2012 at 10:30			

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	a.m., wound care for Resident M was done by LPN # 8 under clean technique. The wound was on the coccyx and approximately 3.5 x 3.5 inch circular and 0.5 inch deep and was beefy red with yellow slough, and a 0.5 inch area of eschar (black). Area surrounding the wound was reddened. The Immediate Jeopardy that began on 12/26/11 was removed on 1/10/12 when the facility began assessing all residents for pressure ulcers and began inservicing all nursing staff, but noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because assessment of residents and inservicing continues and monitoring is to be done. 3. The clinical record for Resident A was reviewed on 1/5/12 at 10:35 a.m. The resident's diagnoses included, but were not limited to, right fractured acetabular (hip) open reduction and diabetes mellitus. The resident was admitted to the facility on 10/20/11. The admission assessment Minimum Data Set (MDS) dated 10/27/11, included, but was not limited to: Cognitively intact, Skin Condition: Resident at risk for developing pressure ulcer. No current pressure ulcers were coded. For bed mobility, resident			

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	required extensive assistance of two person assist and personal hygiene with extensive assist of one person. The Resident Weekly Skin Check Sheet indicated no pressure ulcers on 10/20/11, 10/27/11, 11/3/11, 11/10/11 "No new skin impairments noted," and 11/17/11 "No skin impairment noted." Resident Progress Notes included, but were not limited to, the following: 10/27/11 "Change BLE (bilateral lower extremity) una boots PRN (as needed) only if they become displaced. Have therapy assess RLE (right lower extremity) for lymphedema, massage when wrap is taken down." Documentation was lacking of the heels being assessed prior to 11/1/11. On 11/1/11 "New area found - to R foot 1.5 x 1.0 cm (centimeters) - non - stagable (sic) - NO (New order) received for skin prep q. (every) shift." The Weekly Pressure Ulcer BWAT Report dated 11/1/11, indicated an Unstageable/Deep Tissue Injury was found. The Interim Plan of Care, which was not dated, included, but was not limited to: "Skin Integrity Wound Care R hip incision on admission; Problem: Risk for			

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	Skin Impairment; Goal: Pt will experience no breakdown x 40 days; Approach: 1. Weekly skin assessments; 2. Preventative Care; 3. Notify MD of any changes." A Comprehensive Care Plan Report dated 10/27/11, indicated: Problem: Skin/tissue integrity impaired potential, with a hand written note on 11/1 "NS (Non Stageable) R heel;" Goal 1. 10/27/11 incision heal w/o (without) s/s (signs/symptoms) infection, skin remain free of breakdown; Est (estimated) Date 1/24/12; Approach: 1. 10/27/11 Pressure reduction bed and w/c (wheelchair); staff assist to T/P (turn/position) Q (every) 2 hours in bed; txs (treatments) as MD orders; Monitor skin for changes; Weekly skin assessments; Monitor incision for s/s infection thru healing 11/4 Dr. [name] wound specialist to eval (evaluate) and tx (treat)." A Physician Telephone Order dated 11/10/11 1510 (3:10 p.m.), indicated 1. D/C (discontinue) skin prep to R heel 2. Acquaphor to R heel/foot BID (twice a day) 3. Elevate R heel off of bed 4. Shoe to R foot only with PT (Physical Therapy) (ok to wear splint at all time). Documentation was lacking of the care plan being updated on 11/10/11 to include the skin treatment ordered by the MD.			

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	On 11/10/11 a Wound Care Initial Evaluation was in the clinical record which included, but was not limited to: Diagnosis R heel decub Wound #1 R heel, Stage II, 1.8 x 1.5 x 0.1, no exudate, no granulation, Necrosis dried blister Plan: D/C (discontinue) skin prep & initiate acquaphor BID (two times a day) Shoe on only for PT." Documentation was lacking to indicate the treatment change was updated to the care plan. Follow - up visit on 11/17/11: "Wound 1 R heel, Stage II 1.7 x 0.7 x 1.0. No exudate, no granulation, no necrosis. Diagnosis: R heel decub; Plan: Moisturize and pressure relief. Documentation was lacking the treatment was updated to the care plan. On 1/6/12 at 9:55 a.m., in interview with the Physical Therapist, he indicated he did not see anything on the resident's heel prior to 11/11/11 when he got doctor's orders. 4. On 1/9/2012 at 10:40 a.m., review of the clinical record for Resident H indicated diagnoses included, but were not limited to, Alzheimer's, failure to thrive, chronic heart failure, and diabetes mellitus type II.			

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	The Minimum Data Set (MDS) assessment, dated 12/2/2011, indicated the resident did not have any pressure areas. On 12/18/2011 at 1:00 p.m., resident progress notes indicated a change of condition form indicating "area on coccyx now open 2 cm oblong area." On 12/18/2011, a physician order was obtained to "cleanse area on coccyx with NS (normal saline), pat dry and apply mepilex (spongy barrier dressing) every day." Review of the weekly pressure ulcer BWAT (Bates-Jensen Wound Assessment Tool) dated 12/18/2011, 12/25/2011, 1/2/2012, indicated a stage 2 pressure sore. Review of the indicators of pressure ulcer(s), under extrinsic risk factors, indicated, but was not limited to; resident confined to a chair all or most of the time and is in need of a seat cushion to reduce or relieve pressure and pressure reduction bed, and to turn and reposition every 2 hours and as needed. The resident was identified as "at high risk for skin breakdown." On 1/9/2012 at 12:20 p.m., resident H was observed sitting in the north activity room in a high back wheel chair with a pressure			

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	reducing cushion in place. Review of the comprehensive care plan report dated 12/6/2011, indicated, but was not limited to, the following: Problem-at risk for skin breakdown, Goal-will be free of skin breakdown, Approach-monitor skin changes. Problem-physical mobility, Goal-will not develop further complications of immobility e.g. (for example) pressure sores, contractures, pneumonitis, Approach-turn and reposition every 2 hours. Problem-skin/tissue integrity impaired, Goal-will have skin intact for the next 90 days, Approach-turn and reposition every 2 hours and as needed. A comprehensive care plan report updated on 12/18/2011, indicated: Problem-stage 2 coccyx, Goal - resolve without further complication or infection, Approach-#1 assist with turn and reposition every 2 hours as needed, # 2 encourage change position while in wheel chair every 2 hours and as needed per staff, # 3 treatment per order, # 4 monitor signs and symptoms of infection. On 1/9/2012 at 12:20 p.m., in an interview with Licensed Practical Nurse (LPN) # 7, she indicated the resident's wound is almost healed, but treatment is			

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	still on going. On 1/9/12 at 1:00 p.m.,the facility policy and procedure for Pressure Ulcer Prevention was reviewed and included, but was not limited to: ...9. "....Implement interventions to attempt to stabilize, reduce or remove underlying risk factors. [TL 6102] Risk Analysis Guide. 10. Monitor the impact of the interventions, and modify the interventions as appropriate. 11. Use positioning techniques to keep the resident's heels off the bed. A care plan approach may be raising the foot of a hospital-type bed to elevate the legs at intervals can take pressure off the heels and aid circulation. 12. Evaluate and individualize use of various devices to reduce or relieve pressure and/or reduce skin injuries that may result in pressure ulcers (i.e. heel protectors, heel splints, rectal pouches). a. Increase mobility, activity. b. Reposition every 1-2 hours. For example, residents at higher risk for			

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	pressure ulcers may need repositioning more than every hour when sitting in a chair (especially if they show evidence of stage 1 pressure ulcers with less frequent repositioning). 13. Implement interventions to decrease the magnitude of pressure, friction, and shear on the pressure ulcer and to prevent further pressure ulcers. a. Minimize shear and friction (proper positioning, transferring and turning techniques). b. Maintain HOB at lowest elevation possible. c. Use lifting devices (e.g., trapeze/bed linen). 14. Place residents identified at risk on a pressure-reducing mattress. Avoid standard hospital mattresses. Matching a device's potential therapeutic benefit with the resident's specific situation should choose appropriate support surfaces or devices. For example multiple ulcers, limited turning surfaces, ability to maintain position. [PRO 66108] Specialty Bed/Products [FRM 66106-01] Mattress/bed and/or Products's Request Form			

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	15. Develop care plan on the degree and areas of risk and update as necessary. 16. Educate and document staff and family member/responsible party on interventions to reduce or prevent pressure ulcers. 17. Assess resident from head to toe for skin effectiveness of care plan interventions and document in the resident's medical record: a. Upon admission within 6 hours. b. At least weekly c. Upon transfer and/or discharge [FRM 66107-09] Resident Weekly Skin Check Sheet. [FRM 62003] Treatment Administration Record (TAR) " The Policy for Positioning a Resident with Pressure Ulcers was reviewed on 01/09/2012 at 1:00 p.m. The policy included but was not limited to: Procedure: 1. "...Repositioning a. Reposition resident at lease every two hours whether the resident is in bed or in a chair.			

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	b. Some residents may require repositioning more frequently depending on location of the ulcer and nutritional and hydration status. c. The repositioning schedule should be incorporated into the resident's care plan. 2. Heel Pressure Ulcer a. Place pillow under calf of legs (e.g., off loading ramp off loading boots) to maintain alignment and prevent/contact with bed unless contraindicate (i.e. ,DVT) (deep vein thrombus). b. Assess resident to ensure that pressure is not being redistributed to the calf. c. Assess for new areas of pressure that my be caused by a pressure-relieving device. ..." Documentation Guidelines: 1. " Update resident's care plan with the appropriate positioning intervention." 2. "Communicate with nursing staff positioning intervention." 3. "Document the effectiveness of repositioning the resident in the medical			

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	record." 4. "Document in the resident's medical record on the designated form resident weekly." skin check and need for a specialty/bed/product. 5. "Update the care plan, as the resident's needs change." 6. "Notification of physician and family member/responsible party as necessary." 7. " Signature and Title. " This federal tag relates to complaint IN00101837. 3.1-40(a)(1) 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, observation and interview, the facility failed to ensure a resident was supervised to prevent the resident from falling from bed, in which the resident was found lying on the floor in front of the bed after having a fall 5 hours earlier, for 1 of 2 residents reviewed related to falls in a supplemental sample	F0323	It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident L had no injuries from fall on 12/18/2011.□All residents with	01/30/2012

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	of 3. (Resident L) Findings include: The clinical record for Resident L was reviewed on 1/6/12 at 1:25 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease, congestive heart failure and dementia with behaviors. The resident was admitted to the facility on 8/9/11 and readmitted on 12/28/11. The Quarterly Minimum Data Set dated 11/5/2011 included, but was not limited to: the resident was cognitively intact and had no falls since admission or the prior assessment. The Resident Progress Notes dated 12/18/2011, included, but were not limited to: 12/18/11 6 a.m. "Pt (patient) found on floor in front of bed by CNA (Certified Nursing Assistant). Pt refused to stay sitting and raised herself up to bed. Refused to let me get BP (blood pressure) and vitals. Pt then threw can of Nepro (supplement) at me and was making threatening comments that she would kill me. After this she began to throw fruit and other things in her reach. Tried again for Vitals and BP was 170/90 HR (heart rate)105. Pt would not allow for an O2 (oxygen) (sic). Left room to call DON (Director of Nursing) and aide yelled for		the potential to fall are at risk. Fall intervention rounds were initiated on 11-26-11 twice daily per management for validation of interventions and communication with floor staff. . Implementation of fall interventions according to the needs of each individual resident from the outcomes of the fall risk assessment, bed safety evaluation, and nursing assessment has been initiated.All nursing staff have been in-serviced on the Policy and Procedures for Accidents and Supervision to Prevent Accidents (see attachment I). Chart audits for residents with falls will be completed five times weekly in IDT morning meeting for accuracy and coordination of the Post Fall Evaluation, Care Plan and C.N.A assignment sheets and logged on the IDT Falls review Log (see attachment J).□Twice a day fall intervention rounds will continue by management for 2 months, then once daily for one month. C.N.A. assignment sheets will be turned into the DNS/Designee daily after completion of rounds with all findings identified and initialed. All findings will be corrected immediately and discussed in AM IDT meeting 5 X weekly and reported in PI monthly x 3 months.The DNS or designee will be responsible to ensure this standard has been met.	

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	me again. Found pt throwing her potted plants at the window. Unable to reach DON at this time, call NP (Nurse Practitioner) and sent pt. to [named hospital]. Left message with family to call facility. EMS (Emergency Medical Service) arrived to pick up pt. and she cont. (continued) with threatening comments and gestures. Took pt blood sugar was 278..." The resident was treated for a urinary tract infection. 12/18/11 10:00 a.m. "Res returned to facility [named hospital] ER (emergency room) called with report stating Res was DX (diagnosed) with UTI (urinary tract infection) low potassium level no injury noted from fall x-rays (-) [negative] for Fx (fracture). Res alert with some confusion noted neuro checks initiated Vitals WNL (within normal limits) PERL (pupils equal react to light) moves extremities without difficulty no c/o pain. Requires ext. (extensive) assist of i with transfers & ADL's (Activities of Daily Living). Spoke with Res son made aware of Res' return to facility...." 12/18/11 11:00 a.m. "This nurse called to Res room found sitting in floor by bed near heating unit. C/o Bil. (bilateral) hip and lower back pain. Res left on floor as found with staff remaining @ side. NP aware order to send to [named hospital]			

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	for eval EMS notified Res BP -160/78 p - 92 R - 20 T - 98.9 Blood Sugar 217. Res alert able to recall her name, place, this nurses name, year but disoriented stating she got out of bed to get the 'Bomb' by the heater explained to Res. the item was her water bottle. Res states 'I know but it's a bomb it's gonna blow us all up. I know what's going on here they're making a movie and I'm gonna blow it up.' Unable to reorientate (sic) Res. EMS transferred Res to stretcher remains confused...." The Post Fall Evaluations, dated 12/18/11 for 6:00 a.m. and 11:00 a.m., were reviewed by the IDT (Interdisciplinary Team) on 12/19/11 with no new Intervention Recommendations. A Post Fall Evaluation dated 8/31/11, included, but was not limited to: "Immediate intervention: Perimeter mattress (sic) Res call light in reach, assist with transfer added perimeter mattress." On 8/17/11 a Post Fall Evaluation included, but was not limited to: "Immediate Interventions taken to protect the resident: non-skid socks. Summary of IDT: cont (continue) with plan of care and remind res to wait for assist with transfers." The Patient Nursing Evaluation dated			

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	11/2/11 included, but was not limited to: Morse Fall Risk Scale Score 50 and marked "High Risk = 45 and higher Add risk factors for fall to the care plan. Refer to Falling Star Program." On 11/18/11 the score was 15, indicating the resident was a low risk for falls. The Comprehensive Care Plan dated 8/18/2011, reviewed with the clinical record, included, but was not limited to: "Problem 8: 11/7/11 Potential for falls/injury related to immobility, weakness and psychoactive med use; Goal 3/7/12 1. Falls risk related injuries will be minimized; Hand Written: 8/31/11 Fall - Preventive Mattress; 12/18/11 fall - found on floor @ 0600 @ bedside sent to hosp. for eval & treat." There were no new interventions documented. "12/18/11 @ 1100 Fall found on floor @ bedside - neuro checks sent to hosp for eval & treat." No new interventions were documented on the care plan. On 1/6/12 at 2:58 p.m. with the Central Supply person, Resident L was observed lying in bed on her left side facing the window. The mattress on the bed was not a perimeter mattress and no falling star was on the door frame to indicate the resident was a falls risk. The Central Supply person was aware the resident was			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	a falls risk and indicated the resident had gone out to the hospital and was gone at least 10 days, and the room was cleaned out. He indicated he was responsible for keeping the CNA Assignment Sheets updated. There was nothing on the current sheet to indicate the resident was a falls risk. It was written on 11/21/11 for a low bed, and perimeter mattress. He indicated they have falls meetings routinely and any interventions are reported to him and implemented. The interventions were not re-implemented on the resident's return. The Policy and Procedure for Accidents and Supervision to Prevent Accidents, dated revised 04/28/11, provided by the IDON on 1/6/12 at 2:45 p.m., included, but was not limited to: "Policy: The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents. This includes systems and processes designed to: identify hazard(s) and risk(s); Evaluate and analyze hazard(s) and risk(s); Implement interventions to reduce hazard(s) and risk(s); and Monitor for effectiveness and modify approaches when necessary... Identification of Hazards and Risks 6. Center identifies hazards and risks through which the			

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	Center becomes aware of potential hazards in the patient environment and the risk of a patient having an avoidable accident. Sources for identifying hazards may include: a. Quality assurance activities b. Environmental rounds c. MDS... d. Medical history and physical exam e. Individual observation Evaluation and Analysis 7. Staff (e.g. professional, administrative, maintenance, etc.) are involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each patient. They help to identify solutions to ensure a safe patient environment. 8. Both the center-focused and patient-directed approaches include evaluating hazard and accident risk data, analyzing potential causes for each hazard and accident risk, and identifying and designing interventions (including care plan interventions) based on the severity of the hazards and immediacy of risk. Evaluations should also look at trends such as time of day, location, etc. Interventions for the center-focused approach might include educating staff, repairing the device/equipment,. etc. A patient-directed approach might include implementing the care plan interventions, supervising staff and patients, etc. 9. Center communicates the interventions to relevant staff, assigning responsibility to			

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	appropriately trained individual(s), implementing and documenting interventions. 10. Center implements interventions correctly and consistently, including adequate Supervision. Monitoring and Modification 11. Center has monitoring processes in place to: a. Ensure that interventions are implemented correctly and consistently b. Evaluate the effectiveness of interventions c. Modify or replace interventions, as necessary d. Evaluate new interventions when necessary to make them more effective in addressing hazards and risks. Supervision 12. a. assess the need for assistive devices. b. Care plan and implement preventive measures for the patient at risk for falls. c. Monitor the patient receiving drugs that may cause postural hypotension, dizziness, or visual changes. d. assess patients to determine whether supervision is necessary..." This federal tag relates to Complaint IN00101837. 3.1-45(a)(2)			