

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 802 US HWY 20 E MICHIGAN CITY, IN 46360
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00183032.</p> <p>Complaint IN00183032-Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F323.</p> <p>Survey dates: September 28, 29, 30, October 1, 2, and 5, 2015</p> <p>Facility number: 000236 Provider number: 155344 Aim number: 100287700</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 27 Medicaid: 41 Other: 6 Total: 74</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on</p>	F 0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and it also not to not to be construed as of an admission of interest against the facility, the Administrator or any employee or agents, or any other individuals who draft or may be discussed in the Plan of Correction. In addition preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirement under State and federal law that mandates submission of the Plan of Correction a condition to participate in the Title 18 and Title 19 programs. The submission of this plan of correction within this timeframe should in no way be of non-compliance or admission by the facility. This provider is respectfully requesting paper</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0225 SS=D Bldg. 00	<p>October 9, 2015.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his</p>		compliance. If accepted, all documentation will be faxed or mailed as requested.	

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	<p>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.</p> <p>Based on record review and interview, the facility failed to ensure allegations of neglect and abuse were reported to the State Agency for 1 of 3 allegations of abuse reviewed. (Resident #91)</p> <p>Finding includes:</p> <p>The record for Resident #91 was reviewed on 9/30/15 at 9:27 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, chronic bronchitis, and personal history of noncompliance with medical treatment presenting hazards to health.</p> <p>An entry in the Nursing Progress Notes dated 9/9/15 at 2:14 p.m., indicated the resident put on her call light for staff. When staff entered the room, the resident stated, "you're neglecting me." The resident again put on her call light and stated, "you're starving me."</p> <p>A witness statement provided by a CNA on 9/9/15 indicated the resident had asked staff why they were neglecting her.</p>	F 0225	<p>1. Resident #91 complaints were investigated immediately by the Executive Director/designee. Resident #91 had demanded that staff leave her room and denies abuse. No abuse was noted. The residents Care Plan was updated. She continues to be a resident of this facility. Both incidents were reported to ISDH on 10/22/15.</p> <p>2. Current facility complaints (Concern and comments cards) were reviewed for missed opportunities to report allegations to SBOH on 10/19/15 by the ED/designee. No other allegations noted. All other allegations will be reported to the State Agency per policy.</p> <p>3. Resident complaints will be logged (Complaint log) to track SBOH reports. Any allegations of abuse or neglect will be reported to the State Board of Health (SBOH) within 24 hours by the ED/designee. A review of the SBOH reporting guidelines were discussed with the ED/DON by the Regional Nurse Consultant on 10/5/15. Staff, including all department heads and the ED/DON were educated on</p>	11/04/2015

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F 0226 SS=D Bldg. 00	<p>On 9/15/15, the Administrator had received a call from the resident's daughter which indicated the resident was "terrified of some of our staff." She also indicated the resident did not want her to call with complaints due to her fear of staff.</p> <p>Both of the allegations were investigated and found to be unsubstantiated, however, the allegations were not reported to the State Agency.</p> <p>Interview with the Director of Nursing on 10/5/15 at 1:30 p.m., indicated the allegations of neglect and being terrified were not reported to the State Agency. She indicated in her investigation it was found the resident was not neglected.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 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 their abuse policy and procedure was followed as</p>	F 0226	<p>10/5/15, 10/13/15, and again on 10/19/15 on reporting any allegations to ISDH.</p> <p>4. The log will be monitored by the ED daily in morning meeting Monday through Friday. The manager on weekend duty will notify the ED/DON of any complaints. The complaint log will be discussed in the monthly QI meeting for the next six months. Audit results and system components will be reviewed by the performance improvement committee with subsequent plans of corrections developed and implemented as deemed necessary.</p> <p>5. Date certain November 4, 2015.</p> <p>1. Resident #91 complaints were investigated immediately by the Executive Director/designee.</p>	11/04/2015

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	<p>written related to reporting allegations of neglect and abuse to the State Agency for 1 of 3 allegations of abuse reviewed. (Resident #91)</p> <p>Finding includes:</p> <p>The record for Resident #91 was reviewed on 9/30/15 at 9:27 a.m. The resident's diagnoses included, but were not limited to, muscle weakness, chronic bronchitis, and personal history of noncompliance with medical treatment presenting hazards to health.</p> <p>An entry in the Nursing Progress Notes dated 9/9/15 at 2:14 p.m., indicated the resident put on her call light for staff. When staff entered the room, the resident stated, "you're neglecting me." The resident again put on her call light and stated, "you're starving me."</p> <p>A witness statement provided by a CNA on 9/9/15 indicated the resident had asked staff why they were neglecting her.</p> <p>On 9/15/15, the Administrator had received a call from the resident's daughter which indicated the resident was "terrified of some of our staff." She also indicated the resident did not want her to call with complaints due to her fear of staff.</p>		<p>Resident #91 had demanded that staff leave her room and denies abuse. No abuse was noted. The residents Care Plan was updated. She continues to be a resident of this facility. Both incidents were reported to ISDH on 10/22/15.</p> <p>2.Current facility complaints (Concern and comments cards) were reviewed for missed opportunities to report allegations to SBOH on 10/19/15 by the ED/designee. No other allegations noted. All other allegations will be reported to the State Agency per policy.</p> <p>3.Resident complaints will be logged (Complaint log) to track SBOH reports. Any allegations of abuse or neglect will be reported to the State Board of Health (SBOH) within 24 hours by the ED/designee. A review of the SBOH reporting guidelines were discussed with the ED/DON by the Regional Nurse Consultant on 10/5/15. Staff, including all department heads and the ED/DON were educated on 10/5/15,10/13/15, and again on 10/19/15 on reporting any allegations to ISDH.</p> <p>4.The log will be monitored by the ED daily in morning meeting Monday through Friday. The manager on weekend duty will notify the ED/DON of any complaints. The complaint log will be discussed in the monthly QI meeting for the next six months. Audit results and system components will be reviewed by</p>	

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F 0241 SS=D Bldg. 00	<p>Both of the allegations were investigated and found to be unsubstantiated, however, the allegations were not reported to the State Agency.</p> <p>Interview with the Director of Nursing on 10/5/15 at 1:30 p.m., indicated the allegations of neglect and being terrified were not reported to the State Agency. She indicated in her investigation it was found the resident was not neglected.</p> <p>The facility Abuse policy was reviewed on October 7, 2015. The policy was provided by the Administrator and identified as current. The policy indicated the following: Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to the state survey agency.</p> <p>3.1-28(a)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>		<p>the performance improvement committee with subsequent plans of corrections developed and implemented as deemed necessary.</p> <p>5.Date certain November 4, 2015.</p>	

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	<p>Based on observation, record review, and interview, the facility failed to ensure the resident's dignity was maintained related to failure to cover the urinary catheter drainage bag for 1 of 3 residents reviewed for dignity of the 2 residents who met the criteria for dignity. (Resident #25)</p> <p>Finding includes:</p> <p>1. On 9/28/15 at 10:48 a.m., Resident #25 was observed sitting in her wheelchair in her room. At that time, the resident's foley catheter drainage bag was observed uncovered and clear yellow urine was noted. At 12:10 p.m., the resident was observed in the West dining room. The resident's foley catheter drainage bag was uncovered and clear yellow urine was noted.</p> <p>The record for Resident #25 was reviewed on 9/30/15 at 10:52 a.m. The resident's diagnosis included, but was not limited to, neurogenic bladder.</p> <p>Interview with the Director of Nursing (DON) on 10/1/15 at 1:01 p.m., indicated the facility policy was to cover the foley catheter drainage bag with a dignity bag.</p> <p>3.1-3(t)</p>			F 0241	<p>241 Dignity</p> <p>1. Resident #25 did not have a Foley catheter. However, Resident # 97 Foley catheter tubing was picked up off the floor and the bag was covered.</p> <p>2. Facility audit of Foley catheters was completed on 10/8/15 to ensure the dignity of residents and all Foley catheters have tubing and bag in the privacy bags. No other residents were identified without privacy bags.</p> <p>3. Staff were educated on resident privacy (bag) on 10/01/15 on privacy bag use with all Foley's. Staff also in-serviced on 10/8/15, 10/13/15 and again on 10/19/15 by the SDC on Foley tubing must be off the floor and in a privacy bag. A Foley catheter audit was created to ensure compliance.</p> <p>4. The Audits will be conducted 3 times weekly for 4 weeks and weekly thereafter for five months.. Audits will be discussed in the Quality Assurance meeting monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>1. Date Certain November 4 2015.</p>		11/04/2015

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure a resident was provided a dental referral for teeth restoration or extractions for 1 of 3 residents reviewed for dental services of the 98 residents who met the criteria for dental services. (Resident #16)</p> <p>Finding includes:</p> <p>On 9/29/15 at 11:09 a.m., Resident #16 was observed sitting in her wheelchair in the dining room. At that time, the resident's front teeth were missing.</p> <p>The record for Resident #16 was reviewed on 9/30/15 at 3:17 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, and stroke.</p> <p>A dental referral form dated 5/13/14, indicated to refer to a general dentist. The recommendation was for restorations; multiple areas of decay. The notes indicated to restore if possible and</p>	F 0250	<p>1. Resident #16 had a follow up appointment with the Dentist on 10/20/15. Facility audit was conducted for follow up recommendation from the Dentist by the Nursing Administration on 10/14/15. All other recommendations were completed.</p> <p>2. Nurses will notify MD and family of all dental recommendations and write a physician's telephone order accordingly Based on recommendations additional appointments will be made as necessary. New appointments will be placed on the Appointment List for follow-up. Nurses were educated on notification and writing telephone orders for tracking recommendation on 10/1/15, 10/7/15, 10/13/15 and again on 10/19/15 by the DON</p> <p>3. Dental recommendations will be reviewed after each visit. The appointment list will be audited weekly for follow-up with appointments by the DON/designee for six months. The audits will be discussed in Quality Assurance meeting</p>	11/04/2015

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	<p>to extract if necessary.</p> <p>Nursing Progress Notes dated 5/13/14 at 11:25 a.m., indicated "Seen by Facility Dentist, recommending restoration of decayed teeth or extraction if necessary. Daughter informed. Awaiting return call with decision."</p> <p>A dental exam dated 4/1/15, indicated the resident had no visible sores or infection. There were multiple areas of decay with broken teeth. There had been a referral previously written, however, the resident had not gone to see a Doctor of Dental Surgery (DDS), continued to refer.</p> <p>A dental exam dated 8/26/15, indicated the resident had poor oral hygiene and scaling was not recommended. Schedule in three months for periodic exam.</p> <p>The Significant Change MDS assessment dated 3/26/15, indicated the resident had obvious likely broken or cavity teeth.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/8/15, indicated the resident was not alert and oriented and had no problems with dental care.</p> <p>The current plan of care updated 9/2015, indicated the resident exhibited dental and mouth problems. The Nursing</p>		<p>monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>4.Date Certain November 4 2015.</p>	

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F 0309 SS=D Bldg. 00	<p>approaches were to consider dental consults.</p> <p>Interview with the Social Services Director (SSD) on 10/01/15 at 12:33 p.m., indicated she did not remember the referral from the Facility Dentist back in 2014. She indicated she would call the local dentistry places and see if the resident had been seen. The SSD indicated she did not know if it had been followed up on by the Nursing staff.</p> <p>Interview with RN #1 on 10/1/15 at 12:45 p.m., indicated she did not remember if the resident had gone out to see a dentist for the referral.</p> <p>Interview with the SSD on 10/1/15 at 12:50 p.m., indicated she had just called the daughter and she indicated she was not aware of the referral and would like her mom to see an outside dentist related to the recommendations for extractions or restorations.</p> <p>3.1-34(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>			

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure skin conditions (non pressure related) related to bruises were assessed and monitored for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 11 who met the criteria for skin conditions (non-pressure related). (Resident #C)</p> <p>Finding includes:</p> <p>On 9/29/15 at 10:07 a.m., Resident #C was observed sitting in his chair. At that time, there were multiple areas of purple/bluish discoloration to the left and right hands and fingers.</p> <p>On 9/30/15 at 1:45 p.m., LPN #1 was observed performing a skin assessment of the resident's left and right hands and fingers. At that time, there were multiple red and purple bruises noted to the back of both hands and around his fingers. The LPN indicated the back of the right hand was old scarring from healed bruises and was dark brown in color. The LPN indicated the bruises to his fingers and left hand were new and she was unaware of the bruises. The LPN asked the resident if the bruises were new</p>	F 0309	<p>309 Services for higher well being</p> <p>1. Resident #C bruises were assessed and monitored on 9/30/15. The NP and family were notified on 09/30/15. Skin sheets identifying/describing residents bruises were completed on 9/30/15 by the licensed nurse.</p> <p>2. Facility resident's skin will be assessed for any abnormal conditions (skin tears, wounds and bruises) by the nursing administration by 10/23/15. The physician, resident and families will be notified if any abnormal conditions were noted. All corresponding paperwork will be completed.</p> <p>3. Staff were educated on 10/1/15 on completion of skin assessments by the SDC. Nursing Administration will conduct random skin assessments to ensure abnormal skin concerns are documented on 20% of the resident population weekly. Skin Assessments will be ongoing for 6 months and then as necessary.</p> <p>4. Skin assessment audits will be completed on 20% of the residents weekly for 6 months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as</p>	11/04/2015

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	<p>and happened today and the resident stated, "No."</p> <p>The record for Resident #C was reviewed on 9/30/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, obstructive chronic bronchitis, muscle weakness, chronic kidney disease, high blood pressure, history of alcohol abuse, iron deficiency anemia, and coronary artery disease.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 7/2/15, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14. The resident needed extensive assist with one person physical assist for bed mobility, dressing, eating, and locomotion in the room.</p> <p>The current plan of care dated 7/2015, indicated the resident was at risk for abnormal bleeding related to the use of Aspirin. The Nursing approaches were to observe for and report to Nurse of any bleeding gums, nose bleeds, tarry black stools and unusual bruising.</p> <p>On 9/30/15 at 2:09 p.m., LPN #1 measured the new areas of bruising as followed:</p> <p>a. left hand 4th digit 1.5 centimeter (cm)</p>		<p>deemed necessary.</p> <p>5.Date Certain November 4 2015.</p>				

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F 0314 SS=D	<p>by 1 cm</p> <p>b. right middle finger 3 cm by 2 cm</p> <p>c. 2nd knuckle right hand 0.5 cm by 1 cm</p> <p>d. left digit third finger 3 cm by 2 cm</p> <p>e. top of left hand 5.5 cm by 3.4 cm</p> <p>f. 2nd digit right hand 2 cm by 1 cm</p> <p>The current undated Post-admission Weekly Skin Assessments policy provided by the Director of Nursing was reviewed on 10/1/15 at 10:00 a.m. The policy indicated "A complete assessment is essential to an effective pressure ulcer prevention and treatment program. On a weekly basis, a licensed professional searches for areas of skin that differ from surrounding tissue."</p> <p>Interview with LPN #1 on 9/30/15 at 2:10 p.m., indicated new bruises were to be measured and documented on the non pressure ulcer skin sheet. The bruises were to be measured weekly until healed.</p> <p>Interview with the DON on 10/1/15 at 10:10 a.m., indicated the bruises should have been documented and measured when they were first observed.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL</p>			

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Bldg. 00	<p>PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to the pressure ulcer treatment for 1 of 4 residents reviewed of the 9 residents who met the criteria for pressure ulcers. (Resident #C)</p> <p>Finding includes:</p> <p>On 9/30/15 at 9:20 a.m., Resident #C was observed sitting in his recliner chair in his room. At that time, LPN #1 and QMA #1 were preparing to change the resident's pressure ulcer bandage. At that time, QMA #1 instructed the resident to stand up. The resident stood up and walked over to the dresser and held onto it. LPN #1 pulled down the resident's pants and incontinent brief. At that time, there was no old bandage noted to the right buttock pressure ulcer. The</p>	F 0314	<p>314 Treatment to heal pressure sores</p> <p>1.Resident #C had his treatment completed on 9/30/15 by the licensed nurse.Resident was assessed by nurse. No harm was noted to the resident.</p> <p>2.Facility residents with wounds were audited for intact dressings on 10/6/15 by the Nursing Administration. No other residents were identified without dressings.</p> <p>3.Staff were educated on notifying nursing/therapist upon discovering a wound without a dressing by the DON on 10/6/15, 10/13/15 and again on 10/19/15. Audits will be conducted to ensure compliance. Random audits will be conducted of ten (10%) of residents with wounds weekly for six months.</p> <p>4.Audits will be discussed in Quality Assurance meeting monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans</p>	11/04/2015

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	<p>pressure ulcer was open and red in color. After the treatment was completed, the QMA indicated the resident's incontinent brief was wet with urine.</p> <p>The record for Resident #C was reviewed on 9/30/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, obstructive chronic bronchitis, muscle weakness, chronic kidney disease, high blood pressure, history of alcohol abuse, iron deficiency anemia, and coronary artery disease.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 7/2/15, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14. The resident needed extensive assist with one person physical assist for bed mobility, dressing, eating, and locomotion in the room. The resident had Stage 2 pressure ulcers.</p> <p>A Braden scale assessment (an assessment tool used to measure the risk for pressure ulcers) dated 9/15/15, indicated the resident was at risk for pressure ulcers with a score of 16.</p> <p>The current plan of care dated 9/21/15, indicated the resident had a pressure ulcer to the right buttock. The Nursing</p>		<p>of correction developed and implemented as deemed necessary.</p> <p>1.Date Certain November 4 2015.</p>	

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	<p>approaches were to provide wound care as ordered by the Physician.</p> <p>Physician Orders dated 9/17/15, indicated to Discontinue calmoseptine to buttocks. Cleanse Stage 2 open area to right buttock with normal saline apply Duoderm (a medicated bandage) every 3 days and as needed.</p> <p>The pressure ulcer weekly measurement sheet indicated the pressure ulcer was first observed on 9/17/15. The open area was classified as a Stage 2 and measured 0.4 centimeters (cm) by 1.4 cm. The next measurement was done on 9/25/15 and measured 0.2 cm by 6.2 cm. The pressure ulcer was pink in color and classified as a Stage 2.</p> <p>Interview with LPN #1 on 9/30/15 at 9:40 a.m., indicated there should have been a Duoderm covering the pressure sore. She further indicated the CNA's had not informed her the Duoderm had fallen off. She indicated the Duoderm was to be changed every three days.</p> <p>This Federal Tag relates to Complaint IN00183032</p> <p>3.1-40(a)(2)</p>			

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the foley catheter drainage bag was not on the floor for the 1 of 1 residents reviewed for urinary catheter use. (Resident #25)</p> <p>Finding includes:</p> <p>On 9/28/15 at 10:48 a.m., Resident #25 was observed sitting in her wheelchair in her room. At that time, the resident's foley catheter drainage bag was observed uncovered with the tip of the foley catheter drain sitting on the floor.</p> <p>At 12:10 p.m., the resident was observed in the West dining room with her foley catheter drainage bag uncovered with the tip of the foley catheter drain sitting on the floor under her wheelchair.</p> <p>The record for Resident #25 was reviewed on 9/30/15 at 10:52 a.m. The</p>	F 0315	<p>1. Resident #25 did not have a Foley catheter. However, Resident # 97 Foley catheter tubing was picked up off the floor and the bag was covered.</p> <p>2. Facility audit of Foley catheters was completed on 10/8/15 to ensure the dignity of residents and all Foley catheters have tubing and bag in the privacy bags. No other residents were identified without privacy bags.</p> <p>3. Staff were educated on resident privacy (bag) on 10/01/15 on privacy bag use with all Foley's. Staff also in-serviced on 10/8/15, 10/13/15 and again on 10/19/15 by the SDC on Foley tubing must be off the floor and in a privacy bag. A Foley catheter audit was created to ensure compliance.</p> <p>4. The Audits will be conducted 3 times weekly for 4 weeks and weekly thereafter for five months.. Audits will be discussed in the Quality Assurance meeting monthly</p>	11/04/2015

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F 0323 SS=D Bldg. 00	<p>resident's diagnoses included, but was not limited to, chronic kidney disease and neurogenic bladder with urinary retention.</p> <p>The current plan of care indicated a urinary catheter focus of, at risk of developing Urinary Tract Infection (UTI) due to catheter use, at risk of developing complications due to catheter use.</p> <p>Review of the facility policy on 10/2/15 at 10:00 a.m., which was provided by the Director of Nursing and identified as current, indicated the following: "Keep the collection bag off the floor."</p> <p>Interview with the Director of Nursing on 10/1/15 at 1:01 p.m., indicated that it was the facility's policy to cover the foley catheter drainage bag with a dignity bag and to keep the foley catheter drainage bag from touching the floor.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>				<p>for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>5.Date Certain November 4 2015.</p>		

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	<p>assistance devices to prevent accidents.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident who was at risk for falls had fall prevention measures in place related to a dycem (a non slip mat) for 1 of 4 residents reviewed for accidents of the 4 residents who met the criteria for accidents. (Resident #C)</p> <p>Finding includes:</p> <p>On 9/30/15 at 9:20 a.m., Resident #C was observed sitting in his recliner chair in his room. The resident was asked to stand for his pressure ulcer treatment. After the resident stood up from the recliner chair, there was no dycem observed in the chair.</p> <p>On 9/30/15 at 1:17 p.m., the resident was observed in the recliner chair in his room. There was no dycem noted in the chair.</p> <p>On 9/30/15 at 1:45 p.m., LPN #1 entered the resident's room to do a skin assessment. At that time, the resident was observed sitting in the recliner chair. There was no dycem noted in the chair.</p> <p>The record for Resident #C was reviewed on 9/30/15 at 10:26 a.m. The resident's diagnoses included, but were not limited to, obstructive chronic bronchitis, muscle</p>	F 0323	<p>1. Resident #C Dycem was replaced on 9/30/15 to his recliner chair.</p> <p>2. Facility audit of all safety devices was completed on 10/14/15 by the Interdisciplinary team. Devices were in place or replaced according to physicians orders.</p> <p>3. Staff were educated on ensuring safety devices are in place per physician order on 10/6/15, 10/13/15 and again on 10/19/15 by the DON. A safety audit form was created. Audits will be completed 3 times weekly for 1 month, 2 times weekly for 1 month and weekly for four months.</p> <p>4. Audits will be discussed in the monthly Quality Improvement meeting for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>5. Date Certain November 4 2015.</p>	11/04/2015

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	<p>weakness, chronic kidney disease, high blood pressure, history of alcohol abuse, iron deficiency anemia, and coronary artery disease.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 7/2/15, indicated the resident was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14. The resident needed extensive assist with one person physical assist for bed mobility, dressing, eating, and locomotion in the room.</p> <p>The current plan of care dated 7/10/15, indicated the resident was at risk for falls related to a previous fall. The Nursing approaches dated 9/15/15, indicated place a dycem to the recliner chair.</p> <p>Physician Orders dated 9/15/15, indicated dycem to recliner chair.</p> <p>A fall risk assessment dated 6/25/15, indicated the resident was at risk for falls with a score of 14. Another fall risk assessment dated 9/15/15, indicated the resident's score was 13 at risk for falls. A score above 10 indicated the resident was a high risk.</p> <p>An Incident follow up and recommendation form dated 9/15/15</p>			

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F 0363 SS=D Bldg. 00	<p>provided by the Director of Nursing (DoN), indicated the resident had attempted to pick something up from the floor and slid out of his recliner chair and onto the floor. The resident sustained a skin tear to his left forearm. The follow up plan was to add a dycem to the recliner chair.</p> <p>Interview with LPN #1 on 9/30/15 at 1:45 p.m., indicated there was no dycem in the recliner chair.</p> <p>Interview with QMA #1 on 9/30/15 at 2:24 p.m., indicated there should have been a dycem in the recliner chair while he was sitting.</p> <p>This Federal Tag relates to Complaint IN00183032</p> <p>3.1-45(a)(2)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>Based on observation, record review and interview, the facility failed to ensure the</p>	F 0363	1.Proper utensils will be used to ensure compliance with the recommended dietary	11/04/2015			

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F 0431 SS=D Bldg. 00	<p>menu was followed as written related to serving the correct portion size of french fries in 1 of 2 dining rooms. (The Main dining room)</p> <p>Finding includes:</p> <p>On 9/28/15 at 12:20 p.m., lunch was being served from the steam table in the Main dining room. Dietary Employee #1 was using tongs to serve french fries. The portion size of the french fries varied on each plate being served.</p> <p>The dietary spreadsheet was reviewed on 10/1/15 at 10:00 a.m. The spreadsheet indicated the residents were to receive 4 ounces of french fries.</p> <p>Interview with the Dietary Food Manager on 10/1/15 at 10:02 a.m., indicated there were 4 ounce scoops on the steam table and that was what the dietary employee should have used to serve the french fries rather than the tongs.</p> <p>3.1-20(i)(4)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who</p>		<p>allowances of the Food and Nutrition Board of the National Research Council and National Academy of Sciences.</p> <p>2.The dietary supervisor observed meals to insure that appropriate utensil were utilized for correct serving sizes that meet dietary guidelines.</p> <p>3.Dietary staff were educated on utilizing proper utensils to serve meals to residents on 10/1/15, 10/6/15, 10/13/15 and again on 10/19/15. A new "Utensil Audit" form was created by the Dietary Manager. Observations of meal service will be conducted daily 3 times weekly on a variety of shifts and days to insure appropriate serving utensils utilized for appropriate serving sizes to meet dietary guidelines.</p> <p>4.Observation audits will be discussed in Quality Assurance meeting monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>5.Date Certain is November 4 2015.</p>	

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	<p>establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to ensure the EDK (Emergency Drug Kit) box was locked on 1 of 2 units. (The West Unit)</p> <p>Finding includes:</p> <p>On 10/2/15 at 1:13 p.m., the West Unit</p>	F 0431	<p>1.The EDK was locked on 10/2/15. It was returned to pharmacy and a new EDK was delivered.</p> <p>2.All other EDK's were checked for security on 10/2/15. No other EDK's were noted to be unlocked.</p> <p>3.The licensed nurse was educated on keeping the EDK</p>	11/04/2015

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F 0441 SS=D Bldg. 00	<p>medication room was observed. The top compartment of the EDK box was observed to be unlocked.</p> <p>Interview at the time with RN #1, indicated all the compartments of the EDK box should have been locked.</p> <p>Interview with the Director of Nursing on 10/2/15 at 2:00 p.m., indicated all the compartments of the EDK box should have been locked.</p> <p>3.1-25(k)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>		<p>secure on 10/2/15. Staff were in-serviced on keeping the EDK locked at all times on 10/6/15, 10/13/15 and again on 10/19/15.</p> <p>4.An EDK audit form was created. The EDK will be checked for security three times weekly by the licensed nurse for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>5.Date Certain November 4 2015.</p>	

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure handwashing was done after glove removal during a pressure ulcer treatment. The facility also failed to sanitize scissors during a pressure ulcer treatment for 2 of 3 residents observed during a pressure ulcer treatment. (Resident #C and #139)</p> <p>Findings include:</p> <p>1. On 9/30/15 at 9:20 a.m., Resident #C was observed in his recliner chair in his room. At that time, LPN #1 and QMA #1 were going to change the resident's pressure sore bandage. The resident stood up and walked over to the dresser.</p>	F 0441	<p>1. Resident #C and # 139 were assessed and had no harm with the dressing changes.</p> <p>2. Facility audit of other dressing changes was completed by the Infection Control nurse on 10/05/15. Any infection control issues were addressed immediately.</p> <p>3. All staff were in-serviced on proper hand washing and proper sanitizing scissors on 10/1/15, 10/6/15, 10/13/15 and again on 10/19/15. Licensed staff and therapist was reeducated on proper hand washing and proper sanitizing of scissors on 10/1/15 by the Infection Control nurse. Staff has completed a return demonstration of proper hand washing.</p> <p>4. Random Infection Control audits will be conducted five times weekly by the Infection control</p>	11/04/2015

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	<p>LPN #1 and QMA #1 washed their hands with soap and water and donned clean gloves to their hands. The LPN pulled the resident's pants and his incontinent brief down. The QMA opened the gauze sponges and sprayed normal saline on them. The LPN wiped the area with the saline gauze sponges and then dried the open area. The QMA and the LPN removed their gloves and threw them away in the garbage. Both then, donned another pair of clean gloves to both of their hands without washing their hands with soap and water or using alcohol gel. The LPN placed the Duoderm (a medicated dressing) on the open area.</p> <p>Interview with LPN #1 at that time, indicated she should have washed her hands after glove removal and before donning another pair.</p> <p>The current 7/18/2011 Standard Precautions policy provided by the Director of Nursing indicated "All associates using Personal Protective Equipment (PPE) must observe the following precautions: Follow hand hygiene recommendations immediately or as soon as feasible after removal of gloves or other PPE."</p> <p>Interview with the Director of Nursing on 10/1/15 at 10:10 a.m., indicated the LPN</p>		<p>nurse. The five (5) audits will include hand washing and dressing changes. Audits will be discussed in the Quality Improvement meeting monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as deemed necessary.</p> <p>5.Date Certain November 4 2015.</p>	

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	<p>and the QMA should have washed their hands after removing their gloves.</p> <p>2. On 10/01/15 at 9:01 a.m., Physical Therapist (PT) #1 was observed performing wound care for Resident #139. At that time, the PT was observed to wash her hands with soap and water and donned a pair of gloves to both of her hands. She then proceeded to cut the dirty dressing off the right lower extremity with a pair of scissors. After she finished cutting the dressing, she placed the scissors on the bed between the resident's legs and then rolled the Unna Boot dressing (self adhesive) onto the right lower extremity. She then proceeded to cut the Unna Boot dressing with the scissors and then rolled the Coban dressing (self stick ace wrap) onto the right lower extremity, and cut the dressing with the scissors. The dirty dressing was cut off the left lower extremity. At no time were the scissors cleaned between the clean and dirty dressing changes or between the right and left extremity.</p> <p>Interview with the Physical Therapist on 10/1/15 at 11:19 a.m., indicated she was usually the one who performed the treatment for the resident. She indicated she should have rinsed and cleaned the scissors before she began to cut the clean dressing, or actually before she began to</p>			

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F 0465 SS=E Bldg. 00	<p>wrap the clean dressing. She indicated the facility had policies to make sure there was not any cross contamination.</p> <p>Review of Wound Care Procedures provided by the Director of Nursing on 10/2/15 at 10:00 a.m. and identified as current, indicated to "cut the tape with your clean scissors.... Clean the scissors with 60 seconds of contact with alcohol and place on a clean corner of your setup."</p> <p>3.1-18(a) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure the kitchen was clean related to dried food spillage on pipes, food crumbs and dirt behind the stove and juice machines and adhered dirt on the floor by the water pipes for 1 of 1 kitchens. The facility also failed to ensure the resident's environment was clean related to marred doors, dirty floor tile, marred walls,</p>	F 0465	<p>1.The PVC pipes were cleaned on 9/28/15. On 10/2/15 the crumbs and dirt was cleaned behind the oven, steamer and convection oven, juice machine food prep table and sink by the dietary staff. The bathroom floor tiles and baseboards of resident rooms 308-1, 308-2, 309-1 and 309-2 were cleaned on 10/1/15 by housekeeping staff. The bedroom door of 401-2 was painted on 10/3/15, the toilet riser in room</p>	11/04/2015

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	<p>rusted caulking around toilets, dirty baseboards and rusted toilet seat risers for 2 of 2 units. (The Main Kitchen, the East and West Units)</p> <p>Findings include:</p> <p>1. On 9/28/15 at 9:05 a.m., during the Brief Kitchen Sanitation Tour with the Dietary Food Manager (DFM), the following was observed:</p> <p>A. There was an accumulation dirt and dried food spillage noted on the white PVC pipes under the dish machine and under the three compartment sink.</p> <p>2. The Full Kitchen Sanitation tour on 10/2/15 at 9:15 a.m., with the DFM indicated the following:</p> <p>A. There were food crumbs and dirt noted behind the oven, steamer and convection oven.</p> <p>B. There were food crumbs and paper wrappers noted behind juice machine table.</p> <p>C. There was adhered dirt on the floor around the pipes next to the food prep table and sink.</p> <p>Interview with the DFM on 10/2/15 at</p>		<p>405-2 was replaced on 10/1/15, the wall and nails were repaired in room 503-2 by the Maintenance staff on 10/3/15. The bathroom in 506-2 was cleaned by the Housekeeping staff on 10/3/15, and the bathroom was cleaned and nails removed by Maintenance on 10/3/15. The marred areas of wall in room 511-1 was repaired and painted over.</p> <p>2.A facility audit was conducted on 10/2 /15 of the kitchen by the Dietary manager A facility audit of the residents bathrooms was conducted on 10/14/15 by the Housekeeping manager. Any environmental areas that are in need of cleaning and/or repair will be corrected by 11/4/15.</p> <p>3.Dietary staff were in-serviced on 10/1/15 on cleaning the pipes, and again on 10/19/15. Housekeeping was in-serviced on 10/14/15 and again on 10/19/15 on cleaning the floors. Environment in-servicing was conducted on 10/1/15 and 10/19/15.</p> <p>4.Environmental rounds will be conducted weekly by the ED/ designee. Audits will be discussed in the Quality Improvement meeting monthly for the next six months. Audit results and system components will be reviewed by the Performance Improvement Committee with subsequent plans of correction developed and implemented as</p>	

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	<p>9:35 a.m., indicated all of the above was in need of cleaning.</p> <p>3. During the Environmental Tour on 10/1/15 at 2:22 p.m., with the Director of Environmental Services, Senior Maintenance Director, and the Administrator, the following was observed.</p> <p>300 Hall</p> <p>a. The bathroom floor tile as well as the baseboards were dirty in Room 308-1. Two residents resided in this room.</p> <p>b. The bathroom floor tile as well as the baseboards were dirty in Room 308-2. Two residents resided in this room.</p> <p>c. The bathroom floor tile as well as the baseboards were dirty in Room 309-1. Two residents resided in this room.</p> <p>d. The bathroom floor tile as well as the baseboards were dirty in Room 309-2. Two residents resided in this room.</p> <p>Hall 400</p> <p>a. The bathroom floor tile was dirty and the bedroom door was marred in Room 401-2. Two residents resided in this room.</p>		<p>deemed necessary.</p> <p>5.Date Certain November 4 2015.</p>	

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	<p>b. The toilet seat riser was rusty in Room 405-2. Two residents resided in this room.</p> <p>Hall 500</p> <p>a. The wall by the window was marred and nails were left in the resident's wall in Room 503-2. Two residents resided in this room.</p> <p>b. The bathroom wall had spillage spots on 1 of 4 walls, the floor tile was dirty, and the toilet bowl was rusty in Room 506-2. Two residents resided in this room.</p> <p>c. The bathroom floor was marred and scuffed, the caulking around the toilet was rusty, and nails were left in the residents wall in the bedroom in Room 511-1. Two residents resided in this room.</p> <p>Interview at the time with the Director of Environmental Services, Senior Maintenance Director, and the Administrator, indicated all of the above areas were in need of cleaning and/or repair.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>			

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

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