

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2015
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the investigation of Complaints IN00180120, IN00182782 and IN00183049.</p> <p>Complaint IN00180120-Substantiated. Federal/State deficiencies related to the allegations are cited at F225, F226 and F250.</p> <p>Complaint IN00182782-Substantiated. Federal/State deficiencies related to the allegations are cited at F314, F514 and F520.</p> <p>Complaint IN00183049-Substantiated. Federal/State deficiency related to the allegations is cited at F250.</p> <p>Survey dates: November 16, 17, 18, 19, 20, 23 and 24, 2015</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Census bed type: SNF: 19 SNF/NF: 32</p>	F 0000	<p>Survey Event ID: The submission of this POC does not indicate an admission by Homewood Campus, that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</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>Residential: 34 Total: 85</p> <p>Census payor type: Medicare: 14 Medicaid: 25 Other: 12 Total: 51</p> <p>Sample: 20</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on December 2, 2015.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>				

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	<p>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 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 interview and record review, the facility failed to report an abuse allegation to the state agency in a timely manner for 1 of 4 abuse allegations being reviewed (Resident B) and failed to thoroughly investigate abuse allegations for 3 of 4 abuse allegations being reviewed. (Residents B, C and D)</p> <p>Findings include:</p> <p>1. On 11/23/15 at 9:05 a.m., the</p>	F 0225	<p>Completion Action: Resident # B, # C and # D was reassessed by the Director of Nursing Service on 12/4/15 to verify the location and extent of injury. The physician and resident's sponsor were notified promptly upon completion of the assessment. A thorough investigation was initiated by the Director of Nursing Service and Executive Director.</p> <p>Identify other residents: The campus has determined that all</p>	12/24/2015

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	<p>Executive Director (ED) was notified there was an abuse allegation, which occurred sometime in the middle of July with two employees. The ED was given the employees first names who were involved in the abuse allegation.</p> <p>The ED provided a copy of a handwritten paper dated 7/30/15, on 11/23/15 at 3:10 p.m., written by CNA #1. The paper indicated around 2:30 p.m., Resident B turned her call light on and CNA #1 answered her call light. The paper indicated the resident indicated to CNA #1, that morning she had to go to the bathroom and she had to wait over two hours before staff came to take her and she was in a lot of pain. The resident indicated when the staff came to take her they were "very rough and mean to her." Resident B indicated the girls, who came into her room were a fat curly haired girl and a short long haired girl. She indicated the two girls jerked her around when getting her up. CNA #1 indicated she immediately reported the incident to ED #2. The two staff members identified in the abuse allegation were CNA #3 and CNA #4. There was a mental orientation interview completed by the Director of Social Services (DSS) dated 7/30/15, with a handwritten note at the bottom of the interview "The Boss is taking care of your report."</p>		<p>residents have the potential to be affected.</p> <p>Measures/ Systemic Changes: In-service on abuse for all staff was conducted by the Director of Nursing Services and the Executive Director with all direct care staff addressing circumstances that require reporting appropriate time frames.</p> <p>Monitoring Action: The Director of Nursing Services, or designee, will conduct a random audit of five (5) residents weekly for four (4) consecutive weeks then monthly x 3 months. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>		

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	<p>An "OT [Occupational Therapy] Daily Treatment Note" dated 7/21/15, indicated "... Additionally, while in therapy, pt [patient] made comment someone slammed her into bed. This was immediately reported to acting therapy director, then DON [Director of Nursing]. Additionally, social service came and discussed with therapy my concerns about her sleeping at night and apparent yelling. At this point, patient made same statement to Social service who stated she will look into it and go to ED...."</p> <p>During an interview on 11/23/15 at 3:20 p.m., the ED indicated she had found handwritten information in a folder regarding Resident B and the concern of the abuse allegation. She indicated there was no abuse allegation reported to the state agency for this resident regarding the 7/30/15, allegation and no investigation had been started when the abuse allegation was made.</p> <p>2. On 11/17/15 at 3:52 p.m., Resident C indicated she had been mentally abused by LPN #7, but because of her disease she was not able to remember how long ago. Resident C indicated LPN #7 told her she had to do things that LPN #7 knew the resident would not do and if the</p>			

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	<p>resident did not do the things LPN #7 told her to do, then she got mad at her and was rude to her. She indicated she had either told the ED or the DSS and it had been taken care of and had never happened again.</p> <p>On 11/17/15 at 4:34 p.m., the ED was notified of Resident C's mental abuse allegation.</p> <p>A record review of the facility investigation of the abuse allegation, completed on 11/20/15 at 2:21 p.m., indicated a handwritten interview of Resident C's statement of the abuse allegation was not dated or signed by the staff member who completed the interview. The facility had interviewed and completed abuse questions with nine residents, but no staff members were interviewed.</p> <p>During an interview on 11/20/15 at 2:44 p.m., the ED indicated the abuse allegation for Resident C did not include employee interviews, a signature or date on the resident interview statement, which she thought was completed by the Director of Health Services (DHS). She indicated the investigation was not a thorough investigation without these items.</p>			

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	<p>During an interview on 11/20/15 at 3:30 p.m., the DHS with the Regional Clinical Consultant in attendance indicated she had completed Resident C's interview statement, but she did not get a chance to sign or date it before it was taken from her.</p> <p>3. The record review of the facility investigation of the abuse allegation for Resident D was reviewed on 11/18/15 at 3:38 p.m. The resident's son reported the staff belittled him. The resident was interviewed, six staff interviews were completed, but no other resident abuse interviews were completed. The staff statement written on 9/23/15 at 4:05 p.m., was not signed by the staff member who wrote it. LPN #8 did not date her written statement. RN #9 did not date her written statement.</p> <p>During an interview on 11/20/15 at 2:44 p.m., the ED indicated she knew the staff statements had to have a signature and date to be a thorough investigations.</p> <p>A current policy dated 9/16/2011, titled "Abuse and Neglect Procedural Guidelines" provided by the ED on 11/18/15 at 2:54 p.m., indicated "Purpose: [Name of facility] has developed and implemented processed, which strive to ensure the prevention and</p>			

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	<p>reporting of suspected or alleged resident abuse and neglect... Procedure:... 6. How to investigate and report incidents of actual or suspected abuse or neglect... d. Identification:... vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies as indicated... f. Investigation: i. The Executive Director is accountable for investigating and reporting. II. Refer to the incident Accident Program for investigation procedures. g. Reporting: i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect or misappropriation to local or state agencies...."</p> <p>A current policy dated 11/2010, titled "Accident and Incident Reporting Guidelines" provided by the ED on 11/19/15 at 4:20 p.m., indicated "Purpose: To ensure all accidents, incidents and allegations of abuse involving resident's, visitors, or employees are investigated and reported to the facility administration. Procedure:... 5. Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines...11.</p>			

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F 0226 SS=D Bldg. 00	<p>The following data shall be included in either the Accident and Incident form (front and back) and/or the circumstance and Reassessment form: a. Date and time the accident, incident or abuse allegation took place...e. Name (s) of witness (s) and their account of the occurrence-account should be conducted by an in-person or phone interview. (I/A form only) f. The statement taken by the administrative staff shall be reviewed with the witness for accuracy and signed by the witness (I/A form only)...."</p> <p>This Federal tag relates to Complaint IN00180120.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow the policy on investigating abuse for 3 of 4 residents reviewed for abuse allegations. (Residents B, C and D)</p> <p>Findings include:</p>	F 0226	<p>Completion Action: A thorough investigation was conducted by the Director of Nursing Service and Executive Director regarding the allegations made by residents # B, # C, and #D. Staffing patterns were adjusted to assure the protection of the residents.</p>	12/24/2015

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	<p>1. On 11/23/15 at 9:05 a.m., the Executive Director (ED) was notified there was an abuse allegation, which occurred sometime in the middle of July with two employees. The ED was given the employees first names who were involved in the abuse allegation.</p> <p>The ED provided a copy of a handwritten paper dated 7/30/15, on 11/23/15 at 3:10 p.m., written by CNA #1. The paper indicated around 2:30 p.m., Resident B turned her call light on and CNA #1 answered her call light. The paper indicated the resident indicated to CNA #1 that morning she had to go to the bathroom and she had to wait over two hours before staff came to take her and she was in a lot of pain. The resident indicated when the staff came to take her they were "very rough and mean to her." Resident B indicated the girls, which came into her room were a fat curly haired girl and a short long haired girl. She indicated the two girls jerked her around when getting her up. CNA #1 indicated she immediately reported the incident to ED #2. The two staff members identified in the abuse allegation were CNA #3 and CNA #4. There was a mental orientation interview completed by the Director of Social Services (DSS) dated 7/30/15, with a handwritten note at the bottom of the</p>		<p>Identify other residents: The campus has determined that all residents have the potential to be affected.</p> <p>-</p> <p>Measures/Systemic Changes: In-service on abuse for all staff was conducted by the Director of Nursing Service and Executive Director with all direct care and ancillary staff addressing the campus policies and procedures regarding alleged violations</p> <p>Monitor Action: The Director of Nursing Service, or designee, will conduct a random of five (5) residents weekly for four (4) consecutive weeks then monthly times 3 months. These residents will be assessed and interviewed to ensure that any alleged violations are identified, properly investigated and reported according to campus policy and procedures. This plan of correction will be monitored at the monthly Quality Assurance Committee until such time consistent substantial compliance has been met.</p>	

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	<p>interview "The Boss is taking care of your report."</p> <p>An "OT [Occupational Therapy] Daily Treatment Note" dated 7/21/15, indicated "... Additionally, while in therapy, pt [patient] made comment someone slammed her into bed. This was immediately reported to acting therapy director then DON [Director of Nursing]. Additionally, social service came and discussed with therapy my concerns about her sleeping at night and apparent yelling. At this point, patient made same statement to Social service who stated she will look into it and go to ED...."</p> <p>During an interview on 11/23/15 at 3:20 p.m., the ED indicated she had found handwritten information in a folder regarding Resident B and the concern of the abuse allegation. She indicated there was no abuse allegation reported to the state agency for this resident regarding the 7/30/15, allegation and no investigation had been started when the abuse allegation was made.</p> <p>2. On 11/17/15 at 3:52 p.m., Resident C indicated she had been mentally abused by LPN #7, but because of her disease she was not able to remember how long ago. Resident C indicated LPN #7 told her she had to do things that LPN #7</p>			

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	<p>knew the resident would not do and if the resident did not do the things LPN #7 told her to do, then she got mad at her and was rude to her. She indicated she had either told the ED or the DSS and it had been taken care of and had never happened again.</p> <p>On 11/17/15 at 4:34 p.m., the ED was notified of Resident C's mental abuse allegation.</p> <p>A record review of the facility investigation of the abuse allegation, completed on 11/20/15 at 2:21 p.m., indicated a handwritten interview of Resident C's statement of the abuse allegation was not dated or signed by the staff member who completed the interview. The facility had interviewed and completed abuse questions with nine residents, but no staff members were interviewed.</p> <p>During an interview on 11/20/15 at 2:44 p.m., the ED indicated the abuse allegation for Resident C did not include employee interviews, a signature or date on the resident interview statement, which she thought was completed by the Director of Health Services (DHS). She indicated the investigation was not a thorough investigation without these items.</p>			

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	<p>which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect... Procedure... 6. How to investigate and report incidents of actual or suspected abuse or neglect... d. Identification... vii. The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies as indicated... i. The Executive Director is accountable for investigating and reporting. II. Refer to the incident Accident Program for investigation procedures... g. Reporting: i. Any staff member, resident, visitor or responsible party may report known or suspected abuse, neglect or misappropriation to local or state agencies...."</p> <p>A current policy dated 11/2010, titled "Accident and Incident Reporting Guidelines" provided by the ED on 11/19/15 at 4:20 p.m., indicated "Purpose: To ensure all accidents, incidents and allegations of abuse involving resident's, visitors, or employees are investigated and reported to the facility administration. Procedure... 5. Reporting of incident, accidents and abuse to state and federal agencies shall be in compliance in</p>			

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F 0250 SS=D Bldg. 00	<p>accordance with agency guidelines...11. The following data shall be included in either the Accident and Incident form (front and back) and/or the circumstance and Reassessment form: a. Date and time the accident, incident or abuse allegation took place...e. Name (s) of witness (s) and their account of the occurrence-account should be conducted by an in-person or phone interview. (I/A form only) f. The statement taken by the administrative staff shall be reviewed with the witness for accuracy and signed by the witness (I/A form only)...."</p> <p>This Federal tag relates to Complaint IN00180120.</p> <p>3.1-28(a)</p> <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 interview and record review, the facility failed to ensure the Director of Social Services (DSS) followed up on the emotional status of 3 of 3 residents after abuse allegations were reported. (Resident C, D and B)</p> <p>Findings include:</p>	F 0250	<p>Correction Action: The following residents C, D, and B were assessed by social service designee in regards to their emotional wellbeing following abuse allegations.</p>	12/24/2015

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	<p>1. Resident C's record was reviewed on 11/18/15 at 3:54 p.m. The resident's record lacked Social Service notes to indicate she had followed up with Resident C after the abuse allegation to assess for emotional distress.</p> <p>On 11/17/15 at 3:52 p.m., Resident C indicated she had been mentally abused by LPN #7, but because of her disease she was not able to remember how long ago. Resident C indicated LPN #7 told her she had to do things that LPN #7 knew the resident would not do and if the resident did not do the things LPN #7 told her to do, then she got mad at her and was rude to her.</p> <p>2. Resident D's record was reviewed on 11/19/15 at 4:16 p.m. The resident's record lacked Social Service notes to indicate she had followed up with Resident D after the abuse allegation to assess for emotional distress.</p> <p>The record review of the facility investigation of the abuse allegation for Resident D was reviewed on 11/18/15 at 3:38 p.m. The resident's family member reported the staff belittled him.</p> <p>3. Resident B's record was reviewed on 11/20/15 at 1:17 p.m. The resident's</p>		<p>Identify other Residents: All residents have the potential to be affected by this practice.</p> <p>Measures/Systemic Change: The Executive Director or designee will review all allegations of abuse and follow up on the psychosocial and well being of each allegation with supporting documentation within 24 hours of the event. The allegations will be forwarded to the CCM daily. The Executive Director or designee will complete weekly audits on all medical charts monitoring documentation on each allegation. The Executive Director or designee will forward outcomes of the audits to the Quality Assurance Committee. The Executive Director conducted a in-service to all staff in regards to following the guidelines in reporting, investigation, and following up on all allegation of abuse.</p> <p>-</p> <p>Monitoring Correction Action: Audits results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the Committee.. Corrective action</p>	

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	<p>record lacked Social Service notes to indicate she had followed up with Resident B after the abuse allegation to assess for emotional distress.</p> <p>The ED provided a copy of a handwritten paper dated 7/30/15, on 11/23/15 at 3:10 p.m., written by CNA #1. The paper indicated around 2:30 p.m., Resident B turned her call light on and CNA #1 answered her call light. The paper indicated the resident indicated to CNA #1 that morning she had to go to the bathroom and she had to wait over two hours before staff came to take her and she was in a lot of pain. The resident indicated when the staff came to take her they were "very rough and mean to her." Resident B indicated the girls, which came into her room were a fat curly haired girl and a short long haired girl. She indicated the two girls jerked her around when getting her up. CNA #1 indicated she immediately reported the incident to ED #2. The two staff members identified in the abuse allegation was CNA #3 and CNA #4. There was an mental orientation interview completed by the Director of Social Services (DSS) dated 7/30/15, with a handwritten note at the bottom of the interview "The Boss is taking care of your report."</p>		completion date: 12/4/15	

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F 0274 SS=D Bldg. 00	<p>An "OT [Occupational Therapy] Daily Treatment Note" dated 7/21/15, indicated "... Additionally, while in therapy, pt [patient] made comment someone slammed her into bed. This was immediately reported to acting therapy director then DON [Director of Nursing]. Additionally, social service came and discussed with therapy my concerns about her sleeping at night and apparent yelling. At this point, patient made same statement to Social service who stated she will look into it and go to ED...."</p> <p>During an interview on 11/20/15 at 3:13 p.m., the DSS indicated she did not follow-up with these residents regarding their emotional well-being for 72 hours after an abuse allegation.</p> <p>This Federal tag relates to Complaint IN00180120 and Complaint IN00183049.</p> <p>3.1-34(a)(2)</p> <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will</p>				

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	<p>not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>Based on record review and interview, the facility failed to conduct a comprehensive assessment of a resident within 14 days after the facility determined there had been a significant change in the resident's physical condition for 2 of 4 residents reviewed for Hospice (Residents #49 and #79).</p> <p>Findings include:</p> <p>1. The Clinical record for Resident #49 was reviewed on 11/18/2015 at 2:00 p.m. Diagnoses included, but were not limited to, hypertension, heart disease, heart failure, protein malnutrition, congestive heart disease, anorexia, dementia, and coronary artery disease..</p> <p>A Physician's order, dated 10/29/2015, indicated "...[Name of] Hospice to eval [evaluate] & TX [treat] due to Medical & Physical decline R/T [related to] Dx [diagnosis] of Congested Heart Failure [CHF] and life expectancy of less then 6 months....".</p> <p>A Significant Change Minimum Data Set</p>	F 0274	<p>Correction Action: On 11/18/2015 and 11/11/2015 the MDS Coordinator completed the Comprehensive Significant Change Assessments for Residents #49 & #79. Identify other Residents: All residents have the potential to be affected by this practice.</p> <p>Measures/Systemic Change: The MDS Coordinator attended an in-service presented by the MDS Nurse Consultant on 12/04/2015. Monitoring</p> <p>Correction Action: The DHS or designee will review the clinical record for hospice eval and treat dates for any residents newly admitted to hospice care within the next 3 months. She will then review the MDS assessment schedule to ensure that a Significant Change MDS was set and completed timely (Z0500A&B, and V0200A&B signed within 14 days of the admission date to hospice). Audit results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.</p>	12/24/2015

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	<p>Assessment (MDS), dated 10/29/2015, indicated Resident #49 was on Hospice care and did have a prognosis of six months or less, but was not completed by 11/18/2015.</p> <p>2. The Clinical record for Resident #79 was reviewed on 11/18/2015 at 2:00 p.m. Diagnoses included, but were not limited to, congestive obstructive pulmonary disease, congestive heart failure, dementia, osteoarthritis, anxiety, depression, hypertension and Alzheimer's disease.</p> <p>A Physician's order, dated 10/09/2015, indicated "...this patient is suffering from a life limiting illness with a life expectancy of six months or less, if the disease runs it's normal course....".</p> <p>A Significant Change Minimum Data Set Assessment (MDS), dated 10/15/2015, indicated Resident #79 was on Hospice care and had a prognosis of six months or less, but was not completed until 11/11/2015.</p> <p>During an interview on 11/18/2015 at 3:30 p.m., the MDS Coordinator indicated Residents #49 and #79 were assessed and a change of condition was prepared, but the MDS was not signed by the Director of Health Services within 14</p>			

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F 0278 SS=D Bldg. 00	<p>days of the assessed change in condition.</p> <p>3.1-31(d)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to correctly identify and accurately assess the resident's status regarding Hospice for 2 of 4 residents</p>	F 0278	<p>Correction Action: Residents #3 and #10 have had modifications done to correct J1400 Prognosis, marking the</p>	12/24/2015

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	<p>reviewed for Hospice (Residents #3 and #10).</p> <p>Findings include:</p> <p>1. The Clinical record for Resident #3 was reviewed on 11/18/2015 at 2:00 p.m. Diagnoses included, but were not limited to, dizziness, hyperlipidemia, chronic ischemic heart disease, depression and Congestive Heart Failure.</p> <p>A Physician's order, dated 8/28/2015, indicated The Medical Director/Hospice Team Physician certified the resident's prognosis was six months or less if the disease runs its normal course (primary diagnosis coronary artery disease).</p> <p>A Significant Change Minimum Data Set Assessment (MDS), dated 9/1/2015, indicated Resident #3 was on Hospice care, but did not have a prognosis of six months or less.</p> <p>2. The clinical record for Resident #10 was reviewed on 11/18/2015 at 10:15 a.m. . Diagnoses included, but were not limited to coronary artery disease, atrial fibrillation, hypertension, hydrocephalus and hypokalemia.</p> <p>Physician's orders, dated 12/01/2014 and 9/1/2015, indicated "...this patient is</p>		<p>MDS it set as "yes" to the question "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" These modification were completed and transmitted according to the RAI Manual guidelines.</p> <p>Identify other residents:The facility has determined that all residents have the potential to be affected</p> <p>Measures/Systemic Changes An in-service education program was conducted by the Nurse Consultant and MDS Coordinator, addressing the importance of correctly coding MDS question J1400 as "Yes" when a resident is actively utilizing hospice services.</p> <p>Monitoring Correction Action: An in-service education program was conducted by the Nurse Consultant and MDS Coordinator, addressing the importance of correctly coding MDS question J1400 as "Yes" when a resident is actively utilizing hospice services.</p>		

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F 0309 SS=D Bldg. 00	<p>suffering from a life limiting illness with a life expectancy of six months or less, if the disease runs it's normal course....".</p> <p>A Quarterly Review MDS dated 9/1/2015, indicated Resident #10 was not on Hospice and did not have a prognosis of six months or less.</p> <p>During an interview with the MDS Coordinator, on 11/18/2015 at 3:35 p.m., regarding the Hospice status of Residents #3, she indicated Hospice care was noted on the MDS, and Resident #3 should have had a prognosis of less than six months indicated on the MDS.</p> <p>During an interview with the MDS Coordinator, on 11/18/2015 at 3:45 p.m., she indicated Resident #10 should have had Hospice care noted on the MDS, and Resident #10 should have had a prognosis of less than six months indicated on the MDS.</p> <p>3.1-31(a) 3.1-31(d)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with</p>			

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	<p>the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to follow recommendations from the dialysis center for an elevated Potassium level for 1 of 1 residents reviewed for dialysis. (Resident H)</p> <p>Findings include:</p> <p>Resident H's record was reviewed on 11/18/15 at 2:27 p.m. Diagnoses included, but were not limited to, kidney disease and dialysis.</p> <p>On 11/19/15 at 4:00 p.m., the resident was observed sitting at the nurses station after returning from dialysis. RN #12 was observed removing a binder marked with "Dialysis" from a cloth bag hanging on the back of the resident's wheelchair. RN #12 was observed reviewing the Dialysis binder, which had a Dialysis Communication Form dated 11/19/15. The pre-dialysis information had been completed by the facility, but the dialysis center had not completed their section. A form titled "Tracking My Numbers" dated 11/17/15, indicated the resident's Potassium level was 6.5 MMOL/L (millimoles/liter) and the goal was 3.5 MMOL/L to 6.0 MMOL/L. A handwritten note indicated "K+</p>	F 0309	<p>Correction Action: Stat Potassium level was completed on resident H on 11/20/15. The results of the Potassium level was 4.9 (normal within 3.5 to 5.1). The ADHS is checking all labs weekly for all residents whom are on Dialysis.</p> <p>Identify other residents: The campus has determined that all residents whom are Dialysis has the potential to be affected.</p> <p>Measures/Systemic Changes An in-service was conducted by the Director of Nursing Services in regards to checking all recommendations sent back from the Dialysis on return from the Dialysis Center to ensure follow up on recommendations.</p> <p>Monitoring Correction Action: The Director Of Nursing Services, or designee, will conduct audits weekly for four (4) consecutive weeks to ensure that we are following Dialysis recommendations then monthly times 3 months. The findings to the audits will be forward to the Quality Assurance Committee</p>	12/24/2015			

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	<p>[Potassium] high-please avoid giving bananas, orange jc; [juice] or oranges. Limit potatoes to 1 serving/day. Tomato products occasionally." RN #12 indicated at that time during interview, the dialysis binder was used for the facility and the dialysis center to communicate with one another regarding the resident's dialysis runs.</p> <p>On 11/20/15 at 8:28 a.m., Resident H was observed eating a bowl of oatmeal, a fried egg, a sliced banana and drinking a glass of orange juice. The resident's Breakfast Menu ticket indicated she was on a K+ (Potassium) Restricted Regular diet. She was to be served eggs to order any style and a sliced banana. CNA #13 indicated at that time the clear glasses used to serve juice held 240 ml and the resident had drank 120 ml of orange juice for breakfast. She indicated Resident H liked her orange juice.</p> <p>During an interview on 11/20/15 at 4:41 p.m., the DHS (Director of Health Services) indicated the binder labeled "Dialysis" was the binder used to go to the dialysis center with the resident, which the facility and the dialysis center used to communicate information regarding the resident between the two facilities. She indicated RN #12 should have seen the handwritten note about the</p>		until such time consistent substantial compliance has been met.				

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	<p>resident's high potassium and avoiding certain foods on 11/19/15, then called the physician to clarify if he wanted orders written based on the recommendations from Dialysis.</p> <p>A contract titled "Independent Contractor Agreement For Hemodialysis Services (Outpatient)" dated 6/1/2011, provided by the Executive Director on 11/19/15 at 10 a.m., indicated "...1. Engagement: Responsibilities of Provider:.. 1.6 Documentation: Provider shall submit to facility, on a monthly basis, appropriate documentation of services provided hereunder. Such documentation shall be in the form and shall contain the information requested by Facility. The parties agree to use their best efforts to ensure the efficient transfer of information regarding the status of residents. 1.3 Coordination of Services: In order to facilitate Facility's achievement of its goals and objectives, and the efficient delivery of appropriate care to Facility patients, Facility, through its Administrator and Medical Director, and Provider, through its designated representative, shall coordinate their activities in connection with the provision of hemodialysis services hereunder. These individuals shall meet to develop and implement the resident care plans and to exchange all</p>			

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F 0314 SS=G Bldg. 00	<p>information useful and necessary for the care of the resident...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL 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, interview and record review, the facility failed to ensure pressure ulcers were assessed appropriately for 5 of 5 residents (Residents F, G, H, J and K) and the facility failed to implement pressure ulcer prevention interventions and ensure treatments were ordered in a timely manner for 3 of 3 residents being reviewed for pressure ulcers. (Residents F, H and J)</p> <p>This deficient practice resulted in Resident H developing an Unstageable pressure ulcer (Full thickness tissue loss</p>	F 0314	<p>Correction Action: On November 27, 2015 the Director of Nursing Service and Assistant Director of Nursing Service conducted a pressure ulcer risk assessment and skin assessment on the following residents: F, G, H, J, and K. At this time the wounds was measured, staged, and order was obtained for treatments, and treatments was initiated as ordered. Appropriate revisions were made to the care plans to reflect all current pressure ulcers prevention and interventions. The Director of Nursing Service reviewed the revised care plans with all staff</p>	12/24/2015

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	<p>in which the base of the ulcer is covered by slough (yellow, tan, gray green or brown) and/or eschar (tan, brown or black) in the ulcer bed. Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage cannot be determined.) to her sacral area.</p> <p>Findings include:</p> <p>1. Resident H's record was reviewed on 11/18/15 at 2:27 p.m. Diagnoses included, but were not limited to chronic kidney disease, difficulty walking, dialysis and hypertension.</p> <p>"Nursing Admission Assessment & Data Collection" dated 7/11/15, under the "Skin Plan of Care" indicated the body diagram had an X marked on the sacral area with no explanation as to why the X was documented on the diagram.</p> <p>A "Skin Impairment Circumstance Assessment and Intervention" sheet dated 8/9/15, indicated the resident had a Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister) pressure ulcer to her sacrum area. No measurements were documented.</p>		<p>involved in the care of the residents on November 27, 2015.</p> <p><u>Identify other residents;</u> Pressure ulcer risk assessments and skin assessments were completed for all residents on 11/27/2015 by the nursing team. For those residents at risk, care plans were reviewed to ensure appropriate</p> <p>Interventions. The Director of Nursing Service reviewed the care plans with all staff involved in the care of at risk</p> <p>Residents on November 27, 2015.</p> <p>-</p> <p><u>Measures/Systemic Changes:</u> The Director of Nursing Service and or designee will review pressure ulcer risk assessments, skin assessments, interventions, and timely reporting skin concerns on November 27, 2015. The certified aides are submitting all shower sheets daily to the Charge Nurse to initial and check for new areas. The Charge Nurse will then follow up with the Physician immediately for new orders. The shower sheets are then forwarded to the ADHS to monitor daily. Skin sweeps are being conducted on all residents</p>		

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	<p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 8/26/15, indicated the resident had a Unstageable pressure ulcer to her sacrum. The wound measured 3.0 x 2.5 cm (centimeters). The color of the wound was red outer edges with yellow slough wound bed. The initial identification of the wound was dated 8/26/15. There were signs and symptoms of infections and the resident indicated she was having pain at the site. The wound was a facility acquired wound. The Physician orders dated 8/26/15, indicated Santyl ointment (a debriding agent for pressure ulcers) 30 grams Cleanse area to sacrum with normal saline, apply Santyl to yellow slough area of wound, cover with Optifoam and change every day. Roho mattress to bed-check inflation every shift by pressing down with palm of hand. Roho cushion to wheelchair-check inflation every shift, re-inflate if needed.</p> <p>Typed interview statement by the Medical Records staff member dated 9/11/15, indicated, "During CCM [Clinical Care Meeting] 8/10, the team reviewed a skin impairment circ [circumstance] form for resident [name of this resident] dated 8/9-pressure area to sacrum at a stage 2. There was no treatment order listed for this resident.</p>		<p>weekly times 4 weeks, then monthly times 3 months.</p> <p>Monitoring Correction Action: The Director of Nursing Service, and or designee will review pressure ulcer risk assessments, skin assessments, interventions, care plans on all new admissions on-going. The Director of Nursing Service, and or designee will audit a minimum of 2 admissions per month for three months, then 1 admission per month thereafter unless otherwise determined by he Risk Management Quality/Quality Assurance Committee. Audits will be reviewed by risk Management/</p> <p>Quality Assurance until consistent substantial compliance has been achieved as determined by the committee.</p> <p>-</p>				

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	<p>[Name of nurse] wrote on his pad of paper / 'to do' list to follow up. [Name of nurse] not at work on 8/26. He asked [Name of Medical Record staff member] and [Name of Staffing Coordinator] to complete wound rounds. During CCM, they reviewed a skin circ form for resident [name of this resident] for pressure area to sacrum described as Unstageable. This triggered them to review her during wound rounds. During observation of resident on 8/26, a dressing (hydrocolloid) was noted to the sacrum area-no order in place, not on MAR [Medication Administration Record] to be signed off. The dressing 'appeared' to have been on there awhile-edges rolled up. Wound observation to sacrum-angry around the edges, yellow slough covering wound bed. Wound bed 'soggy' with clear drainage...."</p> <p>Typed interview statement by the Staffing Coordinator dated 9/11/15, indicated, "During 8/9 CCM she [Staffing Coordinator] was in CCM and reviewed 100/200 hall. [Name of nurse] reviewed his hallway of responsibility 300 hall, where resident [name of this resident] resides. Reviewed 8/9 circ form for this resident was in place for a stage 2 to the coccyx. No treatment was listed. [Name of nurse] stated 'I will follow up</p>			

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	<p>on that.' He wrote on his note pad to follow up, as he normally does. 8/26, [Name of nurse] was out this day and asked [Name of Staffing Coordinator] and [Medical Records staff member] to do wound rounds. During CCM, they noted on the 24 hour report for resident [Name of this resident]-'please look at coccyx-it looks bad.' This triggered them to include her into the wound rounds. Wound observation-...Noted hydrocolloid in place to sacrum and dressing 'appeared' to have been on there for a 'long time.' Resident complained of pain to the area when they removed it. Outer area was red/angry, inner area was covered with slough. Could not measure depth... Looked through res [resident's] chart. Noted admit assessment on 7/11 had a X marked on the sacral area, but no description. Nurse was interviewed and she told [Name of Staffing Coordinator] the area was not open, only red. Found 8/9 skin circ documenting a stage 2 to the sacrum and that nothing had been done with it at that time (no treatment implemented)...."</p> <p>On 11/19/15 at 11:36 a.m., the Executive Director, Director of Health Services (DHS) and the Assistant Director of Health Services (ADHS) were all in attendance. At that time the DHS indicated the management team reviewed</p>			

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	<p>all the wounds in the building. She indicated the process to identify wounds started with the CNA's when they gave the residents their showers they would notify the charge nurse if they found any new areas. She indicated after the nurses were notified they would document the new areas either on a pink or green sheet, then they would follow up with the physician for orders. The ADHS indicated the issue with Resident H's pressure ulcer was no one noticed it when it was a Stage II, so there was no treatment or interventions implemented, then it progressed to an Unstageable wound. The ADHS indicated the reason the nurses did not notice the Stage II pressure ulcer on Resident H's sacrum, which progressed to an Unstageable wound was because skin checks were not completed every Wednesday as ordered.</p> <p>On 11/19/15 at 11:48 a.m., with the ED, DHS, ADHS, Medical Records staff member and Staffing Coordinator were all in attendance. At that time the Staffing Coordinator indicated Resident H's pressure ulcer developed into an Unstageable wound between 8/9/15 and 8/25/15. She indicated RN #6 wrote notes on his pad of paper during the morning clinical meeting the day the Stage II pressure ulcer was brought to their attention. She indicated RN #6 always</p>			

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	<p>wrote notes indicating he would follow-up on things, so she thought he was following up on the Stage II pressure ulcer from 8/9/15, so she did not have any idea the resident's wound was not being treated until the next time it was brought to their attention on 8/26/15 during the clinical care meeting. She indicated they had pulled all the CNA shower sheets up to that date and they all indicated the shower sheets were signed off by the CNA's and nurses and the skin was "Okay." She indicated she and the Staffing Coordinator did wound rounds on 8/26/15, for RN #6 and that was when they discovered the Unstageable wound to Resident H's sacrum with no treatment or interventions implemented.</p> <p>2. Resident K's record was reviewed on 11/23/15 at 11:11 a.m. Diagnoses included, but were not limited to, chronic renal insufficiency, hypertension and anemia of iron deficiency.</p> <p>A "Nursing Admission Assessment & Data Collection" note dated 11/13/15, indicated the "Skin Plan of Care" had an X marked on the body diagram on the left side of the middle of the back. "abrasion" was documented above the X with a line drawn toward the X mark on the diagram.</p>			

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	<p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" sheet dated 11/19/15, indicated the initial identification of the pressure ulcer was 11/19/15. The wound was facility acquired. The location of the wound was to the right second toe. No stage was documented on the form. The wound measured 0.7 x 0.5 cm. The color was black. The Physician Orders dated 11/19/15, were apply skin prep to affected area 2nd toe right foot every shift, place gauze between 2nd toe and great toe right foot to relieve pressure and "This wound is Unstageable." The Physician Order dated 11/20/15, was resident to wear slippers secondary to toe wound.</p> <p>During an interview on 11/19/15 at 11:15 a.m., the DHS indicated the Nursing Admission Assessment did not indicate Resident K had an Unstageable pressure ulcer to her right 2nd toe area. She indicated the pressure area was found when management did a skin sweep on 11/19/15. The DHS indicated she identified this pressure ulcer as a facility acquired wound since the nursing staff did not identify it upon the resident's admission to the facility. She indicated the wound was an Unstageable pressure ulcer and was inside the resident's hammer toe.</p>			

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	<p>On 11/23/15 at 2:01 p.m., the Assistant Director of Health Services removed the piece of gauze between the right great and 2nd hammertoe. On the inner right 2nd toe area a black circle area the size of a pencil point tip was observed with redness surrounding the black area. The gauze was replaced between the two toes.</p> <p>3. The clinical record of Resident #F was reviewed on 11/19/2015 at 10:45 a.m. Diagnoses included, but were not limited to, Shortness of Breath (SOB), Vitamin D deficiency, macular degeneration, hearing loss, and Congestive Heart Failure (CHF).</p> <p>Resident #F was admitted to the facility on Monday 11/9/2015 and was assessed for pressure ulcers. Resident #F had an Unstageable ulcer on her right foot/ heel and a pressure ulcer on her left inner ankle area which was red. No measurements were taken by admitting staff.</p> <p>A Physician order, dated 11/11/2015, indicated Skin Prep to inner right heel every shift until healed.</p> <p>A Physician order, dated 11/12/2015, indicated Skin Prep every shift to left inner heel/ankle.</p> <p>On 11/19 /2015 at 2:02 p.m., the Director</p>			

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	<p>of Health Services(DHS) was observed assessing Resident #F for pressure ulcers. Resident #F did have a stage 1 pressure ulcer to her left ankle with a 2 cm x 2 cm measurement . Resident #F had an Unstageable right ankle pressure ulcer measurement of 1.7 cm x 0.5 cm.</p> <p>During an interview on 11/19/2015 at 11:30 a.m., the Director of Health Services(DHS) indicated Resident #F was admitted to the facility on 11/9/2015 and treatment for her pressure ulcers did not begin until 11/11/2015 and 11/12/2015.</p> <p>The Director of Health Services indicated Resident #F should have been treated for her pressure ulcers the day of her admission to the facility.</p> <p>4. The clinical record of Resident #J was reviewed on 11/23/2015 at 1:55 p.m. Diagnoses included, but were not limited to, anxiety, failure to thrive, hypertension, Alzheimer's dementia, and left sided cerebral vascular disease.</p> <p>Resident #J was admitted to the facility on Wednesday 8/26/2015 and was assessed for pressure ulcers. Resident #J had an Unstageable ulcer on her right heel, which measured 2.5 cm x 2.5 cm and the color was black.</p>			

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	<p>A Physician order dated 9/14/2015, indicated Skin Prep to right heel every shift.</p> <p>A Physician order dated 8/26/2015, indicated weekly skin assessments to be completed on Friday of each week.</p> <p>A record review of the Medication Administration Record (MAR), indicated a weekly skin assessment was completed on 9/4/2015. No other weekly assessments were completed for the resident.</p> <p>During an interview on 11/19/2015 at 11:30 a.m., the Director of Health Services indicated Resident #J was admitted to the facility on 8/26/2015, and treatment for her pressure ulcer did not begin until 9/14/2015. Medication record sheet indicated weekly skin assessments were completed x 1 on 9/4/2015, and no other assessments were completed. The Director of Health Services indicated Resident #J should have been treated for her pressure ulcers the day of her admission to the facility and should have been assessed weekly.</p> <p>5. On 11/18/15 at 1:59 p.m., the record review for Resident G was completed. Diagnoses included, but were not limited to, diabetic, atrial fibrillation, cellulitis and high blood pressure.</p>			

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	<p>The AMDA (The Society for Post Acute and Long Term Care Medicine) 2008 Stages of Pressure Ulcers indicated: Stage II- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Stage III- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss.</p> <p>A document titled 'Wound Tracking', dated 10/14/15,. indicated the resident had a Stage III Wound on the right hip.</p> <p>On 11/19/15 at 11:30 a.m., the wound sheets were provided by the Director of Health Services for Resident G's current wounds.</p> <p>The wound sheets indicated: 9/30/15 -Week #1-Right hip area #2 was a Stage 2 and measured 5.2 centimeters (cm) x 3.0 cm x 0.1 cm. The exudate (drainage of fluid from a wound) was pink. The wound bed Color/tissue type/percent/location- pink tissue. The Periwound was documented as pink. The comments section indicated the treatment was optifoam and to continue current</p>			
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	<p>treatment and indicated 'healing'.</p> <p>10/7/15- Week #2 -Right hip area #2, there was no stage documented. The wound was 2.0 cm x 3.0 cm x <0.1 cm and exudate was pink. The wound bed Color/tissue type/percent/location- pink tissue. The Periwound was documented as pink. The comments section indicated the treatment was optifoam and to continue current treatment and indicated "healing."</p> <p>10/14/15- Week #3-Right hip area #2, indicated was now a Stage III. The wound measured 2.5 cm x 3.0 cm. The exudate indicated slough, no odor and scant amount of drainage. There was pain and the treatment was changed to Collagen. Current preventative interventions portion of documentation indicated, "...wound worse MD/resident notified..."</p> <p>10/21/15- Week #4- Right hip area #2 indicated pressure Stage II. The area measured 1.6 cm x 1.6 cm x 0.1 cm . The exudate was red. There was no odor Amount : 0 Consistency : 0 . Wound bed Pain: 0 Color/tissue type / percent/ location: granulation tissue. The wound margins were intact. The surrounding tissue was pink. The current treatment was Collagen. Current preventative</p>			

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	<p>interventions: Significant improvements. The medical interventions section was left blank.</p> <p>10/27/15- Week #5- Right hip area #2- Stage II. The area measured 0.6 cm x 1.0 cm x <0.1 cm. The exudate was documented as Color: red Center Odor: 0 Amount : 0 Consistency :0 Wound bed : Pain : no. Color/tissue type / recent/ location : Pink. Current treatment : Collagen & dressing Current preventative interventions: wound is healing.</p> <p>11/3/15: Week #6- Right hip area #2 -Stage II The area measured 0.5 cm x 1.0 cm x <.1 cm. The exudate: red center. Pain: " A little " Color/tissue type / recent/ location : pink. Wound Margins: Intact. Surrounding tissue: pink and the current treatment was Collagen and optifoam .</p> <p>11/11/15: Week #7- Right hip area #2. Stage II. The area measured 2.2 cm x 2 cm x <0.1 cm. The exudate was documented as beige consistency, some slough. Color/tissue type / percent/ location : pink. Wound Margins: Intact. Surrounding tissue: pink and the treatment was changed to dressing. The current preventative interventions was check fitting on wheelchair , Thera honey</p>			

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	<p>and optifoam change daily and monitor.</p> <p>A request was made from the DHS on 11/19/15 at 11:09 a.m. for the pressure prevention information or any policies.</p> <p>In an interview on 11/19/15 at 12:02 p.m., the DHS indicated they were not sure why the wound for Resident G was assessed at Stage 2 on 10/7/15, then on 10/14/15, as a Stage III with slough, then Stage II again on 10/21/15. The DHS indicated she understood concern with difference in assessment of wound as well as the documentation for assessment was not complete in regards to exudate, wound bed, and interventions and treatment.</p> <p>A current policy titled "Basic Wound Interventions" undated, provided by the DHS on 11/19/15 at 11:00 a.m., indicated "...8. Evaluate wound daily... 9. Assess and document progress toward healing at least every 7 days or with significant change in appearance of wound. Documentation includes, but is not limited to size, color, drainage and odor...."</p> <p>A current policy titled "Pressure Prevention Guidelines" undated, provided by the DHS on 11/19/15 at 11:35 a.m., indicated "Purpose: To</p>			

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	<p>maintain good skin integrity and avoid development of pressure ulcers... Hygiene:...Inspect the skin daily during care for signs of breakdown or changes to the skin. Activity/Mobility:...Place on pressure reduction support surface (bed-chair), Place on pressure relief mattress, Obtain an advanced pressure reduction cushion for wheelchair...."</p> <p>A current policy titled "General Wound and Skin Care Guidelines" undated, provided by the DHS on 11/19/15 at 11:35 a.m., indicated "... Procedure: The following general wound and skin care guidelines should be followed for all residents with potential and/or actual impairment in skin integrity...15. Reevaluate dressing and skin integrity every shift. 16. Reevaluate the wound's response to the prescribed treatment. Make recommendations for changes PRN [as needed]. Inform MD [doctor] of changes in wound status... 20. Document type of wound, location, stage (if applicable), length, width, depth (in cms [centimeters]), base drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flow sheet...."</p> <p>This Federal tag relates to Complaint IN00182782.</p>			

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F 0371 SS=E Bldg. 00	<p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure staff washed their hands appropriately during a meal service in 1 of 2 dining rooms observed.</p> <p>Findings included:</p> <p>1. During an observation of the main dining room on 11/16/2015, the following was observed:</p> <p>At 10:20 a.m., LPN #13 entered the kitchen to collect a cup of coffee and did not wash her hands upon entering or exiting the kitchen.</p> <p>At 11:53 a.m., LPN #13 entered the kitchen to collect a soda and did not wash her hands upon entering or exiting the</p>	F 0371	<p>Correction Action: The dietary staff members involved immediately re-washed their hands and placed new gloves until the meal service was completed. Potentially contaminated resident trays were set aside and new trays were prepared for those residents. Staff members involved were promptly in-serviced on proper sanitary techniques for service on the tray line.</p> <p>Identify other residents: The campus has determined that all residents who consume food by mouth have the potential to be affected.</p>	12/24/2015	

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	<p>kitchen.</p> <p>At 12:05 p.m. CNA #18 entered the kitchen with two glasses for resident refills and did not wash her hands upon entering or exiting the kitchen.</p> <p>At 12:35 p.m., 12:40 p.m. and 12:45 p.m. LPN #13 entered the kitchen to deposit dirty dishes and did not wash her hands upon entering or exiting the kitchen.</p> <p>At 12:34 p.m., 12:42 p.m., and 12:48 p.m. CNA #16 and CNA #4 entered the kitchen to deposit dirty dishes and did not wash their hands upon entering or exiting the kitchen.</p> <p>Throughout the meal service beginning at 12:22 p.m., the Director of Health Services (DHS), the Assistant Director of Health Services (ADHS), LPN #13, CNA #16, CNA #4, RN #17, and the Director of Environmental Services utilized waterless hand cleaning products to substitute for handwashing for more than 4-5 uses without washing their hands with soap and water.</p> <p>During an interview on 11/16/2015 at 1:00 p.m., the Executive Director indicated staff should be washing their hands during meal services with soap and water after 4 or more uses of waterless</p>		<p><u>Measures/Systemic Changes</u> All dietary staff has been in-serviced on the campus policies and practice guidelines for maintaining a sanitary tray line. In-service training observation of each employee performing the procedure. A "Validation Checklist" was completed for each dietary employee to determine if the employee was performing the procedure correctly. Findings were reviewed with each employee. Corrective action was provided as needed.</p> <p><u>Monitoring Correction Action:</u> The Dietary Manager or designee will complete random validation reports of dietary staff performing procedures to ensure staff performance is in accordance with the campus policy. Validation checklists will be reviewed by the Registered Dietitian, (RD) until such time consistent substantial compliance has been achieved as determined by the committee. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.</p>				

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F 0465 SS=E Bldg. 00	<p>hand cleaning products.</p> <p>A policy / procedure "Guidelines for Handwashing" received on 11/16/2015 at 12:56 p.m., from the Executive Director indicated "...12. waterless hand cleaning products such as alcohol based gels, foams, rinses provide an acceptable alternative to handwashing in certain instances...Wash hands with soap and water after 4-5 uses of the waterless products...13. ...The product (waterless) is also not an adequate substitute for handwashing in a food service area...."</p> <p>3.1-21(i)(2)</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 hallway (300) and 4 of 25 resident rooms were clean and in good repair. (Room's #113, 203, 206 and 207)</p> <p>Findings include:</p> <p>1. During the initial tour on 11/16/2015 at 10:30 a.m., the following was observed:</p>	F 0465	<p>Correction Action: The rooms #113, 203, 206, and 207 were cleaned and in good repair on December 4th, 2015.</p> <p>-</p> <p>Identify other residents: The Campus has determined that all rooms have the potential to be affected.</p> <p>-</p>	12/24/2015			

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	<p>a.) The 300 hallway outside rooms 304, 305, 307 and 304 had dirt and debris collected in the corners outside of the bedroom doors.</p> <p>b.) The dining room tables, chairs, pianos and piano benches were chipped peeling and gouged.</p> <p>2. During resident room observations on 11/16/2015 and 11/17/2015, the following was observed:</p> <p>a.) Room #113 on 11/17/2015 at 9:57 a.m., the bedroom closets were chipped and gouged.</p> <p>b.) Room #203 on 11/17/2015 at 10:33 a.m., the bedroom furniture was chipped and gouged.</p> <p>c.) Room #206 on 11/16/2015 at 3:37 p.m., the room divider curtain was stained with brown spots the size of a dime and a quarter.</p> <p>d.) Room #207 on 11/17/2015 at 1:38 a.m., the room furniture was chipped and cracked and the wheelchair seat cushion was ripped and torn.</p> <p>During the environmental tour with the Executive Director, and Director of Plant</p>		<p><u>Measures/Systemic Changes</u> An in-service education program was conducted by the Executive Director with all licensed and non-licensed staff who have direct resident contact. The in-service addressed the importance of identifying broken, defective or inoperable equipment, assuring safety of the residents and communication information regarding equipment to the maintenance supervisor.</p> <p><u>Monitoring Correction Action:</u> The Maintenance Supervisor and Director of Environmental Services will conduct a random audit of rooms and equipment used for five (5) residents, per unit, per week for four (4) consecutive weeks then monthly times 3 months. Maintenance records will be reviewed to ensure that any broken, defective or inoperable equipment, and rooms are identified, properly evaluated, documented in the records and repaired or replace in an expedient manner. This plan of corrective will be monitored at the monthly Quality Assurance Meeting until such time consistent substantial compliance has been met.</p> <p>-</p>		

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	<p>Operations on 11/19/2015 at 2:00 p.m., the following were observed:</p> <p>a.) Room #303, the furniture was chipped and gouged and the footboard for the bed was loose.</p> <p>b.) The 300 hallway outside rooms 304, 305, 307 and 304 had dirt and debris collected in the corners outside of the bedroom doors. (second observation)</p> <p>During an interview on 11/19/2015 at 3:50 p.m., the Director of Plant Operations indicated he was not aware of the facility needing the repairs or hallways were in need of cleaning by housekeeping.</p> <p>During an interview on 11/19/2015 at 4:00 p.m., the Executive Director indicated the facility had a reporting system for all staff to notify the maintenance department of facility needed repairs and housekeeping issues.</p> <p>The policy titled "Work Order Procedures", not dated, received on 11/19/2015 at 4:20 p.m., from the Executive Director indicated "...The use of the three-part work order ticket provides a means to track maintenance request by all campus residents and fellow employees...."</p>			

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F 0514 SS=D Bldg. 00	<p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the documentation for a pressure ulcer was accurate for 1 of 24 resident records reviewed for accurate documentation. (Resident H)</p> <p>Findings include:</p> <p>An "Indiana State Department of Health Survey Report System" report dated 9/11/15 at 10:01 a.m., indicated RN #6 falsified and destroyed Resident H's medical records. The report indicated the follow up dated 9/18/15, indicated when RN #6 was interviewed he admitted to changing the resident's documentation</p>	F 0514	<p>Correction: Action: Treatment records for resident H have been reviewed and treatments are being documented weekly.</p> <p>Identify other Residents: All residents receiving wound treatment have been reviewed for appropriate documentation and treatments.</p> <p>Measures/Systemic Changes The wound treatment records for all residents receiving treatments have been reviewed for appropriate documentation.</p>	12/24/2015

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	<p>regarding a wound that was recorded as Unstageable (Full thickness tissue loss in which the base of the ulcer was covered by slough (yellow, tan, gray, green, or brown) and /or eschar (tan, brown or black) in the ulcer bed. Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined) by a nurse. He admitted to rewriting the resident's pressure ulcer records, CAR (Clinical at Risk) notes, wound logs and telephone orders and "shredding" the original pressure ulcer record dated 8/26/15, recorded as Unstageable, telephone orders and wound tracking log. All of the items were found in the shredder box at the facility. He was terminated on 9/14/15.</p> <p>An "Investigation: Allegation of destruction and falsification of records by (Name of Nurse)" dated 9/11/15, indicated "Allegation: [Name of Nurse] shredded documents related to 8/9/15 and 8/26/15 pressure ulcer to the sacrum for resident [name of resident] then falsified orders, pressure ulcer records and MAR [Medication Administration Record] (tx order) related to this resident. 9/11/15 Interview with [Name of nurse]: Upon my arrival to the campus I interviewed [name of nurse] with [name of facility Corporate employee] present and he</p>		<p>Monitoring Correction Action: The ADHS or designee will monitor documentation of treatments on his/her respective unit for 10 records per week for (1)month then (10) records every (2) weeks for (2) months. Discrepancies will be promptly reported to the Director of Nursing Service. Findings of this audit will be discussed with the Resident Council. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.</p>	
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	<p>provided the following statements: He was off work on 8/26/15. Asked [Name of Medical Records staff member] and [name of Staffing Coordinator] to complete wound rounds that day. Stated they called him to notify him an Unstageable ulcer had been identified for resident [name of resident]. Upon his return on 8/27/15, he observed the wound and noted it to be covered with slough with no depth able to be measured. [Name of employee] from [Name of town] was at the campus on 9/9/15 to help him get caught up. He informed her on 8/26/15 the pressure area was identified as Unstageable. He observed it on 8/27/15 and did not agree that it was Unstageable. He considered it a stage 3 [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling] because of the slough and according to the definitions on the pressure ulcer assessment sheet... He admitted to changing the pressure ulcer documentation for the initial assessment on the purple sheet-he wrote over the U (Unstageable) that was documented and made it a 2... He admitted to re-writing all the pressure ulcer sheets, CAR notes, wound logs, telephone orders for this resident changing the stage and</p>			

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	<p>treatment. he admitted to shredding the original pressure ulcer record for the sacrum dated 8/26 listing the area as Unstageable, telephone orders transcribed by [Name of Medical Records staff member] for 8/26 (3 of them-Santyl, roho and liquifilm orders), wound tracking log...."</p> <p>An Interview statement from the Staffing Scheduler dated 9/11/15, indicated the following statements: "...[Name of Staffing Scheduler] can't remember the exact date, but she witnessed [Name of nurse] with the residents admit assessment from 7/11 and he added in his handwriting 'SL. Red' to the area marked with an X over the sacrum area on the body assessment."</p> <p>An Interview statement from the Medical Records staff member dated 9/11/15, indicated the following statements: "... Over Labor Day weekend [Name of nurse] took the wound and CAR book home x [times] 5 days and re-transcribed all the wound records for the sacrum for resident [name of resident] and all her CAR notes to reflect his changes made to the stage (changed from Unstageable to stage 2 [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured</p>			

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	<p>serum filled blister], then progressed it to a stage 3 with weekly assessment notes). 9/9 [name of nurse] said to [name of Medical Records staff member] 'you know that paperwork you did? It is now gone'... Falsified/changed documents were found in the chart-please see summary for a list of these documents...."</p> <p>An Interview statement from the MDS (Minimum Data Set) Coordinator dated 9/11/15, indicated the following statements: "About 2 weeks ago [name of nurse] told her to wait to do MDS section of resident [name of resident] MDS. 8/31 she asked [name of nurse] 'do I put 8/9 or 8/26 for this wound?' He told her wait. Kept saying 'don't do anything. 9/4 she was looking for the wound book, which is usually kept in [name of nurse] office. She text him asking where it was as she needed it to complete MDS. He informed her he had the wound and CAR book home with him, which he had at home for a total of 5 days. he informed her to wait to complete all wound data into the MDS. 9/9 he came to [name of MDS Coordinator] with orders he had back dated to 8/26. Said 'I want you to start the wound on 8/26.' Today is now 14 days later and wound was truly identified on 8/9-[name of MDS Coordinator] did not feel comfortable dating it 8/26...."</p>			

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	<p>A summary dated 9/14/15, indicated these documents were found in the shredder box by the Medical Records staff member and the Staffing Scheduler: 8/9 Skin Circumstance form for stage 2 to sacrum. IDT signed with Nurse #6's name with no treatment implemented.</p> <p>8/26 original pressure ulcer sheet (purple sheet) completed by Medical Records staff member, listing the area to the sacrum as Unstageable. The U (for Unstageable) was changed to a III.</p> <p>8/26-3 sets of telephone orders ripped into pieces. The ED put the paper back together and taped it. These orders were transcribed by the Medical records staff member and included orders reviewed on 8/26 from MD for Santyl and Optifoam, roho mattress and cushion and liquifilm.</p> <p>8/26 wound tracking log was completed by the Staffing Scheduler. Initially for [name of resident] documented as sacral Unstageable and Santyl treatment order. On the log, the center measurements were changed, yellow slough was marked out, marked out Santyl order and wrote in hydrocolloid as treatment.</p> <p>Documents altered/falsified were as follows:</p>			

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	<p>7/11 admit assessment-body assessment had only X marked over the sacral area initially, with no decryption. The Staffing Scheduler witnessed RN #6 write in "SL. Red" next to the X.</p> <p>August MAR-8/26 order for Santyl added by the Medical Records staff member and signed off as completed by nurses for 8/27 through 8/31. RN #6 marked through the order and wrote "see change, wrong pt."</p> <p>RN #6 wrote 8/26 hydrocolloid order (he was not working in the facility on this date) and this order was never in place prior to 9/9 when he transcribed it. he wrote this order at the top of a three order telephone order page. He proceeded to re-write the Medical Records staff members 8/26 order for roho cushion/mattress and liquifilm all dated 8/26.</p> <p>RN #6 wrote a 9/1 Santyl order-this was originally transcribed on 8/26 by the Medical Record staffing member after the area to the sacrum was identified.</p> <p>August MAR had the 8/26 hydrocolloid order wrote was wrote in (the order he transcribed on 9/9). This order was not on the MAR previous to 9/9. Initials are in place for 8/26 and 8/29 night shift. The</p>			

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F 0520 SS=F	<p>initials do not match the nurses initials who were working these nights. "The initials do look similar to RN #6's handwriting."</p> <p>Resident H's record was reviewed on 11/18/15 at 2:27 p.m. Diagnoses included, but were not limited to, debility, chronic kidney disease, difficulty in walking and diabetes.</p> <p>During an interview on 11/18/15 at 10:05 a.m., the Director of Health Services indicated RN #6 had been terminated because Resident H had an Unstageable pressure ulcer to her sacral area, which RN #6 falsified documents to make it look like the wound was found as a Stage II then progressed to an Unstageable pressure ulcer. She indicated RN #6 had falsified the documents because he did not want the Indiana State Department of Health to find out the resident's pressure ulcer was found at an Unstageable stage.</p> <p>This Federal tag relates to Complaint IN00182782.</p> <p>3.1-50(a)(2)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET</p>				

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Bldg. 00	<p>QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observations, interview and record review, the facility failed to develop and implement appropriate plans of action to address pressure ulcers being assessed appropriately for 5 of 5 residents, failed to implement pressure ulcer prevention interventions and ensure treatments were ordered in a timely manner for 3 of 3 residents as identified during the Annual Recertification and State Licensure survey. (Residents F, G, H, J and K)</p> <p>Findings include:</p>	F 0520	<p>Correction Action: Residents F, G, H, J, and K were assessed on November 27, 2015 in regards to address and implement appropriate treatments and prevention in reference to pressure wounds.</p> <p>Identify other Residents: All residents with pressure wounds have the potential to be affected by this practice.</p>	12/24/2015

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	<p>On 11/24/15 at 3:48 p.m., the Executive Director and Director of Health Services were in attendance for an interview. The Executive Director was queried regarding QAA (Quality Assurance and Assessment) and the identified concerns of the annual survey as follows:</p> <ol style="list-style-type: none"> Residents pressure ulcers were not assessed appropriately for Residents F, G, H, J and K. Prevention interventions were not being implemented and treatments were not being ordered in a timely manner for pressure ulcers for Residents F, H and J. <p>During an interview on 11/19/15 at 11:36 a.m., with the Director of Health Services (DHS), the Executive Director (ED) and the Assistant Director of Health Services in attendance (ADHS), the DHS indicated the management team was aware there was a problem with the pressure ulcers being assessed appropriately, interventions being implemented and treatments being started and there was an action plan in place. The DHS indicated she and the ADHS were responsible to ensure the wounds were being taken care of appropriately. The ADHS indicated the nurses have been educated on the wounds. She indicated there was a break in</p>		<p><u>Measures/Systemic Changes</u> The Director of Nursing Service, and or designee will review pressure ulcer risk assessments, skin assessments, interventions, care plans on all new admissions on-going. The Director of Nursing Service, and or designee will audit a minimum of 2 admissions per month for three months, then 1 admission per month thereafter unless otherwise determined by the Risk Management Quality/Quality Assurance Committee. Audits will be submitted to the Quality Assurance Committee.</p> <p>-</p> <p>-</p> <p><u>Monitoring Correction Action:</u> Audits will be reviewed in the Quality Assurance Committee monthly. This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.</p>	

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R 0000 Bldg. 00	<p>communication regarding the wound for Resident F when she was admitted and that was why she did not get a treatment started from 11/9/15 to 11/12/15. The ED indicated the facility had a systems process breakdown with pressure ulcers regarding identifying the wounds, implementing interventions and getting treatments ordered for the wounds, since Resident F was admitted on 11/9/15 and did not get treatment until 11/12/15.</p> <p>This Federal tag relates to Complaint IN00182782.</p> <p>3.1-52(b)(2)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 34</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 21662 on December 2, 2015.</p>	R 0000	Survey Event ID: The submission of this POC does not indicate an admission by Homewood Campus, that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in	

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R 0064 Bldg. 00	<p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's personal property was taken care of appropriately to prevent a staff member from borrowing the resident's charge card for 1 of 5 residents being reviewed for missing property. (Resident #18)</p> <p>Findings include:</p> <p>1. A handwritten note dated 11/9/15, indicated Resident #18's credit card was canceled due to fraudulent activity.</p> <p>An "Indiana State Department of Health</p>	R 0064	<p>substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.</p> <p>Correction Action: A new investigation was implemented in regards to the credit card for resident # 18. The staff member that was associated with this infraction was terminated. The employee was reported to ISDH, Attorney General, and the professional license board in regards to both Qualified medication aide and certified nursing aide license. <u>Identify other residents:</u> All other residents have the potential to be affected by this practice. <u>Measure/Systemic Changes:</u> The residents and family was notified by the Executive Director in a written letter that our policy is that our staff are not to ask for</p>	12/24/2015

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	<p>Survey Report" was dated 11/10/15, was reviewed on 11/24/15 at 2:56 p.m., indicated QMA #19 allegedly used Resident #18's credit card for her own personal use. The Allegation of misappropriation of resident funds or property was substantiated and the employee was fired.</p> <p>A statement written and signed by CNA #20 dated 11/10/15, indicated QMA #19 was on a cruise with her and CNA #20 witnessed QMA #19 use Resident #18's credit card to purchase a bracelet, a bag and a jewelry box with the card. CNA #20 indicated QMA #19 had told her she had talked to Resident #18's family member about using the credit card to purchase the resident gifts with the card.</p> <p>A list of items QMA #19 used the resident's credit card to purchase was listed as follows: A gold charm bracelet. A mahogany wood jewelry box 5.5 inches wide x 8.5 inches wide. A multicolored throw blanket with an angel. A bag</p> <p>A statement written and signed by QMA #19 indicated she did take Resident #18's credit card while on vacation with the resident's family member's permission.</p>		<p>any credit cards, money, or property. Staff Education was conducted by the Executive Director in regards to the policy in reference to employee accepting or asking for gifts or money from residents. This is addressed in our new hire process. This information was presented to the Resident Council.</p> <p>Monitoring: This plan of correction will be monitored at the Quality Assurance meeting until such time consistent substantial compliance has been met.</p>				

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R 0214 Bldg. 00	<p>She indicated she had picked items up for the resident and she had always done the resident's shopping without any problems.</p> <p>During an interview on 11/24/15 at 2:56 p.m., the Executive Director indicated QMA #19 used Resident #18's credit card to buy items for herself. She indicated the resident's family member indicated she had given her permission to use the credit card, but the credit card was canceled for fraudulent activity after this incident occurred. The Executive Director indicated whether or not the items were gifts from the resident or her family, taking gifts from residents was against the facility policy.</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate individual needs of residents related to significant</p>	R 0214	Deficiency ID: R214	12/24/2015

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	<p>change in conditions for 1 of 5 residents reviewed for Evaluations. (Resident #18)</p> <p>Findings include:</p> <p>Resident #18's record was reviewed on 11/24/15 at 12:25 p.m. Diagnoses included, but were not limited to, difficulty in walking, muscle weakness and osteoporosis.</p> <p>The resident's last evaluation was updated 10/21/15 and it lacked information regarding her falls.</p> <p>Resident #18 had falls on the following dates and times: The "Fall Circumstance Assessment and Intervention" dated 10/30/15 at 1:00 a.m., indicated she fell in her bathroom. Unwitnessed fall. She was not wearing shoes and had on socks only and slipped in her bathroom and fell. She indicated she was not wearing any shoes in the bathroom. The new interventions was a Therapy evaluation and to place non-skid footwear on her.</p> <p>The "Fall Circumstance Assessment and Intervention" dated 11/6/15 at 4:15 a.m., indicated the resident fell in room 514 at the bedside. Unwitnessed fall. The resident tripped and fell over her walker. She had a right eye abrasion. The new</p>		<p>Correction Action: The fall circumstance was updated on resident #18 to include the new intervention.</p> <p>-</p> <p>Identify other residents: All residents have the potential to be affected.</p> <p>-</p> <p>Measures/Systemic Changes: A in-service was conducted on 12/4/15 by the DHS with all nursing staff in regards to completing of fall circumstance forms and follow up. The individual needs of significant changes will be addressed in the morning CCM meeting. The circumstance forms will be forwarded to the CCM by the Legacy Lane coordinator Michelle Huffman daily for review, reviewing root cause analysis, trending, and appropriate interventions. The Legacy Lane Coordinator will conduct 2 audits weekly x 4 weeks, then monthly times 3 months on all significant changes of the residents and forward to the Quality Assurance Committee monthly</p> <p>-</p> <p>Monitoring: The Quality Assurance Committee will review monitored until such time</p>	

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R 0217 Bldg. 00	<p>intervention was to do lab testing.</p> <p>During an interview on 11/24/15 at 1:24 p.m., LPN #11 indicated she had failed to update her evaluation with her fall information.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation</p>		consistent substantial compliance has been met.	

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	<p>of the services to be provided.</p> <p>Based on observation, interview and record review, the facility failed to ensure service plans were updated as resident's individual needs changed or were not signed for 3 of 5 resident's reviewed for service plans. (Residents #12, #14 and #18)</p> <p>1. Resident #12's record was reviewed on 11/24/15 at 10:30 A.M. Diagnoses included, but were not limited to, diabetes mellitus, coronary artery disease, unstable angina, anxiety, hypertension and carotid stenosis.</p> <p>Hospice services and Injection administration were not noted on the service plan for Resident #12.</p> <p>During an interview on 11/24/2015 at 10:45 a.m., Medical Records staff member indicated Resident #12 entered the facility receiving Hospice services.</p> <p>During an interview on 11/24/2015 at 11:50 a.m., LPN #11 indicated Hospice services and injections should have been documented on the service plan for this resident and she had failed to do so.</p> <p>Additionally, LPN #11 indicated the service plans should have been signed by the resident every six months. LPN #11 indicated the service plan dated</p>	R 0217	<p>Decadency ID: R217</p> <p>Correction Action: The Legacy Coordinator updated service plans on Residents # 12, 14, and 18 on December 4th.</p> <p>-</p> <p>Identify other residents: All residents have the potential to be affected by this practice.</p> <p>-</p> <p>Measures/Systemic Changes: _ All service plans were revised and updated by the Legacy Coordinator on 12/4/15.. The Legacy Coordinator audits 3 service plans weekly times 4 weeks then monthly times 3 months. Legacy Director will submits outcome of the audits to the Quality Assurance Committee.</p> <p>-</p> <p>Monitoring: Audits are reviewed in the Quality Assurance Committee monthly until such time consistent substantial compliance has been met.</p> <p>-</p>	12/25/2015	

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	<p>03/20/2015, was the current service plan.</p> <p>2. Resident #14's record was reviewed on 11/24/15 at 9:35 a.m., Diagnoses included muscle weakness, chronic kidney disease and depressive disorder. The last service plan was dated 10/20/15. The Service Plan lacked information regarding the resident was to administer her respiratory treatments herself and there was no signature on the Service plan for 8/13/15, 9/18/15 or 10/20/15. During an interview on 11/24/15, LPN #11 indicated the resident or her representative should sign the Service Plan at least every six months, but she failed to get her service plan signed. She indicated she should have addressed Resident #14's self medication administration on her Service Plan.</p> <p>3. Resident #18's record was reviewed on 11/24/15 at 12:25 p.m. Diagnoses included, but were not limited to, difficulty in walking, osteoporosis and muscle weakness. The last Service Plan was dated 10/21/15. The Service Plan did not address the resident's falls. Resident #18 had falls on the following dates and times: The "Fall Circumstance Assessment and</p>			

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R 0243 Bldg. 00	<p>Intervention" dated 10/30/15 at 1:00 a.m., indicated she fell in her bathroom. Unwitnessed fall. She was not wearing shoes and had on socks only and slipped in her bathroom and fell. She indicated she was not wearing any shoes in the bathroom. The new interventions was a Therapy evaluation and to place non-skid footwear on her.</p> <p>The "Fall Circumstance Assessment and Intervention" dated 11/6/15 at 4:15 a.m., indicated the resident fell in room 514 at the bedside. Unwitnessed fall. The resident tripped and fell over her walker. She had a right eye abrasion. The new intervention was to do lab testing.</p> <p>During an interview on 11/24/15 at 1:24 p.m., LPN #11 indicated she had not addressed Resident #18's falls on her Service Plan.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and</p>			

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	<p>(D) name or initials of the person administering the drug or treatment.</p> <p>Based on observation, interview and record review, the facility failed to provide accurate medication administration for 2 of 5 residents reviewed for medication administration. (Residents #29 and #30) Findings include:</p> <p>1. During a medication pass on 11/24/2015 at 11:20 a.m., LPN #15 was observed pouring 10 milliliters (mls) of medication from a bottle labeled Mary's Magic Mouthwash (for mouth sores) into a medicine cup. The label indicated dose: " As directed." The medication was then administered to Resident #30.</p> <p>During an interview with LPN #11 in attendance, on 11/24/2015 at 11:30 a.m., LPN #15 indicated " I just know " when asked how she determined the amount and directions for administering Mary's Magic Mouthwash. LPN #11 indicated at that time a clarification order was needed to specify the amount and directions for the mouthwash.</p> <p>2. During a medication pass on 11/24/2015 at 11:50 a.m., LPN #11 was observed withdrawing 1.0 mls of liquid from a bottle labeled Poly-Visol (vitamin</p>	R 0243	<p>Corrective Action: LPN # 11 was re-educated on medication the accuracy of medication administration with return observation.</p> <p>-</p> <p>Identify other residents: All residents have the potential to be affected by this practice.</p> <p>Measures/Systemic Changes: Nurses were educated on the guidelines in regards to administration of medication including: documentation, following MD orders, and accuracy on December 4th 2015. Weekly observations x 4 weeks being conducted to ensure accuracy with medication administration. Validation completed on audits and submitted to Quality Assurance Committee monthly meetings.</p> <p>-</p> <p>Monitoring: Audits reviewed monthly in the Quality Assurance Committee until such time consistent substantial compliance is met.</p>	12/24/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2015
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R 0414 Bldg. 00	<p>supplement) using a tuberculin (TB) syringe. The label indicated directions of " one dropper-full daily." The medication was then administered to Resident #29 using the TB syringe.</p> <p>During an interview on 11/24/2015 at 11:55 a.m., LPN #11 indicated the TB syringe was dispensed by the pharmacy to give the Poly-Visol medication. She was unable to indicate how much medication a dropper-full was using the TB syringe. LPN #11 indicated an order for clarification would be necessary.</p> <p>410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview and record review, the facility failed to provide adequate infection control practices to decrease the risk of infection during medication administration for 1 of 5 medication administration observations. (LPN #11) Findings include: LPN #11 was observed prior to the beginning of medication pass on 11/24/2015 at 11:50 a.m., washing her</p>	R 0414	<p>Correction Action: Nurse # 11 was in serviced on infection control practice on December 4th, 2015</p> <p>-</p> <p>Identify other residents: All residents have the potential to be affected by this practice.</p> <p>-</p> <p>Measures/Systemic Changes:</p>	12/24/2015

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	<p>hands for 12 seconds.</p> <p>LPN #11 was observed after administering liquid medication to resident #29 at 11:55 a.m., washing her hands for 13 seconds.</p> <p>During an interview at 12:00 p.m., LPN #11 indicated the proper length of time for hand washing was 30 seconds.</p> <p>A current policy titled " Guidelines for Hand washing " dated 03/2013, provided by the Executive Director on 11/16/2015 at 12:56 p.m., indicated " ...Procedure #8. " Wash well for 20 seconds (ABC or Happy Birthday song), using a rotary motion and friction ..."</p>		<p>Staff education was conducted on December 4th, 2015 in regards to the guidelines in hand washing in regards to medication administration. Weekly validation check list are completed on 2 Nurses per week for proper demonstration of hand washing practice. This audit is completed by Legacy Coordinator weekly and presented to the Quality Assurance Committee.</p> <p>-</p> <p>Monitoring: Audits reviewed monthly in the Quality Assurance Committee until such time consistent substantial compliance is met.</p> <p>-</p>		