

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/22/2012
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NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321
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F0000	<p>This visit was for the Investigation of Complaint IN00114254.</p> <p>Complaint IN00114254-Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: August 21 &amp; 22, 2012</p> <p>Facility number: 000056 Provider number: 155131 AIM number: 100289450</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF: 21 SNF/NF: 181 Total: 202</p> <p>Census payor type: Medicare: 34 Medicaid: 126 Other: 42 Total: 202</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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.

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

PRINTED: 09/14/2012  
FORM APPROVED  
OMB NO. 0938-0391

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	Quality review 8/24/12 by Suzanne Williams, RN			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observations, record review, and interview, the facility failed to provide treatment and services related to the ongoing monitoring of bruising, and acting upon an incident of a LPN attempting to administer an oral medication to a resident with Physician orders to not be given anything orally, for 2 of 3 residents reviewed for bruising and 1 of 3 residents receiving mediations via a gastronomy tube, in the sample of 7. (Residents #D and #F)</p> <p>Findings include;</p> <p>1. The closed record for Resident #D was reviewed on 8/21/12 at 12:00 p.m. The resident was admitted to the facility on 6/12/12. The resident was sent to the hospital on 6/19/12 and was re-admitted to the facility on 6/22/12. The resident's diagnoses included, but were not limited to, pneumonia, cerebral vascular accident (stroke), high blood pressure, anxiety, and osteoarthritis. The resident was sent to the hospital on 8/3/12.</p>	F0309	<p>F – 309 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction.</p> <p>In direct response to the five questions listed on page two of the letter to this facility dated August 27, 20112, the facility offers the following: 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As it relates to Resident D - Observation A, upon surveyor observation of the potential concern, statements were collected from nurses who had signed for the administration of medication during the time period of July 26 – August 22, 2012 for</p>	09/21/2012			

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	<p>a. The Physician Order statement for 7/26/12 through 8/22/12 indicated there were orders for the resident to be NPO (to receive nothing by mouth) and to receive Jevity tube feeding through a gastrostomy feeding tube for a total of 1240 cc (cubic centimeters) per 24 hours. Medications on the typed Physician Order statement indicated there were orders for the resident to receive seven scheduled medications through the gastrostomy tube. There were orders for three medications to be given orally. These three medications included, Tramadol (a medication for pain) with acetaminophen one tablet orally every six hours as needed for pain, Zoloft (a medication for depression) 25 milligrams by mouth once a day, and Colace (stool softener) 100 milligrams orally twice a day. This Physician Order statement was signed as reviewed for accuracy by the Unit Manager on 7/23/12.</p> <p>Review of the MAR (Medication Administration Record) for 7/26/12 through 8/22/12 indicated the Colace was signed out as given orally 7/26/12 through 8/2/12, the Zoloft was signed out as given orally daily 7/26/12 through 8/2/12, and the Tramadol was signed out as given orally once a day on 7/28/12, 7/27/12, 7/28/12, 7/29/12, 7/30/12, 7/31/12, and</p>		<p>Resident D. All nurses who had administered medications confirmed that medications were provided via g-tube during that timeframe. The facility is unable to take any further retrospective action given Resident D was discharged from the facility on August 3, 2012.</p> <p>As it relates to Resident D – Observation B, the facility offers that an incident report had been completed and reviewed by the multidisciplinary team following the August 2, 2012 identification of Resident D's bruise. This discussion occurred while Resident D was in the hospital.</p> <p>As it relates to Resident F – Observation 2, the facility offers that a full head to toe assessment was completed for Resident F. Resident F's physician was informed of the findings and visited Resident F to assess the areas. Resident F's physician indicated he believed the discoloration to be a side effect of aspirin therapy use, however, no changes in the treatment were ordered. Statements have been collected from Licensed Professional Nurses who are routinely assigned to Resident F. All nurses interviewed indicated that the bruising/dyscoloration were considered to be related to Resident F's medical condition, her diagnosis of Purpura as well as Resident F's routine use of</p>				

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	<p>8/2/12.</p> <p>The 8/2012 Nurses' Observation notes were reviewed. An entry made on 8/3/12 at 8:30 p.m. indicated the resident was transferred by ambulance to the hospital emergency room. An entry listed as a "late entry for 8/2/12 at 5:30 p" indicated the writer was informed the resident had been administered oral medication, a respiratory assessment was completed, her lungs were clear and no signs of distress were observed. The physician was notified and no new orders were written.</p> <p>Speech Therapy Weekly Progress Notes for 7/24/12 through 7/30/12 indicated the resident's primary diagnosis was cerebral vascular accident. The notes also indicated the resident was at risk for aspiration.</p> <p>An "Information Sheet" was completed by the Director of Nursing (DON) on 8/3/12. This sheet indicated the DON met with Resident #D's son regarding a concern that occurred on 8/2/12. The son stated when he entered the resident's room on the evening of 8/2/12, the Nurse was getting ready to give the resident medications orally and the son stopped her prior to any medications being given. The Nurse stated that was the way the</p>		<p>blood thinning agents.</p> <p>The facility has already taken several proactive steps to attempt to prevent future re-occurrences including the application of side rail pads to Resident F's bed and the re-assessment of Resident F's transfer status by Physical Therapy to ensure the safest method is being used. Additionally, Occupational Therapy has assessed Resident F's positioning and recommendations have been made to provide Resident F with a narrower wheelchair equipped with bolsters to achieve better positioning.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? As it relates to Resident D – Observation A, the facility commenced in-servicing with all Licensed Professional Nurses regarding the requirement to verify proper route of administration prior to any medication being administered as well as the importance of correcting any observed transcription errors properly. Additionally, the facility has completed a review of the medication administration records for all tube-fed residents to identify and remedy any inconsistencies pursuant to this</p>		

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	<p>order read.</p> <p>A document completed by the facility related to the 8/2/12 medication administration was reviewed. A statement was obtained from the LPN who was in the resident's room with the medication on 8/2/12. The LPN was interviewed by the Staff Development Nurse who wrote down the LPN's statement. The statement indicated at approximately 5:30 p.m., the Nurse went to administer Tramadol (a medication for pain) to the resident, and the Nurse noted the medication had an enteric coating and thought it may occlude the feeding tube and then the medication was crushed and mixed in applesauce, and she went to administer the medication. The resident's son stopped her and the medication was not administered orally. The statement also indicated the LPN stated on the reverse side of the MAR (Medication Administration Record) the Nurse prior to her had documented the Tramadol was given p.o. (orally).</p> <p>Review of the 8/3/12 hospital records indicated the resident was seen in the Emergency room on 8/3/12. The Emergency Room Physician note indicated it was reported by the Nursing Home that someone may have tried to give the resident her medications orally</p>		<p>Plan of Correction.</p> <p>As it relates to Resident D and F, the facility is committed to completing a head to toe assessment for each resident per the weekly skin assessment policy and procedure. Any newly identified bruises not noted on the previous skin check will be documented on a facility incident report and monitoring and documentation will be initiated in accordance with the facility protocol for newly identified bruises.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As it relates to Resident D – Observation A, the facility has engaged discussion with our pharmacy service provider who has committed to completing an audit for all residents who receive their medications via g-tube to ensure the route of administration is noted properly prior to new medication administration records being sent to the facility for placement on our charts.</p> <p>Additionally, the facility has scheduled a formal in-service for all Licensed Professional Nurses and Qualified Medication Aides addressing facility medication administration policy and procedure as well as</p>				

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	<p>and patient may have aspirated. The 8/3/12 chest x-ray report indicated new patchy opacities were noted in the right mid and lower lung fields which were suspicious for an infectious process.</p> <p>When interviewed on 8/21/12 at 3:00 p.m., the facility Administrator indicated she was aware of the concern voiced by the son. She indicated the facility was first notified by the son on 8/3/12 after the reported event occurred. At this time, the Administrator indicated she could not recall the exact date but believed it was around 8/9/12. The Administrator indicated neither of the two Nurses working on the unit informed anyone in Administration of the discrepancy in the Physician orders on 8/2/12. The Administrator indicated it was reported the son stopped the Nurse before she gave the medication orally. The Administrator indicated after they were informed by the resident's son they reviewed the resident's current MAR and Physician orders to clarify them and noted that the MAR had already been changed to read for the medications to be given through the gastrostomy tube rather than orally. The Administrator indicated it was not until today (8/21/12) when they began auditing orders and MARs of other residents' records to ensure there was no possibility of residents with orders to be NPO were</p>		<p>requirements for the proper transcription of physician orders specific to the route of administration, as well as the expected correction process for any identified discrepancies in orders on the medication administration record. Finally, all facility Unit Directors will be in-serviced on the expectations of their initial review of a new medication administration record prior to its use to identify and correct any inconsistent routes of administration.</p> <p>As it relates to Resident D and Resident F, the facility will in-service all Licensed Professional Nurses and facility Ward Clerk staff on the process for properly placing and gathering of completed incident reports in the designated location to ensure timely review and multi-disciplinary discussion. Additionally, relating to on-going monitoring of bruising, all Licensed Professional Nurses will be in-serviced on the facility policy and procedure for monitoring and documenting of identified bruises on the weekly skin assessment form.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? As it relates to Resident D – Observation A, the facility is committed to completing a Quality</p>		

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	<p>receiving oral medications. The Administrator indicated the two Nurses who were working that evening were interviewed and inserviced by the DON. The Administrator stated she was not aware of any of the other Nurses who had worked or signed out the medications as given orally were inserviced or interviewed to verify if the medications had been given incorrectly.</p> <p>When interviewed on 8/22/12 at 12:00 p.m., the DON indicated the resident's son came to the facility on 8/31/12 and informed her of the concern. The DON indicated it was reported the son walked into the room and the Nurse was ready to give the resident oral medications and he stopped her. The DON indicated it was reported the Nurse was seen in the room with a cup with something like applesauce. The DON indicated she then reviewed the resident's clinical record and her MAR and noted the three medications that were listed to be given orally were changed to now read they were to be given through the gastrostomy tube. The DON indicated the Nurse involved was not working and attempted to call her to ask her to come to the facility to review what had occurred on 8/21/12. The DON indicated they were unable to reach the Nurse as she had called off several days and then was on vacation for some days.</p>		<p>Assurance audit on a monthly basis to review medication administration records for the purpose of ensuring that orders are correctly transcribed and carried over accurately from one month to the next. A sample of 100% of residents who receive their medications via g-tube will be audited by the facility Quality Assurance Nurse. This audit will be completed for a period of no less than 6 months and findings will be reported to the facility Quality Assurance Committee on a quarterly basis.</p> <p>As it relates to Resident D and Resident F, the facility Quality Assurance Nurse and/or designee will perform a weekly review of skin checks to ensure that bruises are accurately being documented and monitored through the facility weekly skin assessment process. A sample of 25 residents per week will be reviewed. The findings of this audit will be reported to the Director of Nursing on a monthly basis and presented to the facility Quality Assurance Committee on a quarterly basis. This audit function will remain in place for no less than a period of six month.</p> <p>5. By what date will the systemic changes be completed? September 21, 2012</p>				

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	<p>The DON indicated she did nothing further than checking that this resident's MAR was correct. She indicated they did not review any other resident order sheets or MARs. The DON indicated the Nursing Unit Managers are responsible to check each Physician Order Sheet to verify the orders are correct on the order sheet as that is how they appear on the MAR. She also indicated the Unit Manager signed that she had reviewed the orders on 7/23/12. The DON indicated the Unit Manager should have noted the resident was not to have oral medications as she was NPO and addressed this at that time.</p> <p>Continued interview with the DON at the above time, indicated the facility had planned to inservice the Nurses and to speak to the other Nurses who could have given the medications orally but the inservice and interviews did not occur as of yesterday.</p> <p>b. An entry made in the Nurses' Observation notes on 8/2/12 at 2:30 p.m. indicated the CNA called the Nurse to the resident's room and a bruise was observed to the resident's left leg measuring 10 cm (centimeters) by 4 cm and the resident had no signs or complaints of pain. The Physician was notified.</p>						

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	<p>An Incident Report dated 8/2/12 was reviewed. The report indicated a bruise was noted to the resident's right lateral leg and was purple in color. The Physician and the resident's son were notified. A care plan initiated on 6/13/12 indicated the resident was restless and swings her arms at staff and moves self towards sides of the bed. Interventions that were in place were for the side rails to be padded and the bed to be in the low position. The Investigation section of the report indicated the report was to be reviewed by and signed by the DON, Administrator, and Safety Officer. The report was signed by the DON on 8/10/12 and the Administrator on 8/14/12. The report completed by Administration on 8/10/12, indicated it was suspected the resident bumped her leg on the end of the side rails, and the side rail pad was lowered.</p> <p>When interviewed on 8/22/12 at 12:40 p.m., the Administrator indicated there was a delay in the 8/2/12 Incident Report getting to them. The Administrator indicated the Unit Manager was on vacation and the report did not get to the Multidisciplinary Team to be reviewed until 8/10/12.</p> <p>2. On 8/21/12 at 10:25 a.m., Resident #F was observed sitting in a wheel chair in the hallway across from the Nurses'</p>						

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	<p>station. An area of dark purple bruising was observed on the resident's left upper arm. The area was approximately 2 cm (centimeters) in diameter. A dark purple area was noted to the resident's right upper arm. The area measured approximately 1 cm in diameter.</p> <p>A Skin Assessment form completed on 8/17/12 indicated bilateral arms with purpura (purple areas of discoloration on the skin) and bilateral legs with purpura. There was no further assessment or measurements of the areas.</p> <p>When interviewed on 8/21/12, the Unit Manager indicated the Nurse who completed the Skin Assessment form should have listed and measured each area on the resident's arm rather than writing bilateral purpura, as the form indicated measurement of each area should be written.</p> <p>This federal tag relates to Complaint IN00114254.</p> <p>3.1-37(a)</p>				

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F0314 SS=D	<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 record review and interview, the facility failed to ensure an identified Stage I pressure ulcer was monitored for changes for 1 of 3 residents reviewed for pressure ulcers in the sample of 7. (Resident #D)</p> <p>Findings include:</p> <p>The closed record for Resident #D was reviewed on 8/21/12 at 12:00 p.m. The resident was admitted to the facility on 6/12/12. The resident was sent to the hospital on 6/19/12 and returned to the facility on 6/22/12. The resident's diagnoses included, but were not limited to, pneumonia, cerebral vascular accident (stroke), anxiety, and high blood pressure.</p> <p>An entry made in the 7/25/12 Nurses' Observations notes at 10:25 a.m. indicated the resident was assessed and an area measuring 0.6 cm (centimeters) x 1.8</p>	F0314	<p>F – 314</p> <p>Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and Plan of Correction.</p> <p>In direct response to the five questions listed on page two of the letter to this facility dated August 27, 20112, the facility offers the following:</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The facility is, unfortunately, unable to retrospectively address</p>	09/21/2012			

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	<p>cm was noted to the left side of the resident's coccyx. A Weekly Pressure Ulcer Progress Report, initiated on 7/25/12, indicated a Stage II pressure ulcer (an ulcer with partial thickness loss of the dermis with a red or pink wound bed) was identified to the left coccyx area. The area had 100% red granulation and no drainage was present. An entry on 7/28/12 indicated the Stage II area measured 0.4 cm x 1.1 cm with 20% red granulation tissue and 80% adipose. An entry on 8/3/12 indicated the Stage II pressure ulcer measured 1.3 cm x 1.4 cm with 30% granulation tissue and 70% adipose.</p> <p>Review of the 6/22/12 Initial Nursing Assessment indicated the resident was admitted with a red area to the coccyx. There was no documentation of an assessment of the red area on 6/29/12. A 7/6/12 skin assessment indicated there was no assessment of the red area. The next documentation of an assessment of the coccyx was on 7/25/12.</p> <p>When interviewed on 8/22/12 at 1:50 p.m., the Director of Nursing indicated a red Stage I ulcer was to be assessed weekly by Nursing and documented in the resident's record. The Director of Nursing indicated only Stage II wounds or higher were to be recorded on the Weekly</p>		<p>the surveyor identified concern relative to Resident D. Resident D was discharged to the hospital on August 3, 2012.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>The facility will identify all residents who currently have treatment orders for Stage I pressure ulcers. Each area will be assessed and the findings will be documented in the resident's medical record.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>An in-service will be completed with all Licensed Professional Nursing staff in regards to the expectation of informing the facility Wound Care Nurse of all identified Stage I pressure ulcers. The facility Wound Care Nurse will be responsible, on a weekly basis, for the monitoring and documentation of the status of identified Stage I pressure ulcers.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/22/2012
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	<p>Pressure Ulcer Progress Report.</p> <p>This federal tag relates to Complaint IN00114254.</p> <p>3.1-40(a)(2)</p>		<p>program will be put into place?</p> <p>The facility Director of Nursing and/or Designee will complete a monthly audit of 100% of all residents identified with a Stage I pressure ulcer to ensure that the status of the area is documented in the medical record. The findings will be presented to the Quality Assurance Committee on a Quarterly basis for review for a period of no less than six months.</p> <p>5. By what date will the systemic changes be completed? September 21, 2012</p>		