

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER SPRING MILL HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 W 87TH AVE MERRILLVILLE, IN 46410
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F000000	<p>This visit was for the Investigation of Complaints IN00150482 and IN00150997.</p> <p>Complaint IN00150482- Substantiated. Federal/State deficiencies related to the allegations were cited at F157, F225, F226, F282, F309, F312, and F314.</p> <p>Complaint IN00150997-Substantiated. Federal/State deficiencies related to the allegations were cited at F157, F282, F312, and F314.</p> <p>Survey dates: June 23, 24, 25, and 26, 2014</p> <p>Facility number: 010739 Provider number: 155764 AIM number: 200856890</p> <p>Survey team: Regina Sanders, RN-TC</p> <p>Census bed type: SNF: 35 SNF/NF: 10 Residential: 71 Total: 116</p> <p>Census Payor type: Medicare: 34</p>	F000000	<p>The submission of this plan of correction does not indicate an admission of Spring Mill Health 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 Spring Mill Health Campus. This facility recognized its 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. (Title 18 and 19). 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>	

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

TITLE

(X6) DATE

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

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	<p>Medicaid: 09 Other: 73 Total: 116</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 2, 2014, by Janelyn Kulik, RN.</p>						
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician</p>						

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	<p>intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to notify a resident's physician and family of a change in status, related to pressure areas, weight, and a bruise, for 1 of 4 residents reviewed for physician and family notification in a total sample of 6. (Resident #F)</p> <p>Findings include:</p> <p>1. Resident #F's record was reviewed on 06/24/14 at 8:30 a.m. The resident's</p>	F000157	<p>F157 It is the intent of this facility to ensure that resident's physician and family are notified of a change of status for a resident. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The attending Physician and family were notified of the change of condition related to pressure area, weight and a bruise for resident F. How other residents having the potential to be affected by the same deficient practice will</p>	07/26/2014

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	<p>diagnoses included, but were not limited to multiple sclerosis and Alzheimer's disease. The resident was admitted into the facility on 11/08/13.</p> <p>A) During the initial tour on 06/23/14 at 10:25 a.m., The Director of Health Services (DHS), indicated Resident #F was interviewable, dependent on staff for activities of daily living (ADLs), and had a Stage I (intact skin with non-blanchable redness) pressure ulcer on her buttocks.</p> <p>During an observation of the residents pressure area, on 06/23/14 at 2:55 p.m., with the resident's husband present, RN #1 positioned the resident so she could observe and measure the area. RN #1 removed the resident's brief, and three pressure areas were observed. RN #1 measured each area as follows:</p> <p>Coccyx: 3.5 cm (centimeter) by 2 cm with small area on the top with a 0.1 depth. RN #1 indicated the wound had yellow slough. She indicated the area was a Stage III (full thickness loss, slough may be present but does not obscure the depth of tissue loss). RN #1 then indicated the area was unstagable (slough/eschar; suspected deep tissue injury in evolution).</p>		<p><i>be identified and what corrective action(s) will be taken: DHS will review all change of condition forms for the past 30 days to ensure MD and family notification has been notified of the change of condition. Any deficiencies noted will be corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-in-service the License Nurses on documentation related to notifying the MD and families of any change of conditions. DHS or designee will audit change of conditions forms of 5 residents during the clinical care meetings 5 days per week to ensure notification of change of conditions has been completed. Any deficiencies noted will be corrected at that time. DHS or designee will report findings to the QAA meeting monthly for 6 months or until 100% compliance is obtained. 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: QAA will monitor monthly for 6 months or until 100% compliance is obtained. QAA will make recommendations to the Plan of Correction as needed. Date</i></p>		

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	<p>Left buttocks (upper wound): 1.5 cm by 1 cm. RN #1 indicated the area was unstagable and had dark tissue covering the area.</p> <p>Left buttocks (lower wound): 2.1 cm by 1.5 cm. RN #1 indicated the area was unstagable and necrotic.</p> <p>During an interview on 06/23/14 at 3:15 p.m., Resident #F's husband indicated he had seen the area 2-3 weeks ago and it was small, he indicated the area was worse. He indicated he did not know about the other two areas.</p> <p>A Physician's order, dated 05/14/14, indicated an order for optifoam dressing to the Stage I area on the coccyx.</p> <p>A Physician's telephone order, dated 05/31/14, indicated an order for Medihoney (pressure ulcer treatment) with optifoam dressing daily to pressure area on inner buttock and xenaderm (ointment) to bilateral buttock area.</p> <p>The Medication Administration Record (MAR), dated 06/14, indicated the order for just the optifoam dressing on the coccyx had been discontinued and the new order for the Medihoney had been transcribed and completed for treatment on the area.</p>		<p><i>systemic changes will be completed: July 26, 2014</i></p>				

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	<p>A Nurses' Note, dated 05/31/14 at 8:30 p.m., indicated the resident's physician and family had been notified of the treatment to the area on the inner buttock and the xenaderm to the excoriation area.</p> <p>There was a lack of documentation to indicate the resident's physician and family had been notified of all the pressure areas on the left buttock and coccyx and that the areas were unstagable and the size of the areas.</p> <p>An Individual Plan Report, dated 05/25/14, indicated the resident's physician was to be notified of any skin deficits and to report any non-healing wounds to the resident's physician.</p> <p>During an interview on 06/24/14 at 9 a.m., the DHS indicated the Medihoney was ordered on 05/31/14 when the area first opened. She indicated she had spoke with the nurses who had cared for the resident and they indicated they knew about the areas but had not documented the areas. She indicated she could not find documentation to indicate the physician and the family were made aware of all the areas. She indicated the nurses thought the Medihoney was suppose to be used for all the areas. She indicated the resident had one pressure</p>			

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	<p>area on 05/31/14 and an interview with the CNA who cares for the resident and the CNA indicated the other areas had been there for about a week.</p> <p>During an interview on 06/25/14 at 8 a.m., the RN Nurse Consultant indicated the physician and the resident's husband had been informed of the one area on 05/31/14.</p> <p>B) The resident's weight on 05/04/14 was 167.3, on 05/30/14 was 161.2, on 06/15/14 was 151.6. From 05/04/14 to 06/15/14, the resident had 9.38% weight loss in 30 days.</p> <p>There was a lack of documentation the resident's physician and family had been notified of the significant weight loss.</p> <p>The resident was re-weighed on 06/23/14 and the weight was 150 pounds.</p> <p>During an interview on 06/26/14 at 11:15 a.m., the DHS was unable to provide further information on the physician and family notification of the significant weight loss.</p> <p>A facility policy, titled, "Guidelines for Weight Tracking", dated 06/12, and received from the DHS as current, indicated, "...The physician, responsible</p>				

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	<p>party and dietician shall be notified of a weight variance of > (more than) 5% (unless on a planned weight loss program)."</p> <p>C) An Individual Plan Report, dated 05/29/14, indicated the resident had a bruise on her right arm.</p> <p>An skin monitoring form, dated 05/29/14, indicated the resident had a green/purple colored area on the right arm, which measured 1 cm by 1 cm. and on 06/18/14, the area was 4 cm by 3 cm.</p> <p>There was a lack of documentation to indicate the resident's physician and family had been notified of the bruise until 06/24/14.</p> <p>During an interview on 06/25/14 at 11 a.m., the DHS indicated the physician and the husband had not been notified of the bruise until 6/24/14 and the bruise was found on 05/29/14.</p> <p>A facility policy, titled, "Physician Notification Guidelines", dated 12/06/07 and received from the DHS as current, indicated, "To ensure the resident's physician is aware...change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...The physician</p>			

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F000225 SS=D	<p>should be notified of critical lab results or an immediate need by phone...All other...order requests may be faxed to the physician's office during office hours...During non-office hour times the nurse should notify the physician by phone...need for physician intervention..."</p> <p>This Federal Tag relates to complaints IN00150482 and IN00150997.</p> <p>3.1-5(a)(2)</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 registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source</p>			

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	<p>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 record review and interview, the facility failed to report an allegation of abuse to the Indiana State Department of Health (ISDH), related to an allegation of a staff member providing care in a rough manner, which caused the resident's legs to hurt, for 1 of 4 residents reviewed for abuse/neglect in a total sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 06/24/14 at 12:40 p.m. The resident's diagnoses included, but were not limited to Parkinson's Disease and hypertension.</p>	F000225	<p>F225 It is the intent of this facility to ensure that any allegations of abuse/neglect are reported to the Indiana State Department of Health.</p> <p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:</i></p> <p>The Executive Director reported the allegation of abuse to the State Board of Health related to resident B. The attending Physician and families were notified as well. This was completed on 6/25/2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective</p>	07/26/2014

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	<p>A Nursing Admission Assessment, dated 03/24/14, indicated the resident had no cognition problems.</p> <p>A Nurses' Note, dated 03/31/14 at 12 p.m., indicated the resident had voiced a concern about the previous care she had been provided and had also complained of right leg pain. The note indicated the Director of Health Services (DHS) had been notified of the resident's concern about care.</p> <p>A Resident Concern Form, dated 04/01/14, no time documented, indicated the concern occurred on 03/31/14 at 9:50 a.m. and the resident complained of a staff member handling her roughly causing her legs to hurt. The Resident Concern Form indicated the resident's physician had ordered an x-ray. The investigation part of the form indicated the resident was unsure who the staff member was and other residents were interviewed about care and no other concerns were voiced.</p> <p>A Nurses' Note, dated 04/01/14 at 2:30 p.m., indicated the x-ray results were back and the right femur, right knee, right tibia and fibula all showed degenerative arthritic changes with no evidence of a fracture or dislocation.</p>		<p><i>action(s) will be taken:</i> Resident concern logs for the last 30 days was reviewed for any potential allegation of abuse. Any deficiencies noted were corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-in-service staff on abuse. ED will audit 5 resident concerns in daily stand up meetings 5 days per week and ensure that any allegations will be reported timely. ED will report findings or trends to QAA monthly for 6 months or until 100% compliance is obtained. 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: QAA will monitor for monthly for 6 months or until 100% compliance is obtained. QAA will make recommendation to the Plan of Correction as needed. Date systemic changes will be completed: July 26, 2014</p>	

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F000226 SS=D	<p>During an interview on 06/25/14 at 3 p.m., the Executive Director (ED) indicated he had not reported the allegation of roughness to the ISDH due to he investigated the allegation and had not substantiated the allegation of roughness.</p> <p>This Federal Tag relates to complaint IN00150482</p> <p>3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not reporting an allegation of abuse to the Indiana State Department of Health (ISDH) for 1 of 4 residents reviewed for abuse/neglect in a total sample of 6. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on</p>	F000226	<p>F226 It is the intent of this facility to ensure that the facility abuse policy is followed. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: The Executive Director reported the allegation of abuse to the State Board of Health related to resident B. The attending Physician and families were notified as well. This was</p>	07/26/2014

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	<p>06/24/14 at 12:40 p.m. The resident's diagnoses included, but were not limited to Parkinson's Disease and hypertension.</p> <p>A Nursing Admission Assessment, dated 03/24/14, indicated the resident had no cognition problems.</p> <p>A Nurses' Note, dated 03/31/14 at 12 p.m., indicated the resident had voiced a concern about the previous care she had been provided and had also complained of right leg pain. The note indicated the Director of Health Services (DHS) had been notified of the resident's concern about care.</p> <p>A Resident Concern Form, dated 04/01/14, no time documented, indicated the concern occurred on 03/31/14 at 9:50 a.m. and the resident complained of a staff member handling her roughly causing her legs to hurt. The Resident Concern Form indicated the resident's physician had ordered an x-ray. The investigation part of the form indicated the resident was unsure who the staff member was and other residents were interviewed about care and no other concerns were voiced.</p> <p>A Nurses' Note, dated 04/01/14 at 2:30 p.m., indicated the x-ray results were back and the right femur, right knee, right</p>		<p>completed on 6/25/2014. <i>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:</i> Resident concern logs for the last 30 days were reviewed for any potential allegation of abuse. Any deficiencies noted were corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-in-service staff on abuse. ED will audit 5 resident concerns in daily stand up meetings 5 days per week and ensure that any allegations will be reported timely. ED will report findings or trends to QAA monthly for 6 months or until 100% compliance is obtained. 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: QAA will monitor for monthly for 6 months or until 100% compliance is obtained. QAA will make recommendation to the Plan of Correction as needed. Date systemic changes will be completed: July 26, 2014</p>				

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F000282 SS=D	<p>tibia and fibula all showed degenerative arthritic changes with no evidence of a fracture or dislocation.</p> <p>A facility policy, dated 09/16/11, titled, "Abuse and Neglect Procedural Guidelines", received as current from the Director of Health Services (DHS), indicated, "...PHYSICAL ABUSE...handling roughly...Reporting...Any staff member...may report known or suspected abuse...to local or state agencies. ii. Immediately and not more than 24 hours complete an initial report to applicable state agencies..."</p> <p>During an interview on 06/25/14 at 3 p.m., the Executive Director (ED) indicated he had not reported the allegation of roughness to the ISDH due to he investigated the allegation and had not substantiated the allegation of roughness.</p> <p>This Federal Tag relates to complaint IN00150482</p> <p>3.1-28(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER</p>						

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	<p>CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to follow resident's physician's orders and care plans, related to, weights, skin conditions, and treatment for pressure areas for 1 of 6 residents reviewed for care plans and physician's orders, in a total sample of 6. (Resident #F)</p> <p>Findings include:</p> <p>1. Resident #F's record was reviewed on 06/24/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to multiple sclerosis and Alzheimer's disease. The resident was admitted into the facility on 11/08/13.</p> <p>A) During the initial tour on 06/23/14 at 10:25 a.m., The Director of Health Services (DHS), indicated Resident #F was interviewable, dependent on staff for activities of daily living (ADLs), and had a Stage I (intact skin with non-blanchable redness) pressure ulcer on her buttocks.</p> <p>During an observation of the residents pressure area, on 06/23/14 at 2:55 p.m., with the resident's husband present, RN #1 positioned the resident so she could</p>	F000282	<p>F282 It is the intent of this facility to follow physician's orders and care plans related to weights, skin conditions and treatment of pressure areas. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident F orders for wound treatments were clarified. Resident F bruise was investigated by the Unit Manager. The Physician and family were notified of the bruise. This was completed on 6/24/2014. 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: Resident's physician orders were reviewed for the last 30 days to ensure the nursing was following the correct orders. Any deficiencies noted were corrected at that time. Resident's that had bruises for the last 30 days were assessed to ensure there was an investigation of the cause of the bruise. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will</p>	07/26/2014

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	<p>observe and measure the area. RN #1 removed the resident's brief, and three pressure areas were observed. RN #1 measured each area as follows:</p> <p>Coccyx: 3.5 cm (centimeter) by 2 cm with small area on the top with a 0.1 depth. RN #1 indicated the wound had yellow slough. She indicated the area was a Stage III (full thickness loss, slough may be present but does not obscure the depth of tissue loss). RN #1 then indicated the area was unstagable (slough/eschar; suspected deep tissue injury in evolution).</p> <p>Left buttocks (upper wound): 1.5 cm by 1 cm. RN #1 indicated the area was unstagable and had dark tissue covering the area.</p> <p>Left buttocks (lower wound): 2.1 cm by 1.5 cm. RN #1 indicated the area was unstagable and necrotic.</p> <p>A Physician's order, dated 05/14/14, indicated an order for optifoam dressing to the Stage I area on the coccyx.</p> <p>A Physician's telephone order, dated 05/31/14, indicated an order for Medihoney (pressure ulcer treatment) with optifoam dressing daily to pressure area on inner buttock and xenaderm</p>		<p>re-in-service Licensed staff on following MD orders and to ensure the investigation of bruises is completed. DHS will monitor 5 residents during clinical care meetings 5 days per week change of conditions forms or skin impairment forms that orders have been obtained correctly and the investigation of the bruise was completed. DHS or designee will report findings monthly to QAA monthly for 6 months or until 100% compliance is obtained. 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: QA A will monitor for 6 months or until 100% compliance is obtained. QAA will make recommendations to the plan of correction as needed. Date systemic changes will be completed: July 26, 2014</p>		

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	<p>(ointment) to bilateral buttock area.</p> <p>The Medication Administration Record (MAR), dated 06/14, indicated the order for just the optifoam dressing on the coccyx had been discontinued and the new order for the Medihoney had been transcribed and completed for treatment on the area.</p> <p>A Nurses' Note, dated 05/31/14 at 8:30 p.m., indicated the resident's physician and family had been notified of the treatment to the area on the inner buttock and the xenaderm to the excoriation area.</p> <p>There was a lack of documentation to indicate the resident's physician and family had been notified of all the pressure areas on the left buttock and coccyx and that the areas were unstagable and the size of the areas.</p> <p>An Individual Plan Report, dated 05/25/14, indicated the resident's physician was to be notified of any skin deficits and to report any non-healing wounds to the resident's physician.</p> <p>During an interview on 06/24/14 at 9 a.m., the DHS indicated the Medihoney was ordered on 05/31/14 when the area first opened. She indicated she had spoke with the nurses who had cared for the</p>			
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	<p>resident and they indicated they knew about the areas but had not documented the areas. She indicated she could not find documentation to indicate the physician had been made aware of all the areas. She indicated the nurses thought the Medihoney was suppose to be used for all the areas. She indicated the other areas did not have an order for a treatment but the Medihoney had been being used on the other open areas.</p> <p>During an interview on 06/25/14 at 8 a.m., the RN Nurse Consultant indicated the physician and the resident's husband had been informed of the one area on 05/31/14.</p> <p>B) The resident's weight on 05/04/14 was 167.3, on 05/30/14 was 161.2, on 06/15/14 was 151.6. From 05/04/14 to 06/15/14, the resident had 9.38% weight loss in 30 days.</p> <p>There was a lack of documentation the resident's physician and family had been notified of the significant weight loss.</p> <p>The resident was re-weighed on 06/23/14 and the weight was 150 pounds.</p> <p>An Individual Plan Report, dated 2/25/14 with a goal date of 5/24/14, indicated, "...Please review my overall weight</p>						

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	<p>trends at least once monthly and make any necessary recommendations to my physician for approval should I experience any undesired weight change..."</p> <p>During an interview on 06/26/14 at 11:15 a.m., the DHS was unable to provide further information on the physician and family notification of the significant weight loss.</p> <p>C) An Individual Plan Report, dated 05/29/14, indicated the resident had a bruise on her right arm.</p> <p>An Individual Plan Report, dated 05/25/14, indicated the resident's physician was to be notified of any skin deficits and to report any non-healing wounds to the resident's physician.</p> <p>An skin monitoring form, dated 05/29/14, indicated the resident had a green/purple colored area on the right arm, which measured 1 cm by 1 cm. and on 06/18/14, the area was 4 cm by 3 cm.</p> <p>There was a lack of documentation to indicate the resident's physician and family had been notified of the bruise until 06/24/14.</p> <p>During an interview on 06/25/14 at 11</p>			

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F000309 SS=D	<p>a.m., the DHS indicated the physician and the husband had not been notified of the bruise until 6/24/14 and the bruise was found on 05/29/14.</p> <p>This Federal Tag relates to complaints IN00150482 and IN00150997.</p> <p>3.1-35(g)(2)</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 the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide necessary care and services to a resident, related to not investigating a bruise in a timely manner, for 1 of 3 residents reviewed for abrasions and bruises, in a total sample of 6. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on</p>	F000309	<p>F309 It is the intent of this facility to investigate a bruise in a timely to provide necessary care and services for that resident. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident F bruise was investigated by the Unit Manager. Physician and family were notified of the bruise. This was completed on</p>	07/26/2014

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	<p>06/24/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to multiple sclerosis and Alzheimer's disease. The resident was admitted into the facility on 11/08/13.</p> <p>An Individual Plan Report, dated 05/29/14, indicated the resident had a bruise on her right arm.</p> <p>An skin monitoring form, dated 05/29/14, indicated the resident had a green/purple colored area on the right arm, which measured 1 cm by 1 cm. and on 06/18/14, the area was 4 cm by 3 cm.</p> <p>There was a lack of documentation to indicate an investigation for the cause of the bruise had been completed, and the resident's physician and family had been notified of the bruise until 06/24/14.</p> <p>During an interview on 06/25/14 at 11 a.m., the DHS indicated the bruise was from a laboratory draw. She indicated the investigation had been completed on 06/24/14, the physician and the husband had not been notified of the bruise until 6/24/14 and the bruise was found on 05/29/14.</p> <p>This Federal Tag relates to complaint IN00150482.</p>		<p>6/24/2014. <i>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:</i> DHS reviewed the resident's which had bruising for the past 30 days and reviewed to ensure the investigation process was completed. Any deficiencies noted were corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-in-service Licensed Nurses on completion of the investigation of bruises. The DHS or designee will monitor skin circumstances forms of 5 residents in clinical care meetings 5 days per week to ensure the investigation is completed. Any deficiencies noted will be corrected at that time. DHS or designee will report findings to QAA monthly for 6 months or until 100% compliance is obtained. 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: QAA will monitor monthly for 6 months or until 100% compliance is obtained. QAA will make recommendations to the plan of correction as needed. Date systemic changes will be</p>				

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F000312 SS=D	<p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review and interview, the facility failed to provide the necessary assistance with showers for 3 of 6 residents reviewed for ADL's (Activities of Daily Living) assistance, in a total sample of 6. (Residents #D, #E, and #F)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 06/25/14 at 8:15 a.m. The resident's diagnoses included, but were not limited to, stroke and dementia. The resident was admitted into the facility on 05/30/14 from the hospital.</p> <p>An Admission MDS Assessment, dated 06/18/14, indicated the resident had a short term memory problem and</p>	F000312	<p><i>completed: July 26, 2014</i></p> <p>F312 It is the intent of this facility to provide assistance with ADL's related to showers for residents. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident D, E and F were assisted with showering/bathing. Resident D, E and F were asked preference of time and type of bathing. Care plan and resident profiles were updated with individual's request. 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: DHS reviewed ADL flow records for residents for the last 30 days to very if showers or bathing was</p>	07/26/2014			

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	<p>decisions were poor; cues/supervision required, required extensive assistance of two or more staff for bed mobility, required extensive assistance of one staff for hygiene and was dependent on one staff assistance for bathing. The Customary Routine and Activities indicated it was very important for her to make a choice of a tub bath, shower, bed bath or sponge bath.</p> <p>The admission care plan, dated 06/11/14, indicated the facility would provide assistance of one with ADL's.</p> <p>There was a lack of documentation to indicated a care plan for bathing had been implemented on the Individual Plan Report.</p> <p>The Resident Bathing Type Chart, dated 05/31/14 through 06/24/14, indicated the resident received one shower on 06/20/14.</p> <p>During an interview on 06/26/14 at 11:15 a.m., the DHS indicated she had no further information in regard to the resident's showers.</p> <p>2. Resident #E's record was reviewed on 06/25/14 at 9 a.m. The resident's diagnoses included, but were not limited to, stroke and dementia. The resident was</p>		<p>completed. Any deficiencies noted were corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will ensure resident's preference is followed related to showering or bathing. DHS or designee will monitor, using care tracker, the completion of required bathing or showers. Any deficiencies noted will be corrected at that time. DHS or designee will review 5 residents in clinical care meeting 5 times per week that showers or bathing has been signed off for in care tracker. DHS or designee will report findings to QAA monthly for 6 months or until 100% compliance is obtained. 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: QAA will monitor monthly for 6 months or until 100% compliance is obtained. QAA will make recommendations to the plan of correction as needed. Date systemic changes will be completed: July 26, 2014</p>		

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	<p>re-admitted into the facility from the hospital on 06/13/14.</p> <p>An Admission/15 Day MDS Assessment, dated 06/20/14, indicated the resident had short and long term memory problems, required extensive assistance of 2 or more staff for bed mobility and transfers, was dependent on one staff member for hygiene and 2 or more staff for bathing.</p> <p>An Individual Plan Report, with the date of 06/17/14, indicated the staff needed to provide the resident with personal hygiene and bathing.</p> <p>The Resident Bathing Type Chart, dated 06/13/14 through 06/23/14, indicated the resident had not received a shower and had received one bed bath on 06/16/14.</p> <p>During an interview on 06/24/14, the DHS indicated she could not find documentation to indicate the resident had received a shower.</p> <p>3. During an interview on 06/23/14 at 12:35 p.m., Resident #F indicated she may go days without a shower.</p> <p>During an interview on 06/24/14 at 8:20 a.m., Resident #F indicated she does not always get her showers. She indicated sometimes the staff offers a shower and</p>				

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	<p>she has had a few and sometimes she just gets bed baths. She indicated she refused the shower occasionally and further indicated showers are not often offered to her.</p> <p>Resident #F's record was reviewed on 06/24/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to multiple sclerosis and Alzheimer's disease. The resident was admitted into the facility on 11/08/13.</p> <p>A Quarterly MDS Assessment, dated 05/15/14, indicated the resident's cognition was intact, had no behaviors, required extensive assistance of one for bed mobility, extensive assistance of 2 or more for transfers, extensive assistance of one for hygiene, and was totally dependent on one staff for bathing.</p> <p>The Individual Plan Report, dated 11/20/13, 2/25/14, and 5/25/14, indicated she preferred he showers on Wednesdays and Friday Mornings and required assistance with her ADL's due to physical limitations. The report further indicated the resident had a history of making false allegations against the care providers and when she was angry she sometimes becomes combative and resistant towards the care providers.</p>						

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	<p>The Resident Bathing Type Chart, dated 05/01/14 through 06/24/14 indicated the resident had only received a shower on 05/14/14.</p> <p>A Nurses' Note, dated 06/18/14 at 1:30 p.m. indicated the resident had refused her shower and a bed bath was given. There was a lack of documentation to indicate the resident had refused other showers when offered.</p> <p>During an interview on 06/24/14 at 9:15 a.m., the DHS indicated the resident decides if she wants a shower or not. She indicated there was no documentation to indicate the resident had refused her showers.</p> <p>This Federal Tag relates to complaints IN00150482 and IN00150997.</p> <p>3.1-38(b)(2)</p>				

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F000314 SS=G	<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, record review, and interview, the facility failed to ensure a resident received necessary care and treatments for pressure ulcers, related to assessment, following physician's orders for treatment, and prevention of pressure ulcers, which a resident was not turned and repositioned frequently and had unstagable pressure ulcers, for 1 of 4 residents reviewed for pressure ulcers in a total sample of 6. (Resident #F)</p> <p>Findings include:</p> <p>1. During the initial tour on 06/23/14 at 10:25 a.m., The Director of Health Services (DHS), indicated Resident #F was interviewable, dependent on staff for activities of daily living (ADLs), and had</p>	F000314	<p>F314 It is the intent of this facility to ensure residents receive necessary care and treatments for pressure ulcers, related to assessment, following physician's orders for treatment, and prevention of pressure ulcers by turning and repositioning frequently. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident F wound was assessed by Director of Health Services. Appropriate treatment was obtained and preventive devices were put into place. Attending Physician and family were notified of the area and change of treatments. Care plan was updated to reflect</p>	07/26/2014
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	<p>a Stage One (intact skin with non-blanchable redness) pressure ulcer on her buttocks.</p> <p>Resident #F's record was reviewed on 06/24/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to multiple sclerosis and Alzheimer's disease. The resident was admitted into the facility on 11/08/13.</p> <p>A Quarterly MDS Assessment, dated 05/15/14, indicated the resident's cognition was intact, had no behaviors, required extensive assistance of one for bed mobility, had one Stage I pressure ulcer, and had no pressure ulcers present on admission to the facility.</p> <p>An Individual Plan Report, updated 02/25/14 and reviewed on 05/25/14, indicated the resident had a Stage I area to her left buttock, to observe the wound for healing with care, measure the wound weekly, reposition and turn the resident frequently, follow the physicians orders for wound treatment, the CNA's were to observe the skin during care and report concerns to the Nurse and the Nurses' were to document any new skin areas and notify the physician of any skin deficits.</p> <p>A) The resident was observed in bed laying on her back on 06/23/14 at 10:25</p>		<p>resident current status. 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: DHS or designee completed a skin check of all residents in the Health Care campus on 6/23/14. Any resident with areas identified were assessed and ensured MD, family were notified and appropriate treatments were obtained. Residents will be identified if at risk for breakdown and preventive measures will be implemented. Any deficiencies noted were corrected at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: DHS or designee will re-in-service Licensed Nurses on pressure ulcers, prevention, ensure appropriate treatment are obtained and for preventive measures. DHS or designee will monitor in clinical care meetings 5 days per week to ensure treatments are completed and ensure preventive measures are in place. DHS or designee will ensure pressure ulcers are staged correctly and will be reviewing during weekly wound rounds. DHS or designee will report findings to QAA monthly for 6 months or</p>				

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	<p>a.m., 11:10 a.m., 12:35 p.m., and 1 p.m. (resident had been moved up on the mattress in bed) The resident had a pillow under her left shoulder, and her buttock was still on the mattress at 2:45 p.m.</p> <p>During an interview on 06/23/14 at 12:35 p.m., Resident #F indicated the staff do not offer to turn and reposition her often.</p> <p>During an interview on 06/23/14 at 1 p.m., Resident #F indicated the staff came in and repositioned her a, "little". (The resident remained on her back but had been moved up toward the head of the bed)</p> <p>During an interview on 06/23/14 at 2:45 p.m., the resident indicated she has not asked to be turned, so maybe this was why the staff have not turned her.</p> <p>During an interview on 06/23/14 at 2:45 p.m., the resident's husband indicated the staff do not turn her correctly. He indicated they do not turn her so her buttocks was off the bed.</p> <p>A facility policy, titled, "Turning and Repositioning", dated 10/07, and received as current from the DHS, indicated, "...Turning and repositioning is not routinely documented as this a (sic)</p>		<p>until 100% compliance is obtained. 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: QAA will monitor monthly for 6 months or until 100% compliance is obtained. QAA will make recommendation to the plan of correction as needed. Date systemic changes will be completed: July 26, 2014</p>	

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	<p>normal nursing standard of practice that will be performed in accordance with the resident's care plan..."</p> <p>B) A Nurses' Note, dated 05/14/14 at 3 p.m., indicated the resident had a Stage I 1 cm (centimeter) x (by) 3.2 cm to the buttocks, which was red in color. The note indicated there was a new physician's order to cleanse the area with normal saline and to apply optifoam(dressing) to the open area.</p> <p>A physician's order, dated 05/14/14, indicated an order for Risamine ointment to the redness of the buttocks every shift and to cleanse the Stage I area with normal saline and apply optifoam daily.</p> <p>A pressure ulcer assessment form, dated 05/14/14, indicated the resident had a Stage I (intact skin with non-blanchable redness) pressure area on the buttock which measured 1 cm x 3.5 cm with 0.25 cm depth (area was open with depth-Stage II-partial thickness loss of dermis). The form indicated the area was not present on admission and the treatment was optifoam (dressing).</p> <p>The pressure ulcer assessment form indicated the left buttock area's measurements were as followed: 5/21/14- 1 cm x 3.4 cm x 0.25 cm depth,</p>			

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	<p>Stage I pressure area, red in color with moderate amount of exudate, and the optifoam dressing continued.</p> <p>05/28/14- 2 cm x 3.4 cm x 0.1 cm depth, Stage I, red in color, and the optifoam dressing continued.</p> <p>06/06/14- 2 cm x 3.4 cm x 0.1 cm depth, no stage marked, red in color and now Medihoney (pressure ulcer ointment) and optifoam was now ordered.</p> <p>06/11/14- 2 cm x 3.4 cm x 0.1 cm depth, Stage I, red with moderate exudate, no current treatment marked.</p> <p>6/18/14- 2 cm x 3.4 cm, 0.1 cm depth, Stage I, red with moderate exudate, treatment of Medihoney and optifoam continued.</p> <p>There was a lack of documentation to indicate the resident had other pressure areas on the buttock/coccyx area.</p> <p>A skin impairment assessment, dated 05/31/14 indicated there was excoriation to the bilateral outer buttock, which was read and a new order for Xenaderm (ointment) had been ordered. The assessment form indicated the area had been resolved on 06/22/14. There was a lack of documentation to indicate the</p>			

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	<p>resident had other areas of concern.</p> <p>A Skin Impairment Circumstance, Assessment and Intervention form, dated 05/14/14, indicated the resident had a Stage I area on the buttocks and the resident's physician and family were notified.</p> <p>A Skin Impairment Circumstance, dated 05/31/14 indicated the resident had a Stage I area and excoriation on the buttock, and the "resident has a 1 x 3.2 (cm) area to the inner buttock and excoriation to the outer buttock" and an order for Medihoney and Xenaderm were received from the physician.</p> <p>During an observation of the residents pressure area, on 06/23/14 at 2:55 p.m., with the resident's husband present, RN #1 positioned the resident so she could observe and measure the area. RN #1 removed the resident's brief, and three pressure areas were observed. RN #1 measured each area as follows:</p> <p>Coccyx: 3.5 cm (centimeter) by 2 cm with small area on the top with a 0.1 depth. RN #1 indicated the wound had yellow slough. She indicated the area was a Stage III (full thickness loss, slough may be present but does not obscure the depth of tissue loss). RN #1</p>			

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	<p>then indicated the area was unstagable (slough/eschar; suspected deep tissue injury in evolution).</p> <p>Left buttocks (upper wound): 1.5 cm by 1 cm. RN #1 indicated the area was unstagable and had dark tissue covering the area.</p> <p>Left buttocks (lower wound): 2.1 cm by 1.5 cm. RN #1 indicated the area was unstagable and necrotic.</p> <p>While RN #1 was measuring the areas, she indicated the resident was going to have to be turned more often. She indicated the area was one big area when she last measured it on 06/11/14 and the area was getting better.</p> <p>Measurement of the area on 06/11/14 was 2 cm by 3.4 cm by 0.1 cm depth, area was not large enough to cover the other area located on the coccyx.</p> <p>During an interview on 06/23/14 at 3:15 p.m., Resident #F's husband indicated he had seen the area 2-3 weeks ago and it was small, he indicated the area was worse. He indicated he did not know about the other two areas.</p> <p>During an interview on 06/23/14 at 3:18 p.m., the DHS indicated the nurses'</p>			

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	<p>should have seen the areas were getting worse. She indicated the area started as a Stage I (the area had a 0.25 cm depth when first identified). She indicated she had just ordered an air mattress for the resident.</p> <p>During an interview on 06/24/14 at 9 a.m., the DHS indicated the Medihoney was ordered on 05/31/14 when the area first opened. She indicated she had spoke with the nurses who had cared for the resident and they indicated they knew about the areas but had not documented the areas. She indicated the nurses had not followed through with measuring and assessment of the areas. She indicated she could not find documentation to indicate the physician and the family were made aware of all the areas. She indicated the nurses thought the Medihoney was suppose to be used for all three areas. She indicated the resident had one pressure area on 05/31/14 and an interview with the CNA who cares for the resident and the CNA indicated the other areas had been there for about a week. She indicated she was unaware of the resident's pressure areas and had thought the first area was a stage I so she had not looked at the area.</p> <p>During an interview on 06/24/14 at 10:05 a.m., the RN Nurse Consultant indicated</p>				

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	<p>she had spoke with RN #1 and RN #1 had transposed the measurements. She indicated RN #1 thought if it began at a Stage I then she should always keep the pressure area at a Stage I. She indicated the Nurses' had not assessed the areas correctly. She indicated there was one area then bridged into two areas.</p> <p>The RN Consultant indicated she measured the areas as follows on 06/23/14:</p> <p>Coccyx- 3.5 cm x 2.0 x 0.1 depth, large amount of exudate, yellow/brown 100%, and unstageable.</p> <p>Left buttock (upper)- 1.5 cm x 1 cm, unstageable, black 100%</p> <p>Left buttock (lower)- 2.1 cm x 1.5 cm, unstageable, 100% black</p> <p>During an interview on 06/26/14 at 11:15 a.m., the RN Nurse Consultant indicated the nurses' had not assessed the pressure areas correctly.</p> <p>During an interview on 06/26/14 at 12:20 p.m., the DHS indicated Resident #F had not been discussed in CAR (clinically at risk), she indicated, "we missed that one".</p> <p>A non-dated facility policy, titled,</p>			

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	<p>"Pressure Prevention Guidelines", received from the DHS on 06/24/14 at 10 a.m., indicated, "...Inspect the skin daily during care for signs of breakdown or changes to the skin...Establish an individualized turning schedule if resident is immobile or compromised. Frequency of Position (sic) change is individualized. Notify the nurse to document if the resident refuses turning intervention...Weekly CAR (clinically at risk) review as warranted..."</p> <p>This Federal Tag relates to complaints IN00150482 and IN00150997.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			