

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/11/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LANE ELWOOD, IN46036		
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 8, 9, 10, 11, 2011</p> <p>Facility number: 000372 Provided number: 155522 AIM number: 100289060</p> <p>Survey Team: Toni Maley, BSW, TC Tammy Alley, RN Linn Mackey, RN Donna M Smith, RN (8/8, 9, 10/11)</p> <p>Census bed type; SNF/NF: 81 Total: 81</p> <p>Census payor type: Medicare: 6 Medicaid: 68 Other: 7 Total: 81</p> <p>Sample: 17</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 15,</p>	F0000	Submission of this plan of correction shall not constitute or be construed as an admission by Community Parkview Care Center the allegations contained in this survey report are accurate or reflect accurately the provision of care and service to the residents at Community Parkview Care Center. The facility requests the following plan of correction be considered its allegation of compliance.		

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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F0157 SS=E	<p>2011 by Bev Faulkner, RN</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</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, interview and record review, the facility failed to ensure the resident's physician was notified regarding a change in the resident's</p>	F0157	*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #57's physician has seen her wound	09/10/2011

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	<p>condition which could possible warrant a change in treatment regarding new wound development, a change in the appearance and condition of wound, elevated blood sugars and edema, for 4 of 15 residents reviewed for physician notification in a sample of 17 (Residents #57, #42, #2, and #75).</p> <p>Findings include:</p> <p>1.) Resident #57's clinical record was reviewed on 8/8/11 at 2:50 p.m.</p> <p>Resident #57's current diagnoses included, but were not limited to, dementia and renal insufficiency.</p> <p>Resident #57 had a 6/21/11-6/22/11 "Weekly Wound Tracking Worksheet" (this form was not a part of the clinical record) that indicated the resident had a new stage II pressure area on the left outer ankle which was a 1 cm by 1 cm callused area with a 0.2 cm by 0.2 cm open area in the center. (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.)</p> <p>On 6/22/11, a physician's order was</p>		<p>several times. He has been updated. He is currently scheduled to see her again every two weeks. Her wound is dry with no drainage. Size of the wound is .6cm X .6cm. Resident # 42's physician was notified of new open area on 8/9/11. The wound found on 8/8/11 is now healed. The original wound on the coccyx remains and has not changed. His doctor is aware of the wound and his general condition. LPN # 3 was counselled on the necessity of notifying the physician and the DON regarding all changes. Res # 2's physician was notified on Aug 9th during his rounds. He did a muscular skeletal evaluation and indicated that the right lower extremity had a "well healed hip incision" with no new orders received. He did not make reference to her swollen leg. Her leg has been elevated to decrease the edema. When the physician saw her on 8/9/11 he reviewed all of her blood sugar readings. He was informed at that time of the blood sugar reading of 496 and 469. At that time her blood sugar reading was 88. There were no new orders. Res # 75's area is healed. The physician was notified on 7/19/11. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE</p>		

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	<p>obtained to treat the area on the left outer ankle with skin prep one time daily.</p> <p>A 7/2/11, 4:00 p.m., nursing note indicated the left ankle open area was "larger than last weekend, is reddened around the wound, tender and sl [slight] swollen with scant amount yellow drng [drainage] on her sock."</p> <p>A 7/6/11, "Wound Nurse Assessment" indicated the area was 1.5 cm by .06 cm unstageable with "area covered with yellow 'wet' scab, resident c/o [complains of] pain to area, no s/s [signs or symptoms] infection, periwound slightly pink, scant amount of yellow drainage."</p> <p>The resident first complained on pain/tenderness and the area became wet in appearance with yellow draining on 7/2/11. The clinical record lacked documentation of the physician being notified of the resident's complaints of pain and drainage until 7/12/11.</p> <p>Resident #57 had a 7/12/11 "Wound Nurse Assessment which indicated the wound bed was covered with yellow slough, scant yellow drainage, periwound pink and resident complained of slight pain.</p> <p>The clinical record indicated the physician</p>		<p>TAKEN.All residents have the potential to be affected. A mandatory in-service for all nurses was conducted on 8/24/11 and 8/25/11 regarding the requirement for notifying the physician when there are any changes in a resident's condition. The importance of notifying the physician and documenting that notification was stressed during this meeting. All nurses were tested on their knowledge during this in-service. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. Nurses were informed during the mandatory nurses meetings held on 8/24/11 and 8/25/11 the requirement to notify the physician regarding any changes in a resident's condition. The nurses had to pass a test regarding physician notification and proper documentation. A form has been developed as a tool to help the nurses remember to notify the physician of all changes. An audit tool has been developed to monitor and make sure that the nurses are notifying the physician promptly.*HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. A form has been developed as a tool to help the nurses remember to notify the</p>		

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	<p>was notified on 7/12/11 (10 days after the development of pain and drainage) and an order was obtained to cleanse the area on the left outer ankle with normal saline, pat dry, apply thin layer of Santyl/Bactroban (a wound deriding agent combined with an anti-infective agent) to wound bed, cover with foam, wrap with rolled gauze daily.</p> <p>During an 8/10/11, 3:31 p.m., interview, The Director of Nursing indicated the physician was not notified of the change in the condition of the wound until 7/12/11 when the treatment was changed.</p> <p>Resident #57 had an 8/9/11 physician's progress note which indicated: Left Lower Extremities: "lateral malleolus [outer ankle], left: 2 cm redness, swelling with crater, Ulcer 6 mm. yellow base; is on chemical debridement + [plus] cellulitis to ankle, painful... Plan: Continue Keflex, Santyl, if not better I may need to debried [sic]."</p> <p>2.) On 8/08/11 from 3:15 p.m. to 3:30 p.m., Resident #42's dressing change on his coccyx was observed. During this dressing change, a small, red open area was also observed on the resident's left buttock. During an interview at this same time, LPN #3 indicated the small red open</p>		<p>physician of all changes. An audit tool has been developed to monitor and make sure that the nurses are notifying the physician promptly. The DON or her representative will use this audit tool daily to assure all nurses are notifying the physicians of any changes. Once there is 100% complaince for 30 days, then the audit tool will be used 3 X' weekly. Results of this monitoring will be discussed at the next two QA meetings with the Medical Director. Provided there are no concerns regarding the notification of physicians the audit may be dicsontinued. If concerns are identified, the QA team will determine the frequency of continued monitoring based on the nature of those concerns. The DON will be responsible for monitoring this issue.</p>		

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	<p>area observed on the left buttock was not there on Friday when she last worked. LPN #3 was then observed to complete the coccyx dressing change.</p> <p>On 8/09/11 at 3:15 p.m. during an interview, the Director of Nursing indicated she was made aware today concerning Resident #42's new open area on his left buttock and had contacted the physician and had received a treatment order for the new area.</p> <p>On 8/09/11 at 4:45 p.m. during an interview, LPN #3 indicated she was to call the DON for an open area and the physician if the area was considered "bad." She also indicated she had not considered the open area on the left buttock as "bad" and felt the open area was from tape.</p> <p>Resident #42's record was reviewed on 8/08/11 at 2:40 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II, hypertension, ischemic cardiomyopathy, coronary artery disease, and dementia.</p> <p>The "New Wound Alert Note," dated 8/08/11 at 3:30 p.m., was a small superficial, round in shape and red colored wound, measuring 0.3 centimeters (cm) by 0.3 cm, was found while doing</p>				

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	<p>the resident's coccyx treatment. The doctor was to be notified.</p> <p>No further information indicated the physician had been notified concerning the open area on the resident's left buttock.</p> <p>3.) On 8/08/11 from 2:15 p.m. to 2:35 p.m., Resident #2's right heel dressing was observed. During this dressing change, after the resident indicated her right leg and foot were swollen several times, LPN #1 agreed her right leg and foot were swollen. The resident's right leg and foot were observed swollen with a puffiness around the resident's toes.</p> <p>On 8/10/11 at 11:45 a.m. during an interview, the Director of Nursing indicated the physician was not notified concerning the Resident #2's swollen lower extremities.</p> <p>Resident #2's record was reviewed on 8/09/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus Type II, and congestive heart failure.</p> <p>The physician order, dated 7/28/11, was Accuchecks (glucometer-fingerstick blood sugar) 3 times a day and Humulog</p>			

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	<p>(Insulin) sliding scale per weight base, which was indicated as follows:</p> <p>Weight 108 lbs. (pounds) for weight less than 110 lbs.:</p> <p>Blood glucose (BG): 100 to 174 = 1 unit (u); BG: 175 to 224 = 2 u; BG: 225 to 274 = 3 u; BG: 275 to 299 = 4 u; BG: 300 to 349 = 5 u; BG: 350 to 374 = 6 u; BG: 375 to 399 = 7 u; BG greater than 400 - call physician.</p> <p>The "Progress Notes" indicated the following:</p> <p>On 8/01/11 at 5:46 p.m., the resident's blood sugar was 496 and attempts to reach the physician, nurse practitioner, and the Director of Nursing (DON) were unsuccessful.</p> <p>On 8/01/11 at 7:52 p.m., the blood sugar at 6:30 p.m. was 469, and the DON was notified.</p> <p>On 8/01/11 at 8:35 p.m., no further information was indicated regarding the physician's notification of the blood sugar greater than 400.</p> <p>On 8/08/11 at 7:48 p.m., the resident had reported to the nurse her right leg and knee were swollen and warm to touch. No redness or cyanosis was noted to the right leg, but the leg was edematous with the right knee cap feeling warmer than the</p>				

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	<p>left. She indicated she would notify the doctor.</p> <p>No further information was indicated related to the physician notification regarding the resident's right leg swelling.</p> <p>4. The record for Resident # 75 was reviewed on 8/10/11 at 9:10 a.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus and hypertension.</p> <p>A 7/6/11 "New Wound Alert Note" indicated the resident had an area 1 cm red, and 1/2 cm scabbed area on the right outer ankle. The note indicated the area was cleaned with soap and water and placed on a pillow to relieve pressure. The note indicated the physician was not notified at this time.</p> <p>A "Wound Nurse Assessment," dated 7/14/11, indicated the area to the ankle was 0.2 cm by 0.2 cm., unstageable and was smaller and scabbed. The assessment did not indicate the physician was notified of the area.</p> <p>During interview on 8/10/11 at 2:15 p.m., the Director of Nursing indicated she had spoken to the nurse who found the open area on the resident. The nurse indicated she had not informed the physician because she felt the area was too small.</p>				

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	<p>The Director of Nursing indicated the physician was first notified of the area on 7/19/11.</p> <p>5.) An undated policy titled "Pressure Ulcer Prevention" was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "...2. Treatment will be obtained by the licensed nurse in a timely manner when alteration in skin integrity is identified or potential problem is identified."</p> <p>An undated policy titled "Notification-Resident Status" was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "Policy: It is the policy of...to promptly notify physician...of changes in resident status...Licensed nurse will assess the condition/situation with notification to include at least the following:...b. Significant alteration/change in the resident's plan of care/condition...g. Situations deemed as necessary or appropriate to report that are in the best interest of the resident."</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F0223 SS=A	<p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review, the facility failed to ensure residents were free from verbal abuse for 1 of 1 residents reviewed for verbal abuse in a sample of 17. (Resident 13)</p> <p>Finding include:</p> <p>Resident #13's clinical record was reviewed on 8/8/11 at 3:05 p.m.</p> <p>Resident #13's diagnoses included, but were not limited to, schizophrenia with paranoid features and mood disturbance.</p> <p>A review of a 3/13/11 facility "Fax/Incident Report" indicated the following:</p> <p>Resident #13 was in the main dining room. Dietary Aide #8 was passing drinks to residents. Resident #13 called out for "coffee, coffee, coffee." Dietary Aide #8 yelled for Resident #13 to "shut up." The Weekend Manager approached Dietary</p>	F0223	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident 13 shows no ill effects as a result of the incident. We will continue to monitor him daily for evidence of problems but he does not even remember the incident.*HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be affected. We will continue to perform our criminal history checks and background/reference checks on every employee who hires in. We will also continue to provide abuse in-services indicating that yelling at a resident is verbal abuse as well as information regarding other types of abuse. In the future, if this ever happens again, we will continue to suspend the accused employee pending a thorough</p>	09/10/2011	

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	<p>Aide #8 and immediately asked her to clock out and exit the facility pending investigation of the verbal abuse which the manager had just witnessed. The Weekend Manager then immediately notified the Administrator. An investigation began immediately. Following the investigation, Dietary Aide #8 was terminated. The investigation indicated Resident #13 did not hear the comment due to being very hard of hearing. Resident #13 was monitored and did not display any distress following the event.</p> <p>The facility followed its policy and procedure for the investigation of verbal abuse, which included but was not limited to:</p> <p>a.) All reviewed employees, including Dietary Aide #8, had criminal history checks and reference checks at the time of hire.</p> <p>b.) All reviewed employees, including Dietary Aide #8, received abuse prohibition training at the time of hire and annually or more frequently.</p> <p>c.) Dietary Aide #8 was immediately suspended following the allegation of abuse.</p>		<p>investigation and terminate if found to be at fault. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. We will continue to perform criminal history checks, reference checks and abuse in-services. We will continue to follow our abuse policy and investigate all allegations including suspending the accused employee with termination possible if found to be negligent.*HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. All allegations of abuse will be brought before the QA committee on a quarterly basis. The Administrator and/or Director of Nursing will be responsible for monitoring to assure compliance.</p>		

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F0252 SS=C	<p>d.) Resident safety was maintained during the investigation process.</p> <p>e.) Resident #13's condition was monitored for psychological harm following the event.</p> <p>f.) Current facility personnel were re-inserviced regarding the facility abuse prohibition policy following the event.</p> <p>4.) Review of a current, undated, facility policy titled "Abuse Prevention" which was provided by the Administrator on 8/8/11 at 11:00 a.m., indicated the following:</p> <p>"Verbal abuse-Any use of oral or gestured language that includes disparaging and derogatory terms to residents or their families, or within their hearing distances, to describe residents, regardless of their age, ability to comprehend, or disability."</p> <p>3.1-27(b)</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p>	F0252	*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR	09/10/2011	

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	<p>Based on observations and interviews, the facility failed to ensure a clean and sanitary environment regarding floors, walls, heaters, and ceilings for 11 of 12 rooms observed, for 3 of 3 dining rooms observed, for 1 of 1 therapy room observed, for 1 of 1 activity room observed, for 3 of 3 hallways observed, and for 2 of 3 shower rooms observed. This deficiency had the potential to impact 81 of 81 residents residing in the facility. (Room #'s 317, 108, 112, 106, 205, 212, 214, 303, 311, 312, and 313)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8/08/11 at 3:45 p.m., Room 317 was observed. Upon entering the resident's room, no door threshold was observed between the resident's room and hallway. A brown substance was observed between the floors. The room's floor was observed with various areas of gaps between the 12 inch floor tiles with an accumulation of a brown colored substance in these gaps. On 8/08/11 at 11:50 a.m., the following was observed: In the 300 hallway, the lower carpeted wall below the handrail was observed with various areas of gray to light black 		<p>THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Room 317 has had the floor replaced with a threshold between the room and the hallway. The brown substance was nothing more than the area itself between the tiles, not dirt. We have contracted and paid to have all of the carpet on the lower walls replaced. The date of the contract and when paid is August 31, 2011. The work is scheduled to be completed sometime between October 24, 2011 and November 11, 2011 The therapy room has been stripped and waxed. The tape was being used to measure distance. The tape is being replaced with various colored paint to give a visual aid for residents receiving therapy. In the main dining room, the tile next to the short wall where the ice carts are stored was replaced. The corner tile has also been replaced. The tile below the 1st window in the main dining room has also been replaced and the threshold has been cleaned and shined. A threshold was put at the entrance to the activity room. Some of the floor tiles were replaced. The tiles in the "Cafe" next to the serving area have all been replaced. In the 100 hallway through the double door entry the row of tiles that was cracked has been replaced. The tiles with wax build up in the doorway of the activity room have been</p>		

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	<p>stained/soiled areas and scattered areas of white colored rubbed areas.</p> <p>In the hallway between the 300 hallway and 200 hallway, the lower wall carpeted area was observed with scattered gray to black stained/soiled areas. A one inch thick black mark was observed above the cove base on the lower carpeted wall after the gazebo outside doorway entrance, and a black, handprint-like area on the opposite wall after the electric baseboard. At the end of this hallway, each corner of the hallway had loose, raveling carpeting overlapping and hanging loose.</p> <p>In the 200 hallway and in the 100 hallway, the lower carpeted wall areas were observed with scattered areas of gray to black stained/soiled areas with scattered, loose pieces of carpeting observed hanging over the edge.</p> <p>3. On 8/09/11 at 7:25 a.m., the following was observed:</p> <p>In the therapy room, in the middle of the room, a strip of tape was observed the length of 12 twelve inch floor tiles with shorter pieces of tape along the side of this same tape at various areas. This taped area was observed torn in places with black accumulation of dirt at the edges of the taped areas. The floor was</p>		<p>replaced. The 100 hall shower room has been closed for showers from this point on. We still have two other shower rooms that are in use. The 100 shower room will remain closed until it can be remodeled or repaired properly. Target date for that repair/remodel is January 1, 2012. All heaters (PTAC units) have been cleaned to assure there is no debris under the grill. Room 108 has a cover over the controls. The scratched area on the door of the bathroom in room 108 was not a scratched area at all but simply dark marks from the wheels of the wheelchair as the resident's go in that room. It has been cleaned. In room 112, the ceiling was not soft. The maintenance man was able to smooth the surface and repaint with no problems. There was no water leak. The spot in the ceiling mentioned in room 106 was actually not in the room at all but rather directly outside the room in the hallway. The ceiling tile has been replaced. Room 205 does not have a heater with a grill caved in. Rather that would be in room 201 and that PTAC unit has been ordered to be replaced. It should be here by October 1, 2011. The gray discolored area in the ceiling was repaired and painted. The tile in the hallway outside of rooms 202 and 203 has been replaced. Room 212 now has a threshold and the floor tile was replaced. Room 214</p>		

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	<p>observed with a grayish dull appearance. The exit door metal threshold was observed with a build up of a brown substance in the grooves of the metal threshold.</p> <p>Upon entering the main dining room, the area for the ice cart storage was observed. The second roll of the 12 inch floor tiles next to the short wall was observed. One of these 12 inch floor tiles was observed with a 1 1/2 inch to a 2 inch irregular triangular shaped area missing and with the surrounding 12 inch floor tiles with a brown to dark brown build up in the gap left between them. The corner of this area was observed with a dark brown build up in the corner of this area. Below the first window by the exit door a 12 inch floor tile was observed with an irregular 1 1/2 inch by 1/4 inch missing from the tile. The exit door threshold was observed with grime build up in the metal grooves and in the corners on each side of the door.</p> <p>At the Activity Room's entrance there was no door threshold in place. The floor was uneven with the hallway flooring higher. A build-up of dark brown grime was observed between the two floors.</p> <p>On 8/09/11 at 8:35 a.m. during an interview, the Administrator indicated she</p>		<p>mentioned in the survey is actually room 216. The PTAC unit is being replaced. It has been ordered and should arrive before October 1, 2011. The floor in this room has also been replaced. All PTAC units have been cleaned. Cove base in the cafe on 300 hall has been replaced. All areas mentioned have been cleaned thoroughly. The row of 12 inch floor tile outside of the cafe and between it and the nurses station has been replaced. The shower room on 300 hall has been cleaned thoroughly. Cove base has been applied to the area on the opposite wall of the shower area to assure there is no area exposed. Caulking around the toilet has been replaced. All door areas have had a threshold put in. Room 312 mentioned in the survey is actually room 321. The brown build up has been fixed. The counter top has been repaired and the floor in the bathroom has been replaced. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents could be affected. The Maintenance Supervisor will assure that all preventative maintenance is done on a regular basis. This includes checking floors, cove base,</p>		

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	<p>did not have any present plans for remodeling.</p> <p>On 8/10/11 at 3:20 p.m. during an interview, Physical Therapist #4 indicated he had been here in the present therapy room, and the floor had not been done for a year or more. He indicated the tape was used to mark off distances for therapy's use.</p> <p>3. On 8/09/11 from 9:45 a.m. to 11:25 a.m., the environmental tour was conducted with the Maintenance Supervisor and Housekeeping Supervisor present. The following was observed:</p> <p>a.) The main dining room floor tiles and grime build-up were again observed.</p> <p>b.) In the "Cafe" dining room next to the serving area, 7 and 1/2- twelve inch floor tiles were observed unevenly laid with dented and cracked areas with brown to dark brown substance in the opened areas.</p> <p>c.) In the 100 hallway, the following was observed:</p> <p>Upon entering the 100 hallway through the double door entry, a row of 4 1/2 twelve inch floor tiles was cracked with chips of floor tiles missing where the metal threshold and floor tile met.</p>		<p>thresholds, tile placement, etc. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. The preventative maintenance book will be updated to assure all areas are included. An audit tool has been developed to help monitor all areas of the building. This audit tool will be used 1 time weekly. The Maintenance Supervisor will be responsible for doing the audit.*HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The results of the audit tool will be discussed during the next two (2) quarterly QA meeting with the Medical Director. Provided there are no concerns regarding the environmental issues the audit tool may be discontinued. If concerns are still identified, the QA team will determine the frequency of continued monitoring based on the nature of those concerns. Maintenance Director will be responsible.</p>		

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	<p>A brown to dark brown build-up was observed at the activity room's door threshold. At this same time during an interview, the Housekeeping Supervisor indicated the door threshold could have been a wax build-up when the hallway floor was recently stripped and waxed. She also indicated a towel was supposed to be placed at the bottom of the door to absorb the excess wax.</p> <p>Upon entering the shower room, along the floor, 3 cracked trim wall tiles were observed. The tiles were located with 1 on each side of the sink and 1 under the sink. In the designated used shower, 9- one inch tiles were missing and 4- one half pieces were missing around the drain. Another 4- one inch tiles were missing towards the back of the shower. Along the back of the shower, a black substance was observed accumulated in the grout areas of these tiles. At this same time, during an interview, the Housekeeping Supervisor indicated she had been unsuccessful in trying to clean/remove the black substance in the shower.</p> <p>In Room 108, the heater was observed with loose debris scattered throughout the area below the grill with no cover over the controls of the heater. At this same time, during an interview, the Maintenance</p>						

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	<p>Supervisor indicated it looked like the cover could have broken off. The inside bathroom door was observed with a scratched area across 2/3rds of the lower area of the door.</p> <p>In Room 112, the bathroom ceiling above the toilet was observed with a dinner plate sized area of light brown to yellow raised substance. At this same time, during an interview, the Maintenance Supervisor indicated the area was soft, and he would need to check for a possible water leak.</p> <p>In Room 106's bathroom, the ceiling was observed with a brown dried area measuring a half dinner plate size. At this same time, during an interview, the Maintenance Supervisor indicated he did have an assistant who would make rounds Monday through Friday in an attempt to check/correct cosmetic problems, which included checking ceiling tiles, lights and paint on walls.</p> <p>d.) In the 200 hallway, the following was observed:</p> <p>In Room 205, the grill to the heater was caved in. Brown loose debris and a quarter-sized caked orange to brown substance was observed on top of the grill. Also, a 1/2 saucer-sized yellow, gray discolored area was observed above</p>				

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	<p>the head of the bed on the ceiling.</p> <p>In the hallway between Rooms 202 and 203, a quarter-sized dented area was observed in the middle of the hallway with a dark brown substance in the cracks of the dented area.</p> <p>At Room 212's entrance, an accumulation of brown to dark brown substance was observed at the door's threshold. A triangular piece of floor tile was missing on the hinged side of the door with the same type of brown substance accumulation at each end of the door.</p> <p>In Room 214, the outside frame of the heating unit was loosely fitted with no cover over the knobs. A layer of dust was observed inside the heater with a cobweb containing a bug was hanging from the bottom of the heater. Six of the twelve inch floor tiles below the heater was observed with missing corners and gashes scattered throughout and contained an accumulation of brown to dark brown substance in these areas. At the doorway of this room, the same type of accumulation of brown substance was observed. At this same time, during an interview, the Maintenance Supervisor indicated the heaters were on his list to do monthly.</p>						

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	<p>e.) In the 300 hallway, the following was observed:</p> <p>In Room 303, the heater was observed with loose debris inside the grill.</p> <p>Upon entering the dining room, the cove base was missing on the corner of the entry way leaving an open space. Brown colored build-up was observed along each side of the banisters at the dining room entrance. Along the west wall of the dining room, a brown build-up was observed next to the wall and along a raised area of 1 and 1/2 twelve inch floor tiles under one of the tables. At this same time, during an interview, the Maintenance Supervisor indicated he thought a cabinet had been where the raised area was located. At this same time during an interview, the Housekeeping Supervisor indicated the brown substance along the west wall could be glue.</p> <p>Between the hallway's nurse's station and the dining room, a row of 12 inch floor tiles the width of the hallway was observed cracked with an accumulation of brown to dark brown substance in the cracks.</p> <p>In the shower room, the designated shower was observed with a black accumulation along the groove between</p>				

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	<p>the lighter and the darker 1 inch colored tiles. Along the opposite wall, seven- 4 by 4 wall tiles at the floor level did not have any grout. At this same time during an interview, the Maintenance Supervisor indicated he needed to regrout those tiles. The caulking around the toilet was observed brown in color.</p> <p>At the entrance of Room 311 and Room 313, brown to dark brown build-up was observed in the door thresholds.</p> <p>In Room 312's bathroom, brown build-up was observed along the wall/cove base. The counter top had one half of the dry wall exposed due to the counter top caulking had loosened with the other side of the counter top's caulking cracked. In the resident's room, at least 2 of the 12 inch floor tiles had thin lined cracks with build-up in the cracks and along the door threshold.</p> <p>3.1-19(f)(5)</p>				

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F0309 SS=D	<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 record review and interview, the facility failed to ensure an insulin sliding scale was followed per physician's orders to regulate the resident's blood sugars in the prevention of complications from diabetes mellitus related to hyper- and/or hypoglycemic reactions for 1 of 2 residents reviewed with sliding scale insulin in a sample of 17. (Resident #2)</p> <p>Findings include:</p> <p>Resident #2's record was reviewed on 8/09/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus Type II, and congestive heart failure. The significant change Minimum Data Set assessment, dated 8/04/11, indicated the resident had difficulty with decision making in new situations.</p> <p>The physician order, dated 7/28/11, was Accuchecks (glucometer-fingerstick blood sugar) 3 times a day and Humulog (Insulin) sliding scale per weight base, which was indicated as follows:</p>	F0309	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Resident #2's physician was notified on 8/9/11 and reviewed her blood sugar readings at that time with no new orders. The orders have been clarified and now are for weight based coverage only. The previous orders were conflicting due to her recent return from the hospital and an update on the orders. The nurse who gave the incorrect insulin has been counseled regarding the the proper way to read and interpret the orders and her responsibility to clarify all orders that are conflicting so that this does not happen again. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents receiving weight based insulin orders have the potential to be affected. An in-service for all nurses was held on 8/24/11 and 8/25/11 regarding how to make sure all weight based insulin orders are read and</p>	09/10/2011	

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	<p>Weight 108 lbs. (pounds) for weight less than 110 lbs.:</p> <p>Blood glucose (BG): 100 to 174 = 1 unit (u); BG: 175 to 224 = 2 u; BG: 225 to 274 = 3 u; BG: 275 to 299 = 4 u; BG: 300 to 349 = 5 u; BG: 350 to 374 = 6 u; BG: 375 to 399 = 7 u; BG greater than 400 - call physician.</p> <p>The "Diabetic Orders" record indicated the following:</p> <p>On 7/30/11 at 7:00 a.m., BG was 114 with no insulin coverage given. The resident should have received 1 unit.</p> <p>On 7/30/11 at 4:30 p.m., BG was 174 with 2 u insulin coverage given. The resident should have received 1 unit.</p> <p>On 7/31/11 at 4:30 p.m., BG was 336 with 10 u insulin coverage given. The resident should have received 5 units instead of 10.</p> <p>On 8/10/11 at 11:45 a.m., the Director of Nursing indicated she would check concerning the wrong coverage given for the 7/30 and 7/31 blood sugars as the resident had returned from the hospital at the end of July with a change in her insulin coverage.</p> <p>On 8/10/11 at 3:40 p.m., the DON indicated she did not have any further</p>		<p>clarified to assure each individual order is followed correctly. All nurses were tested on their knowledge. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. During the inservice the nurses were tested on their knowledge regarding the clarification of all new orders and how to interpret the coverage. An audit tool has been developed to monitor the accuracy of the weight based insulin coverage for all residents with weight based insulin orders. The audit tool will be used daily. *HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. An audit tool has been developed to monitor the accuracy of the weight based insulin coverage for all residents with weight based insulin orders. The DON or her representative will use this audit tool daily to assure all nurses are accurately providing insulin. This audit will be discussed during the next two (2) QA meetings. Provided there are no concerns with weight based insulin issues, the audit may be discontinued. If there are concerns than the QA team will determine the frequency of continued monitoring based on the nature of the concerns. This audit will be done daily until 100%</p>		

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F0314 SS=E	<p>information concerning the above blood sugars.</p> <p>3.1-37(a)</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, observation, and interview, the facility failed to ensure residents with pressure ulcers received preventative measures, appropriate treatment, and thorough assessments to promote healing and prevent the possibility of infection for 4 of 4 residents reviewed with pressure ulcers in a sample of 17. (Resident # 22, # 75, # 57, and # 42)</p> <p>Findings include:</p> <p>1. The record for Resident # 22 was</p>	F0314	<p>complaine is achieved and then 2 times weekly after that. The DON will be responsible for this audit.</p> <p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Res #22's area on his coccyx is currently 1.1 by .4 by .1 - basically unchanged. The C.N.A who did not report the lack of a dressing was counseled and educated on 8/10/11. The nurses who did not start the original treatment on 6/24/11 have been counseled and educated. The order to obtain a roho cushion was changed and he now has an order for a waffle cushion while in recliner and in his electric scooter. Res #75's</p>	09/10/2011	

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	<p>reviewed on 8/8/11 at 2 p.m.</p> <p>Current diagnoses included, but were not limited to, depression and weakness.</p> <p>A 7/21/11 Braden Scale indicated a score of 18, indicating a low risk for pressure ulcer.</p> <p>The nursing admission assessment, dated 4/6/11, indicated the resident was admitted on 4/6/11 with a stage III pressure ulcer on his coccyx. A 5/4/11, Wound Nurse Assessment indicated the ulcer was healed.</p> <p>A standard of care note, dated 6/23/11, indicated the resident had a new open area to his coccyx. No measurements were indicated for the pressure ulcer.</p> <p>A physician fax sheet, dated 6/23/11 and signed by the physician on 6/24/11, indicated an order to clean the coccyx with normal saline, dry, apply collagen to wound bed and cover with foam and secure with Medifix every day and as needed.</p> <p>A 6/28/11 Wound Nurse Assessment indicated the pressure ulcer to the coccyx was a stage II and was 1.7 centimeters (cm) by 0.3 cm by 0.1 cm. The assessment indicated the area had no</p>		<p>area is now healed. The LPN who did not notify the physician was counseled and educated. The delay of treatment did not negatively affect the resident as the wound is now healed. Res # 57's physician has seen her wound several times. Her wound is dry with no drainage. Size of the wound is .6cm X .6cm. The skin prep order was from Res 57's physician. We have educated him regarding the proper use of skin prep for an open area. She does continue to have pain with the area and we have addressed her pain with medications. The care plan has been updated. Res #42's area that was found on 8/8/11 is now healed. The wound on his coccyx remains the same. LPN # 3 has been counseled and educated regarding the proper procedure for dressing changes and MD notification and handwashing.</p> <p>*HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents at risk for skin ulcers can be affected. An in-service was held on 8/24/11 and 8/25/11 with all nurses to go over procedures for prevention of pressure ulcers, treatment of ulcers, MD notification, clean dressing change procedures, and handwashing. All nurses were tested on their knowledge during</p>		

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	<p>improvement and the resident was admitted with the ulcer and it had healed and had now reopened.</p> <p>The Treatment Administration Record (TAR) for June 2011 indicated the treatment ordered on 6/24/11 was not initiated until 6/29/11.</p> <p>During interview on 8/10/11 at 8:55 a.m., the Director of nursing indicated she did not know why there was a delay in treatment. She indicated the ordered items were in house stock.</p> <p>The resident was in the hospital from 7/7/11-7/13/11 and returned with the open area to his coccyx measuring 1.7 cm by 0.8 cm by 0.1 cm. as documented on a re-admission assessment dated 7/13/11.</p> <p>Re-admission orders, dated 7/13/11, indicated an order to clean the wound on the coccyx with normal saline, apply collagen to wound bed, cover with foam, secure with Medifix every day and as needed.</p> <p>During a dressing change observation with LPN # 5 on 8/8/11 at 4:15 p.m., LPN # 5 lowered the resident's brief to expose the pressure ulcer on the coccyx. There was no dressing on the coccyx wound. At that time during interview, the LPN</p>		<p>this meeting.*WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. A new "Wound alert note or change in wound condition" form has been developed to assist nurses in assuring that all changes are reported timely. There is also a new "Physician Notification form" in place. The DON will receive the forms daily and will use an audit tool to assist her in assuring that the MD is notified timely as well as all changes to wounds are reported. The audit will be completed daily.*HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The new audit tool will be used by the DON. Results of this audit tool will be brought before the next two (2) quarterly QA committee meetings. These audits will continue 5 times weekly until 100% compliance is achieved. After that time they will be conducted 3 X's weekly. Provided there are no concerns during the QA meeting regarding pressure areas, then the audits may be discontinued. If concerns are still identified, the QA team will determine the frequency of continued monitoring based on the nature of those concerns. The DON will be responsible to monitor</p>		

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	<p>indicated she was unaware the pressure ulcer did not have a dressing on it. She completed the treatment. The pressure ulcer was nickel size in the coccyx area, with a pink wound bed. No drainage or odor was noted.</p> <p>During interview on 8/8/11 at 4:55 p.m., with CNA # 6, she indicated she had layed the resident down prior to the treatment but had not changed his brief because he was not soiled.</p> <p>During interview on 8/9/11 at 9:20 a.m., RN # 7 indicated she had been the nurse for Resident # 22 on 8/8/11 and she had not been informed his dressing was not intact to his coccyx.</p> <p>During interview on 8/9/11 at 10:45 a.m., CNA # 8 indicated she had gotten the resident up and dressed on 8/8/11 around 6:45 a.m. She indicated he did not have a dressing on his coccyx at that time. She indicated she had not informed the nurse because she thought the treatment was discontinued since she had not worked the weekend.</p> <p>Current measurements of the pressure ulcer on 8/2/11 were 1 cm by 0.5 cm by 0.1 cm. There has been no worsening of the wound.</p>		compliance.				

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	<p>A physician order for August 2011 indicated an order for a Roho cushion to be used in the recliner and wheelchair.</p> <p>The resident was also observed sitting in his recliner on 8/8/11 at 2 p.m., and 8/9/11 at 10 a.m., sitting on a waffle cushion.</p> <p>During interview on 8/10/11 at 10:05 a.m., the Director of Nursing indicated the resident had recently changed from the wheelchair to an electric wheelchair. She indicated she had talked with the Occupational Therapist this day, who indicated the Roho cushion had been left with the resident during the last week.</p> <p>2. The record for Resident # 75 was reviewed on 8/10/11 at 9:10 a.m.</p> <p>Current diagnoses included, but were not limited to, Diabetes Mellitus and hypertension.</p> <p>A 7/6/11 New Wound Alert Note indicated the resident had an area 1 cm red, and 1/2 cm scabbed area on the right outer ankle. The note indicated the area was cleaned with soap and water and placed on a pillow to relieve pressure. The note indicated the physician was not notified at this time.</p> <p>A Wound Nurse Assessment form, dated</p>				

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	<p>7/7/11, indicated the right outer ankle was 0.6 cm by 0.6 cm and was an unstageable scab. No treatment was indicated.</p> <p>A wound nurse assessment form, dated 7/12/11, indicated the pressure ulcer was scabbed.</p> <p>A physician order, dated 7/19/11 at 11:50 a.m., indicated an order to clean the right outer ankle with normal saline, dry, then apply Santyl/Bactroban to wound bed and cover with a foam and secure with tape daily.</p> <p>A wound nurse assessment form, dated 7/20/11, indicated the right ankle pressure ulcer was 0.7 cm by 0.6 cm with slough in the wound bed.</p> <p>The TAR for July 2011 indicated the treatment order obtained on 7/19/11 was not initiated until 7/21/11.</p> <p>A wound nurse assessment, dated 8/2/11, indicated the pressure ulcer was 0.4 cm by 0.4 cm and was now scabbed.</p> <p>During interview on 8/10/11 at 2:15 p.m., the Director of Nursing indicated she had spoken to the nurse who found the open area on the resident. The nurse indicated she had not informed the physician because she felt the area was too small.</p>				

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	<p>The Director of Nursing indicated the physician was first notified of the area on 7/19/11. She also indicated she did not know why there was a delay in treatment.</p> <p>3. Resident #57's clinical record was reviewed on 8/8/11 at 2:50 p.m.</p> <p>Resident #57's current diagnoses included, but were not limited to, dementia and renal insufficiency.</p> <p>Resident #57 had a 6/21/11-6/22/11 "Weekly Wound Tracking Worksheet" (this form was not a part of the clinical record) which indicated the resident had a new stage II pressure area on the left outer ankle which was a 1 cm by 1 cm callused area with a 0.2 cm by 0.2 cm open area in the center. (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.)</p> <p>On 6/22/11, a physician's order was obtained to treat the area on the left outer ankle with skin prep one time daily.</p> <p>A review of the manufacturer's instruction for use for "Sureprep No-Sting" skin prep, which was provided by the Assistant</p>				

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	<p>Director of Nursing on 8/10/11 at 3:30 p.m., and identified as the skin prep used by Resident #57 from 6/22/11 to 7/12/11, indicated the following:</p> <p>"Intended Use: Sureprep No-Sting Barrier wipe or wand applicators intended to use as a firm-forming product, that when applied to intact or damaged skin forms a long lasting waterproof barrier which acts as a protective interface between the skin and bodily wastes, fluids, and adhesive products. It is intended as a primary barrier against irritation from body fluids."</p> <p>"Contraindications: Sureprep No-Sting Barrier Film should not be used: 1. On full or partial thickness wounds, or when bacterial protection is needed. Wound dressing should be used in such cases."</p> <p>During an 8/10/11, 3:31 p.m., interview, The Director of Nursing indicated she had not considered the contraindication for use of skin prep when using it on an open area.</p> <p>A review of Resident #57's "Wound Nurse Assessment" for 6/22/11 to 8/8/11 lacked measurements and a description of wound</p>				

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	<p>progress for the weeks of 6/22/11 and 6/28/11.</p> <p>Review of Resident #57's clinical record on 8/9/11 indicated the Director of Nursing made late entries for the above weeks on 8/9/11.</p> <p>A review of nursing notes from 6/24/11 to 7/2/11 lacked any documentation of the size or physical appearance of the wound on the left outer ankle.</p> <p>A 7/2/11, 4:00 p.m., nursing note indicated the left ankle open area was "larger than last weekend, is reddened around the wound, tender and sl [slight] swollen with scant amount yellow drng [drainage] on her sock."</p> <p>A 7/6/11 "Wound Nurse Assessment" indicated the area was 1.5 cm by .06 cm unstageable with "area covered with yellow 'wet' scab, resident c/o [complains of] pain to area, no s/s [signs or symptoms] infection, periwound slightly pink, scant amount of yellow drainage."</p> <p>The resident first complained on pain/tenderness and the area became wet in appearance with yellow draining on 7/2/11. The clinical record lacked documentation of the physician being notified of the resident's complaints of</p>				

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	<p>pain and drainage until 7/12/11 (10 days later).</p> <p>Resident #57 had a 7/12/11 "Wound Nurse Assessment which indicated the wound bed was covered with yellow slough, scant yellow drainage, periwound pink and resident complained of slight pain.</p> <p>The clinical record indicated the physician was notified on 7/12/11 (10 days after the development of pain and drainage) and an order was obtained to cleanse the area on the left outer ankle with normal saline, pat dry, apply thin layer of Santyl/Bactroban (a wound debriding agent combined with an anti-infective agent) to wound bed, cover with foam, wrap with rolled gauze daily.</p> <p>Resident #57 had a 8/5/11 Physician's order for Keflex (antibiotic) 500 mg three times daily for 10 days.</p> <p>A review of Resident #57's clinical record on 8/9/11 indicated the resident lacked a care plan for the treatment of the pressure area on the left outer ankle.</p> <p>During an 8/11/11, 9:55 a.m., interview, the Assistant Director of Nursing indicated Resident #57 did not have a care plan and one was developed on 8/9/11</p>				

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	<p>following inquiry.</p> <p>Resident #57 had an 8/9/11 physician's progress note which indicated: Left Lower Extremities: "lateral malleolus [out ankle], left: 2 cm redness, swelling with crater, Ulcer 6 mm. yellow base; is on chemical debridement + [plus] cellulitis to ankle, painful... Plan: Continue Keflex, Santyl, if not better I may need to debried [sic]."</p> <p>4. On 8/08/11 from 3:15 p.m. to 3:30 p.m., Resident #42's dressing change on his coccyx was observed. With gloved hands, LPN #3 was observed to prepare for the dressing change and placed a plastic bag on the resident's bed at his buttock level. As LPN #3 began to clean the opened coccyx area, a small, red open area was also observed on the resident's left buttock. During an interview at this same time, LPN #3 indicated the small red open area observed on the left buttock was not there on Friday when she last worked. LPN #3 was then observed to complete the cleansing of the coccyx opened area followed by the new open area on the left buttock with soap and water. Next, as LPN #3 applied hydrogel to the open area of the coccyx, she was observed to place hydrogel on the small open area of the left buttock also. With the same gloved hands, LPN #3 was</p>				

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	<p>observed to retrieve a pair of scissors from her uniform pocket. No cleansing was observed prior to LPN #3 cutting the silver alginate to the size of the coccyx open area, which was then used to cover the open coccyx area. After she placed the scissors on top of the plastic bag barrier in the resident's bed, she proceeded to cover the coccyx open area with the foam dressing. After the dressing change was completed, LPN #3 was observed to put the pair of scissors back into her uniform pocket. No cleansing/disinfecting of the scissors was observed. After she returned the dressing supplies to her treatment cart, LPN #3 removed and donned a new pair of gloves. She was then observed to return to the room and assisted repositioning the resident in his bed. She again removed her gloves and elevated the resident's head of bed with the hand crank. No handwashing/handgel use was observed as LPN #3 picked up the bagged trash, placed a new bag in the wastebasket, removed her gloves, and then left the room.</p> <p>On 8/09/11 at 3:15 p.m., during an interview, the Director of Nursing indicated she was made aware today concerning Resident #42's new open area on his left buttock and now had a new order for a treatment.</p>						

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	<p>On 8/09/11 at 4:45 p.m., during an interview, LPN #3 indicated she was to call the DON for an open area and the physician if the area was considered "bad." She also indicated she had not considered the open area on the left buttock as "bad" and felt the open area was from tape.</p> <p>Resident #42's record was reviewed on 8/08/11 at 2:40 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus Type II, hypertension, ischemic cardiomyopathy, coronary artery disease, and dementia.</p> <p>The physician order, dated 7/26/11, was to cleanse the open area on the coccyx with normal saline, dry, apply hydrogel to wound bed, cut silver aquacel to fit and place on wound bed. Cover with foam and secure with Medifix. Change every day and as needed.</p> <p>The "New Wound Alert Note," dated 8/08/11 at 3:30 p.m., indicated a small superficial, round in shape and red colored wound, measuring 0.3 centimeters (cm) by 0.3 cm, was found while doing the resident's coccyx treatment. The doctor was to be notified.</p> <p>5. An undated policy titled "Decubitus</p>				

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	<p>Ulcer-Treatment" was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "...1. The nurse is responsible for identifying skin problems and initiating a preventative plan of care if Stage I develops. If State II develops, the physician is notified of needed treatment and such notifications is documented in the medical record...2. The nurse is responsible for carrying out the treatment of choice as prescribed by the attending physician. 3. Record treatment in the nursing chart and all pertinent observations...."</p> <p>An undated policy titled "Pressure Ulcer Prevention" was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "...potential intervention relative to risk factors:...pressure reducing devices...2. Treatment will be obtained by the licensed nurse in a timely manner when alteration in skin integrity is identified or potential problem is identified."</p> <p>An undated policy titled "Notification-Resident Status" was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "Policy: It is the policy of...to promptly</p>						

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	<p>notify physician...of changes in resident status...Licensed nurse will assess the condition/situation with notification to include at least the following:...b. Significant alteration/change in the resident's plan of care/condition...g. Situations deemed as necessary or appropriate to report that are in the best interest of the resident."</p> <p>An undated policy titled "Clean Dressing Change Policy/Procedure"was provided by the Assistant Director of Nursing on 8/10/11 at 1:50 p.m., and deemed as current. The policy indicated: "...3. Wash hands, apply clean gloves...4. Remove soiled dressing...including gloves. Wash hands...5. Apply clean gloves, and cleanse wound with prescribed solution. 6. Apply medication and dressing as ordered. 7. Discard...gloves...wash hands thoroughly...10. If scissors are used @ (at) any time during the treatment they must be cleaned before and after each use with alcohol prep pads."</p> <p>3.1-40(a)(2)</p>				

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F0323 SS=D	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure preventive devices were in place related to a floor mat and a personal body alarm in the prevention of falls and/or injuries related to falls for 2 of 3 residents reviewed for falls in a sample of 17. (Resident #58 and #11)</p> <p>Findings include:</p> <p>1. On 8/08/11 at 9:30 a.m., during initial tour, no bed was available for Resident #58. At this same time during an interview, LPN #1 indicated Resident #58 was getting a low bed due to she slipped out over the weekend and had a bed alarm.</p> <p>On 8/08/11 at 2:45 p.m. and 3:15 p.m.,</p>	F0323	<p>*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Res #58 had a bed available at all times. Nursing had requested on the morning of 8/8/11 that, while res 58 was in her wheelchair, maintenace bring in a low bed due to a recent fall. At no time did she NOT have a bed. The low bed was provided to her before her nap after lunch. The order was for a low bed with a bedside mat and the nurse who did not get the mat prior to putting her to bed has been counseled and educated. The nurse did obtain the mat that afternoon and it is currently beside her bed.</p> <p>Res #11 currently has an order for a sensor alarm in her chair and the order for a personal alarm has been d/c'd because</p>	09/10/2011	

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	<p>Resident #58 was observed in her low bed with no floor mat present.</p> <p>On 8/09/11 at 3:05 p.m., during an interview, LPN #1 indicated Resident #58 had a floor mat beside her low bed when she went to bed last night. She also indicated extra floor mats were kept in the supply room and/or in the shower room for use.</p> <p>On 8/10/11 at 1:10 p.m., during an interview, the Director of Nursing indicated the floor mat should had been placed next to the resident's low bed.</p> <p>Resident #58's record was reviewed on 8/10/11 at 7:45 a.m. The resident's diagnoses included, but were not limited to, general weakness, anxiety with panic attacks due to delusions, and dysequilibrium. The quarterly Minimum Data Set assessment, dated 7/21/11, indicated the resident rarely made decisions. The resident required limited to extensive assistance of 1 person for transfers and activities of daily living.</p> <p>The physician's order, dated 8/08/11 at 9:00 a.m., was for the resident to be in a low bed with a mat on the floor beside the bed.</p> <p>The "Progress Notes" indicated the</p>		<p>she removes the personal alarm herself. There have been no more falls as of this date. *HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. All residents have the potential to be affected. An in-service was held on 8/24/11 and 8/25/11 with all nurses to go over the importance of safety and following orders for equipment. *WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. An audit tool will be used to monitor all devices for the residents. The DON or her designee will be responsible for this audit tool. The audit tool will be used 5 times weekly until 100% complaince has been achieved for 30 days. *HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR. The results of this audit will be reported during the next two (2) quarterly QA meeting with the Medical Director. Provided there are no concerns regarding safety devices the audit tool may be discontinued. If concerns are still identified, the QA team will determine the frequency of</p>		

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	<p>following:</p> <p>On 8/04/11 at 12:00 p.m., the resident had slid out of her wheelchair and had been attempting to get up without assistance several times.</p> <p>On 8/07/11 at 6:41 a.m., the resident's alarm was sounding. The resident had slid out of her bed onto the floor beside the bed. The resident had indicated she was trying to get up to see what was going on.</p> <p>On 8/08/11 at 9:00 a.m., a new physician's order was received for the resident to be in a low bed with a mat on the floor due to her attempts to get out of bed without assistance.</p> <p>2. On 8/08/11 at 5:15 p.m., Resident #11 was observed in her wheelchair with a top on, her brief halfway off, and no cover for her legs. She was observed to be moving freely around her room going between her doorway, partially in the hallway, and back to her bed. She was also observed to pour herself a glass of water and take a drink. The resident's personal body alarm was observed not clipped to the resident. QMA #51 was notified and indicated the personal body alarm should be clipped to the resident.</p> <p>Resident #11's record was reviewed on 8/10/11 at 7:30 a.m. The resident's</p>		<p>continued monitoring based on those concerns. The audit tool will be used 5 X's weekly until 100% compliance has been achieved for 30 days. Then the audit tool will be used 2 X's weekly. The DOn or her designee will be responsible.</p>		

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	<p>diagnoses included, but were not limited to, dementia with agitated features and osteoarthritis. The quarterly Minimum Data Set assessment, dated 5/06/11, indicated the resident made poor decisions. The resident required extensive assistance of 1 to 2 persons for transfers and activities of daily living.</p> <p>The physician order, dated 6/14/11, was personal alarm when up in a wheelchair or recliner.</p> <p>The "Progress Notes" indicated the following:</p> <p>On 8/08/11 at 9:41 p.m., the resident was found lying on her back on the floor outside of her room with her feet facing the room door. No information was documented related to the resident's personal alarm.</p> <p>3. The "Policy and Procedure for Fall Prevention" was provided by the Assistant Director of Nursing on 8/10/11 at 2:55 p.m. This current policy indicated the following:</p> <p>"...Policy: It is the policy of this facility to provide for the safety of our residents...</p> <p>Procedure:</p>				

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F0465 SS=E	<p>5.) The charge nurse will implement interventions at the time of the fall to prevent further injuries until the IDT [Interdisciplinary Team] can meet to discuss the incident.</p> <p>...7.) The DON (Director of Nursing) will then assure that the interventions are implemented and...."</p> <p>3.1-45(a)(2)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observations and interviews, the facility failed to ensure service areas were sanitary and in good repair related to the condition of the floors, walls, and ceilings for 3 of 4 storage rooms, for 1 of 3 soiled utility rooms, and for 1 of 3 utility rooms. (100 hallway storage room; 100 hallway soiled utility room; "Brief" storage room; 300 hallway clean utility room; 300 hallway storage room; 300 hallway supply room)</p> <p>Findings include:</p> <p>1. On 8/09/11 at 7:25 a.m., floors in the 100 hallway storage room and the 100</p>	F0465	*WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. All floors in the 100 hall storage room and soiled utility room have been thoroughly cleaned and thresholds have been replaced. The 100 hall storage room and soiled utility room have new thresholds. The wall paper on the inner wall next to the hopper has been replaced with waterproof paneling. The floor in the Brief storage room has been replaced. A threshold has been applied in the doorway. In the 300 hall clean utility room behind the sink the floor has been replaced.	09/10/2011	

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	<p>hallway soiled utility room were observed with brown to dark brown build-up in the corners of each side of the doors and at the door thresholds.</p> <p>2. On 8/09/11 from 9:45 a.m. to 11:25 a.m., the environmental tour was conducted with the Maintenance Supervisor and Housekeeping Supervisor present. The following was observed:</p> <p>a.) In the 100 hallway the following was observed:</p> <p>In the soiled utility room, the inner wall next to the hopper was observed above the cove base to be curling/peeling up. At this same time during an interview, the Maintenance Supervisor indicated the wall did get wet while spraying items in the hopper.</p> <p>In the "Briefs" storage room, packages of adult briefs were being stored on shelves. The floor of this storage room was missing 4 twelve inch tiles under one of the shelves. The rest of the floor was discolored and stained with no door threshold in place. Brown to dark brown build-up was observed in the gap between the door entrance and the hallway floor.</p> <p>b.) In the 300 hallway, the following was observed:</p>		<p>A threshold has been added. The baseboard heater in the 300 hall storage room has been repaired. IT is not in use but the front cover has been reapplied. The cove base in that room has been replaced. The floor tiles were replaced. In the supply room on the 300 hall the ceiling has been repaired. The floor tiles have been replaced. Even though it is stated that the Housekeeping Supervisor stated she did not have a schedule for the floors this is incorrect. She does have a schedule. She calls it her spreadsheet but she uses this as a schedule to assure floors are stripped and waxed timely.</p> <p>*HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTION WILL BE TAKEN. No residents were actually affected since these are areas they do not enter.*WHAT MEASURE WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR. All of these areas will be added to the Preventative Maintenance schedule. The Maintenance man will assure that these are checked by completing a weekly audit of the areas. *HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE</p>		

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	<p>In the clean utility room behind the sink, a 1/4 inch gap was observed between the wall and the floor resulting in a build-up of a brown to dark brown substance in this gap. The entire floor was observed discolored and stained with a brown to dark brown accumulation of a substance at the door threshold.</p> <p>In the storage room, a baseboard heater was observed with 1/2 of the front covering falling off. A 2 inch by 2 inch corner next to the water heaters was observed without any cove base/trim in place leaving the area opened with paint observed peeling off above this area. The floor tiles were discolored and/or stained with the floor tiles around the water heaters curling up or missing. At this same time during an interview, the Housekeeping Supervisor indicated she did store bedspreads and pillow and a small amount of extra linen for the back hall if it was needed. These items were observed presently stored in this area. At this same time during an interview, the Maintenance Supervisor indicated the heater was disconnected as it had gotten wet from a past water leak. He also indicated there had been several leaks and was he working on fixing a leak presently. He indicated there was a slow drip now, which was presently observed.</p>		<p>DEFICIENT PRACTICE WILL NOT RECUR. The results of the audit will be discussed during the next two (2) quarterly QA meeting with the Medical Director. Provided there are no concerns regarding the environmental issues the audits may be discontinued. If concerns are still identified, the QA team will determine the frequency of continued monitoring based on the concerns identified. The Maintenance Director will be responsible for compliance.</p>		

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	<p>In the supply room, a brown ring was observed around the ceiling fan with peeling paint on the one side. At least 7-twelve inch floor tiles were observed with 2 and 1/2 inch to 2 inch irregular areas of chipped and/or missing pieces of floor tiles.</p> <p>c.) On 8/10/11 at 3:15 p.m., during an interview, the Housekeeping Supervisor indicated she did not have a schedule for the floors. She indicated the employee who did the floors would check with her to know which floor he was to do, and she generally started at one end of the building and would go through the whole building. She indicated she did not have a set schedule for the floors. At this same time, during an interview, after rechecking the therapy room, the Housekeeping Supervisor indicated the therapy room floor needed to be done as it was a year or more since it had been done.</p> <p>3.1-19(f)</p>				