

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236
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F000000	<p>This visit was for the Investigation of Complaint IN00159632 and Complaint IN00159357.</p> <p>Complaint IN00159632-Substantiated. Federal/State deficiency related to the allegations are cited at F314.</p> <p>Complaint IN00159357-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: December 1 and 2, 2014.</p> <p>Facility number: 000084 Provider number: 155167 AIM number: 100284600</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Karina Gates, Generalist</p> <p>Census bed type: SNF/NF: 116 Residential: 78 Total: 194</p> <p>Census payor Type: Medicare: 21 Medicaid: 58 Private: 37</p>	F000000	<p>Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in this survey report are accurate or reflect accurately the provision of nursing care and services provided to the Residents at Westminster Village North.</p> <p>Please note that the facility respectfully requests that the Department consider the facility to be in compliance upon review of this plan of correction and the supporting documentation contained here-in. In other words, please consider determination of achieved compliance via paper review.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000314 SS=D	<p>Total: 116</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 11, 2014 by Cheryl Fielden, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 interview and record review,</p>	F000314	As noted in the survey report, Resident A no longer resides in	01/01/2015

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	<p>the facility failed to implement pressure ulcer prevention interventions as ordered and per facility policy for 1 of 3 residents reviewed for pressure ulcers. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 10/1/14 at 11:09 a.m. The resident's diagnoses included, but were not limited to, hypertension, left tibia fracture, chronic stage III kidney disease, multiple myeloma, and coronary artery disease.</p> <p>The record indicated Resident #A admitted to the facility on 9/28/14 and was discharged to an acute care hospital on 11/9/14 for evaluation of a wound and abnormal laboratory results.</p> <p>A 9/28/14 skin breakdown risk assessment indicated Resident #A was at risk for skin breakdown related to pressure.</p> <p>A 10/5/14 admission MDS assessment indicated Resident #A was at risk for the development of a pressure ulcer. The assessment also indicated the resident did not have a pressure ulcer.</p> <p>A 9/28/14 admission nursing assessment indicated Resident #A weighed 197 lbs</p>		<p>the facility. Therefore, a plan of correction germane to Resident A is a moot point. This Resident's diagnoses contributed to his wound progression. He had suffered with chronic kidney disease since 2004 and had advanced to Stage III. After transfer to the hospital, the Resident was newly diagnosed with multiple myeloma (please refer to Attachment #1). Even though the Registered Dietician monitored the Resident's status weekly, the Resident continued to refuse meals and a variety of dietary supplements. The Resident had protein malnutrition as evidenced by the lab values of 10/9/14: Albumin=3 (normal=3.2-5); Pre-Albumin=11 (normal=20-40). Even though the Resident had been educated regarding the importance of turning and positioning, the Resident frequently refused to turn and continued to prefer to lie in a supine position or spend long periods of time sitting in a chair. On 10/22/14 and 10/23/14, the Resident had offsite appointments which necessitated ambulance transportation via stretcher. The Resident was out of the facility for several hours for the aforementioned appointments. It is questionable that any turning or repositioning of the Resident occurred for the duration of these two appointments. The attending physician deemed that the</p>		

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	<p>(pounds) on admission to the facility. It also indicated Resident #A did not have any pressure ulcers upon admission to the facility.</p> <p>A facility policy, dated 1/8/2004 and titled "Skin Condition, and Pressure Ulcer Assessment Policy" indicated "...Each resident will be assessed for skin breakdown on bath day each week and during personal care by the CNA..."</p> <p>A potential for skin impairment care plan, dated 11/14/14, indicated nursing staff should "...Monitor/document/report PRN (as needed) any changes in skin status..." and "...Keep skin clean and dry..." and "...Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes..."</p> <p>On 12/1/14 at 2:09 p.m., during an interview, the DON (Director of Nursing) indicated the above care planned interventions were implemented upon Resident #A's admission to the facility to prevent skin breakdown and to monitor changes in skin status. She indicated the dates listed on the care planned interventions referenced above were inaccurate.</p>		<p>Resident's wound was unavoidable (please refer to Attachment#2) due to the severity and multiplicity of the Resident's comorbidities, as well as other mitigating factors, not the least of which were the result of the Resident's execution of his right of choice (please refer to Attachment #3) Please note that at the time of this writing, only one other Resident has a pressure ulcer. This Resident's chart was reviewed during this survey and there were no findings. An audit of this Resident's chart has been conducted to ensure that the appropriate documentation has continued to remain in place for this Resident. PLAN OF CORRECTION 1. Each Resident will continue to be assessed regarding their individual risk for skin breakdown, at the time of admission and shall be care planned, by the admitting nurse or a co-worker. To facilitate this process, detailed instructions and sample care plans have been placed in the admission packets. Please refer to Attachments #4, #5, #6, #7, and #8. The Quality Assurance Nurse has been educating nursing personnel regarding this topic,as evidenced by Attachments #9 and #10. The presence of the aforementioned care plan will be verified by the Unit Coordinator or other Administrative Nurse. The Director of Nursing will monitor for compliance. During the</p>	

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	<p>9/28/14 admission physician orders indicated for Resident #A to receive "...Calmoseptine (a preventative skin barrier medication) to buttocks q (every) shift and PRN (as needed) soilage..." and "...wheelchair cushion..."</p> <p>Medication and treatment administration records for September, October and November of 2014 indicated a treatment for Calmoseptine was not signed by nursing staff on 9/30 for the day, evening, and night shifts. The Calmoseptine entry on the treatment records were not signed for October 10th and 17th, 2014 for the "3-11" shift, and on October 18th for the "11-7" shift.</p> <p>A treatment record entry for Resident #A's wheelchair cushion indicated no nursing staff initials for October 10th and 17th for the "3-11" shift and October 18th for the "11-7" shift.</p> <p>On 12/1/14 at 2:09 p.m., during an interview, the DON indicated nursing staff initials completion of medication and treatment administrations by placing their (nursing staff) initials on the medication and treatment administration records. She indicated not being able to provide verification the Calmoseptine and wheelchair cushion treatments were administered as ordered on the dates</p>		<p>facility's monthly Quality Assurance Meetings, the results of this written monitoring will be reviewed by the Committee for a period of six months. At the end of the six months, the Quality Assurance Committee may elect to cease the monthly Quality Assurance review of this information if 100% compliance is achieved. Going forward, at the time of each MDS review, the MDS Nurses will ensure that a care plan addressing skin risks/issues is in place for all Residents who are in need of the same, based upon the data delineated within the Resident's MDS. On a weekly basis, the MDS Nurses will provide the Administrator with a list of all MDS reviews conducted during that week, noting their review for the necessary care plans. The MDS Nurse will present the results of said reviews during the facility's monthly Quality Assurance Meetings for a period of six months. At the end of the six month period, the Quality Assurance Committee may elect to cease the monthly QA reviews of this information if 100% compliance is achieved. The Administrator will monitor for said compliance as noted above. The Quality Assurance Nurse will be providing additional education to the licensed nursing staff regarding the development of admission care plans at the time of admission to address the risk</p>	

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	<p>listed above.</p> <p>A 10/13/14 wound assessment indicated Resident #A was identified with a left heel pressure ulcer. The assessment indicated treatment for the heel ulcer to include "...Prevalon Boots..." (pressure relieving boots). The assessment indicated the wound was "...first noted on 10/9/14..."</p> <p>A 10/10/14 physician's order indicated for Resident #A to have a wound treatment performed to his left heel daily and to wear pressure relieving boots "...while in bed..." The order also indicated for Resident #A to be seen by a wound management service.</p> <p>Wound management team notes indicated Resident #A's left heel was assessed by the third party wound team on 10/13/14, 10/20/14, and 10/27/14.</p> <p>A 10/24/14 nursing assessment indicated Resident #A had a left heel pressure identified as "stage II" and a coccyx ulcer with measurements of 2.0 cm (centimeters) x 2.0 cm x 0.1 cm. The coccyx ulcer was identified as "Unstageable" The assessment did not indicate if the resident's physician was notified.</p>		<p>for the development of a pressure ulcer and/or the presence of a pressure ulcer at the time of admission. 2. In an effort to minimize the risk of charting omissions germane to pressure ulcer care/interventions, the Treatment Administration Record of all Residents with pressure ulcers will be audited (documented) by the Unit Coordinator daily (on scheduled days of work) for compliance. Said audits will be monitored (documented) weekly by an Administrative Nurse. The Administrator will be given copies of said audits. The results of these audits will be presented during the facility's monthly Quality Assurance Meetings for at least six months. At the end of the six month period, the Quality Assurance Committee may elect to cease the monthly Quality Assurance review of the aforementioned reviews if 100% compliance is achieved. 3. The nurse who failed to document physician notification has been disciplined. In an effort to minimize the risk of future such omissions, a Wound Audit Tool (refer to Attachment #11) has been created to prompt the nurse of each of the necessary steps that must be required upon discovery of a wound. The form will be reviewed by the Unit Coordinator, Quality Assurance Nurse, and Administrator. The Wound Audit Tools will be</p>	

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	<p>A 10/28/14 nursing progress note completed by the wound nurse indicated Resident #A's sacral(coccyx) wound was "...now open..." and "...family to be notified tomorrow d/t (due to) late discovery..."</p> <p>A 10/28/14 nursing assessment indicated Resident #A had a "...Worsening..." pressure ulcer to the coccyx/sacral area and indicated the wound was a stage II ulcer. The assessment indicated the measurements of the wound as 5 cm x 2.5 cm x 0.1 cm.</p> <p>A 10/30/14 physician's order indicated for Resident #A to have a low air loss mattress provided for the resident as a pressure relieving intervention.</p> <p>Medication and treatment administration records for Resident #A for October of 2014 indicated no wound treatments for the resident's sacral/coccyx wound.</p> <p>A physician's order dated, 11/3/14, indicated the following, "...D/C (discontinue) previous Calmo (Calmoseptine) order..." and "...Cleanse Sacral/bil (bilateral) buttocks OA (open area)..." with "...NS (normal saline) Pat dry. Apply Santyl followed by fluffed hydrogel gauze..."</p>		<p>reviewed during the facility's monthly Quality Assurance Meetings for a period of six months. At the end of the six months, the Quality Assurance Committee may elect to cease the monthly review of this information if 100% compliance is achieved. 4. Please note that Resident A resided on the facility's rehab unit. The Rehab Unit receives the bulk of the facility admission. As one would anticipate, the majority of these Residents are admitted directly from the hospital. Many of these Residents have multiple comorbidities which may contribute to the development of a pressure ulcer. Multiple low air loss mattresses were in use on this unit at the time of the survey. However, the facility has since purchased additional low air loss mattresses so that a low air loss is on each bed on this unit. Therefore, each Resident on this unit will be provided a low air loss mattress at the time of admission. This will be a permanent practice for the facility. On a weekly basis, the Unit Coordinator will ensure that each bed on this unit has a low air loss mattress in place, unless there is documentation denoting that the low air loss mattress was removed upon the Resident's request. This review will be documented and forwarded to the Administrator each week. Said results of this review will be</p>	

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	<p>Wound management team notes, dated 11/7/14, indicated Resident #A was seen for a left heel wound, which was previously managed by the wound team, and a "new" sacral wound. The note indicated the sacral wound was first identified on 10/24/14. The note indicated the wounds' were "...Aggravated by pressure and decreased mobility..." The note indicated a recommendation for a wound treatment to the sacral wound.</p> <p>An 11/9/14 nursing assessment indicated Resident #A's coccyx area wound was "...Worsening..." and the wound measured 12 cm x 6 cm x 0.1 cm. The assessment indicated the wound was "...undermining..." and had large, purulent drainage. It also indicated the wound had an "...Odor present..."</p> <p>After Physician notification, the facility sent Resident #A to the emergency room on 11/9/14 for evaluation of the worsening wound. The resident was treated with IV antibiotic therapy for the sacral wound infection and wound debridement (surgical removal of wound tissue). The resident was discharged to a Long Term Acute Care hospital for continued wound management for the left heel and sacral ulcers.</p>		<p>discussed during the facility's monthly Quality Assurance Meetings for a period of six months. At the end of the six months, the Quality Assurance Committee may elect to cease the review of this information at the monthly meetings if 100% compliance has been established.</p> <p>5. Please note that upon investigation of the comments made by C.N.A. #7 it was learned that Resident A had requested to utilize incontinent briefs during the night. The facility has created a formal "policy" regarding the use of incontinent briefs during the night (please refer to Attachment #12). The Quality Assurance Nurse has been educating nursing personnel regarding this policy, as evidenced by Attachments # 13 and #14. The facility will continue to discourage the use of incontinent briefs during the night. However, the facility will honor the Resident's right of choice regarding this matter. Residents who have requested to use incontinent briefs during the night will be allowed to do so and the same shall be denoted on the Resident's care plan and on the C.N.A. Assignment Sheet. Additionally, documented Resident teaching will be done to ensure that the Resident has been advised of the possible negative outcomes as a result of night time use of incontinent briefs. This will be a permanent practice for the</p>				

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	<p>Hospital records, dated 11/9/14, indicated Resident #A was admitted to the hospital with a "...Sacral ulcer..." with measurements of 13 cm wide x 6 cm high and a pressure wound to Resident #A's left heel measuring 5x4 cm.</p> <p>A follow up hospital progress note, dated 11/10/14 indicated Resident #A had an "...Infected decubitus ulcer: obvious purulence, foul smelling..."</p> <p>Hospital discharge records, dated 11/20/14, indicated Resident #A required necrotic tissue debridement and "...coccyx removed for specimens..."</p> <p>On 12/2/14 at 1:42 p.m., during an interview, CNA #4 indicated she had worked "frequently" with Resident #A. She indicated CNA staff did not document whether they turned and repositioned facility residents, including Resident #A. She indicated Resident #A would need assistance with positioning at times. She also indicated she observed Resident #A wearing incontinence briefs in the morning. She indicated facility residents were not supposed to be wearing incontinence briefs while in bed. She indicated she observed Resident #A wearing briefs "a few times".</p> <p>On 12/2/14 at 1:47 p.m., the ADON</p>		<p>facility. On a weekly basis, each Unit Coordinator will provide administrative staff with a list of the Residents requesting the use of incontinent briefs during the night. The Unit Coordinators are responsible and the Administrator will monitor. Additionally, a Quality Assurance Tool(refer to Attachment #15) has been developed for use by the C.N.A.'s during the day shift tour of duty. The Quality Assurance tool will be designed to allow the C.N.A.'s to denote if incontinent briefs are found by Residents who are in bed that have not requested to do so and will be required to forward the completed form to a licensed nurse for follow-up activity. The Unit Coordinators will review this information during the monthly Quality Assurance Meetings for the next six months. At the end of the six month period, the Quality Assurance Committee may elect to discontinue the monthly review of this information if 100 % compliance is achieved. Additionally, the Quality Assurance Nurse has been providing additional staff education regarding the prevention of pressure ulcers, as evidenced by Attachments #16, #17, and #18. It has been a long standing practice of this facility to utilize the services of a wound specialist to ensure that any Resident with a pressure ulcer receives expert care and monitoring until the wound is</p>	

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	<p>indicated it was facility policy to not have residents wear incontinent briefs overnight or while lying in bed unless it was resident choice. She indicated the reason for the policy was to prevent moisture entrapment against resident's skin. She also indicated she was not aware of Resident #A ever requesting to wear briefs overnight or while in bed. She also indicated facility CNA's were made aware of this policy.</p> <p>On 12/2/14 at 2:01 p.m., during an interview, CNA #7 indicated she had worked with Resident #A "many times" during the resident's stay at the facility. She indicated Resident #A was "pretty wet usually" in the mornings when she would arrive to take care of the resident. She indicated Resident #A was "usually wearing diapers" (incontinence briefs) and she indicated staff was not supposed to apply incontinence briefs to residents at any time while the residents were in bed. She indicated she observed Resident #A wearing incontinent briefs "at least 2 or 3 days a week that I worked."</p> <p>On 12/2/14 at 2:26 p.m., during an interview, the DON indicated it was an expectation of facility nursing staff to not allow residents to wear incontinence briefs overnight or while lying in bed due</p>		resolved. This practice shall continue on a permanent basis.	

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	<p>to the risk of skin breakdown. She indicated facility CNA's were made aware of the expectation, or policy, on incontinence briefs.</p> <p>This federal tag relates to complaint #IN00159632.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				