

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155510	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2011
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NAME OF PROVIDER OR SUPPLIER CENTURY VILLA HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 NORTH MERIDIAN STREET GREENTOWN, IN46936
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F0000	<p>This survey was for a Post Survey Re-visit (PSR) to the Recertification and State Licensure Survey completed on August 25, 2011.</p> <p>Survey Dates: October 11, 2011</p> <p>Facility Number: 000549 Provider Number: 155510 AIM Number: 100267470</p> <p>Survey Team: Tammy Alley, RN-TC Toni Maley, BSW Donna M. Smith, RN Linn Mackey, RN</p> <p>Census Bed Type: SNF: 7 SNF/NF: 62 Residential: 35 Total: 104</p> <p>Census Payor Type: Medicare: 13 Medicaid: 28 Other: 63 Total: 04</p> <p>Sample: 9</p> <p>These deficiencies also reflect state</p>	F0000		

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

TITLE

(X6) DATE

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

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F0314 SS=G	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 11, 2011 by Bev Faulkner, RN</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 prevent the development of pressure ulcers for 1 of 2 residents reviewed for pressure ulcers in a sample of 9. (Resident # 28) This deficit practice resulted in Resident # 28 developing two unstageable pressure areas to the bilateral antecubital area of the arms.</p> <p>Findings include:</p> <p>The record for Resident # 28 was reviewed on 10/11/11 at 12:30 p.m.</p> <p>Current diagnoses included, but were not limited to, anxiety, malnutrition, weight</p>	F0314	In addition to diagnoses noted, resident presents with contraction in elbow flexion. Resident has resided in this facility seven years with occasional skin breakdown on coccyx that presents, is treated and heals. She has been on an air mattress for many years, is fed by staff via baby spoon consuming 33% of meals, 120cc of fluids. She often refuses food, taking only a few bites or spits food out of mouth. She often refuses medications. She is on nourishments at 10 am and 3 pm, Magic Cup at meals, 2-Cal with med pass, and Prosource BID. Her current weight is 82#. Resident is totally dependent for all ADLS, use of total hoyer for transfers and is in	10/31/2011	

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	<p>loss and osteoarthritis.</p> <p>An annual 8/23/11 Minimum Data Set Assessment indicated the resident had a limitation in range of motion in the upper extremity on one side.</p> <p>A plan of care, dated 5/30/11, indicated a problem of "Potential for Tissue integrity impairment, hx (history) for pressure ulcer....keep skin clean and dry,...inspect skin q. (every) shift, report changes...."</p> <p>A plan of care, dated 8/30/11, indicated the resident was to receive active assist range of motion upper extremities and to monitor for redness or open areas. The record lacked documentation of the active assist range of motion to the upper extremities for the month of October 2011.</p> <p>Current physician orders for October 2011 indicated an order for"...Geri-gloves at all times except to bathe...." a.m., p.m., and nights. The original date of the order was 8/9/11.</p> <p>Current CNA assignment sheet for October 2011 indicated the resident should wear geri gloves at all times and to remove to bathe.</p> <p>The September 2011 Treatment</p>		<p>reclining gerichair when out of bed.1) Resident's open areas were noted on 10/03/11 during bed bath and treatment began 10/03/11 in addition to ATB for noted redness to left antecubital. The MDS range of motion was documented in error as "active range of motion." It should have been "passive range of motion"; however, the restorative program indicates and was documented as "passive range of motion." This is being corrected and noted on the current MDS. The plan of care also indicated "active" versus "passive range of motion" and was in error. "Passive range of motion" has been being done and documented appropriately in the restorative program. Care plan corrected to reflect "passive range of motion." There was no deficiency in care. This represents a paper error.Physician's orders indicated order for "geri gloves at all times except to bathe." When surveyor observed the resident, the wound nurse had just completed the treatment/dressing change and geri gloves were off for that purpose. Geri gloves were reapplied following treatment. The right antecubital was healed on 10/11/11. There was no area to treat and physician was notified for order change. 10/24/11, left antecubital is HEALED. For prevention, 4x4 gauze will be folded in half and placed in each antecubital daily by the nurse and</p>		

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	<p>Administration Record (TAR) indicated the resident had a skin tear on 9/6/11 on the left antecubital that was treated and healed on 9/12/11. The TAR also indicated the resident had a pressure ulcer on her coccyx that was healed on 9/21/11.</p> <p>The resident's weight record indicated her weights were stable at 81 pounds on 8/15/11 and 86.8 pounds on 10/4/11.</p> <p>A shower sheet, dated 10/3/11, indicated the resident had open area to the right and left antecubital area. LPN # 1 signed the shower sheet.</p> <p>A nursing note, dated 10/3/11 at 11:51 a.m., indicated a 1 centimeter (cm) by 0.5 cm unstageable open area on right antecubital and a 3 cm by 1.5 cm unstageable open area 0.5 cm deep on the left antecubital. The left arm was red and swollen. The physician was notified and an order, dated 10/3/11, was obtained for Rocephin (antibiotic) 1 gram intramuscularly daily for 7 days and to cleanse the bilateral antecubital areas with saline then apply 50/50 mixture of Santyl and Bactroban and cover with a 2 by 2 gauze daily for 14 days.</p> <p>A nursing note, dated 10/4/11 at 2:32 p.m., indicated "Weekly measurements to unstageable areas to bilateral anticubical's</p>		<p>geri gloves continue at all times except to bathe.2) Residents with contractures were observed. Both residents with contractures will have gerigloves and/or 4x4 gauze in antecubital as a precaution with gauze changed daily.3) Skin assessments will be completed weekly as noted on TAR on all residents. CNA's will continue to observe daily during the performance of bathing and dressing and continue reporting any issues to the nurse.4) TARs will be monitored for nurses' acknowledgement on weekly skin assessment by ADON and/or DON on a weekly basis x1 month then monthly x6 months to ensure compliance. It is common knowledge in the medical profession that skin breakdown can occur within a few hours. This resident is a scheduled bed bath twice weekly in addition to daily sponge baths. We strongly believe these areas occurred from one day to the next day. The areas were observed, reported and being treated with one area already healed. As of 10/24/11, there is no skin breakdown. We are actually proud that we have maintained her skin integrity through the years considering her debilitated condition. Again, in our opinion, this was a surveyors opinion and we believe unjust.</p>		

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	<p>[SIC] is left anticubical [SIC] is 3.0 X (by) 1.5 X 0.5 cm area is covered with yellow slough with surrounding skin on elbow deep red in color and slightly warm to touch. Right anticubical (SIC) measures 1.0 X 0.5 cm area is covered with eschar and red in color surrounding area to elbow...."</p> <p>A 10/9/11 nursing note timed 12:23 p.m., indicated "...pressure ulcers continue to bilateral anticubitals. [SIC] Yellow slough noted on the inner surfaces; periphery noted to be deep red in color. Slight warmth noted...remains on antibiotic for skin infection...."</p> <p>During a care observation with CNA # 4 on 10/11/11 at 10:20 a.m., Resident # 28 was in bed. Her left arm was contracted at the elbow and positioned with her arm bent and her hand next to her face, with her right arm bent at the elbow and tucked under the left arm. There were no geri-gloves on the resident. There was a dressing to the left antecubital and the area surrounding the dressing was red in color and no dressing was in place to the right antecubital. The right antecubital had a small dark area in the antecubital area.</p> <p>During interview on 10/11/11 at 2:50 p.m., LPN # 1 indicated she had</p>				

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	<p>completed the assessment and measurements on 10/3/11 when she was notified of the areas. She indicated she was unsure if the areas had been documented on prior to 10/3/11.</p> <p>During interview on 10/11/11 at 3:50 p.m., CNA # 2 indicated Resident # 28 should receive a bath every morning which included taking off the geri-gloves, washing and lotioning the arms.</p> <p>During interview on 10/11/11 at 4 p.m., LPN # 3 indicated she observed the open areas on 10/3/11 and was not aware the areas had been assessed prior to that date.</p> <p>A 9/02 policy titled "Prevention of Decubitus Ulcers-Pressure Areas" was provided by the Assistant Director of Nursing on 10/11/11 at 2:30 p.m., and deemed as current. The policy indicated: "...Early recognition is of extreme importance. Frequently observe the resident's skin, especially over bony and pressure point areas for redness and/or soreness. Remember-bedsore are much easier to prevent than to cure! Small scratches and bruised may be the beginning of decubitus ulcers...Special Notes...4. Use padding between bony prominences...Stage III 1. Broken skin...infection or cellulitis may be present. 4. Eschar may be present...Stage</p>				

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R0000	<p>IV...3. Extent of destruction may not be visible; decayed area may be larger than apparent wound...."</p> <p>A 10/07 policy titled "Pressure Area Protocol" was provided by the Assistant Director of Nursing on 10/11/11 at 2:30 p.m., and deemed as current. The policy indicated: "...Procedure: 1. Each resident will have a Pressure Ulcer Risk Assessment performed as follows:...b. quarterly c. with any significant change in condition...3. Skin observations are made daily during the performance of bathing and dressing the resident. 4. CNAs are responsible for promptly notifying the hall nurse of all observations including: a. redness...j. skin discoloration k. open areas...."</p> <p>3.1-40(a)(1)</p>	R0000			

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

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FORM APPROVED

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