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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155401 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/06/2014 |
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| F000000 | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: September 29, 30, October 1, 2, 3, & 6, 2014</p> <p>Facility number: 000461 Provider number: 155401 AIM number: 100275290</p> <p>Survey Team: Mary Weyls RN TC Laura Brashear RN Vickie Nearhoof RN Geoff Harris RN (October 2, 3, 6, 2014) Brooke Harrison RN</p> <p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Type: Medicare: 4 Medicaid: 59 Other: 14 Total: 77</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2 -3.1.</p> <p>Quality review completed 10/7/14 by</p> | F000000 | <p>Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Health and Rehabilitation that the allegations contained in this survey report are accurate or reflect accurately the provision of service to the residents of Ben Hur Health and Rehabilitation.</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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| F000221 SS=D | <p>Brenda Marshall, RN.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Based on observation, interview, and record review the facility failed to ensure residents weren't restrained for staff convenience and not necessary to treat a medical symptom for 1 of 1 resident reviewed who utilized a chair restraint. (Resident #81)</p> <p>Finding includes:</p> <p>On 9/30/14 at 10:34 a.m. Resident #81 was observed in the secure unit's activity/dining area in a geri-chair with a tray table in place and foot rest of the chair in the raised position. The resident attempted to get out of the chair throwing legs over sides of the raised foot rest. Two staff members were in the room. The resident repeatedly said "Let me out." One of the staff members in room released the resident from the chair and ambulated the resident with hand held assistance. After a short walk the the resident was returned to the chair with the tray table restraint. The resident</p> | F000221 | <p>I. The corrective action taken for this resident is that at the time of the survey, she was being seen by our physical therapist who had ordered an alarmed seat belt as an alternative to the geri-chair table top. The alarmed seat belt was received and has been utilized for this resident since 10/8/14. The resident is able to undo the clasp on the seat belt, therefore it is not a restraint, but rather a notification to staff that she may be attempting unassisted ambulation, which is still not recommended by physical therapy. Physical therapy anticipates to continue to work with this resident to improve balance, gait, and safety awareness, and will then release her to a functional maintenance program with restorative nursing services. The care plan of this resident has been updated to include appropriate use of the seat belt alarm.</p> <p>II. All residents have the potential to be affected. All residents who utilize restraints were assessed by the DNS/Designee to ensure the device</p> | 10/16/2014 |
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| | <p>continued making requests to be out of the chair.</p> <p>On 10/1/14 at at 10:46 a.m.,the resident was in a geri-chair with an attached tray table yelling to be let out of the chair. She was positioned in the chair across the room from other residents. Qualified Medication Aide (QMA) #3 told the resident they would let her out closer to lunch.</p> <p>On 10/1/14 at 2:26 p.m., the resident was in the geri-chair with tray in the activity/dining room positioned across the room from other residents. The resident was sitting up, attempted to get up and had repeated verbalizations that she wanted to get up. QMA #2 was the only staff member present in the room.</p> <p>Upon entrance to the secure unit on 10-3-14 at 10:30 a.m., no staff were observed in the activity/dining room. Resident #81 was in a geri-chair with lap tray. The resident had a magazine on the tray table and was positioned across the room from other residents. The resident asked to be moved up to a dining table with three other residents. Five minutes later The Minimum Data Set (MDS) Coordinator entered the unit, and moved the resident up to the table with the other residents. The nurse left the tray table on</p> | | <p>is being utilized to treat a medical symptom and not for staff convenience. Care plans for these residents have been reviewed and updated as necessary by the DNS/Designee.</p> <p>III. The systemic change that will be implemented is that prior to application of a restraint, each resident will be evaluated by a Physical Therapist or Occupational Therapist to make a recommendation on the least restrictive device that will ensure the resident's safety and well-being.</p> <p>Nursing staff were inserviced by the Director of Nursing Service on 10-16-14 regarding the use of restraints, and following each resident's care plan.</p> <p>IV. To ensure compliance, the Director of Nursing Service or Designee will be responsible to monitor for appropriate use of restraints during daily rounds. Restraint utilization will be monitored, recorded and reported to the Quality Assurance Committee during the next two consecutive quarters. If any non-compliance with regulatory requirements related to restraint use is noted, an action plan will be developed to ensure compliance.</p> <p>V. Evidence regarding inservice training and monitoring for restraint use (only 1 Merry Walker at this time) are provided. Due to evidence provided Ben Hur Health and Rehabilitation requests paper</p> | | | | |

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| | <p>the geri-chair.</p> <p>On 10/6/14 at 1:30 p.m., the resident was observed in a geri-chair with tray during snack time, positioned away from the other residents.</p> <p>The resident's clinical record was reviewed on 10/3/14 at 10:30 a.m. A Minimum Data Set Assessment (MDS) for a significant change, dated 8/13/14, assessed the resident with a history of falls and utilized a restraint device daily. A further assessment indicated the resident required the restraint device related to the inability to stand, lack of safety awareness due to dementia, and had behavioral disturbances. A physician's order dated 5/1/14, was noted to place the resident in a geri-chair with lap tray related to inability to stand independently and lack of safety awareness due to dementia.</p> <p>A form titled "Restraint Use Assessment/Reassessment, provided by the Director of Nursing (DON) on 10/6/14, included, but was not limited to, "Date of initial restraint order 5/6/14 for a lap buddy in wheelchair when noted leg strength poor in merry walker." Documentation on the form included the resident was changed to the geri-chair with lap tray on 6-30-14. The assessment</p> | | compliance for this survey tag #221. | | | | |

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| | <p>dates were noted of 5/6/14, 6/5/14, 7/3/14, 8/3/14, and 9/3/14. The 6/5/14 assessment indicated the resident had taken lap buddy off of wheelchair at times. The 7/3/14 assessment date indicated the resident had been changed to a geri-chair with lap tray on 6/30/14.</p> <p>A "Restraint Use Assessment" with initial date of 5/5/14, was received from the DON on 10/06/14 at 10 a.m., which indicated "... a medical symptom of physical exhaustion from pacing, exploring, and accelerated thoughts and movement. Unable to understand need to rest or have quiet time. Anxiety related to delusional thoughts/situations or inability to sequence thoughts/ideas. She becomes heavy in her stride and leans forward with shuffled gait." The form indicated a Merry Walker was implemented from 5/5/14 to 5/14/14 and the resident "stood and sat on strap X (times) 2 d/c (discontinue) unsafe climbs in/out over arms. Lap buddy in w/c 5/5/14, Geri-chair w (with) laptray 6/30/14 returned from (name) of psychiatric center unsteady-requires 2 people to walk."</p> <p>A plan of care that addressed unintentional weight loss, dated 8/22/14, included an approach of "May use Geri chair with lap tray at meal time as</p> | | | |

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| | <p>needed."</p> <p>The Administrator was interviewed on 10/6/14 at 2:00 p.m. The Administrator indicated a plan of care that addressed the restraint use had not been done.</p> <p>LPN #1 was interviewed on 10/3/14 at 2:20 p.m., the LPN indicated when the resident returned to the facility from the hospitalization on 6/30/14, the resident had declined and a geri-chair with table tray was used. The LPN indicated at that time the resident required assistance of two to ambulate. The LPN indicated the resident has improved and can ambulate with assistance of one now.</p> <p>A facility policy, dated 12, 2000, and identified as current was received from the DON on 10/06/14 at 10 a.m. The policy included, but was not limited to, "PURPOSE: To enhance Resident quality of life by attempting to protect the resident and/or assist the resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being."</p> <p>"POLICY: Restraint use will be employed only by order of physician and the type of restraint shall be specified in the order. Restraint use will be limited to circumstances in which the resident has</p> | | | |

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| F000282 SS=D | <p>medical symptoms that warrant the use of restraints. A restraint shall be applied per nursing personnel trained in proper application." The policy did not address re-evaluation of the need for a restraint, and least amount of time the resident required the device.</p> <p>3.1-3(w)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview the facility failed to ensure residents identified as requiring glasses for vision impairment received this service for 1 of 3 residents reviewed with vision impairment. (Resident #35)</p> <p>Findings include: During interview of Resident #35's spouse on, 10/01/14 at 12:13 p.m., the spouse indicated the resident's eye glasses were missing. The resident's spouse indicated he had reported the missing glasses to the facility and they had look</p> | F000282 | I. The corrective action taken for this resident is that her eyeglasses have now been labeled so that if they are misplaced again, they can be readily identified by staff as belonging to her. II. Residents who require glasses have the potential to be affected. As all residents who require eyeglasses for better vision should have them accessible for wearing, staff was inserviced by the Director of Nursing Services on October 16, 2014 in regard to utilization of the Resident Care Record to identify assistive devices pertinent to each resident. DNS/Designee have reviewed all residents who | 10/16/2014 |

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| | <p>for the glasses.</p> <p>During observation of Resident #35 on 10/1/14 at 12:13 p.m., 10/2/14 at 10 a.m., and on 10/3/14 at 2 p.m. the resident was observed to be not wearing glasses.</p> <p>Resident #35's clinical record was reviewed on 10/3/14 at 2:30 p.m. a significant change assessment, dated 8/20/14, indicated the resident with moderately impaired vision and without corrective lenses.</p> <p>A plan of care was noted, dated 8/27/14, indicating "Visual appliance prescribed to the resident: glasses," with an approach of but not limited to, "Have resident use glasses when out of bed. Store visual appliances in bedside table when not in use."</p> <p>During interview of the careplan coordinator on,10/3/14 at 3 p.m., the coordinator was unaware why the resident was not wearing glasses.</p> <p>During interview of the careplan coordinator on, 10/6/14 at 9 a.m., the coordinator indicated the staff on the residents unit found a box of glasses that were not marked, and the husband was able to identify the resident's glasses.</p> | | <p>are visually impaired to ensure residents have their glasses, and the care plan addressed each resident's visual impairment appropriately. Resident Care Record sheets have been updated accordingly.III. The systemic change that is being implemented to address missing eyeglasses is that a new provider of vision services has been contracted by the facility, and this agency will label not only new eyeglasses made by them for residents, but also eyeglasses currently being utilized by residents. This will assist facility staff in returning eyeglasses to residents when they have become misplaced by the resident. Any new admission care plan and Resident Care Record will be updated to address each resident's visual impairment by the DNS/Designee. To ensure ongoing compliance, the Director of Nursing Service/Designee will be responsible to monitor during daily rounds to ensure that residents are wearing glasses appropriately. If a resident's care plan and/or Resident Care Record sheet indicate a resident should have eye glasses but the resident is not wearing them, the DNS/Designee will attempt to determine why they are not, and inform staff to attempt to locate the eyeglasses if they are determined to be missing. Residents who require new</p> | | |

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| F000309 SS=D | <p>On 10/6/14 at 10 a.m. and 2 p.m., Resident #35 was observed wearing eye glasses.</p> <p>During interview of CNA (certified nursing aide) #7 and QMA (qualified medication aide) #8 on 10/6/14 at 2 p.m., the staff indicated they float, but work routinely on the unit that Resident #35 resides on. Both staff persons were unaware as to whether the resident was suppose to wear glasses.</p> <p>An undated form, titled "Resident Care Record", was received from the DON(Director of Nurses) on 10/06/14 at 2:41 p.m. The form identified, under assistive devices, the resident utilized glasses. The DON indicated this form was available to the CNAs, and indicated the care and services the resident was to receive.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with</p> | | <p>eyeglasses will be referred to our new contracted provider of vision services as they visit the facility, or to the provider of resident's choice.IV. Monitoring will be reported to the Quality Assurance Committee for the next two quarterly meetings, and if non-compliance is noted an action plan will be developed to ensure compliance.V. Evidence of inservice training provided to nursing staff regarding use of the Resident Care Record to identify resident needs and monitoring is provided – in consideration of this evidence Ben Hur Health and Rehabilitation requests paper compliance for survey tag #282.</p> | | | | |

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| | <p>the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review the facility failed to implement measures to attain a resident's highest psychosocial well-being in accordance with a comprehensive plan of care for 1 of 1 resident reviewed for a physical restraint. (Resident #81)</p> <p>Finding includes:</p> <p>On 9/30/14 at 10:34 a.m., Resident #81 was observed in the secure unit's activity/dining area in a geri-chair with a tray table in place and foot rest of the chair in the raised position. The resident attempted to get out of the chair throwing legs over sides of the raised foot rest. Two staff members were in the room. The resident repeatedly said "Let me out." One of the staff members in the room released the resident from the chair and ambulated the resident with hand held assistance. After a short walk the the resident was returned to the chair with the tray table restraint. The resident continued making requests to be out of the chair.</p> <p>On 10/1/14 at at 10:46 a.m., the resident was in a geri-chair with a tray table in place yelling to be let out of the chair. She was positioned in the chair across the</p> | F000309 | <p>I. Resident #81 is no longer in a geri-chair with a lap tray, and therefore she is able to participate more freely with residents in activity/social programs. This resident's plan of care has been reviewed and revised to include measures to more adequately address her psychosocial needs.II. As all residents with a restraint device could be at risk for decline in psychosocial well-being, all residents who utilize restraints were assessed by the DNS/Deisgnee for appropriate utilization of the device. III. The systemic change that is being implemented is that a new position of Memory Care Facilitator has been developed to work exclusively with the residents on the secured memory care unit of the facility. This individual, an LPN employed with full-time status, will be responsible for coordinating services for these residents, to ensure each resident's care needs are met and that quality of life is encouraged through the environment and the delivery of services by all disciplines of the facility. Each resident will be evaluated by a Physical Therapist or Occupational Therapist to make a recommendation on the least restrictive device that will ensure the resident's safety and well-being. Nursing staff were inserviced by the Director of</p> | 10/16/2014 | | | |

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| | <p>room from the other residents. Qualified Medication Aide (QMA) #3 told the resident they would let her out closer to lunch.</p> <p>On 10/1/14 at 2:26 p.m., the resident was in the geri-chair with a tray table in place in the activity/dining room positioned across the room from other residents. The resident was sitting up, attempted to get up and had repeated verbalizations that she wanted to get up. QMA #2 was the only staff member present in the room.</p> <p>Upon entrance to the secure unit on 10/3/14 at 10:30 a.m., no staff were observed in the activity/dining room. Resident #81 was in a geri-chair with a table tray. The resident had a magazine on the tray table and was positioned across the room from the other residents. The resident asked to be moved up to a dining table with three other residents. Five minutes later The Minimum Data Set (MDS) Coordinator entered the unit, and moved the resident up to the table with the other residents. When the resident was moved to the table with the other residents she was quite. At 10:50 a.m. the resident was trying to reach place mats on the table for the noon meal, and was unable to due to the tray table being on the geri-chair. A visitor at the table obtained the napkins and provided</p> | | <p>Nursing Service on 10/16/14 regarding the use of restraints, and following each resident's care plan, and promoting each resident's well being. The DNS/Designee will be responsible to conduct daily rounds, to monitor restraint use, and to ensure care plans are followed. IV. To ensure ongoing compliance, the Memory Care Facilitator will work directly with the interdisciplinary team staff members (i.e. Director of Nursing Services, Director of Social Services, Director of Dietary Services) as well as the Executive Director and Activity Staff to evaluate needs, introduce programs, and ensure measures are implemented to attain each resident's highest psychosocial well-being. The Director of Nursing Service or Designee will be responsible to monitor during daily rounds, and reports of restraint utilization will be made to the Quality Assurance Committee for the next two quarters. If inappropriate use or negative outcomes are noted, an action plan will be developed to ensure compliance.V. Evidence of inservice training and revisions to Resident #81's care plan are provided – due to evidence provided Ben Hur Health and Rehabilitation requests paper compliance for this survey tag #309.</p> | | |

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| | <p>them to the resident to fold. The resident engaged in the activity prior to the meal time.</p> <p>On all of the observations the resident, restrained in a geri-chair, was positioned against a wall, away from dining tables. The resident's chair was positioned behind the back of a recliner utilized by residents in the television area of the room. A large pillow was observed on the base of one of the recliners.</p> <p>Qualified Medication Aide (QMA) #2 was interviewed on 10/1/14 at 2:26 p.m. The staff member indicated the pillow had been placed behind the recliner to prevent other residents from rocking too far back and "whacking" Resident #81. The QMA indicated it was very hard to watch all of the residents and do activities and do care. The QMA indicated she hated to leave the resident in the chair all the time and tried to take her out every couple of hours and let her sit in a recliner.</p> <p>A facility plan of care with problem start date, of 8/22/14, addressed repetitive verbal/physical verbalizations, hand wringing, restlessness, fidgeting, and picking. Resident may yell, curse or swing arm at staff related to dementia with behavioral disturbances.</p> | | | |

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| F000314 SS=D | <p>Approaches included, but were not limited to "Allow resident to have control over situations, if possible. ...Distract resident with physical activities and social interactions. ...Provide 1:1 sessions with resident when anxious. Offer a manicure as it helps calm her. ...Walk with resident as at times she has excessive energy if she is unable to be redirected to another activity.</p> <p>3.1-37(a)</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. Based on observation, interview and record review the facility failed to provide services for 1 of 1 resident with pressure sores to promote healing. (Resident #48)</p> <p>Finding includes: On 9/24/14 at 10:30 am, Resident #48</p> | F000314 | I. Regarding the air mattress for Resident #48 – it is believed that the date listed in the survey report that the surveyor noted the bed to be deflated is incorrect, as this actually occurred on 10/1/14. An electrical power surge was noted mid-morning, likely caused by contractors working in the facility. This power surge was noted and confirmed by survey team | 10/16/2014 |

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| | <p>was observed in bed in the resident's room on a pressure reducing air mattress. The mattress was not inflated. RN #9 entered room as well as LPN #1. Both staff indicated they thought the mattress was inflated. The lights on the air pump were not on. The bed was deflated. The bed was plugged in to an outlet at the foot of the bed. The cord was changed to an outlet at the head of the bed and immediately began to inflate. At 2:30 p.m. with Maintenance staff #10, a circuit tester was used to test the outlet and was found to not have current.</p> <p>On 10/2/14 at 10:45 a.m., with LPN #1 the resident was observed on an air mattress with the head of the bed elevated. The resident's feet were elevated on a pillow and feet were pressed against the foot board of the bed. The nurse indicated he had slid down in bed. At that time a large blistered area with red ring around it was observed on the resident's left heel.</p> <p>On 10/6/14 at 10:30 a.m., a large blistered area with red ring was observed. A dressing was observed on the right outer ankle with a Duoderm dressing dated 10/5/14.</p> <p>On 10/6/14 at 11:09 a.m., the resident's clinical record was reviewed. A nursing</p> | | <p>members, who noted emergency lights in service. A CNA who gave Resident #48 a bed bath at approximately 7:00 a.m. on 10/1/14 indicated no problem with the mattress. An LPN was tending to this resident at approximately 10:15 a.m. on 10/1/14, taking his temperature in his ear and checking the status of his heels, and confirmed she saw nothing wrong with the resident's mattress at that time. An electrician has since evaluated the electrical outlet the bed was initially plugged into when observed to be deflated on 10/1/14, and has determined that the breaker which was blown at the time eliminated the electrical current at the outlet, thus causing the bed to deflate at that time. Electricity has now been restored to this outlet, and no further problems have been noted with the bed. Thus, it is believed that the bed was deflated for a very short period of time prior to observation of the surveyor of it being deflated. Although Resident #48's general condition continues to decline, his heels are improving. As noted in the survey citation, interventions were being planned, evaluated, and implemented to address skin break down – i.e. the air circulating mattress, notification to the physician and treatment order changes, and dietary recommendations to be presented to the physician for</p> | | |

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| | <p>note dated 9/23/14, indicated the resident had a red area on right outer ankle that measured .5 by .5 centimeters. It also included the resident had a 4.5 centimeter, by 2.8 centimeter fluid filled blister on the left heel. The physician was notified and a treatment order, dated 9/23/14, of "Duoderm, change every 3 days" was noted.</p> <p>The nurse's note, dated 9/23/14, indicated the resident was placed on an air mattress .</p> <p>An "Initial Ulcer Assessment" dated 9/23/14, included a blister intact to the left heel 4.5 by 2.8 centimeters and a Stage 1 wound to right outer ankle 0.5 by 0.5 centimeters. The assessment included, but was not limited to, the resident had an overall decline and refused getting out of bed and repositioning at times.</p> <p>A plan of care, dated 9/24/14, addressed the problem of impaired skin integrity: blister left medial heel. Approaches included, but were not limited to, Pressure reducing/redistribution mattress on bed: Air mattress, supplements as ordered.</p> <p>An Interdisciplinary team report, dated 10/3/14, indicated the facility had</p> | | <p>approval. II. Care plans for residents noted to be at risk for skin breakdown will be reviewed and revised as necessary to ensure appropriate interventions are in place to promote skin integrity. Nursing staff was inserviced by the Director of Nursing Services on 10/16/14 regarding pressure ulcer prevention and skin care treatments.III. The Director of Nursing Services presented Inservice education to nursing staff on October 16,2014 in order to evoke a systemic change in nursing management of skin care, specifically in regard to care of residents' heels to prevent skin break down. The DNS/Designee will conduct rounds daily on all shifts to ensure pressure ulcer interventions are in place per the plan of care.IV. As a means of ongoing compliance, the DNS/Designee will monitor for appropriate skin care interventions per residents' plans of care during daily rounds. Non-compliance will be addressed with re-instruction to nursing staff, and issues involving skin breakdown will be recorded and reported to the Quality Assurance Committee for the next two quarters. Any negative outcomes noted in relation to skin care prevention/treatment will result in an action plan to ensure compliance. V. Evidence of Inservice training and monitoring for skin care</p> | | | | |

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| | <p>contacted the family in regard for use of any use of artificial nutrition and hydration measures. The note indicated the resident's appetite was very poor and had significant weight loss. The record indicated the diet was liberalized to regular with ice cream at lunch and supper and "Ensure" (nutritional supplement) 60 milliliters three times a day. An addendum was added to the note indicating the resident had an unstagable pressure wound to the left heel and requested a Multi vitamin supplement from physician.</p> <p>A "Weekly Skin Condition Report," provided by the Director of Nursing (DON), on 10/6/14 at 11:09 a.m., included measurements of the resident's blister on the left heel, on 10/1/14, of 5 centimeters by 3.4 centimeters.</p> <p>On 9/30/14 at 10:30 a.m., Qualified Medication Aide (QMA) #3 was interviewed. The QMA indicated the resident had a blister on the left heel and reddened area on the right and indicated she thought they would be related to pressure.</p> <p>On 10/1/14 at 11:00 a.m., LPN #1 was interviewed. The LPN indicated she had documented the initial wound measurements in the nurses' notes. The</p> | | <p>preventative interventions by the DNS/Designee is provided – due to evidence provided Ben Hur Health and Rehabilitation requests paper compliance for this survey tag #314.</p> | |

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| F000323 SS=D | <p>documentation did not include any staging of the areas. The staff member indicated no further measurements had been done but she could do some today if needed.</p> <p>On 10/6/14 at 1:00 p.m., the Director of Nursing (DON) was interviewed. The DON indicated the facility policy for pressure areas included, but was not limited to, if any areas related to pressure were identified whomever identified the area would initiate an ulcer assessment. If related to pressure nurse would initiate "Pressure Weekly Skin Condition Report." The DON indicated boots had been tried as well as a pillow to elevate heels and the resident either didn't like, or would kick pillow out of the way. The DON indicated dietary recommendations had not been implemented (other than ice cream upon resident's request) and was waiting for the physician to assess due to the resident's respiratory status.</p> <p>3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident</p> | | | | |

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| | <p>receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure 1 of 1 cabinets housing chemicals was kept locked to prevent potential accidents for 13 independently mobile and cognitively impaired residents (Resident's 51, 68, 25, 75, 52, 59, 35, 56, 60, 40, 57, 63, and 54) on the memory care unit.</p> <p>Findings include:</p> <p>On 9/30/14 at 10:34 a.m., a door to a cabinet on the memory care unit which contained chemical supplies was observed to be unlocked. The cabinet door was shut and had a key lock on the upper right corner.</p> <p>The following chemicals were observed stored in the cabinet:</p> <ol style="list-style-type: none"> 1. Microkill wipes. Label observed to have warning to "Keep out of reach of children." 2. A can of disinfectant spray. Label observed to read "Kills most germs," and "Keep out of reach of children." <p>On 9/30/14 at 10:30 a.m. QMA (qualified medication aide) #3 indicated, "That wasn't locked, it should have been." Employee #3 was observed to check the lock on the cabinet door which was</p> | F000323 | <p>I. As noted in the survey citation, the lock on the cabinet which prevented it from locking was immediately repaired by the staff member in attendance. II. All other chemical storage areas have been assessed by the Environmental Services Supervisor, and none were found to be unsecured with chemicals. III. During daily rounds, the Environmental Services Supervisor will monitor chemical storage areas to ensure that no locks are in need of repair/replacement. Any unsecured areas will be addressed by removing the exposed chemical agents, or repair/replacement of the security device they are contained by. Staff was inserviced on 10/14/14 and ongoing by the Executive Director to ensure any cabinet with hazardous materials is locked at all times. IV. As a means of ongoing compliance, the Environmental Services Supervisor will assess during daily rounds for any unsecured chemicals which could present a hazard to residents, and report to the Executive Director. This information will be shared with the members of the Quality Assurance Committee during the next two quarterly meetings, and if non-compliance is found an action plan will be developed to ensure compliance. V. Evidence</p> | 10/14/2014 |

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| | <p>observed to be loose. Employee #3 tightened the lock, and ensured the door was locked.</p> <p>On 10/6/14 at 1:00 p.m., a list of independently mobile and cognitively impaired resident's on the memory care unit was provided by the Director of Nursing (DON). This list indicated the following Resident's #51, 68, 25, 75, 52, 59, 35, 56, 60, 40, 57, 63, and 54.</p> <p>A policy entitled "Safety" was provided by the Administrator on 10/6/14 at 1:15 p.m. This current document indicated "All cleaning supplies must be kept in locked storage...Cleaning supplies in remote locations, i.e., activity room, general public areas, nursing stations, shower rooms, etc...should be locked when not in use."</p> <p>3.1-45(a)(1)</p> | | <p>of Inservice training and daily rounds and monitoring by the Environmental Services Supervisor for unsecured chemical/improper storage are provided –due to evidence provided Ben Hur Health and Rehabilitation requests paper compliance for this survey tag #323.</p> | | | | |