

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155154	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/02/2014
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NAME OF PROVIDER OR SUPPLIER  SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaints IN00145492 and IN00145803.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00146390.</p> <p>Complaint IN00145492: Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00145803: Substantiated . A Federal/State deficiency related to the allegations is cited at F314.</p> <p>Survey dates: March 25, 26, 27, 28, 30, 31 and April 1 and 2, 2014</p> <p>Facility number: 000074 Provider number: 155154 AIM number: 100290050</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Gloria Bond, R.N. (3/25, 26, 27, 28, 31, 4/1, 2) Sandra Nolder, R.N.--(3/25, 26, 27, 28, 30, 31, 4/1)</p> <p>Census bed type: SNF--8 SNF/NF--105 Total--113</p> <p>Census payor type: Medicare--19 Medicaid--69 Other--25</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests a Desk Review in Lieu of a Revisit and that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after April 30, 2014.	

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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F000241 SS=E	<p><b>Total--113</b></p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 10, 2014, by Brenda Meredith, R.N. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to promote care in a manner to maintain each resident's dignity and respect, related to dressing 6 residents in a hospital-type gown prior to an evening meal, not covering residents, allowing non-essential staff to come in and out of the room, and not pulling privacy curtains during personal care for 2 residents. (Residents #14, #43, #50, #60, #81, #94, #97, and #163)</p> <p>Findings include:</p> <p>1. On 3/30/14 at 5:36 P.M., prior to the Sunday evening meal, the following was observed:</p> <p>Resident #60 was sitting in the hallway, next to the Nursing Station and immediately outside the door to the Assist Dining room. The resident had a hospital-type gown on, with a white long-sleeved shirt underneath. The gown was pulled up along the left side of her body, and her left lateral hip area, with the top of an adult brief, was visible.</p>	F000241	<p><b>F241 Dignity and Respect of Individuality</b> The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident's #14, #43, #50, #60, #81, 94, 97, and 163 will be in an environment that enhances and maintains their dignity.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> <b>Pull statement from last POC and put in the as the first sentence.</b></p>	04/30/2014

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	<p>Resident #14, Resident #81, and Resident #50 were observed in the hallway on opposite side of the Nursing Station. All were wearing hospital-type gowns. Resident #14 had a large sheet over her lap, but she had pulled the sheet so that it was between her legs. Both legs from her mid-thigh to her feet were exposed.</p> <p>Resident #43 was observed to be in her room in bed. An over-bed table was positioned in front of her, and the evening meal tray had been placed on it. The resident was wearing a hospital-type gown.</p> <p>At 5:45 P.M., Resident #97 was observed sitting in a "Broda" geri-chair in her room. She had a hospital-type gown on, with hooded velour jacket over her upper body. The gown covered her only to her mid-thigh area. Both legs were uncovered from her thighs to her feet.</p> <p>MDS (Minimum Data Set) assessments for each of these residents' cognitive status indicated the following: 2/7/14--Resident #60 was not interviewable. She was assessed by nursing staff to have severe cognitive impairment. 12/30/13--Resident #14 was unable to complete the resident interview (BIMS--Brief Interview for Mental Status). Nursing staff assessed her to have moderate cognitive impairment. 1/30/14--Resident #81 was unable to complete the resident interview. She was assessed by nursing staff to have moderate cognitive impairment. 1/31/14--Resident #50 was not interviewable. She was assessed by nursing staff to have severe cognitive impairment.</p>		<p>·All residents have the potential to be affected bythe alleged deficient practice.</p> <p>·Staff will be in-serviced on Resident Rights alongwith maintaining Dignity and Privacy of residents by April 30, 2014.</p> <p>·Staff will be in-serviced on ensuring that residentsare appropriately covered at all times.</p> <p>· Staff will bein-serviced on appropriate times to enter a resident's room to provide care.</p> <p>·A full house audit conducted by the MaintenanceSupervisor to ensure that every room has 1 privacy curtain per bed.</p> <p><b>What measures will be put into place or what systemicchanges will you make to ensure that the deficient practice does not recur.</b></p> <p>·All staff will be in-serviced by SDC/Designee onResident Rights along with maintaining Dignity and Privacy of residents byApril 30, 2014.</p> <p>·Staff will be in-serviced by SDC/Designee onensuring that resident is appropriately covered at all times</p> <p>·Staff will bein-serviced by SDC/Designee on appropriate times to enter a residents room toprovide care</p> <p>·Director ofNursing/Designee will conduct resident rounds to ensure residents are receivingDignity and Privacy.</p> <p><b>How will the corrective action(s) be monitored toensure the deficient practice will not recur,</b></p>	

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	<p>2/5/14--Resident #43 was able to complete the resident interview. Her BIMS score was "05" (with 0-7 indicating severe cognitive impairment).</p> <p>1/25/14--Resident #97 was able to complete the resident interview. Her BIMS score was "02."</p> <p>In an interview on 4/1/14 at 9:11 A.M., the Executive Director indicated the minute she and the Director of Nursing walked in on Sunday and saw residents in hospital gowns, they immediately started some inservice training for staff. She indicated residents were not supposed to be in hospital gowns during the day. She indicated she would check to see if there had been any previous inservice training for staff related to use of gowns and/or dressing residents during the day.</p> <p>At the final exit on 4/2/14 at 5:00 P.M., no inservicing documentation, related to dressing residents in appropriate clothing during day time hours, was provided for review.</p> <p>2. On 3/30/14 at 5:44 P.M., Resident #94 was transported by a mechanical lift into her bed by CNA #2, CNA #3 and LPN #4. During peri care, being given by CNA #3, Resident #94 was observed to be left uncovered, with only an undershirt on the top portion of her body and her bottom half naked. The door to her room was observed closed, but her privacy curtain was not pulled completely around her bed. The privacy curtain was observed pulled partially across the foot of the bed between the resident's and her roommate's bed.</p>		<p><b>i.e., what quality assurance program will be put into place</b></p> <ul style="list-style-type: none"> <li>·A ResidentRights CQI tool will be utilized weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold.</li> <li>·Data will be submitted to the CQI Committee for review and follow up.</li> </ul> <p><b>Compliance date:</b> April 30, 2014</p>	

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	<p>During the peri care, 3 staff members came into the room while the resident was uncovered. The first unidentified staff member was a CNA, who knocked on the door. CNA #3 stated "Resident care being given," but the CNA came into the resident's room and asked LPN #4 for the supply keys. The next unidentified staff member was a CNA who knocked on the door. CNA #3 stated "Resident care being given." The CNA came into the resident's room, looked around, and then left. The next staff member was the Assistant Director of Nursing Services (ADNS), who knocked on the door. CNA #3 stated "Resident care being given," and the ADNS opened the door and came into the room.</p> <p>Resident #94 needed a mechanical lift pad at this time. CNA #3 asked the ADNS to get the pad for her. The ADNS returned with a pink incontinence pad, and then left the room to get a mechanical lift pad. She brought back the mechanical lift pad, but it was the incorrect kind for the mechanical lift the CNAs were using for this particular resident. She left and came back into the room with the correct mechanical lift pad. Personal care ended at 6:15 P.M. During this entire time, the privacy curtain was not pulled around the entire bed and the resident was observed to be uncovered and exposed.</p> <p>Resident #94's record was reviewed on 3/31/14 at 5:06 P.M. Diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>The resident's Annual Minimum Data Set (MDS) assessment, dated 1/17/14, indicated she could not complete the Brief Interview for</p>			

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	<p>Mental Status and her Cognitive Skills for Daily Decision Making was severely impaired (never/rarely made decisions).</p> <p>During an interview on 3/30/14 at 6:15 P.M., CNA #3 indicated she should have covered the resident while giving her peri care and pulled her privacy curtain all the way around the bed. She indicated she did not understand why all 3 of the staff members came into the room after she stated "Resident care being given" She indicated the staff members were not to enter a room when resident care was being given.</p> <p>3. On 3/26/14 at 5:30 P.M., there was an odor like feces in the room for Resident #163. CNA #1 was observed to close the door to his room and pull the privacy curtain from the head of his bed to the foot of his bed. The privacy curtain would not go around his bed, and there was no privacy curtain observed in between the resident's and his roommate's bed. The resident's roommate had a privacy curtain in front of the foot of his bed.</p> <p>CNA #1 began to provide peri care for Resident #163. The resident's roommate was not in the room when the peri care was started. The resident was observed to be laying on his right side, and had a brownish-yellow feces-smelling substance smeared on both of his hands and under his fingernails. After she cleansed Resident #163's hands and fingernails, CNA #1 pulled the bed blankets down below his left buttock and exposed his left buttock and left thigh area. Leaving the resident uncovered, CNA #1 left the room to go into the hallway and gather more linens. After she returned, she started giving the resident peri care. He was</p>			

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	<p>observed to have a brownish yellow feces smelling substance smeared over his rectal area. At this time, the resident's door to his room flew open and his roommate walked in and did not close the door behind him. The CNA closed the door and finished giving the peri care.</p> <p>Resident #163's roommate sat down on his bed, and without the privacy curtain being pulled between the beds, he was able to see the peri care that CNA #1 was providing to the resident. The roommate turned his TV on to watch it, then got up and left the room. The roommate again left the door to the room standing open while peri care was being performed. CNA #1 closed the room door, finished the peri care, and got the resident dressed.</p> <p>Resident #163's record was reviewed on 3/31/14 at 1:23 P.M. Diagnoses included, but were not limited to, Alzheimer's, moderate renal insufficiency and advanced Alzheimer's seizure.</p> <p>The resident's Admission MDS assessment, dated 1/11/14, indicated he could not complete the Brief Interview for Mental Status and his Cognitive Skills for Daily Decision Making was severely impaired (never/rarely made decisions).</p> <p>During an interview on 3/26/14 at 5:30 P.M., CNA #1 indicated she should have pulled the privacy curtains when she was giving the resident peri care, and she should have covered him up with a blanket before she left the room to go out into the hallway to get more linens.</p> <p>During an interview on 4/1/14 at 5:15 P.M.,</p>			

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F000282 SS=E	<p>RN #5 indicated she expected the staff to knock on the resident's door before entering, explain to the resident what they were going to do and then pull the privacy curtain and close the door for privacy before giving resident care. She indicated if there was no privacy curtain between the two beds, then the roommate's curtain should be pulled after asking them.</p> <p>A current policy titled "Resident Rights," dated 01/2006, provided on 4/1/14 at 5:18 P.M., by the Director of Nursing indicated "...All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care...."</p> <p>3.1-3(o)(4) 3.1-3(t) 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.</p> <p>Based on interview and record review, the facility failed to follow physician orders for obtaining laboratory tests, checking blood pressures, and administering medications. In addition, the facility failed to implement Care Plan interventions for the prevention of pressure ulcers. This deficiency impacted 5 of 37 residents reviewed for physician's orders and Care Plans. (Residents #4, #40, #78, #125, and #163)</p> <p>Findings include:</p>	F000282	<p><b>F282 Services by QualifiedPersons/Per Care Plan</b> The servicesprovided or arranged by the facility must be provided by qualified persons inaccordance with each resident's written plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by thedeficient practice?</b> ·Resident #4'spressure reduction boots were put in place per care plan</p>				

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	<p>1. The record for Resident #4 was reviewed on 3/28/14 at 10:53 A.M. Diagnoses included, but were not limited to, diabetes mellitus, anemia, seizures, severe anoxic encephalopathy, and dysphagia.</p> <p>A March 2014, physician order recap (recapitulation) sheet included, but was not limited to, the following orders: 2/24/14-Pressure reduction boots.</p> <p>A Care Plan entry, dated 12/11/10, addressed a problem of "At risk for skin breakdown due to impaired mobility, she slides down in her chair and bed and the diagnosis of diabetes and anemia, incontinence and confusion related to brain injury." Interventions included, but were not limited to, "3/3/14--Pressure reduction boots to bilateral feet..."</p> <p>On 3/27/14 at 9:10 A.M., the resident was observed laying in bed with only non-skid socks on her bilateral feet. No pressure reduction boots were in place.</p> <p>On 3/28/14 at 10:00 A.M., the resident was observed in the activity room. She had non-skid socks on her bilateral feet. No pressure reduction boots were in place.</p> <p>On 3/28/14 at 12:50 P.M., the resident was observed in bed with only non-skid socks on her bilateral feet. No pressure reduction boots were in place.</p> <p>On 3/28/14 at 1:18 P.M., the resident was observed in bed with only non-skid socks in place on her bilateral feet. No pressure reduction boots were in place.</p>		<p>·Resident #163's prevalon boots were put into place per care plan.</p> <p>·Resident #40's CBC was drawn on 4/17/14, Hgb A1C order was changed to 1xyearly every September, and weekly BP was discontinued due to no longer being clinically indicated for frequent monitoring.</p> <p>·Resident #125 will be given medications within allowed parameters following physicians order.</p> <p>·Resident #78 will be given medications within allowed parameters following physicians order.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>·Residents receiving blood pressures, medications, and laboratory services have the potential to be affected by the alleged deficient practice.</p> <p>·Care plans for all residents identified will be reviewed and updated if needed by the Interdisciplinary Team according to physician orders.</p> <p>·Physicians orders will be reviewed daily by the Interdisciplinary Team and/or Charge Nurse.</p> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the</b></p>		

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	<p>On 3/28/14 at 5:20 P.M., the resident was observed in the TV lounge with only non-skid socks in place on her bilateral feet. No pressure reduction boots were in place.</p> <p>On 3/30/14 at 6:20 P.M., the resident was observed laying in bed with only non-skid socks on her bilateral feet. She did not have the pressure reducing boots on. Pressure reducing boots were observed to be placed on the geri chair seat.</p> <p>2. The record for Resident #163 was reviewed on 3/31/14 at 1:23 P.M. Diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's, moderate chronic renal insufficiency and advanced Alzheimer's seizure.</p> <p>The Admission Minimum Data Set assessment, dated 1/11/14, indicated the the resident's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The assessment indicated the Resident #163 was at risk for developing pressure ulcers.</p> <p>A Care Plan entry, dated 1/23/14, addressed a problem of risk for skin breakdown or further skin breakdown due to decreased mobility and Alzheimer's. Interventions included, but were not limited to, "1/23/14-...Encourage resident to float heels while in bed as resident will allow...."</p> <p>On 3/26/14 at 2:15 P.M., the resident was observed laying in bed with his feet laying directly on the mattress.</p> <p>On 3/26/14 at 5:30 P.M., the resident was observed laying in bed with his feet laying directly on the mattress.</p>		<p><b>deficientpractice does not recur?</b></p> <ul style="list-style-type: none"> <li>-Care plans for all residents identified will bereviewed and updated if needed by the Interdisciplinary Team according to physicianorders.</li> <li>-Physician'sorders will be reviewed daily by the Interdisciplinary Team and/or ChargeNurse.</li> <li>-Nursingstaff will be in serviced by SDC/Designee on following physicians orders, following care plans, administering medication with parameters of physiciansorders, and monitoring blood pressures by April 30, 2014.</li> </ul> <p><b>-Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>-A Lab andDiagnostics CQI will be utilized weekly x 4, monthly x 6, and quarterlythereafter.</li> <li>-A Care PlanUpdating CQI will be utilized weekly x 4, monthly x 6, and quarterlythereafter.</li> <li>-SDC/Designee willperform Medication Pass Skills Validation weekly x 4, monthly x 6, andquarterly thereafter.</li> <li>-The CQI committeewill review the data collected. If a 100%threshold is not achieved, an action plan will be developed.</li> </ul> <p><b>Compliance date:</b> April 30, 2014</p>	

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	<p>On 3/27/14 at 4:00 P.M., the resident was observed laying in bed with his feet directly on the mattress.</p> <p>On 3/28/14 at 2:20 P.M., the resident was observed laying in his bed and his feet was laying directly on the mattress.</p> <p>During an interview on 3/31/14 at 2:20 P.M., CNA #8 indicated the resident moved his legs in a repetitive flexion and extension motion on the bed.</p> <p>During an interview on 3/31/14 at 2:35 P.M., the Assistant Director of Nursing indicated the resident would dig his heel into the bed, which had caused a deep tissue injury wound to his right heel. She indicated she placed a "Prevalon" boot on him to stop him from digging his heel into the bed.</p> <p>During an interview on 4/1/14 at 4:43 P.M., RN #5 indicated a previous intervention to prevent him from digging his heel in the bed before his wound on his right heel was found, was to "float" his heels with pillows.</p> <p>3. The record for Resident #40 was reviewed on 3/31/14 at 5:45 P.M. Diagnoses included, but were not limited to, congestive heart failure, chronic ischemic heart disease, hypertension and diabetes mellitus.</p> <p>The March 2014, physician order recap (recapitulation) sheet included, but was not limited to the following orders:</p> <p>9/17/07--Check and record BP (blood pressure) weekly on Thursday. 2/08/10--CBC (Complete Blood Count--a blood test for the level of multiple</p>						

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	<p>components of whole blood) every 6 months February and August.</p> <p>6/14/11--Hgb A1C (Hemoglobin A1C--checks blood sugar level averages over 3 months) every 3 months March, June, September and December for diabetes.</p> <p>The resident's blood pressure was not documented for the following dates: 1/16/14-No blood pressure documented in the MAR (Medication Administration Record) or Vital Sign area 1/30/14-No blood pressure documented in the MAR or Vital Sign area 2/20/14-No blood pressure documented in the MAR or Vital Sign area 2/27/14-No blood pressure documented in the MAR or Vital Sign area</p> <p>During an interview on 4/1/14 at 11:25 A.M., the Director of Nursing indicated the resident did not have her Hgb A1C drawn in December 2013 or March 2014.</p> <p>During an interview on 4/1/14 at 4:56 P.M., RN #5 indicated the CBC scheduled for February 2014 had not been drawn.</p> <p>4. During a medication pass observation on 3/31/2014 at 10:46 A.M., LPN #16 was observed administering the cardiac medication Carvedilol 25 mg (milligrams) to Resident #125.</p> <p>Record review of this resident's Physician's orders for March on 3/31/14 at 11:30 A.M., indicated on 3/25/14 an order was written, "...Carvedilol 25 mg po [by mouth] BID [twice per day] at 8 A (bkft)[sic] and (dinner) 6 P"</p>			

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F000309 SS=D	<p>Interview on 4/1/14 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated this was a medication error and it would be brought to the attention of the nurse that administered it.</p> <p>5. During a medication pass observation on 3/31/14 at 11:16 A.M., LPN #17 was observed administering the pain relieving medication, Tylenol 2 tablets by mouth, to Resident #78.</p> <p>Record review of this resident's Physician's orders for March on 3/31/14 at 11:45 A.M., indicated Tylenol 325 mg, "Take 2 tablets (650 mg) by mouth every 8 hours due to moderate pain..." 6 A.M., 2 P.M., 10 P.M.</p> <p>Interview on 4/1/14 at 10:15 A.M., the ADON indicated this was a medication error and it would be brought to the attention of the nurse that administered it.</p> <p>3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to implement an intervention to prevent skin breakdown, for 1 resident who had poor circulation and was at risk for skin breakdown, of 6 residents reviewed for skin issues. (Resident #163)</p>	F000309	<b>F309 Provide Services/Care For Highest Well Being</b>	

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	<p>Findings include:</p> <p>The record for Resident #163 was reviewed on 3/31/14 at 1:23 P.M. Diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's, moderate chronic renal insufficiency and advanced Alzheimer's seizure.</p> <p>The Admission Minimum Data Set assessment, dated 1/11/14, indicated the the resident's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The assessment indicated the Resident #163 was at risk for developing pressure ulcers.</p> <p>A Care Plan entry, dated 1/23/14, addressed a problem of risk for skin breakdown or further skin breakdown due to decreased mobility and Alzheimer's. Interventions included, but were not limited to, "1/23/14-...Encourage resident to float heels while in bed as resident will allow...."</p> <p>On 3/26/14 at 2:15 P.M., the resident was observed laying in bed with his feet laying directly on the mattress.</p> <p>On 3/26/14 at 5:30 P.M., the resident was observed laying in bed with his feet laying directly on the mattress.</p> <p>On 3/27/14 at 4:00 P.M., the resident was observed laying in bed with his feet directly on the mattress.</p> <p>On 3/28/14 at 2:20 P.M., the resident was observed laying in his bed and his feet was laying directly on the mattress.</p>				<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 wellbeing, in accordance with the comprehensive assessment and plan of care. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #163's care plan has been updated and new intervention of prevalon boots have been put into place. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>·All Residents with potential for skin breakdown have the potential to be affected by the alleged deficient practice.</li> <li>·Nursing staff will be educated by the SDC/Designee on implementing interventions to prevent skin breakdown by April 30, 2014.</li> </ul> <p><b>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·Nursing staff will be educated by the SDC/Designee on implementing interventions to prevent skin breakdown by April</li> </ul>		

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F000314 SS=D	<p>During an interview on 3/31/14 at 2:20 P.M., CNA #8 indicated the resident moved his legs in a repetitive flexion and extension motion on the bed.</p> <p>During an interview on 3/31/14 at 2:35 P.M., the Assistant Director of Nursing indicated the resident would dig his heel into the bed, which had caused a deep tissue injury wound to his right heel. She indicated she placed a "Prevalon" boot on him to stop him from digging his heel into the bed.</p> <p>During an interview on 4/1/14 at 4:43 P.M., RN #5 indicated a previous intervention to prevent him from digging his heel in the bed before his wound on his right heel was found, was to "float" his heels with pillows.</p> <p>An "ASC [American Senior Community] Pressure Wound Skin Evaluation Report" form, dated 3/30/14 at 12:50 A.M., indicated the Resident #163ad a new pressure area to his right heel that was acquired in the facility. The report indicated the date it originated on was 3/29/14. The stage was unstageable. The pressure ulcer was a suspected deep tissue injury (DTI) and measured 2.8 x 2.0 x &lt;0.1 cm. There was no tunneling. The wound color was 90% epithelization and 10% DTI. "Scant Serous drainage." The treatment was to paint the ulcer with Betadine.</p> <p>On 4/1/14, a podiatry group consultant note indicated the Resident #163 had no palpable pedal pulses to lower extremities and the ulcer to the right heel was ischemic in nature.</p> <p>3.1-37(a) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL</p>		<p>30, 2014.</p> <ul style="list-style-type: none"> <li>·Resident profiles and Care Plans will be updated with every change in intervention by the Interdisciplinary Team to ensure nursing staff are informed of changes.</li> <li>·The SkinManagement CQI will be completed weekly x4, monthly x 6, and quarterly thereafter.</li> <li>·The CQI committee will review the datacollected. If a 100% threshold is notachieved, an action plan will be developed.</li> </ul> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·The SkinManagement CQI will be completed weekly x4, monthly x 6, and quarterly thereafter.</li> <li>·Resident profiles and Care Plans will be updated with every change in intervention by the Interdisciplinary Team to ensure nursing staff are informed of changes.</li> <li>·The CQI committee will review the datacollected. If a 100% threshold is notachieved, an action plan will be developed.</li> </ul> <p><b>Compliance date:</b> April 30, 2014</p>				

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	<p><b>PRESSURE SORES</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review the facility failed to adequately monitor and prevent 1 residents from developing a stage 2 pressure ulcer. This deficiency affected 1 of 2 residents reviewed for pressure ulcers. (Resident C).</p> <p>Findings include:</p> <p>1. Resident C's record was reviewed on 3/28/14 at 12:50 P.M. Diagnoses included, but were not limited to, a history of falls, a history of prostate cancer, tremor, altered mental status with confusion and Parkinson's.</p> <p>Record review of skin assessments for this resident indicate that the resident was admitted, 12/26/13, with a tear but no pressure ulcers or other ulcers.</p> <p>A physician's order dated 12/27/13 indicated to, "Calmoseptine ointment apply to buttocks every shift. Dx [diagnosis]: skin protectant for reddened buttocks."</p> <p>Physician's orders dated 1/22/14 indicated to, "... cleanse left dorsal foot ulcer with normal</p>	F000314	<p><b>F 314 Treatment/SVCS ToPrevent/Heal Pressure Sores Based on the comprehensiveassessment of resident, the facility must ensure that a resident who enters thefacility without pressure sores does not develop pressure sores unless theindividuals clinical condition demonstrates that they were unavoidable; and aresident having pressure sores receives necessary treatment and services topromote healing, prevent infection and prevent new sores from developing.</b></p> <p>·Resident C nolonger resides in this facility. <b>How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</b></p> <p>·All Residents with potential for skin breakdown havethe potential to be affected by the alleged deficient practice.</p>	04/30/2014

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	<p>saline and pat dry...." "...Cleanse right lower extremity ulcers with normal saline, pat dry...."</p> <p>On 3/12/14 the Resident C's progress notes indicated, "...Wounds LE [lower extremity] continues to show improvement and PT continues with the 4 layer wraps., will have PT continue to treat lower extremities. Yesterday he was noted to have an open area on right gluteal and sacral , today when accessed by wound team the two wounds have now merged to one area...."</p> <p>On 3/12/14 the resident's wound was a stage 2 and measured 7.2 x 3.5 x 0.2cm. Physician's orders on this date indicated, "(1) up grade mattress to low air loss for wound healing.(2) roho to be used in recliner and w/c [wheel chair] when up (3) Dietary consult (4) to be up for meals only...."</p> <p>On 3/17/14 the resident's physician's orders indicated, "...Cleanse wound on right gluteal with N.S.[normal saline] apply calmoseptine peri wound, apply medi-honey to wound bed cover with gauze and cover entire dressing with op-site [change] q[every] day et [and] prm [as needed] soilage dislodgement...."</p> <p>On 3/19/14 the resident's progress notes indicate, "...Resident has wound to coccyx...Coccyx wound is deteriorating...."</p> <p>During an interview on 4/2/14 at 4:03 P.M., LPN #19 and the ADON (Assistant Director of Nursing) indicated that Resident C's pressure ulcer wound was found on wound rounds on 3/12/14 and measures were started immediately to treat it. The ADON indicated it was a stage 2 wound. When it was first found it measured 7.2 x 3.5 x 0.2cm</p>		<p>·Nursing staff will be educated by the SDC/Designeeon implementing interventions to prevent skin breakdown by April 30, 2014.</p> <p>·Resident profiles and Care Plans will be updated with every change in intervention by the Interdisciplinary Team to ensure nursing staff are informed of changes.</p> <p><b>What measures will be put into place or what systemicchanges you will make to ensure that the deficient practice does not recur.</b></p> <p>·Nursing staff will be educated by the SDC/Designeeon implementing interventions to prevent skin breakdown by April 30, 2014.</p> <p>·Resident profiles and Care Plans will be updated with every change in intervention by the Interdisciplinary Team to ensure nursing staff are informed of changes.</p> <p>·The SkinManagement CQI will be completed weekly x4, monthly x 6, and quarterlythereafter.</p> <p>·The CQI committee will review the datacollected. If a 100% threshold is notachieved, an action plan will be developed.</p> <p><b>How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place</b></p> <p>·The SkinManagement CQI will</p>				

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F000323 SS=D	<p>and on 3/19/14 the wound measured 9.5x5.6x0.3cm.</p> <p>Record review indicates on 3/19/14 the resident's code status changed to DNR (Do Not Resuscitate). Provide palliative care.</p> <p>This federal tag relates to Complaint IN00145803.</p> <p>3.1-40(a)(1) 3.1-40(a)(2) 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 receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure a mechanical lift ("Hoyer") transfer was performed safely for 1 resident; and, failed to ensure an electrical cord to oxygen equipment was placed in a safe area of 1 resident's room. (Resident #94 and #130)</p> <p>Findings include:</p> <p>1. The record for Resident #94 was reviewed on 3/31/14 at 5:06 P.M. Diagnoses included, but were not the limited to, chronic pain syndrome, Alzheimer's disease, dementia, and osteoporosis</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 1/17/14, indicated the resident could not complete the Brief Interview for Mental Status and her Cognitive</p>	F000323	<p>be completed weekly x4, monthly x 6, and quarterly thereafter.</p> <p>The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed.</p> <p><b>Compliance date:</b> April 30, 2014</p> <p><b>F323 Free of Accident Hazards/Supervision /Devices</b> <b>The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices</b></p>	

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	<p>Skills for Daily Decision Making was severely impaired (never/rarely made decisions).</p> <p>On 3/27/14 at 9:19 A.M., CNA #6 and CNA #7 were observed to transfer Resident #94 from a "Broda" geri-chair to her bed with a mechanical lift. Neither of the CNAs were observed to support the resident's feet or head during the transfer. The resident was sitting in the mechanical lift sling, hunched over into a "C" shape. CNA #7 moved the Broda chair from underneath the resident, while CNA #6 moved the resident in the lift over to the bed. The resident was swinging in the air as she was being transferred over to the bed.</p> <p>During an interview on 3/27/14 at 9:25 A.M., CNA #6 and CNA #7 indicated they should have supported the resident's head and feet during the transfer from the Broda chair to the bed. CNA #6 indicated she soul have held onto the resident while CNA #7 pulled the chair away from the resident. CNA #7 indicated she should have held onto the resident while she was being transferred to the bed.</p> <p>During an interview on 3/27/14 at 9:35 A.M., RN #5 indicated the CNAs should have transferred the resident with the mechanical lift without swinging her in the air while moving the mechanical lift to the bed. She indicated the spotter person was to support the resident while the other person guided the mechanical lift. The nurse indicated she would be doing inservice training with each of the CNAs on correct mechanical transfers immediately.</p> <p>On 3/30/14 at 5:44 P.M., CNA #2, CNA #3 and LPN #4 were observed to transfer</p>		<p><b>to prevent accidents.</b></p> <p><b>What corrective action(s) will be accomplished forthose residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·CNA's were immediately re-educated and skills validated on how to do aproper transfer via mechanical lift.</li> <li>·The electrical cord to oxygen concentrator is no longer stretched acrossresident #130's room.</li> </ul> <p><b>How will you identify other residents having thepotential to be affected by the same deficient practice and what correctiveaction will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents requiringa mechanical lift for transfer have the potential to be affected by thedeficient practice.</li> <li>·Nursing staff will be educated by SDC/Designee on how to properlytransfer residents via mechanical lift by April 30, 2014.</li> <li>·Staff will be educated bySDC/Designee on how to identify hazards and prevent accidents in facility byApril 30, 2014</li> <li>·SDC/Designee will complete Mechanical Lift Skills Validation for allnursing staff by April 30, 2014.</li> <li>·Mechanical Lift Transfer CQI will be completed weekly x 4, monthly x 6, and quarterly</li> </ul>	

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	<p>Resident #94 from her Broda chair to the bed with a mechanical lift. None of the staff members were supporting the resident's head while she was being transported over to the bed from the chair. LPN #4 was holding her feet. Resident #94 was hunched over into a "C" shape. After peri care was given, CNA #2 and CNA #3 transferred Resident #94 back to the Broda chair with the mechanical lift. The resident was hunched over into a "C" shape in the mechanical lift sling. CNA #3 placed her hand behind the resident's head, while CNA #2 guided the mechanical lift over to the Broda chair, which was positioned against the wall. Neither of the CNAs were supporting the resident's feet. The resident's left foot got caught on the edge of the air mattress. As Resident #94 was moved over to the chair, both feet were dragged over the edge of the bed. The resident was swinging in the air as she was transferred to the Broda chair.</p> <p>During an interview 3/30/14 at 6:15 P.M., CNA #3 indicated one of them should have held Resident #94's feet and head, so her feet did not drag across the mattress.</p> <p>During an interview on 4/1/14 at 4:15 P.M., RN #5 indicated inservicing had been completed in regards to proper use of the mechanical lift after the discussion about improper mechanical lift transfers on 3/27/14.</p> <p>A current skills validation for CNA titled "Mechanical Lift," dated 03/2012, was provided by the Director of Nursing on 4/1/14 at 5:18 P.M. The validation indicated, "Procedure Steps:...19. One staff should guide resident as other staff operates the lift...Assist back to Bed:...9. Follow steps 19-28. 19. One staff should guide resident</p>		<p>thereafter.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·SDC/Designee will complete Mechanical Lift Skills Validation for nursing staff by April 30, 2014.</li> <li>·Mechanical Lift Transfer CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed.</li> </ul> <p><b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·The Mechanical Lift Transfer CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·The Facility Environment Review CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed.</li> </ul> <p><b>Completion Date:</b> April 30, 2014</p>				

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NAME OF PROVIDER OR SUPPLIER  SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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	<p>as other staff operates the lift...."</p> <p>On 4/2/14 at 3:30 P.M., the Executive Director provided the skills check-off sheets for CNAs #2, #3, #6, and #7.</p> <p>The "ARJO Skills Check-Off Sheet--SARA [mechanical lift] 3000" for CNA #2 was dated 12/11/12. The form indicated the CNA had successfully completed the training on the lift, and had demonstrated she was able to perform the task.</p> <p>A "Certified Nurse Aide/Qualified Medication Aide Job Specific Orientation" sheet for CNA #3 was dated 1/31/14. The sheet indicated the CNA had demonstrated appropriate skills in mechanical lift transfers.</p> <p>A "Skills Validation--CNA" form for "Mechanical Lift" for both CNA #6 and #7 were dated 3/27/14.</p> <p>2. On 3/25/14 at 12:54 P.M., an oxygen concentrator was observed positioned next to the foot of the bed for Resident #130. The electrical cord to oxygen concentrator was stretched across the center area of the room, and was plugged into an electrical outlet on the opposite wall. A family member, who was in the room at the time, indicated this was the usual placement of the concentrator and electrical cord. She indicated the facility had provided a multi-outlet surge protector strip, and she thought there were available electrical outlets on it. The surge protector strip was observed to be behind, and under, a dresser which was positioned length-wise at the foot of the resident's bed.</p>			

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F000332 SS=D	<p>On 3/30/14 at 6:00 P.M., the resident was observed sitting in her wheelchair at her room door way. The oxygen concentrator was again positioned at the foot of the resident's bed, with the electrical cord stretched across center of the room and in the walk area, to an electrical outlet on the opposite wall.</p> <p>On 4/2/14 at 9:20 A.M., the resident observed laying in bed. Oxygen concentrator positioned next to bed with electrical cord running across floor and walkway to opposite wall plug in.</p> <p>On 4/2/14 at 9:45 A.M., the Director of Nursing Services was brought to the resident's room. She observed the electrical cord stretched across walkway. In an interview at that time, she indicated that it was unsafe to have the electrical cord stretched across the room floor. She indicated she would move it to an outlet nearer the resident's bed, so it was not crossing the walk way area of the room.</p> <p>3.1-45(a)(1) 3.1-45(a)(2) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure that it was free of medication error rates of 5% or greater. During the medication pass observation, 2 errors were made in an total of 26 opportunities for an error rate of 7.6%.</p>	F000332	<b>F332 Free of Medication Error Rates of 5% or More The facility must ensure that it is free</b>	

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	<p>This deficiency impacted 2 of 4 residents observed receiving medications during the medication pass task. (Residents #125 and #78)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 3/31/2014 at 10:46 A.M., LPN #16 was observed administering the cardiac medication Carvedilol 25 mg (milligrams) to Resident #125.</p> <p>Record review of this resident's Physician's orders for March on 3/31/14 at 11:30 A.M., indicated on 3/25/14 an order was written, "...Carvedilol 25mg po [by mouth] BID [twice per day] at 8 A (bkft) [sic] and (dinner) 6 P"</p> <p>Interview on 4/1/14 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated this was a medication error and it would be brought to the attention of the nurse that administered it.</p> <p>2. During a medication pass observation on 3/31/14 at 11:16 A.M., LPN #17 was observed administering the pain relieving medication, Tylenol 2 tablets by mouth, to Resident #78.</p> <p>Record review of this resident's Physician's orders for March on 3/31/14 at 11:45 A.M., indicated Tylenol 325 mg, "Take 2 tablets (650mg) by mouth every 8 hours due to moderate pain..." 6 A.M., 2 P.M., 10 P.M.</p> <p>Interview on 4/1/14 at 10:15 A.M., the ADON indicated this was a medication error and it would be brought to the attention of the nurse that administered it.</p>		<p><b>of medication error rates of five percent or greater.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #125 will be given medications within allowed parameters following physicians order.</li> <li>·Resident #78 will be given medications within allowed parameters following physicians order. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>·Residents receiving medications have the potential to be affected by the alleged deficient practice.</li> <li>·SDC/Designee will educate Licensed Nurses regarding medication administration per physician's orders.</li> <li>·Physician's orders will be reviewed daily by the Interdisciplinary Team/Charge Nurse, including weekends and holidays.</li> </ul>	

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	3.1-48(c)(1)		<p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·SDC/Designee will educate Licensed Nurses regarding medication administration per physician's orders.</li> <li>·Physician's orders will be reviewed daily by the Interdisciplinary Team/Charge Nurse, including weekends and holidays.</li> <li>·SDC/Designee will perform Medication Pass Skills Validation weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed.</li> </ul> <p><b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·SDC/Designee will observe 5 medication passes to ensure medications are being administered per physicians orders within allowed parameters weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved, an action plan will be developed.</li> </ul>	

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication was administered at the correct time as ordered, following a change in order, resulting in 8 doses being administered 2 hours early for 7 doses and 2 hours 45 minutes late for one dose. This deficiency affected 1 of 4 residents observed administered medication during a medication pass task. (Resident #125).</p> <p>Findings include:</p> <p>During a medication pass observation on 3/31/2014 at 10:46 A.M., LPN #16 was observed administering the cardiac medication Carvedilol 25 mg (milligrams) to Resident #125.</p> <p>Record review of this resident's Physician's orders for March on 3/31/14 at 11:30 A.M., indicated on 3/25/14 an order was written, "...Carvedilol 25mg po [by mouth] BID [twice per day] at 8 A (bkft) [sic] and (dinner) 6 P"</p> <p>Record review of this resident's MAR (Medication Administration Record) indicated the order had been written, "carvedilol 25mg po BID 8 A 4 P"</p> <p>The medication record had initials from 4/25/14 until 4/31/14 on the 4 P.M., line indicating it was given at 4 P.M., on those days instead of 6 P.M. as ordered.</p>	F000333	<p><b>Completion Date:</b> April 30, 2014</p> <p><b>F333 Residents Free of Significant Med Errors</b></p> <p><b>The facility must ensure that residents are free of any significant medication errors.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #125 will be given medications within allowed parameters following physicians order. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>·Residents receiving medications have the potential to be affected by the alleged deficient practice.</li> <li>·SDC/Designee will educate all Licensed Nurses regarding medication administration per physician's orders.</li> </ul>	
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	<p>Interview on 4/1/14 at 10:15 A.M., the ADON (Assistant Director of Nursing) indicated this was transcribed incorrectly from the Physician's order to the MAR.</p> <p>3.1-25(b)(9)</p>		<p>·Physician's orders will be reviewed daily by the Interdisciplinary Team and/or Charge Nurse, including weekends and holidays.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>·SDC/Designee will educate Licensed Nurses regarding medication administration per physician's orders.</p> <p>·Physician's orders will be reviewed daily by the Interdisciplinary Team/Charge Nurse, including weekends and holidays.</p> <p>·SDC/Designee will perform Medication Pass Skills Validation weekly x 4, monthly x 6, and quarterly thereafter.</p> <p>·The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed.</p> <p><b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>·SDC/Designee will observe 5 medication passes to ensure medications are being administered per physicians orders weekly x 4, monthly x 6, and quarterly thereafter.</p> <p>·Data will be submitted to the CQI committee for follow up. If 95% a threshold is not achieved,</p>		

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>		<p>an actionplan will be developed. <b>CompletionDate:</b> April 30, 2014</p>	

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	<p>Based on observation, interview and record review, the facility failed to ensure that 2 licensed nurses handled resident-use equipment in a manner to prevent the possibility of cross contamination during blood glucose testing for 2 of 4 residents reviewed for blood glucose testing. (Residents #37 and #157; LPN #17 and RN #18).</p> <p>Findings include:</p> <p>1. On 3/31/14 at 11:20 A.M., LPN #17 was observed doing a blood glucose test on Resident #37. After entering the resident's room the LPN removed a glucometer from her pocket and laid the blood glucometer on the resident's quilt. She cleansed and dried her hands, put gloves on and pulled a monitoring strip out of a container in her pocket, and a lancet type instrument out of her pocket. Then she put the monitoring strip / reagent strip into the meter. Cleansed the resident's finger, stuck it and wiped the drop of blood on to the monitoring strip to check the resident's blood sugar.</p> <p>After she obtained the reading, she checked a piece of paper and then took a container containing an insulin vial out of her pocket and an insulin syringe out of her pocket. She withdrew 6 Units of insulin from the vial. She then went over and cleansed the resident's abdomen and proceeded to administer the insulin.</p> <p>She cleansed her hands collected the supplies and after leaving the resident's room she disposed of the gloves in her cart's trash and sharps. She then set the glucometer</p>	F000441	<p><b>F441 Infection Control, Prevent Spread, Linens</b>  <b>The facility must establish and maintain an Infection Control Program designed to provide a safe, a sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b>          · Licensed Nursing staff will be educated proper infection technique for administering blood glucose testing and sub q injections.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b>          · All residents receiving blood</p>	04/30/2014

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	<p>down and indicated she needed to go to another unit to get something. After returning from the other unit she used a sani-wipe on the glucometer and returned it to the drawer.</p> <p>During an interview at this time LPN #17 indicated she usually puts a barrier down before putting the glucometer down and indicated she was not aware of anything else she forgot.</p> <p>During an interview on 4/1/14 at 10:15 A.M., the ADON indicated she was not aware of the nurses putting medications and carrying them in their pockets.</p> <p>2. On 3/31/14 at 4:10 P.M., RN #18 was observed doing a blood glucose test on Resident #157. After entering the resident's room the RN put down the glucose monitoring supplies she had in a plastic container by the resident's sink. She then washed her hands for 10 seconds, dried them and put gloves on and put the glucometer on the resident's bedside stand. She then went and removed a glucose testing strip from its container put it in the meter and then took a lancet from the plastic container. She cleansed the resident's finger and stuck it and wiped the drop of blood on to the monitoring strip to check the resident's blood sugar. Afterward she collected the used supplies and disposed of them in her carts trash can. She sanitized her hands and then proceeded to sanitize the glucometer and just put her plastic container with the other glucose monitoring items back in her cart.</p> <p>In an interview at this time RN #18 indicated she usually uses a plastic disposable cup to put the glucometer in instead of a paper</p>		<p>glucose monitoring and sub q injections have the potential to be affected by the alleged deficient practice.</p> <ul style="list-style-type: none"> <li>·SDC/Designee will educate Licensed Nurses regarding on infection technique for administering blood glucose testing and sub q injections by April 30, 2014.</li> <li>·SDC/Designee will complete skills validations for administering blood glucose testing and sub q injections by April 30, 2014.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>·SDC/Designee will educate Licensed Nurses regarding on infection technique for administering blood glucose testing and sub q injections.</li> <li>·Infection Control CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter.</li> <li>·The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed.</li> </ul> <p><b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Infection Control CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter.</li> </ul>	

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F000514 SS=D	<p>towel or other barrier and she must have forgotten this time. She did not indicate she did anything else differently.</p> <p>3.1-18(l)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to ensure clinical documentation of a skin wound was accurate, for 1 of 6 residents reviewed for pressure wounds. (Resident #94)</p> <p>Findings include:</p> <p>The record for Resident #94 was reviewed on 3/31/14 at 5:06 P.M. Diagnoses included, but were not limited to, chronic pain syndrome, Alzheimer's disease, dementia, and osteoporosis</p> <p>A physician's order, dated 3/30/14, indicated "Cleanse open area right hip with Normal Saline; pat dry; apply thick layer of</p>	F000514	<p>The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed.</p> <p><b>Completion Date:</b> April 30, 2014</p> <p><b>F514 Resident Records Complete/Accurate/ Accessible</b> <b>The facility must maintain clinical records on each resident in accordance with accepted professional standards and</b></p>	

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	<p><b>Calmoseptine."</b></p> <p>A Care Plan entry, dated 3/30/14, addressed a problem of impaired skin integrity of the left lateral hip.</p> <p>The "ASC Weekly Summary," dated 3/30/14 at 12:17 A.M., indicated the resident had an open area to her right lateral hip.</p> <p>The "ASC Pressure Wound Skin Evaluation Report," dated 3/31/14 at 8:04 A.M., indicated the resident had a Stage II pressure ulcer to her right hip that was acquired in the facility. The area measured 0.3 by 0.2 by &lt;0.1 cm. The onset date it was documented as 3/30/14. The most severe tissue type was granulation (pink or red tissue with shiny, granular appearance) The wound color was 100% granulation. There was no wound drainage.</p> <p>A progress note, dated 3/31/14 at 8:35 A.M., indicated the resident had a compromised area of skin on the left lateral hip that measured 1.7 by 1.7 by &lt;0.7, with an open area of 0.3 by 0.2 by &lt;0.1 cm. 95% of the area was epithelization tissue and pink fragile skin. The open area was 100% granulation.</p> <p>On 4/1/14 at 10:30 A.M., the resident's right hip was observed to have an open area with a red wound bed with no drainage. There was a pink colored ointment around the periwound of the wound and slightly covering the wound. The wound was open to air.</p> <p>During an interview on 4/1/14 at 11:00 A.M. to clarify which hip was affected, the Assistant Director of Nursing Services (ADNS) indicated she was not sure and</p>		<p><b>practices that are complete; accurately documented; readily accessible; and systematically organized.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident #94's care plan for impaired skin integrity was discontinued.</li> <li>·Resident's #94's progress note was clarified to include accurate information. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></li> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·Wound Nurse/Designee will assess all residents with new skin alterations to ensure accurate documentation.</li> <li>·SDC/Designee will educate Licensed Nurses regarding accurate documentation of new skin alterations.</li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the</b></p>				

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NAME OF PROVIDER OR SUPPLIER  SPRING MILL MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2140 W 86TH ST INDIANAPOLIS, IN 46260
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	would have to look at the resident.  During an interview on 4/1/14 at 11:15 A.M., the ADNS indicated the pressure ulcer was located on the resident's right hip.  3.1-50(a)(2)		<b>deficient practice does not recur?</b> ·Wound Nurse/Designee will assess all residents with new skin alterations to ensure accurate documentation. ·SDC/Designee will educate Licensed Nurses regarding accurate documentation of new skin alterations by April 30, 2014. ·The Skin Management Program CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter. ·The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed. <b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b> ·The Skin Management Program CQI will be completed weekly x 4, monthly x 6, and quarterly thereafter. ·The CQI committee will review the data collected. If a 100% threshold is not achieved, an action plan will be developed. <b>Completion Date:</b> April 30, 2014	