

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/27/2013
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NAME OF PROVIDER OR SUPPLIER  PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: March 20, 21, 22, 25, 26, and 27, 2013</p> <p>Facility number: 000195 Provider number: 155298 AIM number: 100267690</p> <p>Survey team: Janet Stanton, R.N.--Team Coordinator Michelle Hosteter, R.N. Christi Davidson, R.N.</p> <p>Census bed type: SNF/NF--86 Total--86</p> <p>Census payor type: Medicare--19 Medicaid--56 Other--11 Total--86</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 4, 2013, by Brenda Meredith, R.N.</p>	F000000		
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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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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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 and interview, the facility failed to ensure that the dignity of 4 residents was respected, related to random observations of residents being pulled backwards in a geri-chair or having staff standing to assist them in eating. (Residents #8, #15, #24 and 1 unidentified resident; and LPNs #10, 11, #14, and CNA #13)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 3/25/13 at 2:12 P.M., CNA #13 was observed to pull Resident #8 backward in her geri-chair, all the way from the third floor small dining room, around the Nurses Station, to the large dining room on the opposite side.</li> <li>On 3/26/13 at 1:03 P.M. in the third floor dining room, LPN #14 was observed to be standing while she was assisting Resident #15 to each lunch. The nurse continued to stand next to the resident for 20 minutes, while feeding her the food from her</li> </ol>	F000241	<p>It is the practice of Pyramid Point to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>Staff will transport Resident #8 with her geri-chair in front-facing position. Staff will feed Residents #15 and #24 while seated.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>Like residents are those who utilize geri-chairs or broda chairs for transportation. Staff will be re-educated to transport residents in geri-chairs and broda chairs in a forward-facing direction. Like residents are those who require assistance in feeding. Staff will be re-educated to sit down while providing assistance during feeding.</p> <p><b>What measures will be put into place or what systemic changes will be made to</b></p>	04/23/2013			

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	<p>lunch meal.</p> <p>3. In an interview on 3/27/13 at 10:04 A.M., LPN #15 indicated staff were not to pull people backwards while transporting them in a wheelchair or geri-chair. She indicated staff were not to stand to feed a resident who needed assistance. She said "It's a dignity issue."</p> <p>4. On 3/22/13 at 12:20 P.M., the lunch meal was observed in the main dining room on the third floor. LPN #10 was observed to be standing while feeding Resident # 24. LPN #11 was observed to be standing to feed an unidentified resident.</p>		<p><b>ensure that the deficient practice does not reoccur?</b> Staff have been re-educated that the proper and expected way to transport residents in geri-chairs or broda chairs is in a forward-facing direction. CNAs and licensed nurses have been re-educated on the expectation they be seated while providing assistance during feeding. <b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> ED or designee will monitor appropriate transportation of residents in geri-chairs and broda chairs. ED or designee will also monitor that staff is seated while providing assistance while feeding. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. <b>Date to be completed</b> 4/23/2013</p>		

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	<p>The ADON (Assistant Director of Nursing) walked through dining room at 12:30 P.M. and did not say anything to LPN #10.</p> <p>5. In an interview on 3/27/13 at 11:15 A.M., the ADON indicated she was not sure whether the staff should be standing or sitting when feeding a resident. She indicated that she would go to find out. She indicated when residents are transferred in a geri chair they should be pushed facing forward.</p> <p>In an interview on 3/27/13 at 11:49 A.M., the ADON indicated that the staff should be sitting at eye level when feeding a resident.</p> <p>3.1-(3)(t)</p>				

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F000253 SS=D	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to keep the 300 hallway television lounge area free from odors for 1 of 2 television lounge areas observed.</p> <p>Findings include:</p> <p>In an interview with the ADON (Assistant Director of Nursing) on 3/20/13 at 2:45 p.m., she indicated the 300 hallway residents typically start coming into the dining room areas anywhere between 11 a.m. to 12 p.m.</p> <p>There were residents who were sitting and watching television after lunch on 3/25/13 at 1 p.m. The room smelled strongly of urine.</p> <p>There were residents that were observed sitting and watching television after lunch on 3/26/13 at 1 p.m., the room smelled of urine. Resident #30 was observed in a continuous observation from 9:15 a.m. through 1:45 p.m. on 3/26/13. She was taken from the activity area to the television lounge area at 11:45</p>	F000253	<p>It is the practice of Pyramid Point to provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> TV lounge was cleaned.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> TV lounge will be cleaned daily and as needed.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> All staff have been in-serviced on the need to identify odors and address the source, either themselves or to alert appropriate personnel.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> ED or designee will monitor for odors and their source and ensure any odors are corrected.</p>	04/23/2013			

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	<p>a.m., and then ate her lunch. The resident remained in the lounge area until 1:45 p.m.</p> <p>In an interview with CNA # 7 on 3/26/13 at 2:00 p.m., she indicated they usually lay down residents after lunch. CNA #7 indicated she would be getting to Resident #30 here shortly. She indicated CNA # 8 had left at 1 p.m. and she was now was covering the hall.</p> <p>3.1-19(f)</p>		<p>This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly.</p> <p><b>Date to be completed</b> 4/23/2013</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview the facility failed to develop complete and individualized care plans for anticoagulation therapy and for refusing care related to Activities of Daily Living (ADL's) for 2 residents in a Stage 2 sample of 45 residents that were reviewed for care plans. (Resident #52, #97)</p> <p>Findings include:</p> <p>1. The record for Resident #52 was reviewed on 3/25/13 at 11:30 a.m.</p>	F000279	<p>It is the practice of Pyramid Point to develop, review and revise the resident's comprehensive plan of care.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident #52 has been discharged from the facility. The ADL and Behavior care plan for resident #97 has been updated to include the resident's resistance to care.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be</b></p>	04/23/2013			

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	<p>Diagnoses included, but were not limited to, insulin dependent diabetes II, hypertension, hyperlipidemia, coronary artery disease, deep vein thrombosis and pulmonary embolism.</p> <p>A physician's order, dated 3/5/13, indicated, "...Coumadin [a blood thinner] 5 mg [milligrams] po [by mouth] [sign for times] 1 today...in am [a.m.]...PT/INR [Lab Study - Prothrombin/International Normalized Ratio] - call results...then PT/INR [sign for every] week on Monday...."</p> <p>A physician's order, dated 3/8/13, indicated, "Start Coumadin 3 mg [sign for 1] po [by mouth] dly [daily] repeat PT/INR on Monday 3-11-13...."</p> <p>A physician's order, dated 3/11/13, indicated a change in the Coumadin medication administration schedule and to obtain a PT/INR on Monday.</p> <p>A physician's order, dated 3/20/13, indicated, "hold Coumadin Today [sic] [sign for and] Tomorrow [sic] PT/INR Friday."</p> <p>A physician's order dated 3/24/13 indicated, "Coumadin 2.0 mg po today...call...PT/INR results from 3/25/13...."</p>		<p><b>identified and what corrective action will be taken?</b> Like residents are those who have orders for anticoagulant therapy and/or that are resistive to care. Care plans have been developed and implemented for residents that receive anticoagulation therapy and/or that are resistive to care that include measureable goals and specific interventions.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Licensed nursing staff and social workers have been re-educated on the development of care plans for residents receiving anticoagulant therapy and/or that are resistive to care that include measureable goals and specific interventions.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> DON or designee will monitor residents with anticoagulant therapy and/or that are resistive to care for current and updated care plans that include measureable goals and specific interventions. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results</p>	

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	<p>A care plan, dated 2/27/13, titled "Anticoagulation Therapy," indicated Resident #52 was on Aspirin therapy. The section related to Coumadin use was not marked, and goals for therapeutic PT/INR parameters were not marked.</p> <p>During an interview on 3/26/13 at 11:00 a.m., the DoN (Director of Nursing) indicated the care plan was not marked to reflect the resident's Coumadin therapy.</p> <p>2. The record for Resident #97 was reviewed on 3/26/13 at 1:26 p.m.</p> <p>Diagnoses included, but were not limited to, Alzheimer's disease, depression and dementia with agitation and anxiety.</p> <p>During an observation on 3/20/13 at 2:19 p.m., Resident #97 had unshaved facial hair noted on her chin area, and the fingernails on her left hand were fragmented and untrimmed.</p> <p>A nurses note dated 3/24/13 at 3:00 p.m. indicated, "...Refused shower wash up, [sign for change] clothes, family (daughter) has been called several [sign for times] re: [reason]</p>		<p>will be reviewed by QAA committee monthly. <b>Date to be completed</b> 4/23/2013</p>				

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	<p>resident refuses showers, any hygiene assistance frequently. Daughter came to facility to assist [sign for with] shower. Resident refused daughter's help. Will cont. [continue] to attempt to assist [sign for with] showering."</p> <p>During an interview on 3/27/13 at 12:10 p.m., CNA #33 indicated Resident #97 was very territorial and demanding. CNA #33 indicated Resident #97 at times complied to Activities of Daily Living [ADL] care when the resident's daughter was present. CNA #33 indicated the resident refused to get her nails cut or cleaned. CNA #33 indicated the resident's daughter assisted the resident with shaving, showering and personal hygiene once a week. CNA #33 indicated the night shift staff assisted the resident in the early morning to get washed up, and if she refused care it was reported to the day shift staff. CNA #33 indicated ADL care would be re-attempted upon day shift staff arrival at 6:00 a.m.</p> <p>A care plan, dated 1/22/13, titled "Activities of Daily Living (ADL) Care Plan," lacked documentation of individualized interventions related to personal hygiene and bathing. The</p>			

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	<p>care plan lacked goals and individualized interventions to encourage and complete activities related to bathing and personal hygiene.</p> <p>A care plan, dated 1/29/13, titled "Behavior Care Plan," indicated the resident was aggressive or threatening, wandered and rummaged through other's belongings. The care plan lacked documentation that Resident #97 refused care. The box for "Refusing care" was not marked. The care plan lacked goals and individualized interventions related to the resident's episodes of refusing personal hygiene and ADL care.</p> <p>During an interview on 3/27/13 at 12:00 p.m., the DoN was aware Resident #97's record lacked individualized goals and interventions related to personal hygiene, bathing and refusing ADL care.</p> <p>3.1-35(b)(1) 3.1-35(b)(2)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, interview and record review, the facility failed to follow written physician orders and Care Plan interventions related to potential falls, for 1 of 3 residents reviewed who had a history of falls. (Resident #84)</p> <p>Findings include:</p> <p>In an interview on 03/21/2013 10:30:45 A.M., the Assistant Director of Nursing indicated Resident #84 had experienced a fall on 2/23/13 at 6:00 A.M. The resident was found on the floor between his wheelchair and the bed. The resident had gotten up from his wheelchair and was attempting to put himself to bed. The Assistant Director of Nursing indicated he had an alarm on the wheelchair, which was sounding at time. The resident did not sustain any injury.</p> <p>The clinical record for Resident #84 was reviewed on 3/26/13 at 10:42 A.M. Diagnoses included, but were not limited to, hemorrhagic left CVA</p>	F000282	<p>It is the practice of Pyramid Point that 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><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b></p> <p>Resident #84 fall risk care plan was reviewed and updated with current interventions and interventions were verified to be in place.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b></p> <p>Like residents are those scoring 10 or more on their fall risk assessment (high risk). The fall risk care plan for these residents were reviewed and updated to reflect current interventions and interventions were verified to be in place.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b></p>	04/23/2013	

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	<p>(cerebral vascular accident--stroke) with deep right hemiparesis (paralysis), muscle weakness, aphasia (unable to speak), and muscle spasm.</p> <p>The March, 2013 physician order recap (recapitulation) sheet included the following orders:</p> <p>5/5/11--Dycem in wheelchair to prevent sliding off seat of chair. 4/26/12--Stand-up lift for all transfers. 12/6/12--Discontinue bed and chair alarms. 12/7/12--Resident to have chair alarm while up in wheelchair. 12/17/12--Resident to have chair alarm while up in wheelchair. Check for placement every shift. 2/25/13--Pressure pad alarm to bed--check placement and function every shift.</p> <p>A "Fall Risk Care Plan" entry, dated 2/23/13, addressed a problem of "At risk for falls and injuries related to CVA with right hemiparesis." The "Interventions" were listed as: "Provide adequate lighting; observe for side effects of meds; keep call light within reach, keep environment clutter free; pressure sensor pad [alarm] in bed and wheelchair; mattress with bolsters; resident is not</p>		<p>Nursing staff have been re-educated on the expectation for updating fall risk care careplans with current interventions and verification that interventions are in place.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> DON or designee will monitor the fall risk care plans for residents at high risk for falls to ensure the careplans are updated as appropriate and care planned interventions are in place. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly.</p> <p><b>Date to be completed</b> 4/23/2013</p>		

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	<p>to be in room while up in chair related to attempts to get into bed himself."</p> <p>On 3/25/13 at 11:23 A.M., the resident was observed to be up in a high-back wheelchair, propelling himself in hallway from his room to the Nurses Station. A cord for pad alarm was observed at the rear of the wheelchair, hanging down behind the seat, but it was not plugged into any alarm unit. No alarm unit was seen on chair.</p> <p>At 11:40 A.M., CNA #1 pushed the resident to his room door. The resident indicated he wanted to lay down, but the CNA told him it was almost lunch time, and she promised to assist him to bed after he ate. Resident #84 indicated he did not want his room door closed after the CNA brought his roommate out of the room. The resident was then observed to propel himself into the room. The CNA asked him "You won't try to get in bed by yourself if I leave the door open, will you?" Resident responded that he would not try to get in bed by himself.</p> <p>At 11:45 A.M., the resident was observed to be sitting by himself in his room. The alarm cord was not attached to an alarm unit.</p>			

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	<p>At 1:08 P.M., the resident was observed in his wheelchair in the hallway. He propelled himself into his room. The alarm cord was not attached to alarm unit. CNA #1 was observed to walk by, pushing another resident down hall to his room.</p> <p>On 3/25/13 at 1:20 P.M., CNA #1 and CNA 2 were observed while transferring the resident into bed. A "Hoyer" brand mechanical lift with a full body sling was used to transfer the resident to his bed. The alarm did not sound as resident was lifted from the wheelchair seat. An alarm unit was observed on floor beside bed--it was connected to a cord, and pressure pad was on the bed. CNA #2 was requested to check to see if the bed alarm was on--she checked and said she thought it needed a battery--"It's underneath him, anyway." The wheelchair had a cushion, but there was no Dycem either under or over the cushion.</p> <p>On 3/26/13 at 9:21 A.M., the resident was observed in his wheelchair in the small lounge area. The cord to alarm pad not connected to an alarm unit. There was no alarm unit on the wheelchair.</p>			

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	<p>At 10:20 A.M., CNA #3 and LPN #4 were observed to transfer the resident into bed. CNA #3 brought the Hoyer lift into room to use to put the resident into bed.</p> <p>At 12:41 P.M., CNA #3 was observed to bring the resident to small lounge/dining room. The pressure pad alarm cord was not connected to an alarm unit. There was no alarm unit on the wheelchair.</p> <p>At 1:01 P.M., the resident was observed wheeling himself into his room after lunch.</p> <p>At 1:38 P.M., he was observed to continue sitting in his room next to his bed.</p> <p>At 1:43 P.M., the resident was observed to be in his wheelchair next to his bed. After making a motion to come in, the resident pointed to his bed, indicating he wanted to lay down. The call light and cord was laying on floor behind him.</p> <p>At 1:59 P.M., the resident was observed laying in bed. There was a cushion in wheelchair, with the pressure sensor alarm pad on top. There was no Dycem in chair, either under of over the cushion.</p>			

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	3.1-35(g)(2)			

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F000323 SS=D	<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 receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure that physician orders and Care Plan interventions related to potential falls were implemented, for 1 of 3 residents reviewed who had a history of falls. (Resident #84)</p> <p>Findings include:</p> <p>In an interview on 03/21/2013 10:30:45 A.M., the Assistant Director of Nursing indicated Resident #84 had experienced a fall on 2/23/13 at 6:00 A.M. The resident was found on the floor between his wheelchair and the bed. The resident had gotten up from his wheelchair and was attempting to put himself to bed. The Assistant Director of Nursing indicated he had an alarm on the wheelchair, which was sounding at time. The resident did not sustain any injury.</p> <p>The clinical record for Resident #84 was reviewed on 3/26/13 at 10:42 A.M. Diagnoses included, but were</p>	F000323	<p>It is the practice of Pyramid Point to 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><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Residents #83 and #84 fall risk care plan was reviewed and updated with current interventions and interventions were verified to be in place. Interventions requiring placement and function checks have been reviewed to ensure placement on the TAR for documentation of these checks by the staff.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Like residents are those scoring 10 or more on their fall risk assessment (high risk). The fall risk care plan for these residents were reviewed and updated to reflect current interventions and</p>	04/23/2013

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	<p>not limited to, hemorrhagic left CVA (cerebral vascular accident--stroke) with deep right hemiparesis (paralysis), muscle weakness, aphasia (unable to speak), and muscle spasm.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 2/8/13, indicated the resident had a BIMS (Brief Interview for Mental Status) score of "04" (0-7=severe cognitive impairment), was totally dependent on 2 or more staff members for transfers, and had one fall since the previous assessment (12/6/12).</p> <p>The March, 2013 physician order recap (recapitulation) sheet included the following orders:</p> <p>5/5/11--Dycem in wheelchair to prevent sliding off seat of chair. 4/26/12--Stand-up lift for all transfers. 12/6/12--Discontinue bed and chair alarms. 12/7/12--Resident to have chair alarm while up in wheelchair. 12/17/12--Resident to have chair alarm while up in wheelchair. Check for placement every shift. 2/25/13--Pressure pad alarm to bed-check placement and function every shift.</p>		<p>interventions were verified to be in place. Interventions requiring placement and function checks have been reviewed to ensure placement on the TAR for documentation of these checks by the staff.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Nursing staff have been re-education on the expectation to ensure fall interventions are in place and placement and function checks are documented.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</b> DON or designee will monitor that the fall interventions are in place for residents with a high risk for falls and documented. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly.</p> <p><b>Date to be completed</b> 4/23/2013</p>	

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	<p>Physician progress notes included the following information: 12/17/12--"Fell on 12/16/12. No injury. Out of (bed) W/C [wheelchair] apparently attempting to get in bed...." 2/26/13--"Fall no injury noted- -pressure alarm pad bed...."</p> <p>The "IDT (Interdisciplinary Team) Post-Occurrence Assessment and Plan Review" notes included the following: 12/17/12--"Fall on 12/16/12 at 11:55 A.M. FOF [found on floor] right side. Attempted to transfer self from W/C to bed. Alarm placed in W/C. Last fall 9/5/12...." 2/24/13--"Fall on 2/23/13 [no time]. Heard alarm sounding from room. Entered to find res. [resident] on floor between chair and bed, laying on right side without injuries.</p> <p>A "Fall Risk Care Plan" entry, dated 2/23/13, addressed a problem of "At risk for falls and injuries related to CVA with right hemiparesis." The "Interventions" were listed as: "Provide adequate lighting; observe for side effects of meds; keep call light within reach, keep environment clutter free; pressure sensor pad [alarm] in bed and wheelchair; mattress with bolsters; resident is not to be in room while up in chair related</p>			

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	<p>to attempts to get into bed himself."</p> <p>On 3/25/13 at 11:23 A.M., the resident was observed to be up in a high-back wheelchair, propelling himself in hallway from his room to the Nurses Station. A cord for pad alarm was observed at the rear of the wheelchair, hanging down behind the seat, but it was not plugged into any alarm unit. No alarm unit was seen on chair.</p> <p>At 11:40 A.M., CNA #1 pushed the resident to his room door. The resident indicated he wanted to lay down, but the CNA told him it was almost lunch time, and she promised to assist him to bed after he ate. Resident #84 indicated he did not want his room door closed after the CNA brought his roommate out of the room. The resident was then observed to propel himself into the room. The CNA asked him "You won't try to get in bed by yourself if I leave the door open, will you?" Resident responded that he would not try to get in bed by himself.</p> <p>At 11:45 A.M., the resident was observed to be sitting by himself in his room. The alarm cord was not attached to an alarm unit.</p>			

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	<p>At 1:08 P.M., the resident was observed in his wheelchair in the hallway. He propelled himself into his room. The alarm cord was not attached to alarm unit. CNA #1 was observed to walk by, pushing another resident down hall to his room.</p> <p>On 3/25/13 at 1:20 P.M., CNA #1 and CNA 2 were observed while transferring the resident into bed. A "Hoyer" brand mechanical lift with a full body sling was used to transfer the resident to his bed. The alarm did not sound as resident was lifted from the wheelchair seat. An alarm unit was observed on floor beside bed--it was connected to a cord, and pressure pad was on the bed. CNA #2 was requested to check to see if the bed alarm was on--she checked and said she thought it needed a battery--"It's underneath him, anyway." The wheelchair had a cushion, but there was no Dycem either under or over the cushion.</p> <p>On 3/26/13 at 9:21 A.M., the resident was observed in his wheelchair in the small lounge area. The cord to alarm pad not connected to an alarm unit. There was no alarm unit on the wheelchair.</p> <p>At 10:20 A.M., CNA #3 and LPN #4</p>			

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	<p>were observed to transfer the resident into bed. CNA #3 brought the Hoyer lift into room to use to put the resident into bed.</p> <p>At 12:41 P.M., CNA #3 was observed to bring the resident to small lounge/dining room. The pressure pad alarm cord was not connected to an alarm unit. There was no alarm unit on the wheelchair.</p> <p>At 1:01 P.M., the resident was observed wheeling himself into his room after lunch.</p> <p>At 1:38 P.M., he was observed to continue sitting in his room next to his bed.</p> <p>At 1:43 P.M., the resident was observed to be in his wheelchair next to his bed. After making a motion to come in, the resident pointed to his bed, indicating he wanted to lay down. The call light and cord was laying on floor behind him.</p> <p>At 1:59 P.M., the resident was observed laying in bed. There was a cushion in wheelchair, with the pressure sensor alarm pad on top. There was no Dycem in chair, either under of over the cushion.</p>			

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	<p>In an interview on 3/26/13 at 1:57 P.M., LPN #4 indicated documentation of alarm checks were in TAR (Treatment Administration Record).</p> <p>The January, 2013 TAR for Resident #83 listed orders for "Dycem in wheelchair," "Resident to have chair alarm while up in wheelchair," and "Stand up lift for all transfers." Boxes for the Dycem and stand-up lift were initialed, indicating the action was done, for almost all days and shifts. The boxes for the "alarm in wheelchair" were blank. There was no listing for checking placement and function of the alarm.</p> <p>The February, 2013 TAR listed the orders for the Dycem, stand-up lift, chair alarm, and bed pressure pad check for placement and function. The boxes for the Dycem and stand-up lift were initialed, indicating the action was done, for almost all days and shifts. Boxes for the "alarm in chair" were only initialed on 17 days--14 of which were for the night (11 P.M. to 7 A.M.) shift, 1 time for the day (7 A.M. to 3 P.M.) shift, and 2 times for the evening (3 P.M. to 11 P.M.) shift. Boxes for the "pressure pad alarm bed check for placement and function" were only initialed twice,</p>						

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	<p>both on the night shift.</p> <p>The March, 2013 TAR listed orders for the Dycem, stand-up lift, and alarm in chair--"Check every shift." Boxes for the Dycem, stand-up lift, and chair alarm were initialed, indicating the action was done, for almost all days and shifts. The boxes for the Dycem were initialed on 3/25 for all shifts, and 3/26 for the night shift. The stand-up lift was initialed for all three shifts on 3/25. The chair alarm with checks was initialed on the night and day shifts for 3/25.</p> <p>In an interview on 3/26/13 at 2:00 P.M., CNA #7 indicated the Nurse Aide assignment/communication sheets, the "Resident Care Card," were located in a binder at Nurses Station. The aides were to check the sheets for the people they were assigned to at the start of their shift. Any special needs (such as alarms) would be listed on the sheet.</p> <p>A January, 2013 "Resident Assist Care Card" for Resident #84 was blank for any special care instructions, such as an alarm, dycem, or type of lift.</p> <p>The March, 2013 "Resident Assist Care Card" indicated a "Hoyer" brand</p>						

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	<p>mechanical lift was to be used, as well as a "Pressure sensitive" alarm. The sheet had areas to indicated if the alarm was to be used in the bed, the chair, or both. This area was blank.</p> <p>3.1-45(a)(2)</p>			

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to maintain cleanliness in the main ice machine in the kitchen area. This had the potential to affect 83 of 86 residents who may receive ice from the ice machine.</p> <p>Findings include:</p> <p>During the initial tour in the kitchen on 3/20/13 at 9:30 a.m., the ice machine was observed to to have a white flaky substance inside on right side of machine.</p> <p>The Dietary Supervisor indicated in an interview on 3/20/13 at 9:39 a.m., that they do not clean the machine, that the maintenance department cleans the ice machine. A request was made at this time for any information regarding cleaning of the machine.</p> <p>As of the exit conference on 3/27/13 at 4:15 p.m., no information had been</p>	F000371	<p>It is the practice of Pyramid Point to store, prepare, distribute and serve food under sanitary conditions.</p> <p><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> The ice machine was cleaned on 3/21/13.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> All other ice machines were inspected and cleaned as necessary.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Maintenance Director and dietary staff have been re-educated on the expectation for ensuring the ice machine is cleaned per the cleaning schedule.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not</b></p>	04/23/2013			

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	provided about the cleaning of the ice machine.  3.1-21(a)(3)		<b>reoccur?</b> ED or designee will monitor that the ice machines are clean. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. <b>Date to be completed</b> 4/23/2013		

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> 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>Based on observation, interview, and record review, the facility failed to</p>	F000441	It is the practice of Pyramid Point to establish and maintain an	04/23/2013			

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	<p>maintain good sanitation practices when handwashing and sanitizing scissors for 1 of 1 observations made during wound care for Resident #30.</p> <p>Findings include:</p> <p>In an observation on 3/26/13 at 3:15 p.m. LPN #9, the wound treatment and infection control nurse, did wound treatment for Resident #30.</p> <p>LPN #9 gathered all of her wound care treatment supplies and set paper towels down on Resident #30's bedside table.</p> <p>She then went to wash her hands. She washed hands for 5 seconds, then dried them and put on gloves.</p> <p>She then cleaned the wound with wound cleanser and place a sterile swab into the wound to ensure there was no packing left inside of the wound. She then took off gloves and washed hands for 5 seconds. She placed new gloves on and then proceeded to pull her scissors out of her smock pocket and cut the silver alginate packing with her scissors and used another sterile swab to pack inside of the wound. She finished the wound treatment and then pushed the sheet underneath of the residents left</p>		<p>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><b>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</b> Resident #30 had her dressing changed using appropriate infection control procedures.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</b> Residents with wounds have the potential to be affected. Dressing changes will be completed per the policy for clean dressing changes including hand hygiene using the appropriate method at the appropriate times.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</b> Licensed nursing staff have been re-educated on infection control procedures for a clean dressing change including the appropriate method of cleansing hands and instruments.</p> <p><b>How the corrective action will be monitored to ensure the deficient practice does not</b></p>		

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	<p>leg. Resident #30's Foley catheter had leaked and urine had soaked the sheet. She indicated to Resident #30 she would come back shortly to change her sheets.</p> <p>LPN #9 after she had touched the wet sheet with her gloves grabbed her scissors. The scissors were exposed to the urine soaked gloves. She set the scissors down on the counter in the resident's bathroom while she washed her hands. She washed her hands for six seconds. She then dried her hands and then picked the scissors and set them down on top of the wound treatment cart. She then cleaned off the scissors with Steri-wipe for 1 minute. She then took the scissors and placed them back into the treatment cart. She indicated the scissors are only for use for the wound treatment cart.</p> <p>In an interview with LPN #9 she indicated she was not aware of how long to wash the scissors for. She indicated she uses the sanitation wipes used for glucometers.</p> <p>The Steri-wipe instructions indicated, "... to use wipe to thoroughly wipe surface. Treated surface must remain visibly wet for a full two minutes... Area must air dry for at least 5</p>		<p><b>reoccur?</b> DON or designee will monitor that clean dressing changes are completed using infection control procedure including hand hygiene and cleansing of instruments. This will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. <b>Date to be completed</b> 4/23/2013</p>		

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	<p>minutes..."</p> <p>LPN # 9 indicated in an interview on 3/26/13 at 3:45 p.m., that handwashing after touching surfaces with urine with gloves on she was uncertain in the amount of time expected to wash hands. She asked if it was an amount of minutes and wasn't sure what the company policies were for handwashing. She thought it might be 2 1/2 minutes.</p> <p>3.1-18(a) 3.1-18(l)</p>				