

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/28/2013
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NAME OF PROVIDER OR SUPPLIER OAK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN 47561
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F000000	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: October 22, 23, 24, 25, and 28, 2013.</p> <p>Facility number: 000517 Provider number: 155714 AIM number: 100266770</p> <p>Survey team: Terri Walters RN TC Dorothy Watts RN</p> <p>10/22/13,10/25/13,10/28/13 Amy Winger RN</p> <p>10/22/13,10/23/13,10/28/13 Sylvia Martin RN</p> <p>Census bed type: SNF/NF: 24 Total: 24</p> <p>Census payor type: Medicare: 1 Medicaid: 15 Other: 8 Total: 24</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 11/4/13 by Jodi Meyer, RN</p>	F000000		

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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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident was free from physical and verbal abuse from an employee for 1 of 2 allegations of abuse reported to the state agency. Resident #9.</p> <p>Findings include:</p> <p>A facility initial report dated 9/17/13, had been sent to the State Department of Health. The report indicated an incident had occurred on 9/16/13 at 9:50 P.M.</p> <p>"Brief Description of Incident: At approximately 9:50 P.M., it was reported to (nurses name) Charge nurse #1 by (CNA's name) CNA #1 that while she and (CNA's name) CNA #2 were toileting (resident name) Resident #9, began to holler out and CNA #2 hit Resident #9 on the back of the head and told her to 'shut up and quit yelling'. An</p>	F000223	<p>I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013. F - 223 The corrective action taken for those residents found to be affected by the deficient practice is that the staff member identified as CNA #2 was terminated based on the outcome of the investigation into the allegation of abuse. In addition the CNA identified as #1 has received a written counseling regarding the facility policy on reporting any allegation of abuse immediately to the Administrator. The corrective action taken for</p>	11/27/2013	

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	<p>investigation has been opened on this alleged incident."</p> <p>"Results of Investigation: After investigation was completed it the alleged abuse was validated and employee was terminated for elder abuse..."</p> <p>On 10/24/13 at 2:15 P.M., the Administrator and the Director of Nursing (DON) were interviewed regarding the 9/16/13 allegation of abuse. They were made aware CNA #1 had not reported the allegation of abuse which had occurred between 5 - 6 P.M., until 9:50 P.M.</p> <p>On 10/24/13 at 2:15 P.M., during interview with the Director of Nursing (DON), she indicated CNA # 2 had been terminated for abuse and had not been back in facility since 9/16/13 when the abuse had occurred.</p> <p>3.1-27(a) 3.1-27(b)</p>		<p>the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. Social Services Director interviewed all interviewable residents following the allegation of abuse to ensure that no other resident had been physically or verbally abused by the staff. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has reviewed and revised the abuse policy and procedure. The policy now states that all allegations of abuse are to be immediately reported to the Administrator. A mandatory in-service was provided for all facility staff on the revised policy and procedure on abuse. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that the Social Services Director and/or designee will conduct resident interviews to ensure that all residents are free from physical and verbal abuse. These interviews will be conducted weekly for four weeks, then monthly for three months and then quarterly for three quarters. Any allegations of abuse will immediately be brought to the attention of the Administrator and appropriate action taken in accordance with the facility policy and procedure.</p>		

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	I would like to request a desk	11/27/2013			

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	<p>review, the facility failed to ensure a staff member immediately reported an allegation of abuse and/ or the facility immediately reported an allegation of abuse to the state agency for 1 of 2 facility reported allegations of abuse reviewed. This allegation involved Resident #9.</p> <p>Findings include:</p> <p>A nursing note dated 9/16/13 at 11:15 P.M., late entry indicated, " It was reported that approx (approximately) sometime between 5 pm and 6 pm an employee was witnessed smacking the resident in the back of the head. I immediately did a head to toe assessment and found 0 (zero) injuries. I reported to the administration and at that time the employee was no longer in the building. Dr. and family also notified."</p> <p>A facility initial report dated 9/17/13, had been sent to the State Department of Health. The report indicated an incident had occurred on 9/16/13 at 9:50 P.M.</p> <p>"Brief Description of Incident: At approximately 9:50 P.M., it was reported to (nurses name) Charge nurse #1 by (CNA's name) CNA #1 that while she and (CNA's name) CNA #2 were toileting (resident</p>		<p>review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013.F – 225 The corrective action taken for those residents found to be affected by the deficient practice is that the staff member identified as CNA #1 has received a written counseling on reporting any allegations of abuse immediately to the Administrator.</p> <p>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. The facility has reviewed and revised the policy and procedure on abuse. The policy now includes the instructions to report all allegations of abuse immediately to the Administrator. In addition the new Administrator is knowledgeable in the regulations involving immediately reporting any allegation of abuse to the appropriate State agencies. The measures or systematic</p>				

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	<p>name) Resident #9, began to holler out and CNA #2 hit Resident #9 on the back of the head and told her to 'shut up and quit yelling'. ..."</p> <p>On 10/24/13 at 2:15 P.M., the Administrator and the Director of Nursing (DON) were interviewed regarding the 9/16/13 allegation of abuse. They were made aware CNA #1 had not reported the allegation of abuse which had occurred between 5 - 6 P.M., until 9:50 P.M. The DON indicated she had counseled CNA #1 regarding reporting any allegation of abuse immediately. The facility was also made aware the state agency needed to be notified immediately of any allegation of abuse.</p> <p>The facility policy entitled "Oak Village, Inc. Resident Abuse Policy and Procedure (no date)" was received and reviewed on 10/22/13. The policy included, but was not limited to: "...Procedure of Investigation of allegations of Abuse: 2. Staff members of this facility who have concerns regarding abuse, neglect, involuntary seclusion, or misappropriation of property are to report their concerns immediately to the charge nurse..."</p> <p>3.1-28(c)</p>		<p>changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all facility staff on the revised policy and procedure on abuse with special focus on reporting any allegation of abuse immediately to the Administrator who then will in turn immediately report the allegation to the appropriate State agencies. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is all allegations of abuse will be reviewed by the Interdisciplinary Team weekly to ensure that the facility has followed their policy and procedure in the timely reporting of allegations of abuse to the appropriate agencies. The Administrator will be responsible for ensuring that this Quality Assurance review is being completed by the interdisciplinary team weekly for four weeks, then monthly for three months and then quarterly for three quarters.</p>		

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the facility abuse policy had been implemented in regard to the immediate notification of the charge nurse by a CNA in regard to an allegation of abuse. The facility abuse policy also failed to include the immediate notification of the administrator and the state agency for an allegation of abuse in 1 of 2 facility reported allegations reviewed.</p> <p>Resident #9</p> <p>Findings include:</p> <p>A nursing note dated 9/16/13 at 11:15 P.M., late entry indicated, " It was reported that approx (approximately) sometime between 5 pm and 6 pm an employee was witnessed smacking the resident in the back of the head. I immediately did a head to toe assessment and found 0 (zero) injuries. I reported to the administration and at that time the employee was no longer in the building. Dr. and family also notified."</p>	F000226	<p>I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013. F – 226 The corrective action taken for those residents found to be affected by the deficient practice is that the staff member identified as CNA #1 has received a written counseling on reporting any allegations of abuse immediately to the Administrator.</p> <p>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. The facility has reviewed and revised the policy and procedure on abuse. The policy now includes the instructions to report</p>	11/27/2013

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	<p>A facility initial report dated 9/17/13, had been sent to the State Department of Health. The report indicated an incident had occurred on 9/16/13 at 9:50 P.M.</p> <p>"Brief Description of Incident: At approximately 9:50 P.M., it was reported to (nurses name) Charge nurse #1 by (CNA's name) CNA #1 that while she and (CNA's name) CNA #2 were toileting (resident name) Resident #9, began to holler out and CNA #2 hit Resident #9 on the back of the head and told her to 'shut up and quit yelling'. ..."</p> <p>On 10/24/13 at 2:15 P.M., the Administrator and the Director of Nursing (DON) were interviewed regarding the 9/16/13, allegation of abuse. The Administrator and the DON were made aware CNA #1 had not reported the allegation of abuse which had occurred between 5 - 6 P.M., until 9:50 P.M. The DON indicated she had counseled CNA #1 regarding reporting any allegation of abuse immediately. The facility was also made aware the Administrator needed to be notified immediately of an allegation of abuse and that their policy lacked that information. The facility was also made aware their policy lacked documentation</p>		<p>all allegations of abuse immediately to the Administrator. In addition the new Administrator is knowledgeable in the regulations involving immediately reporting any allegation of abuse to the appropriate State agencies. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all facility staff on the revised policy and procedure on abuse with special focus on reporting any allegation of abuse immediately to the Administrator who then will in turn immediately report the allegation to the appropriate State agencies. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is all allegations of abuse will be reviewed by the Interdisciplinary Team weekly to ensure that the facility has followed their policy and procedure in the timely reporting of allegations of abuse to the appropriate agencies. The Administrator will be responsible for ensuring that this Quality Assurance review is being completed by the interdisciplinary team weekly for four weeks, then monthly for three months and then quarterly for three quarters.</p>		

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	<p>indicating immediate notification of the state agency and included only a time period of 3 to 5 days indicating when the investigation would be completed. The Administrator indicated at that time the facility would be updating their abuse policy.</p> <p>The facility policy entitled "Oak Village, Inc. Resident Abuse Policy and Procedure (no date)" was received and reviewed on 10/22/13. The policy included, but was not limited to: "...Procedure of Investigation of allegations of Abuse: ...2. Staff members of this facility who have concerns regarding abuse, neglect, involuntary seclusion, or misappropriation of property are to report their concerns immediately to the charge nurse. 3. The charge nurse will fill out an incident report and all staff with any knowledge regarding the incident will be asked to write a statement as to what you saw, heard or found. From this point on, the content of the investigation must not be discussed with anyone other than those who are investigating the incident. 4. The charge nurse will assess the resident, chart the facts in the resident chart and notify the family and physician. The charge nurse will also notify the Director of Nursing, Social Services and/or the</p>			

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	<p>Administrator..."...9. The investigation will be completed in 3-5 days. A follow up report will be sent if necessary to appropriate agencies..."</p> <p>3.1-28(a)</p>			

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F000240 SS=E	<p>483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.</p> <p>Based on observation and interview, the facility failed to ensure comfortable sound levels related to residents yelling loudly in 1 of the 2 halls of the facility during 4 of 5 survey days. Resident #9, Resident #1, Resident #200, Resident #201, Resident #202 , Resident #203</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 10/23/13 at 10:55 A.M., a resident was heard yelling loudly at the end of the long hall near the nurses' station. The yelling was heard from a distance of proximately 80 feet at the other end of the long hall of the facility in a resident room with the door shut. 2. On 10/23/13 at 3:00 P.M., loud yelling (grunting) was heard from Resident #1 who was observed in his room on the long hall of the facility. 3. On 10/24/13 at 11:15 A.M., Resident #9 was up in a chair in her room (near the nurses ' station on the long hall) yelling loudly at 	F000240	I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013. F – 240 The corrective action taken for those residents found to be affected by the deficient practice is that the residents identified as resident #9 and #1 have been reviewed by their respective psychiatrist/psychologist to review their behaviors and review their medication regimen to ensure their treatment plan is still appropriate to meet the residents' current needs. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this deficient practice. A house wide	11/27/2013			

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	<p>intervals. The yelling could be heard on the other end of the long hall in a resident room with the door closed approximately 80 feet away. The yelling continued again at 11:57A.M., 12:00 noon, 12:02 P.M., and at 2:30 P.M.</p> <p>4. On 10/25/13 at 8:45 A.M., Resident #9 was observed up in her chair in her room, yelling out loudly at intervals.</p> <p>On 10/25/13 at 8:53 A.M., 10:39 A.M., 10:44 A.M., and 11:02 A.M., Resident #9 was observed in her room screaming loudly at intervals.</p> <p>5. On 10/25/13 at 11:08A.M., Resident #9 was in her room and yelled out loudly 10 times at that time. Resident #202 and Res #203 were sitting in chairs across from the nurses ' station. Resident #9's room was on the long hall of the facility the closest room on one side of the hall next to the nurses ' station. Yelling continued and Resident # 202 said to Resident # 203 " Horrible noise" referring to Resident #9's screaming. Resident #203 indicated, " It's (Resident #9's first name)."</p> <p>6. On 10/23/13 at 9:03 A.M., Resident #200 was interviewed</p>		<p>review of all residents has been conducted to determine if there are any other residents who display this type of behavior. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the care plans of those residents who display this type of behavior have been reviewed and up-dated to include additional interventions in an attempt to address this behavior. A mandatory all staff meeting has been conducted to educate the staff on intervening promptly when these behaviors occur. The in-service also included a review of appropriate interventions that can be utilized to address this behavior. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that the residents ' environment is comfortable and that the sound levels are conducive to pleasant living arrangements. This tool will be completed by the Social Service Director weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility quarterly Quality Assurance meeting to determine if additional action is warranted.</p>				

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	<p>confidentially. Resident #200 indicated Resident #9 yells at times. She indicated sometimes you can hear the yelling at the end of the hall. Resident #200 indicated Resident #9 doesn't say anything just hollers. Resident #200 indicated Resident #9 had been sent to a hospital and returned to the facility and was quiet for about a week and then started yelling.</p> <p>7. On 10/25/13 at 10:00 A.M., Resident #201 was interviewed confidentially. Resident #201 indicated, "Everyone has complained about Resident #9 yelling. It's a very unpleasant situation." Resident #201 said," sometimes I close my door and turn my TV on and I can still hear her yelling."</p> <p>8. On 10/28/13 at 9:32 A.M., the Director of Nursing (DON) indicated Resident #9 had been sent to the Emergency Room last night and then had returned to the facility. She indicated Resident #9 returned to the facility upset and had remained upset. She indicated Resident #9's screaming had continued all thru the night last night.</p> <p>On 10/28/13 at 11:30 A.M., Resident #9 continued to scream loudly from</p>				

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	<p>her room. On 10/28/13 at 11:43 A.M., Resident #9's yelling was heard and continued throughout the long hall of the facility.</p> <p>On 10/28/13 at 12:20 P.M., the Administrator and the DON were made aware of the noise problem in regard to yelling by residents heard frequently thru out the facility. The DON indicated at that time the facility knew that the yelling was a problem. The DON indicated the facility had tried several different interventions with Resident #9 and would continue to address the yelling.</p> <p>3.1-32(a)</p>				

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the care plan was revised to include pressure relieving interventions for a resident who experienced an unstageable pressure wound to the left foot for 1 of 1 residents reviewed for pressure in the Stage 2 sample of 19. (Resident #21)</p> <p>Findings include:</p> <p>Resident #21 was observed on 10/22/13 at 10:00 A.M., lying in a reclining chair on her left side with the left foot encased in a podus boot (a</p>	F000280	I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013.F – 280 The corrective action taken for those residents found to be affected by the	11/27/2013	

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	<p>device to relieve pressure to the heels). The left side of the podus boot was observed, at that time, to be in direct contact to the surface of the reclining chair.</p> <p>Resident #21 was observed on 10/23/13 at 12:30 P.M., lying in a reclining chair on her left side with the left foot encased in a podus boot. The left side of the podus boot was observed, at that time, to be in direct contact to the surface of the reclining chair.</p> <p>Resident #21 was observed on 10/23/13 at 1:15 P.M., in a bed with a podus boot on the left lower leg. The left side of the podus boot was observed to be in direct contact to the surface of the bed.</p> <p>The clinical record of Resident #21 was reviewed on 10/23/13 at 2:00 P.M., The record indicated Resident #21 was admitted on 07/06/09. The record further indicated the diagnoses of Resident #21 included, but were not limited to, Peripheral Vascular Disease and Alzheimer's.</p> <p>A Braden Scale Assessment (a tool to determine a resident's risk of developing areas of pressure) dated 04/10/13 indicated Resident #21 was</p>		<p>deficient practice is that the resident identified as resident #21 has had her care plan reviewed and revised. Upon recommendation of the wound nurse the multi-podus boot was discontinued and an order to float heels at all time was received. The care plan has been up-dated to reflect the intervention of floating heels at all times. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been completed to identify all residents at high skin risk. Those residents identified at high skin risk have had their care plans reviewed and up-dated to include all appropriate interventions to aide in the prevention of or healing of pressure wounds. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on appropriate interventions in the plan of care for residents at risk of the development of or treatment of pressure wounds. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that residents identified at high skin risk have appropriate</p>		

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	<p>a high risk to develop pressure.</p> <p>A Braden Scale Assessment dated 08/19/13 indicated Resident #21 was a high risk to develop pressure.</p> <p>A Wound Care Nurse Progress Note dated 09/19/13 indicated, "High risk for skin breakdown. Has Stage 3 OA [open area] It [left] outer foot. Podus boot with foam on at all times...Turned et [and] repositioned q [every] 2 hrs [hours]..."</p> <p>A Wound Log dated 10/18/13 indicated Resident #21 experienced a facility acquired unstageable wound to left outer foot on 06/24/13. The log further indicated the interventions included, but were not limited to, "...positioning pillows, turning/positioning program..."</p> <p>The Wound Care Consultant notes dated 09/06/13 for the wound on the left outer foot indicated, "...Daily dressing change needed due to dressing becoming dislodged/compromised at site due to sheer [sic] and friction...Evaluation Comments...pressure relief to area."</p> <p>The Wound Care Consultant notes dated 10/01/13 for the wound on the left outer foot indicated, "...Daily</p>		<p>care plans in place to aide in the prevention and/or treatment of pressure wounds. The tool will also include observation of the interventions to ensure that the plan of care is being followed. This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility quarterly Quality Assurance meeting to determine if any additional action is warranted.</p>		

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	<p>dressing change needed due to dressing becoming dislodged/compromised at site due to sheer [sic] and friction...Evaluation Comments...pressure relief to area."</p> <p>A Care Plan dated 06/24/13 and updated on 09/11/13 for Unstageable Area on Left outer foot included, but was not limited to, interventions of "Provide measures to decrease pressure...to skin: Pressure reducing mattress...". The care plan lacked any revision related to providing pressure relief to the left outer foot.</p> <p>Resident #21 was observed on 10/28/13 at 11:13 A.M., lying in bed on her left side with the left foot encased in a podus boot. The left side of the podus boot was observed, at that time, to be in direct contact with the surface of the bed.</p> <p>During an interview on 10/28/13 at 11:15 A.M., CNA #3 indicated the left foot of Resident #21 had not been floated for pressure relief because he had not been instructed to float the left foot.</p> <p>During an interview on 10/28/13 at 3:00 P.M., the DON (Director of Nursing) indicated the care plan had not been revised to included pressure</p>				

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	<p>relief to the left outer foot.</p> <p>The policy and procedure for Decubitus Ulcer-Prevention provided by the DoN on 10/28/13 at 2:30 P.M., indicated "... B. Moderate risk...Positioning...e. Use pillows, ...under...bony prominences..."</p> <p>3.1-35(d)(2)(B)</p>			

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</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 ensure care was provided to a resident who was admitted to the facility without a pressure wound, for a resident who was assessed as high risk for development of a pressure wound, in that it resulted in the resident developing an unstageable pressure wound to the left outer foot for 1 of 1 residents who met the criteria for review of pressure. (Resident #21)</p> <p>Findings include:</p> <p>Resident #21 was observed on 10/22/13 at 10:00 A.M., lying in a reclining chair on her left side with the left foot encased in a podus boot (a device to relieve pressure to the heels). The left side of the podus</p>	F000314	I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013.F – 314 The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as #21has been reviewed as it relates to the plan of care of her pressure wound. Upon recommendation of the wound nurse the care plan has been up-dated to reflect the discontinuance of the podus boot	11/22/2013			

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	<p>boot was observed, at that time, to be in direct contact to the surface of the reclining chair.</p> <p>Resident #21 was observed on 10/23/13 at 12:30 P.M., lying in a reclining chair on her left side with the left foot encased in a podus boot. The left side of the podus boot was observed, at that time, to be in direct contact to the surface of the reclining chair.</p> <p>Resident #21 was observed on 10/23/13 at 1:15 P.M., in a bed with a podus boot on the left lower leg. The left side of the podus boot was observed to be in direct contact to the surface of the bed. During an interview, at that time, LPN #2 indicated Resident #21 had experienced a Stage 3 (A full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue) wound to the left outer foot that measured approximately 1.5 cm (centimeters) X 1.5 cm. The wound bed was then observed to have necrotic tissue and minimal serous drainage.</p> <p>The clinical record of Resident #21 was reviewed on 10/23/13 at 2:00 P.M. The record indicated Resident</p>		<p>and the intervention to float heels at all times has been added to the plan of care. The nursing staff has been in-serviced on the change in the plan of care. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit has been completed to identify all residents at high skin risk. Those residents identified at high skin risk have had their care plans reviewed and up-dated to include all appropriate interventions to aide in the prevention of or healing of pressure wounds. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all nursing staff on the facility policies and procedures for the prevention of and treatment of pressure wounds. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure that residents identified at high skin risk have appropriate care plans in place to aide in the prevention and/or treatment of pressure wounds. The tool will also include observation of the interventions to ensure that the plan of care is being followed.</p>		

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	<p>#21 was admitted on 07/06/09. The record further indicated the diagnoses of Resident #21 included, but was not limited to, Peripheral Vascular Disease and Alzheimer's.</p> <p>The most recent quarterly MDS (Minimum Data Set Assessment) dated 09/11/13 indicated Resident #21 experienced moderate cognitive impairment. The Assessment further indicated Resident #21 required total staff assistance of two for bed mobility and had a Stage 3 pressure wound.</p> <p>A Braden Scale Assessment (a tool to determine a resident's risk of developing areas of pressure) dated 04/10/13 indicated Resident #21 was a high risk to develop pressure.</p> <p>A Braden Scale Assessment dated 08/19/13 indicated Resident #21 was a high risk to develop pressure.</p> <p>A Wound Care Nurse Progress Note dated 09/19/13 indicated, "High risk for skin breakdown. Has Stage 3 OA [open area] It [left] outer foot. Podus boot with foam on at all times...Turned et [and] repositioned q [every] 2 hrs [hours]..."</p> <p>The most recent Physician's Order</p>		<p>This tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility quarterly Quality Assurance meeting to determine if any additional action is warranted.</p>		

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	<p>Recap dated 10/01/13 included, but was not limited to, an order for, "...make sure pillow between legs and feet in bed to keep from rubbing rt [right] foot on podus boot..."</p> <p>A Wound Log dated 10/18/13 indicated Resident #21 experienced a facility acquired unstageable wound to left outer foot on 06/24/13. The log further indicated the interventions included, but were not limited to, "...positioning pillows, turning/positioning program..."</p> <p>The Wound Care Consultant notes dated 09/06/13 for the wound on the left outer foot indicated, "...Daily dressing change needed due to dressing becoming dislodged/compromised at site due to sheer [sic] and friction...Evaluation Comments...pressure relief to area."</p> <p>The Wound Care Consultant (WCC) notes dated 10/01/13 for the wound on the left outer foot indicated, "...Daily dressing change needed due to dressing becoming dislodged/compromised at site due to sheer [sic] and friction...Evaluation Comments...pressure relief to area."</p> <p>A Care Plan dated 06/24/13 and updated on 09/11/13 for Unstageable</p>			

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	<p>Area on Left outer foot included, but was not limited to, interventions of "Provide measures to decrease pressure...to skin: Pressure reducing mattress...". The care plan lacked any revision related to providing pressure relief to the left outer foot.</p> <p>During an interview on 10/23/13 at 2:40 P.M., the LPN #1 indicated the left foot of Resident #21 should have been floated to provide pressure relief.</p> <p>During an interview on 10/23/13 at 2:47 P.M., the DON indicated complete pressure relief should have been provided to the left outer foot of Resident #21.</p> <p>Resident #21 was observed on 10/28/13 at 11:13 A.M., lying in bed on her left side with the left foot encased in a podus boot. The left side of the podus boot was observed, at that time, to be in direct contact with the surface of the bed.</p> <p>During an interview on 10/28/13 at 11:15 A.M., CNA #3 indicated the left foot of Resident #21 had not been floated for pressure relief because he had not been instructed to float the left foot.</p>						

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	<p>During an interview on 10/28/13 at 11:19 A.M., the WCC #1 indicated the left foot of Resident #21 should be floated to promote healing. WCC #1 further stated, at that time, "...The best intervention for pressure [wounds] is to relieve the pressure...There should be something placed between the left lower leg and the surface of the bed or chair, so the left foot is floated..." The WCC #1 then indicated Resident #21 had been discovered in June 2013 and had been facility acquired.</p> <p>During an interview on 10/28/13 at 3:00 P.M., the DON (Director of Nursing) indicated the care plan had not been revised to included pressure relief to the left outer foot.</p> <p>The policy and procedure for Decubitus Ulcer-Prevention provided by the DoN on 10/28/13 at 2:30 P.M., indicated "... B. Moderate risk...Positioning...e. Use pillows, ...under...bony prominences..."</p> <p>3.1-40 (a)(1)</p>				

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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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/28/2013	
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F000371 SS=F	<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, interview, and record review, the facility failed to ensure open food bags were covered and/or sealed in the freezer, food stored in the refrigerator was discarded within 3 days, food stored in the refrigerator was labeled and dated. Those observations were made during 1 of 2 kitchen observations. Those conditions had the potential to affect 24 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>During the initial observation tour on 10/22/13 at 10:01 A.M. with the Dietary Manager present, the following observations were made:</p> <ol style="list-style-type: none"> One opened plastic container of Chocolate icing with the date 10/2/13 documented on the side of the container. One plastic container of Bar-b-q 	F000371	I would like to request a desk review. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective November, 27, 2013 to the state findings of the annual survey conducted on October 22, 23, 24, 25 and 28, 2013.F – 371 The corrective action taken for those residents found to be affected by the deficient practice is that no specific residents were identified during the survey however all residents have the potential to be affected by this deficient practice. The facility has conducted an audit of all food storage areas. All items are properly stored in tightly closed containers and are properly labeled and dated. The corrective action taken for the other residents having the potential to be affected by the	11/27/2013			

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	<p>sauce with the date 8/27/13 documented on the lid of the container.</p> <p>3. One large opened bag of lettuce that was dated 10/18/13.</p> <p>4. One quart Ziploc baggie with sliced ham located in the reach-in refrigerator was dated 10/17/13.</p> <p>5. One plastic container with Butterscotch pudding. The documented date on the lid indicated it was opened 10/18/13.</p> <p>6. One salad with cheese located in the reach in refrigerator. No date documented on the shrink wrap covering the salad bowl.</p> <p>7. Four cups of applesauce located in the reach in refrigerator. No dates documented on the shrink wrap.</p> <p>8. One open package of eight frozen country fried steaks located on the 2nd shelf of the walk in freezer. The package was opened to air.</p> <p>The facility's policy and procedure "Kitchen Policies" was reviewed on 10/25/13 at 1:01 P.M. The policy and procedure read as follows: "All leftover food should be destroyed</p>		<p>same deficient practice is that all residents have the potential to be affected by this deficient practice. The facility has conducted an audit of all food storage areas. All items are properly stored in tightly closed containers and are properly labeled and dated. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service was provided for all dietary staff on the facility food storage policies and procedures. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the proper storage of food per facility policy. This tool will be completed by the Food Service Director and/or her designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcomes will be reviewed at the facility quarterly Quality Assurance meeting to determine if any additional action is warranted.</p>		

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	<p>after 72 hours." "Put all leftovers in tightly enclosed containers, with date and label."</p> <p>During an interview with the Dietary Manager (DM) on 10/22/13 at 10:01 A.M., the DM indicated the facility's policy was to disposed of all food after it was 72 hours old. The DM further indicated, at that time, foods should be labeled, dated, covered after it has been opened.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				