

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2013
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F0000	<p>This visit was for the Investigation of Complaints IN00122927 and IN00123428.</p> <p>Complaint IN00122927 - Substantiated. Federal/State deficiencies related to the allegation are cited at F157, F226, F282, F312.</p> <p>Complaint IN00123428 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: February 3, and 5, 2013</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 28 SNF/NF: 108 Total: 136</p> <p>Census Payor Type: Medicare: 27 Medicaid: 89</p>	F0000	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 that the 2567 plan of correction be considered as the letter of credible allegation and request a desk review on or after March 4, 2013.	

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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	<p>Other: 20 Total: 136</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Tammy Alley RN on February 11, 2013.</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to ensure a resident's physician was notified of changes, in that when a resident had the services of an Orthopedic</p>	F0157	F 157 It is the practice of this provider to immediately inform the resident, consult with the residents physician, and if known, notify the resident's legal representation or an interested	03/04/2013

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	<p>surgeon, and the resident had a change in condition, which included a new fracture, the nursing staff failed to notify the surgeon of the fracture, in addition to the signs and symptoms the resident displayed for 1 of 3 resident's reviewed for injury in a sample 4. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 02-05-13 at 8:45 a.m. Diagnoses included but were not limited to, stress fracture, anemia, hypertension, arthritis, dementia, syncope, muscle weakness and rheumatoid arthritis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident sustained a right fractured femur after a fall at home prior to admission. The resident received surgery at a local area hospital and was discharged to the facility with specific discharge instructions.</p> <p>A nurses progress note, dated 01-12-13 at 6:20 a.m., indicated the following:</p> <p>"While assisting with A.M. [morning] care - noted swelling in resident's left</p>		<p>family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental or psychosocial status (i.e a deterioration of health, mental or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e. a need to need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the facility as specified in 483.12(a). It is the practice of this provider to notify the resident , and if known, the resident's legal representative, or an interested family member, when there is change in room or roommate assignment as specified in 483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. It is the practice of this provider to record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # A: the resident no longer resides in the</p>		

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	<p>ankle with a cm [centimeter] in 1/2 [sic] discoloration in the ball of the resident's ankle."</p> <p>The facility attending physician was notified, and the nursing staff received an order to obtain an x-ray of the resident's ankle.</p> <p>The conclusion of the x-ray report, dated 01-12-13 at 4:51 p.m., indicated the resident had a "distal fibula fracture."</p> <p>Interview on 02-03-13 at 9:30 a.m., a concerned family member indicated the nursing staff did not notify the resident's surgeon of the fracture. "We had an appointment the following Monday [01-14-13] and the transfer paperwork, didn't even let the surgeon know about the new fracture. We had to go back to the surgeon a second time [01-17-13] and that's when the surgeon looked at the ankle."</p> <p>The original physician's discharge instructions, dated 11-12-12, indicated the following:</p> <p>"Contact information - [name of physician with telephone number]/Contact [name of local area orthopedic service with the telephone</p>		<p>facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with a change of condition(s) have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on physician notification on February 19, 2013, and ongoing. Education was provided by the Director of Nursing Services and/or designee. Licensed nurses were re-educated on completion of the Resident Referral Form in the electronic medical record when transferring a resident to a physician appointments/referral, including necessary assessment, laboratory and xray results, and/or any pertinent information that is necessary to ensure that the resident;s consulting physician has the necessary information to diagnosis and adjust the residents plan of care, if necessary. Education was provided by the Director of Nursing Services and/or designee. The nursing management team, including the Administrator, Director of Nursing/or designee, monitors the facility activity report and</p>		

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	<p>number] for the following: increase in redness or swelling around your wound, increase in wound drainage. Pain that won't go away with medication, ice and elevation - swelling that won't go away with ice and elevation - fever greater than 101.5 - any questions or concerns. Discharge diagnosis: right periprosthetic femur fracture."</p> <p>Further review of the resident record on 02-05-13 at 12:00 p.m., indicated a notation from the local orthopedic service, dated 01-17-13, which indicated "ankle swelling [on exam], closed fracture of the femur, ankle joint pain, closed fracture of the left distal fibula."</p> <p>Review of facility policy on 02-05-13 at 2:50 p.m., dated as "revised October 2010, titled "Acute Condition Changes - Clinical Protocol," indicated the following:</p> <p>"5. Before contacting a physician about someone with an acute change of condition, the nursing staff will make pertinent observations and collect appropriate information to report to the physician; for example, history of present illness and previous and recent test results for comparison. a. Phone calls to</p>		<p>physician orders 5 x weekly, during daily clinical rounds at the nursing units, to monitor resident change of condition, and physician and family notification. The nurse manager representative notifies the Executive Director and/or designee of any unusual occurrence, if needed. The Medical Records Coordinator, or designee, monitors resident transfer documentation, each business day, to ensure accurate documentation. The Director of Nursing Services is responsible for compliance with physician notification. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>A Change of Condition CQI tool will be completed daily x 4 weeks, monthly x 2 and quarterly x 3, to ensure physician/family notification is completed and change of condition identified. Through the audits, if any non compliance is noted, corrective action will be completed immediately. The audits will be reviewed by the CQI committee and if a threshold of 95% compliance is not met an action plans will be developed to ensure continued compliance.</p> <p>Completion Date: 3/4/13</p>		

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	<p>attending or on-call physician should be made by an adequately prepared nurse who has collected pertinent information, including the resident's current symptoms and status. 6. The nursing staff will contact the physician based on the urgency of the situation."</p> <p>When interviewed for additional information related to a specific facility policy for notification of physician on 02-05-13 at 2:55 p.m., the Director of Nurses indicated "this is all they've got [in regard to the corporation and the complete physician notification policy for notification]."</p> <p>This Federal tag relates to Complaint IN00122927.</p> <p>3.1-5(a)</p>				

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F0226 SS=D	<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 record review and interview the facility failed to ensure the implementation of their policy, in regard to the investigation of an injury of unknown origin for 1 of 3 resident's reviewed for injury in a sample of 4. (Resident "A").</p> <p>Findings:</p> <p>The record for Resident "A" was reviewed on 02-05-13 at 8:45 a.m. Diagnoses included but were not limited to, stress fracture, anemia, hypertension, arthritis, dementia, syncope, muscle weakness and rheumatoid arthritis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident sustained a right fractured femur after a fall at home. The resident received surgery at a local area hospital and was discharged to the facility with specific discharge instructions.</p> <p>A nurses progress note, dated</p>	F0226	<p>F 226</p> <p>Develop/Implement Abuse/Neglect, Etc Policies</p> <p>It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # A – the resident no longer resides in the facility</p> <p>How will you identify other residents having the potential to be</p>	03/04/2013			

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	<p>01-12-13 at 6:20 a.m., indicated the following:</p> <p>"While assisting with A.M. [morning] care - noted swelling in resident's left ankle with a cm [centimeter] in 1/2 [sic] discoloration in the ball of the resident's ankle."</p> <p>The facility received a physician order for an x-ray of the right ankle. The result of the x-ray report, dated 01-12-13 at 4:51 p.m., indicated the resident had a "distal fibula fracture."</p> <p>During interview on 02-05-13 at 1:30 p.m., the Administrator indicated that although the injury was discovered on 01-12-13 she had not been informed of the incident/fracture until 01-14-13 at which time she began the investigative process.</p> <p>Review of facility policy on 02-05-13 at 3:10 p.m., undated, and titled "Accidents & Incidents - Investigation & Reporting," indicated the following:</p> <p>"Policy statement: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises must be investigated and reported to the Administrator."</p>		<p>affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice.</p> <p>Resident allegations/concerns regarding abuse/neglect/misappropriation of funds or unusual occurrences of unknown etiology are reported to the Administrator, and/or designee, and an investigation is initiated immediately. The resident's attending physician and responsible party are notified of any allegation of abuse/neglect per ISDH reportable guidelines. Employees named in an allegation are immediately suspended, pending investigation. Corrective action will be taken, as indicated. The</p>	
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	<p>"Procedure: 1. Reporting of Accident's/Incidents: Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned. The nurse supervisor/charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided. 3. Medical Attention: The nurse supervisor and/or charge nurse shall examine all accident/incident victims; notify the medical director or the victim's personal or attending physician, and inform the physician of the accident or incident. 4. Investigative Action: The nurse supervisor/charge nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. A completed Incident Report Form must be completed and submitted to the DON [Director of Nurses] within 12 hours of the accident/incident. 5. Accident/Incident Report: The nurse supervisor/charge nurse and/or department supervisor shall: Submit the original copy of the Accident Investigation Report Form to the DON</p>		<p>allegation is initially reported to ISDH within 24 hours of notification, and a follow-up report is made within 5 days. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff re-education was provided by the Administrator and/or Director of Nursing Services, or designee, related to the facility abuse policy and procedure on February 19, 2013, and ongoing. The facility conducts Criminal Background checks upon hire and only those prospective employees without criminal history background, per company policy, are hired. Employees are educated by Staff Development Coordinator regarding the abuse/Neglect/misappropriation/SDH reportable guidelines policy and procedure upon hire, and no less than annually, and as needed, including reporting any allegation of abuse to the administrator and/or designee, Resident/Family concern forms are located at nursing units and the receptionist desk to ensure residents and families have an opportunity to voice their concerns, including any allegation of abuse and/or neglect. The Administrator is notified of allegations of abuse/neglect immediately. A Customer Relations Coordinator position has been implemented with the</p>				

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	<p>within 12 hours of the occurrence and to the Administrator within 24 hours of the occurrence."</p> <p>This Federal tag relates to Complaint IN00122927.</p> <p>3.1-28(a) 3.1-28(c)</p>		<p>focus of QIS system to ensure resident/family satisfaction. The Administrator is responsible to monitor compliance with the Abuse Policy and Procedure Program. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The QIS Staff/Resident/Family Abuse Questionnaire regarding abuse allegations, reporting of abuse and/or incidents of injuries of unknown origin, will be utilized with 10 staff members/residents weekly x 4, 5 families weekly x 4; 10 staff members/residents monthly x 2 and 5 families monthly x 2; then 10 staff members/residents and 5 families quarterly x 3. The audits will be reviewed by the CQI committee and if a threshold of 100% compliance is not met, action plans will be to ensure continued compliance.</p> <p>Completion Date: 3/4/13</p>		

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F0282 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, record review and interview, the facility failed to ensure the resident's plan of care was followed for 2 of 4 resident's reviewed for following plan of care in a sample of 4. (Resident's "A" and "B").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 02-05-13 at 8:45 a.m. Diagnoses included but were not limited to, stress fracture, anemia, hypertension, arthritis, dementia, syncope, muscle weakness and rheumatoid arthritis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident sustained a right fractured femur after a fell at home. The resident received surgery at a local area hospital and was discharged to the facility with specific discharge instructions.</p> <p>A review of the resident's Minimum Data Set (MDS) Assessment, dated 11-19-12, indicated the resident had</p>	F0282	<p>F282 Services by Qualified Persons/Per Plan of Care</p> <p>It is the practice of this provider to provide or arrange services provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A: The resident no longer resides in the facility. Resident B: The resident's plan of care was reviewed by the Interdisciplinary Team utilizing the 3 Day Voiding pattern. The plan of care is described on the CNA assignment sheet to provide knowledge to the certified nursing aides on the necessary care the resident requires. The resident receives assistance with toileting per plan of care. How will you identify other residents having the potential to be affected by</p>	03/04/2013			

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	<p>moderate cognitive impairment, and required extensive assistance with transfer, bed mobility and was frequently incontinent of bowel and bladder. The assessment further indicated the resident "has diagnosis of fractured neck of femur and dementia. Resident has physical limitations that prevent [resident] from being able to self toilet. Requires extensive assist of 2 staff with toilet use."</p> <p>Review of the resident's plan of care originally dated 11-29-12, indicated the following:</p> <p>"Category: urinary incontinence: Resident experiences bladder incontinence R/T [related to] physical limitations that prevent [resident] from being able to self toilet."</p> <p>"Approach: Provide incontinence care after each incontinent episode."</p> <p>During an observation on 02-03-13 at 10:45 a.m., the resident was seated in a wheel chair. The resident indicated being up in the wheel chair since "around 6:00 a.m., when they first got me up." The resident further indicated the staff had not toileted nor provided incontinent care, since that time.</p>		<p>the same deficient practice and what corrective action will be taken? Residents who require assistance with toileting have the potential to be affected by the alleged deficient practice. Identified residents were reassessed utilizing the 3 Day Voiding pattern and their plans of care were adjusted, as needed. The resident's CNA assignment sheets were adjusted, as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on utilizing the 3 Day Voiding pattern to determine the resident's toileting needs. The pattern is utilized upon admission, annually, and with a significant change assessment, as needed. The Interdisciplinary Team, including the nurse manager, or designee, and the direct caregivers determine the appropriate toileting plan for each resident, as needed. The plan of care is updated on the CNA assignment sheet, as needed. The information is reviewed during admission audits and the care plan meetings to ensure residents have the appropriate toilet plans to meet their individual needs. Certified nursing assistants were re-educated on toileting programs, incontinent care, and utilization of the CNA assignment sheet to ensure each</p>		

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	<p>When interviewed if the resident thought (resident) the incontinent brief was wet, the resident nodded head "yes."</p> <p>Licensed nurse employee #3 was notified of the resident's incontinence, and then summoned a certified nurses aide employee #6 to assist with providing incontinent care for the resident.</p> <p>The certified nurses aide positioned the resident's wheel chair adjacent to the bed. The certified nurses aide, and the licensed nurse positioned their forearms under the resident's axilla, and in one movement transferred the resident from the wheel chair to the side of the bed. The certified nurses aide indicated, "I can tell [resident] is wet because the brief is squishy like a sponge."</p> <p>The resident was moved to the center of the bed and the resident's slacks were removed. The incontinent brief was saturated with urine and it appeared heavy. The brief was wet from the front and up the back.</p> <p>2. The record for Resident "B" was reviewed on 02-05-13 at 9:45 a.m. Diagnoses included but were not</p>		<p>resident receives services according to their plan of care. A CNA Skills Fair, including incontinent care, transfers, and utilizing the CNA assignment sheet was conducted on 2/18/13. The Director of Nursing Services is responsible for the compliance with resident care plans. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Licensed Nurse Round Sheet CQI will be utilized to verify toileting/incontinent care of 3 residents/hall per day x one month, then 5 residents/hall per week x 8 weeks. Re-education and/or disciplinary action will be given for noncompliance. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure continued compliance Completion Date: 3/4/13</p>		

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	<p>limited to peripheral vascular disease, heart failure, muscle weakness, difficulty in walking, hypertension and sepsis. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS assessment, dated 01-29-13, indicated the resident required extensive assistance with bed mobility, transfers and toileting. In addition the assessment indicated the resident was frequently incontinent of bowel and bladder. "Self performance is a problem."</p> <p>Review of the resident's plan of care, originally dated 08-10-12 indicated "ADL [activities of daily living] / Rehabilitation potentions. Resident is limited in ability to toilet self R/T [related to] _____ [blank]." Interventions to this plan of care included "Provide extensive to limited assistance for toileting as needed."</p> <p>A subsequent plan of care, originally dated, 08-10-12, indicated "Problem: urinary incontinence. Functional urinary incontinence R/T impaint mobility." Interventions to this plan of care included "Provide set up and physical assist times 1 for toileting as needed."</p>			

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	<p>During the initial tour of the facility on 02-05-13, at 10:35 a.m., Licensed Nurse employee #3 indicated the resident was alert and oriented times two, had pneumonia and was incontinent of bowel and bladder.</p> <p>A request was made to check the resident for incontinence and the resident agreed.</p> <p>The licensed nurse "checked" the outside of the resident's incontinent brief and indicated, "[resident] is wet."</p> <p>The licensed nurse untaped the side sections of the brief. During this observation, the brief was observed wet with urine. The brief was saturated up the back of the brief.</p> <p>During this observation, the resident indicated, "They cleaned me up before breakfast."</p> <p>The licensed nurse indicated breakfast usually comes around 8:00 a.m.</p> <p>This Federal tag relates to Complaint IN00122927.</p> <p>3.1-35(b)(1)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview the facility failed to provide incontinent care, in that when residents were unable to self toilet, the nursing staff failed to ensure the resident's incontinent plan of care was followed for 2 of 4 residents reviewed for incontinent care in a sample of 4. (Residents "A" and "B").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 02-05-13 at 8:45 a.m. Diagnoses included but were not limited to, stress fracture, anemia, hypertension, arthritis, dementia, syncope, muscle weakness and rheumatoid arthritis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident sustained a right fractured femur after a fall at home and after surgery at a local area hospital was transferred to the facility for rehabilitation.</p>	F0312	<p>F 312 ADL Care Provided for Dependent Residents It is the practice of this provider to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A: The resident no longer resides in the facility. Resident B: The resident's plan of care was reviewed by the Interdisciplinary Team utilizing the 3 Day Voiding pattern. The plan of care is described on the CNA assignment sheet to provide knowledge to the certified nursing aides on the necessary care the resident requires. The resident receives assistance with toileting per plan of care. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who require assistance with toileting have the potential to be affected by the</p>	03/04/2013			

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	<p>A review of the resident's Minimum Data Set (MDS) Assessment, dated 11-19-12, indicated the resident had moderate cognitive impairment, and required extensive assistance with transfer, bed mobility and was frequently incontinent of bowel and bladder. The assessment further indicated the resident "has diagnosis of fractured neck of femur and dementia. Resident has physical limitations that prevent [resident] from being able to self toilet. Requires extensive assist of 2 staff with toilet use."</p> <p>Review of the resident's plan of care originally dated 11-29-12, indicated the following:</p> <p>"Category: urinary incontinence: Resident experiences bladder incontinence R/T [related to] physical limitations that prevent [resident] from being able to self toilet."</p> <p>"Approach: Provide incontinence care after each incontinent episode."</p> <p>During an observation on 02-03-13 at 10:45 a.m., the resident was seated in a wheel chair. The resident indicated being up in the wheel chair since "around 6:00 a.m., when they first got me up." The resident further</p>		<p>alleged deficient practice. Identified residents were reassessed utilizing the 3 Day Voiding pattern and their plans of care were adjusted, as needed. The resident's CNA assignment sheets were adjusted, as needed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nurses were re-educated on utilizing the 3 Day Voiding pattern to determine the resident's toileting needs. The pattern is utilized upon admission, annually, and with a significant change assessment. The Interdisciplinary Team, including the nurse manager, or designee, and the direct caregivers determine the appropriate toileting plan for each resident, as needed. The plan of care is updated on the CNA assignment sheet, as needed. The information is reviewed during admission audits and the care plan meetings to ensure residents have the appropriate toilet plans to meet their individual needs. Certified nursing assistants were re-educated on toileting programs, incontinent care, and utilization of the CNA assignment sheet to ensure each resident receives services according to their plan of care. A CNA Skills Fair, including incontinent care, transfers, and utilizing the CNA assignment sheet was conducted</p>				

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	<p>indicated the staff had not toileted nor provided incontinent care, since that time.</p> <p>When interviewed if the resident thought (resident) the incontinent brief was wet, the resident nodded head "yes."</p> <p>The licensed nurse employee #3 was notified of the resident incontinence, and then summoned a certified nurses aide employee #6 to assist with providing incontinent care for the resident.</p> <p>The certified nurses aide positioned the resident's wheel chair adjacent to the bed. The certified nurses aide, and the licensed nurse positioned their forearms under the resident's axilla, and in one movement transferred tot he resident to the side of the bed. The certified nurses aide indicated, "I can tell [resident] is wet because the brief is squishy like a sponge."</p> <p>The resident was moved to the center of the bed and the resident's slacks were removed. The incontinent brief was saturated with urine and it appeared heavy. The brief was wet from the front and up the back.</p>		<p>on 2/18/13. The Director of Nursing Services is responsible for the compliance with resident care plans. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Licensed Nurse Round Sheet CQI will be utilized to verify toileting/incontinent care of 3 residents/hall per day x one month, then 5 residents/hall per week x 8 weeks. Re-education and/or disciplinary action will be given for noncompliance. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure continued compliance</p> <p>Completion Date: 3/4/13</p>		

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	<p>2. The record for Resident "B" was reviewed on 02-05-13 at 9:45 a.m. Diagnoses included but were not limited to peripheral vascular disease, heart failure, muscle weakness, difficulty in walking, hypertension and sepsis. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS assessment, dated 01-29-13, indicated the resident required extensive assistance with bed mobility, transfers and toileting. In addition the assessment indicated the resident was frequently incontinent of bowel and bladder. "Self performance is a problem."</p> <p>Review of the resident's plan of care, originally dated 08-10-12 indicated "ADL [activities of daily living] / Rehabilitation potential. Resident is limited in ability to toilet self R/T [related to] _____ [blank]." Interventions to this plan of care included "Provide extensive to limited assistance for toileting as needed."</p> <p>A subsequent plan of care, originally dated, 08-10-12, indicated "Problem: urinary incontinence. Functional urinary incontinence R/T impaired mobility." Interventions to this plan of</p>				

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	<p>care included "Provide set up and physical assist times 1 for toileting as needed."</p> <p>During the initial tour of the facility on 02-05-13, at 10:35 a.m., Licensed Nurse employee #3 indicated the resident was alert and oriented times two, had pneumonia and was incontinent of bowel and bladder.</p> <p>A request was made to check the resident for incontinence and the resident agreed.</p> <p>The licensed nurse "checked" the outside of the resident's incontinent brief and indicated, "[resident] is wet."</p> <p>The licensed nurse untaped the side sections of the brief. During this observation, the brief was observed wet with urine. The brief was saturated up the back of the brief.</p> <p>During this observation, the resident indicated, "They cleaned me up before breakfast."</p> <p>The licensed nurse indicated breakfast usually comes around 8:00 a.m.</p> <p>This Federal tag relates to Complaint IN00122927.</p>			

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	3.1-38(a)(2)(C)			

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F0314 SS=D	<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, record review and interview the facility failed to ensure a resident received treatment for a pressure area, in that when a dependent resident, who was incontinent of urine, was assessed by the nursing staff with an open area, the nurse failed to ensure the dressing was placed over the ulcers to aide in healing and prevention from the areas getting worse for 1 of 3 resident's reviewed for incontinence and pressure ulcers in a sample of 4. [Resident "B"].</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 02-05-13 at 9:45 a.m. Diagnoses included but were not limited to, peripheral vascular disease, heart failure, muscle weakness, difficulty in walking,</p>	F0314	<p>F314 Treatment/SVCS to Prevent/Heal Pressure Sores It is the practice of this provider to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, based on the comprehensive assessment of the resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B: The resident's wound has healed and the resident receives preventative measures to prevent skin breakdown. The resident is seen weekly by the Wound MD and Interdisciplinary team during wound rounds and the resident's plan of care is</p>	03/04/2013	

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	<p>hypertension and sepsis. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's MDS (Minimum Data Set) assessment, dated 01-29-13, indicated the resident required extensive assistance with bed mobility, transfers and toileting. In addition the assessment indicated the resident was frequently incontinent of bowel and bladder. "Self performance is a problem." The assessment also indicated the resident was "at risk" for skin breakdown, but did not have a pressure ulcer at the time of admission to the facility. Further review of this assessment indicated the "need of special mattress or seat cushion to reduce or relieve pressure. Indications included immobility, cognitive loss, incontinence and poor nutrition."</p> <p>Review of the resident's current plan of care, originally dated 08-10-12, indicated "Problem: pressure ulcer." Interventions to this plan of care included, "conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence's, Keep clean and dry as possible. Minimize skin exposure to moisture."</p>		<p>updated, as needed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents with orders for wound treatments have the potential to be affected by the alleged deficient practice. The facility conducted a skin assessment on all residents by 2/15/13, to ensure all skin issues were identified. No new skin impairment issues were identified. Resident Treatment Administration Records were reviewed to ensure the appropriate treatments were noted and being administered per the resident plan of care. CNA assignment sheets were audited to ensure resident's needs related to impaired skin integrity were identified per the residents plan of care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Licensed nurses and Certified nursing assistants were re-educated on the prevention of impaired skin integrity, including toileting and incontinent care and appropriate product usage, turning/repositioning, offloading, and pressure redistribution devices on 2/19/13, and ongoing, by the Director of Nursing, or designee. Licensed nurses were re-educated on the facility skin protocol, including</p>				

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	<p>During the initial tour of the facility on 02-05-13, at 10:35 a.m., Licensed Nurse employee #3 indicated the resident was alert and oriented times two, had pneumonia and was incontinent of bowel and bladder.</p> <p>A request was made to check the resident for incontinence and the resident agreed.</p> <p>The licensed nurse "checked" the outside of the resident's incontinent brief and indicated, "[resident] is wet."</p> <p>The licensed nurse untaped the side sections of the brief. During this observation, the brief was observed wet with urine. The brief was saturated up the back of the brief.</p> <p>Additional record review on 02-05-13 at 11:00 a.m., indicated the resident was assessed with an open area to the coccyx.</p> <p>Review of the nurses progress note, dated 02-02-13 at 3:03 p.m., indicated the following: "Resident [family member] called this evening [for the resident] and complained of pain to coccyx [for the resident]. Writer went to patient's room, Checked coccyx for redness/open areas. Writer observed</p>		<p>application of dressings per the residents plan of care and documentation in the electronic medical record on 2/19/13, and ongoing, by the Director of Nursing, or designee. Licensed nurses were re-evaluated on dressing changes by the Staff Development Coordinator, or designee, by 3/4/13. The Interdisciplinary Team, including the Wound physician, Administrator, Director of Nursing, and Unit Managers, or designees, assess residents with wounds weekly during wound rounds. Physician orders and care plans are revised, as needed. The Director of Nursing is responsible for compliance with the facility wound program. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Licensed Nurse Round Sheet CQI will be utilized to verify wound treatments on 3 residents/hall per day x one month, then 5 residents/hall per week x 8 weeks. Re-education and/or disciplinary action will be given for noncompliance. The audits will be reviewed by the CQI committee and should a threshold of 95% compliance not be met, action plans will be developed to ensure continued compliance Completion Date: 3/4/13</p>				

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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032		
(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	
	<p>4 small < [less than] 1 cm. [centimeter] in size open area on coccyx. Minimal blood tinged drainage from one of sores. Writer called MD [Medical Doctor] and got order for Biatin dressing to coccyx every day. Writer called [family member] as well. Writer turned resident to right side - resident incontinent of bowel and bladder."</p> <p>At the time of the observation during the initial tour of the facility on 02-03-13 at 10:35 a.m., with licensed nurse employee #3 in attendance, the resident did not have the dressing applied to the open areas of the coccyx.</p> <p>3.1-40(a)(2)</p>				