

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2013
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NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402
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F000000	<p>This visit was for the Investigation of Complaint IN00131168.</p> <p>Complaint IN00131168-Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: July 23 & 24, 2013</p> <p>Facility number: 000369 Provider number: 155530 AIM number: 100275190</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 60 Total: 60</p> <p>Census payor type: Medicare: 10 Medicaid: 50 Total: 60</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</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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	Quality review completed on July 27, 2013, by Janelyn Kulik, RN.			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the necessary treatment and services were provided related to lack of ongoing assessment of blisters for 1 of 1 resident reviewed for non pressure ulcer skin conditions in the sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>The closed record for Resident #D was reviewed on 7/23/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, anemia, diabetes mellitus, osteomyelitis (an infection of a bone), depression, acute pancreatitis, pemphigus (a skin disorder) and dementia. The resident was sent to the hospital on 5/13/13 and did not return to the facility.</p> <p>The 2/19/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief</p>	F000309	The facility ensure that all residents are provided necessary care and services. Resident #D has a a full review of the closed chart to identify other problems that may have occurred during the resident's stay. No new issues identified. Wound program has been expanded to include non pressure ulcer skin issues. Nurse have been in-serviced on wound care/management and proper notification when issues occur. Skin assessment have been reviewed to ensure that no areas have been identified that are not on treatment sheets. New skin issues will be monitored by the Wound Nurse or designee. Audits will be completed to verify that all issues will skin are monitored and receive proper treatment per policy. Results of audits will be reported to QA for 3 months or until problem is considered resolved. Problem will be considered resolved when no new issues are noted. All residents have had new skin assessment since survey. All assessment have been reviewed	08/12/2013	

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	<p>Interview for Mental Status) score was (1). This indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required total dependence of staff (full staff performance) of one person for bed mobility and personal hygiene. The MDS also indicated the resident did not have any non pressure or "other" skin problems.</p> <p>The facility policy titled "Skin Condition Monitoring" was reviewed on 7/24/13 at 8:50 a.m. The policy had a revised date of 01/02. The policy was received from the Director of Nursing. The Director of Nursing indicated the policy was current. The policy indicated upon notification of a skin lesion, wound, or other skin abnormality, the Charge Nurse was to assess the area and document the findings. The documentation was to be completed upon identification of the condition and then weekly. The documentation was to include an assessment of the size, shape, depth, color, and presence of granulation or necrotic tissue.</p> <p>The 5/2013 Nurses' Notes were reviewed. An entry made on 5/2/13 at 1:00 p.m. indicated there was a new blister to the resident's inner</p>		to ensure no new areas. Wound Care Nurse or designee is responsible for audits. Monitoring will be on-going or until discontinued by QA. QA will be discontinued when no new areas or issues are noted by audits.				

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	<p>thigh. There was no assessment of the blister and the entry did not indicate which thigh the blister was observed on. Review of the Nurses' Notes from 5/2/13 through 5/11/13 indicated there was no further assessment of or mention of the above inner thigh blister. An entry made on 5/9/13 at 11:20 p.m. indicated there was a blister to the resident's left ear. The entry did not include any assessment of the blister or any measurements of the blister. There was no further mention of the blister on the resident's ear in the Nurses' Notes from 5/9/13 through 5/13/13.</p> <p>When interviewed on 7/24/13 at 8:50 a.m., the Wound Nurse indicated the staff had not completed any wound sheets or assessments of the above two blisters. The Wound Nurse indicated the resident's blister should have been monitored and assessed by staff.</p> <p>When interviewed on 7/24/13 at 10:00 a.m., the Director of Nursing indicated Nursing should follow the policy for "Skin Condition Monitoring" for new non pressure ulcer areas.</p> <p>This federal tag relates to Complaint IN00131168.</p>						

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	3.1-37(a)			

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F000314 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 the necessary treatment and services were provided to promote healing of pressure ulcers related to a dressing not in place as ordered by the Physician and lack of on-going weekly assessments of a pressure ulcer for 2 of 3 residents reviewed with pressure ulcers in the sample of 6. (Residents #C & #D)</p> <p>Findings include:</p> <p>1. During orientation tour on 7/23/13 at 8:40 a.m., Resident #C was observed in bed. LPN #1 and CNA #2 assisted the resident to turn to her side. The staff members removed the resident's disposable brief. There was stool on the inside of the brief. The resident had a red scabbed area</p>	F000314	The facility ensure that all residents are provided necessary care and services. Resident #D has a a full review of the closed to chart to identify other problems that may have occurred during the resident's stay. No new issues identified. Resident has had a skin assessment to ensure that there are no other unidentified skin issues. No new issues noted. Wound program has been expanded to include non pressure ulcer skin issues. Nurse have been in-serviced on wound care/management and proper notification when issues occur. Skin assessment have been reviewed to ensure that no areas have been identified that are not on treatment sheets. New skin issues will be monitored by the Wound Nurse or designee. Audits will be completed to verify that all issues will skin are monitored and receive proper treatment per policy. Results of audits will be reported to QA for 3	08/12/2013			

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	<p>to the right buttock area and an open area to the left buttock area. The open area was approximately 0.5 cm (centimeters) x 0.5 cm. and had a red center. There was no dressing or bandage in place over the open area. There was no dressing observed in the resident's brief.</p> <p>The record for Resident #C was reviewed on 7/23/13 at 9:53 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure, anemia, high blood pressure, end stage renal disease, and dilation of the colon.</p> <p>Review of the 7/2013 Physician Order Statement (POS) indicated there was an order to cleanse the right buttock cheek area with wound cleanser, pat dry, and apply Dermagen and a dry dressing to the area daily and as needed. There was also an order to cleanse the left buttock cheek area with wound cleanser, pat dry, and apply Dermagen and a dry dressing daily and as needed. These orders were dated as initiated on 6/25/13.</p> <p>A Braden Scale assessment for predicting pressure ulcer risk was completed on 6/25/13. The assessment indicated the resident was at high risk for developing</p>		<p>months or until problem is considered resolved. Problem will be considered resolved when no new issues are noted. Resident #C has a full skin assessment No new skin issues noted. All residents have had new skin assessment since survey. All assessment have been reviewed to ensure no new areas. Wound Care Nurse or designee is responsible for audits. Monitoring will be on-going or until discontinued by QA. Audits will be discontinued when no new areas or issues are noted by audits.</p>		

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	<p>pressure ulcers. The 5/8/13 MDS (Minimum Data Set) comprehensive full assessment indicated the resident had no cognitive impairments. The assessment also indicated the resident was dependent on one staff person for bed mobility. The assessment indicated the resident was at risk for the development of pressure ulcer and currently had no unhealed pressure ulcers.</p> <p>The resident's current care plans were reviewed. There was a care plan which indicated the resident had an alteration in skin integrity as evidenced by the presence of a pressure ulcer. The care plan had an "updated" date of 7/17/13. Care plan interventions included, but were not limited to, for treatment to be completed as ordered by the Physician.</p> <p>The 6/24/13 Nurses' Notes were reviewed. An entry made at 9:47 p.m. indicated the resident arrived at the facility via ambulance. The entry also indicated the resident had open areas noted to both the right and left buttock areas.</p> <p>The "Wound History" notes were reviewed. An entry made on 6/26/13 indicated there was a Stage II (a ulcer</p>			

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	<p>with partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed without slough) pressure ulcer to the left buttock. The pressure ulcer measured 2.3 cm x 2.5 cm x 0.1 cm. An entry made on 7/3/13 indicated the pressure ulcer measured 0.5 cm x 0.5 cm x 0.1 cm. An entry made on 7/10/13 indicated the Stage II ulcer measured 0.5 cm x 0.7 cm x 0.1 cm. An entry made on 7/17/13 indicated the left buttock Stage II pressure ulcer measured 0.5 cm x 0.9 cm x 0.1 cm. An entry made on 6/26/13 indicated there was a Stage II pressure ulcer to the right buttock area measuring 2.0 cm x 1.8 cm x 0.1 cm. An entry made on 7/3/13 indicated the right buttock ulcer was closed and the treatment was to continue for another two weeks as protective (SIC).</p> <p>When interviewed on 7/23/13 at 3:10 p.m., RN #1 indicated she came into work at 8:30 a.m. The RN indicated she applied a dressing to the resident's area after a CNA informed her the dressing was not in place. RN#1 indicated she completed the treatment after the resident was observed at 8:40 a.m. The RN indicated the resident had a small open area to the left buttock and identified the area a Stage II ulcer.</p>			

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	<p>When interviewed on 7/23/13 at 8:50 a.m., CNA #1 indicated the resident often had loose stools. The CNA indicated there was no dressing on the resident's buttock areas. The CNA indicated she was aware another CNA cleaned the resident earlier after the resident had loose stools.</p> <p>When interviewed on 7/24/13 at 8:50 a.m., the Wound Nurse indicated the resident's right buttock wound was healed and the resident currently still had a pressure ulcer to the left buttock cheek. The Wound Nurse indicated the resident should have had a dressing in place to the left buttock area when observed on 7/23/13 at 8:40 a.m.</p> <p>2. The closed record for Resident #D was reviewed on 7/23/13 at 10:30 a.m. The resident's diagnoses included, but were not limited to, rheumatoid arthritis, anemia, diabetes mellitus, osteomyelitis (an infection of a bone), depression, acute pancreatitis, pemphigus (a skin disorder) and dementia. The resident was sent to the hospital on 5/13/13 and did not return to the facility.</p> <p>Review of the 5/2013 Physician Order</p>						

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	<p>Statement (POS) indicated there were orders to cleanse the sacral wound with wound wash, pat dry, and apply Santyl (an medicated ointment to debride ulcers) and Aquacell and cover the area with a dressing daily.</p> <p>A Braden Scale assessment for predicting pressure ulcer risk was completed on 4/20/13. The assessment indicated the resident was at high risk for developing pressure ulcers. The 2/19/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (1) . This indicated the resident's cognitive patterns were severely impaired. The MDS assessment also indicated the resident required total dependence of staff (full staff performance) of one person for bed mobility and personal hygiene.</p> <p>The resident's care plans were reviewed. A care plan initiated on 1/4/13 indicated the resident had an alteration in skin integrity as evidenced by the presence of a pressure ulcer. The care plan was last updated on 4/19/13. Care plan interventions included, but were not limited to, perform pressure/wound assessments per schedule and to</p>				

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	<p>provide treatment as ordered.</p> <p>The "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" forms were reviewed. There was a form for a pressure ulcer to the resident's coccyx area. The form indicated the ulcer was initially identified on 1/21/13 and was present on an admission to the facility. The 4/2013 and 5/2013 entries were reviewed. The 4/2013 entries indicated the resident was hospitalized on 4/17/13. Entries were completed on 4/19/13 and 4/24/13. There was only one entry completed for 5/2013. The 4/2013 and 5/2013 were as follows:</p> <p>4/19/13- Stage III (an ulcer with full thickness tissue loss) pressure ulcer measuring 2.8 cm x 2.1 cm x 0.2 cm, scant amount of exudate (drainage), and the wound bed color was 98% red and 2 % yellow.</p> <p>4/24/13- Stage III pressure ulcer measuring 2.7 cm x 2.0 cm x 0.2 cm, scant amount of exudate, and the wound bed color was 98% red and 2% yellow.</p> <p>5/01/13- Stage III pressure ulcer measuring 2.4 cm x 1.8 cm x 0.2 cm, scant amount of exudate, and the wound bed color was 100% red.</p> <p>There were no further measurements or assessments of the coccyx wound after 5/1/13.</p>			

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	<p>The facility policy titled "Decubitus Care/Pressure Areas" was reviewed on 7/24/13 at 8:50 a.m. The policy had a revised date of 05/07. The policy was provided by the Director of Nursing. The Director of Nursing indicated the policy was current. The policy indicated an assessment of each pressure ulcer was to completed and documented upon identification of the ulcer and at least once a week. The assessment of the ulcer was to include the size, stage, site, depth, drainage, color, odor, and treatment.</p> <p>When interviewed on 7/24/13 at 8:50 a.m., the Wound Nurse indicated there was no complete assessment of the resident's coccyx wound between 5/1/13 and 5/13/13.</p> <p>This federal tag relates to Complaint IN00131168.</p> <p>3.1-40(a)(2)</p>				