

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2011
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN47906
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F0000	<p>This visit was for a Recertification and State Licensure survey. This visit included the Investigation of Complaint Number IN00099394.</p> <p>Complaint Number IN00099394 Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: November 28, 29, 30 and December 1, 2011</p> <p>Facility Number: 000271 Provider Number: 155402 AIM Number: 100291260</p> <p>Survey Team: Linda Campbell, RN, TC Diana Zgonc, RN Connie Landman, RN</p> <p>Census Bed Type: SNF/NF: 80 Total: 80</p> <p>Census Payor Type: Medicare: 16 Medicaid: 55 Other: 9 Total: 80</p> <p>Sample: 10 Supplemental Sample: 6</p>	F0000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Heritage Healthcare desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on December 31, 2011. Heritage Healthcare respectfully requests paper compliance with this Plan of Correction.</p>	

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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F0223 SS=B	<p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 2, 2011 by Bev Faulkner, RN</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 record review and interview, the facility failed to prevent verbal and mental abuse in the facility for 1 resident in a sample of 16 and for 2 residents in a supplemental sample of 6. (Residents #69, #85, #86).</p> <p>Findings include:</p> <p>1. A "Fax/Incident Report," dated 11/12/10, and provided by the Executive Director indicated "...Staff member (initials) observed x 3 days serving resident (Resident #86 initials) last at meal time - not served in proper rotation. (Res #86's initials) states he felt he was being retaliated against & belittled and (sic) awful because he had brought up a concern r/t (related to) another resident. Employee admitted to doing this</p>	F0223	<p>It is the policy of this facility to assure that the residents are free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. 1. <i>What corrective action will be done by the facility?</i> Survey findings include incidents that occurred in November and December 2010. These incidents on resident 86,85, & 69 were investigated and concluded per Lifecare's Abuse Policy when they occurred. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> To other residents were affected by these isolated incidents. By review of our investigation. Residents are encouraged to share concerns that may be abuse with staff. Staff have been instructed per Lifecare policy upon hire, and during</p>	12/31/2011	

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	<p>intentionally (sic)...Employee terminated. Staff to be inserviced on types of abuse..." The employee was observed for another meal with the knowledge and consent of the resident.</p> <p>A handwritten statement, dated 11/12/10 and signed by the Dietary Manager, indicated "After employee signed write-up form & was explained why being terminated I asked her if she realized she was serving this resident last & if there was any reason for it? She knew exactly what resident this issue was about & she had no reason for switching diet cards..."</p> <p>A "Termination Report," dated 11/12/10, indicated "...Discharge...Violation of company rule or policy...Refused to follow instructions...Immoral conduct...Employee was discharged d/t (due to) abuse; failure to follow code of conduct policies..."</p> <p>The incident was reported to the Indiana State Department of Health via fax and telephone.</p> <p>2. A "Fax/Incident Report," dated 12/17/10 and provided by the Executive Director, indicated "...On 12/14/10 at approximately 4AM it was reported that CNA (initials) was verbally inappropriate with resident (Res # 85 initials) during</p>		<p>quarterly inservices to contact the Executive Director and immediate supervisor immediately if there is a suspicion or complaint of abuse. Per the Lifecare Abuse policy, each associate will be educated on facility Policy & Procedure regarding abuse, upon hire in the new hire orientation and quarterly thereafter by the Staff Development Coordinator. 3. <i>What measures will be put in place to ensure this practice does not recur?</i> An associate inservice will be conducted in regards to the facility Policy & Procedure regarding abuse by 12/31/2011 by the Staff Development Coordinator. The Social Service Director or designee will continue to review comments & concerns daily to ensure that allegations of abuse are investigated and that associates involved are disciplined accordingly. The Social Service Director or designee will interview 5 residents weekly for 90 days for allegations of verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion. Concerns will be given to Results will be presented to Q.A. Committee monthly. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i> The Social Service Director will bring the results of the weekly interviews to the QA committee meeting for review and recommendations monthly for the</p>		

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	<p>a.m. care. The CNA that was involved in the incident has been terminated...CNA involved was immediately suspended pending investigation. The resident involved was assessed for injuries and showed no signs of distress...The aide involved was terminated following our investigation..."</p> <p>A handwritten statement. dated 12/14/10. and signed by CNA #8 indicated "...CNA #9) told (Res #85) to shut the h--- up...I did not say anything to her, I ran straight out and told (RN #10)..."</p> <p>Staff was inserviced on abuse prevention.</p> <p>The incident was reported to the Indiana State Department of Health.</p> <p>3. A "Fax/Incident Report." dated 5/1/11 and provided by the Executive Director. indicated "...At approximately 7PM on 5/1/11, (Housekeeper #12) was witnessed confronting resident (Res #69's initials) in an agitated manner on (name of hall). The incident was very brief in nature and was from a misunderstanding that had occurred earlier that evening...Resident and staff member were immediately separated following the incident. The E.D. was notified and the associate involved was suspended pending investigation...upon completion of our</p>		<p>next 90 days. At the end of that time period, the Committee members may stop the Social Service Director's reporting of interviews if the company abuse policy is being followed with 100% compliance. The Social Service Director or designee will continue to interview residents periodically for allegations of abuse. Date of Compliance: 12/31/2011</p>		

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	<p>investigation we terminated the associate directly involved...all staff inserviced regarding abuse..."</p> <p>A typewritten statement signed by LPN #13 indicated "...At approximately 7:00 P.M. on May 1, 2011, (Housekeeper #12) (Housekeeping/Laundry) entered (name of hall) and confronted resident (Res #69). To the best of my recollection, (Housekeeper #12) stated to (Res #69) the following: 'I'm tired of you spreading lies about me. You have to stop. You do this to everybody all the time. You're a liar. Just leave me out and get out of my life.' (Housekeeper #12) then exited and (Res #69) was visibly upset, subsequently bursting into tears..."</p> <p>A "Termination Form," dated 5/3/11, indicated "...Employee was inappropriate verbally with resident (Res #69's initials) causing resident to become upset...The associates conduct was offensive in nature and failed to maintain the preservation of dignity, self respect, and residents rights in a loving and caring environment..."</p> <p>The incident was reported to the Indiana State Department of Health.</p> <p>Interview on 11/29/11 at 3:00 P.M., with the Executive Director indicated the three above incidents of abuse were</p>				

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	<p>substantiated but the facility had followed their policies and procedures and they had been reported.</p> <p>Review on 11/28/11 at 10:00 A.M., of a facility policy and procedure dated 7/1/08, provided by the Executive Director, identified as current, and titled "Abuse Investigation Reporting and Response Policy" indicated "...Residents must not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals...If the suspected perpetrator is an associate, the Executive Director shall place the associate on immediate investigatory suspension while completing the investigation...If the reported violation is substantiated, the employee will be terminated from employment...The results of all investigations must be reported to ISDH in writing or by fax...."</p> <p>3.1-27(b)</p>						

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician's orders were followed related to an indwelling catheter and pressure ulcer interventions for 1 of 4 residents with pressure ulcers and 1 of 4 residents with indwelling catheters in a sample of 16. (Resident #7).</p> <p>Findings include:</p> <p>On 11/28/11 at 9:20 A.M., during an initial tour with the Director of Nursing, Resident #7 was identified as having "excoriated buttocks and thighs" with wounds on the thigh which was present on admission to the facility. The resident also was identified as having a Foley catheter "for wounds." Observation indicated there was a regular pressure reducing bed in the room.</p> <p>On 11/28/11 at 2:45 P.M., with Unit Manager (UM) #1, Resident #7 was observed lying in bed on his back. The bed was a regular pressure reducing bed. There was a Foley catheter in place. The resident was assisted to turn to his left side. The UM #1 removed a dressing from the resident's left thigh. There was a</p>	F0282	<p>It is the policy of this facility for qualified persons to provide or arrange services in accordance with each residents written plan of care. 1. <i>What corrective action will be done by the facility?</i> Immediately upon the surveyor's report of concern, Resident #7's physician was contacted regarding the indwelling catheter. A new order was received and noted to continue with foley catheter for wound healing. The wound clinic was notified regarding the order for low air loss mattress and Roho cushion, positioning every 15 minutes, and keeping the weight off posterior thighs. A low air loss mattress was placed on the bed. The Roho cushion and q 15 minute position change was discontinued. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> No other residents were affected by this alleged deficiency. Physician orders for residents that have foley catheters and pressure wounds were reviewed by nursing administration on 11/29/2011 to ensure accuracy of orders and that orders have been followed through with appropriate interventions put in place. Interventions have been placed on care plan and care guides by</p>	12/31/2011			

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	<p>pressure ulcer on the posterior aspect of the resident's thigh and under the scrotum. There was a cushion in a wheelchair at the bedside. The cushion was not a ROHO cushion. UM #1 stated "I believe it's a gel cushion."</p> <p>Resident #7's clinical record was reviewed on 11/28/11 at 1:45 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, advanced dementia, Parkinson's disease, osteopenia, and sacral decubitus.</p> <p>A physician's order, dated 10/10/11, indicated "Wounds...1. Anchor 16F (french) 10cc (cubic centimeter) balloon foley cath (catheter) x 30 days..." Documentation was lacking related to the Foley catheter being removed after 30 days or the physician extending the order for the Foley catheter.</p> <p>A fax to the physician, dated 10/21/11, indicated "Has a foley catheter..." The response indicated "check (indicated by checkmark) c (with) urologist to see if he wants Foley removed." Documentation was lacking in the clinical record to indicate any follow-up with a urologist regarding removal of the Foley catheter.</p> <p>A "Physician Orders Details," dated</p>		<p>nursing administration. 3. <i>What measures will be put in place to ensure this practice does not recur?</i>The night shift nurses will review new physician orders every 24 hours for proper transcription, and to ensure that interventions are physically in place per the physician order. Any discrepancies will be reported to the Director of Nursing or designee daily. SDC will inservice night nurses on above protocol by 12/31/2011. The Director of Nursing/ designee will review new physician orders, the 24 hour report and focus charting during each tour of duty which will occur at least 5 days a week. She will follow up with any discrepancies not consistent with physician orders. The DON or designee will continue with this monitoring and follow through on an ongoing basis. Inservicing will be completed by SDC by 12/31/2011. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i>The DON or designee will bring the results of her monitoring, as well as any remedial action that was required for discrepancies in physician orders, to the monthly QA Committee meeting so that the members may review the results and provide recommendations for any process improvement. The DON will follow up on any recommendations and report the</p>		

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	<p>10/27/11, from the wound clinic physician indicated "...Keep weight off: - post. thighs...Roho cushion...Alternating low air loss mattress...Seat lifts or shift position in chair every 15 minutes..."</p> <p>A physician's order, dated 10/27/11 and signed by the physician, indicated "Roho cushion, alternating low air loss mattress...position q15min (every 15 minutes)...keep off posterior thighs..."</p> <p>Interview on 11/28/11 at 3:20 P.M., with UM #1 indicated she was unaware the physician had ordered a low air loss alternating mattress.</p> <p>Interview on 11/29/11 at 9:25 A.M., with the Therapy Department Manager indicated the resident did have a cushion with a coccyx cut-out. He indicated it was a "foam with gel" cushion. He had placed a Roho cushion in the resident's wheelchair that morning. He indicated the physician's order should have been followed.</p> <p>Interview on 11/29/11 at 9:30 A.M., with Corporate Nurse #4 indicated there was no documentation of follow-up with a urologist related to removing the Foley catheter. She indicated there was no documentation of positioning of the resident to keep pressure off the thighs or</p>		status of each at the next scheduled QA meeting. This process will continue on an ongoing basis.Completion Date 12/31/2011		

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F0314 SS=D	<p>of seat lifts being done every 15 minutes. She stated "I understand the concern."</p> <p>Review on 11/29/11 at 9:50 A.M., of an undated facility policy and procedure, provided by the Director of Nursing, identified as current, and titled "Indwelling Catheters" indicated "...Insert urinary catheters only when justified medically and ordered by the attending physician..."</p> <p>3.1-35(g)(2)</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 interventions to prevent pressure ulcers</p>	F0314	It is the policy of this facility to ensure a resident who enters the facility without pressure sores does not develop pressure sores	12/30/2011	

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	<p>ordered by a physician were implemented for 1 of 4 residents with pressure ulcers in a sample of 16. (Resident #7).</p> <p>Findings include:</p> <p>On 11/28/11 at 9:20 A.M., during an initial tour with the Director of Nursing, Resident #7 was identified as having "excoriated buttock and thighs." The resident had a Foley catheter for "wounds." The resident was admitted with the pressure ulcers from home.</p> <p>On 11/28/11 at 2:45 P.M., with UM #1 and LPN #6, Resident #7 was observed lying in bed in his room. He was lying on his back. UM #1 and LPN #6 assisted the resident to turn on his left side and UM #1 removed a dressing from the resident's left thigh. The following was observed:</p> <p>There were three pressure ulcers on the posterior aspect of the resident's left thigh. They were measured by UM #1 as follows:</p> <p>6.5 cm (centimeters) by 7.6 cm by < (less than) 0.1 cm; identified as a Stage III 1.5 cm by 3.0 cm by < 0.1 cm; identified as Stage III 1.5 cm by 1.5 cm by < 0.1 cm; identified as Stage III</p>		<p>unless the individuals 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. 1. <i>What corrective action will be done by the facility?</i> Immediately upon the surveyor's report of concern, with resident #7 the wound care clinic was contacted to clarify orders, a low air loss mattress was placed on resident # 7's bed. A record of turning and repositioning was placed on the TAR for licensed nurses to assure the responsibility was completed as ordered. Upon contact with the wound care center, the Roho cushion and the q 15-min thigh lifts were discontinued. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> 100% audit of clinical records of residents with pressure wounds was completed 11/29/2011 by nursing administration. No other residents were affected by this alleged deficiency. Physician orders for the last 30 days were reviewed on 11/29/2011 to ensure accuracy of orders and that orders have been followed through with appropriate interventions put in place. 3. <i>What measures will be put in place to ensure this practice does not recur?</i> The night shift nurses will review new physician orders every 24 hours for proper</p>		

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	<p>There was a pressure ulcer under the resident's scrotum measured by UM #1 as 5.0 cm by 1.5 cm by < 0.1 cm; identified as Stage III.</p> <p>The resident was lying on a pressure reducing mattress with a gel cushion in his wheelchair.</p> <p>On 11/29/11 at 8:15 A.M., Resident #7 was observed lying on his back in bed in his room.</p> <p>Resident #7's clinical record was reviewed on 11/28/11 at 1:45 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited, to advanced dementia, Parkinson's disease, osteopenia, neuralgia, and sacral decubitus.</p> <p>A Minimum Data Set (MDS) admission assessment, dated 10/14/11, indicated cognitively impaired, required extensive two-person physical assistance for bed mobility, transfer, and toilet use, had an indwelling catheter, was incontinent of bowel, had 4 Stage II pressure ulcers, was on a pressure reducing devices for bed and chair, and was on nutrition interventions to manage skin problems.</p> <p>A "Braden Scale for Predicting Pressure Sore Risk," dated 10/9/11, indicated a</p>		<p>transcription, and to ensure that interventions are physically in place per the physician order. Any discrepancies will be reported to the Director of Nursing or designee daily.SDC will inservice night nurses on the above protocol by 12/31/2011.The Director of Nursing will review new physician orders, the 24 hour report and focus charting during each tour of duty which will occur at least 5 days a week. She will follow up with any discrepancies not consistent with physician orders. The DON will continue with this monitoring and follow through on an ongoing basis.4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i>The DON will bring the results of her monitoring, as well as any remedial action that was required for discrepancies in physician orders, to the monthly QA Committee meeting so that the members may review the results and provide recommendations for any process improvement. The DON will follow up on any recommendations and report the status of each at the next scheduled QA meeting. This process will continue on an ongoing basis.Completion Date 12/31/2011</p>		

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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3401 SOLDIERS HOME RD WEST LAFAYETTE, IN47906
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	<p>score of 16, at risk for development of pressure ulcers.</p> <p>"Pressure Ulcer Status Records" indicated:</p> <p>Left groin: 10/8/11 - Stage II - 15 cm x 11 cm 11/23/11 - Stage III - 10 cm x 7.2 cm x 0.1 cm</p> <p>Perineum: 10/8/11 - Stage II - 5 cm x 1.5 cm 11/23/11 - Stage III - 2 cm x 2 cm x 0.1 cm</p> <p>Right medial posterior leg: 11/23/11 - Stage III - 2.2 x 0.8 cm x 0.1 cm</p> <p>Left Lower Extremity: (shown as area under left groin wound) 11/10/11 (reopened) - Stage III - 1.0 cm x 0.7 cm x 0.1 cm 11/23/11 - Stage III - 1.0 cm x 0.4 cm x 0.1 cm</p> <p>A resident care plan, dated 10/11/11, indicated "Wounds...10/28/11 Tx (treatment) per order...10/28/11 Follow by WCC (wound care clinic)..."</p> <p>A resident care plan, dated 11/10/11,</p>			

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	<p>indicated "Has Stage 2 pressure ulcer upon admission at scrotum region and right groin...Reposition every 2 hours and prn (as needed) as needed for comfort...Place pressure-reducing mattress and w/c (wheelchair) cushion...Encourage weight shifts while sitting up in chair...Follow up with wound care...Wound care as ordered by physician..."</p> <p>Wound Clinic "Physician Orders Details," dated 10/27/11, 11/4/11, and 11/18/11 indicated "...Keep weight off: - post. (posterior) thighs...Roho cushion...Alternating low air loss mattress...Seat lifts or shift position in chair every 15 minutes..." Further review indicated the residents wounds were debrided on 10/27/11 resulting in the wounds becoming Stage III.</p> <p>A physician' order, dated 10/27/11, indicated "...Roho cushion, alternating low air loss mattress...position q 15 min (every 15 minutes) in chair...Keep off posterior thighs..."</p> <p>Documentation was lacking in the clinical record related to repositioning the resident in bed every two hours or repositioning the resident in the chair every 15 minutes.</p> <p>A "Nutritional Progress Note," dated</p>				

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	<p>10/20/11, indicated "...Recieves (sic) yogurt @ L (lunch) & S (supper) to increase (indicated by arrow) intake to promote wound healing..."</p> <p>Administration Records, dated October and November 2011, indicated documentation was lacking related to the yogurt having been given to the resident.</p> <p>A hospital laboratory report, dated 10/5/11, indicated "...Albumin...3.1 L (low) (3.4-5.2 g/dL [grams per deciliter]).</p> <p>Interview on 11/28/11 at 2:45 P.M., with UM #1 indicated "I believe it's a gel cushion" in the resident's wheelchair.</p> <p>Interview on 11/28/11 at 3:20 P.M., with UM #1 indicated she was unaware the resident had a physician's order for an alternating low air loss mattress.</p> <p>Interview on 11/29/11 at 9:25 A.M., with Physical Therapy Manager indicated the resident had been given a "cushion with a coccyx cutout." He indicated it was a "foam with gel cushion." He stated "it's rated for Stage II but I don't know if it's rated for Stage III." He also indicated he had changed the cushion to a Roho that morning. He indicated the physician's order should have been followed.</p>				

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	<p>Interview on 11/29/11 at 9:30 A.M. with the Corporate Nurse indicated there was no documentation to indicate the resident had been repositioned in bed every two hours or repositioned in the chair every 15 minutes as ordered. She stated "I understand your concern."</p> <p>Review on 11/29/11 at 12:15 P.M., of a facility policy and procedure, dated 10/7/10, provided by the Corporate Nurse, identified as current, and titled "Repositioning" indicated "...A written repositioning schedule is used and should specify the intervention (e.g. reposition on side, pillows between knees) and frequency (e.g, every 2 hours)...Progress notes, assessments, and other documentation support the monitoring and evaluation of the turning and repositioning...Residents who are assessed to be at risk for developing a pressure ulcer should avoid uninterrupted sitting in any chair or wheelchair...Limit time the resident spends seated in a chair (including wheelchairs) without pressure relief..."</p> <p>3.1-40(a)(2)</p>				

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F0371 SS=E	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on record review and observation, the facility failed to ensure the kitchen staff washed their hands and failed to ensure dishware was handled to prevent contamination during 2 of 2 kitchen observations with the potential to effect 79 of 80 residents dining in the facility. (Cook # 1).</p> <p>Findings include:</p> <p>During the initial kitchen tour on 11/28/11 at 9:15 A.M., Cook #1 went to the handwashing sink and was observed washing her hands for less than 10 seconds.</p> <p>During the 2nd kitchen observation on 11/28/11 at 11:45 A.M., (for the noon meal) Cook # 1 was observed opening drawers to retrieve utensils, opening the refrigerator door to retrieve food, filling bottles of vinegar and moving bowls to the service line. The cook then washed her hands for less than 10 seconds, grabbed the trash can lid with bare hands, opened the trash can to throw away the paper towel and closed the lid. Cook # 1 then proceeded to the service line where</p>	F0371	<p>It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State or Local authorities and to store, prepare, distribute and service food under sanitary conditions. 1. <i>What corrective action will be done by the facility?</i> Immediately upon the surveyor's report of concern, Cook #1 was educated on facility hand washing procedures by Staff Development Coordinator on 11/28/2011. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> Residents utilizing dietary service on 11/28/2011 had the potential to be affected by this alleged deficiency, although none were noted with a negative outcome. 3. <i>What measures will be put in place to ensure this practice does not recur?</i> The Staff Development Coordinator will inservice kitchen associates in regards to hand washing between by 12/31/2011. Facility associates will be educated on facility hand washing procedures upon hire during orientation and at least annually thereafter with competency checks completed by SDC. The Dietary Manager or designee will perform 5 random</p>	12/30/2011			

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	<p>she picked up plates with her thumb over the side of the dish and scooped food on to the plates. She also picked up bowls with four fingers inside the bowls and scooped food into them and repeated this process during the food service multiple times.</p> <p>A current facility policy, dated 5/21/04, and titled "Dietary Services" and provided by the Administrator indicated, "Purpose: To prevent contamination of food products and therefore prevent foodborne illness. Personal Hygiene: ... Wash hands carefully with soap and water whenever they become soiled: ... before touching food, clean dishes ... Handwashing Procedure/Checkoff: ... 5. Lather all areas of hands and wrists, rubbing vigorously for at least 20 seconds...</p> <p>3.1-21(i)(3)</p>		<p>hand-washing audits weekly for 90 days.4. How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?The Dietary Manager will bring the results of the weekly hand washing audits to the QA committee meeting for review and recommendations monthly for the next 90 days. At the end of that time period, the Committee members may stop the Dietary Manager's reporting of audits when each kitchen associate has achieved 100% compliance with the hand washing policy. The Dietary Manager will continue to observe all kitchen associates on a random basis to ensure compliance.Completion date 12/31/2011</p>		

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F0425 SS=E	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure a physician's order was obtained to send medications with a resident on discharge or transfer for 2 of 3 residents reviewed for disposition of medications in a sample of 16 and failed to ensure nursing staff followed professional standards for the administration of a seizure medication through the gastrostomy tube (g-tube) for 1 of 1 g-tube medication administration observations (Residents # 72, #82, and #84).</p> <p>Findings include:</p> <p>1. Resident #82's record was reviewed on 11/30/11 at 1:35 P.M.</p>	F0425	<p>It is the policy of this facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 1. <i>What corrective action will be done by the facility?</i> A. Immediately upon the surveyor's report of concern the facility began to retrain licensed nursing personnel on proper discharge of residents from the facility specifically in regards to the Physician Order for discharge with medication by SDC/HIM by 12/31/2011. Resident #82 and #84 have been discharged from the facility. B. Immediately upon the surveyor's report of concern, licensed Practical Nurse #7 was educated and inserviced on</p>	12/30/2011	

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	<p>Diagnoses included, but were not limited to, active psychotic state, hypertension, depression, peripheral vascular disease, fibromyalgia, chronic obstructive pulmonary disease, and anxiety.</p> <p>Resident #82 was discharged from the facility on 11/5/11.</p> <p>A physician's order, written on 11/4/11, indicated the resident could be discharged when 24 hour home care was available. The order did not indicate any medications could be released with the resident.</p> <p>The disposition of medication records indicated the following medications were sent home with the resident: Lexapro, Zyprexa, Alprazolam, Baclofen, Calcium, Docusate Sodium, Famotidine, Furosemide, Plavix, Gabapentin, Lovenox, Potassium Chloride, Lidoderm patches, Lidocaine Jelly, Nicotrol Inhaler, Tamsulosin, Combivent Inhaler, Cyclobenzaprine, Hydrocodone/APAP, and Morphine Sulfate.</p> <p>During an interview with the DON (Director of Nursing), on 12/1/11 at 9:40 A.M., she indicated there was no order to send the medications with the resident and she knew there should be.</p>		<p>facility Policy & Procedures for administering G-tube medications with competency check by SDC.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same practice? A. discharged residents had the potential to be affected by this alleged deficiency, although none were noted with a negative outcome.B. Any residents with G tube had the potential to be affected by this alleged deficiency, although none were noted with a negative outcome.3. What measures will be put in place to ensure this practice does not recur?A. Physician order will be obtained if medications are to be sent with resident upon discharge. Physician orders will be reviewed by charge nurse prior to discharge. Discharge audits will be completed within 24 hours by medical records M-F with the exception of holidays.Staff Development Coordinator will inservice licensed nursing staff on the proper discharge of residents from facility and disposition of medication upon discharge by 12/31/2011.B. The Staff Development Coordinator will inservice licensed nursing personnel on administering of medications via G-tube with a competency check by 12/31/2011. Licensed nurses to have competency checks of G-tube administering of medications upon hire at</p>		

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			orientation and annually thereafter by SDC or designee. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i> A. Medical records to review / audit discharge charts within 24 hours of discharge M-F with the exception of holidays.A. The Director of Nursing shall audit discharge orders to ensure medications sent with discharged residents have appropriate orders. The DON will bring the results of her audits, as well as any remedial action that was required for discrepancies, to the monthly QA Committee meeting for 90 days so that the members may review the results and provide recommendations for any process improvement. The DON will follow up on any recommendations and report the status of each at the next scheduled QA meeting. This process will continue on an ongoing basis.B. The SDC/ DON/ DON/ Nursing Administration will observe every nurse administering medication through G-tube at least once in the next 30 days. If she observes improper administration techniques, education will be provided, and the DON will continue to monitor that nurse's work and observe their performance until she has achieved 100% compliance. The DON will bring the results of her audits, as well as any remedial	

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	<p>2. The record for Resident # 84 was reviewed on 11/30/11 at 2:00 P.M.</p> <p>Diagnoses for Resident # 84 included but were not limited to: Hypertension, Hyperlipidemia, Coronary Artery Bypass Graft, Coronary Artery Disease, Anemia, Carotid Stenosis and Congestive Heart Failure.</p> <p>A physician's order, dated 9/16/11, indicated "Discharge to (name of another facility)."</p> <p>A "Drug Disposition Form," dated 9/16/11, indicated Aspirin, Combivent Inhaler, Diltiazem, Furosemide, Hydrochlorothiazide, Lisinopril, Metoprolol Tartrate, Omeprazole, and Pradaxa were "Sent with Resident."</p> <p>The record lacked documentation of a physicians order for the resident to be discharged to another facility with the medications.</p> <p>Interview on 12/1/11 at 9:40 A.M., with</p>		<p>action that was required for discrepancies, to the monthly QA Committee meeting for 90 days so that the members may review the results and provide recommendations for any process improvement. Completion Date: 12/31/2011</p>		

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	<p>the Director of Nursing indicated there was no order to send the medications with the resident.</p> <p>A facility policy and procedure was requested but not provided by the Director of Nursing for review.</p> <p>3. During medication pass on 11/29/11 at 12:15 P.M., LPN # 7 prepared Phenytonin (Dilantin, a seizure medication) for Resident # 72. The nurse drew up into the syringe 30 ml. of water, unclamped the g-tube and plunged the water into the tube. LPN # 7 then used the syringe to draw up the Phenytonin, unclamped the g-tube and plunged the medication into the g-tube followed by another 30 ml of water.</p> <p>During an interview with LPN # 7 at that time, she indicated the facility protocol was appropriate to push the water and medications through the g-tube.</p> <p>According to the Geriatric Medication Handbook, Eighth Edition and Copyrighted in 2007, Medication Administration via Enteral Tubes, "Procedures: ... 12. Put 15-30 ml (milliliters) of water in syringe and flush tubing using gravity flow ... 13. ... Pour dissolved/diluted medication</p>				

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	<p>in syringe and unclamp tubing, allowing medication to flow by gravity.</p> <p>Review on 11/29/11 at 1:00 P.M., of an undated facility policy and procedure, provided by the Director of Nursing, identified as current, and titled "Feeding Tubes - Instilling Medication" indicated "...Insert medication by syringe slowly into tube..."</p> <p>3.1-25(p)</p>				

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, record review, and interview, the facility failed to ensure side rail assessments were accurately documented for 2 of 13 residents reviewed for assessments in a sample of 16 (Residents #30 and #72).</p> <p>Findings include:</p> <p>1. The record for Resident #30 was reviewed on 11/29/11 at 8:20 A.M.</p> <p>Current diagnoses included, but were not limited to, acute respiratory distress, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, hypoxia, anemia, diabetes mellitus, and osteoarthritis.</p> <p>A side rail assessment, dated 11/14/11, indicated side rails were recommended due to "resident request." Recommended type of rail was marked as 1/4 rail, left upper and right upper. The assessment</p>	F0514	<p>It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systemically organized. 1. <i>What corrective action will be done by the facility?</i> Immediately upon the surveyor's report of concern, Resident #30 and Resident # 72's side rail assessment was reviewed and revised by nursing administration on 11/29/2011. Resident #30 and Resident #72's care plan for side rail usage were both reviewed and updated by nurse administration. On 11/29/2011. 2. <i>How will the facility identify other residents having the potential to be affected by the same practice?</i> No other residents were affected by this alleged deficiency, a 100% clinical record audit for side rail assessment care plans and care guides will be completed by nursing administration by 12/31/2011. 3. <i>What measures</i></p>	12/30/2011	

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	<p>also indicated the rails were to assist with mobility.</p> <p>During an observation of Resident #30 on 11/28/11 at 10:55 A.M., the resident was in bed and appeared to be resting comfortably. Four half (1/2) rails were present on her bed, right and left upper and lower, and all 4 rails were in the up position.</p> <p>On 11/28/11 at 4:45 P.M., Resident #30's 4 side rails were again in the up position during an interview with the resident's daughter.</p> <p>On 11/29/11 at 2:15 P.M. during an observation of the dressing change for Resident #30, the 4 side rails remained in the up position.</p> <p>During an interview with CNA #5 on 11/29/11 at 3:00 P.M., she indicated she always pulled all the rails up because that is how it was when Resident #30 was first admitted.</p> <p>During an interview with the DON (Director of Nursing) and Nurse Consultant on 11/30/11 at 9:00 A.M., the DON indicated a work order had been submitted to the maintenance department on 11/26/11 to remove the bottom rails, but it had not been done yet.</p>		<p><i>will be put in place to ensure this practice does not recur?</i>The Staff Development Coordinator will inservice nursing staff on side rail reduction and assessment by 12/31/2011.New admissions, re-admissions, and residents with changes in condition re: to side rails will have the side rail assessment completed by licensed nurses. Assessments and plan of care and care guides on all new admissions, re-admissions, and residents with changes in condition re: to side rails will be reviewed by the Director of Nursing or designee within 24 hours of admission or change in condition re: side rails for accuracy. 4. <i>How will corrective action be monitored to ensure the practice does not recur and what QA will be put into place?</i>Director of Nursing or Designee will review 5 charts weekly for 90 days to include admissions and re-admissions on side rail assessments and care plan. The DON will bring the results of her audits, as well as any remedial action that was required for discrepancies, to the monthly QA Committee</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155402	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2011
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	<p>On 11/30/11 at 12:50 P.M., during an interview with the Nurse Consultant, she indicated the maintenance individual had informed her the rails were welded to the bed and could not be removed.</p> <p>On 12/1/11 at 9:40 A.M., during an interview with the DON, she indicated the nurses filling out the assessments needed more education on how to fill them out accurately.</p> <p>2. The record for Resident # 72 was reviewed on 11/29/11 at 12:45 P.M.</p> <p>Diagnoses for Resident # 72 included but were not limited to Epilepsy, Coronary Artery Disease, Stroke and Depression.</p> <p>A document for "Evaluation for Use of Side Rails," originally dated 6/23/10 and updated on 11/13/11, indicated the use of side rails as a seizure precaution. The document indicated the resident had 2 (1/2) partial rails to the left and right upper rails.</p> <p>During observation of the resident on 11/28/11 at 11:00 A.M., the resident was in bed with 4 (1/2) partial rails to the left and right, upper and lower rails.</p> <p>During an interview with the DON on</p>			

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	11/30/11 at 9:00 A.M., she indicated the assessment was incorrect and will be corrected. The resident should have been assessed for upper and lower side rails because of seizure precautions. 3.1-50(a)(2)				