

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/05/2016
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NAME OF PROVIDER OR SUPPLIER PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN 46168
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 28 & 29, and May 2, 3, 4, & 5, 2016</p> <p>Facility number: 000121 Provider number: 155215 AIM number: 100290940</p> <p>Census bed type: SNF/NF: 71 SNF: 14 NF: N/A Total: 85</p> <p>Census payor type: Medicare: 9 Medicaid: 52 Other: 24 Total: 85</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 05/11/2016 by 29479.</p>	F 0000	<p>The facility respectfully requests a desk review</p> <p>Preparation and/or execution of the plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies</p> <p>The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law</p>	
F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</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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	<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 ensure staff did not verbally abuse a resident (Resident #47) and failed to prevent a resident (Resident #32) from physically abusing other residents (Residents #2 and #72) for 2 of 5 allegations of abuse reviewed.</p> <p>Findings include:</p> <p>1. During an interview on 4/28/16 at 2:32 p.m., Resident #47 indicated Certified Nursing Aide (CNA) #31 had yelled at him and, "made fun of his face."</p> <p>On 5/4/16 at 4:20 p.m., Resident #47's record was reviewed. The quarterly Minimum Data Set (MDS) assessment, dated 4/4/16, indicated Resident #47 was able to make himself understood, was able to understand others, and had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Incident report, dated 3/30/16, indicated on 3/28/16, Certified Nursing Aide</p>	F 0223	<p>1.DON will implement corrective actions for residents #47 and #32 including:</p> <p>1.CNA was terminated on 4/1/16 who was involved with resident #47 occurrence.</p> <p>2. #32 was placed on 15 minute checks and referral was made for him to see psych services.</p> <p>3.Resident # 72 was relocated to another room on 5/4/16.</p> <p>2.Other random Residents on same hall were interviewed related to abuse extending beyond allegation of #72 and #32 with no other incidents reported. Additionally, all residents interviewable were interviewed for any concerns related to the abuse policy with no other incidents reported.</p> <p>3.DON or designee will implement measures to ensure that this practice does not recur including:</p> <p>1.The policy related to abuse was reviewed and updated as indicated</p> <p>2.An in-servicing of staff on 5/24/16 which included: abuse policy and prevention, the 2567 with incidents reviewed and</p>	05/31/2016

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	<p>(CNA) #31 had gone into Resident #47's room and was, "pointing her finger and 'making fun' of the skin graft on the right side of his face...." The report indicated, "...Upon investigation and interview of other staff, it was determined that [CNA #31] had mentally abused [Resident #47] and was terminated...."</p> <p>During an interview on 5/5/16 at 2:30 p.m., the Director of Nursing (DON) indicated CNA #31 had admitted she had made fun of Resident #47 and the incident was witnessed by another unnamed CNA.</p> <p>During an interview on 5/5/16 at 2:31 p.m., the Administrator indicated Resident #47 was able to understand CNA #31 was making fun of him from the door way, CNA #31 admitted she did it, and the situation was witnessed by another unnamed CNA.</p> <p>2. During an interview on 5/2/16 at 10:18 a.m., Resident #2 indicated another resident hit his right arm. He indicated the resident's room was across from his, and he pointed to the room. He indicated staff witnessed the incident.</p> <p>Resident #2's record was reviewed on 5/2/16 at 3:20 p.m. Resident #2's Minimum Data Set (MDS) assessment, dated 3/25/16, indicated the resident's</p>		<p>discussion on prevention.</p> <p>3.Facility will continue background checks for potential employees, continue new hire abuse in-service during orientation, continue annual abuse in-service requirements and as needed.</p> <p>4.Information related to # 32 was communicated in an in-service via the 2567 and was placed on a care guide (pocket worksheet) for cna's in reference of resident #32 ability to reach out to other residents.</p> <p>5.Social Services will complete random resident interviews of 2 per week for 4 weeks, then 1 per week for 4 weeks, then 2 a month ongoing with results taken, discussed for any updating or changes needed in the monthly QA meeting.</p> <p>4.Administrator or designee will monitor corrective actions to ensure the effectiveness of these actions:</p> <p>1.Administrator will audit Social Service's random resident interviews after completion that they are completed accurately and followed up per the policy and procedure.</p> <p>2.Facility will review the audit results in the monthly QA meeting with discussion of plan of correction and any additional actions for at least 6 months. The QA Process will then determine the need for any ongoing additional or changes to the monitoring.</p>		

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	<p>Brief Interview for Mental Status (BIMS) score was 11 out of 15 indicating the resident's cognition was moderately impaired. Diagnoses included, but were not limited to: traumatic brain injury, cognitive communication deficit, and difficulty walking.</p> <p>The investigative report received from the Director of Nursing (DON), was reviewed on 5/4/16 at 11:00 a.m. The investigation included a written description of the incident. The report indicated, on 4/29/16, a Certified Nursing Aide (CNA) was pushing Resident #32 in his wheel chair in the hallway when they passed Resident #2. Resident #32 reached out and grabbed Resident #2 and struck him in the right arm 3 times with a closed hand. After a head to toe assessment was completed, no injuries were noted. Residents were immediately separated and safety maintained. A follow up done, on 5/3/16, indicated Resident #2 had no signs of mental anguish. Both residents were referred to psych services for their next visit.</p> <p>Resident # 32's record was reviewed on 5/4/2016 at 9:13 a.m. An MDS, dated 3/17/16, indicated a BIMS score of 5 out of 15 which indicated severe cognitive impairment. No mood or behaviors were identified. The MDS indicated Resident</p>			

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	<p>#32 required extensive assistance of one person for bed mobility, hygiene, and dressing, and extensive assistance of two people for transfers, toilet use, and was a total dependence of two people for bathing. The MDS indicated Resident #32 utilized a wheelchair for locomotion with 1 person physical assist. Diagnoses included, but were not limited to: muscle weakness, difficulty walking, and lack of coordination.</p> <p>3. During an interview, on 5/2/16 at 2:10 p.m., Resident #72 indicated his roommate poked his butt two days ago. He indicated staff were aware of the incident.</p> <p>Resident #72's record was reviewed on 5/2/2016 at 3:45 p.m. A Minimum Data Set (MDS), dated 3/16/16, indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating he was cognitively intact. Diagnoses included, but were not limited to: traumatic brain injury, major depressive disorder, and personality disorders.</p> <p>During a review of the reportable incidents on 5/4/16 at 11:00 a.m., the incidents lacked documentation of the incident reported by Resident #72. The Director of Nursing (DON) indicated she was unaware of the incident and would</p>			

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	<p>investigate it.</p> <p>During an interview on 5/04/2016 at 11:51 a.m., Resident #72 told the Executive Director (ED) his roommate poked at his butt 2 days ago. He further indicated he was scared of his roommate and wanted to change rooms.</p> <p>During an interview on 5/04/2016 at 12:01 p.m., Resident #72 named Resident #32 as the one who poked his butt.</p> <p>Resident #32's record was reviewed on 5/4/2016 at 9:13 a.m. An MDS, dated 3/17/16, indicated a BIMS score of 5 out of 15 which indicated severe cognitive impairment. No mood or behaviors were identified. The MDS indicated Resident #32 required extensive assistance of 1 for bed mobility, hygiene, and dressing, and extensive assistance of 2 for transfers, toilet use, and was a total dependence of 2 for bathing. The MDS indicated Resident #32 utilized a wheelchair for locomotion with 1 person physical assist. Diagnoses included, but were not limited to muscle weakness, difficulty walking, and lack of coordination.</p> <p>On 5/4/16 at 3:25 p.m., the Administrator provided the current policy titled, "Abuse Investigations." The policy lacked documentation related to preventing and</p>			

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F 0226 SS=D Bldg. 00	<p>protecting residents from abuse. The Administrator indicated they followed Centers for Medicare and Medicaid Services (CMS) guidelines related to protecting residents from abuse.</p> <p>3.1-27(a)(1) 3.1-27(b)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement its policies and procedures to ensure staff did not verbally abuse a resident (Resident #47) and failed to prevent a resident from physically abusing other residents (Residents #2 and #72) for 3 of 5 allegations of abuse reviewed.</p> <p>Findings include:</p> <p>1. During an interview on 4/28/16 at 2:32 p.m., Resident #47 indicated Certified Nursing Aide (CNA) #31 had</p>	F 0226	<p>1.DON will implement corrective actions for residents # 47 and # 32 including:</p> <p>1.CNA was terminated on 4/1/16 who was involved with resident #47 occurrence.</p> <p>2. #32 was placed on 15 minute checks and referral was made for him to see psych services.</p> <p>3.Resident # 72 was relocated to another room on 5/4/16.</p> <p>2.Other random Residents on same hall were interviewed related to abuse extending</p>	05/31/2016

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	<p>yelled at him and, "made fun of his face."</p> <p>On 5/4/16 at 4:20 p.m., Resident #47's record was reviewed. The quarterly Minimum Data Set (MDS) assessment, dated 4/4/16, indicated Resident #47 was able to make himself understood, was able to understand others, and had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 12 out of 15.</p> <p>Incident report, dated 3/30/16, indicated on 3/28/16, Certified Nursing Aide (CNA) #31 had gone into Resident #47's room and was, "pointing her finger and 'making fun' of the skin graft on the right side of his face...." The report indicated, "...Upon investigation and interview of other staff, it was determined that [CNA #31] had mentally abused [Resident #47] and was terminated...."</p> <p>During an interview on 5/5/16 at 2:30 p.m., the Director of Nursing (DON) indicated CNA #31 had admitted she had made fun of Resident #47 and the incident was witnessed by another unnamed CNA.</p> <p>During an interview on 5/5/16 at 2:31 p.m., the Administrator indicated Resident #47 was able to understand CNA #31 was making fun of him from</p>		<p>beyond allegation of #72 and #32 with no other incidents reported. Additionally, all residents interviewable were interviewed for any concerns related to the abuse policy with no other incidents reported.</p> <p>3.DON or designee will implement measures to ensure that this practice does not recur including:</p> <p>1.The policy related to abuse was reviewed and updated as indicated</p> <p>2.An in-servicing of staff on 5/24/16 which included: abuse policy and prevention, the 2567 with incidents reviewed and discussion on prevention.</p> <p>3.Facility will continue background checks for potential employees, continue new hire abuse in-service during orientation, continue annual abuse in-service requirements and as needed.</p> <p>4.Information related to # 32 was communicated in an in-service via the 2567 and was placed on a care guide (pocket worksheet) for cna's in reference of resident #32 ability to reach out to other residents.</p> <p>5.Social Services will complete random resident interviews of 2 per week for 4 weeks, then 1 per week for 4 weeks, then 2 a month ongoing with results taken, discussed for any updating or changes needed in the monthly QA meeting.</p> <p>4.Administrator or designee will</p>				

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F 0242 SS=D Bldg. 00	<p>the door way, CNA #31 admitted she did it, and the situation was witnessed by another unnamed CNA.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure a resident received showers instead of bed baths according to his preference for 1 of 3 residents reviewed for choices (Resident #47). Finding includes:</p>	F 0242	<p>monitor corrective actions to ensure the effectiveness of these actions:</p> <p>1.Administrator will audit Social Service's random resident interviews after completion that they are completed accurately and followed up per the policy and procedure.</p> <p>2.Facility will review the audit results in the monthly QA meeting with discussion of plan of correction and any additional actions for at least 6 months. The QA Process will then determine the need for any ongoing additional or changes to the monitoring.</p> <p>1.DON will implement corrective actions for resident # 47 affected by this practice including: In-service staff on shower preference on 5/24/16. 2.DON or designee will assess residents having the potential to be affected by this practice, including: residents to be interviewed by 5/26/16 for choices of shower preference and times.</p>	05/31/2016	

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	<p>During an interview on 5/04/16 at 10:21 a.m., Resident #47 indicated he was given bed baths. He indicated he preferred to receive two showers per week, but had not been given a shower in weeks and only received a cold washcloth across his genital area a few times a week, and the staff did not wash his face during those times.</p> <p>Resident #47's record was reviewed on 5/4/16 at 3:55 p.m. The significant change Minimum Data Set (MDS) assessment, dated 2/18/16, indicated Resident #47 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15. The MDS indicated it was "somewhat important" to Resident #47 to choose between showers and baths, and he required two person's assistance with bathing.</p> <p>Resident #47's plan of care, dated 4/6/15 and revisited date 4/13/16, indicated resident and family were aware of the availability of the spa room. Resident did prefer showers on day shift Tuesday and Friday.</p> <p>The document titled "Certified Nursing Assistant (CNA) Bath Check List." for the month of March 2016 indicated the resident received bed baths on 3/1/16, 3/4/16, 3/8/16, 3/15/16, and 3/17/16. For</p>		<p>Care plans and CNA assignment sheets were revised if necessary.</p> <p>3.DON or designee will implement measures to ensure that this practice does not recur, including: Nursing staff in-serviced on shower preferences. DON or designee will monitor once a week x 6 weeks, biweekly x 6 weeks, then monthly x 3 months.</p> <p>4.DON or designee will monitor corrective actions including "Right of Choice" for showers at monthly QA meeting for review and recommendations. This will be done monthly for 6 months. Determination of ongoing monitoring will be completed within the QA process.</p>	

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F 0278 SS=D Bldg. 00	<p>the month of April Resident #47 received bed bath's on 4/5/16, 4/8/16, 4/15/16, 4/16/16, and 4/22/16.</p> <p>During a interview on 05/04/2016 2:30 p.m. Unit Manager#30 indicated that Resident #47 preferred bed baths.</p> <p>On 5/5/16 at 1:35 p.m., the Administrator provided the current policy titled, "Care Planning- Interdisciplinary Team." The policy indicated, "...Nursing Assistants [were] responsible for the resident's care; and others as appropriate or necessary to meet the needs of the resident..."</p> <p>3.1-3(u)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p>			

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	<p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure accurate Minimum Data Set (MDS) assessment coding for hospice services for 1 of 30 residents reviewed for assessments (Residents #11).</p> <p>Finding includes:</p> <p>During an interview on 5/4/16 at 2:32 p.m., Unit Manager #30 indicated Resident #11 was receiving hospice services.</p> <p>Resident #11's record was reviewed on 5/5/16 at 10:40 a.m. The significant change Minimum Data Set (MDS) assessment, dated 11/1/15, indicated Resident #11 received hospice services.</p>	F 0278	<p>1.DON will implement corrective actions for resident #11 affected by this practice, including: MDS for resident #11 has been modified as receiving hospice services on 5/5/16.</p> <p>2.DON or designee will assess residents having the potential to be affected by this practice, including: review of MDS for hospice patients before submission to CMS.</p> <p>3.DON or designee will implement measures to ensure that this practice does not recur, including: in-service MDS staff on 5/26/16.</p> <p>4.DON or designee will monitor corrective actions to ensure the effectiveness of these actions, including: review of MDS for hospice patients during monthly QA meeting. This will be done for 6 months. Determination of</p>	05/31/2016

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F 0314 SS=D Bldg. 00	<p>The quarterly MDS, dated 2/10/16, lacked documentation Resident #11 received hospice services.</p> <p>The physician order, dated 11/10/15, ordered a hospice evaluation for Resident #11. The care plan, dated 11/19/15, indicated, "Resident requires long term placement with hospice...."</p> <p>During an interview on 5/5/16 at 3:43 p.m., the Minimum Data Set (MDS) Coordinator indicated the MDS, dated 2/10/16 was inaccurate and Resident #11 was receiving hospice services.</p> <p>During an interview on 5/5/16 at 3:53 p.m., the Administrator indicated there was no policy related to MDS completion and staff followed the Centers of Medicare and Medicaid Services guidelines.</p> <p>3.1-31(i)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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</p>		ongoing monitoring will be completed within the QA process.				

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	<p>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 implement pressure reducing interventions to prevent a resident from developing unstageable (full thickness tissue loss with wound base covered), suspected deep tissue (blood filled blister), and stage 2 (partial thickness loss) pressure ulcers for 1 of 2 residents reviewed for pressure ulcers (Residents #65).</p> <p>Findings include:</p> <p>During an interview, on 4/29/16 at 11:24 a.m., Licensed Practical Nurse (LPN) #20 indicated Resident #65 had unstageable pressure ulcers on the bilateral heel wounds, and indicated they were scabbed, and he had a stage 2 (partial thickness loss) pressure ulcer on his right buttock.</p> <p>During an observation on 4/29/16 at 2:23 p.m., an open area was observed on Resident #65's buttocks and red, non-blanching discoloration was observed on the coccyx when Certified Nursing Assistant (CNA) #25 provided incontinence care.</p>	F 0314	<p>1.DON will implement corrective actions for resident # 65 affected by this practice: Heel lift boots were placed on resident at that time. Residents care plan was updated to include resident declining heel lift boots at times.</p> <p>2.Facility completed a 100% audit of all residents using Braden scale and pressure ulcer reducing interventions. Interventions reviewed, changed as needed with plan of care updated.</p> <p>3.DON or designee will implement measures to ensure that this practice does not recur, including: in-service of nursing staff on Braden scale and pressure reducing interventions on 5/24/16.</p> <p>1.Unit managers or designee to round 3 X per week X 6 weeks, then weekly within their duties to observe pressure reducing equipment is in place as care planned.</p> <p>2.DON/Designee will review as completed the audits in morning clinical meeting for ongoing compliance weekly.</p> <p>3.Assessments will be completed within admission guidelines for pressure risk and interventions will be implemented at that time.</p> <p>4.Care plan meeting will be held quarterly to include</p>	05/31/2016

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	<p>During an observation, on 05/04/2016 at 10:37 a.m., Resident #65 was observed sitting in his recliner, bilateral heel lift boots were not on, his feet were hanging over the end of the raised recliner. Resident #65 indicated they took the boots off this morning and had not put them back on.</p> <p>During an observation, on 5/4/16 at 11:19 a.m., Resident #56 was sitting in his recliner, bilateral heel lift boots not on and his feet were hanging over the raised recliner leg area.</p> <p>During an observation, on 5/4/16 at 5:02 p.m., Resident #65 was lying in bed no bilateral heel lift boots on.</p> <p>During an observation, on 5/5/2016 at 8:53 a.m., Resident #65 was in the dining room sitting in his wheelchair, he had nonskid socks on and no bilateral heel lift boots on.</p> <p>During an observation, on 5/5/16 at 9:34 a.m., Resident #65 was observed in the dining room with nonskid socks on and no bilateral heel lift boots on, propelling himself with his feet in his wheelchair.</p> <p>During an observation, on 5/5/16 at 9:44 a.m., Resident #65 was observed sitting</p>		<p>completion of a Braden scale assessment and residents care plan will be reviewed for any changes in interventions and residents compliance. Braden scale also will be done prn</p> <p>4. Facility will review the audit results in the monthly QA meeting with discussion of plan of correction and any additional actions for at least 6 months. The QA Process will then determine the need for any ongoing additional or changes to the monitoring.</p>	

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	<p>in his recliner no bilateral heel lift boots on. His feet were resting on the floor and his boots were on the bed.</p> <p>During an observation, on 5/5/16 at 9:55 a.m., Resident #65's feet were elevated in recliner and his heels were hanging off the end of the recliner, no bilateral heel lift boots were on. Resident #65 was then observed getting back in his wheelchair. CNA #24 assisted him and did not offer to put bilateral heel lift boots on his feet. The boots were sitting on his bed.</p> <p>During an observation of bilateral heel dressing changes on 5/5/16 at 11:31 a.m., LPN #20 indicated Resident #65 's pressure ulcers on his heels were unstageable with scabbed areas. The left heel had a yellowish scab on the interior of the heel. The right heel had a blackish scab covering the majority of the heel.</p> <p>Resident #65's record was reviewed on 5/4/16 at 9:50 a.m. Diagnoses included, but were not limited to, type 2 diabetes, muscle weakness, difficulty walking, pain in unspecified joint, and lack of coordination.</p> <p>A Minimum Data Set (MDS), dated 3/9/16, indicated Resident #65 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14 out</p>			

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	<p>of 15. The resident required extensive assistance of 1 for bed mobility, toileting, and hygiene. Extensive assistance of 2 persons was required for transfers. The resident was at risk for pressure ulcers and had 1 or more pressure ulcers at stage 1 or greater. The assessment indicated the resident had two stage 2 pressure ulcers and only 1 was present on admission to the facility. The resident was frequently incontinent of urine and always incontinent of bowel</p> <p>An admission Braden scale for predicting pressure sore risk dated 1/15/16 indicated he had a score of 12, indicating he was high risk for developing pressure ulcers due to moisture, limited mobility and inability to communicate discomfort or pain. The resident had sensory impairment which limited the ability to feel pain or discomfort in the extremities.</p> <p>A physician 's order, dated 4/25/16, indicated heel lift boots were to be utilized at all times every shift for pressure relief.</p> <p>A care plan, dated 1/18/16, indicated the resident had " open areas, " a history of open areas to right buttock, and had open areas to left buttock. He had an open area to right heel. Care plan interventions included, but were not limited to, heel lift</p>			

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	<p>boots at all times every shift for pressure relief.</p> <p>Wound measurements documented on the "Weekly Wound Observation Report," indicated a pressure ulcer on the right buttock on 1/19/16 measuring 0.5 cm (centimeters) in length by 0.5 cm in width, with no depth. The record showed progressive wound healing and the ulcer was "closed" on 4/4/16. A pressure ulcer on the left buttock was 0.5 cm (length) by 0.5 cm (width) by 0.1 cm (depth) on 1/25/16. The wound records indicated the wound was "closed" on 4/18/16. The wound records indicated a pressure ulcer on the right heel on 3/24/16, measuring 3.5 cm in length by 3.5 cm in width. Additional measurements included:</p> <ul style="list-style-type: none"> a. 3/28/16: 3.5 cm in length by 3.5 cm in width. b. 4/4/16: 1.5 cm in length by 1.5 cm in width. c. 4/11/16: 1.5 cm in length by 1.5 cm in width. d. 4/8/16: 1.0 cm in length by 0.8 cm in width. <p>A weekly skin observation report of the left heel indicated a pressure ulcer was acquired on 4/25/16 and measured 3.0 cm in length by 4.0 cm in width.</p>			

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	<p>A progress note dated 5/5/16 at 8:30 a.m., indicated he refused his bilateral heel lift boots.</p> <p>A progress note dated 5/5/16 at 9:48 a.m., indicated he had refused his bilateral heel lift boots.</p> <p>During an interview, on 5/4/16 at 10:49 a.m., Certified Nurse ' s Assistant (CNA) #22 indicated she was unaware of any pressure areas on the resident ' s buttocks.</p> <p>During an interview, on 5/4/16 at 11:02 a.m., LPN #21 indicated she was not sure if Resident # 65 had pressure areas, and was not aware of any interventions.</p> <p>During an interview, on 5/5/16 at 9:36 a.m., LPN #20 indicated she did treatments to Resident #65's buttocks and bilateral heels. She indicated the pressure ulcers on the resident ' s heels were unstageable and he was to wear heel protectors at all times. She indicated his bottom was excoriated.</p> <p>During an interview, on 5/4/16 at 10:58 a.m., CNA #23 indicated she was aware that Resident #65 had bilateral foot pressure areas, but did not know if he had bilateral heel lift boots.</p> <p>During an interview, on 5/5/16 at 10:00</p>			

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	<p>a.m., CNA #24 indicated she was not sure if Resident #65 had precautions or interventions for pressure ulcers.</p> <p>During an interview on 5/5/16 at 10:03 a.m., the Unit Manager indicated Resident #65 refused to wear his bilateral heel lift boots on that day.</p> <p>On 5/5/16 at 1:37 p.m., the Administrator provided the current policy, titled, "Pressure Ulcers/Skin Breakdown...." The policy indicated, "...The nursing staff will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s)...The physician will help identify medical interventions related to wound management...The physician will help the staff review and modify the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions...."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			