

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155651	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/04/2015
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NAME OF PROVIDER OR SUPPLIER  HOMEVIEW CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 27, 28, 29, 30, and 31, 2015 and August 3 and 4, 2015.</p> <p>Facility number: 000353 Provider number: 155651 AIM number: 100291330</p> <p>Census bed type: SNF: 14 SNF/NF: 94 Total: 108</p> <p>Census payor type: Medicare: 14 Medicaid: 68 Other: 26 Total: 108</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise</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's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed for residents who; based on comprehensive assessments; were at risk for and experienced a significant weight loss (Resident #144), development of a pressure ulcer (Resident #180), and a fall (Resident #52).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #14 was reviewed on 7/30/15 at 3:49 p.m. Diagnoses for the resident included, but were not limited to, congestive heart failure and depressive disorder. The resident was admitted to the facility on 2/10/15.</p>	F 0279	<p><b>F279 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</b></p> <p>Resident #144 plan of care was reviewed and revised to ensure that care plans were developed regarding significant weight loss and risk for further weight loss.</p>	09/03/2015

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	<p>An admission Minimum Data Set assessment, dated 2/17/15, indicated the resident's nutritional status was at risk and would be addressed in a care plan created for the resident.</p> <p>The following weights were obtained for Resident #14:</p> <p>2/10/15: 207 (admission weight) 2/21/15: 190 3/27/15: 183 4/17/15: 188 5/22/15: 180 6/19/15: 177</p> <p>A Nutrition at Risk (NAR) note, dated 2/21/15 at 8:58 a.m., indicated the resident had lost 13 lbs pounds) since admission, which was a significant weight loss.</p> <p>A NAR note, dated 3/20/15 at 1:17 p.m., indicated the resident had experienced a 12.2% significant weight loss in 90 days.</p> <p>A Weight Change Note, dated 5/12/15 at 4:28 p.m., indicated a significant weight loss of 13.2% in 90 days.</p> <p>A care plan dated 2/10/15, current through 9/6/15, indicated the resident had congestive heart failure. Interventions</p>		<p>Resident #180 plan of care was reviewed and revised to ensure that care plans were developed regarding risk for and actual development of pressure ulcer. Resident #52 plan of care was reviewed and revised to ensure that care plans were developed regarding fall and potential for further falls. <b>2) How the facility identified other residents:</b> All residents with weight loss or assessed and identified as at risk for weight loss have the potential to be affected. All residents with pressure ulcer development or assessed and identified as at risk for the development of pressure ulcers have the potential to be affected. All residents with falls noted or assessed and identified to be at risk for falls have the potential to be affected. <b>3) Measures put into place/ System changes:</b> A facility care plan audit was completed for current residents identified with weight loss and/or potential for weight loss, residents identified with pressure ulcer development and/or risk for pressure ulcers, residents identified with falls noted and/or at risk for falls to ensure that care plans were developed. Licensed staff will be inserviced on the development of comprehensive care plans. IDT careplan review will be conducted with completion of comprehensive assessments to ensure that a careplan has been</p>	

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	<p>included, "...I will allow myself to be weighed as the physician ordered/as needed, I will consume my diet as ordered..."</p> <p>No other care plans were found in the resident's record regarding nutrition or significant weight loss.</p> <p>On 7/31/15 at 11:50 a.m. the Corporate Dietician indicated it was a new corporate policy that nutritional needs would not have their own care plan, but would be tied into a care plan from another discipline. She indicated there was a, "learning curve" with this new policy.</p> <p>On 7/31/15 at 12:02 p.m., the Certified Dietary Manager indicated, "I should have put in a significant weight loss care plan."</p> <p>2. The clinical record review for Resident #180, completed 8/4/15 at 9:21 a.m., indicated the resident had diagnoses including, but not limited to, hyponatremia and weakness. Hyponatremia is a condition characterized by low blood levels of sodium (salt).</p> <p>The Admission Nursing Assessment completed 6/23/15 at 4:00 p.m., assessed</p>		<p>developed for needs identified in each resident's comprehensive assessment. An audit will be completed in Clinical Meeting on business days to ensure that residents identified with and/ or at risk for significant weight loss, pressure ulcer development and falls, have care plans developed.</p> <p>The DON/designee is responsible for oversight. <b>4)</b></p> <p><b>How the corrective actions will be monitored:</b> The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance. <b>5) Date of compliance: 09/03/15</b></p>	

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	<p>the resident as needing to use a walker for ambulation, as having intermittent confusion, having a history of falls, and requiring assistance of 1 staff person for ambulation and transfers. The resident's skin was assessed as being intact. The assessment lacked an indication of the resident being at risk for pressure ulcers and lacked preventative measures for pressure ulcer prevention.</p> <p>A 5-Day Minimum Data Set (MDS) assessment completed 6/30/15, assessed Resident #180 as being at risk for the development of a pressure ulcer. The clinical record lacked a care plan for the resident being at risk for the development of pressure ulcers.</p> <p>A written care plan initiated on 7/2/15, indicated the resident had a Stage 2 pressure ulcer on the left heel and was at risk for the development of pressure ulcers. The area was described as a fluid filled blister. The interventions included treatment as ordered, resting on a pressure redistribution surface, floating heels while in bed, and observing the skin weekly.</p> <p>During an interview with the Director of Nursing (DON) on 8/4/15 at 11:16 a.m., the DON indicated the resident was not assessed as being at risk for pressure</p>			

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	<p>ulcer development upon admission as the resident was able to ambulate with a walker and indicated the pressure ulcer developed due to the resident's shoes rubbing on the heel.</p> <p>3. The clinical record of Resident #52 was reviewed on 7/31/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, muscle weakness, difficulty walking, and cognitive defects. The resident was admitted to the facility on 6/19/15.</p> <p>An admission Minimum Data Set assessment, dated 6/19/15, indicated Resident #52 was moderately impaired in the ability to make decisions and needed extensive assistance of 2 staff for transferring, walking and toileting.</p> <p>A Quarterly Risk Assessment dated 6/19/15, indicated Resident #52 had intermittent confusion, 1-2 falls in past 3 months, had a balance problem while standing and walking, and was a high risk for falls.</p> <p>A care plan dated 6/19/15, current through 9/16/15, indicated, "I am at risk for falls related to decreased mobility...balance difficulty." Two interventions were initiated on 6/19/15. The interventions were proper footwear</p>			

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	<p>and personal items within reach.</p> <p>A nurse's note dated 7/12/15 at 1:16 p.m. indicated Resident #52 fell in the bathroom. The note indicated the resident had no apparent injuries and was encouraged to ask for assistance with transferring.</p> <p>An Interdisciplinary Team Fall note, dated 7/13/15, indicated the resident went to the bathroom by herself on 7/12/15, lost her balance and fell. "Resident was not supposed to be transferring or toileting herself without staff assistance... [the resident] stated that she did not know she was supposed to have assistance of staff and that she thought she was ok to take herself...Intervention and care plan updated...Resident will request the assistance of staff for transferring..."</p> <p>On 7/13/15 a new intervention was added to the resident's fall care plan, "I will request staff assistance with toileting and transferring until therapy tells me I am able to do it on my own."</p> <p>On 7/31/15 at 11:38 a.m., the Director of Nursing indicated the intervention of the resident requesting staff assistance for toileting and transferring should have been included in the resident's care plan at the time of her admission, so that staff</p>			

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F 0282 SS=D Bldg. 00	<p>and the resident would be aware she needed assistance due to muscle weakness and difficulty walking.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure labs were drawn as ordered by the physician, which resulted in a resident being hospitalized (Resident #136) and fall interventions were implemented according to a resident's care plan (Resident #72).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #136 was reviewed on 8/3/15 at 1:19 p.m. Diagnoses for the resident included, but were not limited to, pneumonia, congestive heart failure, cardiac dysrhythmias, and hyponatremia.</p> <p>Hyponatremia is a condition where the level of sodium in the blood is abnormally low. Sodium is an electrolyte which helps nerves and muscles work,</p>	F 0282	<p><b>F282</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state</i></p>	09/03/2015

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	<p>and helps maintain the fluid balance in the body.</p> <p>Resident #136 was admitted to the facility on 2/11/15. Discharge orders from the hospital, dated 2/11/15, indicated the resident should have a Basic Metabolic Panel (BMP) laboratory blood test drawn 2 - 3 days after her hospital discharge on 2/13/15. A BMP blood test measures the electrolyte and fluid balance in the body.</p> <p>Review of a lab result dated 2/13/15 (a Friday) indicated Resident #136's sodium level was 128. The lab result indicated the normal range for sodium is 135-145.</p> <p>A physician's order dated 2/12/15, indicated Resident #136 should have a BMP drawn weekly on Monday for 4 consecutive weeks.</p> <p>Another lab result, dated 2/16/15 (a Monday), ordered by the physician on 2/14/15, indicated the resident's sodium level was down to 122.</p> <p>No lab results were found in the resident's record for Monday, 2/23/15.</p> <p>On 8/4/15 at 3:00 p.m. the Unit Manager on the 100 Hall indicated she was not aware until Thursday, 2/26/15, that the</p>		<p><i>law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #136 has discharged from the facility. Resident #72 care plan reviewed and observation completed to ensure that fall interventions are in place.</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents requiring lab monitoring have the potential to be affected. All residents at risk for falls have the potential to be affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>An audit of residents noted with current lab orders was conducted to ensure that physician's orders are being followed. An audit of residents noted with risk for falls was</p>	

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	<p>BMP ordered for Resident #136 to be drawn on 2/23/15, had not been drawn as ordered by the physician.</p> <p>A "Stat" (immediately) BMP was ordered by the physician on 2/26/15. The results indicated the resident's sodium level was down to 112. After the physician reviewed the sodium level at 112, the physician ordered the resident to be sent to the emergency room "STAT" for evaluation and treatment.</p> <p>A facility Change in Condition Evaluation, dated 2/26/15, indicated the resident had abnormal vital signs, her oxygen saturation level was decreasing, and, "Labs are critical values." The nurse who filled out the evaluation indicated, "RN: I think the problem may be: Hyponatremia."</p> <p>A nurse's note, dated 2/26/15, at 7:36 p.m., indicated, "Updated on residents condition, resident admitted to [name of hospital] with diagnosis of hyponatremia."</p> <p>A hospital Discharge Diagnosis, dated 3/3/15, indicated, "septic shock-source pulmonary: Resolving... Acute [onset] chronic hyponatremia: Resolving... Acute respiratory failure secondary to pneumonia/volume overload." Volume</p>		<p>completed to ensure that interventions are in place as per plan of care.</p> <p>Licensed staff will be inserviced on obtaining labs as ordered per physician. Licensed staff will be inserviced regarding implementation of fall prevention interventions.</p> <p>Licensed staff will be inserviced related to completing rounds on unit to ensure that fall prevention interventions are implemented as indicated by the plan of care and to ensure that interventions to prevent pressure ulcers are implemented.</p> <p>The Nurse Rounding Tool will be completed each shift.</p> <p>Lab orders will be audited in the Clinical Meeting on business days to ensure that upcoming labs are scheduled as ordered and that previous day scheduled labs were obtained as ordered. Completed Nurse Rounding Tools will be reviewed and ongoing audits will be conducted in the Clinical Meeting on business days to ensure that fall prevention interventions are implemented as indicated by the plan</p>	

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	<p>overload means too much fluid in the blood.</p> <p>The hospital discharge indicated Resident #136 died on 3/3/15.</p> <p>2. The clinical record of Resident #72 was reviewed on 7/30/15 at 3:00 p.m. Diagnoses for the resident included, but were not limited to chronic obstructive pulmonary disease and high blood pressure.</p> <p>Review of a nurse's note dated 7/25/15 at 5:56 a.m., indicated Resident #72 resident was found lying on the floor in her bathroom.</p> <p>A care plan dated 1/2/15, indicated Resident #72 was at risk for falls. Interventions included:</p> <p>7/27/15: Orthostatic blood pressure (blood pressure readings taken while the resident is in lying, sitting and standing positions) day and evening shift times 3 days.</p> <p>No orthostatic blood pressures were found in the resident's record.</p> <p>On 7/31/15 at 12:58 p.m. the Director of Nursing indicated the orthostatic blood pressures had not been done.</p>		<p>of care and to ensure that interventions to prevent pressure ulcers are implemented.</p> <p>The Director of Nursing/ designee is responsible for oversight.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p> <p><b>5) Date of compliance: 09/03/15</b></p>	

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F 0309 SS=G Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 a laboratory blood test was drawn according to physician's orders, resulting in a critical lab level and emergency admission to an acute care hospital. (Resident #136)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #136 was reviewed on 8/3/15 at 1:19 p.m. Diagnoses for the resident included, but were not limited to, pneumonia, congestive heart failure, cardiac dysrhythmias, and hyponatremia.</p> <p>Hyponatremia is a condition where the level of sodium in the blood is abnormally low. Sodium is an electrolyte which helps nerves and muscles work, and helps maintain the fluid balance in</p>	F 0309	<p><b>F309 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</b> Resident #136 has discharged from the facility. <b>2) How the facility identified other residents:</b> All residents requiring lab monitoring have the potential to be affected. <b>3) Measures put into place/ System changes:</b> An audit of</p>	09/03/2015

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	<p>the body.</p> <p>Resident #136 was admitted to the facility on 2/11/15. Discharge orders from the hospital, dated 2/11/15, indicated the resident should have a Basic Metabolic Panel (BMP) laboratory blood test drawn 2 - 3 days after her hospital discharge (2/13/15). A BMP blood test measures the electrolyte and fluid balance in the body.</p> <p>Review of a lab result dated 2/13/15 (a Friday), indicated Resident #136's sodium level was 128. The lab result indicated the normal range for sodium is 135-145.</p> <p>A physician's order dated 2/12/15, indicated Resident #136 should have a BMP drawn weekly on Monday for 4 consecutive weeks.</p> <p>Another lab result, dated 2/16/15 (a Monday), ordered by the physician on 2/14/15, indicated the resident's sodium level was down to 122, below the normal range of 135-145.</p> <p>No lab results were found in the resident's record for Monday, 2/23/15.</p> <p>On 8/4/15 at 3:00 p.m. the Unit Manager on the 100 Hall indicated she was not</p>		<p>residents noted with current lab orders was conducted to ensure that physician's orders are being followed. Licensed staff will be inserviced on obtaining labs as ordered per physician. Lab orders will be audited in the Clinical Meeting on business days to ensure that upcoming labs are scheduled as ordered and that previous day scheduled labs were obtained as ordered. The Director of Nursing/ designee is responsible for oversight. <b>4)</b> <b>How the corrective actions will be monitored:</b> The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance. <b>5) Date of compliance: 09/03/15</b></p> <p>Response to deficiency reported on Resident #136 The initial statement of evidence that requirement not met as evidenced by: ...laboratory blood test was drawn according to physician's orders, resulting in a critical lab level and emergency admission to an acute care hospital, is factually incorrect. There is no way that not drawing a lab results in an abnormal lab. An abnormal lab results from some change occurring in a person and can in no way be altered by either drawing or not drawing a lab. The correct review of the current situation is as follows. This patient had chronic hyponatremia, her</p>		

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	<p>aware until Thursday, 2/26/15, that the BMP ordered for Resident #136 to be drawn on 2/23/15, had not been drawn as ordered by the physician.</p> <p>A "Stat" (to be done immediately) BMP was ordered by the physician on 2/26/15. The results indicated the resident's sodium level was down to 112. After the physician reviewed the sodium level at 112, the physician ordered the resident to be sent to the emergency room "STAT" for evaluation and treatment.</p> <p>A facility Change in Condition Evaluation, dated 2/26/15, indicated the resident had abnormal vital signs, her oxygen saturation level was decreasing, and, "Labs are critical values." The nurse who filled out the evaluation indicated, "RN: I think the problem may be: Hyponatremia."</p> <p>A nurse's note, dated 2/26/15, at 7:36 p.m., indicated, "Updated on residents condition, resident admitted to [name of hospital] with diagnosis of hyponatremia."</p> <p>A hospital Discharge Diagnosis, dated 3/3/15, indicated, "septic shock-source pulmonary: Resolving... Acute [onset] chronic hyponatremia: Resolving... Acute respiratory failure secondary to</p>		<p>baseline was in the low 120's. There had been many episodes in her hospital records of values in the low 110's. Since people with chronic hyponatremia adapt to this and thus don't have the symptoms nor the serious consequences of developing a worsening in the hyponatremia. The reviewed apparently disregarded the note on the record by the nurse practitioner who saw the patient on the day she was transferred out after the lab obtained 2/26/15. This note specifically noted that the patient was having no symptoms related to low sodium. She was transferred merely because a sodium as low as hers was needed more close observation with labs and treatment than what can be expected to be obtained at a skilled nursing facility. The fact that the lab was drawn several days later than the original order is unlikely to have significantly affected her care as it would have been higher earlier in the week, and she was being treated for the hyponatremia already. As the reviewer noted the events at her subsequent hospital stay were related to infection problems with sepsis, which was the primary problem. Her chronic hyponatremia had nothing to do with the infectious problems and her subsequent death. While not drawing the lab to monitor her chronic problem is not good, it did not appreciably affect her care</p>				

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F 0314 SS=D Bldg. 00	<p>pneumonia/volume overload." Volume overload means too much fluid in the blood.</p> <p>The hospital discharge indicated Resident #136 died on 3/3/15.</p> <p>3.1-37(a)</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</p>		<p>since her levels where often down to this range, she was not having symptoms which would indicate an acute change in the sodium level which would have been of more serious nature. The fact that the lab on 2/26 was earlier than the next one obtained could have in fact been beneficial as waiting until the next scheduled lab could have shown it to be even lower. Her transfer to the hospital was more to be able to monitor the sodium more closely and to allow more aggressive treatment to attempt to raise the sodium back to a more comfortable level in a shorter time. This treatment is not appropriate to be done in a skilled nursing facility. The assessment that this was a severe deficiency is not supported by a thorough and accurate assessment of the situation that was ongoing at the time. Sincerely, Dr. Mitch Cornett Attached are the factual care and history of Resident #136 and is the reason for IDR of this Ftag. Please revisit the NP assessment prior to discharge and the care of Dr. Cornett and see that a reverseral is in order of F309.</p>		

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	<p>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 assess a resident upon admission as being at risk for the development of pressure ulcers, failed to implement interventions for pressure ulcer prevention when the resident was assessed as being at risk, and the resident developed a Stage 2 pressure ulcer on the left heel for 1 of 1 residents reviewed for the development of pressure ulcers. (Resident #180)</p> <p>Findings include:</p> <p>The clinical record review for Resident #180, completed 8/4/15 at 9:21 a.m., indicated the resident had diagnoses including, but not limited to, hyponatremia and weakness. Hyponatremia is a condition characterized by low blood levels of sodium (salt).</p> <p>The Admission Nursing Assessment completed 6/23/15 at 4:00 p.m., assessed the resident as needing to use a walker for ambulation, as having intermittent confusion, having a history of falls, and</p>	F 0314	<p><b>F314 The facility requests paper compliance for this citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:</i> Resident #180 assessed, plan of care reviewed and revised as indicated. <b>2) How the facility identified other residents:</b> All residents residing in the facility have the potential to be affected. <b>3) Measures put into place/ System changes:</b> An audit will be completed of all residents to ensure that interventions are implemented to prevent pressure ulcer development. Licensed nursing staff will be inserviced regarding assessment for pressure ulcer risk, implementation of preventative measures and on wound</p>	09/03/2015

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	<p>requiring assistance of 1 staff person for ambulation and transfers. The resident's skin was assessed as being intact. The assessment lacked an indication of the resident being at risk for pressure ulcers and lacked interventions for pressure ulcer prevention.</p> <p>A 5-Day Minimum Data Set (MDS) assessment completed 6/30/15, assessed Resident #180 as being at risk for the development of a pressure ulcer, and the Care Area Assessment (CAA) Summary indicated a care plan would be developed. The Brief Interview for Mental Status (BIMS) assessed the resident as having 15 out of 15, indicating the resident was capable of making decisions. The resident was also assessed as having intermittent periods of confusion.</p> <p>The clinical record lacked a care plan for the resident being at risk for the development of pressure ulcers.</p> <p>A Weekly Skin Observation dated 7/1/15 at 6:14 p.m., assessed Resident #180 as having an intact blister on the left heel.</p> <p>An Initial Pressure Ulcer Report dated 7/2/15 at 2:41 p.m., indicated the pressure ulcer was not present upon admission to the facility, measured 2.8</p>		<p>documentation requirements per facility protocol. Licensed staff will be inserviced related to completing rounds on unit to ensure that fall prevention interventions are implemented as indicated by the plan of care and to ensure that interventions to prevent pressure ulcers are implemented. The Nurse Rounding Tool will be completed each shift. An audit will be completed three times a week, to ensure that residents are assessed for risk of pressure ulcer development and interventions are implemented to prevent the development of pressure ulcers as indicated per assessment findings. An audit will be completed three times a week to ensure that daily wound documentation is completed per facility protocol. Completed Nurse Rounding Tools will be reviewed and ongoing audits will be conducted in the Clinical Meeting on business days to ensure that fall prevention interventions are implemented as indicated by the plan of care and to ensure that interventions to prevent pressure ulcers are implemented. The Director of Nursing/designee is responsible for oversight. <b>4)</b> <b>How the corrective actions will be monitored:</b> The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance. <b>5) Date of</b></p>		

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	<p>cm (centimeters) x (by) 2.5 cm, and was a fluid filled blister. The new careplan interventions in the section marked Treatment included heels up with positioning pillows, family to bring in different shoes, and therapy was notified.</p> <p>A written care plan initiated on 7/2/15, indicated the resident had a Stage 2 pressure ulcer on the left heel and was at risk for the development of pressure ulcers. The area was described as a fluid filled blister. The interventions included treatment as ordered, resting on a pressure redistribution surface, floating heels while in bed, and observing the skin weekly.</p> <p>A physician's order dated 7/4/15 at 2:40 p.m., three days after the ulcer was first discovered, indicated, "Cleanse left heel with cleanser, apply betadine [a solution used to treat minor wounds and infections] to intact blister and cover with foam dressing daily. every [sic] evening shift for blister."</p> <p>The clinical record lacked documentation in the nursing progress notes for the status or description of the wound for 7/3, 7/4, 7/5, and 7/6/15.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 on 8/4/15 at</p>		<b>compliance: 09/03/15</b>	

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	<p>10:46 a.m., LPN #2 indicated the wound had developed after the resident was admitted to the facility and was caused by the resident's shoes rubbing on the heel. When asked what preventative measures were implemented prior to the development of the ulcer, LPN #2 indicated positioning pillows and floating the heels while in bed had been used. LPN #2 indicated the resident had been wearing dress shoes when ambulating prior to the development of the ulcer, and the family had provided tennis shoes once the ulcer developed.</p> <p>During an interview with the Director of Nursing (DON) on 8/4/15 at 11:16 a.m., the DON indicated the resident was not assessed as being at risk for pressure ulcer development upon admission as the resident was able to ambulate with a walker, and indicated the pressure ulcer developed due to the resident's shoes rubbing on the heel. The DON indicated the clinical record lacked documentation of preventative measures implemented prior to the development of the wound and lacked daily documentation of the wound as indicated by the facility policy.</p> <p>The wound on the left heel of Resident #180 was observed on 8/4/15 at 12:50 p.m. The area surrounding the wound was dry and pink in color, the edges of</p>			

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F 0323 SS=D Bldg. 00	<p>the wound bed were slightly lifted from the skin, the area was not fluid filled, appeared to be healing, and was approximately the size of a half a dollar. The resident denied any pain at the site of the wound and indicated the area was healing.</p> <p>On 7/31/15 at 9:00 a.m., the DON provided the undated PCC (Point Click Care) Wound Documentation Protocol and indicated the protocol was the one currently used by the facility for wounds. The protocol indicated, "...5. Daily Wound Documentation - To be completed by the staff nurse or wound nurse daily for any pressure ulcers, diabetic ulcers, vascular or arterial ulcers, and other wounds that require a daily assessment or a dressing...."</p> <p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and</p>			

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	<p>assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure a resident at high risk for falls received adequate assistance for transferring and ambulation for 1 of 7 residents who met the criteria for review of accidents. (Resident #52)</p> <p>Findings include:</p> <p>The clinical record of Resident #52 was reviewed on 7/31/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, muscle weakness, difficulty walking and cognitive defects. The resident was admitted to the facility on 6/19/15.</p> <p>An admission Minimum Data Set assessment dated 6/19/15, indicated Resident #52 was moderately impaired in the ability to make decisions and needed extensive assistance of 2 staff for transferring, walking and toileting.</p> <p>A care plan dated 6/19/15, current through 9/16/15, indicated, "I am at risk for falls related to decreased mobility...balance difficulty." Two interventions were initiated on 6/19/15. The interventions were proper footwear and personal items within reach.</p>	F 0323	<p><b>F323</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>Resident #52 fall care plan reviewed and revised as indicated.</p> <p><b>2) How the facility identified other residents:</b></p>	09/03/2015			

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	<p>A nurse's note dated 7/12/15 at 1:16 p.m., indicated Resident #52 fell in the bathroom. The resident had no apparent injuries and was encouraged to ask for assistance with transferring.</p> <p>An Interdisciplinary Team Fall note, dated 7/13/15, indicated the resident went to the bathroom by herself on 7/12/15, lost her balance and fell. "Resident was not supposed to be transferring or toileting herself without staff assistance... [the resident] stated that she did not know she was supposed to have assistance of staff and that she thought she was ok to take herself...Intervention and care plan updated...Resident will request the assistance of staff for transferring..."</p> <p>On 7/13/15 a new intervention was added to the resident's fall care plan, "I will request staff assistance with toileting and transferring until therapy tells me I am able to do it on my own."</p> <p>On 7/31/15 at 11:38 a.m., the Director of Nursing indicated the the intervention of the resident requesting staff assistance for toileting and transferring should have been included in the resident's care plan at the time of her admission, so that staff and the resident would be aware she needed assistance due to muscle weakness and difficulty walking.</p>		<p>All residents residing in the facility have the potential to be affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>A facility audit will be completed to ensure that fall prevention measures indicated in the plan of care are current, in place and meet the needs of the resident.</p> <p>Facility staff will be inserviced related to initiating, reviewing and updating preventative measures to meet resident needs and reduce risk of falls.</p> <p>Licensed staff will be inserviced related to completing rounds on unit to ensure that fall prevention interventions are implemented as indicated by the plan of care and to ensure that interventions to prevent pressure ulcers are implemented.</p> <p>The Nurse Rounding Tool will be completed each shift</p>	

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	3.1-45(a)(2)		<p>An audit will be completed in Clinical Meeting on business days to ensure that residents identified with falls or at risk for falls, have care plans developed and include preventative measures to meet residents needs and reduce risk of falls. Completed Nurse Rounding Tools will be reviewed and ongoing audits will be conducted in the Clinical Meeting on business days to ensure that fall prevention interventions are implemented as indicated by the plan of care and to ensure that interventions to prevent pressure ulcers are implemented.</p> <p>The DON/designee will be responsible for oversight.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>	

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure outdated food items were discarded and failed to ensure cold foods were served at or below 41 degrees Fahrenheit.</p> <p>Findings include:</p> <p>During the initial tour of the kitchen on 7/27/15 at 11:15 a.m., the following items were observed:</p> <p>a. A tub of dry cereal labeled shredded wheat was sitting on a shelf on a table by the stove and ovens. Handwritten on the lid of the tub was "6/23/15 - discard after 7/23/15."</p> <p>b. Two opened and undated packages of</p>	F 0371	<p>5) Date of compliance: 09/03/15</p> <p>F371</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or</i></p>	09/03/2015

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	<p>hot dog buns were sitting in a crate near the dry storage area. One package contained 9 buns and the other package contained 4 buns.</p> <p>c. An opened and undated package of English muffins was in the crate with the hotdog buns. The package contained 3 muffins.</p> <p>d. Three packages of unopened and undated hamburger buns and 1 package of hotdog buns were in the crate with the opened buns. The Dietary Manager (DM) indicated the buns were kept frozen until needed and then were removed from the freezer for use. The packages of buns were supposed to be dated by the dietary staff when removed from the freezer.</p> <p>e. The walk in cooler had a black tray containing 12 single serving containers of white colored salad dressing. The plastic wrap on the top of the containers indicated to discard after 7/23/15.</p> <p>f. Another black tray contained 8 single servings of salad dressing identified by the DM as poppyseed dressing. The plastic wrap on the top of the containers was undated.</p> <p>g. An opened and undated package of whipped topping was sitting on the</p>		<p><i>executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>No residents were immediately identified, but all residents residing in the facility have the potential to be affected.</p> <p>Mighty Shakes, hamburger buns, hotdog buns, English muffins, and dry cereal identified to be out of date were discarded immediately.</p> <p>Pureed potato salad that temped out of range after meal service was discarded immediately. (No pureed food items are saved after original meal service per policy.)</p> <p><b>2) How the facility identified other residents:</b></p> <p>All residents residing in the facility</p>	

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NAME OF PROVIDER OR SUPPLIER  HOMEVIEW CENTER OF FRANKLIN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 S STATE ST FRANKLIN, IN 46131
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	<p>shelves with the salad dressings.</p> <p>h. A box of high protein shakes dated 7/8/15, date thawed, was sitting on the shelves. The box contained 12 chocolate flavored shakes. The DM indicated the shakes were kept frozen and were removed and placed in the cooler for distribution for between meal snacks. The DM indicated the shakes were good for 30 days after thawing. The label on the shakes indicated the shakes should be consumed within 14 days of thawing (July 22, 2015). The DM indicated the practice of the facility was to use all of the shakes in one box before using the shakes in another box.</p> <p>i. Four chocolate shakes were sitting in a container and were labeled with names of current residents. The DM indicated the shakes were to be used for 2:00 p.m., and bedtime snacks on 7/27/15 (19 days after the shakes had been removed from the freezer).</p> <p>j. The temperature of the pureed potato salad was checked by the DM after serving of the lunch meal was completed and was 52 degrees. During an interview with Dietary Aide (DA) #1 on 7/27/15 at 12:50 p.m., DA #1 indicated the containers of pureed potato salad were removed from the cooler when lunch was</p>		<p>have the potential to be affected.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>The Leftover policy is available in the Policy &amp; Procedure Manual. All staff has been inserviced on those policies and policies and procedures.</p> <p>A monitoring tool of monitoring pull dates and use by dates of all potentially perishable food items will be checked and initaled by Dietary staff members daily.</p> <p>A pull sheet identifying the number of Mighty Shakes and 206 Juice to be pulled daily has been developed and will also be used daily.</p> <p>A product guide for use by/expiration dates of other foods not otherwise identified is available in Dietary.</p> <p>The monitoring tool described above as well as the pull sheet will be audited daily by the DM and/or</p>	

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	<p>started, were placed onto a shelving unit next to the serving line, and were not placed on ice to maintain the temperature.</p> <p>The Retail Food Establishment Sanitation Requirements dated November 13, 2004, in the section in potentially hazardous food, hot and cold holding, indicated, "...Except during preparation, cooking, or cooling,...potentially hazardous food shall be maintained as follows...(A) at forty-one (41) degrees Fahrenheit or less...."</p> <p>During an interview with the DM on 7/27/15 at 1:00 p.m., the DM provided Recommended Food Storage Times Cold and Dry Refrigerated and Frozen Foods dated July 2007, and indicated the policy was the one currently used by the facility. The DM indicated the facility did not have a specific policy for identifying outdated foods for discarding.</p> <p>3.1-(i)(3)</p>		<p>Assistant DM.</p> <p>An audit tool (See attached) will be completed will be completed to ensure that outdated food items were discarded per policy, Mighty Shakes are served per label recommendations, and cold foods are served at or below 41 degrees.</p> <p>Dietary staff were inserviced regarding disposal/ removal of outdated food items, health shakes, and proper line service temperatures</p> <p><b>5) Date of compliance: 09/03/15</b></p> <p>of pureed foods on August 18, 2015.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed weekly times 4, monthly x 2 then quarterly x 1. Further monitoring will be determined by Quality Assurance.</p>				

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