

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2015
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F 000 Bldg. 00	<p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00165440 completed on February 18, 2015.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00162393 completed on January 26, 2015.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00168367.</p> <p>Complaint IN00165440- Not corrected.</p> <p>Survey dates: March 18 & 19, 2015</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 21</p>	F 000	<p>Please reference the enclosed 2567 as "Plan of Correction" for the February 18, 2015 post survey revisit that was conducted at Hammond Whiting Care Center on March 19, 2015. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on April 2, 2015 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly M. Ready, HFA Executive Director</p>	
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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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F 314 SS=D Bldg. 00	<p>Medicaid: 35 Other: 10 Total: 66</p> <p>Sample: 11</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 24, 2015, by Janelyn Kulik, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the necessary treatment and services to promote wound healing were provided</p>	F 314	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Full audit was completed on 3/19/2015 for residents #C and H, which	04/10/2015	

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	<p>after wound changes were identified for 2 of 3 residents reviewed for pressure ulcers in the sample of 11. (Residents #C and #H)</p> <p>Finding include:</p> <p>1. On 3/18/15 at 2:35 p.m., Resident #H was observed in bed. The PT (Physical Therapy) Director was observed rendering wound care to the resident's sacral pressure ulcer. The area was irregular in shape and extended from the sacral area towards both the right and left inner upper buttock areas. The wound was measured by the PT Director and measured 10 cm (centimeters) x 7.5 cm. Slough was present on the wound bed and the PT Director indicated the slough was adherent and over approximately 25% of the ulcer.</p> <p>The record for Resident #H was reviewed on 3/18/15 at 2:00 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, chronic kidney disease, protein calorie malnutrition.</p> <p>The 2/25/15 Initial Data Collection Tool/Nursing Service form was reviewed. The form indicated the resident had a Foley catheter in place, required the assistance of 1-2 staff</p>		<p>included head to toe physical assessment, review of physician orders and treatment administration record, residents plan of care and care directive, pressure ulcer and/or non-pressure skin sheets, and an environmental assessment of residents' interventions and devices to ensure the necessary treatment and services to promote wound healing were provided as deemed necessary. In addition, the registered dietician reviewed both residents on 3/25/2015. Physician and family notification provided for any issues identified. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: A facility skin sweep for at risk residents was completed on 3/18/2015. No skin issues were identified related to this audit. In addition, the registered dietician reviewed residents with wounds on 3/25/2015. All recommendations were noted with appropriate follow-up and physician/family notification as needed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Education was provided by the Executive Director on 3/25/2015 to the Resident At Risk (RAR) IDT members (registered dietician, dietary manager, speech</p>		

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	<p>members for transfers, and had a decreased appetite. The form also indicated the resident had a pressure ulcer on the coccyx area.</p> <p>Review of the 3/2/15 Minimum Data Set (MDS) admission assessment indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one staff member for dressing and personal hygiene. The assessment also indicated the resident was at risk for pressure ulcer and had one unhealed Stage II (partial thickness loss of the dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough) pressure ulcer present upon admission.</p> <p>The current Pressure Ulcer Status Record for the sacral wound was reviewed. An entry made on 3/4/15 indicated the pressure ulcer was Unstageable (full thickness tissue loss in which the base of the ulcer was covered by slough and/or eschar) with a scant amount of drainage noted. The "appearance of the wound " was marked as granular. The next entry was made on 3/12/15. This entry indicated the the ulcer was Unstageable (full thickness tissue loss in which the base of the ulcer was covered by slough and or eschar) with a large amount of drainage noted. The appearance of the</p>		<p>therapist, and activity director) relating to RAR policy, meeting structure, IDT members' role and responsibilities in RAR along with the process of receiving the weekly wound tracking log to ensure timely and appropriate documentation of interventions and goals to promote wound healing are in place as per facility policy. Education relating to pressure ulcer identification, assessment, positioning and devices, documentation requirements, and ongoing monitoring was provided to the nursing staff by the Staff Development Coordinator on 3/18/2015 continuing through 4/8/2015. This education will be ongoing. Re-education was provided by the DON and/or designee to the nursing staff by 4/8/2015 in regards to following residents' plan of care and care directives, Pressure Ulcer Prediction/Prevention/Treatment Pathway, Stop and Watch, and completion of shower/skin sheets. A new wound nurse was hired on 3/19/2015 with orientation and education provided by the Physical Therapy, WCC (Wound Care Certified) corporate consultant. The corporate consultant will continue to be a resource for the new wound nurse and provide ongoing education for the wound care program and program oversight. How the corrective action(s) will be monitored to</p>		

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	<p>wound was marked as "slough" (necrotic or avascular tissue in the process of separating from viable tissue) and "necrotic/eschar(thick, leathery necrotic or devitalized tissue, frequently brown or black)" and the ulcer had deteriorated.</p> <p>The 2/25/15 Interim Care Plans were reviewed. There was a Care Plan in place which noted the resident had a break in skin integrity related to incontinence and a Braden Scale (scale for predicting pressure ulcer risk) score of (14). A score of (14) indicated the resident was at moderate risk for pressure ulcer development. Care plan interventions included for the resident to have a pressure reduction mattress, weekly skin checks, and to be turned or repositioned every two hours when in the bed or chair.</p> <p>Review of the 3/2015 Treatment Administration Record indicated the ordered treatment to the sacrum wound was for staff to cleanse the wound with normal saline, pat dry, and cover with a foam dressing every other day and as needed. The treatment was signed out as completed every other day from 3/1/15 thru 3/17/15.</p> <p>A Physician's order was written on 3/18/15 for the resident to have an air mattress to the bed for wound care and</p>		<p>ensure the deficient practice will not recur:A weekly wound care meeting has been incorporated into the weekly RAR meeting and will be ongoing. Nursing administration will review the weekly RAR meeting minutes/notes along with weekly wound tracking log to ensure appropriate residents are reviewed and necessary orders, treatment administration record, plan of care, and care directives are updated as needed. Nursing administration will perform a weekly audit for 6 months on a minimum of 10 residents to ensure weekly skin checks are completed, along with proper documentation and follow up as per facility policy. Validation of this audit will occur via visual inspection of the resident.Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>		

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	<p>the mattress. A Physician's order written on 3/19/15 indicated the resident to receive one ounce of ProSource Plus (a protein supplement) two times a day due to a low albumin level.</p> <p>Review of the 3/11/15 RAR (Residents at Risk) meeting note indicated the resident was a new admission and had a wound to the coccyx with no weight change.</p> <p>Review of the 3/2015 Nursing Progress Notes indicated there was no documentation of the Registered Dietitian being notified of the change in the pressure ulcer between 3/12/15 and 3/18/15.</p> <p>When interviewed on 3/18/15 at 3:00 p.m. the PT Director indicated she had measured the resident's sacral ulcer on 3/12/15 and a combination of black and yellow tissue was observed on the wound with serosanguinos (fluid appearing pink in color due to mixing with serous (clear or straw colored) drainage. The PT staff indicated she felt the current treatment may not be have been appropriate and recommended at possibly using a topical ointment treatment based on her observation of the area and the use of an air mattress.</p> <p>When interviewed on 3/19/15 at 10:10</p>				

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	<p>a.m., the Director of Nursing indicated the Therapy staff completed the wound assessment and measurements on 3/12/15 due to a change with the Wound Nurse. The Director of Nursing indicated the Therapy staff recorded the assessments and measurements though she did not receive that information until 3/16/15 or 3/17/15. The Director of Nursing indicated that was when she put their information on the resident's Pressure Ulcer sheets</p> <p>When interviewed on 3/19/15 at 10:15 a.m., the Nurse Consultant indicated when there was a decline in pressure ulcers staff usually notified the RD.</p> <p>When interviewed on 3/19/15 at 11:05 a.m., the Nurse Consultant indicated the RD (Registered Dietitian) was in the facility yesterday (3/18/15). The Nurse Consultant indicated Resident #H was not on the list for the RD and they were going to page the RD to verify if the resident's record had been reviewed on 3/18/15.</p> <p>When interviewed on 3/19/15 at 12:30 p.m., the Director of Nursing indicated she had paged the RD and the RD returned the call. The Director of Nursing indicated the RD had not reviewed the resident's chart on her visit on 3/18/15.</p>			

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	<p>The Director of Nursing indicated the resident's record was reviewed with the RD today on the phone and recommendations were made and ordered today.</p> <p>When interviewed on 3/19/15 at 12:40 p.m., the facility Administrator indicated the RD comes on Wednesday and this was when RAR (Residents At Risk) meetings were held.</p> <p>2. On 3/18/15 at 9:35 a.m., Resident #C was observed sitting in wheelchair in his room. There was a cushion in place to the seat of the wheelchair.</p> <p>The record for Resident #C was reviewed on 3/18/15 at 11:23 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, end stage renal disease, high blood pressure, and glaucoma. The resident was hospitalized on 2/10/15 and returned to the facility on 2/16/15.</p> <p>The 2/16/15 Initial Data Collection Tool note indicated the resident was re-admitted from the hospital. The note also indicated the resident had an open wound to the coccyx.</p> <p>Review of the 12/23/14 Minimum Data</p>				

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	<p>Set (MDS) admission assessment indicated the resident required extensive assistance of one staff member for personal hygiene and dressing. The assessment indicated the resident had no current pressure ulcers.</p> <p>The current Pressure Ulcer Status Record was reviewed. An entry made on 3/4/15 indicated the resident had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed without slough) pressure ulcer to the coccyx. The appearance of the wound was noted as granular and no slough or eschar was noted. No drainage was noted from the wound. The next entry was made on 3/12/15. This entry indicated a moderate amount of drainage was noted and the appearance of the wound was noted as "slough" and the wound deteriorated.</p> <p>Review of the 3/2015 Treatment Administration Record indicated the current wound treatment ordered was for staff to cleanse the wound with normal saline, pat dry, apply Santyl (a topical ointment used to debride wound tissue) and cover the area with a dressing daily and as needed.</p> <p>A Physician's order was written on 3/19/15 to discontinue the previous order</p>				

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	<p>for Prostat (a protein supplement) and start ProSource Plus one ounce three times a day for healing needs.</p> <p>The 3/11/15 RAR (Resident at Risk) note was reviewed. The note indicated the resident was seen for a wound and a significant weight loss. The note indicated the plan was to continue to monitor the wound. There were no further RAR notes and no RD (Registered Dietitian notes after 3/12/15.</p> <p>When interviewed on 3/18/15 at 3:40 p.m., the PT Director indicated she had assessed and measured the coccyx wound on 3/12/15 and at that time the tissue was 100% slough.</p> <p>When interviewed on 3/19/15 at 10:10 a.m., the Director of Nursing indicated the Therapy staff completed the wound assessments and measurements on 3/12/15 due to a change with the Wound Nurse. The Director of Nursing indicated the Therapy staff recorded the assessments and measurements though she did not receive that information until 3/16/15 or 3/17/15. The Director of Nursing indicated that was when she put their information on the resident's Pressure Ulcer sheets.</p> <p>When interviewed on 3/19/15 at 10:15</p>			
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	<p>a.m., the Nurse Consultant indicated when there was a decline in pressure ulcers staff usually notified the RD.</p> <p>When interviewed on 3/19/15 at 11:05 a.m., the Nurse Consultant indicated the RD (Registered Dietitian) was in the facility yesterday (3/18/15). The Nurse Consultant indicated Resident #H was not on the list for the RD and they were going to page the RD to verify if the resident's record had been reviewed on 3/18/15.</p> <p>When interviewed on 3/19/15 at 12:30 p.m., the Director of Nursing indicated she had paged the RD and the RD returned the call. The Director of Nursing indicated the RD had not reviewed the resident's chart on her visit on 3/18/15. The Director of Nursing indicated the resident's record was reviewed with the RD today on the phone and recommendations were made and ordered today.</p> <p>When interviewed on 3/19/15 at 12:40 p.m., the facility Administrator indicated the RD came on Wednesday and this was when RAR (Residents At Risk) meetings were held.</p> <p>The facility policy titled "Resident at Risk Meeting (RAR)" was reviewed on</p>			

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	<p>3/19/15 at 12:30 p.m. The policy had a last revised date of 3/1/2013. The policy was received from the Nurse Consultant and identified as current. The policy indicated weekly Resident at Risk meeting were held to review residents who had been identified with nutritional or hydration concerns. Staff were to prepare a list of residents to be reviewed 24-48 hours before the meeting. The policy indicated the review list was to include residents with pressure ulcers if they were not discussed in a weekly skin meeting.</p> <p>This Federal tag relates to Complaint IN00165440.</p> <p>This deficiency was cited on February 18, 2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-40(a)(2)</p>			