

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
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F000000	<p>This visit was for the recertification and State Licensure Survey.</p> <p>Survey dates: December 12, 13, 16, 17, 18, 2013</p> <p>Facility number: 001138 Provider number: 155632 AIM number: 200157070</p> <p>Survey Team: Dorothy Watts, RN, TC Amy Wininger, RN Sylvia Martin, RN 12/12, 12/13, 12/16, 12/18, 2013 Terri Walters, RN</p> <p>Census bed type: SNF: 0 SNF/NF: 41 Residential: 14 Total: 55</p> <p>Census payer type: Medicare: 10 Medicaid: 41 Other: 4 Total: 55</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410</p>	F000000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the facility 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 law. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the HFA or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This Plan of Correction shall constitute this facility's credible allegation of compliance on or before January 10, 2014.</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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	IAC16.2 Quality review completed on December 23, 2013, by Jodi Meyer, RN				

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F000225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	The facility does not employ	01/10/2014			

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	<p>A. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported immediately to the state agency for 1 of 2 facility reported allegations of abuse reviewed. Resident 21.</p> <p>B. Based on interview and record review, the facility failed to ensure criminal background checks were conducted in a timely manner, in that, criminal background checks were not conducted within 3 (three) days of hire for 5 of 10 employee files reviewed. LPN #6, LPN #7, CNA #8, CNA #9, CNA #10</p> <p>Findings include:</p> <p>A. Resident #21 was observed on 12/12/13 at 11:45 A.M., in dining room. Resident #21 was sitting in wheel chair at dining room table.</p> <p>During an interview with resident on 12/12/13 at 2:33 P.M., Resident #21 indicated, she had reported an incident of abuse involving CNA #9; the incident was reported while she was in hospital having scheduled surgery. Resident # 21 indicated, she was unaware of what had happened and that CNA #9 still worked in facility</p>		<p>individuals who have been found guilty of any form of mistreatment, nor does the facility employ any persons with negative findings on the nurse aide registry. The HFA and business office staff reviewed the regulations for completing criminal background checks on employees at hire. The business office staff audited the employee files to ensure background checks were complete. To monitor for compliance, the HFA will review personnel files on the day of hire to ensure documents are complete and in a timely manner. To monitor for continued compliance, the HFA will address any negative findings monthly at the Quality Assurance Performance Improvement meetings for six months. After that time, a negative findings will be discussed as needed. An all staff training on the abuse prohibition and reporting policy was conducted on 12/13/13. The unusual occurrence reporting to State and the facility abuse protocol was reviewed by the HFA and Director of Nursing on 12/30/13. Included was when to report, what to report and how to conduct interviews with staff and residents. The facility abuse policy and reporting will be provide to staff during monthly meetings for six months. The resident right regarding abuse will be reviewed monthly during the resident council meeting. To monitor for</p>		

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	<p>but, only worked down the other halls.</p> <p>A Fax/Incident Report dated 12/03/13 provided by the HCA (Healthcare Administrator) on 12/16/13 at 11:00 A.M., indicated, "...It was reported from a nurse at [name of local hospital] that said resident stated she didn't want said CNA to give her care. As she further stated she didn't not like the way CNA put her to bed".</p> <p>A Facsimile Cover Letter dated 12/04/13 at 9:45 A.M., provided by the DON (Director of Nursing) on 12/18/13 at 1:34 P.M. indicated the Indiana Department of Health was notified of the allegation of abuse on 12/04/13 at 9:45 A.M.</p> <p>On 12/16/13 at 1:50 P.M., during interview the HCA indicated the allegation of abuse was reported to her by a nurse at the hospital on 12/3/13, she was unable to recall the time. HCA indicated Resident #21 did not want to return to facility the incident was investigated, and resident was re admitted. The administrator indicated she was aware the facility policy was incorrect and should be corrected to include the state agency should be notified</p>		<p>compliance, the HFA and/or designee will interview a minimum of 2 staff and 2 residents weekly to ensure understanding of reporting allegations of abuse immediately. Any adverse findings will be reviewed during the monthly QAPI meetings.</p>				

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	<p>immediately of any allegation without a determination if the state agency should be notified.</p> <p>B. The Employee Files were reviewed on 12/17/13 at 10:00 A.M. and the following was noted:</p> <p>1. LPN #6: The Personnel Status Form indicated the Date of Hire was 06/05/13. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 06/19/13. (14 days)</p> <p>2. LPN #7: The Personnel Status Form indicated the Date of Hire was 03/27/13. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 04/18/13. (22 days)</p> <p>3. CNA #8: The Personnel Status Form indicated the Date of Hire was 03/27/13. The</p>				

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	<p>Indiana State Police Limited Criminal History indicated a criminal background check was requested 04/18/13. (22 days)</p> <p>4. CNA #9: The Personnel Status Form indicated the Date of Hire was 01/17/13. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 01/25/13. (8 days)</p> <p>5. CNA #10: The Personnel Status Form indicated the Date of Hire was 06/06/13. The Indiana State Police Limited Criminal History indicated a criminal background check was requested 06/19/13. (13 days)</p> <p>During an interview on 12/17/13 at 11:40 A.M., BOM (Business Office Manager) indicated she was responsible for taking care of the criminal background checks for new employees. She further stated, "It should be done upon hire and I usually do it on the day of orientation...I try to get them done, but I have to use my own personal debit card. Sometimes I have to wait a few days until I have the</p>						

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	<p>money in the account to cover the \$16.00 charge when we do it online... I told the Administrator that I would be a little late with the criminal checks and I would have to wait a few days until I had the money, but I have received no response.</p> <p>During an interview on 12/17/13 at 12:15 p.m., HFA (Health Facilities Administrator) indicated a criminal background check should be initiated prior to an employee working on the floor. The HFA then indicated, at that time, she didn't know the BOM was paying for the criminal background checks out of her own bank account and stated, "...What do you care how we pay for it...what tag does that fall under...I guess I could pay for it out of my own account...". The HFA then indicated by no verbal response</p> <p>The Policy and Procedure for Employee Screening provided by the DON on 12/16/13 at 9:23 A.M. indicated, " ...11. Employee Screening... b. All employees shall have a</p>			

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	<p>criminal background check. i. Initial ...will be conducted in accordance with applicable state and federal laws..."</p> <p>3.1-28(c) 3.1-28(b)(1)(A)</p>			

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure the abuse policy was comprehensive and the abuse policy was followed, in that, the policy did not include immediate notification of the administrator and the Indiana State Department of Health and the criminal background checks were not completed in a timely manner for 5 of 10 employee files reviewed. LPN #6, LPN #7, CNA # 8, CNA #9, CNA #10</p> <p>1. On 12/16/13 at 9:23 A.M., the facility's abuse policy entitled "Resident Safety Abuse Statement" (revision 12/12) was received and reviewed.</p> <p>The policy included but was not limited to: "...REPORTING SUSPECTED VIOLATIONS: a. Any suspected, observed or reported violation of this resident safety policy or any observed unexplained injuries (i.e. Injuries of</p>	F000226	<p>The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect and abuse of residents. The facility does not employ individuals who have been found guilty of any form of mistreatment, nor does the facility employ any persons with negative findings on the nurse aide registry. The facility's "Resident Safety Abuse Statement" was reviewed during the monthly corporate QAPI meeting on 12-30-13. Revisions were made to include notification of the HFA and appropriate State agency immediately of any allegations per State statute. The HFA and business office staff reviewed regulations for completing criminal background checks on employees at hire. To monitor for compliance, the HFA will review personnel files on the day of hire to ensure documents are complete and in a timely manner. To monitor for continued compliance, the HFA will address negative findings monthly at the QAPI meeting for six months. After that time, any negative findings will be discussed as needed.</p>	01/10/2014			

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	<p>unknown origin) to a resident will be reported to the supervisor and the DON and/or Administrator per facility policy immediately.</p> <p>b. The supervisor on duty shall IMMEDIATELY safeguard the resident(s) and report any alleged violations of this resident safety policy or observation of an unexplained injury to the DON and /or Administrator or designee. The DON or the designee will notify the Administrator if they are the first contact.</p> <p>c. The Administrator or designee shall determine if notification should be made to the appropriate regulatory agencies (per state statue) or law enforcement agencies..."</p> <p>On 12/16/13 at 1:50 P.M., during interview with the administrator, she was made aware the facility abuse policy had included to notify the DON first and then the administrator regarding an allegation of abuse. The administrator was also made aware the facility policy included that it would be determined if the state agency would be notified of an allegation and did not include a time period for notification of the state agency. The administrator at that time indicated an allegation should be reported to the administrator</p>			
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	<p>immediately and the facility policy should be changed to indicate to reflect immediately. The administrator also indicated the facility policy should be corrected to include the state agency should be notified immediately of any allegation without a determination if the state agency should be notified.</p> <p>2. The Employee Files were reviewed on 12/17/13 at 10:00 A.M. and the criminal background checks for LPN #6, LPN #7, CNA #8, CNA #9, CNA #10 were not completed within the 3 (three) day time requirement.</p> <p>During an interview on 12/17/13 at 11:40 A.M., BOM (Business Office Manager) indicated she was responsible for taking care of the criminal background checks for new employees. She further stated, at that time, "It should be done upon hire and I usually do it on the day of orientation...I try to get them done, but I have to use my own personal debit card. Sometimes I have to wait a few days until I have the money in the account to cover the \$16.00 charge when we do it online... I told the Administrator that I would be a</p>			

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	<p>little late with the criminal checks and I would have to wait a few days until I had the money, but I have received no response.</p> <p>During an interview on 12/17/13 at 2:15 p.m., HFA (Health Facilities Administrator) indicated the criminal background checks for LPN #6, LPN #7, CNA #8, CNA #9, CNA #10 were not completed within the 3 (three) day time requirement.</p> <p>The Policy and Procedure for Employee Screening provided by the DON on 12/16/13 at 9:23 A.M. indicated, "...11. Employee Screening: ...b. All employees shall have a criminal background check. i. Initial ...will be conducted in accordance with applicable state and federal laws..."</p> <p>3.1-28(a)</p>				

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F000314 SS=G	<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, interview, and record review the facility failed to ensure care was provided, for 1 of 3 residents reviewed in a sample of 3 who met the criteria for review of pressure ulcers, in that, a resident who was admitted with two Stage 1 pressure areas on the buttocks, developed Stage III pressure ulcers to the buttocks and developed a Stage III wound on the coccyx. (Resident #59)</p> <p>Findings include:</p> <p>The Resident Census and Conditions of Residents signed by the DON (Director of Nursing) and provided by the DON on 12/12/13 at 10:55 A.M., indicated there were no residents currently in the facility who experienced pressure ulcers</p>	F000314	<p>It is the practice of the facility to treat residents in the appropriate manner to prevent and/or treat pressure areas that are present. The chart of resident #59 and the charts of other residents with the potential to be affected by this deficiency were reviewed. The care plans and nurse aide assignment sheets were updated as necessary. An inservice on 01-08-14 will review skin assessments, staging pressure areas, preventative measures for pressure areas and updating care plans with the nursing staff. The nursing staff also reviewed the turning and repositioning protocol for residents at risk. The Director of Nursing, the MDS Coordinator and the Certified Wound Care Nurse reviewed the National Pressure Ulcer Advisory Panel information on 01-02-14. To monitor for compliance, the Director of Nursing and/or Wound Care Nurse will observe three treatments and/or assessments</p>	01/10/2014

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	<p>(excluding Stage 1).</p> <p>During a Stage 1 observation on 12/12/13 at 1:52 P.M., Resident #59 was observed to be lying in bed on her left side. During an interview, at that time, a family member of Resident #59 pulled back the covers and stated, "Look at those!" At that time, intact dressings were observed on the left buttock, the right buttock, and the coccyx of Resident #59. During an interview, at that time, the family member of Resident #59 stated, "...they have been there about a month, they just keep getting worse..." The family member then indicated, Resident #59 had been sitting in the recliner at 10:00 A.M., was transferred to a wheelchair at approximately 11:30 A.M., and transported by wheelchair to the dining room. The family member further indicated, at that time, Resident #59 had been sitting in the wheelchair until she was transferred to bed at 1:45 P.M. and stated, "...I was so mad, they finally laid her down..." During an interview on 12/12/13 at 1:54 P.M., Resident #59 indicated she did not want to lay down in bed.</p> <p>During an interview on 12/12/13 at 1:55 P.M., CNA #5 indicated Resident</p>		<p>weekly for six months to ensure accuracy in staging and assessing. The nurse aides will be instructed to immediately report any suspected changes in skin condition to the nurses in addition to documenting on their assignment sheets. The department managers will review assignment sheets and 24 hour reports during IDT meetings for areas of concern. To ensure continued compliance, any areas of concern will be reviewed with the HFA and brought to the monthly QAPI meeting.</p>		

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	<p>#59 had been sitting in the recliner when she arrived on duty at 6:00 A.M. and had been in a sitting position, with pressure to the buttocks and coccyx, in the recliner and/or wheelchair from 6:00 A.M. until approximately 1:45 P.M.. (7 hours and 45 minutes)</p> <p>During an interview on 12/12/13 at 2:00 P.M. the family member of Resident #59 indicated LPN #6 had assured her Resident #59 would be turned and repositioned every 2 hours. The family member then indicated Resident #59 was not getting turned or repositioned enough.</p> <p>During an interview on 12/12/13 at 2:30 P.M. LPN #5 stated, "She has some areas on her bottom, I wouldn't call them pressure, I would call them shearing."</p> <p>During an interview on 12/13/13 at 8:55 A.M., CNA #7 indicated, Resident #59 "was up when I got here at 6:00 a.m. sitting in the wheelchair, then she went to breakfast..." CNA #7 then indicated Resident #59 had just been transferred from the wheelchair to the recliner. CNA #7 further indicated Resident #59 had been in a sitting position, with pressure to the</p>						

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	<p>buttocks and coccyx, in the recliner and/or wheelchair from 6:00 A.M. through 8:55 A.M. Resident #59 was observed, at that time, to be in a sitting position in a recliner. (2 hours and 55 minutes)</p> <p>During an interview on 12/13/13 at 9:40 A.M. LPN #5 indicated she didn't know the initial measurements of the areas because they had only been identified as "open"</p> <p>During an observation of care on 12/13/13 at 11:30 A.M. Resident #59 was observed to be transferred from a sitting position in the recliner to a sitting position in the wheelchair and transported to the dining room. (2 hours and 25 minutes)</p> <p>On 12/13/13 at 12:15 P.M., Resident #59 was observed to be in a sitting position in a recliner. (45 minutes)</p> <p>On 12/13/13 at 2:00 P.M., Resident #59 was observed in a sitting position in a recliner (1 hours and 45 minutes)</p> <p>On 12/13/13 Resident #59 was in a sitting position in a recliner and/or a wheelchair without pressure being relieved to the buttocks and the coccyx from 6:00 A.M. through 2:00 P.M. (8 hours)</p>			

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	<p>On 12/16/13 at 9:30 A.M., Resident #59 was observed in a sitting position in a recliner. During an interview, at that time, CNA #7 indicated Resident #59 was sitting in the wheelchair when she arrived on duty at 6:00 A.M. and had been transported by wheelchair to the dining room for breakfast at approximately 7:30 A.M. CNA #7 then indicated, Resident #59 had been transferred from the wheelchair to the recliner at approximately 8:15 A.M. CNA #7 further indicated, at that time, Resident #59 had been in a sitting position, with pressure to her buttocks and coccyx, in the recliner and/or wheelchair from 6:00 A.M. through 9:30 A.M. (3 hours and 30 minutes)</p> <p>On 12/16/13 at 11:30 A.M., Resident #59 was observed in a sitting position in a wheelchair at the dining room table. (2 hours)</p> <p>During an interview on 12/16/13 at 12:00 P.M., CNA #7 indicated Resident #59 was going to be transferred from the wheelchair to the recliner.</p> <p>On 12/16/13 at 12:15 P.M., Resident #59 was observed in a sitting position in a recliner. (45 minutes)</p>			

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	<p>During an interview on 12/16/13 at 2:20 P.M., CNA #5 stated, "...she prefers to sit up, but we do get her pressure relief every once in a while..."</p> <p>During an observation of care on 12/16/13 at 2:25 P.M., CNA #6 and CNA #5 assisted Resident #59 to stand for LPN #7 to assess the wounds. The coccyx wound was observed, at that time, to be a full thickness wound and contained 90% white slough (necrotic tissue), the left buttock wound was observed to be a full thickness wound and contained 90% white slough, and the right buttock wound was observed to be a full thickness wound and contained 90% white slough.</p> <p>During an interview on 12/16/13 at 2:30 P.M., LPN #7 stated, "...she makes small movements, but she is not on any sort of schedule, we should reposition her every 2 [two] hours..."</p> <p>LPN #7 was observed to measure each wound on 12/16/13 at 2:30 P.M. During an interview, at that time, LPN #7 indicated the coccyx wound contained 75-100 % slough and measured 1.4 cm (centimeters) X 0.7</p>			

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	<p>cm, the left buttock contained 100% slough and measured 1.2 cm X 0.9 cm, and the right buttock contained 100% slough and measured 0.6 cm X 0.8 cm. Resident #59 was observed to return to a sitting position at 2:33 P.M. (8 minutes of standing)</p> <p>On 12/16/13 at 4:00 P.M. Resident #59 was observed to be in a sitting position in a recliner.</p> <p>On 12/16/13, Resident #59 was in a sitting position in a recliner and/or a wheelchair without pressure being relieved to the buttocks and the coccyx from 6:00 A.M. through 2:25 P.M. (8 hours and 25 minutes)</p> <p>The clinical record of Resident #59 was reviewed on 12/16/13 at 3:00 P.M. The record indicated Resident #59 was admitted on 09/25/13 with diagnoses that included, but were not limited to, Lt (left) hip fx (fracture) and Dementia.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 10/02/13 indicated Resident #59 experienced moderate cognitive impairment, required the total assist of 2 (two) staff for bed mobility and transfers, and experienced no episodes of rejecting care.</p>			

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	<p>A Care plan dated 11/22/13 for Cognitive Impairment manifested by confusion, disorientation included, but was not limited to, interventions of "...determine limitations.."</p> <p>A Care Plan dated 10/02/13 for Potential for Tissue Integrity Impairment included, but was not limited to, interventions of "...encourage and assist to reposition, prompting required, ...special care remarks: alert/oriented..."</p> <p>The Care Plan lacked any documentation related to Resident #59 refusing care and/or treatment, being non-compliant with care and/or interventions, or being repositioned for pressure relief in the recliner and/or wheelchair.</p> <p>A CNA Assignment Sheet provided by the DON on 12/13/13 at 3:00 P.M. indicated, "...turning/repositioning...prompting required,,,,special care remarks "alert/oriented..." The Assignment sheet lacked any documentation Resident #59 should be on a repositioning schedule or required the assistance of staff for mobility.</p> <p>A weekly skin assessment dated</p>			

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	<p>09/26/13 at 3:43 A.M. indicated, "...pressure ulcers on admit: has persistent area of skin redness that does not disappear when pressure relieved (Pressure Stage 1) Location: buttocks...". The assessment lacked any documentation related to the measurement of the areas.</p> <p>A weekly skin assessment dated 10/03/13 lacked any documentation related to pressure areas on buttocks</p> <p>A weekly skin assessment dated 10/06/13 lacked any documentation related to pressure areas on buttocks</p> <p>A weekly skin assessment dated 10/09/13 lacked any documentation related to pressure areas on buttocks</p> <p>A weekly skin assessment dated 10/18/13 indicated, "skin intact"</p> <p>A weekly skin assessment dated 10/28/13 indicated, "skin intact"</p> <p>A weekly skin assessment dated 11/13/13 at 12:39 P.M., "...resident has pink raw areas noted on blat [bilateral] buttocks...". The assessment lacked any documentation related to the measurement of the areas.</p>			

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	<p>The Braden Scale policy provided by the DoN on 12/18/13 at 11:30 A.M. indicated, "...Purpose: It is the policy of the facility to use the Braden Scale to identify resident at risk for the development of pressure sores....Protocol: An overall score of 15-18 indicates the resident is at risk for development of pressure sores..."</p> <p>A Braden Scale Assessment dated 10/02/13 indicated Resident #59 was at risk for development of pressure areas.</p> <p>A Braden Scale Assessment dated 10/25/13 indicated Resident #59 was not at risk for the development of pressure sores.</p> <p>A Nursing Progress Note dated 11/19/13 indicated, "...continues to have 3 [three] superficial raw areas on blat (sic) buttocks...no pressure ulcers..."</p> <p>A Nursing Progress Note dated 11/21/13 indicated, "...skin problems: 3 superficial raw areas on blat (sic) buttocks...no pressure ulcers..."</p> <p>A Nursing Progress Note dated 11/25/13 indicated, "...resident has 3 superficial raw areas on blat (sic) buttocks...no pressure ulcers..."</p>			

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	<p>A Nursing Progress Note dated 12/09/13 indicated, "...continues to have superficial areas on blat (sic) buttocks..."</p> <p>A Nursing Progress Note dated 12/11/13 indicated, "...raw open areas on blat (sic) buttocks and coccyx...partial thickness loss of skin layers that presents as an abrasion or blister (pressure stage 2) on blat (sic) buttocks and coccyx (sheared areas) on coccyx 1.6 X 1.0 ...clean but not granulating...left buttock small sheared areas unable to measure, have irregular edges...right buttock 1[one] sheared area 4.0 cm X 1.5 cm...right buttock sheared area 0.9 cm X 1.1 cm..."</p> <p>A Nursing Progress note dated 12/16/13 at 11:38 P.M. indicated "...Partial thickness loss of skin layer that presents as an abrasion or blister (Pressure Stag [stage] 2 on coccyx... shallow area on coccyx, wound bed is white at this time, resident had decreased circulation and was laying on back at time of assessment...description: appears to be smaller in size visually than last assessment...'</p> <p>An OT (Occupational Therapy) note</p>						

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	<p>dated 11/04/13 indicated, "...Ed (educate) pt (patient) on OT PC (Plan of Care), progress made, and risks associated with decrease independence with ADL [Activities of Daily Living]..." The note lacked any documentation related to pressure.</p> <p>An OT note dated 11/22/13 indicated, "...facilitation of optimal positioning for decrease pressure risk..."</p> <p>An OT note dated 11/27/13 indicated, "...Pt ed on importance of repositioning to decrease pressure areas on buttocks..."</p> <p>An OT note dated 11/28/13 indicated, "...Pt ed on importance of good w/c [wheelchair] and bed positioning. Pt and nursig [sic] ed on importance of good turning schedule. Pt reports pain with buttocks secondary to pressure..."</p> <p>An OT note dated 11/29/13 indicated, "... OT facilitation of postural control to increase good w/c positioning... decrease risk of pressure ulcers. ed nursing on importance of increase good w/c, bed, and recliner positioning to decrease pressure on buttocks and coccyx. Nursing reports they are aware and treating buttocks for pressure areas..."</p>			

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	<p>An OT note dated 12/06/13 indicated, "... pt ed on importance of laying down side to side. pt resistive to a turning schedule ...pt required mod [moderate] A for bed mob [mobility] this date..."</p> <p>An OT note dated 12/09/13 indicated, "...compensatory strategy instruction... ability to self correct posture, ability to reposition in w/c to decrease pressure areas and recliner..."</p> <p>An OT note dated 12/11/13 indicated, "...ed pt and cna's on importance of side to side schedule to decrease pressure areas pt agreeable after education on risk of pressure wounds..."</p> <p>An OT note dated 12/12/13 indicated, "... facilitation of postural alignment to decrease pressure areas and sores. ed pt/daughter/and granddaughter on ...side to side rotation in bed and rotating from w/c/recliner and bed every few hours, all parties agreeable after education..."</p> <p>During an interview on 12/16/13 at 10:48 A.M. the DON stated, "...she came in with two red areas on the buttocks... so not really opened up</p>			

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	<p>until 12/11/13..."</p> <p>During an interview on 12/16/13 at 2:00 P.M., the DON indicated she did not know the wounds of Resident #59 contained slough and stated, "...I did not know that, I just looked at them last week and they were a stage 2..."</p> <p>During an interview on 12/17/13 at 3:00 P.M., the DON indicated she could not provide documentation that indicated the resident had been turned and repositioned on a schedule and could not provide supportive documentation to identify if the wounds on the left and right buttocks were the same wounds identified upon admission because the Stage 1 areas had not been properly assessed and/or monitored between the time of admission and wasn't sure when the areas opened. The DON further indicated, at that time, the coccyx wound had been acquired after admission to the facility.</p> <p>During an interview on 12/18/13 at 10:30 A.M., the WCC-RN (Wound Care Certified-Registered Nurse) indicated she had become involved with the wounds on 11/11/13 and she was not aware of any skin concerns before that date. The WCC-RN</p>						

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	<p>further indicated, at that time, she could not provide any documentation of monitoring of the wounds between admission and 11/11/13 and she did not know if the current buttock wounds were the same areas identified upon admission or if the buttock wounds had resolved and the current wounds were facility acquired. She then indicated, the coccyx wound had been acquired after facility admission.</p> <p>During an interview on 12/18/13 at 10:45 A.M., COTA (Certified Occupational Therapy Assistant) #1 indicated, Resident #59 did not want to lay side to side in bed and she wasn't sure which way to proceed. COTA #1 further indicated, at that time, she had not considered a way to off-load pressure to the buttocks or coccyx while the resident was sitting in the recliner. COTA #1 then indicated she did not know if the buttock wounds were facility acquired or present on admission and stated, "...the coccyx wound was not present before 12/03/13, so that was facility acquired..."</p> <p>The policy and procedure for Skin Treatment/Management Protocol provided by DON on 12/16/13 at 2:00 P.M. indicated, "...Pressure Ulcer</p>						

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	<p>Category 1 (Stage 1) non-blanchable intact skin with non-blanchable redness of a localized area usually over a bony prominence. ...May indicate "at risk" persons...treatment protocol...set up for weekly re-assessment and documentation through end of healing plus 4 weeks...includes any interventions that are implemented such as turning, off-loading, pressure relief/...Pressure ulcer Category II (Stage II) partial thickness...partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed without slough. May also present as an intact or open/ruptured serum-filled or serosanguinous filled blister...set up for weekly re-assessment and documentation through end of healing plus 4 weeks...includes any interventions that are implemented such as turning off-loading pressure relief...NOTES: Reassessment and wound progress documentation should be completed at least weekly and as appropriate until the wound is healed. Reassess the resident, interventions and treatment if the ulcer does not show signs of healing as expected (most individuals should show signs of healing within 2 weeks) despite adequate local wound care, pressure redistribution and nutrition... Pressure</p>			

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	<p>Ulcer Category III (Stage III) Full thickness skin loss full thickness tissue loss...slough may be present...set up for weekly re-assessment and documentation through end of healing plus 4 weeks...that are implemented such as turning, off-loading, pressure relief, ..."</p> <p>3.1-40(a)(1)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications located in the</p>	F000431	A pharmacist services are used by the facility and a system is established to record receipt and disposition of drugs and that drugs are labeled in accordance	01/10/2014

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	<p>medication storage refrigerators had the opened dates documented on the vials and, further, that medications were returned to the pharmacy and/or disposed of in a timely manner for 4 of 4 residents who no longer resided in the facility but whose medications were observed in the medication storage room.</p> <p>Findings include:</p> <p>On 12/18/13 at 2:00P.M., an observation of the medication storage room was completed.</p> <p>1. One opened multi-dose vial (10 doses per vial) of Tubersol (medication used to administer tuberculosis skin test) was located in the refrigerator. The bottle's opening date was not documented on the vial. One opened multi-dose vial (10 doses per vial) of Influenza Virus Vaccine (medication used to administer flu vaccinations) was located in the refrigerator. The bottle's opening date was not documented on the vial.</p> <p>The package insert for Tubersol, which is manufactured by Sanofi Pastur Limited, was reviewed on 12/19/13 and read as follows: "A vial of Tubersol (Tuberculin Purified Protein Derivative (Mantoux) which</p>		<p>with currently accepted professional principles. The Director of Nursing checked the medication room and medication carts on 12/19/13 for any outdated or unlabeled medications. Proper disposal of any outdated or unlabeled medication was done. An inservice for licensed nursing on 01/08/14 with pharmacy will review policy for disposing of medication and proper labeling of medication. To monitor for compliance, the Director of Nursing and/or designee will check the medication room weekly for outdated or unlabeled medications. To ensure continued compliance, any adverse findings will be reported to the HFA and reviewed through the QAPI meetings monthly.</p>				

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	<p>has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Failure to store and handle Tubersol as recommended will result in a loss of potency and inaccurate test results."</p> <p>During an interview with RN #15 on 12/18/13 at 2:10 P.M., RN #5 indicated the vials of Tubersol and Influenza should have the date the medication was opened documented on the bottle.</p> <p>2. Located in a cabinet above the counter were medications which had been prescribed for four residents who previously resided at the facility. One box of 30, 3 ml dose vials of Albuterol Sulfate Inhalation Solution 0.083%. Three boxes of Rugby Ready to Use Enema's.</p> <p>During an interview on 12/18/13 at 4:20 P.M., the Director of Nursing (DON), indicated that the medication located in the medication storage room cabinet belonged to four residents who had been discharged from the facility due to death. The DON indicated that the residents had been gone a long time.</p>			

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	<p>The facility's policy and procedure for Destruction of Medication was reviewed on 12/18/13 at 4:25 P.M. The policy and procedure read as follows: "3. Disposal of all drugs will occur within 72 hours of a physician's order discontinuing it's use, the resident's death..."</p> <p>3.1-25(r)</p>			

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure housekeeping services were provided to maintain the facility in a sanitary condition in that a resident's room located on 400 hall had a pervasive odor of urine and the privacy curtain was soiled. Resident #40, Resident #53</p> <p>Findings include:</p> <p>During a Stage 1 room observation on 12/12/13 at 11:24 A.M., Resident #40's bed had a strong odor of urine and the recliner belonging to Resident #53 had a strong, pervasive odor of urine. A brown substance (which appeared to be dried feces) was observed at the bottom quarter of the privacy curtain which was pulled between the resident's beds.</p> <p>During an observation of Resident #40's and Resident #53's room on 12/12/13 at 4:26 P.M. and again on 12/16/13 at 1:53 P.M., Resident #40's bed had a strong odor of urine and the recliner belonging to Resident #53</p>	F000465	It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for the residents, staff and public. The room of the residents affected by this deficiency was checked. The privacy drape had a rust stain and was changed on 12/19/13. The recliner has been replaced. The other rooms in the facility that are occupied by residents were checked for any concerns by the environmental staff and the HFA. An inservice was held on 12/31/13 with the environmental staff to review facility cleaning practice and monitoring resident rooms. The housekeeping staff will monitor rooms during cleaning and make changes as needed. The housekeeping supervisor will make rounds two times weekly to ensure compliance. To ensure continued compliance, the HFA and/or designee will make rounds weekly and address any concerns during QAPI meetings monthly.	01/10/2014	

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	<p>had a strong pervasive odor of urine. A brown substance (which appeared to be dried feces) was observed at the bottom quarter of the privacy curtain.</p> <p>During an interview on 12/16/13 at 1:54 P.M., Housekeeper #1 indicated that the room of Resident #53 and Resident #40 smelled like BM (bowel movement) and urine. Housekeeper #1 further indicated, at that time, the brown substance on the curtain looked like BM (bowel movement) and was probably responsible for the BM odor in the room and the urine odor was coming from the recliner. Housekeeper #1 then stated, " ...if someone told us, we would clean it right away."</p> <p>The facility's policy and procedure for cleaning was provided by the Director of Nursing on 12/18/13 at 4:26 P.M., and it read as follows: "Basic room cleaning. Spot clean windows, walls. Dust all furniture. Empty Trash. Clean TV screens. Clean door frames and knobs. Clean bathroom and all fixtures. Check paper towels and toilet paper. Check all light bulbs. Sweep and Mop."</p> <p>3.1-19(f)</p>			

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R000000	The following Residential deficiencies were cited in accordance with 410 IAC 16.2-5.	R000000	Preparation and execution of this Plan of Correction does not constitute admission or agreement by the facility 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 law. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission against interest of the facility, the HFA or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. This Plan of Correction shall constitute this facility's credible allegation of compliance on or before January 10, 2014.		

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R000409	<p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interview and record review the facility failed to ensure Resident health statements were obtained annually, in that Annual Health Statements were lacking in 7 of 7 clinical records reviewed. Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The Clinical Record of Resident #1 was reviewed on 12/18/13 at 1:00 P.M. The record lacked any documentation of an Annual Health Statement. The Clinical Record of Resident #3 was reviewed on 12/18/13 at 2:00 P.M. The record lacked any documentation of an Annual Health Statement. The Clinical Record of Resident #5 was reviewed on 12/18/13 at 2:30 	R000409	The facility does complete health assessments and statements with no evidence of tuberculosis on admissions. The facility completes an annual physical and PPD on residents. The Director of Nursing audited the charts of the residential unit on 12/31/13. A statement from the attending physician for all residents stating "free of communicable disease to include tuberculosis in an infectious stage" was obtained on 01/02/14. To monitor for compliance, the Director of Nursing will audit the chart of any new admission and the charts of current residents quarterly. To ensure continued compliance, the HFA will review findings with the Director of Nursing with admissions or quarterly.	01/10/2014			

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	<p>P.M. The record lacked any documentation of an Annual Health Statement.</p> <p>4. The Clinical Record of Resident #4 was reviewed on 12/18/13 at 3:00 P.M. The record lacked any documentation of an Annual Health Statement.</p> <p>5. The Clinical Record of Resident #6 was reviewed on 12/18/13 at 3:30 P.M. The record lacked any documentation of an Annual Health Statement.</p> <p>6. The Clinical Record of Resident #7 was reviewed on 12/18/13 at 3:45 P.M. The record lacked any documentation of an Annual Health Statement.</p> <p>7. The Clinical Record of Resident #2 was reviewed on 12/18/13 at 4:00 P.M. The record lacked any documentation of an Annual Health Statement.</p> <p>During an interview on 12/18/13 at 2:45 P.M., the Director of Nursing (DON) stated, "...haven't had 'free of communicable disease ...health statement' has not been on the Doctor's orders for years..."</p>						

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