

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/18/2014
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F000000	<p>This visit was for the Investigation of Complaints IN00160464 and IN00161191.</p> <p>Complaint IN00160464- Substantiated. Federal/State deficiencies related to the allegations are cited at F-246, F-309, and F-363.</p> <p>Complaint IN00161191- Substantiated. Federal/State deficiency related to the allegation is cited at F-314.</p> <p>Survey dates: December 17 & 18, 2014</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF: 31 SNF/NF: 118 Total: 149</p> <p>Census payor type: Medicare: 31 Medicaid: 103 Other: 15</p>	F000000		

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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F000246 SS=D	<p>Total: 149</p> <p>Sample: 12</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on December 23, 2014, by Janelyn Kulik, RN.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, record, review, and interview, the facility failed to ensure the resident's needs were accommodated related to call lights not in reach for 1 of 3 residents reviewed for call lights in place in the sample of 12. (Resident #E)</p> <p>Findings include:</p> <p>During Orientation Tour on 12/17/14 at 8:30 a.m. with ADON #1, Resident #E was observed in bed. The resident was asleep. The bed was in a low position</p>	F000246	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>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</p>	01/17/2015			

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	<p>and a floor mat was in place to one side of the bed. The other side of the bed was up against the wall. The call light cord was hanging from the wall outlet near the foot of the resident's bed. The call light cord was hanging down between the wall and the bed. The call light cord and push button were not in the resident's reach. No staff members or visitors were present upon entering the room. ADON #1 entered the room also at this time. The resident refused incontinence care when asked by the ADON at this time. The call light cord remained in the same location when staff left the room.</p> <p>On 12/17/14 at 9:30 a.m., the resident was observed in bed. The call light cord remained in the same position as above. No staff members or visitors were present in the room. The resident's call light remained out of reach in the same position as above.</p> <p>On 12/17/14 at 10:10 a.m., the resident was observed in bed. The call light cord remained in the same position as above. No staff members or visitors were present in the room. The resident's call light remained out of reach in the same position as above.</p> <p>On 12/17/14 at 10:20 a.m., the resident was observed in bed. The resident was</p>		<p>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.</p> <ol style="list-style-type: none"> 1. Resident # E had call light placed immediately. In service of all departments on placing call lights appropriately for each resident's needs. 2. All residents have the potential to be impacted by the alleged practice. <p>This tag identified on annual survey and in servicing not completed before tag from complaint survey received.</p> <p>Call light audit completed on Unit 100 to ensure working and correct placement, any corrections completed during audit.</p> <p>In serviced all staff on placing call lights appropriately for each resident's needs (copies attached).</p> <ol style="list-style-type: none"> 3. Nursing management to observe call lights in place for 5 residents 2 x weekly (audit tool attached). 4. DHS or designee will monitor compliance through 	

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	<p>awake. The call light cord remained in the same position as above. No staff members or visitors were present in the room. The resident's call light remained out of reach in the same position as above.</p> <p>On 12/17/14 at 11:35 a.m., the resident was observed in bed. No staff members or visitors were present in the room. The resident's call light remained out of reach in the same position as above.</p> <p>On 12/17/14 at 12:17 p.m., 12:35 p.m., and 12:40 p.m., the resident was observed in bed. No staff members or visitors were present in the room. The resident's call light remained out of reach in the same position as above.</p> <p>On 12/17/14 at 12:50 p.m., ADON #1 entered the resident's room. The resident was in bed. The ADON asked the resident if they could change her and the resident refused. The resident's call light remained out of reach.</p> <p>On 12/17/14 at 12:55 p.m., LPN #1 entered the resident's room and asked the resident if they could take her to the bathroom and the resident refused. The resident's call light remained out of reach at this time. The LPN was asked to locate the residents' call light. The LPN</p>		<p>review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will reviewed quarterly for six months.</p> <p>5. 1-17-15</p>	

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	<p>pulled the cord from between the bed and the wall and placed the end of the call light with the button on the resident's bed in her reach.</p> <p>The record for Resident #E was reviewed on 12/17/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, anemia, breast neoplasm, and esophageal reflux.</p> <p>The 10/28/14 Minimum Data Set quarterly assessment indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one staff member for toilet use, personal hygiene, and bed mobility. The assessment indicated the resident required extensive assistance of one staff member for bed mobility and extensive assistance of two staff members for transfers.</p> <p>The resident's current Care Plans were reviewed. The Care Plans had last been reviewed on 10/27/14. A Care Plan initiated on 3/12/14 indicated the resident was at risk for falls related to unaware of safety needs, psychoactive drug use, incontinence and muscle weakness. Care Plan interventions included to ensure the resident's call light was within reach and</p>						

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F000309 SS=D	<p>encourage the resident to use it for assistance, lay the resident down after meals, sensor alarm pad to be placed, and place the resident in common areas while she was out of bed.</p> <p>When interviewed on 12/18/14 at 11:30 a.m., the DON indicated the resident's call light should not have been out of reach.</p> <p>This Federal tag relates to Complaint IN00160464.</p> <p>3.1-3(v)(1)</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. Based on record review and interview,</p>	F000309		01/17/2015

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	<p>the facility failed to provide the necessary treatment and services to attain the resident's highest practicable physical well-being related to failing to follow the facility protocol for constipation for 2 of 3 residents reviewed for being at risk for constipation in the sample of 12. (Residents #E and #F)</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 12/17/14 at 10:00 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, anemia, breast neoplasm, and esophageal reflux.</p> <p>The 12/2014 Bowel and Bladder Elimination record was reviewed. The record indicated the resident had a medium sized bowel movement on 12/11/14 at 9:40 p.m. The resident's next bowel movement was documented on 12/15/14 at 1:23 p.m.</p> <p>The 10/28/14 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident</p>		<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>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.</p> <p>1. Resident # E bowel assessment completed and MD notified. Resident had BM.</p> <p>Resident #F bowel assessment completed and MD notified. Resident noted to have BM 12-18-14.</p> <p>2. All residents have the potential to be impacted by the alleged practice. Facility wide review of BM orders was completed to ensure all steps were present in residents orders</p>				

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	<p>involved in activity, staff provide weight-bearing support) of one staff member for toilet use, personal hygiene, and bed mobility. The assessment also indicated the resident was occasionally incontinent of bowel.</p> <p>The resident's current Care Plans were reviewed. The Care Plans were last reviewed on 10/27/14. A Care Plan initiated on 3/12/14 indicated the resident was at risk for constipation related to decreased mobility and cognitive impairment. Care plan interventions included for staff to follow the facility protocol for bowel management and to monitor the resident's bowel sound with assessments and as needed. The Care Plan also indicated the resident's bowel movement patterns were to be recorded each day.</p> <p>The resident's current Physician orders were reviewed. There were no order for the resident to receive a laxative. The 12/2014 Nursing Progress Notes, Assessment notes, Occurrence forms, and Change in Condition notes were reviewed. There was no documentation of any assessment of the resident's abdomen or of bowel sounds.</p> <p>When interviewed on 12/18/14 at 11:55 a.m., ADON #1 indicated there was a</p>		<p>. Dietary updated on natural laxative being provided daily for nursing. Daily report available to provide nursing management list of residents without BMs in 48 hours and this is reviewed and presented to each unit to follow up on.</p> <p>3. In Service to be completed on BM policy (copy attached)</p> <p>Nursing management to monitor BM report and follow through 5 x week.</p> <p>4. DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will reviewed quarterly for six months.</p> <p>5. 1-17-15</p>				

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	<p>Bowel/Bladder assessment for the staff to complete which would have included an assessment of the resident's abdomen including bowel sounds. The ADON indicated this was not done for Resident #E.</p> <p>When interviewed on 12/18/14 at 8:20 a.m., the Director of Nursing indicated staff were to monitor the resident's bowel movements and follow the Bowel protocol. The Director of Nursing indicated Resident #E should have had a bowel assessment as per the Protocol on 12/14/14.</p> <p>2. The record for Resident #F was reviewed on 12/17/14 at 1:30 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, high blood pressure, and esophageal reflux.</p> <p>The 12/2014 Bowel and Bladder Elimination record was reviewed. The record indicated the resident had a medium bowel movement on 12/12/14 at 7:42 p.m. The resident's next bowel movement was 12/16/14 at 8:56 p.m.</p> <p>Review of the 12/3/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for decision making were moderately impaired. The</p>			

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	<p>assessment also indicated the resident occasionally was incontinent of bowel and required extensive assistance of two staff members for personal hygiene.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 9/20/2014 indicated the resident was at risk for constipation related to decreased mobility, cognitive impairment, short attention span and the use of narcotic medications. Care plan interventions included for staff observe bowel movements for amount and consistency and administer medications and bowel protocol.</p> <p>The 12/2014 Nursing Progress Notes, Assessment notes, Occurrence forms, and Change in Condition notes were reviewed. There was no documentation of any assessment of the resident's abdomen or of bowel sounds.</p> <p>When interviewed on 12/18/14 at 11:55 a.m., ADON #1 indicated there was a Bowel/Bladder assessment for the staff to complete which would have included an assessment of the resident's abdomen including bowel sounds. The ADON indicated this was not done for Resident #F.</p> <p>When interviewed on 12/18/14 at 8:20</p>			

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	<p>a.m., the Director of Nursing indicated Resident #F should have had a bowel assessment on 12/15/14 as per the Bowel Protocol. The Director of Nursing indicated there was no record of any bowel assessment for the resident.</p> <p>The facility policy titled Guidelines for Residents with Constipation was reviewed on 12/18/14 at 8:20 a.m. There was no date on the policy. The Director of Nursing provided the policy and indicated the policy was current. The Policy indicated staff were to monitor daily bowel movements and record elimination. The CNA's were to report any unusual elimination patterns to the Nurse. The policy also indicated if the records indicated the resident had not had a bowel movement in three days, a nursing assessment was to be completed and to included notations about the residents bowel sounds, abdominal distention, firmness, tenderness, or guarding. The results of the abdominal assessments were to be communicated to the Physician with a request for an laxative order.</p> <p>This Federal tag relates to Complaint IN00160464.</p> <p>3.1-37(a)</p>			

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F000314 SS=D	<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 for pressure ulcers were provided related to staff applying a dressing to the coccyx area with lack of assessment of the skin documented for 1 of 3 residents reviewed for Pressure Ulcers in the sample of 12. (Resident #C)</p> <p>Findings include:</p> <p>During Orientation Tour on 12/17/14 at 9:00 a.m., Resident #C was observed in bed. A specialty air mattress was in place on the resident's bed. ADON #2 was present at this time. The resident had</p>	F000314	<p>The facility requests paper compliance for this citation.</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>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</p>	01/17/2015
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	<p>boots on both of his feet. The ADON removed the boots. A dark purplish circular intact blister was noted to the resident's left heel. The blister measured approximately 4.5 cm (centimeters) in diameter. A dark blister was also observed to the resident left heel. The blister area appeared as two round areas connected with a small area in between the round areas. The round areas measured approximately 4 cm in diameter. No drainage was noted from the heel areas. The resident was turned to his side. There was a Duoderm foam dressing which appeared to be peeling off from the resident's sacral/coccyx/buttock area. The area extended from the sacral area to each buttock areas. The area measured approximately 10 cm across and 4 cm down. The area was smaller in the middle (the coccyx area) and larger on each buttock area. There were darkened areas of skin at the coccyx area. There were dark tan areas in each buttock cheek area.</p> <p>The record for Resident #C was reviewed on 12/17/14 at 12:46 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, hyperlipidemia, urinary retention, insomnia, and psychosis. The resident was sent to the hospital on 12/8/14 and returned to the facility from the hospital on 12/11/14.</p>		<p>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.</p> <ol style="list-style-type: none"> Resident #C had skin assessments completed upon return from hospital as part of admission assessments. The assessment noted all skin issues. Treatments were obtained for all skin issues. Interventions to help prevent breakdown implemented. Resident is seen weekly by wound doctor. Nurse who first identified new area to buttocks was educated. All residents have the potential to be impacted by the alleged practice. Skin sweep completed on 300 unit to ensure no other wounds did not have assessments completed per policy. Corrections completed if necessary. Nursing staff to have in servicing completed on wound assessment policy (copy attached) DHS or designee will monitor compliance through review of the audit tools, results of these reviews will be presented monthly at QAPI meeting x 90 	

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	<p>The 11/25/14 Minimum Data Set quarterly assessment indicated the resident's cognitive skills for decision making were severely impaired. The assessment also indicated the resident required extensive assistance of staff for personal hygiene, dressing, and eating. The assessment indicated the resident was always incontinent of bowel and bladder. The assessment indicated the resident was at risk for pressure ulcer development and currently had no pressure ulcers.</p> <p>A Braden Scale assessment for pressure ulcer risk was completed on 12/5/14. The resident's score as (13). A score of (13) indicated the resident was at moderate risk for pressure ulcer development.</p> <p>The resident's Care Plans were reviewed. A Care Plan initiated on 4/18/14 indicated the resident had the potential for impairment in skin integrity related to edema, incontinence and dementia. The Care Plan was last reviewed on 11/25/14. Care Plan interventions included for staff to monitor/document location, size, and treatment of skin injuries.</p> <p>A Skin/Feet assessment was completed on 11/29/14 at 10:14 a.m. The</p>		<p>days. If after 90 days of review, no trends or patterns are identified (3 deficient practices per month is considered a trend) then results will be reviewed quarterly for six months.</p> <p>5. 1-17-15</p>				

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	<p>assessment indicated the resident's skin was warm and the resident had no feet or skin problems noted.</p> <p>An Occurrence Report was initiated on 12/5/14 at 2:43 p.m. The report indicated a blister was noted during a skin check in the shower. The report did not indicate the location of or a description of the blister. The report indicated the Physician was notified and orders were received. A treatment order was obtained to apply Skin Prep to the right heel blister and cover the area with a dressing daily.</p> <p>Review of the resident's record from 12/5/14 through 12/7/14 indicated there was no documentation of the resident having any skin alteration, new pressure ulcers, or any other new skin conditions other than the above blister to the right heel noted between 12/5/14 and 12/7/14. There was no documentation of the resident having any open areas, alterations in skin integrity, or treatments in place to the sacral/coccyx area.</p> <p>A Pressure Ulcer Progress Report note completed on 12/8/14 at 12:15 p.m., indicated the resident had Suspected Deep Tissue Injury (purple or maroon localized area of discolored intact skin of blood filled blister due to damage of</p>			

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	<p>underlying soft tissue from pressure and shear) to the right heel and the left heel. The right heel measured 5.0 cm x 12.5 cm. The left heel measured 8.5 cm x 6.4 cm. The note also indicated the resident had Stage II (partial thickness loss of the dermis presents as a shallow open ulcer with a red pink ulcer bed) pressure ulcers to the right and left buttock areas. The right buttock area measured 4.0 cm x 2.8 cm. The left buttock measured 6.0 cm x 2.5 cm.</p> <p>A SBAR (change in condition) report was completed on 12/8/14 at 11:32 a.m. The report indicated the resident was slow to respond and did not consume his breakfast meal. The report also indicated there was a blister to the heel (right or left no identified) with skin prep and Prafo (protective) boot applied. The report indicated today DTI (Deep Tissue Injury) areas were noted to bilateral heels with the skin intact. The report also indicted the resident had shearing (interaction of gravity and friction against the skin surface which occurs when layers of skin rub each other or when skin remains stationary while the underlying tissue moves, stretching or tearing the blood vessels, causing tissue damage) of his bilateral buttock. The report also indicated the resident's skin turgor was sluggish with worsening of current skin</p>			

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	<p>areas and new skin impairments noted. The resident was to be sent to the hospital.</p> <p>The 12/8/14 Progress Notes were reviewed. A Nursing entry made at 2:25 p.m., indicated the resident was transported to the hospital by ambulance.</p> <p>The 12/11/14 Admission/Re-Admit assessment completed at 5:15 p.m. was reviewed. The assessment indicated the resident had blisters to the right and left heels. The right heel blister measured 6 cm x 8 cm and the left heel blister measured 5 cm x 7 cm. The assessment also noted the resident had a pressure ulcer to the sacrum measuring 6 cm x 7 cm.</p> <p>The 12/16/14 Skin Ulcer Progress Report form was reviewed. The form was completed at 5:46 p.m. The form indicated three skin areas were identified. The areas were to the right heel, the left heel, and the sacrum. The right and left heel ulcers were identified as pressure ulcers and the stage of the ulcers were identified as Suspected Deep Tissue Injuries. The right heel measured 4.5 cm x 12.5 cm. The left heel measured 8.0 cm x 11.0 cm. The sacrum wound was identified as pressure and the stage of the wound was identified as Unstageable</p>						

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	<p>(full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown and/or eschar) tissue in ulcer bed). The form also indicated the area to the resident's bottom presented as one large sacral wound with necrotic tissue present.</p> <p>Hospital reports from 12/8/14 -12/11/14 were reviewed. A Progress Note dated 12/9/14 indicated a RN completed wound assessments. The assessment were completed on 12/9/14 at 3:10 p.m. The note indicated there was a large Stage II pressure ulcer to the coccyx. The wound length measured 6 cm and the width measured approximately 7 cm. The note also indicated no signs or symptoms of infection were noted. The note also indicated the resident had STD (Suspected Deep Tissue Injury) pressure ulcers to the right and left heels.</p> <p>The DON (Director of Nursing) and ADON (Assistant Director of Nursing)#2 were interviewed on 12/17/14 at 2:18 p.m. The ADON indicated RN #1 first noted a blister to the resident's right heel on 12/5/14, Sure Prep treatment was ordered, and therapy obtained a Prafo boot (protective boot) for the resident. The ADON indicated shearing to the resident's buttock was first noted on</p>			

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	<p>12/8/14 before the resident was sent to the hospital. The ADON indicated she had seen the resident in the morning and he did not seem to be his normal self. The ADON indicated staff were having difficulty getting the resident to eat. The resident was put to bed and was assessed and this was when the areas to the buttock and the left heel were observed. The ADON indicated there was a telfa dressing to the area and shearing was noted under the dressing.</p> <p>The DON indicated she saw the resident earlier that morning around approximately 6:00 or 7:00 a.m. The DON indicated the Nurses told her they removed an island (dressing with padding attached to tape) and they had taken it off and skin started peeling with it. The DON indicated at that time she did not ask the Nurses why the resident had the dressing in place or if there was an open area or ulcer present there. The DON indicated the area was beefy red and measured approximately 6 cm x 2.5 cm. The DON indicated she did not know who or when that dressing had first been applied.</p> <p>When interviewed on 12/18/14 at 8:14 a.m., the DON indicated she was able to get hold of the Nurse who worked the night shift from 12/7/14 into the morning</p>						

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	<p>of 12/8/14 for Resident #C. The Nurse informed her a CNA on the night shift told her the resident had a dressing on his coccyx. The Nurse indicated there was a dressing in place to the coccyx and she had not observed a Physician's order for the dressing or any treatment. The Nurse indicated she had not been aware of the resident having any dressing or treatments to the coccyx area at that time. The Nurse indicated she thought the evening shift Nurse may have gotten the order, applied the dressing, and did not document.</p> <p>The DON indicated the Night Nurse did not document the dressing or notify the Physician. The DON indicated there was no determination of why the resident had the dressing to the coccyx or if there were any skin alterations noted whenever the dressing was applied. The DON indicated there was no documentation on the 24 hour shift to shift reports related to why the dressing was in place or if any open areas were present or not. The DON indicated the Nursing staff should have documented any areas or why the dressing was in place and if there was an alteration in the skin the Physician should have been notified of the area and treatment orders obtained to treat the area.</p>			

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F000363 SS=E	<p>The facility policy titled "Pressure Ulcer and Skin Condition Assessment" policy was reviewed on 12/18/14 at 1:08 p.m. There was no date on the policy. The DON provided the policy and indicated the policy was current. The policy indicated all residents were to be observed for skin breakdown daily during care. Changes in skin were to be reported to the Nurse and the Nurse was to be perform a detailed skin assessment.</p> <p>This Federal tag relates to Complaint IN00161191.</p> <p>3.1-40(a)(2)</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p>				

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	<p>Based on observation, record review, and interview, the facility failed to ensure menus were followed related to bread and margarine not served to 6 of 12 residents during the lunch meal service in 1 of 2 Dining rooms observed for meal service on the Special Care Unit. (The 100 Dining Room) (Residents, #L, #M, #P, #H, #J, and #K)</p> <p>Findings include:</p> <p>Meal Service of the Lunch meal in the 100 Dining Room on the Special Care Unit was observed on 12/17/14 at 11:40 a.m. A total of (12) residents were seated at (5) tables in the Dining Room. A menu was posted on a stand in the Dining Room. The posted menu listed sweet and sour meatballs, buttered noodles, peas & carrots, bread, margarine, coffee/tea, and condiments. No bread or margarine was on any of the tables. Staff members wheeled a rolling cart with containers of food items to each table and served the residents their meals.</p> <p>Residents #H, #L, #M, #P, and #J were served meatballs, noodles, peas & carrots, and carrot cake. The residents were not served any bread or margarine at any time throughout the meal. The tray cards on the tables for the above residents indicated no dislikes were listed on any</p>	F000363	<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 executed solely because it is required by the provisions of federal and state law.</i></p> <ol style="list-style-type: none"> The Food Service Manager in-serviced the Dietary staff on the need to ensure that each cart contains everything listed on the spread sheet. All residents had the potential to be affected. Dietary will ensure that all spreadsheet items are provided. The Food Service Manager 	01/17/2015

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	<p>of their tray cards.</p> <p>Resident #K was not served the noodles or the meatballs. The resident was served a grilled cheese sandwich and peas & carrots on his plate. The resident was not served any bread or margarine at any time throughout the meal. No dislikes were listed on the resident's tray card.</p> <p>The record for Resident #K was reviewed on 12/18/14 at 10:22 a.m. The current Physician's orders indicated the resident was to receive a general diet with food of regular texture. The 11/28/14 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required supervision of one person for eating.</p> <p>The record for Resident #H was reviewed on 12/18/14 at 10:15 a.m. The resident's diagnoses included, but were limited to, Alzheimer's disease, joint stiffness, and diabetes mellitus. The current Physician's orders indicated the resident was to receive a general diet with mechanical soft texture foods. The 12/8/14 Minimum Data Set quarterly assessment indicated the resident's BIMS</p>		<p>in-serviced staff on the need to ensure that the meal cart contains all items on the spreadsheet/menu. (copy attached) The Food Service Manager instituted a log to be initialed by the cook for each meal that verifies that all items are present. The Food Service Manager will review at least 5 random meal carts per week. Monitoring tool attached.</p> <p>4. The Executive Director will monitor compliance through review of the monitoring forms. Results of these reviews will be presented monthly at the QAPI meeting, times 90 days. If after 90 days of review, no trends or patterns are identified (three deficient practices per month is considered a trend), then results will be reviewed quarterly for a total of six months.</p> <p>5. 1.17.15</p>				

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	<p>(Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required supervision of one person for eating.</p> <p>The record for Resident #M was reviewed on 12/18/14 at 10:29 a.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, and high blood pressure. The current Physician's orders indicated the resident was to receive a general diet with mechanical soft texture foods. The 10/13/14 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required supervision with set up help for eating.</p> <p>The record for Resident #L was reviewed on 12/18/14 at 10:36 a.m. The resident's diagnoses included, but were not limited to, senile dementia, osteoporosis, and diabetes mellitus. The current Physician's orders indicated the resident was to receive a general diet with mechanical soft texture foods. The 11/12/14 Minimum Data Set quarterly assessment indicated the resident's BIMS</p>			

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	<p>(Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one person for eating.</p> <p>The record for Resident #P was reviewed on 12/18/14 at 10:20 a.m. The resident's diagnoses included, but were not limited to, dementia, osteoarthritis, and depressive disorder. The current Physician's orders indicated the resident was to receive a general diet with regular texture foods. The 10/13/14 Minimum Data Set assessment indicated the the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of one person for eating.</p> <p>The record for Resident #J was reviewed on 12/18/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and congestive heart failure. The current Physician's orders indicated the resident</p>			

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	<p>was to receive a general diet with mechanical soft foods. the 11/26/14 Minimum Data Set quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required supervision of one person for eating.</p> <p>The Dietary Menu's and Spread Sheets were reviewed on 12/17/14 at 1:00 p.m. The Menu indicated the General diet with regular texture foods included, sweet & sour meatballs, buttered noodles, frosted carrot cake, bread, and margarine. The Menu Spread sheet indicated residents with mechanical soft texture ordered were to receive ground meat, buttered noodles, peas & carrots, frosted carrot cake, one slice of bread and margarine.</p> <p>When interviewed on 12/17/14 at 12:50 p.m., CNA #1 indicated she had served the residents their meals in the dining room for lunch. The CNA indicated the food comes on a cart from the Kitchen and the staff served each resident. The CNA indicated the residents were not served bread and margarine for lunch. CNA #1 indicates they do not have bread on the unit and the Kitchen sometimes sends it with the meal. The CNA</p>			

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	<p>indicated no staff called the Kitchen to request bread that she was aware of.</p> <p>When interviewed on 12/17/14 at 1:10 p.m., the Dietary Manager indicated the Kitchen staff prepare the food for the Special Care Unit Dining Rooms and delivers the cart of the food to the unit. The Dietary Manager indicated the menu for the lunch meal today was to include bread and margarine and this should have been sent down with the meal carts. Dietary Cook #1 indicated the bread was not sent to the unit today.</p> <p>This Federal tag relates to Complaint IN00160464.</p> <p>3.1- 20(i)(4)</p>			