

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/10/2014
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F000000	<p>This visit was for the Investigation of Complaint IN00150438 and Complaint IN00151385.</p> <p>Complaint IN00150438 - Substantiated, Federal/State deficiencies related to the allegations are cited at F353 and F514.</p> <p>Complaint IN00151385 - Substantiated, Federal/State deficiencies related to the allegations are cited at F250 and F353.</p> <p>Survey dates: July 9 and 10, 2014</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 9 SNF/NF: 87 Total: 96</p> <p>Census payor type: Medicare: 20 Medicaid: 73 Other: 4 Total: 96</p>	F000000	We as a Facility would like to request a Desk Review.	
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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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F000250 SS=D	<p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 14, 2014 by Jodi Meyer, RN</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were updated to manage behaviors, resulting in resident to resident behaviors, for 2 of 3 residents reviewed with behaviors, in a sample of 6. Residents D and E</p> <p>Findings include:</p> <p>1. On 7/9/14 at 10:50 A.M., during a tour of the Alzheimer's Unit, the Unit Manager indicated Resident D had</p>	F000250	F250 D It is the intent to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 1. Resident D's care plan has been reviewed and up dated with current interventions for behaviors also other placement is being considered for this resident. Resident E's care plan has been reviewed and up dated with current interventions for behaviors. 2.All residents have the potential to be affected by the deficient practice. No other residents were	08/09/2014

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	<p>exhibited behaviors of aggression, and had just returned from a psychiatric stay. Resident D was observed in her room with family present.</p> <p>The clinical record of Resident D was reviewed on 7/9/14 at 3:35 P.M. Diagnoses included, but were not limited to, dementia and senile psychosis.</p> <p>Documentation indicated the resident returned from a psychiatric hospital stay on 6/5/14.</p> <p>Progress Notes included the following notations:</p> <p>6/9/14 at 8:53 A.M.: "Reported to this writer per CNA and Activities that resident was attempting to take another resident outside and became aggressive with staff. Kept interfering in care of other residents...attempted to punch staff...Refusing to leave [other resident's] room so staff can give care. Not easily redirected."</p> <p>6/9/14 at 11:32 A.M.: "Reported per therapy: resident was pushing another resident in wheelchair. Attempted redirection from CNA...Resident would not let go of other resident's wheelchair...Hit therapist twice in shoulder...."</p>		<p>found to be effected by this practice. Nursing and Social Service to in-service nursing staff 7/24/14 on New and/or Worsening Behaviors interventions and how to review interventions and documentation of behaviors and how to implements new interventions when needed. All residents who are displaying behaviors were reviewed by IDT to ensure behavior interventions are in place and effective. 3. Nursing and Social Service to in-service nursing staff 7/24/14 on New and/or Worsening Behaviors interventions and how to review interventions and documentation of behaviors and how to implements new interventions when needed. Resident's who displaying behaviors will have interventions implemented per plan of care and overseen by social service director. If interventions are not effective, the DNS/Designee/Social Service Director will be notified for additional interventions. Residents exhibiting behaviors will be reviewed during IDT meeting to determine root cause and will develop new interventions with care plan updated. 4.To ensure compliance, the Social Worker/Designee is responsible for the completion of the Social Service Behavior CQI tool weekly times 4 weeks, bimonthly times 2 months , monthly times 6 and</p>				

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	<p>6/10/14 at 12:18 P.M.: "IDT [Interdisciplinary Team] reviewed behavior...Resident does have history of this behavior...IDT recommends contacting [psychiatrist] consult for review since this resident just left their facility...Resident continues to be 15 minutes check for the 72 hour [sic]."</p> <p>6/10/14 at 7:15 P.M.: "...Res [resident] became upset towards female CNA when female CNA went into another residents room to provide care, this res followed CNA into room...res became more upset and kicked bed of other resident who was asleep in it at the time, and woke him up. Res then left that room and came down to nurses desk, wheeling male res in w/c [wheelchair]...res cont to try to push male resident in w/c and at this point was trying to assist him in bed...."</p> <p>6/11/14 at 11:37 A.M.: "...CNA had been attempting to redirect resident from [another resident's] room, resident grabbed CNA by the neck and was pulling hair. Scratched CNA's face...attempted to hit CNA again...."</p> <p>A Minimum Data Set (MDS) assessment, dated 6/12/14, indicated the resident had a short-term and long-term memory problem and was moderately impaired in</p>		then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	<p>cognitive skills for daily decision making. The resident exhibited "Physical behavioral symptoms directed toward others" and "Verbal behavioral symptoms directed toward others" "4-6 days, but less than daily." The MDS assessment indicated the behavioral symptoms "Put others at significant risk of physical injury," "Significantly intrude on the privacy or activity of others," and "Significantly disrupt care of living environment."</p> <p>Progress Notes continued:</p> <p>6/13/14 at 7:49 A.M.: "Care conference was held... Both daughters [names] were present along with unit nurse. Discussed resident's behaviors, care plan...They suggested having resident do more 'chores' sweeping, folding, might decrease behaviors."</p> <p>6/14/14 at 7:00 P.M.: "...telling staff when redirected 'I'm gonna kill you if you don't stop messing with me...Res agitated and upset with this nurse...slapped this nurse across face...Will cont to observe."</p> <p>6/17/14 at 2:03 P.M.: "...Has been pacing in the hall and continuously looking in [room number] at a new resident. Looking at staff with aggression...Continues on 15 minute</p>			

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	<p>checks...."</p> <p>6/19/14 at 1:56 P.M.: "Resident very aggressive this AM. Threw items at this writer...At lunch was very verbal and refused medications x 3...."</p> <p>6/19/14 at 10:09 P.M.: "The resident became agitated after dinner this shift. She poured a cup of ice water on her room mate. She than [sic]became fixated with her roommate pulling her around by the arm when staff intervened she started hitting staff slapping staff. She than [sic] placed her arm around room mate neck and shoulder to lead her around. Staff immediately removed her from the area and away from room mate...Interventions were attempted without any results call placed to Dr....."</p> <p>6/20/14 at 10:51 A.M.: "IDT review behavior: Physically aggression with room mate. Assessment: Resident has had an increase in aggression over the past few months. Resident is becoming obsessive in nature with different residents...Intervention: Will continue to monitor with 15 minute checks...."</p> <p>6/23/14 at 1:51 P.M.: "Resident continues to have aggressive behaviors...Grabbed both of my arms tightly and tried to smack my face...she</p>			

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	<p>became violent with CNA and I when we were providing care to another resident...attempted to choke me...."</p> <p>6/24/14 at 6:00 P.M.: "Res. became agitated after supper, was confrontational with other residents, nurse monitored res, one on one, removed other residents from dining area...Res. pushed other res. wheelchairs...Intrusively wandering into other residents rooms...."</p> <p>The resident was transferred to a psychiatric hospital on 6/25/14 and returned to the facility on 7/4/14.</p> <p>Progress Notes included:</p> <p>7/8/14 at 10:01 P.M.: "Resident has been highly agitated this eve. Kept getting residents up from the dinner table after just being seated...Resident would walk away then would go to another residents table and raise her voice and would smack her hand down on the table in front of that resident et [and] jabber words like she was lecturing them...."</p> <p>7/9/14 at 8:30 A.M.: "...this res took fist and struck this nurse in between shoulder blades...res grabbed this nurses wrists and twisted them...res then tried to push this nurse backwards...."</p>			

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	<p>A care plan, dated 1/31/14, indicated a problem of "Behavior: Resient [sic] can become combative with other residents or staff members [sic] ie hitting, grabbing arms, pushing, etc." The approaches, all dated 1/31/14, included: "During meal time and activities keep resident in a consistent spot next to residents she enjoys being around. At bedtime assist resident to bed in order to decrease confusion of time and place. If resident begins to get agitated remove resident from the situation and allow time for her to calm down." Documentation of revision or addition of different approaches was not found in the clinical record.</p> <p>An additional care plan, dated 4/24/14, indicated a problem of "Non compliant with care, weights, and labs." The 1 approach indicated, "Approach with different staff and different times of the day." No other approaches were documented.</p> <p>On 7/10/14 at 9:10 A.M., during an interview with the Social Services Director [SSD], he indicated he did not usually take care of the residents on the Alzheimer's Unit. He indicated he had been "filling in," and that the new Memory Care Facilitator had just started. He indicated he was aware of Resident</p>			

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	<p>D's behaviors, and that she had just returned from a psychiatric stay. He indicated either he or the nursing staff would update the care plans when needed. He indicated each resident who exhibited behaviors had a behavior monitoring form on the unit, but that the behavior plan and interventions would be the same as listed in the care plan.</p> <p>2. The clinical record of Resident E was reviewed on 7/10/14 at 8:54 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbance.</p> <p>A Minimum Data Set (MDS) assessment, dated 6/10/14, indicated the resident scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident had not exhibited any behaviors during the assessment period, including wandering.</p> <p>Progress Notes included the following notations:</p> <p>6/15/14 at 1:45 P.M.: "Resident has been wandering through-out the hallways looking for her husband. Unable to be convinced that her husband does not live here. Has belongings packed in her room."</p>			

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	<p>6/15/14 at 2:14 P.M.: "Heard residents room-mate hollering fot [sic] 'help.' Upon entering her room found res. trying to take her walker away from [Resident F]. Also had an emory [sic] board in her hand and weas [sic] waving it in roommates face threatening her. Residents immediately separated at this time...."</p> <p>6/16/14 at 2:27 P.M.: "IDT meet [sic] to discuss residents behavior: Resident was observed threating [sic] roommate with a emery board...Root cause: IDT thinks resident may have possible UTI [urinary tract infection]. Intervention: Residents were separated. Resident was placed on 15 minute checks. Waiting on labs results."</p> <p>6/17/14 at 7:30 A.M.: "Resident behaviors continue. Resident has stripped her bed and threw all her clothes from closet to floor...Resident is sitting in roommate's chair watching door...."</p> <p>6/18/14 at 1:23 P.M.: "IDT reviewed behavior: Refusing adl [activities of daily living] care...Assessment: Resident has been assess [sic] for pain. Testing for UTI was negative...Root cause: Team feels that this is a natural progression of her dementia. Intervention: Possible placement at behavior unit was denied at</p>			

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	<p>this time by dr...She has prescribed depakote sprinkles to address behaviors."</p> <p>6/26/14 at 9:12 A.M.: "Resident attempting to exit out the unit door this a.m. Kicked the housekeeper who was trying to re-direct her...."</p> <p>6/26/14 at 10:39 A.M.: "Wandering aimlessly through-out the hallways...."</p> <p>6/26/14 at 9:15 P.M.: "Found resident in another resident's room (male) nude except for pull-ups on...Male resident explained that she had just entered and took off clothes and that no contact occurred between residents...[Resident E] was reminded of proper etiquette and behavior and she acknowledged understanding of rules. Will continue to monitor."</p> <p>A care plan, dated 12/31/13, indicated a problem of "Behavior: Resident becomes paranoid leading to personal distress and begins to wander impulsively." The approaches listed 3 interventions: "Allow resident to call husband or family to talk to if she feels anxious or starts to wander. Offer resident an activity to do such as coloring, music, and cooking. Allow resident to help with cleaning or organizing. Resident enjoys helping others and feeling wanted."</p>			

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	<p>Documentation of additional interventions, or revisions of interventions, was not found in the clinical record.</p> <p>On 7/10/14 at 9:10 A.M., during an interview with the SSD, he indicated he was aware of Resident E's behaviors, and that her roommate had been moved. The SSD indicated the physician had refused a request for a psychiatric stay, and thought the resident had been started on Depakote. He indicated he was unsure what interventions would be applicable for the resident, as the resident already had a care plan in place.</p> <p>3. On 7/10/14 at 12:35 P.M., the Medical Records manager provided the current facility "Behavior Management Policy & Procedure," undated. The policy included: "It is the policy...to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological...New or worsening behaviors are reviewed by the IDT [Interdisciplinary Team]...The IDT review should be a discussion with the team as to the behavior event, an evaluation of interventions, presentation of new interventions if applicable...Care should be taken to ensure that</p>			

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F000353 SS=E	<p>interventions and behaviors are changed on the care plan, behavior monitoring record or CNA assignment sheet...."</p> <p>This Federal tag relates to Complaint IN00151385.</p> <p>3.1-34(a)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial</p>			

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	<p>well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure there were sufficient staff on the Alzheimer's Unit to provide activities, toileting assistance, showers, timely meals, and manage behaviors, with the potential to affect 33 of 33 residents residing on both halls of the Alzheimer's Unit.</p> <p>Findings include:</p> <p>On 7/9/14 at 10:50 A.M., during a tour of the "Cottage," or Alzheimer's Unit, the Memory Care Facilitator [MCF] indicated she had just started on 7/7/14.</p> <p>On 7/9/14 at 12:00 P.M., the Director of</p>	F000353	F353 E It is the intent of this facility to provide sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 1.All residents on the cottage are receiving activities as programmed, are receiving toileting assistance as needed, showers are provided as care planned and as needed, meals are provided timely, and interventions for behaviors are implemented as needed. 2. All resident have the potential to be affected by this practice and staffing patterns have been changed to assure proper care to residents. Staffing Patterns have	08/09/2014

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	<p>Nursing (DON) provided CNA assignment sheets for the Alzheimer's Unit. The sheets indicated there were 33 current residents, on 2 different halls. 21 residents required the assistance of 1 staff for their ADLs (Activities of Daily Living), 6 residents required the assistance of 2 staff, and 3 residents required the assistance of "1-2" staff members. 23 residents were either incontinent, or on a toileting schedule. For "Mobility/Transfers," 13 residents required the assistance of 1, 2 required the assistance of 2, and 3 residents were documented as "W/C [wheelchair]" or "Broda." 18 residents were listed as having behaviors. 23 residents were on a "Turn/Reposition" every 2 hour schedule.</p> <p>On 7/9/14 at 12:50 P.M., the "C" dining room was observed to have 8 residents eating their lunch. No staff member was present. 2 family members were present. 1 resident was chanting. 1 resident was observed not to have touched her meal. CNA # 1 was observed to come out of a room down the hall, carrying a bag of dirty linen, and indicated, "Where's the nurse?" After a few minutes, CNA # 1 came to the dining room and started assisting residents. After approximately 10 minutes, LPN # 1 came out of a resident room, and indicated she had been feeding a resident.</p>		<p>been reviewed my Nursing Management and HFA for the Cottage, and it has been determined that the staffing Pattern will be as such. There will be 2 nurses assigned on Days and two nurses on Evening shifts and One Nurse at night. CNA's will be assigned as 3 on Days and 3 on Evenings and 2 on nights. On Days and Evenings there will be a C.N.A assigned to each hall and there will be CNA that is designated as a float between both halls. Also there will be an Activities person assigned to each hall at 7am to 3pm and second shift will come in at 3 and leave between 8 and 9 pm as needed. Nursing and Social Service to in-service nursing staff 7/24/14 on New and/or Worsening Behaviors interventions and how to review interventions and documentation of behaviors and how to implements new interventions when needed. 3.Staffing Patterns have been reviewed my Nursing Management and HFA for the Cottage, and it has been determined that the staffing Pattern will be as such. There will be 2 nurses assigned on Days and two nurses on Evening shifts and One Nurse at night. CNA's will be assigned as 3 on Days and 3 on Evenings and 2 on nights. On Days and Evenings there will be a C.N.A assigned to each hall and there will be CNA that is designated as a float between</p>				

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	<p>On 7/9/14 at 1:15 P.M., the "D" dining room was observed. Several residents were sitting in the dining room. LPN # 2 was passing medications, and indicated the lunch trays had already been picked up. LPN # 2 indicated there was supposed to be an activity assistant who worked on the hall, but that she was only able to work 1/2 days because of school, and had already left. LPN # 2 indicated the staff were supposed to provide the activities scheduled, but that it was difficult to do. She indicated she tried to bring in old movies for the residents to watch on the afternoons that the activity aide was not there.</p> <p>On 7/9/14 at 1:30 P.M. on "D" hall, Activity Aide # 1 indicated she was "doing both [halls] today." She indicated, "The other girl goes to school." The Activity Calendar indicated, "1-1:30 P.M. Reminiscing, 1:30-2:00 P.M. Walking Outdoors." The Activity Aide was informing residents it was time for "exercise."</p> <p>At 1:40 P.M. on the "C" hall, 4 residents were sitting in a lounge area watching TV. 1 resident was sitting alone in the dining room without interaction. Other residents were observed sitting in their rooms. CNA # 1 indicated she was going</p>		<p>both halls. Also there will be an Activities person assigned to each hall at 7am to 3pm and second shift will come in at 3 and leave between 8 and 9 pm as needed. Nursing and Social Service to in-service nursing staff 7/24/14 on New and/or Worsening Behaviors interventions and how to review interventions and documentation of behaviors and how to implements new interventions when needed. Customer Care rounds have been assigned to Department Managers and daily rounds will be made by Department Heads to assure care is being provided & (week-end Managers on the week-ends and reviewed on Monday following the week-end) Department Heads/designee will make rounds 5 days a week to their assigned areas. Any problems noted and or lack off care during these rounds will be reported in morning meeting for daily QCI improvement and correction. At 3:30pm Department Heads will meet with HFA/Designee to report on corrections of assigned CQI problems. If the problem cannot be resolved by 3:30pm the staff person responsible for the correction will have a plan of action for when the issue will be resolved. A manager is to be assigned to the cottage for each meal to ensure assistance is provided. Unit nurses/CNA's and Activities Aids are to monitor units</p>				

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	<p>to give a resident a shower. The Activity Calendar indicated, "1-1:30 short story, 1:30-2:00 P.M. chair exercises."</p> <p>On 7/10/14 at 9:30 A.M., the "C" dining room was observed. 8 residents were in the dining room eating breakfast. CNA # 3 was observed feeding 1 resident, and the Corporate Nurse was observed feeding another resident. LPN # 3 was assisting a resident out of her room to the dining room to start her breakfast. LPN # 3 indicated she did not usually work on that unit, and was unsure what time breakfast was served. CNA # 3 indicated she was unsure when breakfast was supposed to be served, but thought it was "7:30 or 8:00."</p> <p>On 7/10/14 at 10:05 A.M., during an interview with the Scheduling Coordinator, she indicated she currently schedules 2 nurses and 2 CNAs on day and evening shift, and 1 nurse and 1 CNA on night shift. She indicated she "just hired 2 people, and plans on placing a 3rd CNA on day shift." She indicated she schedules according to the number of residents, not the acuity of residents.</p> <p>Confidential interviews with staff members, who worked different shifts, indicated the following:</p>		<p>for behaviors and to insure interventions are in place and being used. 4.To ensure compliance the DNS/Designee will be responsible for the completion of the Nursing Care/ADL's CQI tool weekly times 4 week, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p>	

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	<p>Staff # 1: We do what we can. It's hard to get it all done. We can't do it.</p> <p>Staff # 2: We can't care for all of these residents. Several residents are either total care or require 1:1. Residents are not getting changed in a timely manner, and showers aren't always being given.</p> <p>Staff # 3: We can't get it all done. We try.</p> <p>Staff # 4: They're staffing better now because state is here. We can't get it all done with 1 nurse and 1 CNA on each hall.</p> <p>Staff # 5: If they would just add staff, it would help with the behaviors.</p> <p>Staff # 6: We used to have 3 CNAs on, but now there is just usually 2. A lot of staff won't work back here on the Cottage.</p> <p>During a confidential interview with Family # 1, she indicated she could not say her family member looks clean when she visits. She indicated at times the resident's hair would be "dirty and smelly," or that there would be "BM down the pant legs." She indicated she didn't know if it was really the facility's fault; that her family member may have refused care.</p>			

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	<p>On 7/10/14 at 11:15 A.M., during an interview with the Administrator, she indicated she had only been at the facility for approximately 2 months. She indicated CNAs were hard to recruit in that area. She indicated there should be 3 CNAs on day shift, and a float CNA should be on night shift.</p> <p>This Federal tag relates to Complaint IN00150438 and Complaint IN00151385.</p> <p>3.1-17(a)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview, and record review, the facility failed to ensure to completely document the appearance of a stasis ulcer, for 1 of 5 residents reviewed for documentation, in a sample of 6. Resident C</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed on 7/9/14 at 1:15 P.M.</p> <p>Progress Notes included the following</p>	F000514	F514 D It is the intent of this facility to maintain clinical records that contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 1.Resident C's legs were assessed and orders were clarified by MD. The care plan for resident C was updated and Therapy was notified of changes. 2.All residents are at risk to be effected by this practice. Skin sweep will be done by DNS/Designee to insure that any skin issues are documented and orders are in place and being followed as ordered. 3.In-service all nursing staff concerning skin management wound care, measurements, appearance, drainage and pain. Infection	08/09/2014			

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	<p>notations:</p> <p>7/3/14 at 2:59 A.M.: "Resident received new order this shift from triage for new wound dressing to left outer ankle as requested by therapy [sic]."</p> <p>A Physician's order, dated 7/3/14, indicated, "DC [discontinue] orders for bilateral leg wraps. N.O. [new order] for: Area to outer left aspect of ankle: Cleanse with normal saline, use betadine to area. Apply puracol AG than [sic] wrap with gauze every shift x 10 days."</p> <p>A Progress Note, dated 7/3/14 at 8:51 A.M., indicated, "Tx [treatment] to area L [left] outer ankle as ordered per therapy. Scant amount of drainage noted...."</p> <p>Documentation of the open area was not found in the clinical record.</p> <p>On 7/9/14 at 1:30 P.M., the Director of Nursing (DON) unwrapped a bandage of the resident's left leg. Multiple small superficial open areas were observed on the resident's left shin area, and an open area was observed on the resident's left posterior ankle. The open area had a tannish bed, and had bloody drainage.</p> <p>On 7/10/14 at 8:30 A.M., the DON</p>		<p>control, matrix-training and correct documentation. The DNS will review weekly shower sheets and any other documentation in regards to skin issues and assure that documentation and doctors orders are in place. 4.To ensure compliance, the DNS/Designee is responsible for the completion of the wound and documentation CQI tool with each resident that is found to have wounds will be reviewed weekly times 4 weeks, bi-monthly times 2 months, monthly times 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% compliance is not achieved an action plan will be developed to ensure compliance.</p>				

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	<p>indicated the nurses were supposed to have charted the appearance of the wound, and notified the wound nurse. She indicated she counseled 2 of the nurses for not following the facility's policy. She indicated therapy had previously addressed the wounds on the resident's legs, and they had been healed.</p> <p>On 7/10/14 at 10:00 A.M., the therapy notes for Resident C were reviewed. Notes did not document the appearance of the wound.</p> <p>2. On 7/10/14 at 12:35 P.M., the Medical Records manager provided the current policy on the "Skin Management Program," revised 9/2014 [sic]. The policy included: "...Alterations in skin integrity will be reported to the physician and family member(s)...All alterations in skin integrity will be documented in EMR [electronic medical record]...The facility assigned wound nurse will complete a further evaluation of the wounds identified...."</p> <p>This Federal tag relates to Complaint IN00150438.</p> <p>3.1-50(a)(1)</p>			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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