STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155829		03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS AT LAFAYETTE, THE	2402 SOUTH STREET LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00195552. This visit included the investigation of complaint IN00191723. IN00195552 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F323. Survey dates: March 17 and 18, 2016 Facility ID number: 013499 Provider number: 155829 AIM number: 201285490 Census bed type: SNF: 36 SNF/NF: 10 Residental: 29 Total: 75 Census payor type: Medicare: 23 Medicaid: 6 Other: 17 Total: 46 Sample: 3 These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	155829		03/18/2016

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	Quality Review was completed by 21662 on March 21, 2016.			
F 0314 SS=G Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure 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.			
	Based on record review and interview, the facility failed to assess a resident's pressure ulcer and follow the resident's plan of care causing the pressure ulcer to increase in size from a stage 2 to a Stage 4 for 1 of 3 residents review for pressure ulcers. (Resident B) Findings include: The clinical record for Resident B was reviewed on 3/17/16 at 10:00 a.m. Diagnoses included, but were not limited to, sepsis, pneumonia, calculus of kidney, end stage renal disease, congestive heart failure, anemia, hyperlipidemia, hypothyroidism, diabetes, obstructive sleep apnea, paraplegia, morbid obesity, and muscle weakness.	F 0314	**F314** **Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** All current residents with pressure ulcers have beenre-assessed, proper treatment established, and care plans updated asindicated. 4/1/2016 **Identificationof other residents having the potential to be affected by the same allegeddeficient practice and corrective actions taken**: All current residents have been assessed for skinbreakdown. Any new findings wereaddressed per policy. 4/1/2016 **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:**	04/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155829	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Hospital wound notes, dated 2/7/16, indicated 3 wounds located on the resident's left buttocks and measured at 0.7 cm (centimeters) length by 2.5 cm width, 0.1 cm length by 2 cm width, and 0.1 cm length by 0.8 cm width. Facility nursing notes, dated 2/9/16, indicated the resident was admitted and was very weak. Required maximum assistance of 2 possibly 3 staff for turns. Needed a hoyer lift and physical therapy to get stronger. Clinical documentation, dated 2/10/16, indicated Resident B's skin was warm, dry and no other skin impairments Nursing notes, dated 2/16/16, indicated "...Resident has not been transferred since being admitted due to lower back stenosis...Writer called to resident room to exam resident coccyx wound. Writer noted the top layer skin excoriated with red and bloody skin...Resident encouraged to turn side to side at least every two hours...Wound measures 13 cm x 8.5 cm x 1 cm in depth...." Physician orders, dated 2/16/16, indicated to start Calmoseptine ointment. Apply to coccyx area three times a day and as needed for soilage.		New admissions will be audited by the Director of Post AcuteCare Services or designee for compliance in assessing for pressure ulcers, obtainingmeasurements of wounds, ensuring treatment orders are in place and initiationof plan of care. New admission auditswill occur 5 times weekly x 2 weeks, 3 times weekly x 2 weeks, 1 time weekly x 1month, then monthly x 2. Further auditswill occur as needed to ensure compliance is achieved. Pressure ulcers will be measured weekly by licensednurse. Effectiveness of currenttreatment will be evaluated and changed as indicated. The Director of Post Acute Care Services ordesignee will audit charts weekly x 4 months of all residents with existingpressure ulcers to ensure compliance with obtaining measurements and evaluatingtreatment effectiveness. Further auditswill occur if noncompliance is identified. All licensed nurses have been re-educated on the policy andprocedure regarding pressure ulcers. 4/1/2016 **Howthe corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The results of the audit observations will be reported,reviewed and trended for compliance thru the campus Quality Assurance Committeefor a minimum of 4 months then randomly thereafter for further recommendation.	

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	Nursing notes, dated 2/24/16, indicated new order received for wound care referral. An appointment with the wound care clinic was scheduled. No measurements were evident in the nursing notes. Nursing notes, dated 2/29/16, indicated a dressing was changed to the coccyx wound. Skin was noted to be dark and nonblanchable. The Director of Health Services was called to assess the wound. A new order was received for Maxorb Extra alginate wound dressing to be applied everyday after cleaning with normal saline. No measurements were evident in the nursing notes. Nursing notes, dated 3/1/16, indicated a new order received for granulex to the coccyx wound three times a day. No measurements were evident in the nursing notes. Resident B's plan of care, dated 2/18/16, indicated the resident was identified as at risk for impaired skin integrity related to paraplegia and decreased mobility. Interventions included, but were not limited to, weekly skin assessments by nursing staff and "if you notice any opened or persistently reddened areas on my skin, please tell my nurse so he/she			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	can do an assessment and notify the doctor as needed." Notes from the wound clinic, dated 3/4/16, received on 3/17/16 at 4:07 p.m., indicated "...1. Left buttock to sacrum. Length of wound: 13.5 cm. Depth of wound: unable to determine true depth as the ulcer is 100% covered in dry firm black eschar. Width of wound: 10.0 cm ... 2. Right buttock to sacrum. Length of wound: 8.5 cm. Depth of wound: unable to determine true depth as the ulcer is 100% covered in dry firm black eschar. Width of wound: 7.0 cm ... General Surgeon arrived to observe the patient's pressure ulcers and he agreed that the ulcers are severe and the patient needs surgery to debride the eschar and a plastics consult for surgery and flap future reconstruction is necessary...." During an interview on 3/17/16 at 3:00 p.m., with the Director of Post Acute Care Services, she indicated she was unable to located any other measurements for Resident B's coccyx wounds. Review of the facility policy, titled "Pressure/Stasis/Diabetic Wound Condition Guidelines", no date, received from the Director of Post Acute Care Services on 3/18/16 at 11:15 a.m., indicated "...Policy...4.			

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NAME OF PROVIDER OR SUPPLIER SPRINGS AT LAFAYETTE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2402 SOUTH STREET LAFAYETTE, IN 47904	

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	Re-assessment/measurement weekly or with significant change in wound noting the current treatment, medical interventions provided and comments as needed...." This Federal tag relates to Complaint IN00195552. 3.1-40(a)(1) 3.1-40(a)(2)			
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a safe transfer while using a mechanical hoyer lift causing a witnessed fall and failed to report the incident and follow-up on the incident for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record for Resident B was	F 0323	**F323** **Correctiveactions accomplished for those residents found to be affected by the allegeddeficient practice:** All residents receiving mechanical lift transfers have beenre-assessed for proper transfer technique. **Identificationof other residents having the potential to be affected by the same allegeddeficient practice and corrective actions taken:**	04/11/2016

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	reviewed on 3/17/16 at 10:00 a.m. Diagnoses included, but were not limited to, congestive heart failure, anemia, obstructive sleep apnea, paraplegia, morbid obesity, and muscle weakness. An assessment, dated 2/9/16, indicated Resident B required the use of a mechanical lift to assist with transfers. The plan of care, dated 2/18/16, indicated the resident was at risk for falls. Interventions included, but were not limited to, keep personal items and frequently used items within reach, encourage to use environmental devices such as hand grips and hand rails and make sure areas are free of clutter. During an interview with a confidential source, the source indicated, on 3/18/16 at 9:15 a.m., indicated he witnessed a fall involving Resident B while in the hoyer lift. The date of the fall was undetermined. The facility's fall reports from 1/17/16 to 3/17/16, received from the Director of Post Acute Care Services on 3/17/16 at 10:05 a.m., did not indicate Resident B had a fall. During review of the facility's incident reports, dated from November 2015 to		All residents have been reviewed for the potential need formechanical lifts. **Measuresput in place and systemic changes made to ensure the alleged deficient practicedoes not recur:** All direct care nursing and therapy staff have beeninserviced on proper technique when utilizing the mechanical lift. 4/8/2016 All direct care nursing and therapy staff have beeninserviced on policy and procedure of notification of incidents. 4/8/2016 Director of Post Acute Services or designee will observetransfer of residents with mechanical lift 3 times per week x 1 month then 1time per week x 1 month then monthly x 2 months. **Howthe corrective measures will be monitored to ensure the alleged deficientpractice does not recur:** The results of the audit observations will be reported, reviewedand trended for compliance thru the campus Quality Assurance Committee for aminimum of 4 months then randomly thereafter for further recommendation.	

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	March 2016, received from the Executive Director on 3/17/16 at 11:00 a.m., the reports did not indicate an incident involving Resident B. During an interview with the Executive Director, on 3/18/16 at 11:10 a.m., he indicated he was unaware of an incident involving the transfer of Resident #B. During an interview with the Executive Director, on 3/18/16 at 12:30 p.m., he indicated he interviewed staff about the alleged fall and there was confusion between staff as to whether or not to consider it a fall. He indicated the incident should have been reported to him when it occurred in order it be investigated. Review of the facility policy, titled "Accident and Incident Reporting Guidelines" dated 6/2015, received from the Director of Post Acute Care Services on 3/18/16 at 12:05 p.m., indicated "Purpose: To ensure all accidents, incidents, and allegations of abuse involving residents, visitors, or employees are investigated and reported to the facility administration. Procedure: 1. All accidents, incidents, and allegations of abuse (see Abuse policy) including injuries of unknown source, shall be reported to the Department			

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	supervisor as soon as it is discovered or when information of occurrence is learned. 2. An employee witnessing an accident, incident, or abuse involving a resident, visitor or employee shall report such occurrence as soon as practical. The victim of an accident or incident should not be left unattended to summon help unless it is absolutely necessary. 3. The assigned nurse or nursing supervisor shall complete an assessment and provide medical interventions as warranted...." This Federal tag relates to Complaint IN00195552. 3.1-45(a)(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00191723. IN00191723 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: March 17 and 18, 2016 Facility ID number: 013499 Provider number: 155829 AIM number: 201285490	R 0000		

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	Residental Census: 29 Sample: 3 The Springs of Lafayette was found to be in compliance with 410 IAC 16.2-5 in regard to the investigation of Complaint IN00191723. Quality Review was completed by 21662 on March 21, 2016.			