STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN 46706

(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
F0000	This visit was for the Investigation of Complaints IN00117108 and IN00118950. Complaint IN00117108-Substantiated. No deficiencies related to the allegation are cited. Complaint IN00118950-Substantiated. Federal/state deficiencies related to the allegations are cited at F 223, F 309, F 314, F 441, F 504, F 514. Survey dates: November 30, 2012 and December 4, 5, 6, 2012 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Survey team: Ann Armey, RN TC November 30, 2012 and December 5, 6, 2012 Carol Miller, RN December 4, 5, 2012 Christine Fodrea, RN December 4, 5, 2012 Census bed type: SNF/NF: 55 Total: 55	F0000	This plan of correction is prepared and executed because the provisions of the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the survey allegations.Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents,nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare Center further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care.Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare Center requests paper compliance for F223, F309, F314, F441, F504, and F514.	

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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	Census payor type Medicare: 5 Medicaid: 41 Other: 9 Total: 55 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed by Randy Fry RN			

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F0223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.			
	Based on interview and record reviews, the facility failed to ensure 2 residents were free from verbal abuse by the staff. This deficiency affected 2 of 5 residents reviewed for abuse. (Residents #L, and #N). Findings include: 1. The Unusual Occurrence Report dated 10/1/12 was received and reviewed on 12/5/12 at 10:00 a.m. from the Director Nursing Service (DNS). The Report indicated Resident N had asked for a soda from Cook #7. The Report further indicated Cook #7 told Resident N he did not need another soda and there would not be enough soda for the other residents if he had another soda. The Report indicated Cook #7 moved away from the dietary window and indicated Resident N "..makes to (sic) many demands for things...." and he did not need another soda because he is over weight. The Report indicated Resident N had	F0223	F223 1.Alert and oriented residents with independent mobility have the potential from cook #7 to not have dietary needs met. Cook #7 was immediately suspended pending an investigation then terminated, the complaint was validated. 2.Resident L using call bell at night have potential from LPN #5 to not having call light answered in a timely fashion, and potentially could affect other residents that can use call bell at night. A different nurse cared for Resident L for remainder of night. LPN #5 was suspended pending investigation then terminated, the complaint was validated. 3.Resident N has the potential from CNA #6 for verbal abuse. CNA #6 was clocked out immediately and suspended pending investigation. Findings from investigation validated the complaint and CNA #6 was about to be terminated when he handed in his letter of resignation. 4. The policy on abuse/neglect was update 12/17/12 to include “if	12/18/2012

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	overheard Cook #7's comments and had become upset and had to be removed from the dining room by another staff member. The Report further indicated Cook #7 was suspended immediately and the incident was investigated and the allegations were substantiated and Cook #7 was terminated from employment from the facility. The Employee File for Cook #7 was reviewed on 12/5/12 at 2:45 p.m. and indicated Cook #7 was hired by the facility on 7/11/12 and on 7/17/12 had signed her name that she had received, read, and understood the Abuse and Neglect and Resident Rights Policy's and Procedures. 2. The Unusual Occurrence Report dated 10/10/12 was received and reviewed on 12/5/12 at 10:15 a.m. from the DNS. The Report indicated Resident L had turned on his call light several times and he could overhear LPN #5 tell the CNAs not to answer the resident's call light. Resident L started banging on his table and LPN #5 entered the resident's room and yelled very loudly at the resident to stop banging on the table and "...told the resident that he was lazy and needed to get up. The resident asked for a pain pill and the nurse told him no you only get		any investigation has findings of abuse/neglect in-services will be given to the departments involved. The in-service will include abuse/neglect topics related to the specific incident, to increase education and prevent further incidents." The Administrator and DON will compile all occurrences and share with quarterly QA meeting ongoing. HR will ensure all new hires receive abuse/neglect policy and complete all training. This updated policy and education will be completed by 12/18/12.	

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	one every 6 hrs (hours)." The Report further indicated the nurse from the other hallway intervened and LPN #5 was told to leave the resident's room and was immediately suspended, the incident was investigated and substantiated and LPN #5 was terminated from employment at the facility. The Employee File for LPN #5 was reviewed on 12/5/12 at 2:45 p.m. and indicated LPN #5 was hired by the facility on 7/11/12 and on 7/11/12 had signed her name that she had received, read, and understood the Abuse and Neglect and Resident Rights Policy's and Procedures. 3. The Unusual Occurrence Report dated 12/2/12 was received and reviewed on 12/5/12 at 10:30 a.m. from the DNS. The Report indicated Resident N had asked CNA #6 for a sandwich CNA #6 told the resident he was currently busy and he would make the resident a sandwich when CNA #6 finished his work. The Report further indicated Resident N became upset and wanted CNA #6 "...to work faster." When CNA # 6 finished his work he made the sandwich for the resident and brought it to Resident N's room. Resident N indicated to CNA #6 ' I			

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	thought I told you to stay out of my room.' Resident N " ...then threw sandwiches and pop bottle at cna (sic). Cna (sic) then told Resident he was a nasty fat a_ _." The Report indicated CNA #6 was clocked out immediately and sent home, CNA was suspended and the allegations were substantiated and CNA # 6 was terminated from employment at the facility. The Employee File for CNA #6 was reviewed on 12/5/12 at 2:45 p.m. and indicated CNA #6 was hired by the facility on 8/16/12 and on 8/16/12 had signed his name that he had received, read, and understood the Abuse and Neglect and Resident Rights Policy's and Procedures. 4. The most current Abuse and Unusual Occurrences Policy's and Procedures dated 6/14/12 was received from the Assistant Director Of Nursing and reviewed on 12/4/12 at 11:00 a.m. indicated the section for Training the Employee was missing. 5. On 12/5/12 at 3:00 p.m. an interview with the DNS in regard to the termination of the three employees and the DNS indicated "staff get frustrated and they			

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	respond to the resident verbally. What they (staff) needed to do was to turn around and leave the situation." and to tell a coworker the situation so the coworker could intervene with the resident. The DNS further indicated the terminated staff members were "...good staff." The DNS indicated in regard to the Abuse Prohibition Policy Training of staff is done on computer by Healthcare Academy upon hire and annually by the employee and the DNS felt "the modules are adequate for training on Abuse and Resident Rights." This Federal tag relates to Complaint IN00118950. 3.1-27(b)			

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F0309 SS=D	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 interview and record review the facility failed to ensure assessment was completed for 2 of 3 residents reviewed with elevated temperatures in a sample of 7. (Residents #G and #T) Findings include: 1. Resident #G's record was reviewed 12-5-2012 at 9:33 AM. Resident #G's diagnoses included but were not limited to ventilator dependant respiratory failure, seizure disorder and malnutrition. Nurse's notes dated 10-31-2012 at 10:50 AM indicated Resident #G had a temperature of 99.9. The notes indicated Tylenol was given and was effective in reducing the temperature. The note additionally indicated the Foley catheter was draining well with yellow colored urine. On 11-2-2012 at 2 PM nurse's notes indicated Resident #G had amber urine	F0309	F309 1. Resident G was noted to have a temperature and Tylenol was administered, with no SBAR initiated, this potentially put her and other residents with temperatures at risk for harm, nursing staff in-serviced on SBAR policy. The nurse involved was given a teachable moment on the use of SBARs. 2. Resident T has the potential for a change of condition from LPN #8, potentially putting all residents with an acute change of condition at risk for harm. LPN #8 was given a teachable moment on how to use SBARs and do complete assessments. 3. The nurses were in-serviced on the use of the SBARs and doing complete assessments on residents with a change of condition. In-services will be completed by 12/18/12. The DON or designee will monitor the 24 hour report daily and nurses notes for proper continued assessment and notification of change of condition three times a week ongoing. If the 24 hour report or nurses notes are found to be incomplete for proper ongoing assessment or	12/18/2012

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	and blood tinged sediment with a mucous discharge. The note did not indicate a temperature had been taken. A Nurse's note dated 11-2-2012 at 2:15 PM indicated Resident #G's temperature was 102. Resident #G was sent to the hospital for treatment at that time. There were no further notes regarding any assessment of the urinary output of Resident #G, and no documentation the resident's temperature was taken again. A review of the Medication Administration Record dated 11-2012 indicated Tylenol had not been given on 11-1 and 11-2. In an interview on 12-5-2012 at 10:40 AM, LPN # 3 indicated if Resident #G had been assessed, it would have been documented. LPN #3 further indicated if a resident was having a condition change,assessment and follow up should have been completed. 2. The closed clinical record of Resident #T was reviewed on 12/5/12 at 2:00 p.m.,		notification of change in condition, the DON will identify the person responsible and reeducate that individual if applicable and/or begin progressive discipline.	

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	and indicated the resident was admitted to the facility on 10/29/12, with diagnoses which included but were not limited to, cervical spine injury, quadriplegia, respiratory insufficiency, and anoxic encephalopathy. The resident was transferred to the emergency room on 12/23/12 and expired in the emergency room. Nursing notes indicated the following: On 11/22/12 at 2:30 a.m., Resident #T's temperature was 99 degrees. The noted indicated a new order was obtained to monitor the resident's temperature, treat the temperature et notify the Physician if the resident worsened. On 11/22/12 at 11:30 p.m., indicated the resident's temperature was 100.2 degrees and she had two diarrhea stools. The note further indicated Tylenol was given, and ice packs were applied. On 11/23/12 at 3:00 a.m., "Writer called to res. (resident) room by CNA (Certified Nursing Assistant). Knuckles on res. (resident's) hand are purple in color O2 (Oxygen) sats (Saturation rate) 92% on 3 liters..." There was no documentation a comprehensive assessment, of the residents condition was done, when her knuckles were found to be cyanotic or			

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	that the resident's temperature and vital signs were checked. On 11/23/12 at 5:15 a.m., the physician was notified and a one time dose of the antibiotic Rocephin 1 gram intramuscularly was ordered. On 11/23/12 at 5:20 a.m., "... Writer noticed splotchy purple spots on res. legs. Checked pulse back board placed CPR initiated. EMS called. family notified. LPN #8, who worked with Resident #T, when she was transferred to the hospital, was interviewed on 12/6/12 at 11:45 a.m. LPN #8 indicated, she checked the resident's blood pressure, took periodic temperatures and asked the resident if she was in pain but she did not document the vital signs. She indicated she did not intiate a SBAR (Situational Background Assessment Recommendation) review when she noted the resident's diarrhea or when the resident's knuckles were purple. LPN# 8 indicated she called the physician because Resident T's knuckles were more purple than usual and she felt something was wrong. The death certification indicated Resident #T's cause of death was ventilator associated pneumonia and cervical spine			

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	injury with quadriplegia secondary to a motor vehicle accident. The Managing Change of Condition Policy, dated 2/17/12, provided by the DON (Director of Nursing) on 12/4/12 at 11:15 a.m., indicated, in part,, "Objective: To appropriately assess document, and communicate Changes of Condition (COC)... If the change of condition does not appear life threatening, complete each section of the change of condition SBAR... The following examples of change of condition are... BOWEL diarrhea;... SKIN COLOR sudden pallor; flushing; cyanosis;..." This Federal tag relates to Complaint IN00118950. 3.1-37(a)			

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F0314 SS=D	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 interview and record review the facility failed to ensure assessment of an open area to prevent infection for 1 of 2 residents reviewed with wounds in a sample of 7. (Resident #E) Findings include: Resident #Es record was reviewed 12-4-2012 at 11:39 AM. Resident #E's diagnoses included but were not limited to: depression, peripheral artery disease, and peripheral vascular disease. A physician's order dated 11-7-2012 indicated to treat skin tear on bottom of left foot with Xeroform and a dry dressing. A review of nurse's notes revealed notes dated 11-6-2012 and 11-8-2012 with no mention of the skin tear.	F0314	F314 1. Resident E receiving a skin tear has the potential from LPN #3to not have proper skin care received due to no documentation, and could potentially put other residents who receive skin tears at risk. LPN #3 was given a written warning and reeducated about the importance of documenting. 2. The nurses were in-serviced on documentation and use of SBAR's, doing complete assessments and initiating skin packets for all skin issues.In-services will be completed by 12/18/12. 3. The DON or designee will monitor the 24 hour report daily and nurses notes for proper continued assessment and notification of change of condition three times a week ongoing. If the 24 hour report or nurses notes are found to be incomplete for proper ongoing assessment or notification of change in condition, the DON will identify the person	12/18/2012

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	In an interview on 12-4-2012 at 2:29 PM, LPN #3 indicated she had not completed an occurrence report for the skin tear and had not notified nursing management of the skin tear. A review of weekly skin sheets revealed an assessment for 11-1-2012 and one for 11-15-2012, but no assessment had been documented for 11-8-2012. The assessment dated 11-15-2012 did not address the area on the left foot. A review of nurse's notes dated 11-6-2012 through 11-14-2012 did not reveal any mention of the area on the left foot. On 11-14-2012 a note with no date indicated a dressing had been changed to the foot due to displacement. There was no note of which foot the dressing was on and no note regarding the condition of the left foot. A physician's order dated 11-15-012 indicated to begin Keflex 500 due to cellulitis. The order further indicated to complete a wound culture to the left foot. A review of nurse's notes dated 11-15 through 11-17-2012 did not mention the condition of Resident #E's left foot. There was no indication of assessment of the foot, or if Resident #E had an elevated		responsible and reeducate that individual if applicable and/or begin progressive discipline.	

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	temperature. A review of nurse's notes dated 11-18 through 11-20-2012 did not mention the condition of Resident #E's left foot. There was no indication of assessment of the foot or if Resident #E had an elevated temperature. A nurse's note dated 11-20-2012 at 11:30 Am indicated Resident #E had been discharged to the hospital due to an abscess on his foot. The notes did not indicate which foot had the abscess. In an interview on 12-5-2012 at 11:35 A.M, LPN #3 indicated the abscess on Resident #E's foot was located on his left foot at the area of the skin tear on 11-7-2012. A review of the treatment records indicated the Xeroform dressing had been changed daily between 11-7 and 11-20-2012. In an interview on 12-4-2012 at 2:40 PM, the Assistant Director of Nursing (ADON) indicated no further assessment had been completed to Resident #E's left foot other than what had been documented. The ADON further indicated assessments should have been completed weekly at least.			

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	This Federal tag relates to Complaint IN00118950. 3.1-41(a)(1)			

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F0441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and	F0441	F441 1. Resident F has the potential for infections due to the	12/18/2012

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	record review the facility failed to develop infection control policies which promote consistent adherence to infection control practices consistent with CDC guidelines, and specific to multiple drug resistant organisms. This has the potential to affect all residents residing in the facility. The facility further failed to implement infection control practice to keep oxygen tubing off the floor for 4 of 10 residents reviewed receiving oxygen. (Resident #F, Resident #J, Resident #K, Resident #M) Findings include: 1. Resident #F's record was reviewed 12-5-2012 at 1:30 PM. Resident #F's diagnoses included but were not limited to respiratory failure, and muscle wasting. In an observation on 12-4-2012 at 2:08 PM, Resident #F was sitting in her room on the bed. Resident #F's oxygen tubing hooked up to her trach mask was observed on the floor. In an observation on 12-5-2012 at 9:23 AM, Resident #F was observed lying down in bed. Resident #F's oxygen tubing hooked up to her trach mask was observed on the floor. 2. Resident #J's record was reviewed		oxygen tubing being on the floor, and potentially having all residents with oxygen tubing at risk for infections. 2. Resident J has the potential for infections due to oxygen tubing and trach mask being on the floor, and potentially having all residents with oxygen tubing and a trach mask at risk for infections. 3. Resident K has the potential for infections due to oxygen tubing and trach mask being on the floor, and potentially having all residents with oxygen tubing and a trach mask at risk for infections. 4. Resident M has the potential for infections due to oxygen tubing and trach mask being on the floor, and potentially having all residents with oxygen tubing and a trach mask at risk for infections 5. All staff was in-serviced on proper care for all oxygen tubing, where to store it and what to do if it falls on the floor. In-services will be completed 12/18/12. 6. ADON or designee will monitor oxygen tubing daily on day and night shift for 100% of residents Monday through Friday for four weeks, then 75% of residents Monday through Friday for four weeks, then 50% of residents Monday through Friday for four weeks, then 25% of residents Monday through Friday for twelve weeks 7. The findings of this monitoring will be shared with QA monthly for six months. Per policy of Wesley Healthcare when a resident is known or suspected to have a	

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	12-5-2012 at 9:45 AM. Resident #J's diagnoses included but were not limited to stroke, high blood pressure, and seizures. In an observation on 12-4-2012 at 9:45 AM, Resident #J was sitting in her room on the bed. Resident #J's oxygen tubing hooked up to her trach mask was observed on the floor. In an observation on 12-5-2012 at 9:23 AM, Resident #J was observed sitting up in her room. Resident #J's oxygen tubing hooked up to her trach mask was observed on the floor. 3. Resident #K's record was reviewed 12-5-2012 at 1:35 PM. Resident #K's diagnoses included but were not limited to respiratory failure, airway obstruction and diabetes. In an observation on 12-4-2012 at 2:08 PM, Resident #K was sitting in her room on the bed. Resident #K's oxygen tubing hooked up to her trach mask was observed on the floor. In an observation on 12-5-2012 at 9:23 AM, Resident #K was observed sitting up in bed. Resident #K's oxygen tubing hooked up to her trach mask was observed on the floor.		serious illness or infection that is easily transmitted by direct contact and the patient is not deemed to be colonized to that specific organism and is symptomatic and is being treated for the infection the resident will be placed in contact precautions. Wesley Healthcare policy on hand washing was revised on12/16/12, with the time for scrubbing the hands being changed to 20 seconds.All staff will be in-serviced by 12/18/12. Per policy of Wesley Healthcare infection control tracking is completed by the DON. When a resident is placed on an antibiotic an infection control packet is to be filled out and turned into the DON. The DON will track the infections and residents on the tracking report, these findings will be shared with the QA monthly. The house doctor will be informed when there is three of the same organism in a ten day period.	

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	4. Resident #M's record was reviewed 12-5-2012 at 1:48 PM. Resident #M's diagnoses included but were not limited to respiratory failure, airway obstruction, and high blood pressure. In an observation on 12-4-2012 at 2:08 PM, Resident #M was sitting in her room in her wheelchair. Resident #M's oxygen tubing hooked up to her trach mask was observed on the floor. In an observation on 12-5-2012 at 9:23 AM, Resident #M was observed sitting on her bed. Resident #M's oxygen tubing hooked up to her trach mask was observed on the floor. 5. In an interview on 12-4-2012 at 10:15 AM, the facility was requested to provide a copy of the infection control program for review. On 12-4-2012 at 11:40 AM, the Minimum Data Set (MDS) coordinator provided the following policies: Policy titled Isolation patients-PPE and Nursing; Cleaning of Accucheck devices,Infection Control Inservices, Infection Control Practices, Infection Control tracking, Handwashing, and Infection Control Standard Precautions. The policies included the following:			

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	Isolation patients- Nursing 1. Anytime staff entered the room they must wear isolation gear as per the following order. 2. If the staff had linens to dispose of, to have a coworker bring the hamper to the room, open the lid and then the staff member in the room deposits the bag of linens into the hamper. 3. If the staff took in hard equipment (equipment that must be taken back out of the room) into the room a coworker must bring a disinfectant solution and clean the equipment by wiping it down prior to removing their isolation gear. The equipment is then taken to the doorway, isolation gear is removed, and hands are washed with soap and water and the equipment removed from the room as they left the room. 4. Trays for isolation will be disposable and nothing comes back out of the room. The policy did not indicate when isolation was to be implemented or removed. Handwashing 1. Wet hands with water 2. Apply soap to hands 3. Scrub hands vigorously away from the flow of water so the soap is not washed away for at least 10 seconds. 4. Rinse under warm water. 5. Dry hands 6. Shut off water using a paper towel.			

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	A CDC guideline dated 7-2010 indicated hand washing was recommended for 15-20 seconds. When reviewing the tracking of infections, the facility was asked how it trended the infection rate to determine outbreak. On 12-5-2012 at 10:05 Am, the MDS coordinator provided a handwritten document indicating the infection rate formula. The document did not indicate how the infections were to be trended, or reported. There were no policies developed to address the specifics of transmission of multi drug resistant organisms. This Federal tag relates to Complaint IN00118950. 3.1-18(j) 3.1-18(b)(2)			

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F0504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on interviews and record reviews, the facility failed to ensure the resident's Laboratory tests were done as ordered by the Physician. This deficiency affected 1 of 1 resident, whose laboratory tests were reviewed, in a sample of 7. (Resident D). Finding include: The record of Resident D was reviewed on 12/4/12 at 11:30 a.m., and indicated Resident D's diagnoses included, but were not limited to, cancer of the oropharynx, pneumonia, and dehydration. Resident D was admitted to the facility on 11/19/12. The Hospital Physician's discharge Orders for Resident D, dated 11/19/12, indicated to obtain 2 laboratory tests a Basic Metabolic Panel (BMP) and a Complete Blood Count (CBC) on 11/22/12 and test for Magnesium on 11/26/12. The BMP and the CBC laboratory test results for 11/22 and the Magnesium test ordered for 11/26/12 were not on the resident's chart.	F0504	F504 1. Resident D being admitted from hospital has the potential for abnormal labs due to nurse improperly transcribing orders and potentially could affect other new residents upon admission. The nurses that improperly transcribed orders received a written warning. 2. Labs that are collected by staff are to be labeled correctly to ensure proper processing and correct lab results for each resident. 3. The DON or designee will monitor every new admission for accuracy and to ensure all orders are transcribed correctly ongoing. 4. All nurses in-serviced on transcribing orders correctly and accurately. In-services will be completed by 12/18/12.	12/18/2012

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	The Treatment Administration Record (TAR) dated 11/22/12 did not have the BMP and CBC documented on the TAR. The Physician's Orders Policy, updated 6/14/12, received from the Minimum Data Set Coordinator and reviewed on 12/5/12 at 8:15 a.m., indicated 3. "The Nurse ...is to transcribe the order verbatim onto the appropriate administration record." On 12/5/12 at 9:45 a.m., the Director of Nursing Services (DNS) was interviewed in regard to the laboratory test results for the BMP and CBC and indicated the BMP and CBC were not done as ordered by the Physician on 11/22/12 . The DNS further indicated the nurse who had done the Admission Orders did not transcribe the Physician's Orders for the BMP and the CBC on to the resident's Treatment Administration Record for 11/22/12 so the laboratory tests for the BMP and CBC got missed. A document was received and reviewed from DNS on 12/5/12 at 10:00 a.m. indicated she had contacted the Laboratory and the blood had been drawn by LPN #1, at the facility on 11/26/12 and a vial of blood had been sent to the laboratory without a label on the vial of blood.			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on interview and record review, the facility failed to ensure documentation was complete in regard to an intake and output record (Resident #D), a wound assessment (Resident #E), a condition assessment (Resident #T) and a transfer to the hospital (Resident #T) This deficiency affected 3 of 7 residents, whose documentation was reviewed in a sample of 7. Finding include: 1. The record of Resident D was reviewed on 12/4/12 at 11:30 a.m., and indicated Resident D's diagnoses included, but were not limited to, cancer of the oropharynx, pneumonia, diarrhea, and dehydration. Resident D was admitted to the facility on 11/19/12 with a	F0514	F514 1. Resident D having the potential for dehydration was at risk due to not having adequate intake and output records and could potentially affect other residents who are on intake and output recording. All nurses involved received a written warning, every nurse was in-serviced on the importance of proper documentation. In-services will be completed by 12/18/12. 2. see F314 3. see F309	12/18/2012

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	tracheostomy. Hydration Assessment Form dated 11/19/12 indicated the resident was at risk for hydration problems. Dehydration Risk Assessment Form dated 11/19/12 indicated a score of 9 and a total score of 10 or above represents a high risk for dehydration. Physician's Admission Orders dated 11/19/12 indicated flush peg tube (an external tube inserted into the resident's stomach) with 150 milliliters (ml) every 6 hours, Jevity 1.2 continuous infusion of 70 ml an hour by peg tube and lasix (a diuretic) 20 milligrams a day times 2 days. The Intake and Output Form dated 11/19/12 through 11/26/12 indicated there was no documentation of Resident D's Intake for the day shift from 11/21 through 11/25/12. Medication Record dated 11/19 through 11/26/12 for Resident D indicated the Peg tube flushes for 150 ml every 6 hours was signed as done. Nutritional Assessment Form dated 11/23/12 indicated Resident D had received nothing by mouth since			

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	admission on 11/19/12 due to the resident not able to swallow safely related to oral cancer. Nurse's Note dated 11/27/12 at 10:00 a.m. indicated the resident was sent to the cancer center to have treatment of chemotherapy and radiation and the Physician's office called the facility to inform them the resident was sent to the hospital Emergency Room with a diagnosis of dehydration. The Policy for Intakes and Outputs dated 4/18/11 was received and reviewed on 12/5/12 at 8:15 a.m. from the Minimum Data Set Coordinator indicated "Intakes are to be obtained and recorded on the following: 1. Patients receiving enternal nutrition." On 12/5/12 at 8:30 a.m. an interview with the Assistant Director of Nursing in regard to the resident's dehydration indicted the laboratory tests done in the Hospital Emergency Room on 11/27/12 did not indicate the resident was dehydrated. On 12/5/12 at 9:00 a.m. an interview with the Director of Nurses Services in regard to Resident D's intakes indicated the Nurses were responsible for documenting the resident's intakes on the Intake Form.			

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	2. Resident #Es record was reviewed 12-4-2012 at 11:39 AM. Resident #E's diagnoses included but were not limited to: depression, peripheral artery disease, and peripheral vascular disease. A physician's order dated 11-7-2012 indicated to treat skin tear on bottom of left foot with Xeroform and a dry dressing. A review of nurse's notes revealed notes dated 11-6-2012 and 11-8-2012 with no mention of the skin tear. In an interview on 12-4-2012 at 2:29 PM, LPN #3 indicated she had not completed an occurrence report for the skin tear and had not notified nursing management of the skin tear. A review of weekly skin sheets revealed an assessment for 11-1-2012 and one for 11-15-2012, but no assessment had been documented for 11-8-2012. The assessment dated 11-15-2012 did not address the area on the left foot. A review of nurse's notes dated 11-6-2012 through 11-14-2012 did not reveal any			

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	mention of the area on the left foot. On 11-14-2012 a note with no date indicated a dressing had been changed to the foot due to displacement. There was no note of which foot the dressing was on and no note regarding the condition of the left foot. A physician's order dated 11-15-012 indicated to begin Keflex 500 due to cellulitis. The order further indicated to complete a wound culture to the left foot. A review of nurse's notes dated 11-15 through 11-17-2012 did not mention the condition of Resident #E's left foot. There was no indication of assessment of the foot or if Resident #E had a temperature. A review of nurse's notes dated 11-18 through 11-20-2012 did not mention the condition of Resident #E's left foot. There was no indication of assessment of the foot or if Resident #E had a temperature. A nurse's note dated 11-20-2012 at 11:30 Am indicated Resident #E had been discharged to Lutheran hospital due to an abscess on his foot. The notes did not indicate which foot had the abscess. In an interview on 12-5-2012 at 11:35 Am, LPN #3 indicated the abscess on Resident #E's foot was located on his left			

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	foot at the area of the skin tear on 11-7-2012. A review of the treatment records indicated the Xeroform dressing had been changed daily between 11-7 and 11-20-2012. In an interview on 12-5-2012 at 8:40 AM, the Assistant Director of Nursing (ADON) indicated the nurse responsible for the assessment of the skin tear had made a late entry on 12-4-2012 at 2:45 PM. The ADON further indicated the nurse should have completed the documentation at the time of the assessment. 3. The closed clinical record of Resident #T was reviewed on 12/5/12 at 2:00 p.m., and indicated the resident was admitted to the facility on 10/29/12, with diagnoses which included but were not limited to, cervical spine injury, quadriplegia, respiratory insufficiency, and anoxic encephalopathy. The resident was transferred to the emergency room on 12/23/12 and expired in the emergency room.			

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(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
	Nursing notes indicated the following: On 11/22/12 at 2:30 a.m., Resident #T's temperature was 99 degrees. The noted indicated a new order was received to monitor the resident's temperature, treat the temperature et notify the physician if the resident worsened. On 11/22/12 at 11:30 p.m., the resident's temperature was 100.2 degrees and she had two loose stool. The note further indicated Tylenol was given, and ice packs were applied. On 11/23/12 at 3:00 a.m., "Writer called to res. (resident) room by CNA (Certified Nursing Assistant). Knuckles on res. (resident's) hand are purple in color O2 (Oxygen) Sats (Saturation rate) 92% on 3 liters. Res. name put on NP (Nurse Practitioner's) list..." There was no documentation a comprehensive assessment, of the residents condition was done, when her knuckles were found to be cyanotic or that the resident's temperature and vital signs were checked. On 11/23/12 at 5:15 a.m., the physician was notified and a one time dose of the antibiotic Rocephin 1 gram intramuscularly was ordered.			

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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706	

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	On 11/23/12 at 5:20 a.m., "...Writer noticed splotchy purple spots on res. (resident's) legs. Checked pulse back board placed CPR initiated. EMS called. family notified." There was no documentation when the EMS arrived, when they left or where they transported Resident #T. LPN #8, who worked with Resident #T, when she was transferred to the hospital, was interviewed on 12/6/12 at 11:45 a.m. LPN #8 indicated, she checked the resident's blood pressure, took periodic temperatures and asked the resident if she was in pain but she did not document the vital signs or assessment. She indicated she was sure she checked the vitals because when she called a physician, she always gave them the resident's current vitals, laboratory results and oxygen saturation rate. EMS records were obtained and reviewed on 12/6/12 at 11:59 a.m. and indicated the EMS was called at 6:02 a.m., was on the scene at 6:15 a.m., left the facility at 6:28 a.m. and arrived at the hospital at 6:30 a.m. This Federal tag relates to Complaint IN00118950.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY HEALTHCARE	1751 WESLEY ROAD AUBURN, IN 46706

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	3.1-50(a)(1)			