

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155696	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/07/2014
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NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 COLLEGE AVE VINCENNES, IN 47591
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 31, April 1, 2, 3, 4, 7, 2013</p> <p>Facility number: 003237 Provider number: 155696 AIM number: 200374360</p> <p>Survey team: Dorothy Watts, RN TC Terri Walters, RN 3/31/14, 4/1/14, 4/2/14, 4/3/14, 4/7/14 Amy Winger, RN Sylvia Martin, RN</p> <p>Census bed type: SNF: 22 SNF/NF: 36 Residential: 22 Total : 80</p> <p>Census payor type: Medicare: 20 Medicaid: 26 Other: 34 Total: 80</p> <p>Residential Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 9, 2014, by Jodi Meyer, RN</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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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided to a resident receiving dialysis services, in that, the resident was not monitored for post-dialysis complications, the bruit/thrill was not checked every shift, and/or the graft/fistula site was not monitored for bleeding for 1 of 1 residents who met the criteria for review of dialysis services. (Resident #121)</p> <p>Findings include:</p> <p>During an interview on 03/31/14 at 12:09 P.M., Resident #121 was observed lying in bed and indicated the nursing staff did not check on her when she returned in the evening from dialysis.</p> <p>The clinical record of Resident #121 was reviewed on 04/02/14 at 10:00 A.M. The record indicated the diagnoses of Resident #121 included, but were not limited to, end stage renal disease with hemodialysis.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/17/14 indicated Resident #121 experienced minimal cognitive impairment and received dialysis services.</p>	F000309	<p>Res #121 has orders and careplans updated and staff that care for her have been educated on these. Completion Date 4-30-14</p> <p>There were no other residents affected by the deficient practice and through inservicing will prevent recurrence. Completion Date 4-30-14</p> <p>Licensed nurses inserviced on daily hemodialysis shunt assessment and post dialysis complications. Completion Date 4-30-14</p> <p>DHS/designee will review all residents receiving dialysis weekly to ensure careplan/orders are current and reflective of assessment.</p> <p>A list of all residents receiving dialysis will be provided to QA committee monthly along with a copy of their plan of care for review to ensure compliance x12 months.</p>	04/30/2014			

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	<p>The most recent Physician's Order Recap dated 03/12/14 included, but was not limited to orders for, "...Dialysis M-W-F (Monday-Wednesday-Friday)..."</p> <p>A Care Plan for Vitals dated 03/17/14 indicated, "... I receive dialysis 3 times per week. My goal is to not experience any complication from the hemodialysis. Please check for a bruit and thrill every shift... monitor for pain, numbness, tingling, and changes in color or temperatures in my extremities... please check my graft/fistula site for bleeding..."</p> <p>The Nursing notes from 03/10/14 through 03/31/14 lacked any documentation related to the monitoring Resident #121 for complications of hemodialysis, the presence of bruit/thrill, and/or the monitoring of the graft/fistula site for bleeding.</p> <p>During an interview on 04/03/14 at 10:40 A.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate Resident #121 had been monitored for complications of hemodialysis, the bruit/thrill had been checked every shift and/or the graft/fistula site had been monitored for bleeding. The DON then stated, "...We just missed it..."</p> <p>The Policy and Procedure for "Guidelines for Monitoring Shunt: Hemodialysis Arteriovascular Access (AV)" provided by the DON on 04/03/14 at 11:06 A.M. indicated, "...Purpose: To effectively provide monitoring of vascular access utilized for hemodialysis. Procedure: 1. Monitor AV shunt daily...2. Monitor the AV shunt daily for thrill and bruit..."</p>			

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F000314 SS=D	<p>The Policy and Procedure for "Guideline for Dialysis Provider Communication" provided by the DON on 04/03/14 at 11:05 A.M. indicated, "...Procedure: 5. Upon return from the Dialysis Provider the campus shall: a. Provided ongoing monitoring of the shunt site for signs of complication..."</p> <p>3.1-37(a) 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure pressure sores were identified and treatments were not provided according to the Physician's order and changed when appropriate to promote healing for 1 of 3 residents who met the criteria for review of pressure sores. (Resident # 83)</p> <p>Findings include:</p> <p>On 4/3/14 at 9:35 A.M., Resident #83 was observed in bed being provided incontinent care by CNA #6 and CNA #7.</p>	F000314	Resident #83 has been assessed with current treatment and careplan reviewed with all nurses that provide skin treatment for him. Completion Date 4-30-14 ADDENDUM:4/29/14 All current residents had a full body skin assessment completed with current treatment and careplans in place as appropriate. All residents have the potential to be affected by the alleged deficient practice therefore through inservices and changes in procedure will ensure that skin impairment is identified timely and ordered treatments are in place	

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	<p>Resident #83 had foam boots on in bed and his right great toe had a black discolored area on the tip of the toe approximately 0.5 cm. Two Stage 2 pressure areas were observed, at that time, on the left and right buttocks near the coccyx area with redness surrounding the pressure areas. Pressure areas approximately 0.5 cm (width) x 1.5 cm (length) with the left buttock area appeared larger than the right pressure area. CNA #6 during interview, at that time, indicated the pressure areas were not new areas. CNA #7 indicated, at that time, the resident should have a patch (dressing) on his buttocks. CNA #6 indicated he had not had a foam dressing on his buttocks that a.m. before breakfast when care had been provided.</p> <p>On 4/3/14 at 10:15 A.M., RN #8 indicated she would do treatments to right great toe and the right heel area. She also indicated she would have to get a treatment order for the redness of his buttocks. During skin prep application the right great toe was observed to have a black area of the toe approximately 0.5 cm.</p> <p>On 4/2/14 at 10:05 A.M., Resident #83's clinical record was reviewed. Resident #83 had been admitted to the facility on 8/30/13. Diagnoses included but were not limited to, diabetes, Parkinson's disease, seizure disorder, and left sided hemiparesis. His current Minimum Data Set Assessment (MDS) dated 3/5/14, indicated extensive assistance of two or more staff for bed mobility and transfers. The MDS indicated walking in the resident's room or corridor had not occurred.</p> <p>The resident's current care plan included the problem of alteration in skin integrity dated 3/26/14 which addressed a right heel stage E</p>		<p>and changed when appropriate to promote healing. Completion Date 4-30-14 Systemic change will include licensed nurse inservice on carrying out ordered treatments and skin assessment and all nursing staff inserviced on keeping treatment on and in place. Completion Date 4-30-14 DHS/Designee will observe 2 wounds and treatments per day/5 days per week x 30 days, then 2 wounds and treatments per week x 30 days, then 2 wounds and treatments per month thereafter to ensure they are accurately identified with appropriate treatment in place. Results of audits will be forwarded to the QA committee monthly for six months and quarterly thereafter with further suggestions/recommendations as deemed necessary by committee.</p>				

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	<p>pressure ulcer. Documentation indicated the right heel pressure area related to immobility and non-compliance with turning and repositioning and/or treatments. "Will refuse usually to turn." Interventions included but not limited to, examine skin daily, turn and reposition every 2 hours and when needed, pressure reducing mattress, treatment per physician's orders, and "...Z flow boots to both feet @ (at) all times. Remove q (every) shift et check skin..."</p> <p>A care plan dated 3/10/14, addressed the skin condition problem of a blood blister related to "foot board." Interventions included but not limited to, assess and document changes in skin status and "... Prevent pressure to area..."</p> <p>A hospital transfer sheet dated 2/4/14, indicated the resident had been readmitted to the facility on 2/4/14. A section of the hospital transfer sheet included "...Pressure Areas: R (right) buttocks-two circular areas-Foam Dressings..."</p> <p>Facility Nursing Admission note dated 2/4/14 at 5:30 P.M., indicated, "Returned by ambulance..." "... Area on coccyx 1 cm x 1 cm abraded foam dressing No S/S (signs and symptoms) of infection healing (sic)."</p> <p>The facility Nursing Admission Assessment dated 2/4/14, included but was not limited to, a stage 1 or greater wound of 1 cm x 1 cm, abraded area of the right buttock.</p> <p>A Skin Impairment Circumstance, Assessment and Intervention record initiated 3/9/14, indicated a deep tissue injury , "...Stage (if pressure): unstageable suspected Deep Tissue Injury..." of the right</p>			

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	<p>great toe. The record also included an IDT (Interdisciplinary Team) review dated 3/10/14, indicated, "...area assessed et found to be a blood blister from possibly hitting footboard..."</p> <p>A facility skin sheet entitled, "Other Skin Impairment Assessment record initiated 2/4/14 was reviewed on 4/3/14 at 11:15 A.M. The documentation indicated skin tear on the buttocks that were present when the resident had been readmitted to the facility on 2/4/14. Measurements recorded were 1 cm x 1 cm with a depth of "surface." Treatment instructions were to use "foam to coccyx dly (daily) et prn (when needed)."</p> <p>The weekly assessments of the skin tears of the buttocks continued with measurements increasing, as follows: 2/25/14 3 cm x 1 cm and zero depth, 3/4/14 4 cm x 2 cm and zero depth, 3/11/14 4 cm x 1.5 cm and zero depth, 3/18/14 3.8 cm x 12 cm and zero depth, 3/25/14 6 cm x 7 cm and zero depth, "no open areas just redness." 4/2/14 5 cm x 5.6 cm and zero depth. Documentation was lacking of treatment change since treatments had started on 2/4/14 when the resident had returned from the hospital. On 4/3/14 at 11:15 A.M., the April 2014 treatment sheet lacked documentation of the foam dressing being applied on 4/1/14 and 4/2/14.</p> <p>On 4/7/14 at 4/7/14 at 9:15 A.M., the Director of Nursing (DON) and the Assistant Director of Nursing(ADON) were interviewed regarding the resident's skin impairment areas. The DON and ADON were made aware of 2 pressure sores Stage 2, left and right buttock which had been observed on 4/3/14 during care observation. The DON</p>			

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	<p>and ADON were also made aware that no dressing had been in place on the resident's buttocks when care had been observed on 4/3/14 at 9:35 A.M. as per physician orders. The facility also was made aware of documentation that indicated a blood blister of right great toe had been identified and documented as an other skin impairment and not as a pressure ulcer. The DON and ADON indicated at that time they would assess Resident #83's skin.</p> <p>On 4/7/14 at 10:30 A.M., the DON during interview indicated she had observed the areas on the buttocks but didn't think they were pressure areas but more "denuded" and redness all around the areas.</p> <p>On 4/7/14 at 12:20 P.M., a facility "Wound Staging and Identification Educational Information policy (no date) was received and reviewed. The policy included but was not limited to, "...3. Denuded skin is the loss of epidermis or the first layer of the skin caused by exposure to urine, feces, body fluids, wound exudates, and friction. Denuded skin can occur when fragile skin exposed to urine is cleansed too harshly (friction) removing the first layer of skin..."</p> <p>On 4/7/14 at 11:28 A.M., the ADON provided skin sheets dated 4/7/14 which included but were not limited to the following:</p> <p>An Other Skin Impairment Assessment dated 4/7/14, documented a denuded area of the left inner top buttocks, 0.9 cm x 0.7 cm and a depth < 0.1. The area had been present on admission (2/4/14). Another skin impairment sheet initiated 4/7/14, documented a denuded area of the right inner lower buttock. The area</p>			

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F000323 SS=G	<p>measured 0.2 cm x 0.3 cm and depth < 0.1 cm and had been present on admission (2/4/14).</p> <p>Another denuded area on the right inner buttock measured 1.8 x 0.5 cm with a depth < 0.1 and had not been present on admission (2/4/14). Treatment for the 3 areas were to use an Exuderm dressing every 3 days and skin prep around area.</p> <p>New physician orders dated 4/7/14 at 10:45 am: "1. Nystatin cream to peri area and buttocks Q(every) shift. 2. D/C (discontinue) tx (treatment) to buttocks. 3. Start: Cleanse area on inner L (left) & R (right) buttocks, pat dry, apply skin prep to outer area & apply exuderm Q 3 days."</p> <p>3.1-40(a)(2) 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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure a resident received adequate supervision and/or interventions were properly implemented and/or provided for 1 of 2 residents who met the criteria for review of falls. This deficient practice resulted in the resident experiencing a hip fracture. (Resident #98).</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure a resident with a chest restraint/positioning device was positioned appropriately to</p>	F000323	<p>Res #77 has had vest positioning device discontinued and OT evaluation and careplan updated with changes. Staff that care for him have been inserviced on these changes. Completion Date 4-30-14</p> <p>Res #98 has changed her discharge plan and will remain here long term. She has fall interventions in place including a pad alarm being reinstated. Staff that care for her have been inserviced on her plan of care. Completion Date 4-30-14</p>	

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	<p>prevent risk of injury from a chest restraint/device for 1 of 1 resident reviewed for a restraint/device in the stage 2 sample. (Resident #77)</p> <p>Findings include:</p> <p>A. Resident #98 was observed on 4/1/14 at 12:30 P.M., sitting in a wheelchair at the dining room table. The clinical record for Resident #98 was reviewed on 4/3/14 at 10:00 A.M. The clinical record indicated Resident #98 was admitted to the facility on 9/9/13 at 11:00 A.M., with diagnoses that include, but were not limited to, the following, history of left hip fracture, history of falls, difficulty walking, muscle weakness, toxic encephalopathy (a brain condition). The care plans include, but were not limited to, the following: Potential for Falls care plan was initiated 9/19/13, and interventions included pad alarm at all times, assist of one with transfers.</p> <p>Fall Circumstance and Assessment included in the chart indicated, Resident #98 fell on the following days.</p> <p>Fall # 1 occurred on 9/9/13 at 8:30 P.M., Resident #98 fell while transferring self in room with no injuries. A pad alarm was placed.</p> <p>Fall #2 occurred on 9/13/13 at 2:40 P.M. Resident #98 slid out of her recliner, resulting in no injuries. The facility placed dycem (a non slip surface) in the recliner and resident 's personal items were to be placed within reach.</p>		<p>ADDENDUM</p> <p>4/29/14 a review of all current residents who have had a fall in the prior 90 day period have been reviewed and appropriate fall interventions and careplans have been updated as appropriate.</p> <p>There were no other residents with a vest positioning device and through inservicing and implementation of initial minimum 6 day monitoring will ensure those residents most at fall risk will have appropriate interventions to prevent injury from falls.</p> <p>Completion Date 4-30-14</p> <p>Systemic change includes minimum 6 day monitoring of admissions for fall risk with an alarm in place to ensure safety during this period .Completion Date 4-30-14 DHS and IDT team will review all assessments upon completion of minimum 6 day monitoring for appropriate interventions and plan of care to be instituted. Results of monitoring along with all falls will be forwarded to QA committee monthly x6 months for review and quarterly thereafter.</p>		

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	<p>Fall #3 occurred on 10/11/13 at 7:50 P.M., Resident #98 was transferring self and w/c (wheelchair) rolled out from under her, the fall resulted in no injuries. The facility referred Resident #98 to Occupational Therapy (OT) for positioning.</p> <p>Fall #4 occurred on 10/15/13 at 5:40 A.M., Resident #98 was found on floor in bathroom, the fall resulted in no injuries. A toileting schedule was started as an intervention.</p> <p>Fall #5 occurred on 11/23/14 at 2:30 A.M., indicating Resident #98 was observed sitting on the floor in her room. A pressure alarm was placed on her bed as an intervention.</p> <p>A Nurse's note dated 12/22/13(sic) (correct date 11/22/13) at 2:30 P.M., indicated Resident #98's alarms were removed in response to a family request.</p> <p>A Nurse's note dated 11/23/14 at 2:30 A.M., indicated Resident #98 was observed sitting on the floor in her room. The intervention was to reinstate the pad alarm while in bed.</p> <p>A Nurse's note dated 11/23/13 at 4:10 A.M., indicated Resident #98 voiced complaints of right hip pain. "New order received to send res (resident) to GSH ER (local hospital)..."</p> <p>A Nurse's note dated 11/23/13 at 9:15 A.M., indicated Resident #98 was admitted to a local hospital with a diagnosis of right hip fracture.</p> <p>The Director of Nursing (DON) was interviewed on 4/4/14 at 10:30 A.M., regarding Resident #98's history of falls. She indicated Resident #98 had been admitted to the facility on 9/9/13 for therapy after repair of a left hip fractured. She also indicated the resident's alarms were discontinued on 11/22/13 at the request of her family. That was in preparation for Resident #98 to be</p>			

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	<p>discharged to the assisted living unit of the facility.</p> <p>During an interview on 4/4/14 at 10:30 A.M., the DON indicated no interventions had been implemented when the alarms were removed. The DON confirmed no additional intervention had been implemented to ensure the resident's safety in response to the alarms being discontinued.</p> <p>A Physical Therapy note dated 11/20/13 indicated, Resident #98 had continued to show decreased safety awareness and she continued to be a high fall risk while being up ad lib (up at liberty) when in room. Physical Therapy Assistant #1 was interviewed on 4/4/14 at 1:25 P.M., she indicated she had been part of the team that had worked with Resident #98 during her initial admission. She further indicated, at that time, Resident #98 was a high risk for falls on 11/23/13 when Resident #98 experienced a fall that resulted in a fracture of the right hip.</p> <p>B. On 3/31/14 at 2:52 P.M., Resident #77 was observed sitting in his w/c leaning forward and to his right side wearing a vest chest restraint. He was feeding himself a snack. The right strap of vest restraint was against the resident's neck. LPN #6 was made aware of Resident #77's leaning position and position of the restraint strap. LPN #6 then explained to Resident #77 he needed to be repositioned. LPN #6 and LPN #7 then repositioned Resident #77 in his w/c so the vest strap was not against his neck.</p> <p>Resident #77's clinical record was reviewed</p>			

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	<p>on 4/3/14 at 8:53 A.M. He had been admitted to the facility on 5/3/12. His diagnoses included, but were not limited to, Parkinson's Disease, anxiety, dementia, and muscle weakness. His current Minimum Data Set Assessment (MDS) dated 2/20/14, indicated bed mobility and transfers required extensive assistance of 2 or more staff.</p> <p>April 2014 physician orders included but were not limited to: "... (10/29/13) positioning vest to be worn in w/c (wheel chair) w (with) /all meals & prn (when needed) r/t (related to) poor trunk control (postural instability & gait instability d/t (due to) Parkinson's W/Paralysis Agitans). 10/29/13/ positioning vest is to be worn one hour after meals r/t poor trunk control (postural instability d/t Parkinson's W/Paralysis Agitans...)"</p> <p>A manufacturer's instruction sheet was included in the resident's treatment record for the Butterfly Chest Harness (chest vest restraint). The instruction sheet included, but was not limited to, "... THIS IS NOT A SAFETY DEVICE. IT IS TO BE USED ONLY FOR POSITIONING. IT MUST BE USED IN CONJUNCTION WITH A METAL SEAT BELT!"</p> <p>His current care plan included, but was not limited to, "...3/10/13 I use a positioning vest as a restraint to my W/C at all meals & as needed due to poor trunk control (postural instability), & gait instability due to a Parkinson with paralysis agitans. Remove vest 1 hour after meals as needed..." "... Assess for and notify my physician of any restraint associated problems. Benefits for this includes reduction of falls, provide feeling of security, & maintain body positioning. Remove & perform skin assessment every</p>			

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	<p>shift. Evaluate for reduction quarterly & as needed. Please review my interventions in 90 days to determine if changes are needed..."</p> <p>On 4/2/14 at 10:51 A.M., Resident #77 was observed sitting in his wheelchair in the TV area of the nursing station. He was wearing a chest vest device. A bed pillow was positioned under his right arm and across his lap. He was leaning forward and to the right side. The right strap of the vest was laying against his neck. CNA #8 came over to the resident asking him to toilet. She was made aware the resident was leaning to the right and the strap of the device was against the resident's neck. She indicated in regard to the resident's leaning position that it happens and staff then reposition the resident.</p> <p>On 4/2/14 at 3:00 P.M., Resident #77 was observed sitting in the TV area of the nurses station. He was wearing his vest device and was leaning forward and to his right side.</p> <p>On 4/3/14 at 8:30 A.M., observed resident sitting in w/c in restorative dining room feeding self breakfast. No positioning vest on just a seat belt. The Resident was leaning forward and to his right side.</p> <p>On 4/3/14 at 9:20 A.M., Resident #77 was observed wearing his positioning vest and the resident was leaning to his right side with his head on his right arm which was on a pillow. The strap of the vest was observed, at that time, to be against his neck. LPN #6 was made aware of his position. She indicated his vest device was difficult to adjust and required frequent adjustment.</p> <p>On 4/3/14 at 11:45 A.M., Occupational</p>			

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F000431 SS=D	<p>Therapy (OT) Staff #1 indicated Resident #77 had utilized the vest positioning device since September 2013.</p> <p>OT #1 further indicated at that time Resident# 77 had been discharged from therapy on 9/20/13 and nursing staff had been instructed on interventions to correct positioning problems. OT staff #1 then indicated he had noticed the resident leaning. He indicated he had ordered a device last week to be applied to the right arm of the resident's wheelchair to correct the positioning of the resident. He indicated the new device had not arrived.</p> <p>On 4/3/14 at 11:50 A.M., the Director of Nursing (DON) indicated the facility did not have an order for the seat belt (manufacture's instructions indicated needed to be worn with chest restraint) until 3/31/14. Resident #77 had been observed wearing a seat belt with his chest vest device thru out the survey . The DON and OT therapist were made aware at that time of the risk related to the res leaning forward and to the right in his w/c with the vest strap on the right side up against his neck. The DON and OT Therapist #1 agreed that the vest restraint strap against the resident's neck could be a potential hazard.</p> <p>On 4/7/14 at 11:45 A.M., a "Physical Restraint Information and Consent" form dated 11/4/13, was reviewed. The documentation indicated the positioning vest was a risk not limited to, "... Increased risk of strangulation, or death..."</p> <p>3.1-45(a)(2) 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p>						

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	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to properly label and store a multi-dose vial of intravenous medication obtained from the emergency drug kit, dispose of expired medications in a</p>	F000431	All residents have the potential to be affected by the alleged deficient practices and through alterations in processes and inservicing will ensure correct actions to store a multidose vial with label, dispose of expired meds in treatment cart and label	04/30/2014

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	<p>timely manner, and/or medications in the treatment cart were not labeled with the name of the medication and direction for its use for 1 of 1 medication storage refrigerators and 1 of 1 treatment carts reviewed.</p> <p>Findings include:</p> <p>During a medication storage observation on 4/4/14 at 10:15 A.M., the following was observed:</p> <ol style="list-style-type: none"> 1. A vial of reconstituted Vancomycin HCL1 gm was observed lying on its' side on the top shelf in the medication refrigerator. The vial was observed, at that time, to not have a label or identifying information. During an interview, at that time, LPN #6 indicated the vial of Vancomycin belonged to Resident #48 and that the vial had been opened on 04/03/14. LPN #6 further indicated the vial had been retrieved from the EDK (Emergency Drug Kit) and should have been labeled with the resident's name and open date. 2. An out of date tube of triple antibiotic ointment was observed in the 200 hall drawer. During an interview, at that time, RN #3 indicated the antibiotic ointment had been discontinued and should have been disposed. 3. Two expired tubes of Lidex (a coricosteroid ointment) ointment. RN #3 indicated, at that time, the ointment was expired, but still in use. 4. One plastic zip lock baggie with two 		<p>all treatments with directions for use are carried out. Completion Date 4-30-14 LPN #6 and RN #3 will have individualized inservice on correct labeling and storage requirements. Completion Date 4-30-14 Addendum:4/29/14 all medication carts, treatment carts, and medicine storage areas were audited to ensure that all are labeled and stored as appropriate. Licensed nursing staff will be inserviced on proper procedure for EDK med labeling and med storage requirements. Completion Date 4-30-14 DHS/designee will randomly audit med storage areas and med/treatment carts 2x/week for 30 days, weekly for 30 days and 2x randomly per month thereafter for correct storage and labeling procedures. Audits will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and to ensure compliance with requirement.</p>	

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F009999	<p>unidentified syringes of cream.</p> <p>During an interview on 4/4/14 at 3:15 P.M., RN #3 indicated the medication in the plastic baggie was Premarin vaginal cream and it was brought in by the family.</p> <p>The facility's policy and procedure, IC10: Medication Label was provided by the (DON) Director of Nursing and reviewed on 4/4/14 at 3:30 P.M. and it read as follows: "...A. Labels are permanently affixed to the outside of the prescription container...B. Each prescription medication label includes: 1. Resident's name 2. Specific directions for use, including route of administration...3. Medication name...4. Strength of medication...5. Prescriber's name. 6. Date dispensed 7. Quantity of medication 8. Expiration of medication...."</p> <p>The facility's policy and procedure, IC10: Medication Storage was provided by the DON and reviewed on 4/4/14 at 3:30 P.M. and it read as follows: "...I. Outdated...medications...are immediately removed from stock, disposed of according to procedure for medication disposal...."</p> <p>On 4/4/14 at 10:35 A.M., the DON was made aware of the unlabeled Vancomycin in the refrigerator and she indicated there should have been a label with the resident's name as well as the date the bottle was opened.</p> <p>3.1-25(k) 3.1-25(o)</p>	F009999	There were no residents affected by the deficient practice and through corrective measures will ensure staff	

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	<p>Based on interview and record review, the facility failed to ensure 6 hours of dementia training was provided to all employees within the first 6 months of employment, in that, dementia training was not provided for 4 of 10 employee files reviewed. (LPN #10, CNA #10, CNA #11, RN #10)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The employee file of LPN #10 was reviewed on 04/03/14 at 1:00 P.M. The employee file indicated the hire date of LPN #10 was 07/09/13 (9 months and 25 days of employment) and lacked any documentation of dementia training. 2. The employee file of CNA #10 was reviewed on 04/03/14 at 1:05 P.M. The employee file indicated the hire date of CNA #10 was 02/13/13 (14 months and 21 days of employment) and lacked any documentation of dementia training. 3. The employee file of CNA #11 was reviewed on 04/03/14 at 1:10 P.M. The employee file indicated the hire date of CNA #11 was 09/24/13 (6 months and 10 days of employment) and lacked any documentation of dementia training. 4. The employee file of RN #10 was reviewed on 04/03/14 at 1:15 P.M. The employee file indicated the hire date of RN #10 was 09/10/13 (6 months and 24 days of employment) and lacked any documentation of dementia training. <p>During an interview on 04/03/14 at 2:20 P.M., the ADON (Assistant Director of Nursing) indicated no documentation could be provided to indicate</p>		<p>have the required dementia inservices required by state rule.</p> <p>All current employees will receive the 6 required hours of dementia training. Completion Date 4-30-14</p> <p>Systemic change will include a 6 hour dementia training initiated during the orientation process and be placed on the personnel file checklist. Completion Date 4-30-14</p> <p>AP/Payroll will ensure all dementia inservices are received and a copy placed in personnel file for all new employees. Completion Date 4-30-14</p> <p>Audits and proof of training with expected compliance will be achieved through immediate corrective action and inservicing as stated above. Results of audits will be forwarded monthly to QA committee for review of compliance.</p>				

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R000000	dementia training had been provided to LPN #10, CNA #10, CNA #11, and/or RN #10. The Policy and Procedure for "Summary of Educational Requirements..." provided by the ED on 04/07/14 at 3:00 P.M. indicated, "...All nursing home staff with regular resident contact must receive six hours of dementia-specific training within six months of hire..." 3.1-14(u)	R000000					
R000356	The following Residential Findings were cited in accordance with 410 IAC 16.2-5 410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.	R000356	Resident #19, #2, #21, #6 and #5 have their pictures in the emergency	04/30/2014			

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	<p>Based on interview and record review, the facility failed to ensure the emergency information file contained a photograph for 5 of 5 residents who met the criteria for review of emergency file information. (Resident #19, Resident #2, Resident #21, Resident #6, Resident #5)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The clinical record of Resident #19 was reviewed on 04/07/14 at 9:15 A.M. The record indicated Resident #19 was admitted on 08/03/10. The emergency information file lacked a photograph of Resident #19. 2. The clinical record of Resident #2 was reviewed on 04/07/14 at 10:30 A.M. The record indicated Resident #2 was admitted on 10/13/11. The emergency information file lacked a photograph of Resident #2. 3. The clinical record of Resident #21 was reviewed on 04/07/14 at 9:30 A.M.. The record indicated Resident #21 was admitted on 09/26/13. The emergency information file lacked a photograph of Resident #21. 4. The clinical record of Resident #6 was reviewed on 10:00A.M. The record indicated Resident #6 was admitted on 02/13/13. The emergency information file lacked a photograph of Resident #6. 5. The clinical record of Resident #5 was reviewed on 04/07/14 at 10:40 A.M. The record indicated Resident #5 was admitted on 10/19/13. The emergency information file lacked a photograph of Resident #5. 		<p>binder.</p> <p>There were no residents affected by this deficient practice and none that were potentially affected.</p> <p>AL Manager inserviced on requirement to have photographs included in the emergency binder upon admission. Completion Date 4-30-14</p> <p>Executive Director will review Emergency binder monthly for compliance with requirement.</p> <p>Audit and compliance will be reported to QA committee monthly x12 months.</p>	

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	<p>During an interview on 04/07/14 at 10:45 A.M., Residential LPN Supervisor #1 indicated the emergency information file contained no photographs for Resident #19, Resident #2, Resident #21, Resident #6, and Resident #5.</p> <p>During an interview on 04/07/14 at 10:50 A.M., the ED (Executive Director) indicated the emergency information file should include a photograph for resident identification purposes in the event of an emergency.</p> <p>The Policy and Procedure for Emergency Information File provided by the ED on 04/07/14 at 12:00 P.M. lacked any documentation related to a resident photograph being included in the emergency file.</p>			