

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/02/2014
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F000000	<p>This visit was for the Investigation of Complaint IN00140009 and Complaint IN00140622.</p> <p>Complaint IN00140009 - Substantiated, Federal/State deficiencies related to the allegations are cited at F314.</p> <p>Complaint IN00140622 - Substantiated, Federal/State deficiencies related to the allegations are cited at F155 and F323.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: December 30 and 31, 2013 January 2, 2014</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type:</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of a conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Medicare: 11 Medicaid: 52 Other: 17 Total: 80</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 3, 2014, Jodi Meyer, RN</p>				

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F000155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>Based on interview and record review, the facility failed to follow through with the physician regarding a resident's advance directive for a "Do Not Resuscitate" order, for 1 of 4 residents reviewed with advance directives, in a sample of 9. Resident A</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident A was reviewed on 12/30/13 at 4:45 P.M. The resident was admitted to the facility on 6/29/13.</p>	F000155	<p>1. Resident A no longer resides at the facility. 2. All residents with an advanced directive have the potential to be affected. All residents advanced directives were audited by the Administrator to ensure residents' wishes were followed. No other resident was affected by the deficient practice. 3. All nurses were educated on the Do Not Resuscitate Policy by the CEC, ADM and/or designee by 2/1/2014. Medical Records will be auditing the documentation related to the DNR forms to ensure physician orders are obtained and the face sheet is updated upon admission and quarterly. 4. To ensure</p>	02/01/2014			

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	<p>An OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER form, dated 6/29/13, was signed by Resident A and 2 witnesses. The "Signature of attending physician" was left blank.</p> <p>The electronic medical record face sheet indicated the resident's code status was "DNR."</p> <p>Signed Physician recertification orders, dated October 2013, indicated the resident was a "DNR."</p> <p>Signed Physician recertification orders, dated November 2013, indicated, "Code Status Full Code."</p> <p>Documentation that the resident had revoked her DNR request from October to November was not found in the clinical record.</p> <p>A Progress Note, dated 11/29/13 at 8:47 P.M. and recorded as a late entry on 12/2/13 at 11:04 A.M., indicated, "CNA came and told this nurse that [Resident A] needs help...with head still sideways felt for a pulse and there was a pulse...DNR was faxed to hospital...."</p> <p>On 12/31/13 at 3:15 P.M., during</p>		<p>compliance, the DNS/Designee is responsible for the completion of the advanced directive/code status CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. The completion date is 2/1/2014.</p>		

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	<p>interview with LPN # 2, she indicated on 11/29/13, she ran out to assist Resident A. She indicated herself and the ADON (Assistant Director of Nursing) initiated CPR. She indicated the EMTs soon arrived and took over CPR. LPN # 2 indicated "it was confusing whether she was a code or not" so they started CPR. LPN # 2 indicated she would look on her report sheet to determine if a resident was a "DNR."</p> <p>On 1/2/14 at 11:10 A.M., during interview with RN # 1, she indicated on 11/29/13 she went outside to check on Resident A, who was unresponsive. She indicated she felt a pulse; other nurses were coming to help and she went in to call 911. RN # 1 indicated her electronic report sheet indicated Resident A was a "DNR," and a yellow paper was in the chart, but that since the yellow paper was not signed by the physician, it was assumed the resident was a full code. RN # 1 indicated she explained this to the hospital.</p> <p>On 1/2/14 at 12:05 P.M., during interview with the Administrator, she indicated it is the facility policy to check the chart, and if a yellow paper is in the chart, the resident is</p>				

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	<p>a DNR. She indicated the yellow paper is to be signed by the physician.</p> <p>2. On 1/2/14 at 12:05 P.M., the Administrator provided the current facility policy on "Do Not Resuscitate," revised 3/12. The policy included: "It is the policy of this facility that all residents/responsible parties will be given the right to formulate an advance directive for 'DO NOT RESUSCITATE' at admission/readmission...If the resident/representative chooses to formulate and issue the advanced directive for DO NOT RESUSCITATE (DNR), the Admission Director will notify the admitting nurse/designee...The admitting nurse will contact the attending physician and obtain a signed DNR order. The OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER FORM must be signed/dated by the physician...The attending physician may fax both the signed OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER form and the order for Do Not Resuscitate to the facility...must be copied on yellow paper...The admitting</p>			

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	<p>nurse/designee will ensure the resident's electronic medical record will be updated in accordance to the resident's DNR status."</p> <p>This Federal tag relates to Complaint IN00140622.</p> <p>3.1-4(f)(7)</p>			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to develop and/or implement a plan of care for a resident at risk for physical aggression and elopement, resulting in a resident exiting the facility unattended, for 1 of 3 residents reviewed with behavior symptoms, in a sample of 9. Resident G</p> <p>Findings include:</p> <p>1. On 12/30/13 at 5:15 P.M., Resident G was observed sitting at a table in the dining room of the locked Alzheimer's unit. LPN # 1 indicated at that time that Resident G had been moved off of the locked unit due to "getting into it with [Resident H]." LPN # 1 indicated Resident G "had got outside," and was moved back to the locked unit that day. LPN # 1 indicated, "It was pretty smart to have moved him back."</p> <p>The clinical record of Resident G</p>	F000250	<p>1. Resident G has been recently assessed and found to meet the criteria for a locked unit. Resident G now resides on the locked unit and the care plan reflects the needs of the resident as they relate to the need for structured activities to improve quality of life, assistance with ADLs and assistance with decision making. 2. All residents with physical aggression and elopement potential have the potential to be affected. These residents were reviewed in the monthly behavior meeting and care plans were updated to reflect each resident's needs related to physical aggression and elopement by the IDT. 3. Nursing and social services staff will be educated on the behavior management program including care planning, documentation, and supervision. Education will be completed by CEC, ADM, and/or designee by 2/1/2014. Residents who exhibit physical aggression and/or elopement will have care plan reviewed to ensure the care plan and approaches are up to date by the IDT on a weekly basis during IDT meeting as needed. 4. To ensure compliance, the</p>	02/01/2014			

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	<p>was reviewed on 12/30/13 at 5:30 P.M. Diagnoses included, but were not limited to, dementia.</p> <p>A Minimum Data Set (MDS) assessment, dated 10/15/13, indicated the resident scored a 6 out of 15 for cognition, with 15 indicating no memory problems. The resident required extensive assistance of two + staff for transfer, and extensive assistance of one staff for ambulation. The resident exhibited no behavior symptoms.</p> <p>Progress Notes included the following notations:</p> <p>12/2/13 at 9:45 A.M.: "Res. [resident] pushed roommate when roommate tried to adjust thermostat on PT-AC (Heater/AC) unit. Res. got right hand caught in door as res. was leaving room, co-res. was shutting door. Res. was immediatley speparated [sic] and 15 min. checks started...Will continue to monitor."</p> <p>12/2/13 at 6:35 P.M.: "Resident was notified of room change and he became very upset and cursing up and down the hall. Attempted to reasure [sic] him that is [sic] was for his safety to move rooms. Not effective he became even</p>		<p>DNS/Designee is responsible for the completion of the behavior management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. The completion date is 2/1/2014.</p>				

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	<p>worse...was trying to exit the unit but staff intevened [sic] and he was redirected back to the room. Resident became very upset again cursing and grabbed staff members arm...."</p> <p>12/2/13 at 6:51 P.M.: "This MCF [memory care facilitator] heard res. yelling from my office...Res. was slamming doors, yelling...Res. was separated from co-res. by 4 staff members as he kept going to co-res. new room...Police called to help calm residents...."</p> <p>12/2/13 at 7:21 P.M.: "Order to go to [psychiatric unit] received from [name of physician]. Guardian aware."</p> <p>A hospital history and physical, dated 12/3/13, included: "...admitted secondary to violent aggressive behavior towards his roommate...."</p> <p>Progress Notes continued:</p> <p>12/10/13 at 2:58 P.M.: "Resident readmitted to facility at this time via facility van with staff. Taken to [room number, off of locked unit]...."</p> <p>12/18/13 at 1:55 A.M.: "...Res. is alert with some confusion noted.</p>			

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	<p>Walks per self throughout facility...."</p> <p>12/22/13 at 7:23 A.M.: "...Res. Alzheimer apparent when res. told me he was going to the justice of the peace come in and marry him...."</p> <p>An "Event Report," dated 12/22/13 at 1:02 P.M., indicated: "Description, Exit seeking behavior...just had lunch...res had light coat on and was attempting to leave the facility. Asked where was going res stated 'goin outside, maybe walk a circle around the block and come back.' Advised res we'd have to get him heavier coat it is too cold, and will need someone to go with him. Res became angry...What interventions are we putting in place to prevent another behavior? [Left blank]...."</p> <p>Progress notes continued:</p> <p>12/24/13 at 12:36 A.M.: "...Does cont [continue] to go to the doors and look outside. Cont with 15 min checks as ordered for safety. Has not voiced any concerns of leaving the facility...."</p> <p>12/24/13 at 2:37 P.M.: "Resident asked numerous times to go outside this shift. This nurse explained that it is cold outside and better to stay in.</p>						

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	<p>Resident insisted so CNA took resident outside for a few minutes hoping that would help. Resident was fine for a while then started asking again. Resident easily redirected."</p> <p>12/27/13 at 1:12 P.M.: "Resident is currently wearing his coat and hat, and states to this nurse: 'I'm headed out to go walk around and maybe go to the post office.' This nurse redirected resident to the dining room for activites, and resident stated: 'I'll wait there for now but you have to take me with you when you leave here so I can run my errands.'...."</p> <p>12/28/13 at 1:39 P.M.: "CNA witnessed resident walking outside of building. CNA et [and] this nurse retrieved resident. Resident took back to [locked unit] per administration...."</p> <p>A plan of care regarding the resident's history of physical aggression was not found in the clinical record. A plan of care regarding the resident's risk for elopement prior to 12/30/13 was not located in the clinical record.</p> <p>On 12/30/13 at 7:30 P.M., during</p>				

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	<p>interview with the Adminsitrator, she indicated that Resident G was actually alert and oriented, and "knew what he was doing" when he went outside.</p> <p>On 12/30/13 at 7:50 P.M., during interview with CNA # 1, she indicated the incident with Resident G happened on 12/28/13 "just after lunch." CNA # 1 indicated CNA # 2 remarked to her, "Is he [Resient G] supposed to be outside?" CNA # 1 indicated she saw the resident outside step off of the sidewalk and into the parking lot by a car. She indicated at first she thought he may have been with a visitor, but when she saw him go past the car, she realized he was by himself. She indicated the resident had gone out the "300-400 doors," and was approximately 15 feet down the sidewalk.</p> <p>On 12/31/13 at 9:35 A.M., during interview with the Memory Care Facilitator (MCF), she indicated she handled social services for residents on the locked unit. She indicated a nurse came and got her on 12/2/13 when Resident G and Resident H were having a verbal argument. The MCF indicated both residents admitted they pushed each other,</p>			

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	<p>but that was unwitnessed. She indicated prior to this episode, Resident G had shown no behaviors of physical aggression. She indicated the residents told her that Resident F started to slam the door, when Resident G put his arm in the door and got his hand caught. The MCF indicated she kept Resident G with her during the day, but that "the behaviors kept escalating." The MCF indicated the resident was transferred to a behavior unit, and when he returned to the facility, he went to the "general population." She indicated she did not want the resident back on the locked unit, due to he was the "instigator." She indicated she did not develop a care plan due to no prior history of aggression.</p> <p>On 12/31/13 at 10:10 A.M., during interview with the Social Services Director (SSD), she indicated she was responsible for behavior management on the general units. She indicated when Resident G returned from the psychiatric unit, he "was the sweetest man ever." She indicated she had just forgotten to develop a plan of care regarding physical aggression. The SSD indicated the first she heard of Resident G's exit seeking was on</p>			

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	<p>12/24/13, when she received a phone call at home. She indicated she had been off of work until 12/30/13, and developed a care plan at that time for elopement risk.</p> <p>2. On 12/31/13 at 11:00 A.M., the Administrator provided the current facility policy on Behavior Management, undated. The policy included: "...Care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents...The behaviors that have been identified as requiring monitoring...and associated interventions identified on the care plan should then be transferred to the monitoring form...are also listed on the CNA assignment sheet to assist in communication of individualized interventions...."</p> <p>3.1-34(a)</p>				

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to identify a leg rest causing pressure until a pressure sore developed; failed to properly apply a lateral support pressure relieving device; and failed to treat the area as ordered (Resident F). The facility also failed to identify a pressure area until it was unstageable and failed to assess the area with measurements and appearance</p>	F000314	<p>1. The residents that were identified during survey were reviewed and documentation was revised to meet the needs of the residents. Resident F care plan and CNA assignment reflects the use of pressure relieving device. Resident D pressure ulcer is being treated per physician's order. Resident E pressure ulcer has been assessed with measurement and appearance.</p> <p>2. All residents who are at risk for the development of pressure ulcers have the potential to be affected. All residents with a</p>	02/01/2014	

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	<p>when first found (Resident E). The facility failed to treat another pressure area as ordered (Resident D). This affected 3 of 3 residents reviewed with pressure areas in a sample of 9.</p> <p>Findings include:</p> <p>1. On 12/30/13 at 11:45 A.M., LPN # 3 indicated Resident F had a pressure area on his left shin. LPN #3 indicated the pressure area was caused by the wheelchair leg.</p> <p>On 12/30/13 at 1:05 P.M., Resident F was observed sitting up in his wheelchair in the dining room. No cushioning or padding was observed on either wheelchair leg.</p> <p>On 12/30/13 at 2:50 P.M., 4:25 P.M., and 7:10 P.M., Resident F was observed sitting up in his wheelchair in the hallway. No cushioning was observed on either wheelchair leg.</p> <p>On 12/30/13 at 7:05 P.M., CNA # 3 indicated Resident F "liked to stay up for a long time." LPN # 4 indicated at that time that Resident F had a dressing on his left leg, and she would change it later that night.</p> <p>On 12/31/13 at 9:00 A.M., a request</p>		<p>pressure ulcer that reside at the facility were assessed by DNS/Designee and documentation was revised to ensure staged appropriately, pressure relieving devices are in place, treatment and care plan was appropriate. 3. Nursing staff will be educated on the need for pressure prevention and pressure relieving devices, care plan interventions, resident profiles, MAR and TAR completion, and dressing changes as well as the skin management program by the CEC or her designee by Feb. 1, 2014. Nursing administration will complete a competency on dressing changes with all nurses by 2/1/2014. The ADNS and RSM will be educated by regional clinical care on proper staging of wounds to ensure staging of pressure ulcers reflects the actual wound stage. DNS/designee will conduct rounds on all shifts to ensure physician's orders for wound care is followed, and to ensure wound preventative measures are in place per plan of care and CNA assignment sheets. DNS/Designee will conduct weekly skin assessments on residents who have a pressure ulcer to ensure residents' skin integrity is monitored. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the skin management program CQI tool weekly times 4 weeks, bi-monthly</p>				

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	<p>was made of LPN # 3 to observe the pressure area on Resident F's leg at some time that day. On 12/31/13 at 3:15 P.M., an additional request was made of the Clinical Education Coordinator to observe the resident's pressure area.</p> <p>On 12/31/13 at 3:20 P.M., an assessment was made of Resident F's pressure area on his left shin. No dressing was on the area. The area was approximately the size of a half dollar, with a red and yellow base. LPN # 2 indicated at that time that the "left leg rest caused it." There was no padding or cushion on the left leg rest. LPN # 2 indicated she had not taken off the resident's dressing, but that she had just asked the CNAs to put shorts on him for easier observation.</p> <p>At that same time, CNA # 4 was interviewed. She indicated she had just got the resident changed and dressed into shorts. She indicated the resident did not have a dressing on his left leg.</p> <p>On 12/31/13 at 3:40 P.M., LPN # 4 was interviewed. She indicated she worked the evening of 12/30/13, but that the resident "was already in bed and didn't want me to mess with his</p>		<p>times 2 months , monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. The completion date will be 2/1/2014.</p>				

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	<p>leg." LPN # 4 indicated, "He had a shower though last evening." LPN # 4 indicated the CNAs would have removed his dressing when they gave him his shower.</p> <p>On 12/31/13 at 3:50 P.M., CNA # 3 was interviewed. She indicated she worked the evening of 12/30/13, and that Resident F did not receive a shower. She indicated she could check the "shower book" for sure. CNA # 3 then checked the "shower book," and indicated, "No, he gets one tonight."</p> <p>The clinical record of Resident F was reviewed on 12/31/13 at 3:00 P.M. Diagnoses included, but were not limited to, hemiparesis, mild mental retardation, and history of CVA.</p> <p>A Minimum Data Set (MDS) assessment, dated 10/28/13, indicated Resident F scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. Resident F required extensive assistance of two+ staff for bed mobility, transfer, and personal hygiene. The resident required extensive assistance of one staff for locomotion on and off of the unit. The resident had no pressure ulcers.</p>				

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	<p>A Progress Note, dated 11/25/13 at 2:25 P.M., indicated, "IDT [interdisciplinary team] wound note: resident has pressure areas to left LE [lower extremity] to proximal lateral LE and distal lateral LE. New interventions include to pad w/c [wheelchair] at leg rest where LE hits to reduce pressure and risk for injury. New order for TAO [triple antibiotic ointment] to open areas, cover with non-stick TELFA, cover with Kerlix, and ACE wrap from toes to knees."</p> <p>A Pressure Wound Report, dated 11/25/13, included: "New area. Wound present on admission, No...Stage II, Most severe tissue type, Slough (Yellow or while tissue adhering to ulcer bed)...Describe measurements in cm [centimeters] [Lenght x Width x Depth] 3.5 x 2 x 0.2..Describe wound color, red/yellow, Describe wound drainage, clear to yellow...."</p> <p>A Care Plan, dated 11/25/13, included: "Problem, Resident has impaired skin integrity: L [left] shin. Approach, Pressure reducing/redistribution cushion in chair, Pressure reducing/redistribution mattress on</p>			

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	<p>bed, Treatment as ordered, Turn and reposition every 2 hours."</p> <p>A Physician's order, dated 11/25/13 and on the December 2013 orders, indicated, "Apply TAO to all open areas on left lower extremity, then apply non-stick telfa, cover with kerlix and cover with ace wrap toe to knee." The Treatment Administration Record (TAR) indicated the treatment was to be done at bedtime.</p> <p>A Pressure Wound Report, dated 12/26/13, included: "...Stage II, Slough, left shin, 1.8 x 1.4 x 0.3...90% red 10% yellow, small amount of clear drainage...cleanse area with wound cleanser, apply TAO, cover with non stick telfa and wrap with kerlix and ace bandage."</p> <p>The most recent progress wound note, dated 12/26/13 at 3:24 P.M., indicated: "IDT wound note: Resident has area to left shin. Width and depth of wound have increased this week with small amount of clear drainage noted. Wound bed is red with scattered yellow tissue. Peri wound is bright red, dry and scaly with increased edema. Current tx is to apply TAO to area and cover with non stick Telfa and wrap with ACE</p>				

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	<p>bandage toe to knee and cover with Kerlix... Resident prefers to sit in his wheelchair throughout day and evening hours with BLE [bilateral lower extremities] unelevated...Wheelchair has been modified by therapy due to wound on leg...turned and repositioned every two hours..."</p> <p>On 12/31/13 at 4:15 P.M., during interview with the Administrator, she indicated the resident was to have his wheelchair leg rest padded. She indicated, "We ordered a lateral leg support because he picked at the other cushioning." The Administrator also indicated the resident had refused his dressing change on 12/31/13 evening.</p> <p>On 1/2/14 at 3:15 P.M., during interview with the Therapy Manager, she indicated the resident had a temporary lateral support in his wheelchair to reduce pressure, and a gelatin pad was on order. The Therapy Manager indicated she assessed the resident on 12/31/13, and the resident had the lateral support applied incorrectly. She indicated the Occupational Therapist had started inservicing all staff on the correct positioning of the support.</p>			

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	<p>2. On 12/30/13 at 11:45 A.M., LPN # 3 indicated Resident D had a pressure area on his coccyx or buttocks.</p> <p>On 12/30/13 at 4:20 P.M., Resident D was observed out of his room, sitting in a wheelchair.</p> <p>On 12/30/13 at 6:50 P.M., CNA # 5 and CNA # 6 indicated they were going to lay Resident D down in bed. The CNAs transferred the resident to bed and a skin assessment was requested at that time. There was no dressing on the resident's buttocks or coccyx. The resident's bilateral inner buttocks were reddened, with superficial open areas on both buttocks. Old, scar-like areas were also observed. CNA # 5 indicated the areas "flare up sometimes."</p> <p>On 12/31/13 at 2:35 P.M., the clinical record of Resident D was reviewed. Diagnoses included, but were not limited to, history of stage IV pressure ulcer and senile dementia.</p> <p>A Minimum Data Set (MDS) assessment, dated 12/16/13, indicated the resident required extensive assistance for bed mobility</p>			

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	<p>and transfer, and did not ambulate. The MDS assessment indicated the resident had one Stage II pressure ulcer.</p> <p>A Pressure Wound Skin Evaluation Report, dated 12/19/13 at 3:09 P.M., indicated: "New area, Wound present on admission, No, Stage II, Granulation, right buttock, 1 x 2.4 x <0.1, red shallow wound bed with red/white maceration to surrounding bilateral buttocks...."</p> <p>A Physician's order, dated 12/19/13, indicated, "Cleanse [right] buttock wound with wound cleanser, apply skin prep around wound area and then apply hydrocolloid dressing to wound. [Change] on Thurs/Sundays and prn [as needed] for soilage/dislodgement til healed...."</p> <p>The most recent wound note, dated 12/26/13 at 3:52 P.M., indicated, "IDT wound note: Stage II area to right buttock remains. Wound bed 100% red granulation tissue. Peri wound is red blanchable. Bilateral buttocks is red/white macerations and is blanchable...Resident has impaired mobility, confusion, anemia, renal insufficiency, incontinence of urine and heart disease...."</p>			

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	<p>A Pressure Wound Skin Evaluation Report, dated 12/26/13, indicated: "Stage II, .5 x .8 x <0.1, wound color red, current treatment, cleanse with wound cleanser, apply skin prep and cover with hydrocolloid dressing, applying calazyme cream to maceration to buttocks."</p> <p>On 12/31/13 at 4:45 P.M., during interview with the Administrator, she did not offer information why the resident did not have a dressing on as ordered by the physician.</p> <p>3. On 12/30/13 at 11:45 A.M., LPN # 3 indicated Resident E had a pressure area on his right heel.</p> <p>On 12/30/13 at 7:10 P.M., a skin assessment on Resident E was requested. The resident was lying on an air flow mattress with a pressure relieving boot on his right leg. A pressure area was observed on the resident's right heel. The wound bed was covered in brownish scabbed-like tissue. LPN # 4 indicated she thought the resident may have been admitted with the area.</p> <p>The clinical record of Resident E was reviewed on 12/31/13 at 1:55</p>				

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	<p>P.M.</p> <p>A Care Plan, dated 5/9/13 and updated 7/10/13, indicated the following problem: "Resident is at risk for skin breakdown due to impaired mobility due to CVA with left sided paralysis, dx [diagnosis] of diabetes, heart disease, anemia, slides down in bed/chair, incontinence, confusion/memory problems, hx [history] of pressure wounds." The Approaches included: "Assess and document skin condition weekly and as needed. Notify MD of abnormal findings."</p> <p>A MDS assessment, dated 9/4/13, indicated the resident had a short-term and long-term memory problem, and was severely impaired in cognitive skills for daily decision making. The resident required extensive assistance of two+ staff for bed mobility, transfer, and personal hygiene. The resident had 1 Stage II pressure area.</p> <p>A Weekly Nursing Summary and Skin Assessment, dated 9/23/13 at 6:38 P.M., indicated: "Residents skin is warm and dry, pink...Indicate any NEW areas of skin alteration in past 7 days, None...If resident has an open area, do they have pain at the</p>				

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	<p>site, N/A...."</p> <p>A Resident Progress Note, dated 10/3/13 at 1:54 P.M., indicated, "Resident noted to have area on R heel and open area on R and L buttock. Pressure relieving boots on at this time. MD notified. DON [Director of Nursing] aware."</p> <p>A Pressure Wound Skin Evaluation Report, dated 10/3/13, indicated: "R heel, New area, Stage [left blank], Most severe tissue type [left blank], Describe measurements [left blank], Describe wound color [left blank]...Physician Notified: No, Family notified: No, Care Plan Reviewied: No...."</p> <p>A Weekly Nursing Summary and Skin Assessment, dated 10/7/13 at 6:30 P.M., included: "Residents skin is warm and dry, pink...Indicate any NEW areas of skin alteration in past 7 days, None...If resident has an open area, do they have pain at the site, N/A...."</p> <p>The next notation regarding the right heel, dated 10/8/13 at 12:57 P.M., indicated, "...Continues to rec. [receive] TX [treatment] as per orders to R heel...Will continue to monitor."</p>			

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	<p>A Pressure Wound Skin Evaluation Report, dated 10/9/13, indicated: "Right heel...Date area originally ordered 10/03/2013, Stage III, Most severe tissue type, Slough (Yellow or white tissue adhering to tissue bed), Describe measurements in cm, 3 x 3.4, Describe wound color, re [sic], yellow...."</p> <p>A Progress Note, dated 10/14/13 at 7:28 A.M., indicated, "Wound/NAR [nutrition at risk] note. Resident has areas to Left buttock and Right buttock...." Documentation of the right heel pressure ulcer was lacking at that time.</p> <p>On 12/31/13 at 5:00 P.M., during interview with the Administrator, she indicated she had been at the facility since the end of October. She indicated she "walked the former DON out" related to issues such as identification and documentation of skin issues.</p> <p>4. On 12/31/13 at 4:15 P.M., the Administrator provided the current facility policy on the "Skin Management Program," revised 9/2013. The policy included: "...Weekly skin assessments will be completed on all residents with or</p>			

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	<p>without alterations in skin integrity. Alterations in skin integrity will be reported to the physician and family member(s)...All alterations in skin integrity will be documented in EMR [electronic medical record]. Pressure reduction devices are to be put in place immediately...The care plan will be initiated/revised addressing any new areas. Direct care givers will be notified of skin alterations and specific care needs...Wound rounds will be completed on a weekly basis to assess all wounds...."</p> <p>5. STAGES OF PRESSURE ULCERS, AMDA - 2008, included: Stage I: Intact skin with nonblanchable redness of a localized area, usually over a bony prominence...Note: This area may be painful, firm, soft, warmer or cooler compared to adjacent skin. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister. Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage</p>			

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	<p>IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling. Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the ulcer bed. Note: Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined.</p> <p>This Federal tag relates to Complaint IN00140009.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000323 SS=G	<p>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>Based on observation, interview, and record review, the facility failed to ensure a resident at risk for falls was supervised, in that alarms were used in place of supervision, resulting in a fall with a head laceration requiring sutures, for 1 of 3 residents reviewed for falls, in a sample of 9. Resident B</p> <p>Findings include:</p> <p>1. On 12/30/13 at 11:45 A.M., LPN # 3 indicated Resident B had fallen recently.</p> <p>The clinical record of Resident B was reviewed on 12/30/13 at 1:45 P.M. Diagnoses included, but were not limited to, mental retardation,</p>	F000323	<p>1. Resident B's chart was reviewed and was updated to reflect the resident's needs related to fall interventions. 2. All residents who are at risk for falls have the potential to be affected by this deficient practice. No other residents were affected by the deficient practice. All residents with a fall within the past month were reviewed and the care plans were updated to reflect the current fall interventions by DNS/Designee. 3. All staff will be educated on fall interventions, device placement, and need for supervision including the fall management program by the CEC, ADM or designee by Feb. 1, 2014. Falls will be reviewed by the IDT team the next business day to ensure appropriate fall intervention is in place. The manager on call will review falls on the weekend to ensure new</p>	02/01/2014

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	<p>bipolar disorder, and osteopenia.</p> <p>A Minimum Data Set (MDS) assessment, dated 10/11/13, indicated the resident scored a 0 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance for bed mobility, transfer, and toilet use. A test for "Balance during Transitions and Walking" indicated the resident was "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, walking, turning around, and surface-to-surface transfer.</p> <p>A "Fall Event" note, dated 12/9/13 at 3:22 P.M., included: "Slid down recliner to floor. Was fall witnessed, Yes. Describe what the resident was doing prior to the fall, Res [resident] sitting in recliner in TV room, leaned recliner fwd [forward] [with] foot pedal on floor et slid down to floor...Was resident incontinent at time of fall, Yes...What intervention(s) was put into place to prevent another fall, Will not attempt recliner."</p> <p>A "Fall Event" note, dated 12/11/13 at 2:40 P.M., included: "Fall. Was fall witnessed, No. Describe what</p>		<p>fall interventions are in place. The IDT will determine the need for a change to the immediate intervention. IDT will conduct a monthly falls meeting to review trending and residents with multiple falls. 4. To ensure compliance, the DNS/Designee is responsible for the completion of the fall management CQI tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. 5. The completion date is 2/1/2014.</p>				

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	<p>the resident was doing prior to the fall, In bed...Was resident incontinent at time of fall, No...What intervention(s) was put into place to prevent another fall, bed in lowest position with mat."</p> <p>A "Fall Event" note, dated 12/13/13 at 12:22 P.M., included: "Unwitnessed fall. Was fall witnessed, No. Describe what the resident was doing prior to the fall, resting in bed...Did the resident hit his/her head? Unwitnessed...Was resident incontinent at time of fall, No...Document any environmental factors observed in area of fall, Floor clear, mat at bedside, bed in low position, pad alarm in place et functioning properly. What intervention(s) was put into place to prevent another fall, bed in low position."</p> <p>Progress Notes included the following notations:</p> <p>12/15/13 at 10:00 A.M.: "Resident witnessed crawling out of bed onto floor mat by staff, res wanted to be in his w/c, bed was in lowest position when resident crawled onto floor mat next to bed."</p> <p>A Progress Note, dated 12/22/13 at</p>			

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	<p>7:16 A.M., indicated: "Res. slept well but did try to crawl out of [sic] twice last night...."</p> <p>A "Fall Event" note, dated 12/22/13 at 6:50 P.M., included: "Fall. Was fall witnessed, No. Describe what the resident was doing prior to the fall, eating dinner. Describe the position of the resident when first observed after fall, Res sitting on buttocks, back up against bed, bed side table tipped over, and food scattered all over room. Describe resident appearance at time of fall, Beeding [sic] noted to forehead. Area cleansed noted cut...Did the resident hit his/her head? Yes...Order to send to er to eval and tx [evaluate and treat]...Was resident incontinent at time of fall, No...Document any environmental factors observed in area of fall, Bed side table. What intervention(s) was put into place to prevent another fall, Res to eat in d/r [dining room]. So res can be monitored more closely."</p> <p>A hospital emergency room note, dated 12/22/13, included: "...Chief complaint: Injury to head and face patient was sent from the nursing home after he reportedly rolled out of bed and fell to the floor. He sustained a laceration to his mid</p>			

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	<p>forehead region...The patient complains of mild pain...Forehead: 3.0 laceration of the central forehead...."</p> <p>A Progress Note, dated 12/23/13 at 8:20 A.M., indicated, "Received report from [name] at [name of hospital] ER at 10:00 pm on 12-22-13. Res. received 4 sutures to the forehead from the fall and a small abrasion to the R [right] hip...."</p> <p>A "Fall Event" note, dated 12/24/13 at 2:27 P.M., included: "Fall. Was fall witnessed, No. Describe what the resident was doing prior to the fall, lying in a bed. Describe the position of the resident when first observed after fall, lying on his right side on a pillow. Describe resident appearance at time of fall, clothes on, no shoes, just socks...Did the resident hit his/her head? Unwitnessed...Was resident incontinent at time of fall, No...Document any environmental factors observed in area of fall, none. What intervention(s) was put into place to prevent another fall, pull tab alarm to bed."</p> <p>An IDT Fall review, dated 12/26/13 at 11:07 A.M., indicated, "Res had a fall on 12/24/13 at 2:27 P.M...Res</p>			

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	<p>has pad alarm to bed per care plan. Neuro checks were already in progress from previous fall. Res will have pull tab alarm placed on while in bed to alert staff when res leans forward while in bed...."</p> <p>A Care Plan, initially dated 12/18/12 and updated 12/24/13, indicated: "Resident is at risk for fall due to: New environment, fx [fracture] to hip, dx [diagnosis] of seizures, hx of fall in past 3 months...incontinence, impaired gait/balance, us of assistive device, hx of non-compliance." Approaches included: "12/24/13 Pull tab alarm while in bed, 12/23/13 Resident to eat meals in dining room, 12/11/13, Bed in lowest position with mat, 12/22/13 personal alarm to wheelchair, 12/18/12 Call light in reach."</p> <p>An additional Care Plan, dated 12/16/13, indicated: "Resident crawls out of bed onto the floor." The 2 approaches listed were: "Encourage resident to wait for assistance from staff before getting out of bed. Ensure residents [sic] bed is in lowest position."</p> <p>On 12/30/13 at 4:20 P.M., Resident B was observed lying in bed. 4</p>						

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	<p>sutures were observed on the resident's mid-forehead.</p> <p>On 1/2/14 at 5:25 P.M., during interview with the Administrator, she indicated the alarms were sounding during the resident's falls. The Administrator indicated, "With him, it's a behavior. He crawls out of bed." The Administrator indicated she was doing an audit regarding the number of alarms in the facility, and was trying to reduce the number of alarms.</p> <p>2. On 12/31/13 at 11:00 A.M., the Administrator provided the current facility policy on the "Fall Management Program," revised 9/2013. The policy included: "It is the policy...to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls...All falls will be discussed by the interdisciplinary team...to determine root cause and other possible interventions to prevent future falls...."</p> <p>This Federal tag relates to Complaint IN00140622.</p>						

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