

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155294	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/17/2014
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NAME OF PROVIDER OR SUPPLIER  FORUM AT THE CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 8505 WOODFIELD CROSSING BLVD INDIANAPOLIS, IN 46240
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey Dates: December 8, 9, 10, 11, 12, 15, 16 and 17, 2014.</p> <p>Facility number: 000191 Provider number: 155294 AIM number: N/A</p> <p>Survey team: Sandra Nolder, RN-TC Michelle Hosteter, RN Gloria Bond, RN</p> <p>Census bed type: SNF: 44 Residential: 18 Total: 62</p> <p>Census payor type: Medicare: 21 Other: 23 Total: 44</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on December 19, 2014.</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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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to provide a resident a choice of bathing frequency and a resident on the time and number of therapy sessions for 2 of 4 residents reviewed for choices. ( Residents #137 and #88).</p> <p>Findings include:</p> <p>1. During an interview on 12/08/2014 at 4:55 p.m., Resident #137 indicated she did not have a choice on how often she took a shower. She received a shower on Tuesdays and Fridays. She indicated she would like to take a shower every other day if she could, but did not know she had a choice. She thought she could only have 2 showers a week.</p> <p>During an interview on 12/11/2014 at 3:25 p.m., the DON (Director of Nursing) and the SSD (Social Service Director),</p>	F000242	<p><b>F242</b></p> <p><i>In response to cited findings, the following actions will be taken:</i></p> <p>F-242 483.15(b) Forum residents have the right to make significant life choices</p> <p><b>A)</b> During the survey, resident #137 was advised she could bathe more frequently than was scheduled. Her preferences were noted with care plans updated. Resident #88 was advised she could refuse or re-schedule therapy sessions as desired.</p> <p><b>B)</b> All residents in the facility have the potential to be affected by this alleged deficient practice. Bathing preferences identified during creation of the multi-disciplinary set will be audited by the MDS nurse to identify any other residents who prefer bathing frequencies different than those scheduled. The Rehabilitation Director or her designee will interview residents with sessions scheduled more than once daily to determine if timing preferences are being observed. Any concerns will be reported to treating therapists. The Activity Director or designee will interview each affected resident to determine it bathing</p>	01/16/2015
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	<p>the SSD indicated that a verbal evaluation of choices relating to showers and times was done on admission and put on an admission assessment.</p> <p>The resident's record was reviewed on 12/11/2014 at 3:30 p.m. The resident's admission record titled, "Data Collection Tool..." indicated the resident needed physical assistance for bathing. The line with, "Preference --Tub --Shower --other Frequency--Daily --Every other day --Bi weekly --Weekly Time of Day --AM - -PM...", was not filled out.</p> <p>During an interview on 12/12/2014 at 3:10 p.m., Resident #137 indicated she was getting a shower as the facility had it scheduled, but she had not been given a choice on days or how often.</p> <p>During an interview on 12/12/2014 at 3:20 p.m., R.N.#1 indicated the shower schedule was done on admission according to what room the resident was residing in, unless there was a special request.</p> <p>2. On 12/11/2014 at 2:45 p.m., Resident #88 was observed being taken by wheel chair to therapy. The resident was overheard informing PT (Physical Therapist) #9 she was tired of going to therapy 3 to 4 times per day and did not</p>		<p>preferences are being observed. Any findings will be directed to Charge nurse for follow-up and implementation of desired bathing options. Care plans will be updated to reflect preferences for bathing and/or therapy changes.</p> <p>C) Team members will receive training with respect to resident preferences. New residents will be interviewed to ascertain therapy timing and bathing preferences. Preferences will be implemented with related care plans. Resident bathing preferences and therapy preferences will be discussed at the next three (3) monthly resident council meetings to gauge ongoing accommodation of resident preference for bathing. Negative results will trigger another comprehensive audit for resolution as indicated above.</p> <p>D) Clinicians or managers will continue to collect resident preference data and provide it for creation of the resident's MDS. Observation of resident preferences will be added to the monthly resident council agenda as a means to gauge ongoing compliance. Subsequent findings will be addressed on an individual basis.</p> <p>The HFA or designee will interview 25% of newly admitted residents weekly for the next 30 days then 25% of newly admitted residents bi-weekly for the next 30 days to ensure compliance. He will review Resident Council meeting minutes on a monthly basis and will attend meetings no the next 30 days. The Activity Director will continue to collect related resident observations monthly as a part of the resident council agenda to gauge ongoing compliance. Subsequent findings will be addressed on an</p>		

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	<p>want to go at that time. RN #2 was heard gently encouraging the resident to go to therapy. The resident was observed going to therapy by wheel chair with PT #9.</p> <p>PT #9 indicated she would bring her right back.</p> <p>On 12/11/2014 at 3:00 p.m., the resident was observed participating in therapy in the therapy area. The resident was observed willingly cooperating.</p> <p>Resident #88's record was reviewed on 12/12/2014 at 10:15 a.m. Diagnoses included, but were not limited to dementia, high blood pressure and depression.</p> <p>During an interview on 12/12/2014 at 10:20 a.m., the Therapy Supervisor indicated the therapy schedules were done with respect to the resident's choices. The residents that were alert were asked about their preferences. The resident's that were not as alert, the family was asked. The schedules were updated regularly.</p> <p>The Therapy Supervisor indicated that if a resident did not want to go to therapy, the therapist was to check back later with the resident. Sometimes a resident needed to be encouraged to go to therapy.</p>		<p>individual basis.</p> <p>The HFA and/or DON will review Resident Council meeting minutes on a monthly basis and will attend meetings no less than quarterly to ensure compliance. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E) Date of compliance with proposed actions</b> <b>January 16, 2015</b></p>	

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F000256 SS=D	<p>The residents may initially not want to go to therapy and then change their minds once they were in the therapy area. If the resident continued to decline to want to go to therapy, they had the choice to receive therapy in their room.</p> <p>The Therapy Supervisor indicated Resident #88 was not scheduled to go to therapy from 3 p.m. or after.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p> <p>483.15(h)(5) ADEQUATE &amp; COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to provide adequate lighting of at least a minimum of 20 foot-candles in a resident's room, for 1 of 1 rooms checked for lighting illumination. (Resident #63)</p> <p>Findings included:</p> <p>On 12/8/14 at 1:50 p.m., Resident #63 indicated he read a lot and had trouble seeing as his vision was bad and the lighting in the room did not help. He indicated his son had purchased a light and that helped some.</p>	F000256	<p><b>F256</b></p> <p><i>In response to the cited findings the following actions will be taken: F-246</i> 483.15(e)(1) Forum residents have sufficient lighting available for comfort and practical living.</p> <p><b>A)</b> During the survey, additional lighting was provided to #63's room.</p> <p><b>B)</b> All residents in the facility have the potential to be affected by this alleged deficient practice. Foot-candle levels will be assessed in all resident rooms by the Director of Maintenance and/or Director of Housekeeping for practical applications (reading and activities of daily living). Areas in need of additional foot-candles will have wattage increased</p>	01/16/2015

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F000282 SS=D	<p>On 12/15/14 at 12:30 p.m., the foot-candles that were measured in Resident # 63's room, was observed to be 9 foot-candles at the spot in the room where the resident sat to read.</p> <p>On 12/16/2014 10:30 a.m., with the Maintenance Director (MD) in attendance, the foot-candle level was observed to be 11 where the resident sat to read. The MD indicated he had not checked light levels in the resident's rooms. He indicated he thought the minimum foot-candle level was 20.</p> <p>3.1-19(dd)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure Physician orders were followed for a</p>	F000282	<p>in related light fixtures and/or have new fixtures installed and/or receive portable lamps where indicated. In all cases, residents' preferences will dictate what additional lighting may or may not be added.</p> <p>C) Housekeeping personnel will receive special instruction and training ensuring light levels are adequate and fixtures are in good working order. Related findings will be reported to the Maintenance Director for corrections. Sufficient lighting in rooms will be discussed at the next three (3) monthly resident council meetings to gauge ongoing sufficient lighting levels. Negative results will trigger another comprehensive audit for resolution as indicated above</p> <p>D) The HFA will audit for compliance on weekly Quality Assurance/Environmental rounds. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p>E) Date of compliance with proposed actions <b>January 16, 2015</b></p> <p><b>F282</b> <i>In response to the cited findings R/T to</i></p>	01/16/2015			

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	<p>pressure ulcer preventative device and dressing changes were not completed appropriately for 1 of 33 residents reviewed for following Physician orders (Resident #141) and failed to follow the Care Plan for the appropriate placement of a catheter bag for 1 of 33 residents reviewed for following Care Plans. (Resident #138)</p> <p>Findings include:</p> <p>Resident #141's record was reviewed on 12/11/2014 at 10:01 a.m. Diagnoses included, but were not limited to, cellulitis of the leg, ulcer of the lower extremity, end-stage renal disease on hemodialysis, hypoxia, sepsis (infection of the blood), lymphedema of a limb, diabetes, chronic diastolic heart failure, chronic lower extremity edema, left lower extremity redness and drainage and peripheral vascular disease.</p> <p>a. The resident's December 2014, Medication Administration Record (MAR) included, but were not limited to, the following orders: 12/5/14--Right lower extremity with tubigrip and Leeder boot at all times. Check placement q (every) shift.</p> <p>A continuous observation of Resident #141 had occurred on 12/11/14 from</p>		<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN, <i>the following actions will be taken:</i></p> <p><b>A)</b> Resident #141 discharged permanently from the community. While still a resident, care plans and physician orders were reviewed and observed by attending personnel. Subsequent to the surveyor's observations Resident #138's urinary drainage bag was maintained below his bladder and caregivers were reminded of correct placement needs. Currently and during the survey, the community used and uses urinary drainage bags with anti-reflux devices.</p> <p><b>B)</b> All residents with orders for pressure ulcer preventative devices, wound changes and catheter leg bags have the potential to be affected by the alleged deficient practice. Care plans for current residents will be reviewed to identify such residents. Related care will be observed. Non-compliant practices will be addressed with care givers.</p> <p><b>C)</b> Current staff members will be re-educated on following care plans and associated orders. Residents with orders/care plans related to pressure ulcer preventative devices, wound dressing changes and/or urinary catheters will be identified by the</p>	

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	<p>10:00 a.m., until 5:30 p.m. On the following dates and times the resident did not have the Leeder boot on her right lower extremity.</p> <p>12/11/14 at 10:00 a.m., 12/11/14 at 11:15 a.m., 12/11/14 at 11:50 a.m., 12/11/14 at 12:46 p.m., 12/11/14 at 1:11 p.m., 12/11/14 at 1:42 p.m., 12/11/14 at 2:13 p.m., 12/11/14 at 4:00 p.m., 12/15/14 at 8:50 a.m. and 12/15/14 at 5:10 p.m.</p> <p>During an interview on 12/12/14 at 1:57 p.m., the ADON indicated Resident #141 did not have her Leeder boot in place on 12/11/14, when she removed the right heel dressing. The ADON indicated the resident had a Physician order to have the Leeder boot on at all times. At that time, the Scheduler indicated the resident did have her Leeder boot in her room, but it was not on her right lower extremity when the dressing change was completed to her right heel on 12/11/14.</p> <p>b. Resident #141's December 2014, Medication Administration Record (MAR) included, but were not limited to the following orders: 12/8/14--Apply Calmoseptine to open areas at right upper inner buttocks and right mid inner buttocks. Cover with 4 x 4 Mepilex foam dressing. Change daily until healed.</p>		<p>MDS nurse. Care plans will be cross-checked with all related MD orders. Any found to be inconsistent will be corrected immediately. Personnel associated with errors will be re-trained and/or reprimanded to correct records and practices as indicated. The DON or her designee will randomly audit 25% of the orders/care plans (as of January 5, 2015) to ensure they are being followed and executed properly. Any findings will be identified with direct care staff and related education will be provided and documented.</p> <p><b>D)</b> The DON or her designee will audit all care plans of new residents with catheters and/or wound dressings and/or pressure ulcer preventative devices against MD orders for the next thirty (30) days. 50% of related records will be audited bi-weekly for the subsequent thirty (30) days then monthly for the next thirty (30) days. Any found to be inconsistent will be corrected immediately. Personnel associated with errors will be re-trained and/or reprimanded to correct records and practices as indicated. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E)</b> Date of compliance with proposed actions: January 16,</p>				

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	<p>On 12/11/2014 at 11:25 a.m., RN #2 was observed applying Calmoseptine to Resident #141's three pressure wounds to her coccyx area and two pressure ulcers to the right upper inner and mid buttocks that were reddened in color with the top layer of skin removed. RN #2 did not apply the Mepilex foam dressing to the resident's right upper inner and right mid buttocks at that time. There was no Mepilex foam dressing observed on the resident's right buttocks when her brief was removed and pericare was completed. The three pressure areas to the coccyx area were reddened in color with the top layer of skin removed.</p> <p>During an interview on 12/12/2014 at 10:21 a.m., RN #2 indicated she should have placed a Mepilex foam dressing on the resident's right upper inner and right mid inner buttocks after applying Calmoseptine on 12/11/14. She indicated when a dressing is displaced the CNA's were supposed to notify the nurse, so the dressing could be reapplied.</p> <p>During an interview on 12/12/14 at 1:57 p.m., the ADON indicated there should have been a Mepilex dressing placed on the resident's right inner and right mid inner buttocks if it had become dislodged.</p>		2015.	

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	<p>During an interview on 12/12/14 at 3:25 p.m., the DON indicated she expected the nurses to immediately reapply a dressing on a resident's wound that had become dislodged.</p> <p>c. Resident #141's December 2014, Medication Administration Record (MAR) included, but were not limited to the following orders: 12/10/14--Cleanse the resident's left lower extremity (LLE) with 0.9% Normal Saline (wound cleansing solution). Apply a thin layer of Santyl (a wound debriding ointment) with a popsicle stick to the superior ankle and lateral calf wound beds. Cover the wounds with Mepilex Silver (an anti-microbial) foam dressing, the cover with an ABD (abdominal) pad. Secure the dressings with kerlix guaze. Change the dressing daily and as needed for soilage.</p> <p>On 12/11/2014 at 4:45 p.m., the Assistant Director of Nursing (ADON) (who was also the wound nurse) washed her hands and donned clean gloves. She removed the old dressings from the resident's LLE by soaking them off with Normal Saline (a wound cleanser) and placed the old dressings with a moderate amount of serosanguineous drainage on the resident's bed. The wound had a faint</p>			

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	<p>foul odor.</p> <p>She washed her hands and donned clean gloves. She sprayed the resident's upper wound to the LLE with wound cleanser starting at the shin area just below the knee area and sprayed down to the ankle area, then sprayed the lower wounds to the LLE from the ankle back up to the knee direction. The wound solution ran down from the top wound to the lower wounds. She wiped the upper wound to the LLE with two 4 x 4 guaze dressings, then laid them on top of the old dressings lying on the bed. She wiped the lower wounds to the LLE with two 4 x 4 guaze dressings, then laid them on top of the other dirty dressings lying on the bed. She removed her dirty gloves, threw them in the trash can, washed her hands and donned clean gloves. The Scheduler who had been holding the resident's leg up, laid the resident's leg back down on the bed, which lacked a clean barrier to lay her leg down on.</p> <p>The ADON applied Santyl (a wound debriding ointment) to the lower wounds on the LLE with a tongue depressor, then flipped the tongue depressor over and applied Santyl to the upper wound to the LLE, with the same tongue depressor, then placed the trash on top of the dirty dressings on the bed. She removed her</p>			

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	<p>gloves and washed her hands. The ADON placed her unwrapped dressing supplies next to the dirty dressings on the bed. She opened the Mepilex Silver (an anti-microbial) dressings and laid them on top of the opened packages sitting next to the dirty dressings on the bed, while she donned clean gloves.</p> <p>The ADON placed the Mepilex Silver dressings on the upper and lower wounds to the LLE. She removed her gloves, washed her hands and donned clean gloves. She opened an ABD (abdominal) pad and placed it on the lower wounds on the LLE towards the left knee to cover part of the wounds. She unwrapped another ABD pad and placed it next to the first ABD pad to cover the rest of the lower wounds on the LLE. She looked for her third ABD pad with her gloves on. She looked on the nightstand, looked under the clean unwrapped dressings and while lifting up the clean unwrapped dressings, she touched the dirty dressings with her gloves. She went to the resident's dresser and obtained an ABD pad and unwrapped it and placed it on the upper wound on the LLE. She removed her gloves, washed her hands and donned clean gloves.</p> <p>The ADON opened the Mepilex foam dressings and sat them on top of the</p>			

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	<p>empty packages next to the dirty dressings on the bed. She placed one Mepilex foam dressing over the ABD pads at the bottom of the resident's LLE and another Mepilex foam dressing over the ABD pads at the top of the resident's LLE. She wrapped the resident's LLE from her left toes to below her knee with Kerlix guaze. She taped the Kerlix. She threw away her trash. She removed her gloves, washed her hands and donned clean gloves.</p> <p>During an interview on 12/11/2014 5:35 p.m., the ADON indicated she should have set a table up to place her wound supplies on and had a trash bag to place her trash in. She indicated when she cleansed the LLE wounds she should have used 4 x 4 dressings and sprayed the 4 x 4 dressings instead of spraying the entire surface of the upper and lower wounds to the LLE from top to bottom allowing debris to run from the top wound to the bottom wound. She indicated she should not have cleansed the wounds, then placed the leg back on the same bed linen.</p> <p>During an interview on 12/12/2014 1:57 p.m., the ADON indicated she had misread the Physician treatment order to the upper and lower wounds to the LLE. She indicated there should not have been</p>			

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	<p>any Mepilex dressing placed over the ABD pads.</p> <p>2. On 12/11/2014 at 11:50 a.m., Resident #138's record was reviewed. Diagnoses included, but were not limited to, urinary retention, frequent UTIs (urinary tract infections), hypertension, and BPH (Benign Prostatic Hyperplasia-enlargement of the prostate gland causing difficulty in urination). The resident's record indicated he had a urinary catheter in.</p> <p>On 12/12/2014 at 10:35 a.m., the resident was observed in bed on his back. His urinary catheter was attached to a leg bag, which was strapped to the top and inner aspect of his leg. There was urine in the bag and some of the urine flowed into the tubing from the bag leading to the bladder.</p> <p>On 12/15/2014 at 4:50 p.m., with the ADON (Assistant Director of Nursing) and LPN #4 present, the resident was observed lying in bed with his urinary catheter attached to the inner aspect of his leg. The catheter bag was half full of urine and the urine was in the tubing leading to his bladder. The resident indicated it was uncomfortable to pee into the tube.</p> <p>During an interview on 12/15/2014 at</p>			

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F000309 SS=D	<p>5:00 p.m.,CNA #3 indicated she emptied the urinary catheter bag at the end of the shift. If the resident laid down for a nap, he kept his leg bag on. The bag was changed at night to a gravity drainage bag. It was changed first thing in the morning to a leg bag.</p> <p>The resident's care plan titled, "Incontinence Bladder" and dated 12/3/14, indicated the resident was at risk for an altered pattern of urinary elimination related to his benign prostate enlargement. One of the goals was for the resident to be free from signs and symptoms of infection related to his urinary catheter placement. The plan of action included, but was not limited to, catheter care per policy.</p> <p>A current facility policy titled,"Leg Bag," dated 1/1/01 was reviewed on 12/16/2014 at 10:30 a.m. The policy indicated,"...Keep drainage bag lower than bladder at all times...."</p> <p>3.1-35(g)(2)</p> <p>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</p>			

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	<p>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 a dressing change was completed without potential for infection for 1 of 1 residents observed for a dressing change. (Resident #141)</p> <p>Findings include:</p> <p>Resident #141's record was reviewed on 12/11/2014 at 10:01 a.m.</p> <p>Diagnoses included, but were not limited to, cellulitis of the leg, ulcer of the lower extremity, end-stage renal disease on hemodialysis, hypoxia, sepsis (infection of the blood), lymphedema of a limb, diabetes, chronic diastolic heart failure, chronic lower extremity edema, left lower extremity redness and drainage and peripheral vascular disease.</p> <p>The resident was released from the hospital on 12/4/14, where she was treated with four different intravenous antibiotics for cellulitis (skin infection) to her LLE (left lower extremity).</p> <p>On 12/11/2014 at 4:45 p.m., the Assistant Director of Nursing (ADON) (who was also the wound nurse) washed her hands and donned clean gloves. She removed</p>	F000309	<p><b>F309</b> In response to the cited findings R/T to 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING the following actions will be taken:</p> <p><b>A)</b> Resident #141 discharged permanently from the community. Subsequent to the surveyor's observations, wound dressings were properly administered as ordered by the attending MD.</p> <p><b>B)</b> All residents with dressed wounds have the potential to be affected by the alleged deficient practice during wound dressing applications. Wounds will be assessed by licensed nurses with abnormal findings reported to attending physicians. Residents with orders/care plans related to wound dressing changes will be identified by the MDS nurse. <b>C)</b> Current staff members will be re-educated on wound assessments and infection control practices. The DON or her designee will provide infection control re-training to licensed nursing personnel. Following this, personnel will be observed for compliance during at least one (1) dressing change during the next thirty (30) days. Personnel who do not follow correct infection control protocols will be re-trained and/or reprimanded. Repeat findings identified with particular staff and related education will be provided and documented.</p>	01/16/2015

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	<p>the old dressings from the resident's LLE by soaking them off with Normal Saline (a wound cleanser) and placed the old dressings with a moderate amount of serosanguineous drainage on the resident's bed. The wound had a faint foul odor.</p> <p>She washed her hands and donned clean gloves. She sprayed the resident's upper wound to the LLE with wound cleanser starting at the shin area just below the knee area and sprayed down to the ankle area, then sprayed the lower wounds to the LLE from the ankle back up to the knee direction. The wound solution ran down from the top wound to the lower wounds. She wiped the upper wound to the LLE with two 4 x 4 gauze dressings, then laid them on top of the old dressings lying on the bed. She wiped the lower wounds to the LLE with two 4 x 4 gauze dressings, then laid them on top of the other dirty dressings lying on the bed. She removed her dirty gloves, threw them in the trash can, washed her hands and donned clean gloves. The Scheduler who had been holding the resident's leg up, laid the resident's leg back down on the bed, which lacked a clean barrier to lay her leg down on.</p> <p>The ADON applied Santyl (a wound debriding ointment) to the lower wounds</p>		<p><b>D)</b> The DON or her designee will observe atleast one (1) dressing change for each resident with such orders for the nextthirty (30) days. 50% of new admission dressing changes will be auditedbi-weekly for the subsequent thirty (30) days then monthly for the next thirty(30) days. The DON or designee will observe woundcare rounds once a week until compliance is established then randomly at leastonce a week. Any personnel found to be out ofcompliance will be corrected immediately. Personnel associated with errors will be re-trained and/or reprimanded to correct records and practices as indicated.The DON or her designee will audit all care plans of new residents withcatheters and/or wound dressings and/or pressure ulcer preventative devicesagainst MD orders for the next thirty (30) days. 50% of related records will beaudited bi-weekly for the subsequent thirty (30) days then monthly for the nextthirty (30) days. Any found to be inconsistent will be correctedimmediately. Personnel associated with errors will be re-trained and/orreprimanded to correct records and practices as indicated. Compliance data willbe referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E)</b> Date of compliance with</p>				

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	<p>on the LLE with a tongue depressor, then flipped the tongue depressor over and applied Santyl to the upper wound to the LLE, with the same tongue depressor, then placed the trash on top of the dirty dressings on the bed. She removed her gloves and washed her hands. The ADON placed her unwrapped dressing supplies next to the dirty dressings on the bed. She opened the Mepilex Silver (an anti-microbial) dressings and laid them on top of the opened packages sitting next to the dirty dressings on the bed, while she donned clean gloves.</p> <p>The ADON placed the Mepilex Silver dressings on the upper and lower wounds to the LLE. She removed her gloves, washed her hands and donned clean gloves. She opened an ABD (abdominal) pad and placed it on the lower wounds on the LLE towards the left knee to cover part of the wounds. She unwrapped another ABD pad and placed it next to the first ABD pad to cover the rest of the lower wounds on the LLE. She looked for her third ABD pad with her gloves on. She looked on the nightstand, looked under the clean unwrapped dressings and while lifting up the clean unwrapped dressings, she touched the dirty dressings with her gloves. She went to the resident's dresser and obtained an ABD pad and unwrapped it and placed it on the</p>		proposed actions: January 16, 2015.	

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	<p>upper wound on the LLE. She removed her gloves, washed her hands and donned clean gloves.</p> <p>The ADON opened the Mepilex foam dressings and sat them on top of the empty packages next to the dirty dressings on the bed. She placed one Mepilex foam dressing over the ABD pads at the bottom of the resident's LLE and another Mepilex foam dressing over the ABD pads at the top of the resident's LLE. She wrapped the resident's LLE from her left toes to below her knee with Kerlix gauze. She taped the Kerlix. She threw away her trash. She removed her gloves, washed her hands and donned clean gloves.</p> <p>During an interview on 12/11/2014 5:35 p.m., the ADON indicated she should have set a table up to place her wound supplies on and had a trash bag to place her trash in. She indicated when she cleansed the LLE wounds she should have used 4 x 4 dressings and sprayed the 4 x 4 dressings instead of spraying the entire surface of the upper and lower wounds to the LLE from top to bottom allowing debris to run from the top wound to the bottom wound. She indicated she should not have cleansed the wounds, then placed the leg back on the same bed linen.</p>			

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F000314 SS=D	<p>A current policy titled "Clean Dressing Change" dated 06/01/07, indicated "1.0 Purpose: To ensure that a licensed nurse or therapist applies dressings using clean technique to promote wound healing and prevent cross-contamination among and between residents and caregivers. 2.0 Fundamental Information:.. Dressing Multiple Wounds-when dressing multiple wound, plan procedures from cleanest or least contaminated wound to the dirtiest or most contaminated wound...Maintain the Clean Field-once the clean field is established, prevent contamination by reaching onto the clean field after hands have been cleansed and never after gloves have touched anything off the field...3.0 Procedure: 3... Clean work surface and wash hands. 4. Prepare clean field and place plastic bag within easy reach, but not on floor or within clean field...7. Protect linens to prevent soiling during dressing change. 8. Remove soiled dressing and gloves, place in bag for disposal...10. clean wound as ordered. Carefully dry skin around wound...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL</p>			

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	<p><b>PRESSURE SORES</b> 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 wound assessments were complete, the appropriate treatment for a dressing change was completed and a prevention intervention was in place for pressure ulcer wounds for 1 of 3 residents reviewed for pressure ulcers. (Resident #141)</p> <p>Findings include:</p> <p>Resident # 141's record was reviewed on 12/11/2014 at 10:01 a.m. Diagnoses included, but were not limited to, cellulitis of the leg, ulcer of the lower extremity, end-stage renal disease on hemodialysis, hypoxia, sepsis, lymphedema of limb, diabetes, chronic diastolic heart failure, chronic lower extremity edema, left lower extremity redness and drainage and peripheral vascular disease.</p>	F000314	<p><b>F314</b> In response to the cited findings R/T to 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES the following actions will be taken: <b>A)</b> Resident #141 discharged permanently from the community. Subsequent to the surveyor's observations, pressure reduction devices were properly administered as ordered by the attending MD. <b>B)</b> All residents with pressure reduction devices have the potential to be affected by the alleged deficient practice. Residents with orders related to pressure reduction devices will be identified by the MDS nurse. <b>C)</b> Current staff members will be re-educated on pressure reduction devices and wound prevention. Care plans will be cross-checked with all related MD orders. Any found to be inconsistent will be corrected immediately. The DON or her designee will randomly audit 25% of orders and application of devices to ensure they are properly applied. Any findings will</p>	01/16/2015

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	<p>The resident's December 2014, Medication Administration Record (MAR) included, but were not limited to the following orders:</p> <p>12/5/14--Right lower extremity with tubigrip and Leeder boot at all times. Check placement q (every) shift.</p> <p>12/8/14--Apply Calmoseptine to open areas at right upper inner buttocks and right mid inner buttocks. Cover with 4 x 4 Mepilex dressing. Change daily until healed.</p> <p>A document titled "Braden Scale" dated 12/4/14, indicated the resident's Braden Score was 12, which indicated she was at high risk for pressure ulcers.</p> <p>A document titled "Braden Scale for Predicting Pressure Sores" dated 12/11/14, indicated the resident's Braden Score was 11, which indicated she was at high risk for developing pressure ulcers.</p> <p>a. An "Initial Wound Evaluation" dated 12/04/14, under the "Initial Wound Description" indicated wound #6, the buttock wound type was an open area that was acquired at the hospital and measured 7.0 cm (centimeters) x 3.0 cm. The wound edges were jagged and the wound bed description was black and tan. The wound did not have any drainage or odor. There was no Stage for the wound</p>		<p>be identified with direct care staff and related education will be provided and documented. Personnel will be re-trained and/or reprimanded to correct practices as indicated. D) The DON or her designee will observe atleast one (1) application of pressure reduction device(s) for each residentwith such orders for the next thirty (30) days. 50% of new admissionpressure reduction devices will be audited bi-weekly for the subsequent thirty(30) days then monthly for the next thirty (30) days. TheDON or designee will observe wound care rounds once a week until compliance isestablished then randomly at least once a week. Any personnefound to be out of compliance with application of devices will be correctedimmediately. Personnel associated with errors will be re-trained and/orreprimanded to correct records and practices as indicated. Compliance data willbe referred to the Quality Assurance Committee for review and recommendations. E) Date of compliance with proposed actions: January 16, 2015.</p>	

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	<p>found documented on this form.</p> <p>An "Initial Wound Evaluation" dated 12/04/14, under the "Initial Wound Description" indicated wound #2, the left foot-heel type was eschar (black dead tissue) that was acquired at the hospital and no measurements were found documented on this form. No stage, wound bed description, drainage or odor presence was documented on this form.</p> <p>An "Initial Wound Evaluation" dated 12/04/14, under the "Initial Wound Description" indicated wound #3, the right heel type was eschar that was acquired at the hospital and no measurements were found documented on this form. No stage, wound bed description, drainage or odor presence was documented on this form.</p> <p>A nurses note dated 12/04/14 at 5 p.m., as a late entry indicated the resident had bilateral heel wounds with eschar and the peri-wound skin areas were suspected deep tissue injuries (SDTI's). There was no types, stages of the heel wounds or measurements of these wounds found documented in the nurses note. The resident had a buttocks wound that measured 7.0 cm x 3.0 cm. There was no type or stage documented in the nurses note regarding this wound.</p>			

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	<p>A "Weekly Wound Progress Note" undated indicated Wound #1 was to the right inner buttocks. The type of wound was due to incontinence and where the wound was acquired indicated other. The wound measured 1.2 x 0.8 cm. The wound edges were defined. The wound bed was red and the peri-wound tissue was pink. Wound #2 was to the right mid inner buttocks. The type of wound was due to incontinence and where the wound was acquired indicated other. The wound measured 2.2 x 1.0 cm. The wound edges were jagged. The wound bed was pink and the peri-wound tissue was normal.</p> <p>There was no wound assessment of the two right inner buttock wounds found completed by the ADON (Wound nurse).</p> <p>On 12/15/2014 at 10:20 a.m., the resident was observed to have a reddened area to her coccyx area with the top layer of skin removed, a reddened area to her right upper inner and right mid buttock with the top layer of skin removed. The right mid buttock wound had an open area in the middle of the wound. The DON indicated during interview, at that time, the right mid inner buttock wound was a new open area since 12/12/14. The wound was open with a red wound bed</p>			

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	<p>and a reddened periwound. The entire area of the buttock and coccyx wounds measured 7.0 x 5.0 x 0.2 cm.</p> <p>During an interview on 12/9/14 at 5:35 p.m., the Assistant Director of Nursing (ADON) indicated she was the wound nurse and she had looked at the resident's heel wounds and they were unstageable, but she did not know Resident #141 had a buttock wound when she was admitted. She indicated the nurses assessed the wounds when the resident was admitted or when a wound was first discovered, then she would assess the wound on the next wound round day.</p> <p>During an interview on 12/09/2014 at 5:40 p.m., the Director of Nursing (DON) indicated she had assessed the resident's wounds to her heels and buttocks upon admission and they were pressure wounds and they all had black and tan wound beds.</p> <p>During an interview on 12/12/2014 at 1:57 p.m., the ADON indicated the resident had newly facility acquired left inner buttock wounds as of 12/8/14. She indicated Resident #141 was to have the Calmoseptine on her coccyx as of 12/5/14 and the Calmoseptine and Mepilex foam dressing on the inner left buttock wounds as of 12/8/14. She</p>			

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	<p>indicated the resident had a 7 x 3 cm area of redness to her buttocks on 12/5/14 when she assessed her wounds. She indicated the resident had open areas on the left inner and left mid buttocks that she had assessed on 12/8/14, but she had not measured, staged or documented them. She indicated the open areas were not assessed on 12/10/14, during wound rounds, so she did not know the status of the open areas as of 12/12/14. She indicated the 6 x 2 x 0.2 cm measurement of the coccyx wound on 12/10/14, included three open areas, but she had only counted this as one pressure ulcer on the coccyx. She indicated these areas opened after the resident was admitted to the facility.</p> <p>During an interview on 12/12/2014 at 3:25 p.m., the DON indicated the resident had non-blanchable redness that measured 7.0 x 3.0 cm to her bilateral inner buttocks that fanned out to the outer buttocks in the shape of a butterfly upon admission to the facility.</p> <p>During an interview on 12/09/2014 at 5:41 p.m., the Regional Director of Health Services (RDHS) indicated the ADON was the wound nurse and she should look at the wounds when a resident was admitted. She indicated the DON should have staged the pressure</p>			

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	<p>wounds to the resident's heels and buttocks when she assessed them upon admission as part of the assessment of the wounds upon admission to the facility on 12/4/14, but only the DON and Wound Nurse (ADON) were allowed per policy to stage wounds, not a regular floor nurse.</p> <p>During an interview on 12/12/14 at 3:25 p.m., the DON indicated she was not aware Resident #141 had open areas to her left inner and mid buttocks that was discovered on 12/8/14, and had not been measured, staged, assessed or documented on the wound rounds on 12/10/14.</p> <p>During an interview on 12/15/2014 at 5:50 p.m., the Administrator indicated the DON indicated to him that she should have staged the resident's buttocks wounds and measured and staged the heel wounds as the policy required her to do when the resident was admitted. He indicated the Initial Wound Evaluation that had the right and left heel wounds stages and measurements on it without a signature or date on the back page, was dated and signed on 12/9/14.</p> <p>b. On 12/11/2014 at 11:25 a.m., RN #2 was observed applying Calmoseptine to Resident #141's three pressure wounds to</p>			

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	<p>her coccyx area and two pressure ulcers to the right upper inner and mid buttocks that were reddened in color with the top layer of skin removed. RN #2 did not apply the Mepilex foam dressing to the resident's right upper inner and right mid buttocks at that time. There was no Mepilex foam dressing observed on the resident's right buttocks when her brief was removed and pericare was completed. The three pressure areas to the coccyx area were reddened in color with the top layer of skin removed.</p> <p>During an interview on 12/12/2014 at 10:21 a.m., RN #2 indicated she should have placed a Mepilex foam dressing on the resident's right upper inner and right mid inner buttocks after applying Calmoseptine on 12/11/14. She indicated when a dressing is displaced the CNA's were supposed to notify the nurse, so the dressing could be reapplied.</p> <p>During an interview on 12/12/14 at 1:57 p.m., the ADON indicated there should have been a Mepilex dressing placed on the resident's right inner and right mid inner buttocks if it had become dislodged as of 12/11/14.</p> <p>During an interview on 12/12/14 at 3:25 p.m., the DON indicated she expected the nurses to immediately reapply a dressing</p>			

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	<p>on a resident's wound that had become dislodged.</p> <p>c. A continuous observation of Resident #141 had occurred on 12/11/14 from 10:00 a.m. until 5:30 p.m. On the following dates and times the resident did not have the Leeder boot on her right lower extremity.</p> <p>12/11/14 at 10:00 a.m., 12/11/14 at 11:15 a.m., 12/11/14 at 11:50 a.m., 12/11/14 at 12:46 p.m., 12/11/14 at 1:11 p.m., 12/11/14 at 1:42 p.m., 12/11/14 at 2:13 p.m., 12/11/14 at 4:00 p.m., 12/15/14 at 8:50 a.m. and 12/15/14 at 5:10 p.m.</p> <p>During an interview on 12/12/14 at 1:57 p.m., the ADON indicated Resident #141 did not have her Leeder boot in place on 12/11/14 when she removed the right heel dressing. The ADON indicated the resident had a Physician order to have the Leeder boot on at all times. At that time, the Scheduler indicated the resident did have her Leeder boot in her room, but it was not on her right lower extremity when the dressing change was completed to her right heel on 12/11/14.</p> <p>A current policy titled "Skin and Wound Management Program Overview" dated 06/01/07, indicated "1.0 Purpose: To present an overall view, description and</p>			

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F000315 SS=D	<p>framework of the Five Star Quality Care's Skin and Wound Management Program...3.0 Procedure: ...4. When a break in skin integrity is identified, the licensed nurse will document a detailed assessment in the medical record including type (pressure ulcer, arterial ulcer, venous insufficiency ulcer/wound etc. if known) size, location, drainage, odor, peri-wound area and wound bed if able to be visualized. Documentation will also contain treatment orders obtained and MD/family notification. The designated wound nurse or the DON/designee will stage the wound within 24 hours of notification for consistency in staging...6. Residents with newly identified or known pressure ulcers/wounds will be assessed by the interdisciplinary team upon notification and weekly thereafter, and a care plan will be developed, implemented, evaluated and re-evaluated to treat actual pressure ulcers/wounds and minimize risks of further occurrences...."</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates</p>			

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	<p>that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to follow urinary catheter bag interventions for a resident with a history of urinary tract infections. This deficient practice affected 1 of 2 residents reviewed for urinary catheter use. (Resident #138).</p> <p>Findings include:</p> <p>On 12/11/2014 at 11:50 a.m., Resident #138's record was reviewed. Diagnoses included, but were not limited to, urinary retention, frequent UTIs (urinary tract infections), hypertension, and BPH (Benign Prostatic Hyperplasia-enlargement of the prostate gland causing difficulty in urination). The resident's record indicated he had a urinary catheter in.</p> <p>On 12/12/2014 at 10:35 a.m., the resident was observed in bed on his back. The resident indicated at this time that therapy had brought him back to his room and he was resting in bed on his back. His urinary catheter was attached to a leg bag. The leg bag was strapped to the inner aspect of his leg. There was urine in the</p>	F000315	<p><b>F315</b> <i>In response to the cited findings R/T to</i> 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER, <i>the following actions will be taken:</i></p> <p><b>A)</b> Subsequent to the surveyor's observations Resident #138's urinary drainage bag was maintained below his bladder and caregivers were reminded of correct placement needs. Currently and during the survey, the community used and uses urinary drainage bags with anti-reflux devices.</p> <p><b>B)</b> All residents with catheter leg bags have the potential to be affected by improper placement of drainage bags. Currently only Resident #138 has a leg bag.</p> <p><b>C)</b> Personnel who provide catheter care and/or care to residents with catheters will be re-trained for correct placement of drainage bags. The DON or her designee will randomly audit for placement of bags on 2/3 shifts for ten days beginning on January 5, 2015 to ensure</p>	01/16/2015

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	<p>bag and some of the urine flowed into the tubing leading to the bladder.</p> <p>On 12/15/2014 at 4:50 p.m., with the ADON (Assistant Director of Nursing) and LPN #4 was present, the resident was observed laying in bed with his urinary catheter attached to the inner aspect of his leg. The catheter bag was half full of urine and the urine was in the tubing leading to his bladder. The resident indicated it was uncomfortable to pee into the tube.</p> <p>During an interview on 12/15/2014 at 5:00 p.m.,CNA #3 indicated she emptied the urinary catheter bag at the end of the shift. If the resident laid down for a nap, he kept his leg bag on. The bag was changed at night to a gravity drainage bag. It was changed first thing in the morning to a leg bag.</p> <p>A current facility policy titled,"Leg Bag," dated 1/1/01, was reviewed on 12/16/2014 at 10:30 a.m. The policy indicated,"...Keep drainage bag lower than bladder at all times...."</p> <p>The resident's care plan dated 12/2/14, indicated, "connect leg bag for drainage bag to gravity at night below bladder level for proper drainage...."</p>		<p>placement requirements are being followed. Any findings will be identified with direct care staff and related education and or counseling will be provided and documented.</p> <p><b>D)</b> The DON or her designee will audit catheter bag placement on 75% of all shifts for the next thirty (30) days. 50% of shifts will be audited bi-weekly for the subsequent thirty (30) days then monthly for the next thirty (30) days. Any found to be inconsistent will be corrected immediately. Personnel associated with errors will be re-trained and/or reprimanded to correct practices as indicated. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E)</b> Date of compliance with proposed actions: January 16, 2015.</p>	

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F000323 SS=D	<p>The resident's record indicated a lab urinalysis had been done on 12/5/14, which indicated the resident had a urinary tract infection with, " moderate bacteria," in which he had just completed treatment for.</p> <p>The resident's care plan titled, "Incontinence Bladder" and dated 12/3/14, indicated the resident was at risk for an altered pattern of urinary elimination related to his benign prostate enlargement. One of the goals was for the resident to be free from signs and symptoms of infection related to his urinary catheter placement. The plan of action included, but was not limited to, catheter care per policy and physician order.</p> <p>3.1-41(a)(2)</p> <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. Based on observation, interview and record review, the facility failed to ensure a safe transfer method was provided to prevent a potential accident hazards for 1 of 1 transfer observation. (Resident #1)</p>	F000323	<p><b>F323</b> <i>In response to the cited findings R/T to</i> 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVI CES,</p>	01/16/2015

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	<p>Findings included :</p> <p>On 12/11/14 at 3:35 p.m., Resident #1 was observed to be very sleepy and mumbling, but not really opening her eyes or responding to touch or verbal stimulation very well. CNA #6 and CNA #7 each placed their arms under each side of the resident's armpit. Then, CNA #6 and #7 lifted the resident up underneath of her armpits with one arm, and lifted the resident up by her pants with the other hand and lifted her from her wheelchair and set her down on the bed. The resident started to yell and opened her eyes.</p> <p>During an interview on 12/11/14 at 3:40 p.m., LPN #8 indicated the aids should have used a gait belt when transferring the resident.</p> <p>During an interview on 12/11/14 at 3:45 p.m., the Director of Nursing indicated that a resident should not have been transferred with the CNA's lifting underneath of the resident's arms. She indicated a Hoyer lift, gait belt, or head and shoulder approach would be best.</p> <p>During an interview on 12/12/2014 at 1:45 p.m., the Administrator indicated the gait belt training documentation that</p>		<p><i>he following actions will be taken:</i></p> <p><b>A)</b> Subsequent to the surveyor's observations Resident #1 has been transferred properly, using a gait belt and/or other safety measures. Personnel were immediately re-trained concerning transfers and gait belt usage.</p> <p><b>B)</b> All residents who require assistance with transfers are subject to this alleged deficient practice.</p> <p><b>C)</b> Residents in need of assistance with transfers will be identified by the MDS nurse. Personnel who assistance with transfers will be re-trained for correct technique and/or utilization of safety equipment (gait belts). The DON or her designee will randomly audit for safe transfers on 2/3 shifts for ten days beginning on January 5, 2015 to ensure protocols are being followed. Any findings will be identified with direct care staff and related education and or counseling will be provided and documented.</p> <p><b>D)</b> The DON or her designee will audit for safe transfers on 75% of all shifts for the next thirty (30) days. 50% of shifts will be audited bi-weekly for the subsequent thirty (30) days then monthly for the next thirty (30)</p>		

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F000327 SS=D	<p>the CNA's were given and signed, indicated the understanding of the use of a gait belt, and when and how to use a gait belt.</p> <p>The Certified Nursing Aid job description dated 12/1/01, was signed in agreement by both CNA #6 and #7 on their hire dates, which indicated, "...10. Utilize proper techniques and devices to transfer and position/re-position a resident...."</p> <p>The Transfer Policy dated 11/1/01, indicated, "...3.0 PROCEDURE...Using a transfer belt during activities...The resident should wear a transfer belt whenever he or she is being transferred. A transfer belt is used for all transfer activities for the following reasons: To provide a firm grasping surface for the staff person, To protect the resident from accidental trauma to skin. To give the resident a sense of security. To allow the staff person to lower the resident gradually (to the floor if necessary ) without injury to either party...."</p> <p>3.1-45(a)(2)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with</p>				<p>days. Any transfers found to be inconsistent with safe techniques will be corrected immediately. Personnel will be re-trained and/or reprimanded to correct practices as indicated. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E)</b> Date of compliance with proposed actions: January 16, 2015.</p>		

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	<p>sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received adequate fluids for 1 of 1 residents reviewed for hydration. (Resident # 1)</p> <p>Findings included:</p> <p>On 12/11/14 at 10:30 a.m., the record review for Resident #1 was completed. Diagnoses included, but were not limited to, dementia depression, high blood pressure and anxiety.</p> <p>A nurse's note dated 4/30/14, indicated the resident was having paranoid behavior and that the resident would not drink water believing it was poisoned and would only drink cranberry and orange juice combined. A nurse's note dated 9/25/14, indicated the resident had told staff she knew they had poisoned the drink they had offered her.</p> <p>A Care Plan dated 12/8/14, indicated, "...At risk for exhibiting paranoid delusions as evidence by that staff is poisoning her water..."</p> <p>On 12/11/2014 12:47 p.m., a pitcher of water was observed underneath the resident's television on a dresser. The</p>	F000327	<p><b>F327</b></p> <p><i>In response to the cited findings R/T to 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION, the following actions will be taken:</i></p> <p><b>A)</b> Resident #1 was the only resident identified as being at risk for dehydration. Subsequent to surveyor observations, the resident was offered fluids in the form of ice cream, jello, popsicles and other high volume liquid foods. Success is impeded by the resident's continuing paranoid delusions.</p> <p><b>B)</b> All residents with a history of paranoid behaviors and fear of being poisoned via drink are at risk for the alleged deficient practice. Residents at risk or with recent history of dehydration will be identified by the MDS Nurse and/or Medical Records Clerk.</p> <p><b>C)</b> Personnel will be re-trained as indicated to ensure ongoing compliance with avoidance of dehydration. Interventions will include frequent offers of drink, varied options of beverages, ice chips, soups and other high volume liquid foods.</p> <p><b>D)</b> The DON or her designee</p>	01/16/2015

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	<p>water pitcher was 1/4 full of thin liquid. .</p> <p>On 12/11/2014 2:50 p.m., a full fresh pitcher of ice water was setting on the resident's dresser.</p> <p>On 12/11/14 at 3:35 p.m., the resident's tongue was observed to be very dry in appearance. At 3:37 p.m., CNA #7 indicated the resident was given by the CNA's a combination of orange and cranberry juice to drink since she did not like water.</p> <p>On 12/11/14 at 4:00 p.m., a request was made of the Director of Nursing for any information regarding interventions to increase fluid consumption.</p> <p>The hospice nurse documentation dated 11/5/14, 11/19/14 and 12/3/14, indicated,"...fluid adequacy (&gt;1000 cc (cubic centimeters) or four 8 oz.(ounces) cups/day: Inadequate as evidence by poor turgor...."</p> <p>On 12/16/2014 10:00 a.m., the Dietician indicated she had not been aware the resident had a fear of drinking water. She indicated she only knew that they offered her lemonade and juice at meals.</p> <p>The meal intake records for consumption of fluids for November and December</p>		<p>will randomly audit 25% of fluid intake records for such residents for ten days beginning January 5, 2015. Interventions will be put into place to address any at-risk individuals. The DON or her designee will audit 50% of fluid intake records for at-risk residents bi-weekly for the subsequent thirty (30) days then monthly for the next thirty (30) days. Any personnel found to be out of compliance with dehydration avoidance protocols will be re-trained and/or reprimanded as indicated. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>E)</b> Date of compliance with proposed actions: January 16, 2015.</p>		

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	<p>2014 indicated :</p> <p>11/1/14 : Resident refused fluids</p> <p>11/2/14 : 480 milliliters (ML)</p> <p>11/3/14 : 600 ML</p> <p>11/4/14 : 240 ML</p> <p>11/5/14 : 480 ML</p> <p>11/12/14 : 620 ML</p> <p>11/13/14 : 240 ML</p> <p>11/14/14: 1080 ML</p> <p>11/15/14 : 420 ML</p> <p>11/16/14 : 480 ML</p> <p>11/17/14 : 480 ML</p> <p>11/18/14 : 600 ML</p> <p>11/19/14 : 300 ML</p> <p>11/26/14 : 480 ML</p> <p>11/27/14 : 120 ML</p> <p>11/28/14 : 480 ML</p> <p>11/29/14 : 480 ML</p> <p>11/30/14 : 420 ML</p> <p>12/1/14 : 290 ML</p> <p>12/2/14 : 480 ML</p> <p>12/3/14 : 420 ML</p> <p>The Hydration/Fluid Management, dated 1/5/11, indicated, "...4.0 PROCEDURES ...2. Fluid will be offered to each resident during, in-between meals and during activities (unless contraindicated)...4. If the resident refuses water, alternative acceptable fluids will be offered...."</p> <p>3.1-46(b)</p>			

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F000329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to monitor specific targeted behaviors to support the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary drugs. (Resident #1)</p> <p>Findings included:</p> <p>1. On 12/11/14 at 10:30 a.m., the record review for Resident #1 was completed. Diagnoses included, but were not limited to, dementia depression, high blood</p>	F000329	<p><b>F329</b></p> <p><i>In response to the cited findings R/T to 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS, the following actions will be taken:</i></p> <p><b>A)</b> Resident #1's had behavior documentation revised in December to reflect observations of symptoms/behaviors for corresponding psychotropic medications. Behaviors will continue to be monitored daily and interventions implemented in</p>	01/16/2015

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	<p>pressure and anxiety.</p> <p>The physician's recapitulation for December 2014, indicated the resident had an order dated 2/10/14, for Quetiapine fumarate (an antipsychotic medication) 50 milligrams 1 tablet orally 2 times a day for atypical psychosis, 25 milligrams every evening with 50 milligrams to total 75 milligrams</p> <p>A psychiatric follow up note dated 2/27/14, indicated, "...Patient seen for psych eval [evaluation] secondary to physician order due to behaviors, agitation, aggression, dep [depression] anx. [anxiety] by chronic non-compliance. Staff reports patient continues to yell out 'help' or 'oh god' and can still be agitated...aggression with care new on Norco BID...Seroquel decreased recently GDR [gradual dose reduction] to 50 mg q [every] am and 75 mg q hs [bedtime]. Wellbutrin 37.5 mg (8/13)...history that patient won't drink water due to believing it is poisoned by staff...."</p> <p>A nurse's note dated 4/30/14, indicated the resident was having paranoid behavior and that the resident would not drink water believing it was poisoned and would only drink cranberry and orange juice combined. A nurse's note dated</p>		<p>accordance with the care plan.</p> <p><b>B)</b> All residents who receive psychotropic medications have the potential to be affected by this alleged deficient practice. Residents utilizing psychoactive medications were reviewed in December, 2014 with behaviors updated as indicated to support the use of the medication. Residents utilizing psychoactive medications were reviewed in December, 2014</p> <p><b>C)</b> Pharmacy/MD recommendations for GDR will be followed per state/federal guidelines for all residents receiving psychotropic medications. Community will continue to conduct monthly behavior meetings with pertinent members to review behaviors and GDR recommendations. Care plans will be scheduled with residents/responsible parties as needed to ensure education and improve compliance. Staff training will be completed regarding appropriate behavior monitoring, as well as observation and documentation with the GDR process to ensure optimal management with resident behaviors. Compliance data will be referred to the Quality Assurance Committee for review and recommendations.</p> <p><b>D)</b> Date of compliance with</p>	

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	<p>9/25/14, indicated the resident had told staff she knew they had poisoned the drink they had offered her. The resident frequently would attempt to hit staff, was verbally aggressive and scratched and cussed at staff.</p> <p>A Care Plan dated 12/8/14, indicated, "...resident receiving psychiatric consult services per MD order to provide supportive counseling and/or Neurological/Psychiatric, evaluation for education and long range planning... resident is currently receiving Seroquel for a dx (diagnosis) of atypical psychosis. At risk for exhibiting paranoid delusions as evidence by that staff is poisoning her water, yelling out hitting staff...plan of action/approach: approach in calm manner, re-approach and allow resident to calm down before re-approaching, alternate care givers, adjust room temperature, engage in meaningful activity, encourage and assist resident to activity programs, offer fluids/snacks, and redirect/assist resident to a less stimulated environment...."</p> <p>The behavior tracking sheets for February through November 2014, were reviewed. The behavior tracking sheets for February and March 2014, indicated paranoia, the April-November behavior sheets indicated hitting and mood changes as the</p>		proposed actions: January 16, 2015.		

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R000000	<p>behaviors being monitored for the use of Seroquel. Paranoia was not a behavior being tracked.</p> <p>During an interview on 12/16/2014 9:36 a.m., the Social Service Director indicated she was new to the position and she had started tracking the behaviors specifically for residents in the last few months, and prior to that the nursing staff were doing it. She indicated the main behavior being monitored for the use of Seroquel was paranoia.</p> <p>3.1-48(a)(3)</p>	R000000		
R000117	<p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential</p>			

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	<p>nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure there was a CPR (cardiopulmonary resuscitation) and first aid certified staff member in the facility available for residents at all times. This had the potential to affect 18 of 18 residents currently residing in the facility.</p> <p>Findings include:</p> <p>The employee records were reviewed on 12/17/2014 at 9:20 a.m. The employee CPR and First Aid certifications were reviewed.</p> <p>RN #5 was the only staff member in the nursing facility that had CPR and First Aid certifications.</p> <p>During an interview on 12/17/14 at 2:30 p.m., the Administrator indicated he did not have anymore staff members that were CPR or First Aid certified.</p>	R000117	<p><b>R117</b> <i>In response to the cited findings R/T to R117 - 410 IAC 16.2-5-1.4(b) Personnel, the following actions will be taken:</i></p> <p><b>A)</b> No residents had immediate CPR needs within the past twelve (12) months on the unit surveyed. First aid is and has been provided by licensed nurses assigned to this unit and/or the skilled nursing facility. They are available 24-hours/day.</p> <p><b>B)</b> All resident have the potential to be affected by unavailability of CPR/First Aid-certified personnel.</p> <p><b>C)</b> Training is under arrangement and will be conducted as soon as practical to meet this requirement. Appropriately certified staff members will be scheduled to ensure as many shifts as possible have coverage until 100% of</p>	01/16/2015

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R000354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s:		shifts can be covered. CPR/First Aid training will be provided to staff members without certificates in three segments. The initial group will be trained on or before January 14, 2015, the next group will be trained on or before January 28, 2014 and the final group will be trained on or before February 11, 2015.  <b>D)</b> The Memory Care (Residential Care) Manager will oversee staffing schedules to ensure all shifts have at least one (1) CPR/First Aid certified staff member in place. In the future, the Manager will monitor expiration dates of certificates and staff turnover to ensure training is provided for ongoing compliance.  <b>E)</b> Date of compliance with proposed actions: January 14, 2015, January 28, 2015 and February 11, 2015.		

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	<p>(A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to have a completed transfer paper for a resident. This affected 1 of 2 resident's reviewed for transfers(Resident #618).</p> <p>Findings include:</p> <p>Resident #618's record was reviewed on 12/17/2014 at 10:45 a.m. Diagnoses, included but were not limited to, altered mental status, dementia, and depression.</p> <p>The resident's record indicated the resident was sent to the hospital after a fall on 10/28/2014. The record lacked a transfer form.</p> <p>During an interview on 12/17/2014, the Memory Care Director indicated she was not sure where the transfer form was, but she would look for it.</p> <p>As of exit on 12/17/2014 at 4 p.m., the facility was unable to locate the transfer form.</p>	R000354	<p><b>R354</b> In response to the cited findings R/T to R354 - 410 IAC 16.2-5-1-8 1(g)(1-7) Clinical Records, the following actions will be taken: <b>A)</b> The cited resident had no adverse outcome as a result of incomplete clinical records being available. <b>B)</b> All resident have the potential to be affected by incomplete or missing clinical records. <b>C)</b> Staff members who facilitate resident transfers to other health providers will be trained to use transfer forms including the following information:</p> <p>(1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and</p>	01/16/2015

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			<p>(E) current diet and condition on transfer.</p> <p>(6) Diagnosis.</p> <p>(7) Date of chest x-ray and skin test for tuberculosis</p> <p><b>D) The Memory Care (Residential Care) Manager or her designee will audit 100% of transfer records for the next thirty (30) days. 50% of related records will be audited bi-weekly for the subsequent thirty (30) days then monthly for the next thirty (30) days. Any found to be inconsistent will be corrected immediately. Personnel associated with errors will be re-trained and/or reprimanded to correct records and practices as indicated.</b></p> <p><b>E) Date of compliance: January 16, 2015</b></p>		