

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155275	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF PRINCETON THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 W VINE ST PRINCETON, IN 47670
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F000000	<p>This visit was for the Investigation of Complaint IN00126491.</p> <p>Complaint IN00126491- Substantiated, Federal/State deficiencies are cited at F272 and F314.</p> <p>Survey dates: April 4 and 5, 2013</p> <p>Facility number: 000175 Provider number: 155275 AIM number: 100274440</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 17 Medicaid: 41 Other: 4 Total: 62</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</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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	Quality review completed on April 9, 2013, by Jodi Meyer, RN			

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure a Minimum Data Set [MDS] assessment was accurate regarding skin ulcers, for 1 of 3 residents reviewed with ulcers, in a sample of 3.</p>	F000272	It is the intent of this facility to ensure a MDS assessment is accurate regarding skin ulcers. 1. Action Taken 1. MDS Coordinator was inserviced/educated on correct	04/15/2013

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	<p>Resident C</p> <p>Findings include:</p> <p>On 4/4/13 at 10:00 A.M., the closed clinical record of Resident C was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, and Alzheimer's disease.</p> <p>A Physician's order, dated 12/19/12 and on the March 2013 orders, indicated, "Treatment, [Left] heel apply skin prep, cover [with] ABD pad, wrap [with] kerlix."</p> <p>An additional Resident Care Plan, dated 12/12 and updated 2/28/13, indicated, "Blister to Lt [left] heel vascular Stage 2." The Nursing interventions included: "Tx [treatment] as ordered...Skin check [with] care [and] wkly...Notify Dr. as needed."</p> <p>Skin assessment sheets included the following:</p> <p>"3/4/13, Wound type: blister, Location: [Left] heel, Length, Width, Depth: 2.1 x 2.2 cm [centimeters], Color: red, Drainage: serosang [thin bloody], Odor [none]. Current treatment: Clean, cover [with] COPA [cushioned dressing] [and] kerlix, skin prep."</p>		<p>coding of the MDS regarding accuracy of skin ulcers. 2. The MDS for Resident C was middified with the accurate information related to the ulcers. 2. Others Identified 1. 100% audit completed on all residents and no other areas were identified 2. Audit was completed for a 30 day look back window for discharged residents to assure MDS is accurate. 3. Systems in Place 1. DON/Designee to review MDS's daily for any resident with breakdown for proper coding. 4. Monitoring 1.DON/Designee to monitior MDS of any resident with breakdown to ensure proper coding done on the MDS,will be monitored ongoing and adressed at monthly QA until deemed by Committee as unnnecessary to continue monitoring. 2. Any issues/findings identified will be immediately addressed. Any issues identified will be discussed in daily stand up meeting. Any findings will be discussed with Medical Director at Quarterly QA meeting and as needed. 5. Date of compliance 1. 4/15/13</p>	

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	<p>A Minimum Data Set [MDS] assessment, dated 3/5/13, indicated Resident C had no pressure areas, no foot lesions, and no arterial or venous ulcers.</p> <p>On 4/5/13 at 10:40 A.M., during interview with the Director of Nursing [DON], she indicated the MDS Coordinator should review the skin sheets to determine what to code on the MDS assessment.</p> <p>This federal tag relates to Complaint IN00126491.</p> <p>3.1-31(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 interview and record review, the facility failed to ensure a resident dependent for care received adequate pressure ulcer treatment, in that the facility failed to notify the physician and obtain treatment for a documented right heel ulcer and coccyx ulcer, and failed to identify additional pressure ulcers on a resident's hip and scrotum, resulting in multiple ulcers including 2 draining heel ulcers, for 1 of 3 residents reviewed with pressure areas, in a sample of 3. Resident C</p> <p>Findings include:</p> <p>1. On 4/4/13 at 10:00 A.M., the closed clinical record of Resident C was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, diabetes mellitus, and Alzheimer's disease.</p>	F000314	<p>It is the intent of this facility to ensure that residents dependent for care receive adequate pressure ulcer treatment, the physicians are notified, treatments are obtained and all areas are properly identified. 1. Action Taken A. 100% audit of ALL current residents to ensure no undocumented pressure areas was completed. B. All weekly skin records were reviewed of residents with breakdown to ensure MD notification and treatments were in place. C. All nurses were in-serviced on MD notification, treatments for wounds, and the skin QA program and policy. D. The nursing staff was in-serviced on the shower sheets and procedure to notify the nurse on any abnormal areas. E. The CNA care guide was updated to include any residents with actual open areas and who is at risk and with current interventions. 2. Others Identified A. No other</p>	04/15/2013			

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	<p>A Physician's order, dated 12/19/12 and on the March 2013 orders, indicated, "Treatment, [Left] heel apply skin prep, cover [with] ABD pad, wrap [with] kerlix."</p> <p>On 4/5/13 at 12:00 P.M., Medical Records staff # 1 provided a Nursing Summary and Braden Scale for Predicting Pressure Sore Risk, dated 2/22/13. The Summary included: "...confused @ times, Does not walk...total assist [with] ADLs [activities of daily living], dressing, bathing, toileting..." The Braden Scale included: Sensory Perception Slightly Limited, Skin Constantly Moist, Activity Chairfast, Mobility Very Limited, Nutrition Probably Inadequate, and Friction and Shear Potential Problem. The Total Score was 12 ["High Risk: Total Score [equal or below] 12]."</p> <p>A Resident Care Plan, dated 6/5/12 and updated 2/28/13, indicated, "Potential for skin breakdown." The Nursing interventions included: "1. Enc. [encourage] turn, reposition...Skin check wkly [weekly] [and] PRN [as needed]. 6. Notify Dr. of changes."</p> <p>An additional Resident Care Plan, dated 12/12 and updated 2/28/13, indicated, "Blister to Lt [left] heel vascular Stage 2." The Nursing interventions included: "Tx</p>		<p>residents were identified. 3. Systems In Place A. A nurse is identified and will complete a weekly round of all areas. B. Weekly PAR meeting to be completed with the IDT team. C. Daily stand up meeting - New or worsening areas to be discussed per the skin QA program. D. All residents to receive a weekly skin check with follow up per program as needed. 4. Monitoring will be ongoing and addressed at each montly QA/medical Director meeting until deemed unnecessary to continue monitoring. A. Any issues/findings identified will be immediately addressed. Any issues identified will be discussed in daily stand up meeting. Any findings will be discussed with Medical Director at quarterly QA meeting and as needed. 5. Date of Compliance. 1. 4/15/13</p>		

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	<p>[treatment] as ordered...Skin check [with] care [and] wkly...Notify Dr. as needed."</p> <p>A Minimum Data Set [MDS] assessment, dated 3/5/13, indicated Resident C scored a 8 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident was totally dependent on one staff for bed mobility and dressing, and totally dependent on two + staff for transfer. The resident did not ambulate. The MDS assessment incorrectly indicated the resident had no pressure areas, no foot lesions, and no arterial or venous ulcers.</p> <p>Skin assessment sheets included the following:</p> <p>"3/4/13, Wound type: blister, Location: [Left] heel, Length, Width, Depth: 2.1 x 2.2 cm [centimeters], Color: red, Drainage: serosang [thin bloody], Odor [none]. Current treatment: Clean, cover [with] COPA [cushioned dressing] [and] kerlix, skin prep."</p> <p>"3/11/13, Wound Type: blister, Location: [Left] heel, Length, Width, Depth 2.8 x 3.8, Color: black soft center, Drainage: small amts...Current Treatment, Clean, cover [with] COPA [and] kerlix, skin prep."</p>						

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	<p>"3/18/13, Wound Type: blister, Location: [Left] heel, Length, Width, Depth 2.8 x 5 cm, Color: black [with] soft surrounding tissue, Drainage: minute...Current Treatment, Clean, cover [with] skin prep, COPA [and] kerlix."</p> <p>An additional skin assessment sheet, dated 3/18/13, indicated, "Wound Type: blister open, Location: [Right] heel, Length, Width Depth: 4 x 5.2, Color: red [and] black...Current Treatment: [left blank]."</p> <p>Documentation that the physician was notified of the right heel area, or treatment received for the area, was not observed in the clinical record.</p> <p>An additional skin assessment, dated 3/23/13, indicated, "Location, coccyx, Length width depth: 2.5 x 1.2, Color, red, Tissue Type Code: 2, Tx Progress [left blank]."</p> <p>Nurse's Notes, dated 3/23/13 at 1:30 P.M., indicated: "...Res [resident]...unable to swallow food @ this time. Yellowish discharge noted from penis foreskin. Dr. notified and ordered to send Res. to hospital for eval and treat."</p> <p>The resident was transferred to the hospital on 3/23/13 at 2:30 P.M. A</p>			

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	<p>facility transfer form, dated 3/23/13, indicated: "Presence of Decubitus: Yes, coccyx...."</p> <p>A hospital Emergency Room record, dated 3/23/13 at 2:50 P.M., indicated, "Chief Complaint:...Pt. [patient] has decub [pressure ulcer] on Lt. [left] hip and coccyx, decub on scrotom [sic] and decub on heels...Pt. has decub on Rt. [right] heel that is approx. [approximately] 5 cm [centimeters] x 4 cm and is black and draining brown liquid...Lt heel has decub that is approx 7 cm x 4.5 cm and is black with some yellow tissue above it and draining brown liquid...Left hip has area that is red with small abrasions. Scrotum is red, swollen and has an open place that is draining yellow fluid...Coccyx has wound that is not draining, red...6:30 P.M. Decub to both heels have strong foul odor...."</p> <p>On 4/4/13 at 1:45 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was the nurse who had performed the weekly skin assessments, and had sent the resident out to the hospital on 3/23/13. Regarding the skin assessment sheets, LPN # 1 at first indicated both of the resident's heels had open areas. LPN # 1 then indicated she must have written "right heel" by mistake, and had meant the left heel. LPN # 1 indicated the</p>			

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	<p>resident's coccyx had been red, and that she had informed the Director of Nursing about that. LPN # 1 indicated the resident's coccyx "opened up" the morning of 3/23/13, and she had not informed the physician prior to the resident being transferred to the hospital.</p> <p>On 4/5/13 at 10:25 A.M., facility inservices for the year were reviewed. There were no inservices regarding skin care or wound care for the years 2012 or 2013.</p> <p>An inservice, dated 2/11/13, indicated, "Resident Care." CNA assignment sheets were attached to the inservice. Resident C's entry indicated, "...Special Instructions, confused, brush teeth, total assist." The assignment sheet did not address skin prevention care measures.</p> <p>On 4/5/13 at 10:40 A.M., the Administrator and Director of Nursing [DON] were interviewed. The Administrator indicated she had been at the facility approximately 2 weeks. The DON indicated nursing staff are to check and measure residents' wounds weekly. The DON indicated Resident C had wounds to both heels, and she was unsure why there was no treatment order for the right heel. The DON indicated they had found the resident's open area on his</p>						

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	<p>coccyx the morning of 3/23/13. The DON indicated she was unaware of additional open areas.</p> <p>2. Stages of Pressure Ulcers, AMDA - 2008, includes the following information: <u>Suspected Deep Tissue Injury</u>: Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissues. <u>Stage I</u> : Intact skin with nonblanchable redness of a localized area, usually over a bony prominence. <u>Stage II</u>: 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. <u>Stage III</u>: 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. <u>Stage IV</u>: 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. <u>Unstageable</u>: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow,</p>			

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	<p>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>3. On 4/5/13 at 9:00 A.M., the Director of Nursing provided the current facility policy on "Pressure Ulcer Assessment and Staging," dated 7/1/11. The policy included, "Guideline: When a pressure area is identified, an accurate assessment will be completed; a treatment program will be initiated and monitored...Procedure: 1. When the Charge Nurse is aware of skin breakdown, whether in-house or upon a resident's admission, area is assessed and initial treatment started per physician orders...Initiate a treatment sheet and complete the Pressure Sore Report. Document site, stage, size, depth, drainage, color, odor, prevention and treatment response. 4. The physician's order will include: a) type of treatment, b) how often to be done c) how to be cleaned, if appropriate d) site of application...6. The physician is to be notified when a pressure sore develops and skin conditions do not show improvement within 2 weeks...Skin Condition Monitoring...1) When the Charge Nurse is aware of skin lesions,</p>						

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	<p>wound, venous ulcers, or other skin abnormalities, the area is to be assessed and documented...3) Initiate treatment per Physician's order...4) Documentation of skin conditions must occur upon identification and at least once each week...Quality Assurance Skin Assessment...1) Observations of a resident's skin are made upon each time the resident is provided person care [sic] by the CNA's and licensed nurses...."</p> <p>This federal tag relates to Complaint IN00126491.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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