

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F000000	<p>This visit was for the Investigation of Complaint IN00134055.</p> <p>Complaint IN00134055-Substantiated. Federal/state deficiencies related to the allegations are cited at F225, F226, and F309.</p> <p>Survey dates: August 19 & 20, 2013</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Janet Adams, RN, TC</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 7 Medicaid: 39 Other: 10 Total: 56</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. This facility respectfully requests consideration of paper</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	IAC 16.2. Quality review completed on August 26, 2013, by Janelyn Kulik, RN.		compliance for the cited deficiencies.	

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, record review,</p>	F000225	What corrective action(s) will be	09/18/2013			

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	<p>and interview, the facility failed to ensure injuries of unknown original were thoroughly investigated related to a skin tear and a bruise not investigated for 1 of 3 residents reviewed for injuries of unknown origin in the sample of 9. (Resident # H)</p> <p>Findings include:</p> <p>On 8/19/13 at 4:00 p.m., Resident #H was observed sitting in a wheelchair in the hallway across from the Nurses' Station. The resident was wearing a short sleeve blue shirt. The resident had a skin tear covered with steri strip's (adhesive cloth strips used to keep a wound closed) in place to an area around his left elbow.</p> <p>The record for Resident #H was reviewed on 8/19/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease, high blood pressure, diabetes mellitus, coronary artery disease, and psychotic disorder with delusions.</p> <p>A Minimum Data Set (MDS) quarterly assessment was completed on 6/28/13. The assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 10. This</p>		<p>accomplished for those residents found to have been affected by the deficient practice: The facility conducted an investigation to determine the cause of the skin tear and bruised area to Resident H left and right forearms. The skin tear is now healed and the bruise is fading in color How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility resident skin integrity audit was completed to identify any skin issues requiring additional investigation if the cause is uncertain. No issues were identified via this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur : Licensed Nursing Staff were inserviced on by the Staff Development Coordinator regarding the policy and procedure for timely investigation of bruises and skin tears of unknown origin. This education was completed 8/31/13. Investigations will be conducted by Nursing Administration and discussed with the interdisciplinary team during the daily clinical meeting (Monday through Friday). Facility staff were also inserviced on use of the Interact "Stop and Watch" forms to report any skin related issues to the licensed nurse in a timely manner. How the</p>		

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	<p>indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of one staff member for transfers, bed mobility, dressing, and hygiene. The assessment also indicated the resident had no ulcers or skin tears.</p> <p>A care plan initiated on 11/20/12 indicated the resident was at risk for abnormal bleeding or hemorrhage due to receiving an anticoagulant medication. The care plan was last reviewed on 7/12/13. Care plan interventions were to observed the resident and report any signs or symptoms such as bleeding gums, nose bleeds, or unusual bruising.</p> <p>Review of the 8/13 Physician Order Statement indicated the resident was to receive Plavix (a medication to prevent clots by thinning the blood) 75 milligrams once a day. The Physician's order for the Plavix was originally received on 10/11/12. There were no Physician orders written on 8/9/13 related to any skin tears.</p> <p>The July 2013 Nursing Progress</p>		<p>corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing or designee will conduct an audit of the completed "Stop and Watch" Forms and 5 resident skin records on a weekly basis for 12 weeks and byweekly for 8 weeks then monthly for 2 months until a 90-100% threshold is acheived to insure an investigation was initiated if deemed necessary all corresponding documentation was completed per facility protocol. Staff education to be provided as necessary. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain is: 9/18/13</p>		

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	<p>Notes were reviewed. An entry made on 7/18/13 at 12:33 p.m. indicated the Nurse was notified of a 8.9 cm (centimeter) x 4.0 cm and a 5.2 cm x 1.0 cm discolorations to the right forearm. The areas were purple in color, the skin was intact, and the resident propelled himself in the wheelchair. The Physician and the family were notified and no new orders were given by the Physician. An entry made on 7/18/13 at 9:57 p.m. indicated the resident denied pain or discomfort to the right forearm. An entry made on 7/19/13 at 6:35 a.m. indicated the resident continued to have bruising to the right upper arm and geri sleeves (cloth coverings to protect the skin on the arms and hands) were being worn.</p> <p>The August 2013 Nursing Progress Notes were reviewed. The first entry made in August was dated 8/16/13 at 1:45 p.m. There was no documentation of any skin tears or bruises in this entry.</p> <p>A Non- Pressure Skin Condition Record was initiated on 8/9/13. The form indicated a skin tear was noted to the resident's left forearm. The skin tear measured 1.5 cm x 1 cm with no necrotic skin, a scant amount of drainage, and the wound color was</p>			

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	<p>red/pink. The entry noted the Physician was notified</p> <p>Review of the August 2013 Treatment Administration Record (TAR) indicated a treatment to monitor the skin strips to the left forearm for signs and symptoms on the 7-1, 3-11, and 11-7 shifts until they fall off was written on the TAR. This treatment was signed off as completed 8/9/13 through 8/19/13.</p> <p>An "Incident/Accident Data Entry Questionnaire" form was initiated on 7/18/13 at 12:00 a.m. This form was completed by Nursing staff and indicated Resident #H was observed with purple discoloration to the right forearm and there were no witnesses to the incident. The form indicated the Physician and the resident's family/legal representative were notified on 7/18/13. The form also indicated the resident was currently receiving anti coagulant medications. There was no facility or management investigation completed related to the above right forearm bruise.</p> <p>There was no "Incident/Accident Data Entry Questionnaire" form completed on 8/9/13 for the left forearm skin tear. There was no facility or management investigation related to</p>				

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	<p>the above left forearm skin tear.</p> <p>When interviewed on 8/19/13 at 12:00 p.m., the facility Nurse Consultant indicated the facility protocol was for the staff member first noting any injury or accident to fill out the Incident/Accident Data Entry Questionnaire and this was then reviewed by management and an investigation was initiated to determine the cause of the event.</p> <p>When interviewed on 8/19/13 at 12:15 p.m., the Director of Nursing indicated the incident forms (Incident/Accident Data Entry Questionnaire) were completed on the computer and she had access to them. The Director of Nursing also indicated the procedure was also for management to review incident reports, 24 hour Nursing shift reports, and new Physician orders at each daily AM meeting with several department heads present and then a complete investigation was started. The Director of Nursing indicated an "Incident Follow-Up & Recommendation" form was used for investigations.</p> <p>When interviewed on 8/20/13 at 7:45 a.m., the Director of Nursing indicated there was an Incident/Accident Data</p>				

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	<p>Entry form initiated by the Nurse on 7/18/13 and this must have been missed as an investigation was never initiated. The Director of Nursing indicated an incident report form had not been completed on 8/9/13. The Director of Nursing indicated the staff were signing out a treatment to monitor the area but the Nurse did not write the order, nor did this skin tear appear on the 24 hour report so the skin tear was not investigated as the Nurse did treat the area and notified the Physician but failed to write the order to monitor, start an Incident form, or include the information about the new skin tear on the 24 hour report.</p> <p>The facility policy titled "Protection of the Residents: Reducing the Threat of Abuse and Neglect" was reviewed on 8/19/13 at 10:35 a.m. The facility Administrator provided the policy and indicated the policy was current. There was no date on the policy. The policy indicated all reports of abuse would be investigated promptly and thoroughly. The policy also indicated "All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) were to promptly reported.</p>			

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	<p>This federal tag relates to Complaint IN00134055.</p> <p>3.1-28(d)</p>			

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F000226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, record, review, and interview, the facility failed to follow the facility Abuse policies related to the lack of investigations of injuries of unknown origin for 1 of 3 resident's reviewed for injuries of unknown origin in the sample of 9. (Resident #H)</p> <p>The facility also failed to follow their Abuse Policies related to the Elder Justice Act in regards to ensuring documentation was complete verifying Student Nurses and CNA's received information on the Elder Justice Act.</p> <p>Findings include:</p> <p>1. The record for Resident #H was reviewed on 8/19/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease, high blood pressure, diabetes mellitus, coronary artery disease, and psychotic disorder with delusions.</p>	F000226	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The facility conducted an investigation to determine the cause of the skin tear and bruised area to Resident H left and right forearms. The skin tear is now healed and the bruise is fading in color and smaller in size as documented on the Non-Pressure Skin Record. The facility Staff Development Coordinator completed inservice training related to the Elder Justice Act with each nurse and C.N.A student currently completing clinical rotations in the facility. Verification of understanding by the students was completed by each signing an acknowledgement. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility resident skin integrity audit was completed to identify any skin issues requiring additional investigation if the cause is uncertain. No issues were identified via this audit. An audit of the vendors who visit the facility was completed by the</p>	09/18/2013	

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	<p>A Minimum Data Set (MDS) quarterly assessment was completed on 6/28/13. The assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was 10. This indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of one staff member for transfers, bed mobility, dressing, and hygiene. The assessment also indicated the resident had no ulcers or skin tears.</p> <p>The July 2013 Nursing Progress Notes were reviewed. An entry made on 7/18/13 at 12:33 p.m. indicated the Nurse was notified of a 8.9 cm (centimeter) x 4.0 cm and a 5.2 cm x 1.0 cm discolorations to the right forearm. The areas were purple in color, the skin was intact, and the resident propelled himself in the wheelchair. The Physician and the family were notified and no new orders were given by the Physician. An entry made on 7/18/13 at 9:57 p.m. indicated the resident denied pain or discomfort to the right forearm. An entry made on 7/19/13 at 6:35 a.m. indicated the resident continued to have bruising to the right</p>		<p>facility Executive Director to ensure that education related to the Elder justice Act was completed and acknowledgements signed. Issues were addressed immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nursing Staff were inserviced on by the Staff Development Coordinator regarding the policy and procedure for timely investigation of bruises and skin tears of unknown origin. This education was completed 8/31/13. Investigations will be conducted by Nursing Administration and discussed with the interdisciplinary team during the daily clinical meeting (Monday through Friday). Facility staff were also inserviced on use of the Interact "Stop and Watch" forms to report any skin related issues to the licensed nurse in a timely manner. The Executive Director completed educational training with the corporate nurse related to the Elder Justice Act and educational of vendors. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Director of Nursing or designee will conduct an audit of the completed "Stop and Watch" Forms and 5 resident skin records on a weekly basis for 12 weeks and byweekly for 8 weeks then monthly for 2 months</p>				

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	<p>upper arm and geri sleeves (cloth coverings to protect the skin on the arms and hands) were being worn.</p> <p>The August 2013 Nursing Progress Notes were reviewed. The first entry made in August was dated 8/16/13 at 1:45 p.m. There was no documentation of any skin tears or bruises in this entry.</p> <p>An "Incident/Accident Data Entry Questionnaire" form was initiated on 7/18/13 at 12:00 a.m. This form was completed by Nursing staff and indicated the Resident #H was observed with purple discoloration to the right forearm and there were no witnesses to the incident. The form indicated the Physician and the resident's family/legal representative were notified on 7/18/13. The form also indicated the resident was currently receiving anti coagulant medications. There was no facility or management investigation completed related to the above right forearm bruise.</p> <p>There was no "Incident/Accident Data Entry Questionnaire" form completed on 8/9/13 for the left forearm skin tear. There was no facility or management investigation related to the above left forearm skin tear.</p>		<p>until a 90-100% threshold is acheived to insure an investigation was initiated if deemed necessary and all corresponding documentation was completed per facility protocol. Staff education to be provided as necessary. The Executive Director will ensure that all outside vendors receive education related to the Elder Justice Act and sign a corresponding acknowledgement of the training. An audit will be conducted on a quarterly basis to ensure that facility remains in compliance with training requirement. All forms will be placed in a binder and education to be completed on an annual basis. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain is: 9/18/13</p>		

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	<p>When interviewed on 8/19/13 at 12:00 p.m., the facility Nurse Consultant indicated the facility protocol was for the staff member first noting any injury or accident to fill out the Incident/Accident Data Entry Questionnaire and this was then reviewed by management and an investigation was initiated to determine the cause of the event.</p> <p>When interviewed on 8/19/13 at 12:15 p.m., the Director of Nursing indicated the incident forms (Incident/Accident Data Entry Questionnaire) were completed on the computer and she had access to them. The Director of Nursing also indicated the procedure was also for management to review incident reports, 24 hour Nursing shift reports, new Physician orders at each daily AM meeting with several department heads present and then a complete investigation was started. The Director of Nursing indicated an "Incident Follow-Up & Recommendation" form was used for investigations.</p> <p>When interviewed on 8/20/13 at 7:45 a.m., the Director of Nursing indicated there was an Incident/Accident Data Entry form initiated by the Nurse on</p>				

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	<p>7/18/13 and this must have been missed as an investigation was never initiated. The Director of Nursing indicated an incident report form had not been completed on 8/9/13. The Director of Nursing indicated the staff were signing out a treatment to monitor the area but the Nurse did not write the order, nor did this skin tear appear on the 24 hour report so the skin tear was not investigated as the Nurse did treat the area and notified the Physician but failed to write the order to monitor, start an Incident form, or include the information about the new skin tear on the 24 hour report.</p> <p>The facility policy titled "Protection of the Residents: Reducing the Threat of Abuse and Neglect" was reviewed on 8/19/13 at 10:35 a.m. The facility Administrator provided the policy and indicated the policy was current. There was no date on the policy. The policy indicated all reports of abuse would be investigated promptly and thoroughly. The policy also indicated "All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) were to promptly reported.</p> <p>2. The facility Administrator was</p>			

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	<p>interviewed on 8/20/13 at 11:15 a.m. related to the Abuse Prohibition Protocol task. The facility Administrator stated she became the facility Administrator in April of 2013. The Administrator indicated she was the one who trains new employees on the reporting requirements of the Elder Justice Act during orientation. When asked to indicate how the facility notifies each covered individual of the reporting obligations on an annual basis the Administrator indicate she has not done this yet.</p> <p>The Administrator and Nurse Consultant then provided documentation of the Pharmacy, Laboratory, Dental and Podiatry Consultant companies had signed verification of notification of the Elder Justice reporting obligations within the past year. There was no documentation of any schools who bring their students to this facility for clinical training having been notified on an annual basis.</p> <p>When interviewed on 8/20/13 at 11:30 a.m., the Director of Nursing indicated they have had Nursing and CNA students in the facility. The Director of Nursing indicated the Staff Development Nurse reviews the facility Abuse Policy with the students</p>			

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	<p>but had not instruct them on the Elder Justice Act.</p> <p>The facility policy titled "Reporting Suspected Crimes under the Elder Justice Act Policy" was reviewed on 8/19/13 at 10:35 a.m. The facility Administrator provided the policy and indicated it was current. The policy indicated all persons must be notified of the reporting procedures when they become a Covered Individual and on an annual basis. The policy also indicated the Executive Director is responsible for ensuring that documentation that the facility has meet the requirements is maintained.</p> <p>This federal tag relates to Complaint IN00134055.</p> <p>3.1-26(a)</p>			

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services related to following Physician orders for the treatment of hypoglycemia (low blood sugar) for 1 of 3 residents reviewed for blood glucose monitoring and the administration of insulin in the sample of 9. (Resident #F)</p> <p>The facility also failed to ensure the necessary care and services were provided related the monitoring of bruises and skin tears for 3 of 3 residents reviewed for non pressure related skin conditions in the sample of 9. (Resident's #F, #G, and #H)</p> <p>Findings include:</p> <p>1. The record for Resident #F was reviewed on 8/19/13 at 9:40 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, congestive heart failure, depressive</p>	F000309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Staff Development Coordinator provided education regarding adherence to physician orders related to blood sugar monitoring to the licensed nurse who provided care to Resident F on 7/20/13. The bruised areas to Resident F's left upper arm are now healed. The scabbed areas to Resident G's right outer calf are healed. The care plan for Resident H has been amended to reflect the use of geri sleeves. The resident's right forearm bruise is being monitored and measured weekly via the Non-Pressure Skin Condition Record. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken: Full facility resident skin integrity audit was completed to identify any skin issues requiring additional investigation if the cause is uncertain. No issues were identified via this audit. Care</p>	09/18/2013			

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	<p>disorder, and malignant brain neoplasm.</p> <p>The 6/13/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS(Brief Interview for Mental Status) score was (4). A score of (4) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight bearing support) of staff for transfers, bed mobility, dressing, and hygiene.</p> <p>A Care Plan initiated on 9/20/12 indicated the resident was at risk for complications of diabetes including hypoglycemia(low blood sugar) and hyperglycemia (high blood sugar). The care plan was last revised on 7/29/13. Care plan interventions included to administer medications as ordered.</p> <p>Review of the 7/2013 Physician Order Statement indicated there were orders for the resident to receive blood glucose monitoring four times a day with sliding scale insulin coverage. The order for sliding scale insulin coverage was as follows: Novolin R (Regular) insulin to be</p>		<p>plans were reviewed to ensure current data related to the use of adaptive/protective equipment is reflected as indicated. An audit of glucose monitoring orders for all current residents was completed encompassing the previous 30 days to ensure that licensed nurses had adhered to the physician ordered parameters. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nursing Staff were inserviced by the Staff Development Coordinator regarding the policy and procedure for timely investigation of bruises and skin tears of unknown origin and the policy for ongoing assessment and monitoring via the Non-Pressure Skin Condition Record. This education was completed 8/31/13. Investigations will be conducted by Nursing Administration and discussed with the interdisciplinary team during the daily clinical meeting (Monday through Friday). Facility staff were also inserviced on use of the Interact "Stop and Watch" forms to report any skin related issues to the licensed nurse in a timely manner. Licensed staff will also be inserviced on the facility blood sugar monitoring protocol and adherence to specified physician orders. How the corrective action(s) will be monitored to ensure the deficient</p>		

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	<p>injected per sliding scale: Below 200 - no coverage to be given 200-250 - inject 4 units 251-300 - inject 6 units 301-350 - inject 8 units 351-400 - inject 10 units 401 & above- inject 12 units and call the Physician. There were also Physician orders for Glucagen 1 mg (milligram) injection IM (intramuscularly) as needed for blood sugar less then 40, wait 10 minutes and recheck blood sugar. There was also a Physician order for Glutose 15 gel (40%) to be give orally as needed for blood sugar below 40 , and to recheck the blood sugar after 10 minutes.</p> <p>Review of the 7/2013 Medication Administration Record indicated no doses of either the Glucagen or the Glutose were administered on 7/20/13.</p> <p>The 7/2013 Nursing Progress Notes were reviewed. An entry made on 7/20/13 at 6:00 a.m. indicated the resident was showing signs and symptoms of hypoglycemia at approximately 2:15 a.m. The resident was sweating and said she did not feel good. The resident's blood sugar was checked and the result was (25),</p>		<p>practice will not recur: Director of Nursing or designee will conduct an audit of the completed "Stop and Watch" Forms and 5 resident skin records on a weekly basis for 12 weeks and byweekly for 8 weeks then monthly for 2 months until a 90-100% threshold is acheived to insure an investigation was initiated if deemed necessary and all corresponding documentation was completed per facility protocol. Nursing Administration to audit blood sugar monitoring records once weekly for 12 weeks and byweekly for 8 weeks then monthly for 2 months until a 90-100% threshold is acheived to ensure adherence to physician orders. Administration will audit the Non-Pressure Skin Records twice weekly and until a 90-100% threshold is acheived to ensure documentation is complete and timely. Any identified issues will be addressed immediately. Audit results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. Date Certain is: 9/18/13</p>		

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	<p>applesauce, peanut butter crackers, and an orange were given. The blood sugar was rechecked 15 minutes later and was 45. The blood sugar was rechecked 15 minutes later and was 75. The resident stated she felt better and her 6:00 a.m. blood sugar was 196.</p> <p>An "Incident/Accident Data Entry Questionnaire" report was completed on 7/17/13 at 8:00 p.m. The report indicated the CNA reported the resident had linear bruising to the left upper arm. The skin investigation by the RN indicated the there were linear bruises 4-5 cm (centimeters) and they were brown in color.</p> <p>A Non-Pressure Skin Condition Record was initiated on 7/18/13. This record indicated a bruise was noted the resident's left upper arm. The bruise measured 2 cm x 3 cm. There were no further entries on the report.</p> <p>When interviewed on 8/19/13 at 12:30 p.m., the Director of Nursing indicated the bruises were to be monitored weekly by completing the Non Pressure Skin Condition Record with the measurements and an assessment of the area.</p> <p>When interviewed on 8/19/13 at</p>						

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	<p>12:00 p.m., the Nurse Consultant indicated the Nurse did not administer the ordered treatment for the above low blood sugar level.</p> <p>2. On 8/19/13 at 12:04 p.m., Resident #G was observed sitting in wheel chair in her room. Unit Manager #2 removed the resident's shoes and socks to complete a skin assessment. There was a 2 x 2 dressing with a clear transparent cover to the resident's upper outer right calf area. There was no date on the dressing. There were three scabbed areas noted when the dressing was removed. The areas were approximately 1 cm x 1 cm , .5 cm x .5 cm and 1 cm x .5 cm. The areas were all scabbed with no drainage noted.</p> <p>Review of the 7/2013 and 8/2013 Treatment Administration Record indicated there were no orders for any treatments or dressing to the right calf areas.</p> <p>An "Incident/Accident Data Entry Questionnaire" form was completed on 7/28/13 at 8:00 p.m. The form indicated the resident was sitting in her wheel chair and turned sideways and scraped her outer right leg. The</p>				

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	<p>Physician was notified on 7/29/13 at 7:00 a.m.</p> <p>The 7/2013 and 8/2013 Nursing Progress Notes were reviewed. An entry made on 7/29/13 at 6:54 a.m. indicated the resident had a 4 cm (centimeter) x 1.5 cm superficial scrape to the right outer calf, the area was cleaned and covered. The resident stated she turned sideways in her wheelchair and scraped her leg. The resident had no complaints of pain. There were no further entries related to the right out leg calf between 7/30/13 and 8/18/13.</p> <p>A Non-Pressure Skin Condition Record was initiated on 7/28/13. The record indicated there was a scrape to the right outer calf and the area measured 4 cm x 1 1/2 cm, the color was red, and no drainage was observed. There were no further weekly entries made on the record.</p> <p>When interviewed on 8/19/13 at 11:45 a.m., LPN #2 indicated she was assigned to care for the resident today and yesterday. The LPN indicated she was not aware of any skin conditions or skin scrapes to the resident. The LPN indicated she was not informed of or aware of the dressing to the right calf area.</p>			

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	<p>When interviewed on 8/19/13 at 11:50 a.m., the Unit Manager indicated there was no treatment order for the dressing. The Unit Manager indicated the skin areas should have been assessed weekly on the non pressure report which included an assessment of the area until the area was healed.</p> <p>3. The record for Resident #H was reviewed on 8/19/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, Parkinson's Disease, high blood pressure, diabetes mellitus, coronary artery disease, and psychotic disorder with delusions.</p> <p>The July 2013 Nursing Progress Notes were reviewed. An entry made on 7/18/13 at 12:33 p.m. indicated the Nurse was notified of a 8.9 cm (centimeter) x 4.0 cm and a 5.2 cm x 1.0 cm discolorations to the right forearm. The entry indicated the areas were purple in color, the skin was intact, and the resident propelled himself in the wheelchair. The Physician and the family were notified and no new orders were given by the Physician. An entry made on 7/18/13 at 9:57 p.m. indicated the resident denied pain or discomfort to the right</p>			

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	<p>forearm. An entry made on 7/19/13 at 6:35 a.m. indicated the resident continued to have bruising to the right upper arm and geri sleeves (cloth coverings to protect the skin on the arms and hands) were being worn.</p> <p>A care plan initiated on 11/20/12 indicated the resident was at risk for abnormal bleeding or hemorrhage due to receiving an anticoagulant medication. The care plan was last reviewed on 7/12/13. Care plan interventions were to observed the resident and report any signs or symptoms such as bleeding gums, nose bleeds, or unusual bruising. The use of geri sleeves was not listed on the resident's care plan.</p> <p>An "Incident/Accident Data Entry Questionnaire" form was initiated on 7/18/13 at 12:00 a.m. This form was completed by Nursing staff and indicated Resident #H was observed with purple discoloration to the right forearm and there were no witnesses to the incident. The form indicated the Physician and the resident's family/legal representative were notified on 7/18/13. The form also indicated the residents was currently receiving anti coagulant medications.</p> <p>There was no Non-Pressure Skin</p>						

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	<p>Condition Records initiated for the right forearm bruise. There were no ongoing assessment of or measurements of the bruise noted on any skin records.</p> <p>When interviewed on 8/19/13, the Director of Nursing indicated a Non-Pressure Skin Condition form should have been initiated and completed weekly until the area was resolved.</p> <p>This federal tag relates to Complaint IN00134055.</p> <p>3.1-37(a)(1)</p>			