

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155671	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/18/2015
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NAME OF PROVIDER OR SUPPLIER  OAKWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1143 23RD ST TELL CITY, IN 47586
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: March 12, 13, 16, 17 and 18th, 2015</p> <p>Facility Number: 002512 Provider Number: 155671 AIM Number: 200278690</p> <p>Survey Team: Sylvia Scales, RN-TC Dorothy Watts, RN (3/12, 3/13, 3/17, 3/18 2015) Terri Walters, RN Amy Wininger, RN (3/12, 3/13, 3/16, 3/17 2015)</p> <p>Census Bed Type: SNF: 16 SNF/NF: 60 Residential: 21 Total: 97</p> <p>Census Payor Type: Medicare: 16 Medicaid: 38 Other: 22 Total: 76</p> <p>These deficiencies reflect state findings</p>	F 000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 3-18-15 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 4-17-15 We respectfully request a desk review for compliance.</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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F 314 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 24, 2015 by Jodi Meyer, RN</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, a dependent resident admitted to the facility without pressure ulcers, developed two pressure ulcers for 1 of 3 residents who met the criteria for review of pressure. (Resident #13)</p> <p>Findings include:</p> <p>Resident #13 was observed on 3/16/15 at 8:25 A.M., in the hallway sitting in a wheelchair.</p>	F 314	<p>Corrective action Resident #13 wounds have been assessed by physician and wound certified therapist with current assessment and careplans reviewed and updated to reflect pressure reduction interventions including periods of complete pressure relief. <b>How others were effected</b> There were no other residents affected by alleged deficiency however residents at risk of developing pressure ulcers have the potential to be affected by alleged deficient practice and through altercations in processes and inservicing, the campus will ensure measures to prevent the</p>	04/17/2015

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	<p>Resident #13 was observed on 3/16/15 at 10:30 A.M., in the therapy room sitting in a wheelchair.</p> <p>Resident #13 was observed on 3/16/15 at 12:35 P.M., in the hallway sitting in a wheelchair.</p> <p>The clinical record of Resident #13 was reviewed on 3/16/15 at 10:00 A.M. The record indicated Resident #13 was admitted on 1/17/15, with diagnoses including, but not limited to, CVA (Cerebrovascular Accident).</p> <p>The Nursing Admission Assessment dated 01/16/15, Resident #13 was admitted to the facility with no pressure ulcers to the bilateral buttocks and/or was at risk to develop a pressure ulcer.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 1/23/15, indicated Resident #13 experienced mild cognitive impairment and/or unsteadiness during transitions and walking, required the extensive assistance of one person for bed mobility and/or transfers, and was at risk for the development of pressure areas.</p> <p>The March 2015 Physician's Order Recap included, but was not limited to, an order for, "...assist with turning and</p>		<p>development of new pressure areas and provide care for current pressure ulcers in accordance with physician's orders. What measures were put into place All nursing staff have been inserviced on pressure reduction interventions and utilization of resident profiles/assignment sheets to identify residents at risk for developing pressure ulcers and the interventions in place. "risk for skin breakdown" will be added to the profile/assignment sheet for all residents who are at risk of skin breakdown. All licensed nursing staff have been inserviced on wound plan of care guidelines/ wound risk assessment guidelines and identification and assessment of skin impairments. How monitored DHS/designee will complete a random audit on 3 different residents to assure pressure relief is provided per the care plan 5x a week times one month; 3 x week times one month; then weekly with results forwarded to the QA committee monthly x6months and quarterly thereafter for review and further suggestions/comments.</p> <p><b>Completion Date 4-17-15</b></p>	

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	<p>repositioning (sic) every two hours and as needed..."</p> <p>A Skin Impairment Circumstance, Assessment, and Intervention Report dated 2/22/15 at 4:20 A.M., indicated Resident #13 experienced an abrasion on the right buttock. The report included a handwritten notation of, "...2/24/15 area not over a boney [sic] prominice [sic]...does not appear pressure related..."</p> <p>A care plan dated 3/6/15 indicated, "...I have an abrasion noted to my bilateral buttocks..." The plan of care lacked any interventions related to complete pressure relief to the bilateral buttocks.</p> <p>A care plan dated 3/9/15 indicated, "...potential for alteration in my skin integrity relate to my overall debility, my past CVA, and my decline in mobility...provide me with pressure redistribution products for my bed and chair Provided me with assistance as I need it for bed mobility...Use a draw sheet for turning and repositioning me to decrease the probability of my getting shear or friction injuries. I have a low profile Roho (an inflatable pressure reducing overlay) cushion to my wheelchair to assist with pressure reduction. Encourage me to use my Roho cushion in my recliner chair...provide me</p>			

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	<p>with a weekly skin assessment via a licensed nurse..." The plan of care lacked any interventions related to complete pressure relief to the bilateral buttocks.</p> <p>A Skin Impairment Assessment dated 2/22/15 indicated Resident #13 experienced a red abrasion to the right buttock on that date which measured 1.0 cm (centimeters) length X 1.0 cm width X 0.5 cm depth. (Wound #2) The assessment lacked any interventions related to complete pressure relief to the right buttock.</p> <p>A Skin Impairment Assessment dated 3/10/15 indicated Wound #2 was purple and red, measured 2.8 cm length X 1.0 cm width X 0.1 cm depth, and/or caused pain to Resident #13. The assessment lacked any interventions related to complete pressure relief to the right buttock.</p> <p>A Skin Impairment Assessment dated 3/10/15 indicated Resident #13 experienced a purple abrasion on the left buttock on that date. (Wound #1) The assessment lacked any interventions related to complete pressure relief to the left buttock.</p> <p>A Nursing note dated 2/22/15 at 4:30 A.M. indicated, "...Abrasion to right</p>			

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	<p>buttock noted during tolieting [sic]..."</p> <p>A Nursing note dated 2/24/15 at 10:00 A.M. indicated, "...weekly skin assessment complete..." The note lacked any documentation related to the wound on the right buttock.</p> <p>A Nursing note dated 3/6/15 at 6:00 P.M. indicated, "...'abrasions' to bil. [bilateral] buttocks assessed at this time, area red, blanches, appears to be excoriation in nature...area is not on boney [sic] prominence...resident's daughter states 'she gets that from time to time'..." The note lacked any intervention related to complete pressure relief to the bilateral buttocks.</p> <p>A Nursing note dated 3/10/15 at 10:30 A.M. indicated, "...Weekly skin assessment complete. Abrasion noted to left buttock noted..." The note lacked any intervention related to complete pressure relief.</p> <p>During an interview on 3/16/15 at 11:50 A.M., RN #1 indicated Resident #13 did not have any pressure ulcers, but had experienced abrasions on the bilateral buttocks.</p> <p>During an observation of care on 3/16/15 at 2:00 P.M., a full thickness wound on</p>			

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	<p>the left inner buttock (Wound #1) was observed to contain a large amount of slough and a full thickness wound on the right inner buttock (Wound #2) was observed to contain a small amount of slough. The DON (Director of Nursing) indicated, at that time, the wounds were abrasions and not related to pressure.</p> <p>During an interview on 3/16/15 at 2:05 P.M. Resident #13 stated, "...those are from sitting on my sitter too much..."</p> <p>During an observation of care on 3/16/15 at 2:15 P.M., RN #2 indicated Wound #1 measured 1.0 cm length X 1.0 cm depth and contained 90% white slough. RN #1 then indicated Wound #2 measured 0.6 cm length by 0.5 cm width with 10% slough.</p> <p>A Skin and Wound Care Guideline provided by RN #2 on 3/16/15 at 2:40 P.M. indicated, "...Stage 3 or Full Thickness-Full thickness...slough may be present..."</p> <p>The Policy and Procedure for Basic Wound Interventions provided by RN #2 on 3/16/15 at 2:40 P.M. indicated, "...Develop and implement...positioning plan to relieve pressure from affected area(s)..."</p>			

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	<p>The Policy and Procedure for Selection of Therapeutic Support Surfaces Guidelines provided by RN #2 on 3/16/15 at 2:40 P.M. indicated, "...Procedure and considerations:...2...a. Pressure 1. If interface pressure (the pressure that occurs at the interface between the body and the support surface) exceeds capillary pressure for a prolonged period of time, ischemia results which leads to tissue death..."</p> <p>During an interview on 3/16/15 at 3:00 P.M., the Therapy Director indicated, the wounds were not related to pressure because they were not located over a bony prominence. The Therapy Director then indicated the wounds were related to moisture, but had not performed a formal assessment of the wounds. The Therapy Director further indicated, at that time, Resident #13 was able to reposition from one sitting surface to another independently, and achieved complete pressure relief to the bilateral buttocks during those transfers.</p> <p>During an observation on 3/17/15 at 8:10 A.M., the wounds bed of Wound #1 and Wound #2 were observed to be pink and red and contain no slough.</p> <p>During an interview on 3/17/15 at 10:30 A.M., the DON indicated no</p>			

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F 323 SS=D Bldg. 00	<p>documentation could be provided to indicate Resident #13 received complete pressure relief to the bilateral buttocks prior to between 2/2/15 and 3/15/15. The DON then indicated Resident #13 had been provided complete pressure relief on the afternoon of 3/16/15 for approximately two hours. The DON then indicated Wound #1 and Wound #2 had improved since the observation on 3/16/15. The DON further indicated, at that time, the root cause of both wounds was related to the gluteal folds rubbing against each other when the resident shifted positions.</p> <p>The policy and procedure for Wound Staging and Identification provided by the DON on 3/17/15 at 11:00 A.M. indicated, "...Considerations...8...Pressure ulcers as defined by the NPUAP [National Pressure Ulcer Advisory Panel] is a localized injury to the skin and/or underlying tissue usually over a bony prominence ... pressure in combination with shear and friction..."</p> <p>3.1-40(a)(1)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident</p>			

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	<p>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 adequate supervision was provided, and/or effective interventions were implemented, in that, residents identified as a risk to experience falls were not provided supervision and/or effective interventions were not implemented and the residents continued to experience falls for 2 of 3 residents who met the criteria for review of accidents. (Resident #88, Resident #53)</p> <p>Findings include:</p> <p>1. During an interview on 3/13/15 at 12:08 P.M., UM (Unit Manager) #1 indicated Resident #88 had recently experienced a fall while in the bathroom. UM #1 further indicated, at that time, Resident #88 was not compliant with safety interventions.</p> <p>On 3/13/15 at 12:12 P.M., Resident #88 was observed sitting in a wheelchair watching television in the resident's room with alarms in place.</p> <p>The clinical record of Resident #88 was reviewed on 3/13/15 at 3:30 P.M. The record indicated the diagnoses of</p>	F 323	<p>Corrective action Resident #88 care plan has been reviewed and updated. Staff who provide care to resident have been updated on revised plan of care. Resident's activity preferences have also been reviewed and updated. Resident #53 care plan has been reviewed and updated and staff that provide care for him have been updated on current plan of care. Resident's activity preferences have also been reviewed and updated. How others are effected All residents have the potential to be effected by the alleged deficient practice and through increased engagement and oversight by staff will reduce chances for opportunities of fall. Measures put into place All staff will be inserviced on fall prevention guidelines and interventions and hourly rounding guidelines. Care plans on all residents at risk for falls have been reviewed for appropriate interventions and are updated. DHS updated Activity Director on residents at risk for falls and will follow up with Activity Director weekly through C.A.R. (clinically at risk) meeting on all residents being reviewed for fall risk. How monitored DHS/designee will complete a random audit on 3 different residents to assure fall</p>	04/17/2015

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	<p>Resident #88 included, but were not limited to, falls, head injury, and dementia with behaviors.</p> <p>The Nursing Admission Assessment dated 3/19/14 indicated Resident #88 was at risk to experience a fall and, "...impaired cognition related to head injury..." with interventions including, but not limited to, "...provide assistance with transfers and ambulation as needed..."</p> <p>An OT (Occupational Therapy) Progress Summary dated 10/2/14 indicated Resident #88 required staff assistance of verbal, visual, and tactile cues with toilet transfers, initiation cues for locking wheelchair brakes, and further indicated, "...it should be emphasized that pt [patient] varies from day to day requiring anywhere from CGA [contact guard assist] to max [maximum] A [assist] for transfer. Pt unable to judge when...safety is at risk..."</p> <p>A Quarterly MDS (Minimum Data Set) assessment dated 11/19/14 indicated Resident #88 experienced moderate cognitive impairment, required the extensive assistance of two staff for transfers, the extensive assistance of one staff for toileting, and had a history of falls.</p>		<p>interventions/supervision are provided per the care plan 5x a week times one month; 3x a week for one month; then weekly with results forwarded to the QA committee monthly for 6 months and quarterly thereafter for review and further suggestions/comments. Completion Date 4-17-15</p>				

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	<p>An Annual MDS assessment dated 2/18/15 indicated Resident #88 experienced moderate cognitive impairment, required the extensive assistance of one staff for transfers and toileting, and had a history of falls.</p> <p>A Resident First Conference note dated 12/2/14 indicated Resident #88 was at risk to experience falls and included, but was not limited to, interventions of, "...call don't fall sign, encourage proper footwear, call light in reach..."</p> <p>The March 2015 Physician's Order Recap included, but was not limited to, an order originally dated 12/6/14 for, "...pressure alarm to bed..."</p> <p>Fall #1</p> <p>A Fall Circumstance, Assessment and Intervention report dated 1/17/15 at 1:35 P.M., indicated Resident #88 experienced an unwitnessed fall while, "transferring self from toilet to wheelchair ...states forgot to lock brakes et [and] w/c [wheelchair] rolled back...noncompliant with calling for assist...no cognitive impairment...history of falls...interventions:...therapy evaluation...ensure w/c brakes are locked...anti rollbacks to w/c and call</p>			

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	<p>don't fall sign above toilet...root cause: forgot to put brakes on et noncompliant with calling for assist..."</p> <p>A Nursing note dated 1/17/15 at 1:35 P.M. indicated, "...observed on bathroom floor in front of toilet...resident states...was transferring self from toilet to w.c [wheelchair] et forgot to lock brakes et w/c rolled back et ...fell to floor..."</p> <p>An PT [Physical Therapy] Progress Summary dated 1/20/15 indicated, "...has improved to requiring 50% VC [voice command]...for locking of w/c brakes, 'call don't fall' signs have been placed in patient's room and patient has been educated on the importance of calling nursing staff to assist with the completion of all functional transfers..."</p> <p>During an interview on 3/16/15 at 9:00 A.M., the DON (Director of Nursing) indicated Resident #88 was not compliant with calling for assistance and frequently propelled the wheelchair into the bathroom and independently transferred from the wheelchair to the toilet.</p> <p>Fall #2</p> <p>A Fall Circumstance, Assessment and Intervention report dated 2/20/15 at 8:30 P.M., indicated Resident #88 experienced</p>						

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	<p>a witnessed fall in the resident's room with interventions of, "...call bell...reacher...encourage to...ask for assistance; PT/OT eval [evaluation]...supply a reacher...root cause: reaching for an object off the floor..."</p> <p>A Nursing note dated 2/20/15 at 8:25 P.M. indicated, "...Nurse in room...res [resident] sitting on side of bed ..."</p> <p>A Nursing note dated 2/20/15 8:30 P.M. indicated, "...Res alarm sounding. Nurse entered room to see res reaching for object on floor. Proceeding to help res with object et res fell out of bed onto knees...intervention to remind/encourage to call for assistance et [and] PT/OT eval..."</p> <p>A PT daily treatment note dated 2/23/15 indicated, "...PT eval completed ... transfers required SBA [stand by assist]...Pt. and care giver educated on proper walker placement in such a way the pt's [patient] walker is within reach from pt's bed and pt's recliner..."</p> <p>During an interview on 3/16/15 at 9:05 A.M., the DON (Director of Nursing) indicated Resident #88 had been sitting on the side of the bed when the nurse exited the room to the hallway. The</p>			

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	<p>DON then indicated the nurse heard the alarm, saw the resident reaching for an object on the floor, the nurse re-entered the room, but couldn't get to the resident in time to prevent the fall. The DON then indicated a reaching tool was provided to prevent further falls and stated, "The problem is [Resident #88] thinks...can do it independently without help."</p> <p>A Resident First Conference note dated 3/4/15 indicated Resident #88 experienced falls and included, but was not limited to interventions of, "...call don't fall sign, anti rollback brakes, scoop mattress, pressure alarm bed, proper footwear..."</p> <p>Fall #3</p> <p>A Fall Circumstance, Assessment and Intervention report dated 3/7/15 at 2:15 P.M., indicated Resident #88 experienced an unwitnessed fall in the resident's bathroom. A handwritten notation on the report indicated, "Resident stated slid to floor didn't fall, asked who turned off alarm... stated [Resident #88] did when on floor you hold button long enough it will go off..." The report further indicated Resident #88 experienced cognitive impairment and had a history of experiencing falls with interventions of,</p>				

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	<p>"...alarm to bathroom door..." A handwritten notation at the end of the report indicated, "...3/9/15 d/c [discontinue] br [bathroom] door alarm start nonskid strips to br floor..."</p> <p>A Nursing note dated 3/7/15 2:00 P.M. indicated, "Resident sitting in w/ch [wheelchair] in...room..."</p> <p>A Nursing note dated 3/7/15 at 2:15 P.M., indicated, "Resident found laying on his bathroom floor. Resident stated 'I did not fall, I slid to floor while looking for my H/A [hearing aid] (which are in...ears)...'. Staff asked resident who turned off...w/ch alarm and resident stated that [Resident #88] turned it off when...got on the floor ...stated "you push that button long enough and it will turn off..."</p> <p>A Care Plan for Falls dated 3/10/15 indicated, "...I am at risk for fall r/t [related to] my overall debility, require assist of staff for my transfers and ambulation, noncompliance with calling for assistance prior to transferring (sic) myself..."</p> <p>During an interview on 3/16/15 at 9:10 A.M., the DON indicated she did not know when the pressure alarm was added to the wheelchair. The DON then</p>			

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	<p>indicated the bathroom door alarm was discontinued because it upset Resident #88 and non-skid strips had been added to the bathroom floor. The DON further indicated, at that time, it was difficult to develop an effective safety plan and/or provide supervision because Resident #88 was not compliant and doesn't like group activities.</p> <p>2. On 3/16/15 from 8:30 through 9:00 A.M., Resident #53 was observed in a wheel chair with a self releasing alarming seat belt in place. Resident #53 was observed leaning to the right, asleep.</p> <p>The clinical record for Resident #53 on 3/15/15 at 8:44 A.M., diagnoses include, but were not limited to, dementia, debility, and history of falls.</p> <p>The care plans for Resident #53 were reviewed and included, but were not limited to, ADL's initiated 2/18/15. Interventions included but were not limited to, transfer with assist of two, antiroll back brakes to wheel chair, wander guard bracelet initiated 10/13/15, and encouraging Resident #53 to lay down after meals.</p> <p>A care plan initiated 2/18/15 included, but was not limited to Self releasing alarming seat belt to wheel chair as an enabler. "I am able to release upon</p>			

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	<p>command by nursing"</p> <p>A care plan for incontinence of bowel and bladder was initiated 11/18/14. Interventions included, but were not limited to, "Assist of two with my toileting when I get up, before and after I eat, when I get ready for bed and as needed, allow me plenty of time for my needs..."</p> <p>A "FALL CIRCUMSTANCE, ASSESSMENT AND INTERVENTION" dated 12/10/14 at 1340 (1:40 P.M.) indicated Resident #53 asleep in a wheelchair and "I had a recent fall because was [sig] leaning over sleeping in my w/c [wheel chair] et [and] fell out of w/c." Resident #53 had a carpet burn to the left side of head from the fall. The immediate interventions included dicem to wheel chair to evaluate for positioning in wheel chair and encourage resident to lie down after meals.</p> <p>The nursing notes were reviewed and included, but was not limited to, 12/10/14 1350(1:50 P.M) "Resident was found by Nurse [sig] [name of nurse] laying face forward on the floor in the hallway."</p> <p>A "FALL CIRCUMSTANCE, ASSESSMENT AND</p>			

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	<p>INTERVENTION" dated 1/17/15 at 7:10 A.M., indicated resident #53 was found on floor in the doorway of the front lobby. "Other: resident states 'was looking for toilet'." The immediate intervention put into place was a therapy evaluation, and an alarming seat belt.</p> <p>The Nurse's Notes dated 1/17/15 at 7:05 A.M., indicated "Alarm alerted staff to front lobby was resident was noted sitting on ground outside doorway with w/ch [wheelchair] beside resident..." The notes also included, "...he was looking for 'toilet' ".</p> <p>A Nurse's Note dated 1/17/15 at 7:30 A.M., included, but was not limited to, "resident toileted @ [at] this time- [sic] incontinent of BM [Bowel Movement] et [and] urine..."</p> <p>During an interview with the Director of Nursing (DON) on 3/17/15 at 10:00 A.M. she indicated, Resident #53 had fallen on 12/10/14 after falling asleep in the wheel chair and had an abrasion to the forehead as a result of the fall. She further indicated the immediate intervention was to attempt to lay resident #53 down after meals but he often refused. She indicated no documentation could be provided of refusals. During the interview the DON further indicated the fall on 1/17/15 had</p>			

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	<p>occurred in the front lobby area. She indicated Resident #53 was propelling self and attempted to exit facility getting the wheel stuck in the entry way and fell out as a result receiving an abrasion to the forehead. She further the immediate intervention for this fall was to place a self releasing seat belt so Resident #53 would be reminded not to stand.</p> <p>On 3/17/15 at 09:55 A.M., Resident #53 was observed to be sitting in the Health Center lobby asleep in a wheel chair.</p> <p>On 3/17/15 at 10:40 A.M., Resident #53 was observed to be asleep in a recliner in the Health Center Lobby.</p> <p>During an interview with PTA #1 on 3/18/15 at 9:00 A.M., she indicated Resident #53 had been evaluated for wheel chair positioning on 12/12/14. She indicated some adjustments were made to Resident #53's wheel chair at this time, including lowering it so Resident #53 would be able to better self propel and anti rollback mechanism so the chair would not roll away from Resident #53. She further indicated Resident #53 was evaluated on 1/20/15 for standing ability only as a request by the family to see if Resident #53 would qualify for readmittance to the facility's memory care unit.</p>			

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F 371 SS=F Bldg. 00	<p>On 3/18/15 at 10:00 A.M. through 10:20 A.M., Resident #53 was observed to be slumped forward in a wheelchair with eyes closed and self releasing seat belt in place.</p> <p>During an observation on 3/18/15 at 10:40 A.M., Resident # 53 was observed to release the self releasing seat belt when asked by the Assistant Director of Nursing.</p> <p>The Policy and Procedure for provided by the DON on 3/16/15 at 10:45 A.M. indicated, "...strives to maintain a hazard free environment...implement preventative measure...Definition: A fall is considered to be an unintentionally coming to rest on the...floor...when a resident is found on the floor, a fall is considered to have occurred."</p> <p>3.1-45(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and</p>	F 371	No residents were found to be	04/17/2015

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	<p>record review, the facility failed to ensure staff had hair completely contained in a hair restraint during 3 of 3 kitchen observations. This had the potential to affect 75 of 76 residents who resided in the building.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Cook #1, DA (Dietary Assistant) #4, and DA #5 were observed on 3/12/15 at 8:45 A.M., in a food preparation area with hair extruding from a cap.</li> <li>2. The CDM (Certified Dietary Manager), Cook #1, and DA #1 were observed on 3/13/15 at 9:00 A.M., in a food preparation area with hair extruding from a cap.</li> <li>3. DA #2 was observed on 3/13/14 at 9:20 A.M., in a food preparation area with hair extruding from a cap.</li> <li>4. The CDM, DA #6, DA #4, and Cook #1 were observed on 3/16/15 at 11:00 A.M., in a food preparation area with hair extruding from a cap.</li> </ol> <p>The Policy and Procedure for Dietary Hair Restraint provided by the CDM on 3/16/15 at 11:45 A.M. indicated, "...All Dining Service employees will be required to wear hair restraints as</p>		<p>effected from the alledged deficient practice. How others effectedAll residents have to potential to be effected by the staff's deficient practice. With Inservicing of the Dietary staff on the proper use of hair restraints, while in a food preparation area, residents will no longer have the potential to be effected by the deficient practice.Measures put into placeDietary staff will be inserviced on the proper use of hair restraints to insure deficient practice does not recur. How Monitored ED/Designee will observe the use of hair restraints by dietary staff daily x2 weeks, 3 days weekly x2 weeks and 1 day weekly thereafter. Results of audit will be forwarded to QA committee monthly x3 and quarterly thereafter. Corrected deficiency date will be 4-17-15 We cordially request paper compliance on all deficiencies.</p>		

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R 000  Bldg. 00	<p>required by the 2009 Federal Food Code...are designed and worn to effectively keep their hair from contacting exposed food..."</p> <p>During an interview on 3/16/15 at 3:45 P.M. the HFA (Health Facilities Administrator) indicated the dietary employees should have hair completely contained in a hair restraint when in a food preparation area.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 3-18-15 Please accept this plan of correction as the provider's credible	

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R 356 Bldg. 00	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <p>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available.</p> <p>Based on interview and record review, the facility failed to ensure the emergency information file contained complete allergy information for 3 of 5 residents who met the criteria for review of emergency file information. (Resident #R 926, Resident #R 587, Resident #R 920)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #R 926 was reviewed on 3/18/15 at 10:58</p>	R 356	<p>aggregation of compliance effective on or before 4-17-15 We respectfully request a desk review for compliance.</p> <p>Corrective actions Resident #R926 emergency file allergy information has been updated. Resident #R587 emergency file allergy information has been updated. Resident #R920 emergency file allergy information has been updated. Other at risk There were no other residents affected by the noncompliance. Measures put into place Inserviced Assisted Living Coordinator on the emergency file criteria. Assisted Living Coordinator/designee will review</p>	04/17/2015

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	<p>A.M. The most recent Physician's Order Recap dated 3/1/15 indicated Resident #R 926 experienced medication allergies to Demerol (pain medication). The emergency file lacked any documentation related to allergies.</p> <p>2. The clinical record of Resident #R 587 was reviewed on 3/18/15 at 10:25 A.M. The most recent Physician's Order Recap dated 3/1/15 indicated Resident #R 587 experienced medication allergies to morphine (pain medication), Clindamycin (antibiotic), Cymbalta (antidepressant), Bactrim (antibiotic) and Microbid (urinary antiinfective). The emergency file lacked any documentation related to allergies.</p> <p>3. The clinical record of Resident #R 920 was reviewed on 3/18/15 at 12:05 P.M. The most recent Physician's Order Recap dated 3/1/15 indicated Resident #R 920 experienced medication allergies to morphine (pain medication), sulfa (antibiotic), penicillins (antibiotic) and Tramadol (pain medication). The emergency file documented only an allergy to morphine.</p> <p>During an interview on 3/18/15 at 1:58 P.M., the Unit Manager #1 (UM) was made aware the emergency files were incomplete and/or inaccurate in regards</p>		<p>emergency binder (resident files) monthly. Assisted Living Coordinator/designee will update emergency file daily with any changes. All other resident emergency files have been audited to ensure complete allergy information is listed. How MonitoredDHS/designee will review 5 random residents emergency files weekly x 1 month; 3 random residents weekly x2 weeks and monthly thereafter. Audits will be submitted to QA committee monthly for review x 6 months then quarterly thereafter. QA committee will review emergency binder monthly for complete and accurate contents. Deficiency date to be corrected 4-17-15</p>		

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	<p>to the documentation of allergies for Resident #R 926, Resident #R 587 and Resident #R 920. The UM #1 indicated that the face sheets and the emergency files should contain information related to all allergies. At that time, the UM#1 indicated, that the emergency files lacked the correct information concerning allergies.</p> <p>The Policy and Procedure for Emergency Information File dated 2010 was provided by Director of Nursing on 3/18/15 at 2:40 P.M. and read as follows, "...The file should contain the following information...Listing of any known allergies..."</p>				