

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/04/2015
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NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN RD GREENFIELD, IN 46140
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F 0000 Bldg. 00	<p>This visit for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: July 28, 29, 30, 31 & August 3, & 4 2015.</p> <p>Facility number : 005954 Provider number: 155767 AIM number: 201068810</p> <p>Census bed type: SNF: 51 SNF/NF: 10 Residential: 61 Total: 122</p> <p>Census payor type: Medicare: 24 Medicaid: 10 Other: 27 Total: 61</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Recertification and State Licensure survey August 4, 2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's family of changes in a resident's treatments. This affected 1 of 5 residents reviewed for notification of changes. (Resident #38)</p>	F 0157	<p>F 157</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident # 38- Has</p>	09/03/2015

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	<p>Findings included:</p> <p>Resident #38's record was reviewed on 7/30/2015 at 11:17 a.m. The record indicated Resident #38 was admitted with diagnosis that included, but were not limited to, congestive heart failure, dementia, diabetes mellitus, high blood pressure, fast heart rate, atrial fibrillation, depression, leg ulcers, physical debility, and anemia.</p> <p>An Admission Minimum Data Set assessment, dated 7/1/15, indicated Resident #38 was severely impaired in cognitive skills for daily decision making.</p> <p>A resident admission record indicated Resident #38 was not responsible for herself, and for an emergency contact, a family member was listed.</p> <p>A cardiopulmonary resuscitation consent was signed on 6/24/15 by a family member who was listed as the Power of Attorney (POA).</p> <p>A physician's telephone order for labwork, dated 7/8/15, indicated the box for resident notification had been checked, but not the box for family notification.</p>		<p>been discharged from facility.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review changes in a resident's treatment for past 7 days to ensure the POA, resident, or responsible party has been notified.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed staff and therapists on the following guideline: Responsible Party Notification</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review changes in a resident's treatment to ensure the POA, resident, or responsible party has been notified.</p> <p>The results of the audit observations will be reported,</p>				

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	<p>During an interview, on 8/03/2015 at 1:55 p.m., the Director of Health Services (DHS) indicated the family wasn't notified about the labwork, they notified the resident.</p> <p>A physician's telephone order, dated 6/30/15, indicated a Speech Therapy evaluation and treatment, secondary to increased confusion, for cognitive skills retraining, to maximize safety and independence for home. The telephone order did not have the box for resident or family checked that would have indicated they were notified, nor the date, or who was contacted. A "Speech Therapy Plan of Care", dated 6/30/15, included, but was not limited to, "Informed Consent: Treatment plan, including benefits, risk and alternatives discussed with patient and/or family, who agree to treatment." No names or dates of who the family member was that was notified could be found.</p> <p>On 8/3/15, at 1:56 p.m., the DHS indicated she would have to talk to the Speech Therapist for this information and no other information was provided.</p> <p>During an interview, on 8/03/2015 at 1:59 p.m., the Director of Health Services indicated Resident #38's daughter is the one they contact for changes; she is the</p>		<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>POA.</p> <p>A physician's telephone order, dated 7/20/15 at 2:45 p.m., indicated "(1) D/C (discontinue) polymem treatment and dressings to BLE (bilateral lower extremities). (2) Wrap BLE Q (every) day [with] ace wraps to [decrease] edema." Neither box was checked that would have indicated the resident or family had been notified, nor the date, or who was contacted.</p> <p>During an interview, on 8/3/15 at 2:00 p.m., the DHS provided a second copy of the physician's order, dated 7/20/15 at 2:45 p.m. The second copy indicated the box where family was notified had been checked, and dated 7/20/15. A first copy of the order had been provided on 7/31/15 at 3:45 p.m. The first copy was blank where the resident, family, name, and date would have been documented. The DHS indicated she didn't know how the box had been checked after the first copy had been provided.</p> <p>A policy titled "Guidelines for Responsible Party Notification", with an effective date of 11/8/10, was provided by the Director of Health Services, on 7/31/15 at 3:54 p.m. The policy indicated, but was not limited to, "Family notification of diagnostic testing and</p>			

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F 0282 SS=D Bldg. 00	<p>change of condition. Purpose: To ensure the resident's responsible party is aware of all diagnostic testing results or change in condition in a timely manner. Procedure...2. The responsible party should be notified of change in condition or diagnostic testing results in a timely manner...5. Documentation of notification or notification attempts should be recorded in the resident medical record."</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow their plan of care to transfer a resident with assistance of 2 persons, for 1 of 3 residents reviewed for skin conditions, of 6 who met the criteria for skin conditions (non-pressure related). (Resident #102)</p> <p>Findings include:</p> <p>Resident #102's record was reviewed on 7/31/15 at 11:12 a.m. Her diagnoses included but were not limited to, Alzheimer's disease with delusions,</p>	F 0282	<p>F 282</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #102 was re-assessed for appropriate assist with transfers used per plan of care.</p> <p>Identification of other residents having the potential to be</p>	09/03/2015

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	<p>dementia, chronic pain, glaucoma, and falls.</p> <p>Resident #102's admission Minimum Data Set (MDS) assessment dated 5/20/15, indicated she required extensive assistance of 2 persons for transfer and bed mobility.</p> <p>An Activity's of Daily Living plan of care for Resident #102, initiated 5/20/15, indicated "I have problems providing my own care r/t (related to) decreased mobility and Hospice care... At present I require assist of two with transfers...."</p> <p>On 7/31/15 at 1:18 p.m., Resident #102 was observed being transferred from her Broda chair to her bed with the assistance of CNA #6 and the use of a gait belt. Resident #102 stood with assistance from CNA #6, pivoted, and then sat down on the side of her bed. CNA #6 lifted Resident #102's legs into the bed and assisted her to lay down.</p> <p>On 8/3/15 at 1:44 p.m., Resident #102 was observed being transferred from her Broda chair to her bed with the assistance of CNA #5 and the use of a gait belt. Resident #102 stood with assistance from CNA #5, pivoted, and then sat down on the side of her bed. CNA #5 lifted Resident #102's legs into the bed and</p>		<p>affected by the same alleged deficient practice and corrective actions taken: DHS or designee will observe residents requiring assist with transfers to ensure staff provides adequate assistance/supervision per plan of care.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following: Interdisciplinary team care plan guidelines / Plan of Care</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe resident's requiring assist with transfer to ensure staff provides adequate assistance/supervision per plan of care.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>	

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F 0309 SS=D Bldg. 00	<p>assisted her to lay down. CNA #5 indicated Resident #102 required 1 person assistance for transfers. If she was unfamiliar with the amount of staff a resident required for transfers she would ask the nurse or the other CNA working the same hall. Staff were usually given the information in report and she could write the information down on a 24 Hour Sheet and carry that with her.</p> <p>On 8/3/15 at 2:02 p.m., LPN #3 indicated staff could view a resident's profile in the Kiosk. A view of Resident #102's profile in the Kiosk at that time indicated "At present I require assist of two with transfers."</p> <p>An Interdisciplinary Team Care Plan Guideline provided by the Director of Health Service on 8/4/15 at 9:50 a.m., indicated: "... g. Nurse managers shall communicate pertinent care plan approaches to the nursing staff via the Resident Profile, in the clinical software...."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>		compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review the facility failed to assess and monitor bruising for 1 of 3 residents who met the criteria for non pressure related skin conditions. (Resident #26)</p> <p>Findings include:</p> <p>On 7/29/15, at 11:01 a.m., a purple area, approximately the size of a quarter, was observed on Resident #26's top left hand. Resident #26 indicated he didn't know how he got the discolored area.</p> <p>Resident #26's record was reviewed on 7/30/2015 at 2:45 p.m. The record indicated Resident #26 had diagnoses that included, but were not limited to, dementia with behaviors, chronic kidney disease, high blood pressure, anemia and coronary artery disease.</p> <p>A medication review indicated the following that could increase bruising: Aspirin 81 milligrams, chew 1 by mouth every day for coronary artery disease, with a start date of 7/1/15.</p> <p>A care plan, with a start date of 7/13/15, indicated: "I have potential for abnormal</p>	F 0309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #26 skin was assessed and any areas monitored.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Skin assessments were completed on current residents. Any new areas of impairment were assessed and monitored.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate nursing staff regarding Accident and Incident reporting guidelines. Licensed nurses will be re-educated regarding skin assessments, and completion of</p>	09/03/2015

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	<p>bleeding tendencies r/t (related to) I have Dx (diagnosis) of anemia. Observe me for s/sx (signs/symptoms) covert bleeding...unexplained bruising, etc...."</p> <p>On 7/31/2015 at 10:22 a.m., LPN #5 checked Resident #26's record and indicated she didn't see where there was anything documented about a bruise on his left hand and then looked at his hand. LPN #5 checked for lab draws and indicated he hadn't had a lab draw. LPN #5 checked the shower sheet, and indicated the last assessment during a shower she had was dated 7/22/15, and didn't show anything related to skin issues. Review of "CNA skin assessment detail reports", from 7/24/15 to 7/30/15, indicated the answer to "Did you see a new skin problem?" was answered "No" on all shifts.</p> <p>On 7/31/2015 at 11:37 a.m., Resident #26 was observed in a common area in his wheelchair, watching TV. When he was interviewed about the bruise on his left hand, he looked at his hand and did not answer. The bruise was the size of a quarter, purple in color, with a faint green tint.</p> <p>During an interview on 8/3/15, at 12:14 p.m., the DHS indicated she would have to look into the bruising.</p>		<p>the Skin Impairment Circumstance, Assessment, and Intervention.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Skin assessment complete and any new areas of impairment are assessed and monitored.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>On 8/3/15 at 12:27 p.m., the Director of Health services provided a "Skin Impairment Circumstance, Assessment and Intervention" that indicated the bruise on the top of the left hand was investigated on 7/31/15, and a possible contributing factor was an aspirin daily and diagnosis of anemia.</p> <p>During an interview, on 8/3/15 at 5:10 p.m., the DHS indicated resident's skin is monitor for bruising through weekly skin assessments and if a bruise is found, they start a skin assessment form and the area is monitored for 72 hours. She indicated a skin sheet is initiated for the bruise also, and if they don't know how the bruising occurred, they start an investigation.</p> <p>A policy for "Other Skin Assessment Guidelines", with no effective date, was provided by the DHS, on 8/4/15 at 9:50 a.m. The policy indicated: "Purpose; is to utilize, describe, and monitor the healing process of skin impairments other than pressure or stasis ulcers. Procedure; 1. This 2 sided document is completed in black ink by an RN/LPN and is a part of the resident's permanent record. a) Complete one form for each impaired area. b) All measurements are recorded in centimeters...2. Initiate the form when</p>			

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F 0312 SS=D Bldg. 00	<p>an area of impairment, (e.g.; skin care, rash, excoriation, abrasion, burn, cut, open lesion, bruise, and/or surgical wound) is identified. 3. Complete the section titled "Initial Identification" in it's entirety...5. Document description of wound using the documentation key...."</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review the facility failed to assist with oral care for a resident dependent on staff for her oral care for 1 of 3 residents that met the criteria for dental status and services (Resident #34).</p> <p>Finding include:</p> <p>During observation on 7/29/15 at 9:47 a.m., Resident #34's lower teeth were heavy with the debris and her upper dentures were hanging down from the roof and moving when she spoke.</p> <p>Interview with family member #1 on 7/29/15 at 2:47 p.m., indicated when they would visit Resident #34 her dentures</p>	F 0312	<p>F 312</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident # 34 teeth are free of debris and oral care is being provided.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents oral cavity will be</p>	09/03/2015

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	<p>were loose.</p> <p>During observation on 7/30/15 at 11:06 a.m., Resident #34 was in an activity. Resident #34's upper dentures were coming down from the roof of her mouth when she would talk with the activity staff.</p> <p>During observation on 7/30/15 at 12:15 p.m., Resident #34 was being assisted with her lunch by LPN #2. During the resident's meal her upper dentures were continuously falling down from the roof of her mouth as she ate.</p> <p>During observation on 7/31/15 at 1:25 p.m., Resident #34 was asleep in her recliner, her upper dentures had fallen from the roof of her mouth and were hanging out of her mouth while she slept.</p> <p>During observation on 8/3/15 at 10:00 a.m., Resident #34 was sitting in common area with several other residents. The resident's bottom teeth were heavy with debris caked in between her teeth.</p> <p>Interview with LPN #3 on 8/3/15 at 10:08 a.m., indicated the aides were responsible to clean residents teeth who were unable to do it for themselves. LPN #3 indicated the residents teeth were</p>		<p>observed to ensure teeth are free of debris and residents will be interviewed to ensure oral care is being provided/assisted with.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the nursing staff on the following : Guidelines for Oral Care.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1.) Resident's oral cavity will be observed to ensure teeth are free of debris. 2.) Resident's will be interviewed and/or observed to ensure oral care is being provided/ assisted with.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>	

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	<p>to be cleaned in the morning and sometimes at night. LPN #3 indicated the aides were responsible to apply adhesive to dentures when the resident wakes up in the morning.</p> <p>During observation on 8/3/15 at 10:11 a.m., Resident #34 had an empty bottle of denture adhesive in her bathroom.</p> <p>Review of the record of Resident #34 on 8/3/15 at 10:25 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, Alzheimer's disease, depression and Cerebral Vascular Accident (CVA) (stroke).</p> <p>The Annual Minimum Data Set (MDS) assessment for Resident #34, dated 4/19/15, indicated she needed extensive assistance of one person to brush her teeth.</p> <p>The plan of care for Resident #34, dated 4/19/15, indicated the resident had upper and lower dentures and she needed assistance with oral care in the morning. The resident's partial dentures were to be soaked at night time and she required adhesive to her dentures to keep them in her mouth.</p> <p>The monthly nursing assessment for Resident #34, dated 7/3/15, indicated she</p>		randomly thereafter for further recommendation.	

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	<p>was dependent on 1 staff for her oral care. The resident had full or partial dentures.</p> <p>The social service progress note for Resident #34, dated 7/15/15 (no time), indicated the resident's family had voiced concerns that lower dentures need to be cleaned regularly and her upper dentures needed to be observed for needing adhesive applied.</p> <p>During observation on 8/3/15 at 2:55 p.m., Resident #34 was asleep in bed with her upper dentures falling out of her mouth. Interview with CNA #3 indicated the resident's dentures were falling out of her mouth and she was unable to find denture adhesive in the resident's room.</p> <p>Interview with family member #2 on 8/3/15 at 4:40 p.m., indicated Resident #34 had full upper dentures and partial dentures on the bottom with some natural teeth. The family member indicated they had found her with upper dentures falling down and this inhibited her speech. The family member indicated on 6/3/15, they had taken the resident to a family reunion and her upper dentures were falling down. The family member indicated when the resident's dentures were falling down there was food observed between the roof of her mouth and her dentures.</p>			

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F 0314 SS=D Bldg. 00	<p>The family member indicated sometimes the resident's upper dentures will stay in and other times they will fall down, the family member felt this was due to inconsistent denture adhesive application.</p> <p>Interview with the Director of Health Services (DHS) on 8/3/15 at 5:10 p.m., indicated it was the aides and the nurses responsibility to ensure residents teeth/dentures were clean and denture adhesive was applied to dentures for residents who were unable to do this for themselves independently. The DHS indicated the care tracker alerted staff to which residents required assistance with oral care.</p> <p>3.1-38(a)(3)(C)</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 provide a resident with an existing</p>	F 0314	F 314	09/03/2015

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	<p>coccyx pressure ulcer, a pressure relieving device in her Broda chair, for 1 of 3 residents reviewed for skin conditions, of 6 who met the criteria for skin conditions (non-pressure related). (Resident #102)</p> <p>Findings include:</p> <p>Resident #102's record was reviewed on 7/31/15 at 11:12 a.m. Her diagnoses included but were not limited to, dementia and chronic pain.</p> <p>Resident #102's admission Minimum Data Set (MDS) assessment dated 5/2015, indicated she required extensive assistance of 2 persons for bed mobility and transfers. She required extensive assistance of 1 person for toileting and she was frequently incontinent of urine. She had 2 stage 2 pressure ulcers. She utilized a pressure relieving device in bed and received pressure ulcer care. She received Hospice services.</p> <p>A Skin plan of care for Resident #102 with no initiation date indicated "I have potential for alterations in my skin integrity... Provide me with pressure redistribution products for my bed and chair...."</p> <p>A Monthly Nursing Assessment for</p>		<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #102 wound has healed</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will: Review residents with skin impairment to ensure prevention interventions are in place per plan of care.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Pressure Prevention</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure</p>	

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	<p>Resident #102 dated 7/4/15, indicated she did not have any pressure ulcers and she utilized a pressure relieving/reducing device in her bed and chair.</p> <p>A Change In Condition Form for Resident #102 dated 7/17/15, indicated she had a stage 2 pressure ulcer on her coccyx that measured 2.5 centimeters (cm) long by 1.5 cm wide.</p> <p>A Change In Condition Form for Resident #102 dated 7/29/15, indicated her stage 2 pressure ulcer on her coccyx measured 1.6 cm long by 0.5 cm wide by less than 0.1 cm deep. She had a low air loss mattress, a wheelchair cushion, and received frequent repositioning.</p> <p>On 7/31/15 at 1:18 p.m., Resident #102 was observed being transferred from her Broda chair to her bed with the assistance of CNA #6. Resident #102's Broda chair seat had a piece of dycem laid on it and a white vinyl alarm pad laid on top of the dycem. No pressure redistribution device was on the Broda seat. CNA #6 indicated there was no pressure redistribution device on the Broda seat.</p> <p>On 8/3/15 at 1:44 p.m., Resident #102 was observed being transferred from her Broda chair to her bed with the assistance of CNA #5. Resident #102's Broda chair</p>		<p>compliance: Residents with skin impairments have prevention interventions in place per plan of care.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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F 0464 SS=E Bldg. 00	<p>seat had a piece of dycem laid on it and a white vinyl alarm pad laid on top of the dycem. No pressure redistribution device was on the Broda seat. CNA # 5 indicated she did not believe Resident #102 used a pressure redistribution device in her Broda chair.</p> <p>On 8/3/15 at 2:02 p.m., LPN #3 indicated staff could view a resident's profile in the Kiosk. A view of Resident #102's profile in the Kiosk at that time indicated "provide me with pressure redistribution products for my bed and chair."</p> <p>3.1-40(a)(2) 483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. Based on observation and interview, the facility failed to provide adequate dining space in the assisted dining room for 2 of 3 dining observations and 1 of 2 dining rooms observed. This had the potential to affect 10 resident's.</p> <p>Findings include:</p>	F 0464	<p>F 464</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient</p>	09/03/2015

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	<p>On 7/28/15 at 12:20 p.m., the assisted dining room was observed to have 10 residents seated at dining tables. 4 Staff and 2 visitors were observed assisting residents with their lunch. There was no walking space in between the chairs and if some of the residents had needed to be removed from the dining room, other residents would have had to be moved away from their table.</p> <p>On 7/30/15 at 12:55 p.m., Resident #102's daughter indicated she often assisted her mother with dining in the assisted dining room. She felt like the assisted dining room was to small. When the dining room was full, she could not walk around the room or between the tables and she was pretty much stuck in her chair until staff removed other residents away from their table.</p> <p>On 8/3/15 at 12:45 p.m., 10 residents were observed seated in the assisted dining room at the dining tables. 4 Staff were observed assisting residents with their lunch. There was no walking space in between the chairs and if some of the residents had needed to be removed from the dining room, other residents would have had to be moved away from their table. An unidentified staff member indicated "we need more room in here."</p>		<p>practice: Residents being assisted with their meals by a family member are now being seated in the main dining room to provide for adequate space and safety of residents, family and staff.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will ensure residents being assisted with their meals by a family member are now being seated in the main dining room to provide for adequate space and safety of residents, family and staff.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate nursing staff and meal managers regarding residents being assisted with their meals by a family member are now being seated in the main dining room to provide for adequate space and safety of residents, family and staff.</p>	

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F 0501 SS=F Bldg. 00	<p>On 8/3/15 at 3:53 p.m., the Director of Health Services (DHS) indicated when a residents family member wanted to assist with feeding their family member, the staff asked and encouraged them to take their family member into the main dining room because the assisted dining room gets overcrowded. The DHS indicated the facility had a limit of 10 residents and 4 staff in the assisted dining room at one time. She indicated the assisted dining room was crowded with 14 people.</p> <p>An interview with the DHS and Executive Director on 8/3/15 at 5:10 p.m., indicated the Meal Manager was responsible for monitoring the assisted dining room for resident safety and to ensure no more than 10 residents are in the room at one time.</p> <p>3.1-19(cc)(4)</p> <p>483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.</p> <p>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.</p>		<p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations of the assisted dining room will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents being assisted with their meals by a family member are now being seated in the main dining room to provide for adequate space and safety of residents, family and staff.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Based on interview and record review, the facility failed to ensure the Medical Director reviewed and approved the resident care policies annually. This had the potential to affect 112 residents in the facility.</p> <p>Findings include:</p> <p>On 7/31/15, at 4:00 p.m., the attestation page from the facility's policy and procedure book was requested from the Director of Health Services (DHS). The DHS indicated all facility policies and procedures are on the facility drive, for example, if you need a policy under nursing, you look under nursing. The Executive Director indicated, at that time, they have not reviewed their policies annually. He indicated that it has not been done since he has been in the facility, almost two years and that when they attend their next Quality Assurance meeting, they will make it a priority to have that done. He indicated as the policies are updated, they are put on the computer.</p> <p>During an interview, on 8/4/15, at 4:10 p.m., the Executive Director indicated the Medical Director is coming in on Friday to address this issue.</p>	F 0501	<p>F 501</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The Medical Director has reviewed and approved the resident care policies.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The Medical Director has reviewed and approved the resident care policies.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will ensure Medical Director has reviewed and approved resident care policies annually.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits</p>	09/03/2015	

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R 0000 Bldg. 00	<p>3.1-13(j)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 61</p> <p>Sample: 7</p> <p>Springhurst Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>and /or observations for the resident care policies will be conducted by the DHS or designee monthly times 6 months to ensure compliance: Medical Director has reviewed and approved.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p>Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Recertification and State Licensure survey August 4, 2015. Please accept this plan of</p>	

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			correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.		