

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155327	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/23/2013
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NAME OF PROVIDER OR SUPPLIER  UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00127162 and IN00127492.</p> <p>Survey Dates: April 15, 16, 17, 18, 19, 22, and 23, 2013</p> <p>Facility number: 000220 Provider number: 155327 AIM number: 100267650</p> <p>Survey team: Leia Alley, RN-TC Patten Allen, BSW Marcy Smith, RN Dinah Jones, RN</p> <p>Census bed type: SNF: 26 SNF/NF: 122 TOTAL: 148</p> <p>Census payor type: MEDICARE: 26 MEDICAID: 93 OTHER: 29 TOTAL: 148</p> <p>These deficiencies reflect state</p>	F000000	<p>UPDATED</p> <p>This plan of correction is to serve as University Heights Health and Living Community's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by University Heights Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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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	findings cited in accordance with 410 IAC 16.2.  Quality Review completed on May 02, 2013; by Kimberly Perigo, RN.				

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F000223 SS=D	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to keep a resident free from sexual abuse for 1 of 4 resident reviewed for abuse. (Resident #E.)</p> <p>Findings Included:</p> <p>A facility report titled Resident Reported Abuse, dated 4/7/13, was reviewed on 4/22/13 at 9:30 a.m.</p> <p>The report indicated that Resident #E reported an allegation of being touched inappropriately by Resident #M on 4/7/13.</p> <p>Review on 4/22/13 at 10:00 a.m., of Resident #E's Quarterly Minimum Data Set (MDS) assessment indicated Resident #E scored a 14/15 for the Brief Interview for Mental Status (BIMS), which indicated Resident #E was cognitively intact (having no memory or mental issues).</p>	F000223	<p><b>F 223 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</b></p> <p>I. Resident #E was protected immediately from abuse, when the incident was reported, by constant supervision of the resident that was accused. Resident #M no longer resides at the facility.</p> <p>II. Facility staff immediately began to interview other alert and oriented residents residing on the same hall as Resident #M, and no other concerns were noted or reported.</p> <p>III. The systemic change includes that any resident referred from, or with a recent stay at a special care, locked unit for a person with dementia, and/or a resident with multiple episodes of wandering and a diagnosis of Dementia, prior to admission, will be reviewed by the Director of Nursing, Administrator or designee to determine risk of intrusive wandering. Appropriate decisions will be made and care plan</p>	05/23/2013			

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	<p>During an interview on 4/22/13 at 3:00 p.m., with Resident #E, they indicated being touched inappropriately, by another resident in the facility, and reported it. Resident #E indicated Resident #M (alleged perpetrator) lived on the same hall they did and came into other residents rooms often, and "walked around a lot."</p> <p>The clinical record for Resident #M was reviewed on 4/23/13 at 11:00 a.m.</p> <p>Diagnoses included but were not limited to Alzheimer's disease and dementia.</p> <p>Resident #M was admitted to the facility on 4/5/13.</p> <p>Resident #M's Minimum Data Set (MDS) assessment, dated 4/9/13, indicated Resident #E scored a 1/15 for the Brief Interview for Mental Status (BIMS), which indicated Resident #M was severely cognitively impaired (very confused with poor or impaired judgement).</p> <p>Hospital discharge paperwork for Resident #M dated 4/4/13, indicated the following:</p>		<p>interventions put in place to supervise the resident after admission. If a private room is available, it may be utilized or the roommate situation will be considered. Appropriate interventions for intrusive wandering and/or for placement on the Memory Care Unit (Alzheimer Unit) will be considered prior to admission and when intrusive wandering occurs. If it is determined that the resident's needs require admission to the Memory Care Unit or a private room and a bed is not available, the admission will be declined or delayed until a qualified bed or placement on the Memory Care Unit is available.</p> <p>Education will be provided to Admissions Personnel, Assistant Administrator, Administrative nurses, Social Services and nursing staff regarding the systemic change.</p> <p>IV.</p> <p>The Director of Nursing and/or Administrator or designee will audit all new admission inquiries for the need of a bed on the Memory Care Unit, and for intrusive wandering with each admission inquiry. The Unit Manager or designee will audit the Matrix documentation for intrusive wandering daily (Monday through Friday) at the clinical meeting and for an appropriate intervention. In addition, the weekend supervisor will audit for</p>		

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	<p>"Patient had some agitation overnight, was trying to get up and walk" "History/Indication: Falls, confused, has Alzheimer's" "Assessment and Plan, Physical Therapy working with patient, will need to be careful with patient in the future, as he is a fall risk and will be on anticoagulation. Patient with some confusion, think that this is delirium in the setting of dementia." "Patient has been trying to get up and wander."</p> <p>A facility nurses note dated 4/5/13 at 8:00 p.m., the date of Resident #M's admission, indicated "Res [resident] found in hallway naked, was combative with staff when redirecting to room and dressing, attempted to hit, kick, punch, and scratch. ADON (Assistant Director of Nursing) notified of behavior, res [resident] ref [refused] to go to bed, was asst by staff x2 [2 staff assisting] to chair in hall by nurses station."</p> <p>A facility nurses note dated 4/5/13 at 9:55 p.m., indicated "Resident has gone into room 500, was pacing and playing with bed controls, fidgeting with linens, has toileted, large formed BM [bowel movement] has put self in bed in room 500, currently asleep."</p>		<p>intrusive wandering on the weekends and place an appropriate intervention. The audit will continue for a total of 12 months. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed. Date of completion: May 23, 2013</p>	

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	<p>A facility nurses note dated 4/6/13 at 1:02 p.m., indicated "this writer found resident asleep in room 500 this am [morning] took resident back to [indicates gender] room [indicates room number] changed [indicates gender] and has call light and bed side table ate 50% of breakfast then resident was found wandering with no clothing on by CNA (Certified Nurses Assistant) took back to room and put gown and brief on resident later in the morning resident was found in 501 urinating on floor. resident was again taken back to [indicates room number] and given lunch resident was counting aloud from 1-10 repeatedly and would not respond to this writer went back and checked on residents lunch tray and [indicates gender] was eating resident seems very confused and unaware of surroundings resident was not combative this shift just could not keep [indicates gender] still for long resident wanders without using walker and takes slip socks off he is considered a fall risk however."</p> <p>The clinical record indicated Resident #M was placed on 1:1 observation (a staff person with resident at all times) on 4/8/13 after the allegation of having touched Resident #E inappropriately was reported.</p>			

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	<p>During an interview on 4/23/13 at 10:15 a.m., with the Assistant Administrator, she indicated since Resident #E was cognitively intact she believed Resident #E's allegation to be true and they decided to send Resident #M to a psychiatric facility for evaluation and treatment. She also indicated she was aware that Resident #M lived in an Assisted Living community with their spouse, on a special, locked dementia care unit. She indicated at the time of Resident #M's admission, there was not a bed available on the facility's Alzheimer's care unit and assumed that due to recent hospitalization he was debilitated and not able to walk or wander.</p> <p>During an interview with the Admissions personnel on 4/23/13 at 10:30 a.m., she indicated that a corporate nurse evaluates the residents records while at the hospital and sends the paperwork to her for review, then she hands the paperwork off to the Director of Nursing (DON) for further review. She indicated Resident #M came as a "Silent Referral" which is a back up plan for when facility placement is not the family's first choice. She did not indicate if she knew Resident #M was formerly living on a special care,</p>			
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	<p>locked unit for persons with dementia.</p> <p>During an interview with the Director of Nursing at 11:00 a.m. on 4/23/13, she indicated she can only remember reviewing the medication records for Resident #M and thought he may have had some issues with major depression. She indicated she was aware Resident #M lived in an assisted living community formerly, but did not indicate she was aware it was a special care, locked unit for persons with dementia.</p> <p>A facility policy titled "Abuse Prevention", dated April, 2011, stated "Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse."</p> <p>This Federal tag relates to Complaint IN00127162.</p> <p>3.1-27(a)(1)</p>				

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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, interview, and</p>	F000225	F225 483.13(C)(1)(ii)-(iii), (c)(2)-	05/23/2013			

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	<p>record review, the facility failed to ensure an allegation of staff to resident abuse had been immediately reported to the administrator for 1 of 3 alleged violations of abuse of a resident. This had the potential to affect 148 residents residing in the facility. (Resident # 182, Certified Nursing Assistant (C.N.A.) # 10, Staffing Coordinator)</p> <p>Findings include:</p> <p>Facility written reports of an alleged violation of abuse provided by the facility, were reviewed on 4/22/13 at 2:30 p.m.,</p> <p>An initial Resident Abuse Report, indicated On April 11, 2013 at 1:36 am, Staffing Coordinator, received a call from C.N.A. #10, an Employee who was terminated on April 10, 2013; due to poor job performance. C.N.A. #10 stated " _____ [name] why did I get fired"</p> <p>Then proceeded to ramble on about how she is not a bad person, and there are others that work here that are bad.</p> <p>C.N.A. #10 ask me if she would lose her license or get in to trouble if she reported abuse that happened before and she did not report.</p> <p>After asking, I ask her what she was</p>		<p><b>(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b></p> <p>I. C.N.A. #10 is no longer employed by the facility. The Staffing Coordinator was provided education during the survey process regarding immediate reporting of allegations of abuse to the Administrator. Resident #182 shows no fear of staff or adverse psychosocial concerns.II. All allegations of staff to resident abuse are being immediately reported to the administrator per facility policy.An audit will be completed for all allegations of staff to resident abuse over the last 60 days for verification of immediate reporting to the Administrator. Any concerns will be addressed.III. The systemic change includes that all grievances and/or allegations of abuse will be reviewed at the daily meeting (Monday through Friday). This review will include an audit of immediate notification of the Administrator.Education will be provided to facility staff regarding the Abuse Policy and Procedure with emphasis on immediate notification of the Administrator. In addition, education is provided to all new hires regarding the facility's Abuse Policy and Procedure.IV. The Administrator or designee will audit all allegations of abuse weekly for immediate notification of the administrator. This audit will continue weekly for 60 days,</p>		

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	<p>talking about and she stated she witnessed a C.N.A. hit a resident in the mouth during care ( 2 to 3 weeks ago). She stated that, "c.n.a then told her that we can't let then treat us like this." I advised her she needed to tell me who it was. She stated it was C.N.A. #11, she was afraid to report. After continuously rambling I advised her she should have reported this and she needed to contact the Administrator Immediately.</p> <p>I reported my conversation to the ADON at 8:15 am on April 11, 2013.</p> <p>I told C.N.A. #10 we needed to talk about what she told me in our conversation, she said that her and C.N.A, #11 was given Resident #182 a shower and she was holding his arm while C.N.A., #11 was washing him. She stated, " He is strong and I could not hold his arms." She said he was hitting C.N.A. #11 so C.N.A. #11 reached up and hit him in the mouth, making his mouth bleed. She said C.N.A. #11 then stated, "We can't let them treat us like this."</p> <p>She then stated that C.N.A. #11 told the Nurse that he was fighting them in the shower and he was swinging his arms around and had hit himself in the mouth.</p>		<p>then monthly for duration of 12 months of monitoring. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed. Date of completion: May 23, 2013</p>		

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	<p>According to Time Card Report accused C.N.A #11 was not on the schedule for 04/11/2013, or 04/12/2013, but at 11:45 am on 04/12/2013 C.N.A. #11 reported to the Administrator's office and was suspended pending an investigation.</p> <p>During observation of Resident # 182 on 4/21/13 at 3:05 p.m., The resident was observed sitting in the dining room on 300 hallway, waiting on a snack. The resident did not appear to be distress, nor fearful of staff. He did appear to be content and in a friendly, cheerful, and relaxed mood.</p> <p>On 4/22/13 at 5:00 p.m., an interview with Administrator, Assistant Administrator, and Director of Nursing indicated that they were informed of the allegation of abuse on 4/11/2013 at 8:21 a.m., by a text from Assistant Director of Nursing. After Staffing Coordinator, reported to ADON at 8:15 am on 4/11/2013. They indicated this was the first time of hearing about the allegation of the abuse, that they had not received a call at home or a page.</p> <p>On 4/23/2013 at 10:05 am, during an interview with Administrator, and the D.O.N. indicated; "Employee #1 (C.N.A. #10) was</p>				

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	<p>terminated on 04/10/2013 for poor job performance," as documented on Resident Abuse Investigation Report. Employee #1 made call of allegation of abuse to Staffing Coordinator at 1:30 a.m. on 4/11/2013. Employee #2 (C.N.A. #11) was not on duty at time of allegation. Follow up conversation with Employee #1 on 4/11/2013 where it was admitted "drinking last night.... should have reported earlier." Employee #1 received training on reporting suspicion of a crime on 10/04/2012 No injury found on resident or any other residents on unit.</p> <p>The Administrator acknowledged his Staffing Coordinator and C.N.A #1 failed to follow their policy and procedure of reporting to the Administrator immediately or contacting the Administrator or D.O.N at home after hours.</p> <p>3.1-28(c)</p>				

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F000226 SS=D	<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, interview, and record review, the facility failed to implement their policy of immediately reporting to the administrator an allegation of staff to resident abuse for 1 of 3 alleged violations of abuse of a resident. This had the potential to affect 148 residents residing in the facility. (Resident # 182, Certified Nursing Assistant (C.N.A.) # 10, Staffing Coordinator)</p> <p>Findings include:</p> <p>Facility written reports of an alleged violation of abuse provided by the facility, were reviewed on 4/22/13 at 2:30 p.m.,</p> <p>An initial Resident Abuse Report, indicated On April 11, 2013 at 1:36 am, Staffing Coordinator, received a call from C.N.A. #10, an Employee who was terminated on April 10, 2013; due to poor job performance. C.N.A. #10 stated, " _____ [name] why did I get fired" Then proceeded to ramble on about</p>	F000226	<p><b>F226 483.13(c)</b> <b>DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</b></p> <p>I. The Administrator was notified of the allegation of abuse involving Resident #182 and C.N.A. #10.</p> <p>II. All allegations of staff to resident abuse are being immediately reported to the administrator per facility policy. An audit will be completed for all allegations of staff to resident abuse over the last 60 days for verification of immediate reporting to the Administrator. Any concerns will be addressed.</p> <p>III. The systemic change includes that all grievances and/or allegations of abuse will be reviewed at the daily meeting (Monday through Friday). This review will include an audit of immediate notification of the Administrator. Education will be provided to facility staff regarding the Abuse Policy and Procedure with emphasis on immediate notification of the Administrator. In addition, education is provided to all new</p>	05/23/2013			

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	<p>how she is not a bad person, and there are others that work here that are bad.</p> <p>C.N.A. #10 ask me if she would lose her license or get in to trouble if she reported abuse that happened before and she did not report.</p> <p>After asking, I ask her what she was talking about and she stated she witnessed a c.n.a. hit a resident in the mouth during care ( 2 to 3 weeks ago). She stated that, "c.n.a. then told her that we can't let then treat us like this." I advised her she needed to tell me who it was. She stated it was C.N.A. #11, and was afraid to report.</p> <p>After continuously rambling I advised her she should have reported this and that she needed to contact the Administrator Immediately.</p> <p>I reported my conversation to the ADON at 8:15 am on April 11, 2013.</p> <p>I told C.N.A. #10 we needed to talk about what she told me in our conversation, she said that her and C.N.A. #11 was given Resident #182 a shower and she was holding his arm while C.N.A., #11 was washing him. She stated, " He is strong and I could not hold his arms." She said he was hitting C.N.A. #11 so C.N.A. #11 reached up and hit him in the mouth, making his mouth bleed. She said</p>		<p>hires regarding the facility's Abuse Policy and Procedure.</p> <p>IV.</p> <p>The Administrator or designee will audit all allegations of abuse weekly for immediate notification of the administrator. This audit will continue weekly for 60 days, then monthly for duration of 12 months of monitoring.</p> <p>The results of the audit will be discussed at the monthly Quality Assurance Committee meeting for duration of 12 months and the frequency and duration may be increased if needed.</p> <p>Date of Compliance: May 23, 2013</p>				

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	<p>C.N.A. #11 then stated, " We can't let them treat us like this." She then stated that C.N.A. #11 told the Nurse that he was fighting them in the shower and he was swinging his arms around and had hit himself in the mouth.</p> <p>According to Time Card Report accused C.N.A #11 was not on the schedule for 04/11/2013, or 04/12/2013, but at 11:45 am on 04/12/2013 C.N.A. #11 reported to the Administrators office and was suspended pending an investigation.</p> <p>During observation of Resident #182 on 4/21/13 at 3:05 p.m. The resident was observed sitting in the dining room on 300 hallway, waiting on a snack. The resident did not appear to be distress, nor fearful of staff. He did appear to be content and in a friendly, cheerful, and relaxed mood.</p> <p>Review of the facility's Policy and Procedure titled "Abuse Prevention, (revised April 2011 th) on 4/22/13 at 9:15 a.m., indicated, "... On page 4, under IV.</p> <p>IDENTIFYING &amp; RECOGNIZING SIGNS AND SYMPTOMS OF ABUSE</p> <p>Policy Statement</p>				

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	<p>Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to their supervisor who will report to the Administrator immediately.</p> <p>Page 6, under VII. REPORTING ABUSE TO:</p> <p>A. ADMINISTRATOR</p> <p>Policy Interpretation and Implementation</p> <p>#3. The administrator and director of nursing services must immediately be notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and director of nursing services must be called at home or must be paged and informed of such incident."</p> <p>On 4/22/13 at 5:00 p.m., an interview with Administrator, Assistant Administrator, and Director of Nursing indicated that they were informed of the allegation of abuse on 4/11/2013 at 8:21 a.m., by a text from Assistant Director of Nursing. After Staffing Coordinator, reported to ADON at</p>						

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	<p>8:15 am on 4/11/2013. They indicated this was the first time of hearing about the allegation of the abuse, that they had not received a call at home or a page.</p> <p>On 4/23/2013 at 10:05 am, during an interview with Administrator, and the D.O.N. indicated; "Employee #1 (C.N.A. #10) was terminated on 04/10/2013 for poor job performance," as documented on Resident Abuse Investigation Report. Employee #1 made call of allegation of abuse to Staffing Coordinator at 1:30 a.m. on 4/11/2013. Employee #2 (C.N.A. #11) was not on duty at time of allegation. Follow up conversation with Employee #1 on 4/11/2013 where it was admitted "drinking last night.... should have reported earlier." Employee #1 received training on reporting suspicion of a crime on 10/04/2012 No injury found on resident or any other residents on unit.</p> <p>The Administrator acknowledged his Staffing Coordinator and C.N.A. #1 failed to follow their policy and procedure of reporting to the Administrator immediately or contacting the Administrator or D.O.N at home after hours.</p>						

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F000241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to treat a resident with respect and dignity. (Resident #120.)</p> <p>Findings Included:</p> <p>During an observation and interview of Resident #120 on 4/16/13, at 9:45 a.m., Resident #120 requested a glass of cranberry juice. The interview was halted and the juice was requested from a nurse, near by, in the hallway.</p> <p>CNA (Certified Nursing Assistant) #2, who was unaware Resident #120 was being observed, came into Resident #120's room and in a loud, demeaning manor said, "[Resident #120's name]what do you need, I told you I would get your juice. I had to get 2 people off the pot and that's an emergency [Resident #120's name], your juice is not an emergency."</p> <p>During an interview with the Director of Nursing on 4/16/13 at 2:30 p.m.,</p>	F000241	<p><b>F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>I. Resident #120 is being treated with respect and dignity. C.N.A. #2 was given education regarding treating a resident with respect and dignity during the survey process.</p> <p>II. Other alert and oriented residents under the care of this C.N.A. over the last 30 days will be interviewed for concerns with being treated with respect and dignity. Any concerns will be addressed.</p> <p>III. The systemic change includes quarterly education for staff regarding treating residents with respect and dignity. Education will be provided to facility staff regarding treating residents with respect and dignity.</p> <p>IV. The Social Service Staff or designee will randomly interview 5 alert and oriented residents from varying units in regards to staff treating them with respect and dignity weekly for 4 weeks, then monthly for a total of 12 months. The results of these reviews will be</p>	05/23/2013	

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	<p>she indicated she would discuss with CNA #2 that residents were to be treated as if they were a loved one, and that maintaining a residents dignity is expected from staff.</p> <p>A facility policy titled "Abuse Prevention", dated April, 2011, indicated that staff will have the "knowledge and training to further ensure each resident is treated with individual respect and dignity."</p> <p>3.1-3(t)</p>		<p>discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed.</p> <p>Date of completion: May 23, 2013</p>	

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F000272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p> <p>1. Based on record review and interview, the facility failed to ensure an admission Minimum Data Set (MDS) assessment for urinary</p>	F000272	<p><b>F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>I. A corrected MDS was completed for resident #79 and shows an accurate assessment for urinary incontinence.</p>	05/23/2013

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	<p>incontinence was accurate. This affected 1 of 4 residents who met the criteria for review of a decline in urinary continence in a total sample of 32. (Resident #79)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #79 was reviewed on 4/18/13 at 2:00 p.m.</p> <p>Diagnoses for Resident #79 included, but were not limited to, urinary tract infection and muscle weakness.</p> <p>Resident #79 was admitted to the facility on 12/17/12.</p> <p>An admission MDS, dated 12/24/12, indicated Resident #79 was always continent of urine.</p> <p>A significant change MDS, dated 2/28/13, indicated Resident #79 was occasionally incontinent.</p> <p>A facility admission bladder assessment, dated 12/17/12, indicated Resident #79 was not continent. Risk factors for incontinence included impaired mobility, dependence for transfers, urine leakage, urinary tract infection, diuretics, leakage with cough, sneeze, physical activity, strong, uncontrolled</p>		<p>II. An audit will be completed for all MDS assessments completed in the last 30 days, in regards to accuracy of assessment for urinary incontinence. Any concerns will be addressed.</p> <p>III. The systemic change includes that residents will be assessed for urinary continence during their assessment reference period for a new MDS, and a new Urinary Continence Assessment/Observation will be completed in the computerized record. The MDS nurse will review this assessment as well as the C.N.A. documentation regarding the current status of urinary continence/incontinence.</p> <p>Education has been provided to all MDS staff regarding accuracy of assessment for urinary continence and use of the assessment/observation as well as the C.N.A. documentation in the clinical record.</p> <p>IV. The MDS Coordinator or designee will audit all completed MDS's for accuracy of assessment in regards to urinary continence with each new assessment for the next 30 days, then 3 records weekly for 4 weeks, then 1 MDS monthly for a duration of 12 months of monitoring. The results of these reviews will be discussed at the facility Quality</p>	

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	<p>urgency prior to incontinence, urine loss on way to toilet, and urge incontinence.</p> <p>During an interview with MDS Nurse #6, on 4/18/13 at 2:25 p.m., she indicated she was not able to find any evidence that Resident #79 was "always continent" when she was admitted to the facility. She indicated the urinary incontinence assessment of "always continent" on the admission MDS assessment, dated 12/24/12, was a error.</p> <p>3.1-31(d)</p>		<p>Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed.</p> <p>Date of completion: May 23, 2013</p>	

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) <b>DEVELOP COMPREHENSIVE CARE PLANS</b> A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure an individualized care plan with specific interventions was developed for a resident who was admitted with a pressure ulcer for 1 of 1 residents who met the criteria for review of pressure ulcer care in a sample of 32. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record of Resident #B was reviewed on 4/19/13 at 9:00 a.m.</p>	F000279	<p><b>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>I. The care plan for Resident #B is individualized with specific interventions developed for the pressure ulcer. The care plan for Resident #46 had a care plan for pain added during the survey process</p> <p>II. All residents admitted with a pressure ulcer have been identified and their care plans are individualized with specific interventions to promote healing of</p>	05/23/2013	

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	<p>Diagnoses for Resident #B included, but were not limited to, fractured hip and pressure ulcer.</p> <p>Resident #B was admitted to the facility on 3/4/13.</p> <p>A Pressure Ulcer Evaluation, dated 3/5/13, indicated Resident #B had a Stage 2 pressure ulcer on her coccyx, present at admission. It measured 4.0 cm (centimeters) by 4.5 cm. by 0.1 cm. A Stage 2 pressure ulcer is a partial loss of thickness to the dermis.</p> <p>A physician's order, dated 3/5/13, indicated Resident #B was to have Calmoseptine applied to her coccyx every shift. Calmoseptine is a skin protectant.</p> <p>A Pressure Ulcer Evaluation, dated 3/11/13, indicated Resident B's coccyx pressure had deteriorated to a Stage 3. It measured 6.0 cm. by 6.5 cm. by 0.1 cm. A Stage 3 pressure ulcer indicates a full thickness loss of tissue. The evaluation indicated treatment for the resident's coccyx pressure ulcer would be changed to cleaning with normal saline, and applying Santyl daily. Santyl is an enzymatic, debriding ointment used to treat pressure ulcers.</p>		<p>the pressure ulcer.</p> <p>All Residents with pain have been identified and have a care plan for pain.</p> <p>III.</p> <p>The systemic change includes that</p> <ul style="list-style-type: none"> <li>· All new orders related to treatment of a pressure ulcer on a resident admitted with a pressure ulcer and residents with new pain medication orders will be reviewed at the daily (Monday through Friday) morning clinical meeting and the care plan will be reviewed and updated at that time.</li> <li>· Daily charting and new observations are reviewed during the clinical meeting to review for pain and/or any decline in a pressure ulcer on a resident admitted with a pressure ulcer, and the need for a treatment change and update of the plan of care. The physician will be notified and treatment and care plan updated as needed.</li> <li>· All residents admitted with a pressure ulcer are reviewed at the weekly at risk meeting, with a review of the status of the wound, the current treatment and the plan of care.</li> </ul> <p>Education will be provided to licensed nurses regarding the use of specific interventions being utilized to promote healing for a resident admitted with a pressure ulcer and care planning for the presence of pain. Education will be provided to</p>				

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	<p>A careplan for Resident #B, dated 3/5/13, indicated a problem of, "[name of resident] has a pressure ulcer to her coccyx." The goal was, "Area will heal without complication." Approaches were, "Diet as ordered, Pressure reducing mattress, Pressure relieving cushion to wheelchair, Therapy to eval[uate] and [treat], Treatment to coccyx as ordered."</p> <p>The care plan did not indicate any specifics regarding the stages of Resident #B's pressure ulcer, the treatments being used to promote healing or reevaluations to determine if the treatments were effective.</p> <p>During an interview with the Director of Nursing on 4/22/13 at 12:25 p.m., she indicated "We just put 'treatment per order' rather than put in specifics because they can change so frequently."</p> <p>2) During an interview with Resident #46 on 4/15/13 at 3:00 p.m., she indicated the facility has run out of her pain medication and she has gone long periods of time with out pain medication.</p>		<p>administrative nurses regarding the systemic change.</p> <p>IV.</p> <p>The Director of Nursing or designee will audit the care plan of all residents admitted with a pressure ulcer for use of specific interventions being utilized to promote healing of the pressure ulcer, and a pain care plan for residents with documented pain weekly for duration of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed.</p> <p>Date of completion: May 23, 2013</p>				

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	<p>The clinical record for Resident #46 was reviewed on 4/15/13 at 3:30 p.m.</p> <p>Diagnoses include but were not limited to, chronic low back pain, osteoarthritis (a degenerative joint disease) and osteoporosis (a disease where bones become more fragile).</p> <p>A physicians order dated 2/21/13, stated "Percocet (opioid analgesic-drug that relieves pain) tablet; 10-325mg, 1 tablet by mouth every 6 hours PRN (as needed)."</p> <p>A facility care plan for pain monitoring was requested of the Director of Nursing (DON) on 4/19/13 at 10:00 a.m.</p> <p>The DON provided a "Care Plan History" report that indicated a care plan for pain had been in place previously and discontinued on 3/1/13 due to "problem discontinued".</p> <p>During an interview with the DON on 4/19/13 at 11:00 a.m., she indicated a care plan had been developed and then discontinued. She indicated she was unsure why the care plan was discontinued, however indicated Resident #46 was assessed every shift for pain monitoring.</p>			

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F000282 SS=D	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to provide services as indicated by the plan of care, and failed to follow a physicians order for blood sugar monitoring. The facility failed to provide services for 2 of 3 Residents as indicated by the plan of care(Resident #B and #C), and failed to follow physicians orders for 1 of 10 residents reviewed for unnecessary medications (Resident 269).</p> <p>Findings Include:</p> <p>1. The clinical record for Resident #269 was reviewed on 4/18/13 at 11:30 a.m.</p> <p>Diagnoses include but were not limited to diabetes mellitus.</p> <p>A physicians order written 3/29/13 indicated, if blood sugar level was "greater than 350 call the doctor."</p>	F000282	<p><b>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I.</b> Resident #269's physician has been notified of the blood sugar results greater than 350, per the physician's order, in April and thereafter per the physician's order. Resident #B &amp; #C are receiving weekly skin assessments as indicated in the plan of care. II. All residents with physician's orders for blood sugar monitoring have been identified and an audit will be completed for following the physicians order for blood sugar monitoring. Any concerns will be addressed. All residents will be reviewed for weekly skin assessments. Any concerns will be addressed. III. The systemic change includes: All newly admitted residents with physician's orders for blood sugar monitoring will have their orders and electronic medication record reviewed for inclusion of a mandatory field for physician notification in the event that the blood sugar is at a range for physician notification per MD order. This review is completed during the clinical meeting the day after the admission and/or with changes in blood sugar</p>	05/23/2013	

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	<p>Blood sugar levels were as follows, 4/5/13, 4:00 p.m., blood sugar level was 367, 4/8/13, 4:00 p.m., blood sugar level was 363, 4/9/13, 12:00 p.m., blood sugar level was 533, and on 4/10/13, 4 p.m. blood sugar level was 417. No information was found in the clinical record, that Resident #269's doctor was notified of the blood sugar levels.</p> <p>Further information was requested from the Director of Nursing (DON), on 4/18/13 at 1:30 p.m.</p> <p>During an interview with the DON on 4/18/13 at 3:30 p.m., she indicated the medical doctor had not been notified as indicated by orders.</p> <p>2. The clinical record of Resident #B was reviewed on 4/19/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, fractured hip and pressure ulcer.</p> <p>Resident #B was admitted to the facility on 3/4/13.</p> <p>A care plan for Resident #B, dated 3/5/13, indicated a problem of, "Resident is at risk for skin</p>		<p>monitoring. Any concerns will be addressed and the physician notified. Weekly skin assessments will be reviewed daily, Monday through Friday, during the clinical meeting for completion. Any concerns will be addressed and corrected. Education will be provided to Administrative nurses regarding the systemic change. In addition, education will be provided to licensed nurses regarding the correct format for blood sugar monitoring in the electronic medication record, to include a mandatory field for physician notification in the event that the blood sugar is at a range for physician notification per MD order. Licensed nurses will also be provided education regarding completion of weekly skin assessments per facility policy.IV.The Unit Manager or designee will review the electronic medication record for following a physicians order for blood sugar monitoring weekly for 4 weeks, on residents with orders for blood sugars. Auditing will then continue every other week for 4 weeks, then monthly for a total of 12 months of monitoring. Any concerns will be addressed.The Unit Manager or designee will review for completion of weekly skin assessments daily, Monday through Friday, for duration of 12 months of monitoring. Any concerns will be addressed.The results of these reviews will be</p>		

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	<p>breakdown [related to] impaired mobility. The goal was, "Resident will be free from skin breakdown." Approaches included, "Weekly skin assessment."</p> <p>Review of skin assessments for Resident #B, indicated they had been done on 3/7/13, 3/14/13, 3/21/13, and 4/8/13. No documentation was found which indicated Resident #B's skin had been assessed between 3/21/13 and 4/8/13, or after 4/8/13.</p> <p>Further information was requested from the Director of Nursing (DON) on 4/19/13 at 3:00 p.m. regarding skin assessments done between 3/21/113 and 4/8/13, and after 4/8/13. She indicated pressure ulcer evaluations had been done on Resident #B's coccyx pressure ulcer, but no other overall skin assessments had been done during these weeks to monitor for further skin breakdown.</p> <p>3. The clinical record of Resident #C was reviewed on 4/18/13 at 11:00 a.m.</p> <p>Diagnoses for Resident #C included, but were not limited to, Alzheimer's disease, limb swelling and muscle</p>		discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed. Date of completion: May 23, 2013		

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	<p>weakness.</p> <p>Resident #C was admitted to the facility on 8/29/12.</p> <p>A care plan for Resident #C, dated 9/6/12 and updated 2/20/13, indicated a problem of, "[resident's name] is at risk for skin breakdown [related to] decreased mobility. The goal was, "Resident's skin will remain intact." Approaches included, "Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences."</p> <p>Weekly Skin Inspections were found in Resident #C's record for 2/6/13, 3/5/13, and 3/26/13.</p> <p>Further information was requested from the DON on 4/18/13 at 3:00 p.m., regarding whether any Weekly Skin Inspections had been done for Resident #C in February, March, or April, 2013, other than on 2/6/13, 3/5/13, and 3/26/13.</p> <p>On 4/19/13 at 11:00 a.m., the DON indicated she was not able to find any other Weekly Skin Inspections for Resident #C for February, March or April, 2013. At that time she provided shower sheets which had been filled out for Resident #C. The DON</p>				

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	<p>indicated at that time the shower sheets were filled out by a Certified Nursing Assistant (CNA) and signed by a nurse. The shower sheets had a front and back picture of the naked human body for the CNA to mark any skin irregularities, a "yes" or "no" question to be circled "Skin issue identified (circle one)," followed by "If Yes Nurse Notified IMMEDIATELY." The CNA was supposed to fill in the name of the nurse she notified about any new skin issues.</p> <p>A review of the shower sheets indicated the following:                  2/1/13 - no skin issues identified. CNA documented "Nothing new."                  2/5/13 - no skin issues identified.                  2/12/13 - no skin information found on this sheet                  2/15/13 - no skin issues identified. CNA documented "Nothing new."                  2/19/13 - no skin issues identified. CNA documented "Nothing new."                  2/26/13 - no skin information found on this sheet                  3/5/13 - no skin issues identified                  3/8/13 - no skin information found on this sheet                  3/12/13 - no skin information found on this sheet                  3/15/13 - no skin issues identified                  3/19/13 - no skin information found on this sheet</p>						

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	<p>3/22/13 - no skin issues identified 3/26/13 - picture of back of resident's body marked with "bruise" in 2 places. No information which indicated if a nurse was notified immediately, or the name of the nurse notified. 3/29/13 - no skin issues identified 4/2/13 - no skin information found on this sheet. CNA had written "Shower completed." 4/5/13 - No skin information found on this sheet 4/9/13 - no skin information found on this sheet 4/12/13 - no skin issues identified 4/16/13 - no skin issues identified</p> <p>There was a licensed nurse's signature on all the shower sheets, but there was no indication the nurse had inspected the resident's skin herself, or documented the findings.</p> <p>A facility policy, dated 4/2011, titled "Skin Care and Pressure/Non-Pressure Ulcer Management Program," received from the Nurse Consultant on 4/22/13 at 10:55 a.m., indicated, "...Risk Interventions...12. Complete a documented weekly skin inspection...", "...Weekly Skin Inspection - A licensed nurse should inspect skin on a weekly schedule and document findings..."</p>						

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F000314 SS=D	<p><b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></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, record review, and interview, the facility failed to ensure a resident who was admitted with a pressure ulcer received treatment in a timely manner to promote healing and prevent deterioration for 1 of 1 residents who met the criteria for review of care of pressure ulcers in a sample of 32. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record of Resident #B was reviewed on 4/19/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #B included, but were not limited to, fractured hip and pressure ulcer.</p> <p>Resident #B was admitted to the facility on 3/4/13.</p>	F000314	<p><b>F314 483.25(c)TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></p> <p>I. Resident #B is receiving treatment in a timely manner to promote healing and prevent deterioration of the pressure ulcer.</p> <p>II. All residents admitted with a pressure ulcer have been identified and will have their treatments reviewed for administration of treatment in a timely manner to promote healing and prevent deterioration. Any concerns will be addressed.</p> <p>III. The systemic change includes: · All new orders related to treatment of a pressure ulcer on a resident admitted with a pressure ulcer will be reviewed at the daily (Monday through Friday) morning clinical meeting for timely treatment to promote healing and prevent</p>	05/23/2013			

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	<p>A Pressure Ulcer Evaluation, dated 3/5/13, indicated Resident #B had a Stage 2 pressure ulcer on her coccyx, present at admission. It measured 4.0 cm (centimeters) by 4.5 cm. by 0.1 cm. A Stage 2 pressure ulcer is a partial loss of thickness to the dermis.</p> <p>A physician's order, dated 3/5/13, indicated Resident #B was to have Calmoseptine applied to her coccyx every shift. An information sheet on Calmoseptine, printed on 4/22/13 from the manufacturer's website, indicated it "is approved by the FDA [Food and Drug Administration] as a 'skin protectant drug product.' The FDA defines a skin protectant drug product as a product that 'temporarily protects injured or exposed skin or mucous membrane surfaces from harmful or annoying stimuli and may provide relief to such surfaces."</p> <p>A Treatment Administration History for Resident #B for March, 2013, indicated Calmoseptine was applied to her coccyx every shift from 3/5/13 through 3/31/13.</p> <p>A Pressure Ulcer Evaluation, dated 3/11/13, indicated Resident B's coccyx pressure had deteriorated to a Stage 3. It measured 6.0 cm. by 6.5 cm. by 0.1 cm. A Stage 3 pressure</p>		<p>deterioration.</p> <ul style="list-style-type: none"> <li>· Daily charting is reviewed during the clinical meeting to review for any decline in a pressure ulcer on a resident admitted with a pressure ulcer, and the need for a treatment change to promote healing and prevent deterioration. The physician will be notified and treatment updated as needed.</li> <li>· All residents admitted with a pressure ulcer are reviewed at the weekly at risk meeting, with a review of the status of the wound, and the current treatment to promote healing and prevent deterioration.</li> </ul> <p>Education will be provided to licensed nurses regarding receiving treatment for a pressure ulcer in a timely manner to promote healing and prevent deterioration.</p> <p>Education will be provided to administrative nurses regarding the systemic change.</p> <p>IV.</p> <p>The Director of Nursing or designee will review the current status of the pressure ulcer and for receiving treatment in a timely manner to promote healing and prevent deterioration of the pressure ulcer of all residents admitted with a pressure ulcer weekly for a duration of 12 months of monitoring.</p> <p>The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the</p>		

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	<p>ulcer indicates a full thickness loss of tissue. The evaluation indicated treatment for the resident's coccyx pressure ulcer would be changed to cleaning with normal saline, and applying Santyl daily. Santyl is an enzymatic, debriding ointment used to treat pressure ulcers.</p> <p>The Treatment Administration History for Resident #B for March, 2013, indicated the treatment using Santyl was not started until 3/15/13, 4 days after the treatment was ordered.</p> <p>A physician's order for the Santyl, dated 3/15/13, indicated "Cleanse area to coccyx with normal saline, pat dry. Apply Santyl to wound bed and cover with foam dressing. Secure with transparent dressing. Change daily and prn soilage."</p> <p>A Pressure Ulcer Evaluation, dated 3/18/13, indicated Resident #B's coccyx wound measured 5.0cm. by 4.2cm. by 0.1cm.</p> <p>A Pressure Ulcer Evaluation, dated 3/25/13, indicated Resident #B's coccyx wound measured 4.5cm. by 4.0cm. by 0.1cm.</p> <p>A Pressure Ulcer Evaluation, dated 4/1/13, indicated Resident #B's</p>		<p>frequency and duration of the reviews may be increased if needed. Date of Completion: May 23, 2013</p>		

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	<p>coccyx wound measured 3.3cm. by 3.5cm.</p> <p>A Pressure Ulcer Evaluation, dated 4/8/13, indicated Resident #B's coccyx wound measured 2.5cm. by 2.5cm by 0.1cm.</p> <p>During an observation of Resident #B's coccyx wound on 4/22/13 at 2:00 p.m., the wound appeared to be healing well. The wound base was pink, surrounding tissue appeared normal.</p> <p>On 4/22/13 at 2:00 p.m., further information was requested from the Director of Nursing (DON) regarding why the facility waited for 4 days, 3/11/13 - 3/15/13, to start the new Santyl treatment after Resident #B's pressure ulcer was found to have deteriorated to a Stage 3.</p> <p>On 4/22/13 at 4:40 p.m., the DON indicated she was not sure why the new treatment was delayed for 4 days. She indicated it was a possibility that the nurse who indicated on the Pressure Ulcer Evaluation on 3/11/13 that a new treatment was going to be started, forgot to "push the send button twice when she put the order in."</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155327		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/23/2013	
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227			
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F000441 SS=E	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	<b>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>	05/23/2013			

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	<p>ensure staff on the 500 hall followed proper hand washing techniques and maintained sanitary technique when passing medications for 1 of 7 observations of medication administration. This had the potential to affect 17 of 17 residents residing on the hall. (LPN #3)</p> <p>Findings include:</p> <p>1. During an observation of medication administration on the 500 Hall on 4/18/13 at 9:51 a.m., Licensed Practical Nurse (LPN) #3 was administering pills to Resident #B. LPN #3 picked up 5 pills out of the medication cup, one by one, with her bare fingers, and placed them in Resident #B's mouth.</p> <p>2. After administering the pills to Resident #B, she entered the residents bathroom and washed her hands for 7 seconds.</p> <p>3. During an observation of medication administration on the 500 Hall on 4/18/13 at 10:02 a.m., LPN #3 was preparing medications for Resident #154. LPN #3 indicated at this time that Resident #154 was unable to swallow pills or capsules, and they needed to be crushed in applesauce. LPN #3 picked up a</p>		<p>I. Resident #B and Resident #154 are receiving medications in a sanitary manner during medication pass. LPN #3 received education regarding proper hand washing techniques and maintaining sanitary techniques when passing medications during the survey process.</p> <p>II. Licensed nurses will complete a skill competency observation regarding proper hand washing techniques and maintaining sanitary technique when passing medications. Any concerns will be addressed.</p> <p>III. The systemic change includes that licensed nurses will complete a skill competency observation regarding proper hand washing techniques and maintaining sanitary technique when passing medications upon hire, every 6 months and as needed. Any concerns will be addressed.</p> <p>Education will be offered to licensed nurses regarding passing medications in a sanitary manner and proper hand washing techniques and maintaining sanitary techniques when passing medications.</p> <p>IV. The Staff Development Coordinator or designee will monitor for medications being passed in a sanitary manner and proper hand washing techniques with one nurse</p>				

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	<p>Docusate Sodium 100 mg, an uncrushable, liquid filled, capsule with her bare fingers, attempted to poke a hole in it with a needle, dropped the capsule on the floor, picked it up with her bare fingers and threw it away, removed another Docusate Sodium 100 mg. capsule, attempted to cut it open with scissors, and finally cut the whole capsule in half, still holding the capsule with her bare fingers, and placed both halves in applesauce, indicating "It will melt."</p> <p>During an interview with LPN #4 on 4/23/13 at 9:00 a.m., she indicated there were 17 residents receiving pill or capsule medications on the 500 hall on 5/18/13 at 10:00 a.m.</p> <p>A facility policy, dated October, 2009, titled "Handwashing/Hand Hygiene," received from the Director of Nursing (DON) on 4/19/13 at 4:00 p.m., indicated, "...Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water..."</p> <p>During an interview with the DON on 4/19/13 at 2:30 p.m., she indicated nurses who were passing medications should not be touching the pills or capsules with their bare hands. She indicated she would give an inservice</p>		<p>5 days a week, on varying shifts for 4 weeks. This monitoring will continue with 3 observations per week for 4 weeks, then 1 observation for week for 4 weeks, then monthly thereafter for a total of 12 months of monitoring. The results of these reviews will be discussed at the facility Quality Assurance Committee meeting monthly for 12 months, and the frequency and duration of the reviews may be increased if needed. Date of Completion: May 23, 2013</p>	

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	<p>about this immediately.</p> <p>3.1-18(l)</p>			