

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/07/2012
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF THE WILLOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ELIZABETH DR VALPARAISO, IN 46383
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F0000	<p>This visit was for the Investigation of Complaint IN00109031.</p> <p>Complaint IN00109031-Substantiated. Federal/state deficiencies related to the allegation are cited at F309.</p> <p>Unrelated deficiency cited.</p> <p>Survey date: June 7, 2012</p> <p>Facility number: 000078 Provider number: 155158 AIM number: 100289310</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 67 Total: 67</p> <p>Census payor type: Medicare: 17 Medicaid: 36 Other: 14 Total: 67</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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

TITLE

(X6) DATE

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

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	Quality review 6/11/12 by Suzanne Williams, RN			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services to maintain the resident's highest practicable physical well being related to the lack of providing treatment and monitoring of skin rashes and not arranging for a Dermatology referral, for 2 of 3 residents reviewed for skin rashes in the sample of 6. (Residents #F and #G)</p> <p>Findings include:</p> <p>1. On 6/7/12 at 11:20 a.m., RN #1 was observed completing a skin assessment and providing a skin assessment for Resident #F. The resident was in bed. The RN assessed the resident's bilateral abdominal/groin folds. Redness was noted across the lower abdomen and down the groins folds bilaterally. There were no open areas noted. The RN applied Nystatin powder (an antifungal medicated powder) to the areas. The Resident then asked the RN if she could</p>	F0309	<p><b>F309 1) Corrective action for the residents found to have been affected by the deficient practice:</b> 1. LPN Contacted resident F's physician to treat area to Rt. upper buttock order obtained on (June 7, 2012) for TX to resident #F right upper buttock. 2. Consultation for Resident F to see wound care doctor was scheduled for (June 13 2012) Resident was seen by wound doctor on (June 13,2012) skin integrity data sheet done on (June 7, 2012) by LPN, non pressure skin condition record done on (June 7, 2012) By LPN 3. Nurse's note completed on (June 8, 2012) by LPN that includes assessment. Nurse's note completed on (June 22, 2012) by RN that included assessment with Measurements. 4. Cna #1 was inserviced on (June 8 2012) by DON on bathing sheets and how to report any areas immediately to charge nurse. 5. Resident # G Has an appointment to be seen by a dermatologist on (June 26, 2012) Order for dermatologist appointment D/C on (June 13, 2012) Resident refused and</p>	07/07/2012			

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	<p>apply it to the area on her back. The RN then assisted the resident with turning to her left side. A deep red/purplish colored area was observed to the top of the right buttock area up to the area where the buttock meet at the sacral level. The area was approximately 9- 10 centimeters in diameter. There were raised moist pinpoint areas also noted around the perimeter of the reddened area. The resident stated the area was itching and hurting last night. The resident stated the area had been there about three months.</p> <p>The record for Resident #F was reviewed on 6/7/12 at 10:15 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, end stage renal disease, depression, and coronary artery disease. Review of the 6/12 Physician Order Statement indicated there was an order to apply Nystatin powder topically once daily for redness to the abdominal folds. The order was initially written on 3/20/12. There was an order for apply barrier cream to the peri area and the buttocks every shift and as needed for dry skin as preventative. There was no Physician order to treat the red/purplish areas to the upper right buttock area.</p> <p>Review of the 4/12 Treatment Records indicated there an order written on 3/7/12 to cleanse the area to the right buttock</p>		<p>wanted to be seen by wound Doctor Resident #G seen by wound Doctor on (June 13, 2012) New TX Ordered nurse's notes regarding rash update on (June 14, 2012) Social Service noted confirm that resident refused to see dermatologist on (June 22, 2012) Assessment of neck rash in Nurses Note on (June 22, 2012) skin integrity sheet updated (June 7, 2012) 6. RN# 1 was inserviced on day of survey (June 7, 2012) by DON to ensure orders are obtained by physician prior to any treatment and to look at Physician order's in chart, check Treatment administration record ,completing a nurse's note on area identified, how to fill out a non-pressure skin record and the importance of providing treatments timely according to physician' orders, and appropriate re-assessment time period 7. Upon review of the shower sheets and skin sheets (June 7, 2012) for resident's F &amp; G, none of the residents in question had any evidence to assume they had a negative change in condition therefore indicating that their care needs had not been met. <b>Corrective action taken for those residents having the potential to be affected by the same deficient practice:</b> 8. 100 % skin sweep was done in facility on (June 8, 2012) by clinical staff to ensure every resident had been assessed by nursing, no other</p>		

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	<p>with normal saline, apply Xenaderm (a medicated topical ointment) and cover with an ABD (a type of bandage) pad daily and as needed for soilage. The words "D/C'd healed" were written across the column where the above treatment would have been signed out after staff provided the treatment. The treatment was not signed out the month of April 2012.</p> <p>Review of the 5/12 and 6/12 Treatment records indicated no treatments were signed out as completed to the right buttock area rash.</p> <p>A Non-Pressure Skin Condition Record was initiated on 4/23/12 and indicated the resident had two rash areas to the right buttock. The areas were identified as Area A and Area B. The following measurements were recorded for the areas as follows:</p> <p>4/23/12 Area A: 6 cm x 6 cm Area B: 8 cm x 6 cm</p> <p>5/4/12 Area A: 8 cm x 5 cm Area B: 5 cm x 6 cm</p> <p>5/9/12 Area A: 5 cm x 11 cm Area B: 8 cm x 5 cm</p> <p>5/16/12 Area A: 7 cm x 6 cm</p>		<p>new area were found. From (June 7-13, 2012) 100% audit was done on resident's charts who have skin issues, checking to ensure there are physician orders written for any area's identified, orders are on treatment administration record, there are no holes on TAR's, by clinical staff. 9. Non-pressure skin condition records were updated and current, weekly skin integrity data collection sheets are completed, accurate and up to date, and each resident identified with skin areas has an updated completed entry in the nurse's notes on (June 20, 2012). 10. Shower sheets compared to the shower schedules was completed by nursing administration on (June 14, 2012) to ensure residents are receiving the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. <b>Measures/systemic changes put into place to ensure the deficient practice does not recur:</b> 11. In-servicing and education was completed on (June 18 2012) by Nursing Administration on head to toe assessments, physician's orders, including writing order for 14 days and then reassessing, treatment administration records, non-pressure skin condition record, weekly skin integrity data sheets, 24 hr report, and timeliness and accuracy doing a nurse's note and what should be</p>				

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	<p>Area B: 9 cm x 5 cm 5/23/12 Area A: 8 cm x 11 cm Area B: 8 cm x 6 cm There were no measurements or assessments after 5/23/12.</p> <p>The Weekly Skin Integrity Data Collections sheet was reviewed. The sheet indicated the resident's skin condition was to be assessed and staff were to check the boxes that applied. The boxes that could be checked included, "skin intact", "bruises", "redness", "rash", "dark skin tone", "old", "new", amongst others.</p> <p>Entries on the form were dated 3/30/12, 4/3/12, 4/6/12, 4/10/12, 4/12/12, and 4/28/12. The rest of the entries on the sheet were blank. There were no further "Weekly Skin Integrity Data Collection" sheets for 5/12 and 6/12. None of the above boxes were checked on any of the above entries except 4/3/12. The 4/13/13 was only marked "old."</p> <p>Review of the current Nurses' Notes indicated the last entry was made on 5/17/12 at 7:00 p.m. There were no further assessments of the right buttock area in the resident's record.</p> <p>A Physician's Progress Note dated 6/7/12 was noted in the resident's record at 3:30</p>		<p>in the note including date and time. <b>Correction actions will be monitored to ensure the deficient practice will not recur:</b> 12. DON/Designee to audit the bathing sheets in conjunction with the shower schedule (5) five times weekly until a threshold of 100% x 90 days audit findings to PI Committee monthly x 6 months. PI committee will determine need for ongoing audits. Plan to be updated as indicated. To ensure the bathing needs are being met. 13. Don/designee will review physician orders and nurses notes m-f in clinical meeting. 14. Don/designee to audit tar's 5 times weekly until threshold of 100% x 90 days. Then Don or designee will audit log 2 times weekly until threshold of 100% x 90 days for compliance. Audit findings to PI Committee monthly x 6 months. PI Committee will determine need for ongoing audits. Plan to be updated as indicated. 15. Don/designee to audit non-pressure skin record and weekly skin integrity data sheets 1 time weekly until threshold of 100% x 6 mos. for compliance. Audit findings to PI Committee monthly x 6 months. PI Committee will determine need for ongoing audits. Plan to be updated as indicated.</p> <p><b>Completion date July 7,</b></p>		

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	<p>p.m. The progress note indicated the Physician was called to see the resident by the nurse for a rash to the right buttock and lower back. The Progress Note indicated the resident had a "papular macular" rash "(cutaneous candidiasis infection)". The Progress note indicated the area was to be treated with Lotrison/Polysporin cream mixture(topical mixture of an antibiotic and steroid) three times a day. The Physician also recommended a consultation for the wound care doctor to see the resident.</p> <p>When interviewed on 6/7/12 at 11:35 a.m., the Resident #F stated she had informed the Nurse of the discomfort in the area on 6/7/12 and the Nurse observed the area. The resident stated the area has been there a couple months.</p> <p>When interviewed on 6/7/12 at 11:45 a.m., RN #1 indicated she was not aware of the area on the right buttock. The RN indicated the outgoing shift nurse did not inform her of the area or any treatments to be done to the area. The RN indicated the resident's Physician was at the facility and was going to assess the area.</p> <p>When interviewed on 6/7/12 at 11:55 a.m., CNA #1 indicated she had transferred to the resident to the toilet</p>		<b>2012</b>	
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	<p>earlier this morning. The CNA indicated she had observed the large red area to the resident's buttock a few days ago when she last worked. The CNA indicate she did not apply any cream to the area as she does not apply creams to any areas unless she had been instructed by the Nurse.</p> <p>When interviewed on 6/7/12 at 2:00 p.m., the Director of Nursing indicated the residents are to receive a shower or bed bath twice a week, and the Weekly Skin Integrity Data Collection forms were to initiated by the CNA giving the shower and the Nurse was to complete the assessment and document all areas on the form or mark intact. The Director of Nursing indicated there were not completed forms for Resident #F for May or June 2012. The Director of Nursing indicated there was no ordered treatment for the area observed to the resident's right buttock. The Director of Nursing indicated all there was no further assessments of the area. The Director of Nursing indicated she was unaware of the why the 3/7/12 treatment to the right buttock had been discontinued and no further treatment was ordered. The Director of Nursing indicated LPN #1 was recently hired to assist with wound care and LPN #1 was the Nurse who initiated the Non Pressure Skin Condition form for Resident #F and a treatment should have</p>			

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	<p>been in place.</p> <p>When interviewed on 6/7/12 at 1:30 p.m., LPN #1 indicated she had started assisting with wound care and she initiated the Non-Pressure Skin Condition Record on 4/23/12 and last measured the areas on 5/23/12. The LPN indicated she did not provide treatments.</p> <p>2. On 6/7/12 at 2:50 p.m., LPN #1 was observed completing a skin assessment for Resident #G. The resident was in bed. The LPN assisted the resident to turn to her left side. Dark reddish/light purplish discoloration was noted across the right buttock and to a smaller area of the left buttock. The area also extended to both sides of the resident's back to the armpit level. The LPN applied an ointment to the above areas. The resident was then repositioned on her back. The LPN asked the resident to raise her chin. A red area was observed along the lower part of her neck where the chin rested when the resident's head was flexed down. The area was approximately 8 cm (centimeters) across and 1 cm top to bottom.</p> <p>The record for Resident #G was reviewed on 6/7/12 at 10:42 a.m. The resident's diagnoses included, but were not limited to, anxiety state, schizophrenia, high</p>			

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	<p>blood pressure, and cellulitis of the back and buttock.</p> <p>Review of the 6/12 Physician Order Statement indicated there was an order to apply Silver Sulfadiazine 1% cream every shift to the back and buttock until clear. The order was initially written on 1/29/12. There was also an order to apply Silver Sulfadiazine 1% cream topically to the reddened areas on the resident's neck every shift until clear. The order was initially written on 3/28/12.</p> <p>Review of the 5/12 Physician orders indicated there was an order written on 5/20/12 for the resident to be referred to be seen by a Dermatologist (skin doctor).</p> <p>Review of the 5/12 and 6/12 Treatment Record indicated the above treatments were signed out as completed as ordered.</p> <p>The 6/1/2012 Physician's Progress Note indicated the resident's back was macerated. The Progress Note also indicated the resident would not get off her back.</p> <p>Review of the 3/12 Nurses' Notes indicated there were no entries made on 3/28/12. An entry made on 3/29/12 at 3:00 a.m. indicated red peeling skin was noted to the neck area and the treatment</p>			

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	<p>was rendered. An entry made on 3/30/12 at 4:00 a.m. indicated the red peeling skin remains to the neck. An entry made on 3/31/12 at 7:25 p.m. indicated red peeling skin was noted on the neck.</p> <p>Review of the May 2012 Weekly Skin Integrity Data Collection form indicated there was only entry completed. The form indicated the resident's skin condition was to be assessed and staff were to check the boxes that applied. The boxes that could be checked included, "skin intact", "bruises", "redness", "rash", "dark skin tone", "old", "new", amongst others. The first entry was made on 5/9/12 and entry was signed by both the CNA and the Nurse.</p> <p>Review of the 4/12 Nurses' Notes indicated an entry was made on 4/1/12 at 3:30 a.m. This entry indicated the red peeling skin to the neck remains present. An entry made on 4/2/12 at 3:00 a.m. indicated the neck area remained red. There were no further assessment of the neck area in the April 2012 Nurses' Notes.</p> <p>The first entry in the 5/12 Nurses' Notes was made on 5/16/12 at 12 (no am or pm indicated). This entry indicated the ambulance service was called to arrange for transportation for an appointment on 6/7/12. There were no assessments of the</p>				

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	<p>neck rash in the 5/12 Nurses' Notes from 5/16/12 through 5/30/12. There was no documentation of the any attempts made to arrange for the resident to be seen by a Dermatologist.</p> <p>When interviewed on 6/7/12 at 2:00 p.m., the Director of Nursing indicated skin rashes were to be monitored. The Director of Nursing indicated she could not located a policy related to the assessment of skin rashes. The Director of Nursing indicated nursing staff should have been documenting ongoing assessments of rashes and the treatments. The Director of Nursing indicated the Weekly Skin Integrity Data Collection sheets should have been completed twice a week by the CNAs and the Nurses were to assess the skin area at that time. The Director of Nursing indicated there was only the one sheet completed in May, and there was no assessment of the neck rash in May 2012 while the resident continued to receive treatment to the area. The Director of Nursing also indicated there had been no arrangements made for the resident to be seen by a Dermatologist as ordered by the Physician.</p> <p>This Federal tag relates to complaint IN00109031.</p> <p>3.1-37(a)</p>			

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F0333 SS=D	<p>483.25(m)(2) <b>RESIDENTS FREE OF SIGNIFICANT MED ERRORS</b> The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure residents were free of significant medication errors related to administration of a cardiac medication daily when the Physician orders indicated the medication was to be administered twice a week for 1 of 1 resident reviewed for significant medication errors in the sample of 6. (Resident #D)</p> <p>Findings include:</p> <p>The closed record for Resident #D was reviewed on 6/7/12 at 12:00 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, end stage renal disease, bladder malignancy, and diabetes mellitus. The resident was admitted to the facility on 2/23/12. The resident was sent to the hospital on 5/1/12 and returned to the facility on 5/3/12.</p> <p>Review of a 5/1/12 hospital Physician Consultation report indicated the resident had an internal cardiac defibrillator in place and was admitted because he had recurrent ventricular shocks from the defibrillator.</p>	F0333	<p><b>F333 1) Corrective action for the residents found to have been affected by the deficient practice:</b> Resident #D had expired prior to survey, however did not expire due to Medication error and facility self-reported this incident 2. <b>Corrective action taken for those residents having the potential to be affected by the same deficient practice:</b> 100% audit was completed on (date) by omnicare pharmacy for residents on digoxin. No other residents were found to be affected 3. <b>Measures/systemic changes put into place to ensure the deficient practice does not recur:</b> 100% inservice was done on (May 14, 2912) by M. Patrick RN, DON to nursing staff on the complete triple check procedure of how to check medications upon arrival until given, including checking orders, checking medication administration record, and checking the label or card once it comes into facility for accuracy. <b>4. Correction actions will be monitored to ensure the deficient practice will not recur:</b> Don/designee to audit new digoxin orders 5 times week until threshold of 100% x 90 days. Then Don or designee will</p>	07/07/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/07/2012
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	<p>The 5/3/12 re admission Physician orders indicated there was an order for the resident to receive Digoxin (a cardiac medication to treat irregular heart rates) 125 mcg (micrograms) one tablet two days a week on Wednesdays and Saturdays.</p> <p>Review of the 5/12 Medication Administration Record indicated the Digoxin 125 mcg was signed out as given daily 5/4/12 through 5/12/12. The doses were signed out and the resident's pulse rate was recorded under the Nurse's initials.</p> <p>A Resident Transfer Record was completed on 5/13/12 (no time indicated). The form indicated the resident was unresponsive and was transferred to the hospital.</p> <p>When interviewed on 6/7/12 at 3:00 p.m., the Director of Nursing indicated the resident was sent to the hospital on 5/13/12 and expired at the hospital. The Director of Nursing indicated she reviewed the resident clinical record on 5/14/12 and noted the medication error at that time. The Director of Nursing indicated the admission Physician order for the Digoxin medication was transcribed correctly on the Medication Administration Record and the</p>		<p>audit log 2 times weekly until threshold of 100% x 90 days for compliance Audit findings to PI Committee monthly x 6 months. PI Committee will determine need for ongoing audits. Plan to be updated as indicated <b>Completion date July 7, 2012</b></p>	

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	<p>instructions on the box the pharmacy sent the Digoxin in was labeled correctly. The Director of Nursing indicated the medication was administered daily 5/4/12 through 5/12/12 and the resident should not have received the Digoxin on 5/4/12, 5/6/12, 5/7/12, 5/8/12, 5/10/12, and 5/11/12.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			