

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155738	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
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NAME OF PROVIDER OR SUPPLIER MILTON HOME, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 206 E MARION ST SOUTH BEND, IN 46601
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190479.</p> <p>Complaint IN00190479 - Substantiated. Federal/State deficiencies are cited at F282 and F314.</p> <p>Survey dates: February 23 and 26, 2016.</p> <p>Facility number: 001141 Provider number: 155738 AIM number: 200905640</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 4 Medicaid: 17 Other: 7 Total: 28</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on March 6, 2016.</p>	F 0000	<p>The preparation or execution of this plan of correction doesnot constitute admission or agreement of provider of the truth of the factsalleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared andexecuted solely because it is required by the position of Federal and StateLaw. The Plan of Correction is submittedin order to respond to the allegation of noncompliance cited during theComplaint Survey (IN00190479) February 26, 2016. Please accept this Plan of Correction as TheMilton Home's credible allegation of compliance effective March 27, 2016. The Milton Home respectfully requests a deskreview with paper compliance to be considered in establishing that the provideris in substantial compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review and interview, the facility failed to follow the plan of care for a resident who required a Hoyer lift transfer for 1 of 3 residents reviewed for transfers. (Resident C)</p> <p>Finding includes:</p> <p>On 2/23/16 at 3:00 P.M., a clinical record review was conducted for Resident C. Resident C was admitted to the facility on 6/2/14 with diagnoses that included, but were not limited to, dementia, congestive heart failure and surgical wound right lower extremity secondary to cellulitis.</p> <p>A physicians order, dated 12/14/15, indicated "...Hoyer lift for all transfers due to (B) [bilateral] knee contractures and pts. [patients] inability to bear weight...."</p> <p>A quarterly MDS (Minimum Data Set) assessment, dated 2/3/16, indicated Resident C performed her transfers with</p>	F 0282	<p><u>F282</u></p> <p>1.Resident C has appropriate lift/equipment (pads)available. 2.All residents who require assistance intransfers with the use of mechanical devices have the potential to be affectedby this deficient practice. Residentstransfer needs have been assessed by Therapy Department. 3.Director of Nursing to provide in service onfollowing care plans/ proper transfer procedures on 3/19/16. All transfer orders will be reviewed by DONor designee; the review is to ensure the care plan have been initiated/updatedas necessary. Audits and/orobservations related to transfers will be conducted by the DON or designee 2times per week times 4 weeks, then monthly times 5 months to ensure compliance 4.All transfer orders will be reviewed by DON ordesignee; the review is to ensure the care plan have been initiated/updated asnecessary. Audits and/orobservations related to transfers will be conducted by the</p>	03/27/2016

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	<p>total dependence of 2 or more staff persons.</p> <p>On 2/26/16 at 11:20 A.M., CNA (Certified Nursing Assistant) #1 and CNA #2 were observed transferring Resident C from a wheelchair to a bed. Resident C was transferred using a gait belt and 2 people. During an interview conducted at the time of the transfer, CNA #1 indicated Resident C was supposed to be transferred using a Hoyer lift (mechanical lift device) but they transferred her with 2 persons and a gait belt because of the unavailability of a Hoyer sling. She indicated this had been ongoing for about 2 months. CNA #1 indicated staff had asked for a sling to be purchased for Resident C but it had not been ordered. CNA #1 further indicated Resident C had a meshed sling that was used for showers but the staff did not want to use it for routine transfers.</p> <p>On 2/26/16 at 11:45 A.M., an interview was conducted with the Administrator of the facility. The Administrator indicated he was the person responsible to purchase Hoyer slings and he had purchased Resident C a Hoyer sling that she had been fitted for as well as for each resident who required a Hoyer transfer. He further indicated he purchased extra slings in a variety of sizes so that if a need existed</p>		<p>DON or designee 2times per week times 4 weeks, then monthly times 5 months to ensure compliance. The results of the audit andor observations will be reported, reviewed and trended for compliance throughthe facility Quality Assurance Committee for a minimum of 6 months thenrandomly thereafter for further recommendations</p>	

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F 0314 SS=D Bldg. 00	<p>for a sling there would always be one of every size available. He further indicated the sling for Resident C was available to be used and provided the sling for observation at the time of the interview.</p> <p>On 2/26/16 at 12:00 P.M., an interview was conducted with the DON (Director of Nursing). The DON indicated the facility did not have a policy or procedure related to the use of Hoyer lifts but that the staff should have transferred Resident C as ordered by the physician.</p> <p>This Federal tag relates to Complaint IN00190479.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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</p>			

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	<p>services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview and record review, the facility failed to ensure a resident, who had developed a pressure ulcer to her right medial heel was consistently assessed, monitored and reevaluated to ensure the pressure ulcer didn't deteriorate further for 1 of 4 residents reviewed for pressure ulcers. (Resident C)</p> <p>Finding includes:</p> <p>On 2/23/16 at 3:15 P.M., the clinical record for Resident C was reviewed. Resident C was admitted to the facility on 6/2/14 with diagnoses including, but not limited to, peripheral vascular disease, hypothyroidism, coronary artery disease, congestive heart failure and atrial fibrillation.</p> <p>A MDS (Minimum Data Set) assessment, dated 2/3/16, indicated Resident C had a Stage 3 (Full thickness tissue loss, subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure depth of tissue loss. May include undermining and tunneling) pressure ulcer.</p>	F 0314	<p><u>F 314</u></p> <p>1. ResidentC pressure ulcer reviewed and proper tracking initiated</p> <p>2.All residents with skin conditions have thepotential to be affected by this deficient practice. Residents with skin issues/pressure ulcers have been reviewed and proper tracking initiated</p> <p>3.Nurse identified to work with DON to assess/recordwound tracking every seven days to include measuring length, width and depthwhere possible. Further documentation to include status of wound perimeter,wound bed and healing progress. Auditsand/or observations will be conducted by the DON or designee 2 times per weektimes 4 weeks, then weekly times 5 months to ensure compliance.</p> <p>4.Audits and/or observations will be conducted bythe DON or designee 2 times per week times 4 weeks, then weekly times 5 monthsto ensure compliance. The results of theaudit and or observations will be reported, reviewed and trended for compliancethrough the facility Quality Assurance Committee for a minimum of 6 months thenrandomly thereafter for</p>	03/27/2016

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	<p>A " Non-Pressure Skin Condition Report," dated 11/15/15, indicated "...Date first observed: 11/15/15...Site/Location: R [right] inner heel 3cm [centimeter] by 3cm soft black area. area is closed. zero [sic] drainage noted...Condition is: other pressure unstageable...."</p> <p>A care plan, created on 11/19/15 and revised on 1/25/16, indicated, but was not limited to: "...Has US [unstageable] to right heel...Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Record improvements and declines to the MD [medical doctor]...."</p> <p>The clinical record lacked documentation to indicate the pressure ulcer had been assessed, monitored or reevaluated from 12/12/15 through 1/8/16.</p> <p>An interview was conducted with the DON (Director of Nurses) on 2/26/16 at 4:00 P.M. The DON indicated she could not find documentation to indicate the wound had been measured with the treatment reevaluated from 12/12/15 through 1/8/16. She further indicated that all wounds should be assessed and measured at a minimum of every 7 days.</p>		further recommendations	

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	<p>A treatment should be reevaluated every 2 weeks to ensure it is appropriate to promote wound healing.</p> <p>An interview was conducted with the MDS Coordinator on 2/26/16 at 4:15 P.M. The MDS Coordinator indicated [name of wound physician] had not been to the facility to assess the wound due to the holidays.</p> <p>The current policy titled, Prevention of Pressure Ulcer, dated as 2/2016, was provided by the DON at 10:00 A.M. The policy indicated "...Policy: It is the policy of this community to prevent development of pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and residents having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing...Monitor the impact of the interventions...Weekly skin assessment to include measurements, tx and changes (every 7 days)...Modify the treatment if no progress within 2 weeks of initiation of treatment...."</p> <p>This Federal tag relates to Complaint IN00190479.</p> <p>3.1-40(a)(1)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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