

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155566	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/31/2012
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NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580
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F0000	<p>This visit was for Investigation of Complaint IN00108976.</p> <p>Complaint IN00108976 - Substantiated. Federal/state deficiencies related to the allegation are cited at F225, F226, and F514.</p> <p>Survey dates: May 30 and 31, 2012</p> <p>Facility number: 000359 Provider number: 155566 AIM number: 100274920</p> <p>Survey team: Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census payor type: Medicare: 2 Medicaid: 39 Other : 11 Total: 52</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 6/06/12 by Suzanne</p>	F0000	<p><b>This plan of correction is to serve as Warsaw Meadows Care Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Warsaw Meadows Care Center or it's 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. We are in full compliance as of June 22, 2012 and respectfully request paper review.</b></p>	

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

TITLE

(X6) DATE

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

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	Williams, RN			

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F0225 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 record review and interview, the facility failed to ensure an injury of</p>	F0225	F225 483.13(c)(1)(ii)-(iii), (c)(2)-(4) INVESTIGATE/REPORT/ALLEG	06/22/2012			

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	<p>unknown source, a bruise, was immediately reported to the Administrator, thoroughly investigated and reported to the Indiana State Department of Health, in a timely manner. This affected 1 resident in a sample of 3, Resident B.</p> <p>Findings include:</p> <p>The closed record for Resident B was reviewed at 3:20 p.m., on 5/30/12. Diagnoses included, but were not limited to, Alzheimer's dementia with behavioral disturbance.</p> <p>A nursing note, dated 4/23/12, indicated Resident B had returned to the facility from the hospital.</p> <p>Review of a nursing note, dated 5/20/12, at 3:00 p.m., indicated a family member of Resident B reported the resident had a bruise above her left breast, and indicated the resident told her she was hit by someone. Resident B then indicated, "I was hit in the front and slapped on the back" when staff were cleaning her up in the bathroom.</p> <p>Review of a follow-up report, addressed to the Indiana State Department of Health (ISDH), dated 5/20/12, indicated Resident B was noted to have a 4 centimeter by 2 centimeter yellow bruise</p>		<p><b>ACTIONS/INDIVIDUALS</b> It is the practice of Warsaw Meadows Care Center to 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. I. Resident B no longer resides in the facility. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. As indicated in the survey report, the facility has an abuse prevention and reporting policy. Nursing personnel have been re-educated on this policy. This re-education reinforced the importance of promptly reporting any potential abuse allegations to the Administrator immediately and to the Indiana State Department of Health within the required timeframe. Nursing personnel have been re-educated on the incident/accident policy and the need to complete an incident report and investigate/assess bruises of unknown origin at the time of discovery. Nursing assistants were re-educated on completion of the "shower sheet" to ensure bruises are documented and reported when observed. In addition, incident</p>		

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	<p>above the left areola. During investigation, the resident had reported a staff member had hit her; however, after a complete investigation, the bruise most likely occurred when the resident leaned over the nurse's station desk to reach for the cat as the resident did frequently. The bruise was noted to be in line with the edge of the nurse's station and the resident recently started on Coumadin therapy.</p> <p>There was no documentation in the resident record regarding any bruises to the resident's breast, until 5/20/12 at 3:00 p.m., when the resident's family member reported the bruise.</p> <p>An investigation was completed by the facility. Review of the investigation, at 5:00 p.m., on 5/30/12, indicated the following: 5/21/12 at 8:00 a.m., CNA #11 stated she saw a bruise on Resident B on 5/14/12, but the bruise looked old. The CNA did not mark the bruise on the shower sheet, however did report the bruise to RN #12.</p> <p>5/21/12 at 8:15 a.m., RN #12 indicated she did not remember the conversation with CNA #11, however, was aware of bruises on the resident on 5/16/12, at which time she spoke with the Assistant Director of Nurses about the bruises.</p>		<p>reports are being reviewed during the interdisciplinary clinical meeting Monday through Friday.</p> <p>IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure compliance. This audit will include a skin assessment to identify any bruises or other skin abnormality and a review of the "shower sheet". If areas are discovered the QI audit will determine if an incident report was completed, and if reporting and investigating were conducted as required. A random sample of 5 residents will be reviewed weekly for 30 days; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations as necessary.</p>				

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	<p>5/21/12 An investigative note, documented by the ADNS, indicated she spoke with RN #12 on 5/16/12, regarding a bruise on Resident B that was reported on RN #12 on 5/16/12. RN #12 indicated the bruise was yellow, old, and faded and she could barely measure it. The ADNS told RN #12 not to do an incident report for the bruise based on the assessment.</p> <p>The note further indicated the ADNS was then educated regarding the accident/incident policy, that all bruises, no matter the stage of healing, should be documented and investigated.</p> <p>LPN #1 was interviewed, at 2:55 p.m. on 5/30/12, and indicated the CNAs should report any skin issues observed during care. She indicated the residents were showered twice a week, and the CNAs were responsible to report anything unusual to the nurse.</p> <p>CNA #11 was interviewed, on the telephone, at 9:44 a.m., on 5/31/12. she indicated she gave Resident B a shower on 5/14/12, and noticed a "real yellow bruise figure 8 shape" on the resident's left breast. She indicated the resident had been in the hospital and she assumed the bruises were from the hospital visit. CNA #11 indicated she assumed the bruises were old, so she reported the</p>			

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	<p>bruise to RN #12, who told the CNA she already knew about the bruise. CNA #11 indicated she didn't document the color or location of the bruise on the shower sheet, but only wrote "no new" bruises. She indicated she was later told by the Director of Nurses that she should document this information on the shower sheet, whether the bruise was old or new.</p> <p>RN #12 was interviewed, at 10:00 a.m. on 5/31/12, and indicated on May 16, 2012, one of the CNAs reported she observed a bruise on the resident's breast. RN #12 indicated she then saw the bruise and it was a pale, light yellow color, she could tell it had decreased in size, and was probably linear at one time. She indicated she consulted with the Assistant Director of Nursing, who told her she didn't have to document on an incident report. RN #12 indicated she normally would do an incident report and document in the record.</p> <p>RN #12 also indicated the resident's daughter had brought in some new bras for the resident, which were too small, and this might have caused the bruising. She also indicated the resident would lean over the counter at the nurse's station, on the secured unit, and this might have caused the bruising on her breast.</p> <p>RN #12 indicated she didn't remember if CNA #11 had told her about the bruising</p>			

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	<p>on the resident's breast on 5/14/12.</p> <p>The Assistant Director of Nursing was interviewed, at 11:28 a.m., on 5/31/12. She indicated when she interviewed CNA #11 during the investigation, CNA #11 had told her she saw the bruise on 5/14/12, and reported it to RN #12. She indicated RN #12 reported seeing a faded yellow bruise on the resident's left breast on 5/16/12, but the Assistant Director of Nursing told RN #12 she didn't have to document the bruise on an incident report. She indicated since this incident, both she and RN #12 received inservicing from the Director of Nursing on documenting the bruising on an incident report and in the resident record.</p> <p>Review of the policy for accident and incidents- assessing, investigating and reporting, dated April, 2011, and provided by the Assistant Director of Nursing, at 9:40 a.m. on 5/31/12, indicated all accidents or incidents involving residents shall be investigated, the date and time of the incident, the nature of the injury/illness(e.g. bruise, fall, nausea, etc.), the licensed nurse would complete an assessment of the resident. Also, the charting and documentation policy was included in the policy for accidents and incidents, and indicated all services provided to the</p>				

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	<p>resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record.</p> <p>Review of the abuse prevention policy, dated as revised on September 2011, provided by the Director of Nursing on 5/30/12, indicated the following:</p> <p>All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management.</p> <p>Should an incident or suspected incident of resident abuse, neglect, or injury of an unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.</p> <p>It is the responsibility of the employees, facility consultants, attending physicians, family members, visitors, etc, to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management.</p> <p>Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately.</p>			

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	This Federal tag relates to Complaint IN00108976.  3.1-28(c) 3.1-28(d) 3.1-28(e)				

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F0226 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 record review and interview, the facility failed to implement its policy and procedure related to investigating and reporting an unusual occurrence, a bruise of unknown origin, for 1 resident in a sample of 3, Resident B.</p> <p>Findings include:</p> <p>The closed record for Resident B was reviewed at 3:20 p.m., on 5/30/12. Diagnoses included, but were not limited to, Alzheimer's dementia with behavioral disturbance.</p> <p>A nursing note, dated 4/23/12, indicated Resident B had returned to the facility from the hospital.</p> <p>Review of a nursing note, dated 5/20/12, at 3:00 p.m., indicated a family member of Resident B reported the resident had a bruise above her left breast, and indicated the resident told her she was hit by someone. Resident B then indicated, "I was hit in the front and slapped on the back" when staff were cleaning her up in the bathroom.</p>	F0226	<p><b>F226 483.13(c)</b> <b>DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES</b> It is the practice of Warsaw Meadows Care Center to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property. I. Resident B no longer resides in the facility. II. All residents have the potential to be affected. This is being addressed by the systems described below. III. As indicated in the survey report, the facility has an abuse prevention and reporting policy. Nursing personnel have been re-educated on this policy. This re-education reinforced the importance of promptly reporting any potential abuse allegations to the Administrator immediately and to the Indiana State Department of Health within the required timeframe. Nursing personnel have been re-educated on the incident/accident policy and the need to complete an incident report and investigate/assess bruises of unknown origin at the time of discovery. Nursing assistants were re-educated on completion</p>	06/22/2012	

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	<p>Review of a follow-up report, addressed to the Indiana State Department of Health (ISDH), dated 5/20/12, indicated Resident B was noted to have a 4 centimeter by 2 centimeter yellow bruise above the left areola. During investigation, the resident had reported a staff member had hit her; however, after a complete investigation, the bruise most likely occurred when the resident leaned over the nurse's station desk to reach for the cat as the resident did frequently. The bruise was noted to be in line with the edge of the nurse's station and the resident recently started on Coumadin therapy.</p> <p>There was no documentation in the resident record regarding any bruises to the resident's breast, until 5/20/12 at 3:00 p.m., when the resident's family member reported the bruise.</p> <p>An investigation was completed by the facility. Review of the investigation, at 5:00 p.m., on 5/30/12, indicated the following: 5/21/12 at 8:00 a.m., CNA #11 stated she saw a bruise on Resident B on 5/14/12, but the bruise looked old. The CNA did not mark the bruise on the shower sheet, however did report the bruise to RN #12. 5/21/12 at 8:15 a.m., RN #12 indicated</p>		<p>of the "shower sheet" to ensure bruises are documented and reported when observed. In addition, incident reports are being reviewed during the interdisciplinary clinical meeting Monday through Friday. IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure compliance. This audit will include a skin assessment to identify any bruises or other skin abnormality and a review of the "shower sheet". If areas are discovered the QI audit will determine if an incident report was completed, and if reporting and investigating were conducted as required. A random sample of 5 residents will be reviewed weekly for 30 days; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations as necessary.</p>				

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	<p>she did not remember the conversation with CNA #11, however, was aware of bruises on the resident on 5/16/12, at which time she spoke with the Assistant Director of Nurses about the bruises.</p> <p>5/21/12 An investigative note, documented by the ADNS, indicated she spoke with RN #12 on 5/16/12, regarding a bruise on Resident B that was reported on RN #12 on 5/16/12. RN #12 indicated the bruise was yellow, old, and faded and she could barely measure it. The ADNS told RN #12 not to do an incident report for the bruise based on the assessment.</p> <p>The note further indicated the ADNS was then educated regarding the accident/incident policy, that all bruises, no matter the stage of healing, should be documented and investigated.</p> <p>LPN #1 was interviewed, at 2:55 p.m. on 5/30/12, and indicated the CNAs should report any skin issues observed during care. She indicated the residents were showered twice a week, and the CNAs were responsible to report anything unusual to the nurse.</p> <p>CNA #11 was interviewed, on the telephone, at 9:44 a.m., on 5/31/12. she indicated she gave Resident B a shower on 5/14/12, and noticed a "real yellow</p>			

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	<p>bruise figure 8 shape" on the resident's left breast. She indicated the resident had been in the hospital and she assumed the bruises were from the hospital visit. CNA #11 indicated she assumed the bruises were old, so she reported the bruise to RN #12, who told the CNA she already knew about the bruise. CNA #11 indicated she didn't document the color or location of the bruise on the shower sheet, but only wrote "no new" bruises. She indicated she was later told by the Director of Nurses that she should document this information on the shower sheet, whether the bruise was old or new.</p> <p>RN #12 was interviewed, at 10:00 a.m. on 5/31/12, and indicated on May 16, 2012, one of the CNAs reported she observed a bruise on the resident's breast. RN #12 indicated she then saw the bruise and it was a pale, light yellow color, she could tell it had decreased in size, and was probably linear at one time. She indicated she consulted with the Assistant Director of Nursing, who told her she didn't have to document on an incident report. RN #12 indicated she normally would do an incident report and document in the record.</p> <p>RN #12 also indicated the resident's daughter had brought in some new bras for the resident, which were too small, and this might have caused the bruising.</p>			

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NAME OF PROVIDER OR SUPPLIER  WARSAW MEADOWS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 E PRAIRIE ST WARSAW, IN 46580			
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	<p>She also indicated the resident would lean over the counter at the nurse's station, on the secured unit, and this might have caused the bruising on her breast. RN #12 indicated she didn't remember if CNA #11 had told her about the bruising on the resident's breast on 5/14/12.</p> <p>The Assistant Director of Nursing was interviewed, at 11:28 a.m., on 5/31/12. She indicated when she interviewed CNA #11 during the investigation, CNA #11 had told her she saw the bruise on 5/14/12, and reported it to RN #12. She indicated RN #12 reported seeing a faded yellow bruise on the resident's left breast on 5/16/12, but the Assistant Director of Nursing told RN #12 she didn't have to document the bruise on an incident report. She indicated since this incident, both she and RN #12 received inservicing from the Director of Nursing on documenting the bruising on an incident report and in the resident record.</p> <p>Review of the policy for accident and incidents- assessing, investigating and reporting, dated April, 2011, and provided by the Assistant Director of Nursing, at 9:40 a.m. on 5/31/12, indicated all accidents or incidents involving residents shall be investigated, the date and time of the incident, the nature of the injury/illness(e.g. bruise,</p>						

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	<p>fall, nausea, etc.), the licensed nurse would complete an assessment of the resident. Also, the charting and documentation policy was included in the policy for accidents and incidents, and indicated all services provided to the resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record.</p> <p>Review of the abuse prevention policy, dated as revised on September 2011, provided by the Director of Nursing on 5/30/12, indicated the following:</p> <p>All reports of resident abuse, neglect and injuries of an unknown source shall be promptly and thoroughly investigated by facility management.</p> <p>Should an incident or suspected incident of resident abuse, neglect, or injury of an unknown source be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.</p> <p>It is the responsibility of the employees, facility consultants, attending physicians, family members, visitors, etc, to promptly report any incident, suspected incident, or allegation of neglect or resident abuse, including injuries of an unknown source, and theft or misappropriation of resident property to facility management.</p>			

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	<p>Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately.</p> <p>This Federal tag relates to Complaint IN00108976.</p> <p>3.1-28(a)</p>			

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F0514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to document a bruise when it was first observed, and an assessment for a bruise, for 1 resident in a sample of 3, Resident B.</p> <p>Findings include:</p> <p>The closed record for Resident B was reviewed at 3:20 p.m., on 5/30/12. Diagnoses included, but were not limited to, Alzheimer's dementia with behavioral disturbance.</p> <p>A nursing note, dated 4/23/12, indicated Resident B had returned to the facility from the hospital.</p> <p>Review of a pressure ulcer risk assessment, and general skin condition report, dated 4/23/12, indicated the resident had some dark purple bruising on the bilateral arms, and the right lower</p>	F0514	<p><b>F514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE</b> It is the practice of Warsaw Meadows Care Center to maintain each resident's clinical record in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. I. Resident B no longer resides in the facility. II. A skin assessment has been completed on all residents-no other unknown bruising was discovered. III. As indicated in the survey report, the facility has an abuse prevention and reporting policy. Nursing personnel have been re-educated on this policy. This re-education reinforced the importance of promptly reporting any potential abuse allegations to the Administrator immediately and to the Indiana State Department of</p>	06/22/2012	

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	<p>abdominal area.</p> <p>Review of a nursing note, dated 5/20/12, at 3:00 p.m., indicated a family member of Resident B reported the resident had a bruise above her left breast, and indicated the resident told her she was hit by someone. Resident B then indicated, "I was hit in the front and slapped on the back" when staff were cleaning her up in the bathroom.</p> <p>Review of a follow-up report, addressed to the Indiana State Department of Health (ISDH), dated 5/20/12, indicated Resident B was noted to have a 4 centimeter by 2 centimeter yellow bruise above the left areola. During investigation, the resident had reported a staff member had hit her; however, after a complete investigation, the bruise most likely occurred when the resident leaned over the nurse's station desk to reach for the cat as the resident did frequently. The bruise was noted to be in line with the edge of the nurse's station and the resident recently started on Coumadin therapy.</p> <p>There was no documentation in the resident record regarding any bruises to the resident's breast, until 5/20/12 at 3:00 p.m., when the resident's family member reported the bruise.</p>		<p>Health within the required timeframe. Nursing personnel have been re-educated on the incident/accident policy and the need to complete an incident report and investigate/assess bruises of unknown origin at the time of discovery. Nursing assistants were re-educated on completion of the "shower sheet" to ensure bruises are documented and reported when observed. In addition, incident reports are being reviewed during the interdisciplinary clinical meeting Monday through Friday.</p> <p>IV. The Director of Nursing or her designee is conducting quality improvement audits to ensure compliance. This audit will include a skin assessment to identify any bruises or other skin abnormality and a review of the "shower sheet". If areas are discovered the QI audit will determine if an incident report was completed, and if reporting and investigating were conducted as required. A random sample of 5 residents will be reviewed weekly for 30 days; then monthly for 6 months. Results of all audits are being reported to the facility's QA Committee monthly for additional recommendations as necessary.</p>				

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	<p>An investigation was completed by the facility. Review of the investigation, at 5:00 p.m., on 5/30/12, indicated the following:</p> <p>5/21/12 at 8:00 a.m., CNA #11 stated she saw a bruise on Resident B on 5/14/12, but the bruise looked old. The CNA did not mark the bruise on the shower sheet, however did report the bruise to RN #12.</p> <p>5/21/12 at 8:15 a.m., RN #12 indicated she did not remember the conversation with CNA #11, however, was aware of bruises on the resident on 5/16/12, at which time she spoke with the Assistant Director of Nurses about the bruises.</p> <p>5/21/12 An investigative note, documented by the ADNS, indicated she spoke with RN #12 on 5/16/12, regarding a bruise on Resident B that was reported on RN #12 on 5/16/12. RN #12 indicated the bruise was yellow, old, and faded and she could barely measure it. The ADNS told RN #12 not to do an incident report for the bruise based on the assessment.</p> <p>The note further indicated the ADNS was then educated regarding the accident/incident policy, that all bruises, no matter the stage of healing, should be documented and investigated.</p> <p>Review of the CNA May 2012 weekly</p>						

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	<p>bath checklist sheets for Resident B indicated the following:</p> <p>5/3/12 no skin conditions</p> <p>5/7/12 resident refused bath times 3</p> <p>5/10/12 under bruise was recorded, "old ones"</p> <p>5/14/12 under bruise was recorded, "no new"</p> <p>5/17/12 resident refused bath times 3</p> <p>LPN #1 was interviewed, at 2:55 p.m. on 5/30/12, and indicated the CNAs should report any skin issues observed during care. She indicated the residents were showered twice a week, and the CNAs were responsible to report anything unusual to the nurse.</p> <p>CNA #11 was interviewed, on the telephone, at 9:44 a.m., on 5/31/12. she indicated she gave Resident B a shower on 5/14/12, and noticed a "real yellow bruise figure 8 shape" on the resident's left breast. She indicated the resident had been in the hospital and she assumed the bruises were from the hospital visit. CNA #11 indicated she assumed the bruises were old, so she reported the bruise to RN #12, who told the CNA she already knew about the bruise. CNA #11 indicated she didn't document the color or location of the bruise on the shower sheet, but only wrote "no new" bruises. She indicated she was later told by the</p>				

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	<p>Director of Nurses that she should document this information on the shower sheet, whether the bruise was old or new.</p> <p>RN #12 was interviewed, at 10:00 a.m. on 5/31/12, and indicated on May 16, 2012, one of the CNAs reported she observed a bruise on the resident's breast. RN #12 indicated she then saw the bruise and it was a pale, light yellow color, she could tell it had decreased in size, and was probably linear at one time. She indicated she consulted with the Assistant Director of Nursing, who told her she didn't have to document on an incident report. RN #12 indicated she normally would do an incident report and document in the record.</p> <p>RN #12 also indicated the resident's daughter had brought in some new bras for the resident, which were too small, and this might have caused the bruising. She also indicated the resident would lean over the counter at the nurse's station, on the secured unit, and this might have caused the bruising on her breast.</p> <p>RN #12 indicated she didn't remember if CNA #11 had told her about the bruising on the resident's breast on 5/14/12.</p> <p>The Assistant Director of Nursing was interviewed, at 11:28 a.m., on 5/31/12. She indicated when she interviewed CNA #11 during the investigation, CNA #11</p>			

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	<p>had told her she saw the bruise on 5/14/12, and reported it to RN #12. She indicated RN #12 reported seeing a faded yellow bruise on the resident's left breast on 5/16/12, but the Assistant Director of Nursing told RN #12 she didn't have to document the bruise on an incident report. She indicated since this incident, both she and RN #12 received inservicing from the Director of Nursing on documenting the bruising on an incident report and in the resident record.</p> <p>Review of the policy for accident and incidents- assessing, investigating and reporting, dated April, 2011, and provided by the Assistant Director of Nursing, at 9:40 a.m. on 5/31/12, indicated all accidents or incidents involving residents shall be investigated, the date and time of the incident, the nature of the injury/illness(e.g. bruise, fall, nausea, etc.), the licensed nurse would complete an assessment of the resident. Also, the charting and documentation policy was included in the policy for accidents and incidents, and indicated all services provided to the resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record.</p> <p>This Federal tag relates to Complaint</p>			

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	IN00108976.  3.1-50(a)(1) 3.1-50(a)(2)				