

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2016
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00209090, IN00209845 and IN00210153.</p> <p>Complaint IN00209090 - Substantiated. Federal/State deficiencies related to allegations are cited at F282 and F323</p> <p>Complaint IN00209845 - Substantiated. Federal/State deficiency related to the allegations is cited at F312.</p> <p>Complaint IN00210153- Substantiated. Federal/State deficiencies related to the allegations are cited at F254, F309, and F312.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: September 18, 19, and 20, 2016</p> <p>Facility number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Census bed type: SNF/NF: 66 SNF: 4 Total: 70</p>	F 0000	<p>The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation.</p> <p>This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVIEW.</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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F 0254 SS=E Bldg. 00	<p>Census payor type: Medicare: 5 Medicaid: 60 Other: 5 Total: 70</p> <p>Sample: 9</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on September 22, 2016.</p> <p>483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. Based on observation and interview, the facility failed to have clean linen available for morning care for the Willow Bend Unit. This deficient practice had the potential to affect 36 of 36 resident residing on Willow Bend Unit. (Resident B)</p> <p>Findings Include: During an observation of the Willow</p>	F 0254	<p>F254 Clean Bed/ Bath Linens in Good Condition What corrective action will be accomplished for those residents found to have been affected by the deficient practice? New linens, including pillow cases, bath blankets, gowns , towels, wash cloths, draw sheets, flat sheets, fitted sheets and clothing protectors were ordered by our Housekeeping/ Laundry Supervisor and have been received in the</p>	10/20/2016

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	<p>Bend linen closet with CNA # 5 at 7 a.m., there were no washcloths, towels, sheets, bath blankets or draw sheets. There were 2 pillow cases. There were several packages of the dry wipes used in place of washcloths. During interview at this time with CNA # 5, she indicated there was not enough linen to get the residents up in the morning and this was a common problem with no linen in the morning.</p> <p>During a care observation of Resident B on 9/18/16 at 7:22 a.m., with CNA # 5 and CNA # 6, CNA #6 used one end of a wet towel to wash the resident's face and neck. She then with the same towel, applied periwash to the towel and washed the resident's peri area. Then with the same towel, CNA # 6 washed the resident's rectal area that had bowel movement on it. She used as much of the towel as possible then began washing with the dry wipes, after spraying each of them with peri wash. CNA #6 indicated the dry wipes did not work well, but there was no other linen to use for care at this time.</p> <p>During observation of the Willow Bend linen closet at 7:42 a.m., the closet was full of linen.</p> <p>During an interview with Laundry</p>		<p>facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All other residents in the facility have the potential to be affected by the same deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A new "Par level" inventory sheet was created in order to keep better count of linen in facility. Hours of laundry staff have been adjusted to include a night shift laundry aide. Facility in process of hiring for this night shift position currently.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the Housekeeping/Laundry Supervisor or designee is responsible for the completion of a linen inventory sheet weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action</p>	

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F 0282 SS=D Bldg. 00	<p>Personal # 10 on 9/18/16 at 8:09 a.m., she indicated she arrived at 6 a.m., and there was not a night shift laundry person. She indicate when she arrived there were no towels and wash cloths on Willow Bend. She indicated there were none ready in the laundry, so she had to dry loads before it could be brought up to the unit. She indicated that some days it could take a while to get linen to the halls if she had to wash and dry loads.</p> <p>This Federal tag relates to complaint IN00210153.</p> <p>3.1-19(g)(4)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure Insulin was administered as the physician ordered for 2 of 3 residents reviewed for insulin administration. (Resident D and E)</p> <p>Findings Include:</p>	F 0282	<p>plan will be developed to ensure compliance and disciplinary action taken as needed.</p> <p>F282 Services by Qualified Persons/ Per Care plan What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident D and resident E's Humalog</p>	10/20/2016			

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	<p>During an interview with RN # 1 on 9/18/16 at 7 a.m., she indicated she had given ordered 7 a.m., insulin's between 6-6:30 a.m., for Resident D and E. She indicated, when queried as to why these residents received their insulin so early in the morning, she did not know.</p> <p>1. The record for Resident D was reviewed on 9/19/16 at 8:20 a.m. Diagnoses included, but were not limited to, Diabetes and carcinoma of left breast.</p> <p>Current physician orders for September indicated an order for Humalog Insulin (a short acting insulin) 17 units: "...Special Instructions: with breakfast...once a day..." 7 a.m.</p> <p>A plan of care, dated 8/17/16, indicated a problem of hypo/hyperglycemia related to diabetes with approaches that included, but were not limited to, "monitor blood sugars as ordered and give medication as ordered."</p> <p>2. The record for Resident E was reviewed on 9/19/16 at 9 a.m. Diagnoses included, but were not limited to, Diabetes and history of falling.</p> <p>Current physician orders for September indicated orders for Humalog Insulin (a short acting insulin) 10 units "...Special</p>		<p>insulin orders were reviewed, and timing of administration was adjusted to ensure insulin is administered timely. RN#1 was educated on administering insulin as ordered and appropriate timing of Humalog Insulin administration.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All other residents with physician's orders for Humalog insulin have the potential to be affected by this deficient practice. DNS reviewed all physician's orders of resident's who receive Humalog insulin. PA adjusted the timing of humalog insulin orders as indicated to ensure medication is administered appropriately in relation to meals.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Nurses were re-educated on appropriate timing of Insulin administration, including the importance of Humalog insulin being administered 15 minutes prior to meals to prevent hypoglycemic reactions. DNS/designee will review administration history of Humalog Insulin weekly to ensure medication is being given as ordered.</p>	

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F 0309 SS=D Bldg. 00	<p>Instructions: with breakfast Once A Day..." 7 a.m.</p> <p>A plan of care, dated 4/25/16, indicated a problem of hypo/hyperglycemia related to diabetes with approaches that included, but were not limited to, "monitor blood sugars as ordered and give medication as ordered."</p> <p>During an interview with the Director of Nursing on 9/20/16 at 12 p.m., she indicated insulin should be given as ordered by the physician. She indicated the residents should not have received the insulin so early prior to breakfast.</p> <p>The Nursing 2014 Drug Handbook indicated Humalog Insulin should be given only 15 minutes before a meal to prevent hypoglycemic reactions.</p> <p>This Federal tags relates to complaint IN00209090.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>		<p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS/designee is responsible for the completion of the Diabetic Monitoring QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. The threshold of 95% is not achieved an action plan will be developed to ensure compliance and disciplinary action taken as needed.</p>	

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure preventative skin measures were done, failed to provide ordered treatment for skin concerns and failed to ensure a worsening skin condition was identified and treated in a timely manner for 2 of 4 residents reviewed for skin conditions. (Resident J and G)</p> <p>Findings include:</p> <p>1. During the initial tour at 5:20 a.m., on 9/18/17 with RN # 1, Resident J was in bed. There was a dressing to his left heel dated 9/14/16. RN # 1, at that time during interview, indicated the dressing was dated 9/14/16 and she was unsure how often it was to be changed.</p> <p>During an observation on 9/19/16 at 7 a.m., with MDS Coordinator #2, the resident was in bed with his bilateral heels laying on the bed with non-skid socks on. At that time, during interview, the MDS Coordinator indicated he was to have off loading boots at all times. She then retrieved them from the dresser at the foot of the bed and placed them on the resident's feet.</p>	F 0309	<p>F309 Provide Care/ Services For Highest Well Being</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident J's skin was assessed by the DNS on 9/19/2016. PA was notified of resident's skin condition. PA discontinued resident's treatment order to left heel as it is no longer indicated. Education was provided to the appropriate nurses' regarding following physician's orders.</p> <p>Resident G's skin was assessed by the ADNS on 9/19. PA and family were notified of skin condition. New orders were placed by PA. Resident's plan of care was updated accordingly</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents with skin breakdown have the potential to be affected by this alleged deficient practice. DNS will have observed all resident's with current treatment orders in place for a skin condition to ensure treatments were in place as ordered by 10/20/16. Nurse Management team will have</p>	10/20/2016

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	<p>The record for Resident J was reviewed on 9/19/16 at 11:28 a.m. Diagnoses included, but were not limited to, Heart failure and Peripheral Vascular Disease.</p> <p>A Plan of Care, dated 9/1/16, indicated a problem of impaired skin integrity left plantar heel arterial wound with approaches that included, but were not limited to, "pressure reducing boots to bilateral feet at all times; remove for care."</p> <p>Current physician orders indicated orders for: Apply foam dressing to left plantar heel daily as preventative. Pressure reducing boots to bilateral feet at all times, may remove for care.</p> <p>2. During the initial tour on 9/18/16 at 5:15 a.m., Resident G was in bed with a brief on and had a folded sheet and bath blanket under her, each 4 layers thick. She had redness and raised areas on her peri-area, inner thighs, posterior thighs, waist, abdomen and around her sides to her buttocks. She had a duoderm dressing to her right posterior thigh dated 9/14/16.</p> <p>The record for Resident G was reviewed on 9/19/16 at 10:47 a.m. Diagnoses included, but were not limited</p>		<p>reviewed all recent weekly summaries by 10/20/16 to ensure that any identified skin condition has been addressed and treated accordingly. No other residents were found to be affected. Appropriate treatment orders were discontinued by PA when found to be no longer indicated. All residents with preventative measures for skin breakdown in place have the potential to be affected. DNS reviewed all resident's profiles/orders with preventative measures in place to ensure interventions were appropriate and in place. No other residents were found to be affected</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Education will be provided to Licensed Nurses on following physician's orders, ensuring preventative measures are completed, notifying PA and DNS of new or worsening skin conditions and ensuring a treatment is put in place timely. Nursing staff will be re-educated on proper care for incontinence and ensuring preventative measures are in place.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, ie., what quality assurance program will be</p>	

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	<p>to, bladder disorder: spasms, dysuria, and seborrhic dermatitis.</p> <p>Current physician orders indicated orders for: Hydrocoloid apply to right posterior thigh for prevention every 3 days. House barrier to right and left thighs every shift: preventative treatment as ordered.</p> <p>A Plan of care, dated 9/14/16, indicated a problem of "at risk for skin breakdown related to history of skin breakdown" with approaches that included, but were not limited to, "assess and document skin condition weekly and as needed and notify physician of abnormal findings as needed."</p> <p>Observation Event weekly summary, dated 9/17/16, indicated an open area to left thigh and on 9/10/16 indicated discoloration/Rashes all over the skin.</p> <p>Progress Note, dated 9/14/16 at 10:30 a.m., indicated slight open area to left outer thigh, cream applied as ordered.</p> <p>On 9/19/16 at 12:18 p.m., the DON (Director of Nursing) and Administrator were informed of the Skin condition concern for Resident G. The DON indicated she knew the resident had a</p>		<p>put into place?</p> <p>To ensure compliance, the DNS/ designee is responsible for the completion of the Skin Management QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed and disciplinary action taken as needed to ensure compliance.</p>	

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F 0312 SS=D	<p>history of skin concerns, but she was not aware of the skin condition on the abdomen and sides at present. She indicated she would have the Nurse Practitioner assess the resident.</p> <p>On 9/20/16 at 12 p.m., during interview with the ADON, with the DON present, he indicated he was unaware of the skin irritation to the resident's brief area, abdomen and sides. He indicated the nurse practitioner had seen the resident on 9/19/16 and had ordered new treatments.</p> <p>A 7/2016 policy titled "Skin Management Program" was provided by the DON on 9/20/16 at 11:20 a.m., and deemed as current. The policy indicated: "...3. Offloading devices will be utilized...10. Residents identified at risk for skin breakdown will have appropriate prevention interventions put in place...All alteration in skin integrity will be documented in the medical record...a plan of care will be initiated..."</p> <p>This Federal tag relates to complaint IN00210153.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT</p>			

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Bldg. 00	<p>RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to ensure incontinent care was provided in a timely manner to prevent saturation in urine with brown staining for 2 of 6 observed for incontinent care. (Resident K and F)</p> <p>The facility also failed to ensure incontinent products were on appropriately, nails were clean and resident clothing was changed timely for 1 of 6 residents reviewed for incontinence and grooming. (Resident B)</p> <p>Findings include:</p> <p>1. During initial tour at 5:40 a.m., on 9/18/17 with RN # 1, RN # 1 indicated Resident K was total care and incontinent of urine. At that time, the resident was in bed and her brief, gown, and bed padding were saturated with urine. There was a strong odor of urine and her gown had drying urine brown rings. During interview at that time, RN #1 indicated the resident was wet and had brown rings on her gown.</p> <p>The record for Resident K was reviewed on 9/19/16 at 11:05 a.m. Diagnoses</p>	F 0312	<p>F 312 ADL Care Provided For Dependent Residents</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents that were identified were provided incontinent care, nail care and appropriate grooming.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All dependent residents have the potential to be affected by this alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>RN #1 received education/disciplinary action regard the failure to ensure appropriate care was provided to dependent residents. Nursing staff will be educated on providing incontinent care, nail care and daily grooming for all dependents residents during am and pm care and as needed on or before October 20, 2016.</p> <p>Licensed Nurses will complete daily resident care round audit tool each</p>	10/20/2016

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	<p>included, but were not limited to, history or urinary tract infections, dementia and diabetes.</p> <p>Current physician orders indicated orders for no brief in bed.</p> <p>A plan of care, dated 6/29/16 indicated the resident was at risk for skin breakdown, with approaches that included, but were not limited to, no briefs in bed and incontinent care as needed.</p> <p>2. During an observation on 9/19/16 at 9:07 a.m., Resident F was in bed with a gown on and there was a strong smell of urine. CNA # 4 at that time indicated he would be providing her morning care in 30 minutes.</p> <p>During interview with Resident F on 9/19/16 at 9:15 a.m., she indicated she had not yet had morning care and she had not been changed during the night.</p> <p>At 9:35 a.m., CNA # 4 began to provide morning care to Resident F. During the care observation at this time, as CNA #4 removed the resident's brief, it was saturated in urine. The draw sheet, gown, bottom sheet and mattress was saturated with urine with drying brown rings on the sheet down to the resident's upper knees.</p>		<p>shift, including observation of fingernails and toenails, appropriate grooming and clean bed linens weekly x 4 weeks, then bi-weekly x 3 months, and then monthly to identify any resident with needs.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS/ designee will complete the Resident Care Round QAPI tool weekly x 4 weeks, monthly x 6 months and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the Quality Assurance Committee overseen by the ED. If the threshold of 95% is not achieved an action plan will be developed to ensure compliance. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee.</p>	

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	<p>At this time, the DON (Director of Nursing) was requested to come to the room. She arrived at 9:59 a.m., and observed the urine saturation of the resident. CNA #4 continued morning care. The resident was scratching at her back, sides and buttocks during the care and indicated her skin itched. CNA #4 indicated at this time he would usually provide morning care to Resident F after breakfast and that night shift should change her prior to shift change.</p> <p>During interview with the Director of Nursing on 9/19/16 at 10:03 a.m., during the observation of care, she indicated the resident was saturated and had brown rings of drying urine on the sheets.</p> <p>The record for Resident F was reviewed on 9/19/16 at 10:15 a.m. Diagnoses included, but were not limited to, history of urinary tract infections and heart failure.</p> <p>Plan of care dated 8/18/16 indicated: "A problem of recurrent urinary tract infections with approaches that included, but were not limited to, provide incontinent care and toilet per schedule. A problem of risk for injuries secondary to skin desensitized with approaches that included, but were not limited to, keep skin clean and dry."</p>			

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	<p>A progress note, dated 9/10/16, indicated Resident F was alert and oriented times three, able to voice needs and wants, and was incontinent of bowel and bladder.</p> <p>3. During a care observation of Resident B on 9/18/16 at 7:22 a.m., with CNA # 5 and CNA # 6, the resident was observed to have a black substance under his right hand fingernails.</p> <p>CNA #6 used one end of a wet towel to wash the resident's face and neck. She then with the same towel, applied periwash to the towel and washed the resident's peri area. Prior to providing peri care, CNA #6 removed a wet blue brief and a dry beige brief from the resident. At that time during interview, CNA # 5 indicated the resident usually wore two briefs when they came into work on day shift. Then with the same towel, CNA # 6 washed the resident's rectal area that had bowel movement on it. She used as much of the towel as possible then began washing with the paper wash cloths after spraying each of them with peri wash. CNA #6 indicated the dry wash clothes did not work well but there was no other linen to use for care at this time. The resident was dressed in a white T-shirt with black sleeves and black stars on it, tan pants</p>			

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	<p>and a button up long sleeve light mauve shirt.</p> <p>During an observation on 9/19/17 at 7:04 a.m., and 9:26 a.m., the resident was in bed with the same T- shirt that had been placed on him the prior morning. The tan pants and mauve shirt were laying on the wheelchair by his bed.</p> <p>On 9/20/16 at 11:10 a.m., during interview with CNA #5, she indicated clothing should be changed daily.</p> <p>During an observation on 9/20/16 at 11:05 a.m., the resident was in bed and remained in the same T-shirt as placed on him on 9/18/16. The resident had multiple clothing items in his closet.</p> <p>During interview on 9/20/16 at 11:30 a.m., the ADON (Assistant Director of Nursing) indicated the resident had plenty of clothing for daily changes.</p> <p>During interview with the Director of Nursing on 9/20/16 at 12 p.m., she indicated residents should not be placed in 2 briefs.</p> <p>A 11/2014 policy titled "Bladder Program was provided by the Director of Nursing on 9/20/16 at 11:20 p.m., and deemed as current. The policy indicated:</p>			

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F 0323 SS=D Bldg. 00	<p>"...If a resident is totally incontinent and unable to be placed on a toilet or bedpan, resident should be checked and changed every 2 hours...."</p> <p>The Federal tag relates to complaints IN00209845 and IN00210153.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(2)(C) 3.1-38(a)(3)(A) 3.1-38(a)(3)(E)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure fall interventions were in place for 1 of 1 resident reviewed for falls. (Resident C)</p> <p>Findings Include: The record for Resident C was reviewed on 9/19/16 at 7:46 a.m.</p>	F 0323	<p>F323 Free of Accident Hazards/ Supervision/ Devices What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident's call light was put within reach. Bright colored tape continues</p>	10/20/2016

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	<p>Physician orders dated 9/7/16 indicated Colored tape to call-light: "...Special Instruction: Fall intervention...."</p> <p>A plan of care, dated 9/7/16, indicated the resident was at risk for falls, with approaches that included, but were not limited to, color enhanced call light.</p> <p>Progress notes indicated on: 9/6/16 Found on the floor in room, no injuries. 9/7/16 IDT (Interdisciplinary Team) note: unwitnessed fall from the bed at 7 a.m., no injuries, blood sugar 251, immediate intervention was to assess and assist with incontinent care, as well as "...encourage call light use...IDT recommends putting colored tape on call to enhance call light position...."</p> <p>On 9/19/16 at 8:25 a.m., the resident was in bed with her eyes closed with her color enhanced call light on the floor by the night-stand. At 8:32 a.m., CNA # 8 went into the room and exited, the call light remained on the floor. At 8:40 a.m., CNA # 8 went into the room and picked up the resident's meal tray.</p> <p>During an observation with RN # 9 on 9/19/16 at 8:45 a.m., the resident's call light was on the floor. At that time, RN #</p>		<p>to call light as a reminder for resident to use call light for assist.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents with fall interventions in place have the potential to be affected by this deficient practice. DNS will all resident's profiles/ orders by 10/20/16 to ensure that fall interventions are appropriate, functioning properly, and in place. No other resident's were found to be affected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Nursing staff will be re-educated on ensuring fall interventions are in place and functioning properly at all times and utilizing resident's profiles to identify resident's individualized interventions. Nursing staff will be re-educated on the importance of call lights remaining within resident reach at all times. Resident care plan/ profiles will be updated timely with all new fall interventions. High fall risk residents/ residents with recent falls profiles will be audited daily to ensure fall interventions are in place by the DNS/Customer Care</p>	

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F 0328 SS=D Bldg. 00	<p>9 picked up the call light and placed it on the bed.</p> <p>During an interview with the Director of Nursing on 9/20/16 at 12 p.m., she indicated she had no policy related to call light placement, but call lights should be in reach of the residents.</p> <p>This Federal tag relates to Complaint IN00209090.</p> <p>3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and</p>		<p>Rep/ designee. All resident's care plans and resident profiles will be audited a minimum of quarterly.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance, the DNS/ designee is responsible for the completion of the Fall Management QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed and disciplinary action taken as needed to ensure compliance.</p>				

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	<p>Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure oxygen therapy was applied by licensed staff and as physician ordered flow for 1 of 2 residents reviewed for oxygen therapy. (Resident B)</p> <p>Findings include:</p> <p>During the initial tour on 9/18/16 at 5:20 a.m., Resident B was in bed with his eyes open. His oxygen was on via nasal cannula and the concentrator was set at 3 liters. At that time during interview, RN # 1 indicated the oxygen should be at 2 liters.</p> <p>During a care observation on 9/18/16 at 7:22 a.m., with CNA # 5 and CNA # 6, the resident's oxygen concentrator was not on. After they provided care to the resident, CNA # 5 turned on the concentrator and placed the nasal cannula in Resident B's nose. The resident indicated he did not feel the Oxygen. The CNA then removed the cannula and placed it in a cup of water that was sitting on the bedside table. She indicated the oxygen was not working. She then removed the tubing from the concentrator and also removed the short tubing between the humidification bottle and the concentrator. She indicated she would</p>	F 0328	<p>F 328 Treatment/ Care For Special Needs</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Education was provided to CNAs # 5 and #6 on applying oxygen therapy and changing the rate of liter flow is not within their scope of practice. Education was provided to LPN # 7 on providing care to residents that require oxygen therapy.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?</p> <p>All residents with oxygen orders have the potential to be affected by the same deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>All cnas were educated on providing oxygen care within their scope of practice which includes filling the portable oxygen tanks. Nurses were educated on providing care to residents that require oxygen therapy.</p> <p>How will the corrective actions be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance, the DNS/ designee is responsible for the completion of</p>	10/20/2016

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	<p>now have to get the nurse. At 7:37 a.m., LPN # 7 arrived and checked the resident's oxygen saturation and attempted to fix the concentrator. Being unable to do so, she exited the room and returned with a new concentrator and placed oxygen on the resident at 2 liters via nasal cannula.</p> <p>During interview on 9/18/17 at 7:40 a.m., with CNA # 5, she indicated the CNA's could turn the concentrators on and off since some residents did not need oxygen during the day.</p> <p>The Record for Resident B was reviewed on 9/19/16 at 7:19 a.m. Diagnoses included, but were not limited to, Dementia, Heart Failure, and mild cognitive impairment.</p> <p>Current physician orders indicated an order for oxygen at 2 liters per nasal cannula every night. Original date of order was 7/29/16.</p> <p>During an interview with CNA # 7 on 9/20/16 at 11:05 a.m., she indicated CNA's could apply the oxygen therapy and change the rate of liter flow if the nurse informed them to do so, as with a new order.</p> <p>During an interview with the Director of</p>		<p>the Oxygen Therapy QAPI tool weekly x 4 weeks, monthly x 6 months, and then quarterly until continued compliance is maintained for two consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed and disciplinary action taken as needed to ensure compliance.</p>	

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	Nursing on 9/20/16 at 12 p.m., she indicated she did not have a policy for oxygen administration, but the CNA's could not adjust liter flow of oxygen or administer oxygen therapy. 3.1-47(a)(6)				