

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/23/2012
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F0000	<p>This visit was for the Investigation of Complaint IN00105961 and Complaint IN00106125.</p> <p>Complaint IN00105961 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F309.</p> <p>Complaint IN00106125 -- Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: March 22 and 23, 2012</p> <p>Facility number: 010996 Provider number: 155665 AIM number: 200232210</p> <p>Survey Team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 102 Total: 102</p> <p>Census payor type: Medicare: 12 Medicaid: 84 Other: 6 Total: 102</p> <p>Sample: 4</p>	F0000	Preparation and or execution of this plan of correction in general, or this correction action in particular, does not constitute an admission or agreement by Jennings Healthcare Center of the facts alledged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal law.	

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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	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 30, 2012 by Bev Faulkner, RN</p>			

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F0282 SS=D	<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 interview and record review, the facility failed to follow the physician's orders for dressing changes twice daily to a resident's lower extremities, allowing 5 consecutive dressing changes to be missed. When dressing changes were resumed, the facility identified foreign bodies, noted as "maggots," in the wound bed of one of the wounds. This deficient practice affected 1 of 3 residents reviewed for dressings to open areas in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 3-22-12 at 10:55 a.m. It indicated he was admitted to the facility on 3-2-12. His diagnoses included, but were not limited to chronic lymphedema (severe swelling) to both lower extremities, diabetes, renal (kidney) insufficiency, stage I pressure area to the buttocks, chronic dyspnea (difficulty breathing), urinary retention, benign prostatic hypertrophy (enlarged prostate) and obstructive sleep apnea.</p>	F0282	<p>F 282 S/S = D Services by Qualified Persons/Per Care Plan</p> <p>Criteria # 1 A. Resident A's Advanced Registered Nurse Practitioner (ARNP) notified at 9:00pm with orders received and noted on March 19 th 2012. B. Treatment completed by the Unit Manager and Assistant Director of Nursing per ARNP orders on 3/19/2012 at 9:30pm. C. Resident A was seen by primary care physician on 3/22/2012. D. Care Plan reviewed for resident A . E. All residents with dressings were assessed for presence of any foreign bodies. There were none found. F. Licensed Practical Nurse is no longer employed at this facility.</p> <p>Criteria # 2 A. Skin sweeps initiated to identify any areas of skin impairment with presence of foreign bodies. B. Pest control notified on 3/20/2012 for building treatment. C. Silent Insect Eliminators ordered from Direct Supply on 3/22/2012.</p>	04/10/2012			

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	<p>In interview with the Assistant Director of Nursing (ADON) on 3-22-12 at 4:03 p.m., she indicated the resident had copious amounts of drainage prior to using the Unaboos. She indicated the drainage would pool on the floor under his legs. The ADON indicated that prior to the Unaboos, a dry dressing with ABD pads (large absorbent dressing) and Kerlix (a rolled type gauze dressing) were used to cover the resident's lower legs. The Treatment Administration Record (TAR) indicated the Unaboos were placed on the resident on 3-8-12 as ordered by the physician and were to be changed weekly.</p> <p>In interview with the ADON on 3-22-12 at 4:03 p.m., she indicated on 3-15-12, the nurse on duty contacted her to inform her the Unaboot had been removed and it was saturated with drainage and the skin under the Unaboot appeared macerated (very moist in appearance.) She indicated she suggested to the nurse to leave the area open to air until the physician or nurse practitioner was contacted for further instructions. Physician orders were received on 3-16-12 at 4:00 p.m., which indicated to cleanse both lower extremities with antibacterial soap and rinse with water, then pat dry and then apply Alginate with Silver to any open areas, cover with ABD pads and secure in place with Kerlix. This was ordered to be</p>		<p>D. Silent Insect Eliminators equipment placed in building on 4/2/2012.</p> <p>Criteria #3 A. Licensed staff re-educated by the Director Of Clinical Services and the Assistant of Clinical Services on the importance of following physicians orders on March 26 th , 2012. B. Licensed Staff re-educated by DOCS and ADOCS on the importance of documentation. C. Unit Managers will QI monitor weekly skin sweeps and Treatment Administrative Records (TARS) 5 times per week for 1 month then 3 times per week for 1 month, then monthly to ensure skin sweeps are completed and physicians orders are followed regarding treatment management.</p> <p>Criteria #4 A. DCS will QI monitor weekly skin sweeps and TARS weekly for 1 month then monthly. Ongoing. B. Findings will be brought to the RM/QI committee for review and development of an action plan to ensure physicians orders are followed.</p> <p>Criteria # 5</p>				

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	<p>done twice daily. The first time this was documented as being done was 3-16-12 on the evening shift on the TAR. It was not documented on the TAR or in the nursing notes again until 3-19-12 at 8:00 p.m. This would indicate the dressing change was missed 5 consecutive times between 3-16-12 and 3-19-12.</p> <p>In a telephone interview with LPN #1 on 3-23-12 at 9:15 a.m., she indicated she had cared for Resident #A on 3-15-12, 3-17-12 and 3-18-12 on the day shift. She indicated she was unaware of any changed physician orders for Resident #A, except to obtain a wound culture. She indicated she had noticed an order in the TAR for a dressing change with an ABD pad. She indicated the order looked like the orders prior to the Unaboos, but since it did not have a start date on it, she indicated she thought it was his old orders. She indicated, "I didn't check his orders, but I should have...I feel bad that I missed the dressing changes."</p> <p>In interview with LPN #2 on 3-22-12 at 5:20 p.m., he indicated he was the nurse who conducted the dressing change on 3-19-12 at 8:00 p.m. He indicated he was trying to help the evening shift nurses and went to do the dressing change. He indicated the evening shift nurse had told him that she was unaware of the dressing</p>			

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	<p>change orders and had not taken the time to verify Resident #A's physician orders. Nursing notes signed by LPN #2 on 3-19-12 at 8:00 p.m., indicated, "Began removing Kerlix wrap which was noted to be mostly saturated with drainage. Pulled back corner of ABD pad on the anterior portion of left lower extremity and noted that wound bed was infested [sign for with] maggots..."</p> <p>A notation in the nurse's notes, dated 3-19-12 at 2:00 a.m., indicated drainage to the lower extremities was present and that a culture was obtained from the wound drainage. It indicated, "Re-wrapped." The notation did not indicate from which leg the drainage was obtained or that a complete dressing change process as indicated by the physician orders was conducted. The laboratory results of this wound culture did not indicate the area from where the culture was obtained.</p> <p>In interview with the Administrator on 3-22-12 at 4:25 p.m., she indicated the changes in orders for any resident are located on the "24 hour notes." She indicated the changes in orders for Resident #A was indicated on the 24 hour notes. She indicated the day shift and evening shift nurses assigned to care for Resident #A on 3-17-12 and 3-18-12 and</p>			

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	<p>both signed off on the 24 hour notes to indicate they were aware of the changes. She indicated, "You are seeing the same thing we did [on the TAR]. The dressing change was not done on those dates...When we discovered the problem, we noticed the dressings weren't charted."</p> <p>This Federal tag relates to Complaint IN00105961.</p> <p>3-1-35(g)(2)</p>				

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F0309 SS=D	<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 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview, observation and record review, the facility failed to ensure the resident was monitored and assessed routinely during treatment and dressing changes to the lower extremities as indicated by missing 5 sequential dressing changes in a 3 day period. Upon resuming the dressing changes, one of the wounds was found to have foreign bodies present, identified by the facility as "maggots." This deficient practice adversely affected 1 of 3 residents reviewed for dressing changes to open areas in a sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 3-22-12 at 10:55 a.m. It indicated he was admitted to the facility on 3-2-12. His diagnoses included, but were not limited to chronic lymphedema (severe swelling) to both lower extremities, diabetes, renal (kidney) insufficiency, stage I pressure area to the buttocks, chronic dyspnea (difficulty breathing), urinary retention, benign prostatic hypertrophy (enlarged prostate)</p>	F0309	F-309 S/S=DProvide Care/Services for Highest Well BeingCriteria # 1A. Resident A's Advanced Registered Nurse Practitioner (ARNP) notified at 9:00pm with orders received and noted on March 19 th 2012.B. Treatment completed by the Unit Manager and Assistant Director of Nursing per ARNP orders on 3/19/2012 at 9:30pm.C. Resident A was seen by primary care physician on 3/22/2012.D. Care Plan reviewed for resident A .E. All residents with dressings were assessed for presence of any foreign bodies. There were none found. F. Licensed Practical Nurse is no longer employed at this facility. Criteria # 2A. Skin sweeps initiated to identify any areas of skin impairment with presence of foreign bodies.B. Pest control notified on 3/20/2012 for building treatment.C. Silent Insect Eliminators ordered from Direct Supply on 3/22/2012.D. Silent Insect Eliminators equipment placed in building on 4/2/2012. Criteria #3A. Licensed staff re-educated by the Director Of Clinical Services and the	04/10/2012			

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	<p>and obstructive sleep apnea.</p> <p>The clinical record indicated a nursing assessment was conducted upon admission to the facility. This assessment indicated the resident had 2+ edema (large amount of swelling) of the legs with weak pedal (foot) pulses present. It did not indicate any complaints of lower extremity discomfort or pain. A skin assessment tool for potential for skin breakdown indicated Resident #A was a low risk for such problems. A nursing note on the evening of admission indicated the resident's body, area not specified, "has brown flaky patches [sign for with] obvious signs of poor hygiene."</p> <p>Nursing notes on 3-7-12 at 6:15 p.m., indicated the resident's legs "continue to drain serous (clear) fluid from blister like areas."</p> <p>The physician's History and Physical (admission) note, dated 3-8-12, indicated "some extreme severe chronic bilateral lower extremity edema that is now weeping at times ...worsening bilateral lower extremity edema ...We will start Unaboos [specialized device used with open wounds for the lower legs and/or feet] at this time for his edema and hope that will cause some compression to help with his edema on his lower extremities."</p>		<p>Assistant of Clinical Services on the importance of following physicians orders on March 26 th , 2012.B. Licensed Staff re-educated by DOCS and ADOCS on the importance of documentation.C. Unit Managers will QI monitor weekly skin sweeps and Treatment Administrative Records (TARS) 5 times per week for 1 month then 3 times per week for 1 month, then monthly to ensure skin sweeps are completed and physicians orders are followed regarding treatment management. Criteria #4A. DCS will QI monitor weekly skin sweeps and TARS weekly for 1 month then monthly. Ongoing.B. Findings will be brought to the RM/QI committee for review and development of an action plan to ensure physicians orders are followed. Criteria # 5</p>		

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	<p>In interview with the Assistant Director of Nursing (ADON) on 3-22-12 at 4:03 p.m., she indicated the resident had copious amounts of drainage prior to using the Unaboos. She indicated the drainage would pool on the floor under his legs. The ADON indicated that prior to the Unaboos, a dry dressing with ABD pads (large absorbent dressing) and Kerlix (a rolled type gauze dressing) were used to cover the resident's lower legs. The Treatment Administration Record (TAR) indicated the Unaboos were placed on the resident on 3-8-12, as ordered by the physician, and were to be changed weekly.</p> <p>In interview with the ADON on 3-22-12 at 4:03 p.m., she indicated on 3-15-12, the nurse on duty contacted her to inform her the Unaboot had been removed and it was saturated with drainage and the skin under the Unaboot appeared macerated (very moist in appearance). She indicated she suggested to the nurse to leave the area open to air until the physician or nurse practitioner was contacted for further instructions. Physician orders were received on 3-16-12 at 4:00 p.m., which indicated to cleanse both lower extremities with antibacterial soap and rinse with water, then pat dry and then apply Alginate with Silver to any open areas, cover with ABD pads and secure in</p>						

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	<p>place with Kerlix. This was ordered to be done twice daily. The first time this was documented as being done was 3-16-12 on the evening shift on the TAR. It was not documented on the TAR or in the nursing notes again until 3-19-12 at 8:00 p.m. This would indicate the dressing change was missed 5 consecutive times between 3-16-12 and 3-19-12.</p> <p>In a telephone interview with LPN #1 on 3-23-12 at 9:15 a.m., she indicated she had cared for Resident #A on 3-15-12, 3-17-12 and 3-18-12 on the day shift. She indicated she was unaware of any changed physician orders for Resident #A, except to obtain a wound culture. She indicated she had noticed an order in the TAR for a dressing change with an ABD pad. She indicated the order looked like the orders prior to the Unaboos, but since it did not have a start date on it, she indicated she thought it was his old orders. She indicated, "I didn't check his orders, but I should have...I feel bad that I missed the dressing changes."</p> <p>In interview with LPN #2 on 3-22-12 at 5:20 p.m., he indicated he was the nurse who conducted the dressing change on 3-19-12 at 8:00 p.m. He indicated he was trying to help the evening shift nurses and went to do the dressing change. He indicated the evening shift nurse had told</p>				

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	<p>him that she was unaware of the dressing change orders and had not taken the time to verify Resident #A's physician orders. Nursing notes signed by LPN #2 on 3-19-12 at 8:00 p.m., indicated, "Began removing Kerlix wrap which was noted to be mostly saturated with drainage. Pulled back corner of ABD pad on the anterior portion of left lower extremity and noted that wound bed was infested [sign for with] maggots..." The nurse practitioner was notified of the wound with the maggots in it at 8:06 p.m. The nurse practitioner returned a call to the facility at 9:00 p.m. to provide cleansing and irrigation instructions to rid the wound of the maggots and then instructed the facility to resume the previous wound care orders.</p> <p>A notation in the nurse's notes, dated 3-19-12 at 2:00 a.m., indicated drainage to the lower extremities was present and that a culture was obtained from the wound drainage. It indicated, "Re-wrapped." The notation did not indicate from which leg the drainage was obtained or that a complete dressing change process as indicated by the physician orders was conducted. The laboratory results of this wound culture did not indicate the area from where the culture was obtained.</p>			

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	<p>In interview with the Administrator on 3-22-12 at 4:25 p.m., she indicated the changes in orders for any resident are located on the "24 hour notes." She indicated the changes in orders for Resident #A was indicated on the 24 hour notes. She indicated the day shift and evening shift nurses assigned to care for Resident #A on 3-17-12 and 3-18-12 had both signed off on the 24 hour notes to indicate they were aware of the changes. She indicated, "You are seeing the same thing we did [on the TAR]. The dressing change was not done on those dates...When we discovered the problem, we noticed the dressings weren't charted."</p> <p>In interview with the attending physician on 3-22-12 at 11:07 a.m., he indicated Resident #A has multiple health issues. He indicated the nurse practitioner saw the resident on 3-16-12 and did not note anything at that point. He indicated, "His leg looks like a typical chronic venous stasis ulcer." He indicated, "As for the maggots, you know they use to be the standard of care for wounds. They have a tremendous ability to eat the bad tissue...still can be very effective. If they had called me instead of the nurse practitioner, I would have probably said to just leave 'em. I understand from the nurses and what I saw today, there's a lot less drainage now."</p>						

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	<p>An observation of Resident #A's lower extremities was made during a dressing change on 3-22-12 at 4:03 p.m., conducted by the ADON. The resident's lower extremities appeared with multiple areas of dark brown, black and pink areas from mid foot to above the knees. Both feet appeared swollen. On the anterior portion of both legs, below the knee and estimated at 6 inches by 2 inches was a more reddened area of a superficial depth, moist area, similar in appearance to a burn was identified by the ADON as the affected wound area. Upon removal of the old dressing, there was no indication of drainage on the wound or the old dressing. No odor was noted and the wound area was without any foreign bodies. The ADON indicated the resident experienced copious amounts of drainage that would pool on the floor under his feet when the facility initially began dressing changes. She indicated the drainage was now minimal.</p> <p>"Maggot Debridement Therapy" (copyright 1995-2010) was retrieved on 3-22-12 from the Wound Care Information Network website. The information indicated maggots are fly larvae which have been hatched from eggs which were laid by adult female flies. It indicated the life cycle of a fly is</p>			
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NAME OF PROVIDER OR SUPPLIER  JENNINGS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265		
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	<p>that an adult female fly lays it eggs and within 8-24 hours, the larvae develop. Within 4-7 days, the larva develops into a pupa and within 10-20 days it develops into an adult fly. The article indicated that although "Maggot Debridement Therapy" is a valid option for some types of non-healing wounds, only medical grade maggots should be used, not merely "garbage maggots" as not all species of flies are considered safe.</p> <p>This Federal tag relates to Complaint IN00105961.</p> <p>3.1-37(a)</p>				

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F9999	<p>State Finding</p> <p>3.1-9 PERSONAL PROPERTY</p> <p>(g) The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to have documentation of the personal effects of 1 of 3 residents reviewed for resident's personal property inventory listings in a sample of 4. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 3-23-12 at 12:05 p.m. His diagnoses included, but were not limited to Alzheimer's type dementia with behaviors, depression, delusions, sexual behaviors and agitation, mood disorder, high blood pressure, COPD (chronic</p>	F9999	<p>State Finding F9999-Personal Property</p> <p>Criteria #1 Resident D has discharged from the facility.</p> <p>Criteria #2 All residents admitted to the facility with clothing and personal items have the potential to be affected.</p> <p>Criteria #3 A. Nursing staff re-educated by the Assistant Director of Nursing on the importance of inventory completion on 4/6/2012 to include adding inventory as indicated and review inventory upon discharge. B. Responsible parties of new admissions will be educated on the importance of clothing inventory. A letter will be mailed to the responsible party of current residents educating them on the clothing inventory and importance of keeping it current and accurate. C. Medical Records / designee will QI monitor for inventory sheets upon admission to ensure the clothing inventory is complete. Negative findings will be addressed.</p> <p>Criteria #4 Medical Records Director will present findings to the RM/QI</p>	04/10/2012	

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	<p>obstruction pulmonary disease) and insomnia. He was admitted to the facility on 8-2-11. He was discharged in the care of his son/guardian on 3-11-12.</p> <p>Review of the clinical record indicated an absence of an inventory listing of Resident #D's personal effects. In interview with the Medical Records staff person on 3-23-12 at 3:45 p.m., she indicated, "I could not find his inventory sheet, so I'm pretty sure one wasn't done."</p> <p>In interview with a family member on 3-23-12 at 12:32 p.m., he indicated he did not recall ever filling out an inventory sheet for Resident #D's personal items. He indicated since discharge, the resident was missing a razor and several items of clothing. He indicated he had purchased several items of clothing for Resident #D during his stay at the facility, but did not have any staff mention to him to place those items on an inventory list. He indicated he recalled the staff did mark the clothing with the resident's name.</p> <p>In interview with the Administrator on 3-23-12 at 4:15 p.m., she indicated she had not been contacted by any family member of Resident #D since discharge regarding any issue, including any missing personal items. She indicated that several items of Resident #D were</p>		<p>meeting monthly for review and development of action plan to ensure the facility is following Policy and Procedure as it relates to Personal Inventory Sheets.</p> <p>Criteria #5 4/10/2012</p>				

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	<p>found in the laundry after he left the facility. She indicated, "His leaving was a surprise to all of us. None of the family had said anything about [name of resident] going to Florida."</p> <p>3.1-9(g)</p>			