

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155061	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/14/2015
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NAME OF PROVIDER OR SUPPLIER WOODLAND HILLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 403 BIELBY RD LAWRENCEBURG, IN 47025
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 8, 9, 10, and 14, 2015</p> <p>Facility number: 000022 Provider number: 155061 AIM number: 100274510</p> <p>Census bed type: SNF/NF: 33 Total: 33</p> <p>Census payor type: Medicare: 2 Medicaid: 31 Total: 33</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on December 21, 2015.</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</p>	
F 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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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	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to maintain a safe environment for residents as evidenced by sharps cabinets not containing disposable sharps containers for 2 of 4 respiratory/treatment carts with attached sharps cabinets.</p> <p>Findings include:</p> <p>During an observation on 12/08/2015 at 11:10 A.M., a respiratory cart on the first floor had a sharps cabinet attached to the side. The sharps cabinet was missing the inner disposable sharps container and lid, which left an opening in the cabinet that could be reached into. There was trash, including used alcohol swabs, observed in the bottom of the cabinet. There were no sharps in the container.</p> <p>During an observation on 12/09/2015 at 9:05 A.M., the same treatment cart and sharps cabinet on the first floor was missing the inner disposable sharps container and lid. There was trash, including used alcohol swabs, observed in the bottom of the cabinet.</p> <p>During an observation on 12/09/2015 at</p>	F 0323	<p>F323 Requires the facility to maintain a safe environment for residents. 1. Sharps cabinet was immediately emptied and removed from the cart. 2. All residents have the potential to be affected. All medication and treatment carts were assessed to ensure that disposable sharps containers are placed in the sharps cabinets. No concerns were noted. See below for corrective measures. 3. The sharps disposable policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. The DON or his designee will monitor all medication and treatment carts to ensure disposable sharps containers are present in the sharps cabinet daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before January</p>	01/01/2016

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	<p>9:44 A.M., a treatment cart on the second floor had a sharps cabinet attached to the side. The sharps cabinet was missing the inner disposable sharps container and lid, which left an opening in the cabinet that could be reached into. There was trash, including a used needle and a used disposable shaving razor, observed in the bottom of the cabinet.</p> <p>During an observation and interview on 12/09/2015 at 10:02 A.M., the DON (Director of Nursing) and the Administrator viewed the sharps cabinet on the second floor treatment cart that was missing the inner disposable sharps container and lid. The DON indicated there was supposed to be an inner container in the cabinet and sharps should not be sitting in the bottom. She further indicated that nurses removed the inner containers when they were full and were supposed to replace the container afterwards.</p> <p>The current facility policy titled, "Sharps Disposal", and dated 10/2014, was provided by the DON on 12/09/2015 at 10:25 A.M. and reviewed at that time. The policy indicated, "...Needles/sharps disposable containers will be located in the medication room and/or on the medication carts as needed...Place all used needles and syringes in</p>		1, 2016.				

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F 0371 SS=E Bldg. 00	<p>needles/sharps disposable container after use..."</p> <p>3.1-45(a)(1)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure food was stored and served in a sanitary manner related to dented cans, expired food, uncovered food on hall carts, hand hygiene, dirty dishes being placed with clean dishes, and improper use of silverware. This deficient practice had the potential to affect 31 of 33 residents who received food prepared in the facility kitchen.</p> <p>Findings include:</p> <p>1. During an observation on 12/08/2015 at 10:48 A.M., one can of Fancy Golden Cream Style Corn, with a 3 x 1 inch dent</p>	F 0371	<p>F371 Requires the facility to ensure food is stored and served in a sanitary manner.</p> <p>1. All dented cans were removed for use. Foods were assessed to ensure there was a date open label and a use by date. Foods served to the residents will be covered at the time of service. Nursing staff was educated on sanitary food service. 2. All residents have the potential to be affected. Dented can will be placed to the side and marked for non use. Foods will be continued to be labeled with an open and use by date. All foods served to the residents will be covered at the time of service. Nursing staff will serve food in a sanitary manner when serving the residents their meal trays. No</p>	01/01/2016

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	<p>in the middle of the can, and one unlabeled, undated can, with a 4 x 1 inch and a 2 x 1 inch dent, were located in the dry storage area of the kitchen.</p> <p>During an interview on 12/08/2015 at 11:07 A.M., the DM (Dietary Manager) indicated that cans are dated when they are brought in and should not be used if they are undated or did not have a label.</p> <p>During an interview on 12/10/2015 at 10:03 A.M., the DM indicated it was her job to check the cans and dented cans were not to be used.</p> <p>The current facility policy titled, "Storage of Foods Under Sanitary Conditions" and dated 11/2014, was provided by the Administrator on 12/10/2015 at 2:10 P.M. and reviewed at that time. The policy indicated, "...Canned goods with a compromised seal are discarded and/or removed from the kitchen for return to the vendor for credit..."</p> <p>2. During an observation on 12/10/2015 at 9:42 A.M., a large jar of Sweet Pickle Relish with an open date of 10/5 (October 5, 2015) and a use by date of 12/5 (December 5, 2015) was located in Refrigerator #1.</p> <p>During an interview on 12/10/2015 at</p>		<p>concerns were noted. See below for corrective measures. 3. The Room Service, Refrigerated foods/Nourishment Pantries, Storage of food under sanitary conditions policy and procedures were reviewed with no changes made. (See attachment D, E, and F) The nursing staff was inserviced on the hand washing policy and procedure was reviewed with no changes made. (See attachment G) The staff was inserviced on the on the above procedure. 4. The dietary Manager or her designee will monitor all deliveries to ensure no dented cans/unlabeled cans are placed on the shelf for use weekly until 100% compliance is obtained and maintained. The dietary manager or her designee will monitor the refrigerators daily times for two weeks , then three times per week thereafter until 100% compliance is obtained and maintained. The dietary manager will monitor each meal to ensure all foods is covered at the time of service. (See attachment F) The DON or her designee will monitor a one dining room service to ensure proper hand washing is occurring as well as sanitary food service daily times for weeks, weekly times four weeks, then monthly times three months then quarterly until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance</p>		

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	<p>9:42 A.M., the DM indicated the jar of relish should no longer be in the refrigerator. She further indicated that she normally checks "every other day or so" and that relish had not been used recently.</p> <p>The current facility policy titled, "Storage of Foods Under Sanitary Conditions" and dated 11/2014, was provided by the Administrator on 12/10/2015 at 2:10 P.M. and reviewed at that time. The policy indicated, "...All food items stored in the refrigerator must be labeled and dated..."</p> <p>The current facility policy titled, "Refrigerated Foods/Nourishment Pantries" and dated 10/2014, was provided by the DON (Director of Nursing) on 12/14/2015 at 3:14 P.M. and reviewed at that time. The policy indicated, "...Pickled Relish...90 days unopened. 45 days opened..."</p> <p>3. During an observation on 12/10/2015 at 11:10 A.M., 19 meal trays were located on two carts in the hall outside the dining room on the second floor. On each of the 19 trays there was an uncovered plate or bowl of cottage cheese and peaches.</p> <p>During an observation on 12/10/2015 at</p>		meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before January 1, 2016.		

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	<p>11:33 A.M., one of the meal carts that held trays containing opened plates or bowls of cottage cheese and peaches was located at the end of the second floor hall with the food still uncovered.</p> <p>During an interview on 12/10/2015 at 11:40 A.M., LPN (Licensed Practical Nurse) #1 indicated all food would normally be covered up when it was sent up from the kitchen.</p> <p>During an interview on 12/14/2015 at 1:51 P.M., the ADON (Assistant Director of Nursing) indicated food should be covered while in the halls.</p> <p>The current facility policy titled, "Room Service" and dated 11/2014, was provided by the Administrator on 12/10/2015 at 2:10 P.M. and reviewed at that time. The policy indicated, "...All food is to be covered during transportation and distribution to the residents...All food/drinks are to be covered..."</p> <p>4. During a dining observation on the second floor on 12/08/2015 at 11:31 A.M., QMA (Qualified Medication Aide) #3 used Resident #56's knife to pry the resident's plate out of the plate warmer. The QMA set the knife down on the resident's napkin, poured a cup of coffee,</p>			

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	<p>dropped the coffee, picked the cup up off the floor, placed the dirty cup into the bucket of ice that contained prefilled cups of drinks, poured a new cup of coffee, and stirred sugar into the coffee using Resident #56's knife. QMA #3 took Resident #7's tray off the cart, prepared her food, took a straw out of the cabinet, opened the straw and extended it touching the ends of the straw with her bare hands, and placed the straw in the resident's drink. The QMA then prepared Resident #10's tray, moved the resident's walker to the side, sat down next to the resident, and started feeding Resident #10. The QMA did not wash her hands or use hand sanitizer during the entire observation. Five residents received drinks that were located in the ice bucket after QMA #3 placed the dirty cup into the bucket.</p> <p>During a dining observation on the second floor on 12/10/2015 at 11:14 A.M., CNA (Certified Nursing Assistant) #4 adjusted Resident #24's blanket, moved her wheelchair, moved Resident #39 in her wheelchair, then assisted Resident #10 to stand and move to a chair by holding onto her arm and waist. CNA #4 then moved Resident #29 in his wheelchair, picked up a used cup and an opened packet of cookies and disposed of them in the garbage can. CNA #4</p>			

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	<p>continued to pull one meal cart into the dining room, retrieved clothing protectors, passed out clothing protectors to all of the residents, placed the extra clothing protectors on top of the cabinet, moved one of the meal trays down on the cart, and then used hand sanitizer. CNA #4 then prepared the first resident's tray, turned on the heater per resident request, opened a straw for Resident #7 touching the ends of the straw with her bare hands, and stirred sugar into the resident's drink using the straw. After preparing Resident #10's tray, CNA #4 sat down to feed the resident without washing her hands or using hand sanitizer. While feeding the resident, CNA #4 picked Resident #7's straw out of one drink and moved it to the other, touching the top of the straw with her bare hands.</p> <p>QMA #3 prepared trays for Resident #29 and Resident #42. As the QMA bent to retrieve drinks for the tray, the QMA's hair was hanging within an inch of the uncovered plates of cottage cheese and peaches. The QMA's hair was not pulled back and she was not wearing a hairnet.</p> <p>During a dining observation on the second floor on 12/14/2015 at 11:22 A.M., CNA #4 used Resident #7's knife to pry the resident's plate out of the plate warmer and used the same knife to cut</p>			

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	<p>the resident's food. The CNA used Resident #9's fork to lift the resident's plate out of the plate warmer, cut up the resident's food with the same fork, and left the fork for the resident to use while eating.</p> <p>During an interview on 12/14/2015 at 1:51 P.M., the ADON indicated staff should not be using the residents' silverware to remove plates from plate warmers. She further indicated dirty dishes should not be put back with drinks that were going to be served because it could contaminate the clean cups. The ADON indicated staff should wash hands before passing trays, if they touch something considered dirty, or if they had direct contact with a resident. She also indicated hand sanitizer should be used after every three residents served if direct resident contact is not made.</p> <p>The current facility policy titled, "Handwashing/Hand Hygiene" and dated 10/2014, was provided by the Administrator on 12/10/2015 at 2:10 P.M. The policy indicated, "...Situations that require hand hygiene include...Before and after direct resident contact...before and after eating or handling food...before and after assisting a resident with meals...upon and after coming in contact with a resident's intact</p>			

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F 0441 SS=D Bldg. 00	<p>skin...after handling soiled equipment or utensils..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>				

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	<p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to ensure infection control practices and standards were maintained related to sharp containers for 2 of 8 carts (first floor Respiratory Cart and second floor Treatment Cart) with sharp containers and hand washing for 1 of 2 observations of wound care. (Resident #29)</p> <p>Findings include:</p> <p>1. During an observation on 12/08/2015 at 11:10 A.M., a respiratory cart on the first floor sharps cabinet was missing the inner disposable sharps container and lid, which left an opening in the cabinet that could be reached into.</p> <p>During an observation on 12/09/2015 at 9:05 A.M., the same treatment cart and sharps cabinet on the first floor was missing the inner disposable sharps container and lid. There was visible trash observed in the bottom of the cabinet.</p> <p>During an observation on 12/09/2015 at</p>	F 0441	F441 Requires the facility to ensure infection control practices and standards are maintained. 1. Sharps cabinet was immediately emptied and removed from the cart. Staff was educated on proper hand washing 2. All residents have the potential to be affected. All medication and treatment carts were assessed to ensure that disposable sharps containers are placed in the sharps cabinets. Nursing staff will continue on going observations of hand washing to ensure infection control is being maintained. No concerns were noted. See below for corrective measures. 3. The sharps disposable and hand washing policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above procedure. 4. The DON or his designee will monitor all medication and treatment carts and hand washing to ensure disposable sharps containers are present in the sharps cabinet and hand washing daily times four weeks, then weekly times four weeks, then every two weeks	01/01/2016

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	<p>9:44 A.M., a treatment cart on the second floor had a sharps cabinet which was missing the inner disposable sharps container and lid, which left an opening in the cabinet that could be reached into. There was trash, including a used needle and a used disposable shaving razor, observed in the bottom of the cabinet.</p> <p>During an observation and interview on 12/09/2015 at 10:02 A.M., the DON (Director of Nursing) and the Administrator viewed the sharps cabinet on the second floor that was missing the inner disposable sharps container and lid. The DON indicated there was supposed to be an inner container in the cabinet and sharps should not be sitting in the bottom. She further indicated that nurses removed the inner containers when they were full and were supposed to replace the container afterwards.</p> <p>The current facility policy titled, "Sharps Disposal" and dated 10/2014, was provided by the DON on 12/09/2015 at 10:25 A.M. and reviewed at that time. The policy indicated, "...Needles/sharps disposable containers will be located in the medication room and/or on the medication carts as needed...Place all used needles and syringes in needles/sharps disposable container after use..."</p>		<p>times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before January 1, 2016.</p>	

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	<p>2. During an observation on 12/10/2015 at 9:28 A.M., LPN (Licensed Practical Nurse) #1 was providing wound care for Resident #29's pressure ulcer located on the right lateral ankle. LPN #1 gathered her supplies and walked into Resident #29's room, then without washing her hands, LPN #1 donned gloves and started wound care. LPN #1 removed the soiled dressing, removed her soiled gloves, washed her hands for 6 seconds and donned new gloves, then applied the wound treatment (silver alginate) with a dry dressing. LPN #1 removed her gloves and indicated she needed to wash her hands. LPN #1 walked out of Resident #29's room and back to the treatment cart. LPN #1 placed the unused supplies into the treatment cart, walked into the nursing office, touching the door, and washed her hands for 8 seconds. LPN #1 walked out of the nursing office and assisted Resident #42 by touching the resident's arm.</p> <p>During an interview on 12/10/2015 at 9:36 A.M., LPN #1 indicated she should of washed her hands, prior to donning gloves when she was providing wound care. LPN #1 further indicated she did not wash her hands long enough and should of washed her hands for 60 seconds.</p>			
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F 0465 SS=D Bldg. 00	<p>The current facility policy, dated 10/2014 and titled, "Handwashing/Hand Hygiene", was provided by the Administrator on 12/10/2015 at 2:10 P.M. The policy indicated, but was not limited to, the following: "...rub hands together vigorously, as follows for at least 20 seconds, covering all surfaces of the hands and fingers."</p> <p>3.1-18(a) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a sanitary environment in the second floor dining room. This had the potential to affect 17 of 17 residents residing on the second floor who could utilize the second floor dining/television room.</p> <p>Findings include: On 12/08/2015 at 11:30 A.M., the second</p>	F 0465	<p>F465 Requires the facility to provide a sanitary environment in the second floor dining room.</p> <p>1. Walls were washed and cleaned in the second floor dining room. Walls in the dining room have also been painted with washable paint</p> <p>2. All dining rooms were thoroughly cleaned and walls were washed. No concerns were noted. See below for corrective measures.</p> <p>3. The housekeeping supervisor and her staff was inserviced regarding a sanitary environment in the dining</p>	01/01/2016			

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	<p>floor dining room was observed to have splattered areas on three of the four walls and scuff marks on one wall. The three walls, excluding the wall with the windows, had tan-colored splatter marks the entire length of the walls ranging from pencil eraser to dime size marks from the floor up three feet on the lower part of the walls. The corner where the trash can was located had a large amount of food splatters on the two adjoining walls with a mixture of food particles and tan-colored splatters ranging from pencil eraser to dime size marks from the floor up three feet on the lower part of the wall. The left hand wall had a cream and brown splattered area two feet long by one foot wide with dime size to two inch by one inch drip marks running down the wall. During this dining observation, coffee was spilled and splattered on the wall next to the cabinet. The coffee was wiped up from the floor but not from the wall. The wall opposite the window had scuff marks two feet long by two inches from the tables being scraped along the wall.</p> <p>During an observation on 12/10/2015 at 11:03 A.M., the second floor dining room continued to have food splattered on three of the four walls including by the trash can. The stains from the coffee spill on 12/08/2015 remained on the wall. Five</p>		<p>rooms. 4. The administrator or her designee will monitor the environment in the dining areas to ensure sanitation is maintained(walls, tables and floors are cleaned) daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment H) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before January 1, 2016.</p>	

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	<p>residents were sitting in the dining room at this time waiting for lunch.</p> <p>During an observation on 12/14/2015 at 1:15 P.M., the second floor dining room continued to have food splattered on three of the four walls with a large concentration of food splatters in the corner behind the trash can and coffee stains on the wall beside the cabinet.</p> <p>During an interview on 12/14/2015 at 1:53 P.M., the House Keeping Manager indicated the walls had flat paint on them and when washed the paint came off the walls. She indicated the walls were not washed at all because of this reason.</p> <p>During an interview on 12/14/2015 at 2:12 P. M., the Administrator indicated cleaning and repainting the second floor dining room was on her list of things to do. No list was provided, nor were any documents, to indicate paint had been ordered for the dining room. The Administrator indicated it was unacceptable to not clean the walls.</p> <p>3.1-19(f)(5)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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 observation, interview and record review, the facility failed to complete accurate clinical documentation related to pressure sores, post dialysis assessments and psychotropic medication side effect monitoring for 4 of 17 residents reviewed for documentation. (Resident #8, #10, #29 and #32)</p> <p>Findings include:</p> <p>1. The clinical record was reviewed for Resident #32 on 12/10/2015 at 11:45 A.M. The quarterly MDS (Minimum Data Set) assessment dated 09/18/2015, indicated the resident was alert and oriented and had a BIMS (Brief Interview for Mental Status) of 15. Diagnoses included, but were not limited to anxiety, end stage renal disease, atrial fibrillation,</p>	F 0514	F514 Requires the facility to complete accurate clinical documentation related to pressure sores, post dialysis assessments and psychotropic medication. 1. Resident #8, #10, #29, #32's documentation was reviewed. As of January 1st, 2016 their clinical documentation is complete and accurate. 2. All residents have the potential to be affected. All resident's documentation were reviewed to ensure their pressure sores, post dialysis assessments, and psychotropic medication side effect form is complete and accurate. No concerns were noted. See below for corrective measures. 3. The documentation policy and procedure was reviewed with no changes made. (See attachment I) The staff was inserviced on the on the above procedure. 4. The	01/01/2016

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	<p>coronary artery disease, and chronic obstructive pulmonary disease. Resident #32 had a Care Plan for, "End Stage Renal Disease and receives hemodialysis, thus has the potential for complications associated with hemodialysis". Resident #32 was also on a blood thinner for atrial fibrillation.</p> <p>The original dialysis order was provided by the Corporate Nurse Consultant on 12/14/2015 at 10:27 A.M. and reviewed at that time. The order indicated Resident #32 was to receive hemodialysis every Monday, Wednesday and Friday.</p> <p>The Post Dialysis Assessment forms were provided by the Administrator on 12/10/2015 at 2:55 P.M. and reviewed at that time. The instructions indicated assessments were to be completed upon return from each dialysis visit. Assessments were to include: date, time, blood pressure, pulse, respirations, resident's general condition upon return, and a signature of the nurse completing the assessment. Assessments for Resident #32 were left blank for the following dates:</p> <p>12/09/2015 12/07/2015 12/04/2015 12/02/2015</p>		<p>DON or his designee will monitor all documentation concerning pressure ulcers, post dialysis assessments, and psychotropic medication side effect monitoring for accuracy daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before January 1, 2016.</p>				

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	<p>11/27/2015 11/20/2015 11/13/2015 11/06/2015 10/30/2015 10/19/2015</p> <p>The 24-Hour Nursing Reports were provided by the DON (Director of Nursing) on 12/14/2015 at 9:00 A.M. for the above listed dates. Vital signs were noted on 11/20/2015 only.</p> <p>The Nurse's Notes were provided by the Administrator on 12/10/2015 at 2:55 P.M. The clinical record lacked Nurse's Notes that indicated vital signs were taken following dialysis on any of the above listed dates.</p> <p>During an interview on 12/10/2015 at 2:30 P.M., LPN (Licensed Practical Nurse) #2 indicated Resident #32 went to dialysis every Monday, Wednesday and Friday. LPN #2 further indicated it was the facility policy to take the resident's vital signs upon return from dialysis and confirmed that she obtained vital signs on the resident following dialysis on the days when she was working.</p> <p>During an interview on 12/14/2015 at 11:03 A.M., the Compliance Officer indicated when a resident returns from</p>			

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	<p>dialysis staff were to check for a bruit and a thrill at the dialysis port site. The Nurse Consultant also indicated the staff nurse was to make sure the resident was "doing ok" overall and for a resident on coumadin and dialysis, the resident's dialysis port site was to be checked.</p> <p>An interview was conducted on 12/14/2015 at 11:35 A.M. with the DON. The DON indicated when a resident comes back from dialysis a post dialysis sheet is filled out with vital signs, bruit and thrill information.</p> <p>Review on 12/14/2015 at 2:56 P.M., of the resident's care plan, physician's orders and facility policy did not indicate vital signs were to be taken upon return from dialysis.</p> <p>During an interview on 12/14/2015 at 2:58 P.M., Resident #32 indicated staff took her vital signs when she returned from dialysis but they did not always come in right away when she got back.</p> <p>2. The clinical record for Resident #8 was reviewed on 12/14/2015 at 3:15 P.M. The "Psychotropic Medication Side Effect Monitoring Flowsheet", which indicated the nurse had monitored for medication side effects, was to be initialed by the nurses at the end of each shift. The flowsheets for Resident #8 had</p>			

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	<p>missing nurse initials for the following days and shifts:</p> <p>Night shift - September 1, 2, 3, 5, 6, 7, 8, 10, 12, 15, 18, 19, 22, 24, 25, 26, and 29, 2015.</p> <p>Day shift - September 1, 4, 5, 6, 8, 11, 15, 18, 19, 20, 22, and 29, 2015.</p> <p>Evening shift - September 1, 2, 4, 5, 6, 7, 9, 11, 14, 17, 18, 23, 24 and 28, 2015.</p> <p>Night shift - November 3, 5, 6, 10, 12, 13, 17, 19, 20, 21, 23, 26, 28, 29, and 30, 2015.</p> <p>Day shift - November 1, 3, 6, 10, 13, 14, 15, 17, 20, 24, 27, 28, and 29, 2015.</p> <p>Evening shift - November 2, 4, 5, 9, 11, 12, 16, 18, 19, 20, 25, 27, 28, and 29, 2015.</p> <p>During an interview on 12/14/2015 at 1:28 P.M., the DON (Director of Nursing) indicated the facility staff could not locate Resident #8's "Psychotropic Medication Side Effect Monitoring Flowsheet" for October, 2015.</p> <p>The clinical record for Resident #10 was reviewed on 12/14/2015 at 3:30 P.M. The resident's "Psychotropic Medication Side</p>			

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	<p>Effect Monitoring Flowsheet", that was to be initialed by the nurses at the end of each shift, indicating they had monitored for side effects, had missing nurse initials for the following days and shifts:</p> <p>Night shift - September 18, 20, and 23, 2015.</p> <p>Evening shift - September 2, 3, 7, 8, 12, 13, 15, 17, 21, 22, 25, 26, 27, and 29, 2015.</p> <p>Night shift - October 25, 2015.</p> <p>Evening shift - October 5, 6, 10, 11, and 13, 2015.</p> <p>Evening shift - November 12 and 22, 2015.</p> <p>During an interview on 12/14/2015 at 1:28 P.M., the DON (Director of Nursing) indicated that she was in the process of re-educating the nurses because there was some confusion about how to fill out the side effect monitoring sheets. The DON indicated every date on the monitoring sheet should have the nurse's initials for each shift. 3. During an observation on 12/10/2015 at 9:24 A.M., LPN (Licensed Practical Nurse #1 performed wound care for Resident #29's pressure ulcer located on the right lateral</p>				

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	<p>ankle.</p> <p>During an interview on 12/10/2015 at 9:37 A.M., LPN #1 indicated Resident #29 had a pressure ulcer on his right lateral ankle. LPN #1 further indicated that Resident #29 currently only had one pressure ulcer and it was on his right lateral ankle.</p> <p>During an interview on 12/09/2015 at 2:00 P.M., the ADON (Assistant Director of Nursing) indicated Resident #29's wound was a Stage 3 pressure ulcer and was located on the resident's right ankle. The ADON further indicated she staged it at a stage 3 because the open area had yellow slough.</p> <p>During an interview on 12/10/2015 at 1:33 P.M., the ADON indicated the care plan was documented for Resident #29's left lateral ankle. The ADON further indicated it was an error and it should have been documented for the resident's right ankle.</p> <p>The Clinical Record for Resident #29 was reviewed on 12/10/2015 at 10:34 A.M. Resident #29's "Pressure Area" care plan indicated the resident had a pressure area located on the left lateral ankle. The care plan was dated 09/10/2015 and the interventions were</p>						

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	<p>documented as revised on 10/30/2015 and 12/04/2015.</p> <p>The "Comprehensive Physician's Order Sheet", dated 09/10/15, indicated to apply Santyl to the open area on the resident's right ankle and cover with a dry dressing daily.</p> <p>The "Comprehensive Physician's Order Sheet", dated 10/30/15, indicated the staff were to discontinue Santyl to the resident's right ankle and apply Therahoney to the area daily, cover with a dry dressing, and reevaluate the area in two weeks.</p> <p>The "Comprehensive Physician's Order Sheet", dated 12/04/2015, indicated the staff were to discontinue Therahoney to the right outer ankle and change to using Silver Alginate on the right outer ankle and cover with a dry dressing every day.</p> <p>The "Initial Pressure/Ulcer Assessment", dated 09/10/2015 indicated Resident #29 had a Stage 3 pressure ulcer located on his right lateral ankle. The wound bed was pink with yellow slough.</p> <p>The "Ongoing Assessment of Pressure Ulcer", dated from 10/15/2015 through 12/04/2015, indicated Resident #29 had a Stage 3 pressure ulcer on his right lateral</p>			

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	<p>ankle.</p> <p>The "Nutritional Progress Note" dated 9/17/2015 indicated, "...aware new pressure ulcer L (left) outer ankle, Stage 2 ..."</p> <p>The "Nutritional Progress Note" dated 11/23/2015 indicated, "...res [resident] has Stage 2 pressure ulcer on L lateral ankle..."</p> <p>The "Nutritional Progress Note", dated 12/09/2015 indicated "... res cont [continues with] Stage 2 pressure ulcer on L lateral ankle. Area improved."</p> <p>The current "Charting and Documentation Policy" was provided by the DON on 12/14/2015 at 3:05 P.M. and reviewed at that time. The policy indicated, "...Document significant information...Document normal behavior, progressive signs, attitudes, and moods as well as abnormalities and pathological signs...Documentation should be complete, concise, and factual."</p> <p>3.1-50(a) 3.1-50(f)</p>			