

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/04/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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F 000  Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: February 26, 27, March 2, 3, 4, 2015</p> <p>Facility number: 000180 Provider number: 155282 AIM number: 100274190</p> <p>Survey team: Amy Wininger, RN, TC Terri Walters, RN Dorothy Watts, RN Sylvia Scales, RN (February 26, 27, March 2, 2015)</p> <p>Census bed type: SNF/NF: 104 Residential: 21 Total: 125</p> <p>Census payor type: Medicare: 16 Medicaid: 60 Other: 28 Total: 104</p> <p>Residential sample: 7</p>	F 000	<p>Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed solely because it is required by the provisions of the Federal and State law for the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 225 SS=D Bldg. 00	<p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed on March 11, 2015 by Jodi Meyer, RN</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>			

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	<p>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was immediately reported to the State Department of Health for 1 of 2 allegations of abuse reviewed. (Resident #119)</p> <p>Findings include:</p> <p>On 3/2/15 at 8:33 A.M., Resident #119 was observed in bed with her eyes closed and no distress noted.</p> <p>On 3/3/15 at 11:15 A.M., a facility allegation of abuse report with the incident date of 2/16/15 at 4:00 P.M., was reviewed. The report included, but was not limited to, "...Brief Description of Incident: Resident [#119] reports CNA 'treats roommate [sic] like an angel. 'Let me 'flop down' &amp; threw my legs in bed. Talks to my roommate [sic] about me..."</p> <p>During interview with the Administrator</p>	F 225	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All future allegations of abuse will be reported immediately to the administrator and other officials in accordance of state law- including the state survey and certification agency 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 residents have the potential to be affected All allegations of abuse will be reported immediately to the administrator and other officials in accordance of state law- including the state survey and certification agency What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and other administrative staff were educated on the requirement to report all allegations of abuse immediately to the state survey</p>	03/18/2015

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	<p>on 3/3/15 at 11:15 A.M., she indicated Resident #119's daughter had reported the above allegation to Social Service (SS) staff #2 on 2/16/15 at 4:00 P.M. The Administrator indicated when SS staff #2 was off the phone with the daughter she had contacted the Administrator regarding the allegation. The Administrator indicated the allegation of abuse had not been reported to the State Department of Health until 2/17/15 at 1:53 P.M. The Administrator was made aware, at that time, an allegation of abuse on 2/16/15 had not been immediately reported to the state agency. The Administrator indicated she thought she had 24 hours to report an allegation of abuse to the state agency.</p> <p>The facility policy entitled "Abuse and Neglect" (revision date 9/13) was reviewed on 3/2/15 at 2:45 P.M. The policy included, but was not limited to, "...Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with the state law, including the state survey and certification agency..."</p> <p>3.1-28(c)</p>		<p>and certification agency How the corrective action will be monitored to ensure the deficient practice will not recur; Audits will be conducted on all allegations of abuse to ensure that it was reported immediately to the administrator and other officials in accordance to state law that includes the state survey and certification agency Audits will be done weekly x4 and monthly x3 Audits will be reviewed by the QA committee at monthly meeting and if not 100% compliant x3 months, committee will recommend further education and additional audits for another 3 months until 100% compliance is reached</p>	

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F 226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to follow the facility abuse policy to report an allegation of abuse immediately to the State Department of Health for 1 of 2 allegations of abuse reports reviewed. (Resident #119)</p> <p>Findings include:</p> <p>On 3/2/15 at 8:33 A.M., Resident #119 was observed in bed with her eyes closed and no distress noted.</p> <p>On 3/3/15 at 11:15 A.M., a facility allegation of abuse report with the incident date of 2/16/15 at 4:00 P.M., was reviewed. The report included, but was not limited to, "...Brief Description of Incident: Resident [#119] reports CNA 'treats roommate [sic] like an angel. 'Let me 'flop down' &amp; threw my legs in bed. Talks to my roommate about me..."</p> <p>During interview with the Administrator on 3/3/15 at 11:15 A.M., she indicated Resident #119's daughter had reported</p>	F 226	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; All future allegations of abuse will be reported immediately to the administrator and other officials in accordance of state law- including the state survey and certification agency 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 residents have the potential to be affected All allegations of abuse will be reported immediately to the administrator and other officials in accordance of state law- including the state survey and certification agency What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Administrator and other administrative staff were educated on the requirement to report all allegations of abuse immediately to the state survey and certification agency How the corrective action will be monitored to ensure the deficient practice</p>	03/18/2015
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	<p>the above allegation to Social Service (SS) staff #2 on 2/16/15 at 4:00 P.M. The Administrator indicated when SS staff #2 was off the phone with the daughter she had contacted the Administrator regarding the allegation. The Administrator indicated the allegation of abuse had not been reported to the State Department of Health until 2/17/15 at 1:53 P.M. The Administrator was made aware, at that time, that the facility has not followed the facility abuse policy and had not immediately reported an allegation of abuse to the state agency. The Administrator indicated she thought she had 24 hours to report an allegation of abuse to the state agency.</p> <p>On 3/3/15 at 11:30 A.M., the Administrator was made aware the facility policy entitled "Abuse and Neglect" (revision date 9/13) included, but was not limited to, "...Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with the state law, including the state survey and certification agency..."</p> <p>3.1-28(c)</p>		<p>will not recur; Audits will be conducted on all allegations of abuse to ensure that it was reported immediately to the administrator and other officials in accordance to state law that includes the state survey and certification agency How the corrective action will be monitored to ensure the deficient practice will not recur; Audits will be conducted on all allegations of abuse to ensure that it was reported immediately to the administrator and other officials in accordance to state law that includes the state survey and certification agency Audits will be done weekly x4 and monthly x3 Audits will be reviewed by the QA committee at monthly meeting and if not 100% compliant x3 months, committee will recommend further education and additional audits for another 3 months until 100% compliance is reached</p>	

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F 241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided in a manner to promote dignity, in that, staff did not sit down to assist residents with eating and/or drinking in 1 of 5 dining rooms observed. (Garden Ridge)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During an observation in the Garden Ridge dining room on 2/26/15 from 12:15 P.M. to 12:30 P.M., RN #10 was observed to travel between dining tables and assist residents with eating and/or drinking from a standing position. The RN #10 was observed to not sit down when assisting residents with eating and/or drinking.</li> <li>2. During an observation in the Garden Ridge dining room on 2/27/15 from 12:20 P.M. to 12:35 P.M., RN #10 was observed to travel between dining tables and assist residents with eating and/or drinking from a standing position. The</li> </ol>	F 241	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Staff have been educated on this unit with identified residents on sitting when assisting residents in eating and drinking Stools have been purchased for staff use to sit with residents during meals. 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 residents who require assistance with meals have the potential to be affected All staff will be educated on sitting with resident to assist in meals/drink. Stools are available for staff in all dining rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff will be educated on sitting with resident during meal assistance Stools will be available in all dining rooms for staff use. How the corrective action will be monitored to ensure the deficient practice will not recur; DNS or ADNS will conduct random audits during meals to</p>	04/03/2015

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F 242 SS=D Bldg. 00	<p>RN #10 was observed to not sit down when assisting residents with eating and/or drinking.</p> <p>3. During an observation in the Garden Ridge dining room on 3/3/15 at 8:25 A.M. through 8:40 A.M., RN #10, LPN #10, and CNA #10 were observed to travel between dining tables and assist residents with eating and/or drinking from a standing position. RN #10, LPN #10, and CNA #10 were observed to not sit down when assisting residents with eating and/or drinking.</p> <p>The Policy and Procedure for "Nutritionally Dependent Resident" provided by the HFA (Health Facilities Administrator) on 3/3/15 at 2:45 P.M. indicated, "Purpose...To provide dignity...Procedure...2...f. Sit at either the right or left of the resident..." During an interview, at that time, the HFA indicated staff should sit next to the resident when assisting with eating and/or drinking.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact</p>		<p>ensure staff are sitting during the time they assist residents. These audits will be weekly x4 and then monthly x3. Report of audit results will be given to the QA committee to review and if not 100% compliant x 3 months will make recommendations for further education and/or other interventions QA committee will request additional audits until 100% compliance is reached x 3 months.</p>		

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	<p>with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's choice of being provided 2 showers a week had been provided for 1 of 1 resident who voiced concern for not receiving 2 showers a week. (Resident #46)</p> <p>Findings include:</p> <p>Resident #46 was observed sitting in a chair in her room on 2/27/15 at 8:58 A.M., with no distress noted.</p> <p>Her clinical record was reviewed on 2/26/15 at 12:34 P.M. Her Quarterly Minimum Data Set assessment dated 1/26/15 indicated a cognitive score of 15 (cognition intact).</p> <p>On 2/27/15 at 8:58 A.M., during interview, Resident #46 indicated at times she only received 1 shower a week instead of the 2 showers a week that she preferred.</p> <p>During interview with the Director of Nursing (DON) on 3/3/15 at 4:15 P.M., the DON indicated Resident #46 had a preference for showers to be provided on the evening shift. She indicated the</p>	F 242	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #46 will have showers 2x/week in the evening per her choice 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 residents have the potential to be affected Resident shower choices will be identified during the admission process, care plan conferences and resident council meetings What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Resident shower choices will be identified on admission, care plan reviews, and resident council meetings How the corrective action will be monitored to ensure the deficient practice will not recur; The DNS or ADNS will do random audits to interview residents to ensure they are receiving shower per their choice The audits will be done weekly x4 then monthly x3. Audit finding will be reported to the monthly QA committee for 100% compliance. If not 100% compliant x 3months, QA committee will recommend further education and interventions Committee will then</p>	04/03/2015

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	<p>facility had no policy regarding showers. The DON indicated the facility followed the state regulation of providing 2 showers a week.</p> <p>On 3/3/15 at 4:15 P.M., the DON provided documentation of showers being provided for Resident #46 and/or the refusal of showers from the dates of 1/1/15 through 3/3/15. The documentation included, but was not limited to, showers had not been provided or refused on the dates of January 8-14, February 12-18, and February 24- March 3, 2015.</p> <p>Resident #46's current care plan with a revision date of 5/27/14 included, but was not limited to, an intervention of "...BATHING: Resident requires assistance (extensive assistance) with bathing/showering (twice per week) and as necessary..."</p> <p>On 3/4/15 at 9:30 A.M., the DON was made aware of the resident's choice of 2 showers a week had not been provided on the dates of 1/8-1/14/15, 2/12-18/15, and 2/24-3/3/15. She agreed documentation was lacking that 2 showers a week had been provided.</p> <p>3.1-3(u)(3)</p>		require additional audits x3 months until 100% compliance is reached.		

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F 314 SS=G Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure care was provided, in that, a dependent resident admitted without a pressure ulcer on the right heel, developed a pressure ulcer on the right heel (Resident #116) and/or a dependent resident admitted with a pressure blister on the right heel developed a pressure ulcer on the right heel (Resident #76) for 2 of 3 residents who met the criteria for review of pressure. This deficient practice resulted in Resident #116 experiencing an Unstageable pressure ulcer on the right heel and/or Resident #76 experiencing a Stage 3 pressure ulcer to the right heel.</p> <p>Findings include:</p> <p>1. During an observation on 2/27/15 at</p>	F 314	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #116 and #76 had their care plans reviewed and up-dated on 3/6/15. Care plan interventions were placed on Treatment Record to ensure care was provided. 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 residents with Braden score of 18 or less have the potential to be affected. Residents with Braden score of 18 and less will have care plans reviewed and interventions updated These interventions will be put on the treatment administration record (TAR) to ensure care was provided. What measures will be put into place or what systemic changes will be made to ensure</p>	04/03/2015

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	<p>8:55 A.M., Resident #116 was observed being transferred from her wheelchair to her recliner. At that time she wore blue heel protectors.</p> <p>The clinical record of Resident #116 was reviewed on 3/2/15 at 9:30 A.M. The clinical record indicated Resident #116 was admitted to the facility on 9/23/14 with no skin impairment noted to the right heel and diagnoses including, but not limited to, weakness, altered mental status, urinary tract infection, and a Stage 2 pressure area to buttocks.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 9/29/14 indicated Resident #116 was at risk for developing a pressure ulcer, was cognitive intact and needed the extensive assistance of 2 people for bed mobility and transfers.</p> <p>The Nursing Admission Assessment dated 9/23/14 indicated Resident #116 had skin impairments including, but not limited to, right buttock upon admission. No skin impairment to the right heel was documented.</p> <p>A Care Plan dated 10/3/14 noted: "...The resident has potential for pressure ulcer development R/T decreased mobility, weakness, H/O [history of] pressure ulcer Stage 2 to left [right]</p>		<p>that the deficient practice does not recur; All residents with Braden score of 18 or less have the potential to be affected. Residents with Braden score of 18 and less will have care plans reviewed and interventions updated These interventions will be put on the treatment administration record (TAR) to ensure care was provided How the corrective action will be monitored to ensure the deficient practice will not recur; DNS and Wound Care Nurse will do weekly audits x4 then monthly x3 that will review residents care plan for interventions and that documentation was completed on TAR's. Findings of audits will be reviewed with the QA committee and if not 100% compliance x 3 months will make further recommendations for additional education and/or interventions. QA committee will also recommend further audits until 100% compliance is reached x 3 months. Wound Care nurse will continue to report monthly to the QA committee on number of wounds, type, and intervention follow-up.</p>	

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	<p>buttock...Turning/repositioning program every shift per facility protocol. Reposition with (2 people)..." The care plan dated 10/3/14 lacked documentation related to providing pressure relief to Resident #116's heels.</p> <p>A "Braden Scale for Predicting Pressure Sore Risk" assessment for Resident #116 dated 9/30/14 was provided by the Wound Care Nurse (WCN) on 3/3/15 at 4:45 P.M. Resident #116's Braden score was 17. The Intervention Guide on the form read as follows: "...Score 17...Mild Risk (Score of 15-18)...Intervention Guide...Protect Heels..."</p> <p>A Physician's Order dated 10/28/14 indicated an order for "...Normal saline cleanse suspected deep tissue injury to right heel..."</p> <p>A Physician's Order dated 1/20/15 indicated an order for "...Normal saline cleanse unstageable pressure ulcer to right heel...Apply Santyl to wound bed. Cover with calcium alginate and foam..."</p> <p>A "Wound Data Collection" form for Resident #116 dated 10/27/14 read as follows: "...Right heel...Suspected Deep Tissue Injury...Length...cm 3.0...width...cm 2.9...Depth...cm 0.1...Minimum</p>			

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	<p>Drainage...Serosanguineous..."</p> <p>A "Wound Data Collection" form for Resident #116 dated 11/10/14 read as follows: "...Right heel...unstageable d/t [due to] eschar present over 80% ...Length...cm 2.5...width...cm 2.1..."</p> <p>A "Wound Data Collection" form for Resident #116 dated 3/2/15 read as follows: "...Right heel...Stage 3 pressure ulcer...Length...cm 0.8...width...0.8...Depth...cm 0.2...Minimum Drainage...Granulation % 60...Slough % 40..."</p> <p>A copy of the Clinical Practice Guideline was provided by the Wound Care Nurse (WCN) on 3/3/15 at 3:10 P.M., and on page 8, Stages of Pressure Ulcers read as follows: Stages of Pressure Ulcers "...Suspected deep tissue injury Purple or maroon area of discolored intact skin...due to damage of underlying soft tissue from pressure and/or shear..." "Unstageable Full thickness tissue loss in which the base of the ulcer is covered by...eschar (tan, brown or black) in the ulcer bed..." "...Stage 3 Full thickness loss..."</p> <p>During an observation of a dressing change to Resident #116's right foot on 3/3/15 at 11:20 A.M., the WCN indicated</p>			

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	<p>the Stage 3 pressure ulcer measured the same as it did on 3/2/15 and had 60% granulation and 40% slough. At that time, the WCN indicated she did not know what had caused the pressure ulcer.</p> <p>During an interview on 3/4/15 at 10:50 A.M., PT #1 indicated Resident #116 was very weak on admission and needed the assistance of 2 people for transfers and bed mobility.</p> <p>During an interview on 3/4/15 at 9:45 A.M., the Wound Care Nurse (WCN) indicated Resident #116 was at high risk for developing a pressure ulcer and should have had pressure relief provided to her feet, due to a history of a pressure ulcer, and the diagnoses of weakness and decreased mobility. The WCN further indicated she was unable to provide documentation that Resident #116 was provided pressure relief to her heels from admission on 9/23/14 to 10/27/14 when the deep tissue injury occurred.</p> <p>A Policy and Procedure titled "Lower Extremity Ulcers" was provided by the Heath Care Administrator on 3/4/15 at 10:52 A.M., and it read as follows: "...6. Interventions will be documented, implemented and added to the care plan..."</p>			

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	<p>A Policy and Procedure titled "Pressure Ulcer Practice Guidelines" was provided by the Heath Care Administrator on 3/4/15 at 10:52 A.M., and it read as follows: "...INITIAL RISK ASSESSMENT...Prevention strategies should be developed and implemented at the time of admission based upon the initial assessment of the causative factors that contribute to the resident's risk for skin breakdown...Include these prevention strategies on the resident's care plan. Inform caregivers of prevention strategies..."</p> <p>2. During an observation on 3/2/15 at 9:48 A.M., Resident #76 was observed in her room sitting in her wheelchair. At that time she wore a blue air boot to the right lower leg and foot.</p> <p>The clinical record of Resident #76 was reviewed on 3/2/15 at 9:30 A.M. The clinical record indicated Resident #76 was initially admitted to the facility on 8/13/13. Resident #76 was readmitted to the facility from the hospital on 1/8/15. Resident #76's diagnoses included, but were not limited to, paraplegia, weakness, dementia.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 11/11/14 indicated Resident #76 was at risk for developing a</p>			

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	<p>pressure ulcer, experienced moderate cognitive impairment and needed the extensive assistance of 2 people for bed mobility and transfers.</p> <p>A Nursing Admit Re-admit Data Collections form dated 1/8/15 indicated Resident #76 had a Stage 2 pressure ulcer to the right medial heel.</p> <p>A Care Plan initiated on 10/3/14 read as follows: "...The resident has potential for pressure ulcer development R/T lower extremity paraplegia, weakness, loss of mobility and dementia...Interventions...Monitor nutritional status..."</p> <p>A Lab Specimen Report for Resident #116 dated 1/21/15 read as follows: "...Total Protein 5.7 L [low] 6.3 -8.2 g/dl [normal range]" "Albumin 2.8 L 3.5 -5.0 g/dl [normal range]"</p> <p>A "Wound Data Collection" form for Resident #76 dated 1/8/15 read as follows: "...Right heel...medial heel - serous filled blister. Stage 2 pressure ulcer...Length...cm 3.0...width...cm 3.3..."</p> <p>A "Wound Data Collection" form for Resident #76 dated 1/26/15 read as follows: "...Right heel...Stage 2 pressure ulcer-blister remains intact...Length...cm</p>			

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	<p>4.0...width...cm 3.4...tx [treatment] changed from skin prep to betadine..."</p> <p>A "Wound Data Collection" form for Resident #76 dated 2/9/15 read as follows: "...Right heel...unstageable pressure ulcer d/t [due/to] eschar present... Length...2.3...width...cm 1.5..."</p> <p>A copy of the Clinical Practice Guideline was provided by the WCN on 3/3/15 at 3:10 P.M., and on page 8, Stages of Pressure Ulcers, read as follows: ...Stage 2 Partial thickness loss of dermis...May also present as an intact ...blister "...Unstageable Full thickness tissue loss in which the base of the ulcer is covered by...eschar (tan, brown or black) in the ulcer bed..."</p> <p>A Policy and Procedure titled "Pressure Ulcer Practice Guidelines" was provided by the Health Care Administrator on 3/4/15 at 10:52 A.M., and it read as follows: "...Staff should monitor lab studies as ordered for signs of undernutrition or malnutrition..."</p> <p>During an interview on 3/3/15 at 2:23 P.M., the Wound Care Nurse (WCN) indicated Resident #116's lab report dated 1/21/15 showed a low protein level of 5.7</p>			

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F 431 SS=D Bldg. 00	<p>g/dl (normal range 6.3 -8.2 g/dl ) and a low albumin level of 2.8 g/dl (normal range 3.5 -5.0 g/dl), but no intervention had been implemented. A protein supplement had not been provided for Resident #116 to promote healing.</p> <p>A Policy and Procedure titled "Pressure Ulcer Practice Guidelines" was provided by the Heath Care Administrator on 3/4/15 at 10:52 A.M., and it read as follows: "...Staff should monitor lab studies as ordered for signs of undernutrition or malnutrition..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration</p>			

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	<p>date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure, medications were stored securely, in that, medications were observed unsecured and unsupervised by a licensed staff member for 8 of 9 residents whose medications were delivered to the 2nd avenue dining room. (Resident #81, Resident #3, Resident #27, Resident #42, Resident #25, Resident #22, Resident #118, Resident #31)</p> <p>Findings include:</p> <p>During a random observation on 2/26/15 at 12:15 until 12:38 P.M., 2 duffle bags were observed sitting on the floor by a wall to the left in the 2nd avenue dining room. UM #2 was observed collecting</p>	F 431	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents involved will be have their medications stored securely upon delivery 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 residents on medication have the potential to be affected Medications will be stored securely upon delivery. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will be educated to secure medications upon delivery How the corrective action will be monitored to ensure the deficient</p>	04/03/2015	

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	<p>the bags. At that same time during an interview she indicated the bags contained the facilities medication shipment for the 100 and 500 halls and the bags were observed to not be sealed. She further indicated that medications needed to be stored in a secure room and/or cart.</p> <p>A pharmacy shipment list dated 2/26/15 was provided by the DON on 3/2/15 at 1:45 P.M., the list included, but was not limited to:</p> <p>Resident #81, metoprolol tartrate (a medication used to treat high blood pressure and chest pain) 25 mg 28 tabs.</p> <p>Resident #3, furosemide (a diuretic) 40 mg 14 tabs, warfarin (an anticoagulant) 3 mg 2 tabs, warfarin 2 mg 12 tabs.</p> <p>Resident #27, lisinopril (an anti-hypertensive medication) 2.5 mg.</p> <p>Resident #42 furosemide 20 mg 14 tabs, furosemide 40 mg 28 tabs, clonazepam (a controlled anti-anxiety medication) 0.5 mg 14 tabs, sertraline (an antidepressant) 50 mg 14 tabs, gabapentine (a medication used for nerve pain) 300 mg 14 tabs, amlodipine (an anti-hypertensive) 10 mg 14 tabs, tramadol (a pain medication) 50 mg 28 tabs.</p>		<p>practice will not recur; The QA nurse or DNS will do audits 2x month on proper delivery and securing of medications. These audits will be done for 3 months. Audit findings will be reported to the QA committee and if not 100% compliant x 3 months will make further education and/or recommendations. Committee will also request continued audits until 100% compliance reached x 3 months</p>		

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F 465	<p>Resident #25, Diltiazem (anti-hypertensive, anti-arrhythmic medication) 120 mg 14 caplets, digoxin 0.125 mg (a medication to treat heart failure) 14 tabs, furosemide 20 mg 14 tabs.</p> <p>Resident #22, venlafaxine (an antidepressant) 225 mg 14 tabs, metoprolol tartrate 25 mg 28 tabs, amlodipine 5 mg 14 tabs.</p> <p>Resident #118 furosemide 20 mg 28 tabs, atenolol (an anti-hypertensive) 25 mg 14 tabs, Nuvigil (a controlled medication used to increase wakefulness) 150 mg 14 tabs.</p> <p>Resident #31, metoprolol tartrate 25 mg, 56 tabs, nifedipine (an anti-hypertensive medication) 30 mg, 28 tabs.</p> <p>During an interview on 2/26/15 at 1:00 P.M., the DON indicated the medications were reviewed and put away, she further indicated that future medication deliveries would be stored in the medication room.</p> <p>3.1-25(m) 3.1-25(n)</p> <p>483.70(h)</p>						

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SS=F Bldg. 00	<p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>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 ensure kitchen floors were clean and free of dust, soil, and dried food particles for 1 of 2 kitchen tours. This had the potential to affect 100 of 104 residents who resided at the facility.</p> <p>Findings include:</p> <p>1. On 3/2/15 at 11:31 A.M., the kitchen was toured with the Assistant Food Service Manager (AFSM). The back hall of the kitchen was observed to have black soil along the doorway floor edges of the Food Service Manager's office, the paper storage room, the food storage room, and the cleaning storage/mop room. Particles of black soil were observed in the doorway floor edges and could be removed when scraped along the doorway floor edges. The edges of the flooring and baseboard down the back hall to the kitchen exit door and the flooring edges along the walk-in refrigerator contained black soil. The ASFM was made aware of the black soiling of the floor at that time. The ASFM agreed to the soiling and indicated she would tell the staff who cleaned the</p>	F 465	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Dietary manager and floor technician employee cleaned kitchen floor on 3/3/15 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 residents have the potential to be affected Staff education provided to dietary and floor tech employees to thoroughly clean floor. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Education will be provided to dietary and floor tech employees on cleaning of floor A cleaning schedule will be maintained to ensure floors are being cleaned. How the corrective action will be monitored to ensure the deficient practice will not recur; QA nurse and dietary manager will do weekly audits x4 then monthly x3 to ensure floor is being cleaned Audit findings will be reported to the QA committee and if not 100% compliant x 3 months, will make recommendations for additional education and continued audits until 100%</p>	04/03/2015	

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	<p>kitchen floors.</p> <p>2. The 3/2/15 at 11:37 A.M., the kitchen tour continued into the food preparation area of the kitchen. The flooring underneath and behind the stove area, the shelving units across from the stove, the cabinets, the equipment through out the food preparation area, and 3 stainless steel ware pieces were observed to have a large amount of dust, soil, and dried food particles. When a hand swipe was performed on the flooring underneath the kitchen appliances and equipment a large amount of dust, soil, and dried food particles were observed. The AFSM was made aware of the soiling at that time and she began to remove the soil, food particles and dust accumulated from the hand swipe. On 3/2/15 at 11:45 A.M., the Food Service Manager (FSM) was made aware of the soiling of the floor under the kitchen appliances and equipment and the floor edges of the food preparation area.</p> <p>3. During interview with the Dietician on 3/3/15 at 3:05 P.M., the Dietician indicated she was aware of the soiling of the kitchen floors. She indicated the facility was taking care of soiled kitchen floors. The Dietician indicated the cleaning of the kitchen floors in regard to under the equipment and appliances</p>		compliance reached x 3 months.	

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R 000  Bldg. 00	<p>should be done monthly. The FSM on 3/3/15 at 3:10 P.M., indicated the cleaning of the kitchen floors in regard to pulling out equipment and cabinets will be done monthly. A kitchen floor cleaning schedule and/or policy was requested at that time. The FSM indicated, at that time, she was unsure if there was a facility policy or cleaning schedule related to cleaning of kitchen floors. On 3/4/15 at 8:44 A.M., no facility kitchen floor cleaning schedule or policy had been provided.</p> <p>3.1-19(f)</p> <p>Good Samaritan Society Northwood Retirement Community was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 000	Credible Allegation of Compliance and Correction: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of corrections prepared and/or executed solely because it is required by the provisions of the Federal and State law for the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/04/2015
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			constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual		