

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2013
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NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN 47460
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F000000	<p>This visit was for the Investigation of Complaint IN00124010.</p> <p>Complaint IN00124010 - Substantiated. Federal/state deficiencies related to the allegations are cited at F314.</p> <p>Survey date: February 18, 2013</p> <p>Facility number: 010892 Provider number: 155661 AIM number: 200229560</p> <p>Survey team: Kimberly Perigo, RN-TC</p> <p>Census bed type: SNF: 10 SNF/NF: 82 Total: 92</p> <p>Census payor type: Medicare: 04 Medicaid: 74 Other: 14 Total: 92</p> <p>Sample: 04</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>How will this include individualized position changes (of no more than 2 hour intervals), as indicated by your policy and procedures?Owen Valley staff members will get to the dialysis center at the same time of the day that position changes would occur for the Resident, based on the Resident's individualized care plan, as if the Resident's were still in our facility.How will this provide prompt incontinence care and/or position changes as needed and/or requested from the affected Resident?The Resident does not typically report incontinent episodes. The staff become aware of incontinent episodes during routine check and position changes, which would be the same when the Resident is in the dialysis center. The dialysis Clinical Manager reported that if staff members are sent with the Residents, the staff members would not be allowed to go into the treatment areas due to confidentiality and privacy of other clients at the dialysis center. The dialysis center will call Owen Valley Health Campus immediately upon learning of an incontinent episode and staff members from Owen Valley Health Campus will immediately go to the dialysis center to provide care. Dialysis center staff members will bring the Resident</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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	Quality review completed on February 20, 2013, by Jodi Meyer, RN		out to the lobby for the Owen Valley staff to provide care. You have indicated your monitoring of systemic changes, to prevent recurrence of the deficient practice, will be less than six months. What measurable criteria will your facility implement to indicate whether the monitoring can be stopped at your established time frame or to continue the monitoring. (low threshold % to continue with optimal % to indicate the monitoring can be stopped. Audits will be completed until 100% compliance has occurred for three consecutive months, and reported to the QA Committee.		

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F000314 SS=D	<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 1 of 3 residents reviewed for treatment and services to promote healing and prevention of pressure sores received assistance with incontinence hygiene and pressure reduction as indicated by the resident's care plan and facility's Pressure Prevention Guidelines. (Resident #C)</p> <p>Findings include:</p> <p>Observation of Resident #C on February 18, 2013 at approximately 10:30 a.m., during initial tour indicated Resident #C was in bed, on a low air loss mattress, positioned on her right side. A pillow was behind Resident #C's back. Continued observation indicated at approximately 10:45 a.m., staff</p>	F000314	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:1. On February 19, 2013 a phone conference was conducted between Linda St. John RN DHS, Owen Valley Health Campus and Kathy Robbins RN Clinical Manager, Fresenius Medical Care, to develop a plan of care for a resident found to have been affected by the alleged deficient practice.2. A communication form will be sent with the resident to each dialysis treatment. (Attachment A)3. Due to Fresenius policy that states "Anyone who is a non-staff member of Fresenius is not permitted in the treatment area", staff from Fresenius will call staff at Owen Valley Health Campus if incontinent care is needed for the resident. Owen Valley Staff members will respond to assist in hygiene care for the resident. Staff from Fresenius will contact staff</p>	03/20/2013	

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	<p>repositioned Resident #C to the left side. A pillow was again positioned behind Resident #C.</p> <p>Resident #C's clinical records were reviewed on February 18, 2013 at 11:30 a.m. Resident #C's diagnoses included, but were not limited to chronic kidney disease.</p> <p>Pressure Ulcer Assessment Forms indicated:</p> <p>"10/9/12 [initial identification] L [left] buttock stage II [partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/ruptured blister]. Length 2.5 - Width 2.1 - Depth < [less than] 0.1 [wound measurement in centimeters]. ... 2/15/13 healed."</p> <p>"7/12/12 [initial identification] R [right] heel stage I [persistent area of skin redness that does not disappear after pressure is relieved. (May appear red, blue or purple)]. Length 1.0 - Width 1.5 - Depth 0 [wound measurement in centimeters]. ... 2/12/13 [most current wound assessment] Length 2.0 - Width 2.0 - Depth 2.0."</p>		<p>at Owen Valley Health Campus if the resident is voicing desire to be repositioned or any complaints and/or non-verbal signs of pain/discomfort. Staff members at Owen Valley Health Campus will immediately respond to Fresenius to provide needed care.4. Two staff members will go to Fresenius Medical Care at the same time the resident would need to be repositioned (per policy and care plan) if she were in her home facility, and will reposition the resident and also assess for incontinence at Fresenius Medical Care during every dialysis treatment. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:1. All non-ambulatory dialysis residents that would be admitted to the facility have the potential to be affected by the same alleged deficient practice. Currently there are no other residents in the facility with similar medical conditions.2. Owen Valley Health Campus DHS will in-service all nursing department management team members on the plan of action listed under corrective actions and this will be applied to all future admits with similar medical condition.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:1.</p>				

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	<p>"7/12/12 [initial identification] L [left] heel state I [persistent area of skin redness that does not disappear after pressure is relieved. (May appear red, blue or purple)]. Length 3.0 - Width 3.1 - Depth 0 [wound measurement in centimeters]. ... 2/12/13 [most current wound assessment] Length 2.0 - Width 1.2 - Depth 0.1]."</p> <p>The most recent Minimum Data Set Assessment (evaluation of physical, mental, and psychosocial health status) dated January 13, 2013; indicated Resident #C's cognitive status was coded at 6; severe cognitive impairment (dependent on nursing staff for daily decision making). Resident #C required extensive assistance from nursing staff for bed mobility (how resident moved to and from lying position, turned side to side, and/or positioned body while in bed), transfer care (how resident moved between surfaces), and hygiene. Resident C had implementation of an indwelling catheter for maintenance of urine and was always incontinent of bowel.</p> <p>Resident #C's Care Plan dated July 18, 2012 (date initiated); with an updated date of October 16, 2012; indicated "ADL [activities of daily</p>		<p>Medical Records will notify the nursing department management team during the audit of all new admits that are to receive dialysis and are to receive extensive assist from nursing staff for mobility, transfer care, and hygiene. The plan of action will immediately be put in place for the new admit.2. Plan of action will be put in place immediately if current resident develops a similar medical condition.3. DHS/Designee will complete staff in-servicing related to care being provided to the resident during dialysis related to positioning by March 20, 2013.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:1. Medical Records will complete audit of all new admits for the inability to reposition themselves and/or the presence of appointments where the resident will be sitting for periods of time that would include scheduled repositioning times if the resident was in our facility. (Attachment B)Audit will be completed on all new admits for 3 months and reviewed in QA Committee monthly for 3 months.No residents suffered any ill effects from the alleged deficient practice.Completion Date: March 20, 2013</p>		

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	<p>living] self-care deficit. Needs assistance or is dependent in: Bed mobility, Transfer, ... Personal hygiene. Interventions [care staff implement due to deficit]: Assist with: personal hygiene, ... Bed mobility ... Transfers Turn and reposition, shifting weight to enhance circulation with care Goals: Will not develop any complications related to decreased mobility." A Care Plan dated October 30, 2012 (date initiated); indicated "Skin Condition Pressure Ulcer Stage II Lt [left] upper buttock ... Interventions: ... Provide incontinence care after each incontinent episode." A Care Plan dated July 18, 2012 (date initiated); with an updated date of October 16, 2012; indicated "Alteration In Skin Integrity Pressure Ulcer back of Rt [right] heel - Pressure Ulcer Left heel. Interventions: ... pressure reducing mattress on bed. Goal: Area will heal ..."</p> <p>On February 18, 2013 at 2:40 p.m.; the Director of Nursing provided a copy of the facility's Pressure Prevention Guidelines (non-dated) which indicated, "Purpose: To maintain good skin integrity and avoid development of pressure ulcers. Procedure: Care plan interventions shall be implemented based on risk</p>			
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	<p>factors identified in the nursing assessment. Interventions may include but not be limited to:</p> <p>Hygiene: Clean skin with premoistened wipes or periwash, rinse and dry thoroughly after incontinent episode. ...</p> <p>Activity/Mobility: ... Establish an individualized turning schedule if resident is immobile or compromised. Frequency of position change is individualized. ... Place on pressure reduction support surface (bed - chair). Place on pressure relief mattress. ... Elevate heels off the bed ..."</p> <p>Resident #C's clinical records indicated a physician order for renal dialysis three times per week; on Monday, Wednesday, and Friday.</p> <p>The Director of Nursing was interviewed on February 18, 2013 at 1:35 p.m. The Director of Nursing indicated Resident #C left for dialysis at approximately 1:00 p.m. and returned at approximately 5:00 to 5:30 p.m. Resident #C remained at dialysis without the presence nor assistance from facility nursing staff.</p> <p>On February 18, 2013 at 1:30 p.m.; the Director of Nursing provided a copy, dated May 21, 2007, of the</p>			

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	<p>facility's Outpatient Dialysis Services Agreement. The agreement indicated, "... 5. The Dialysis Unit will conform to standards not less than those required by any applicable laws and regulations of any local, state or federal regulatory body, as the same may be amended from time to time. The Company will provide only dialysis services and will perform no other services, medical or otherwise ..."</p> <p>On February 18, 2013 at 9:35 a.m.; the Manager of Outpatient Dialysis Center, attended by Resident #C, was interviewed. During the interview, the Manager indicated their facility was an ambulatory dialysis center. Residents are positioned in a chair, that can be reclined, during their treatment. The Manager further indicated Resident #C has had episodes of bowel incontinence. Resident #C has also verbalized, " 'My butt hurts' " and requested to be turned and/or repositioned off her buttocks, often. The staff at the dialysis center are not contracted to provide turning services nor incontinence care.</p> <p>Resident #C's Pressure Ulcer Assessment Forms related to the right and left heel; with the initial date</p>			

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	<p>of July 12, 2012 indicated; "2/5/13 Comments: eval [evaluate] chair @ dialysis for leg placement, float heels." Documentation dated February 18, 2013 (late entry for February 07, 2013) in Resident #C's Nursing notes/comments indicated, "Per report from charge nurse, dialysis was contacted after consulting with therapy and nurse and request made to place pillow under residents legs during dialysis. Dialysis requested we send pillow ..."</p> <p>Continued interview on February 18, 2013; with the Director of Nursing indicated being aware of two times Resident #C had been incontinent of bowel while at dialysis. When the center called, nursing facility staff had driven to the dialysis center and provided incontinence care. When asked about nursing staff having provided turning and repositioning care while at the dialysis center, as indicated by Resident #C's Care Plan and the facility's Pressure Prevention Guidelines; the Director of Nursing indicated they did not.</p> <p>This Federal tag relates to complaint IN00124010.</p> <p>3.1-40(a)(2)</p>				

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