

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/22/2016
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NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF SHELBYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2309 S MILLER ST SHELBYVILLE, IN 46176
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190309 and IN00190948.</p> <p>This visit resulted in a Partially Extended Survey-Substandard Quality of Care-Immediate Jeopardy.</p> <p>Complaint number IN00190309-Substantiated. Federal/state deficiencies related to the allegations are cited at F-514</p> <p>Complaint number IN00190948-Substantiated. Federal/state deficiencies related to the allegations are cited at F-311, 312 and 314.</p> <p>Survey dates: January 17, 19, and 20, 2016</p> <p>Partially Extended Survey date: January 21 &amp; 22, 2016</p> <p>Facility number: 000009 Provider number: 155022 Aim number: 100274760</p> <p>Census bed type: SNF/NF: 66 Total: 66</p>	F 0000	Preparation and/or execution of this Plan of Correction does not constitute 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 Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Laws.	

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 0311 SS=D Bldg. 00	<p>Census payor type: Medicare: 4 Medicaid: 51 Other: 11 Total: 66</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on January 29, 2016</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview, and record review, the facility failed to apply a splint daily according to a Restorative Program for 1 of 3 residents reviewed for receiving Restorative Services. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on 1/19/16 at 9:42 a.m. Current physician's</p>	F 0311	<p><b>F311</b></p> <p>It is the practice of the facility to ensure residents receive appropriate treatment and services to maintain or improve their abilities. Resident #F was re-evaluated and is no longer restorative appropriate but is hospice appropriate. Resident #F will use palm guards to bilateral hands per MD orders.</p> <p>All residents who require restorative nursing could be affected.</p> <p>Restorative logs will be put in</p>	02/12/2016

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	<p>orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to, severe advanced Alzheimer's dementia, peripheral vascular disease, seizure disorder, rheumatoid arthritis, insulin dependent diabetes type 2, high blood pressure, history of stroke with right side deficit, incapacitated with pain, osteoporosis, anxiety, depression, chronic kidney disease, irregular heartbeat/palpitations, difficulty swallowing, and dehydration.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 11/28/15, indicated Resident #F was severely impaired in cognitive skills for daily decision making, rarely/never made decisions, required was totally dependent on two of staff for bed mobility, did not walk, required assist of one staff for eating and bathing, was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had two stage two pressure ulcers and one unstageable pressure with eschar (slough or dead tissue).</p> <p>"Restorative Program" documentation, dated 12/17/15, indicated Resident #F was enrolled in a passive ROM and splinting program, and "...Program #1: PROM (passive range of motion) warm wash cloth to left hand. Apply left splint</p>		<p>place for all residents who require restorative nursing. All nursing staff will be educated on restorative nursing. Audit all restorative logs weekly x3 months then every other week x3 months. (Attachment #7) Results will be reviewed by Quality Assurance committee and recommendations will be followed.</p>	

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	<p>before breakfast. Pt. wears splint til lunch unless pt. uncomfortable. Remove splint before lunch meal &amp; do PROM. Goal: Patient will tolerate left splint from ADLS to lunch time with PROM daily for contracture mgt (management). Program #2: Right splint P/ROM/AROM (active range of motion), hand hygiene [with] warm cloth. Splint on after lunch to supper meal. Remove splint for evening/supper meal. P/ROM/AROM. Goal: Pt. will tolerate right splint from after noon meal to evening meal daily with no discomfort or red pressure areas."</p> <p>A care plan, dated 1/19/16, indicated: "Focus: Restorative Nursing for splinting of hands. Goal: Splints will be applied daily as ordered through next review. Interventions: Document on restorative nursing form daily. Report any issues to charge nurse. Warm wash cloth to left hand prior to passive range of motion exercises, then perform passive ROM (range of motion) exercises, then apply left hand splint and leave on until lunch meal. To have lunch, then apply right hand splint for four hours or until supper meal as tolerated by [Resident #F]. Report to nurse any red or open areas."</p> <p>Resident #F was observed not wearing a splint on either hand on the following</p>			

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	<p>days and times: 1/17/16 at 12:50 p.m., 1/19/16 at 9:18 a.m., 1/19/16 at 11:31 a.m., 1/19/16 at 12:40 p.m., and on 1/19/16 at 2:10 p.m.</p> <p>On 1/21/16 at 1:40 p.m., CNA #2 indicated they apply the splint on the left hand in the morning before breakfast, and the left splint comes off at lunch time, the right splint goes on a lunch and stays on until supper then is removed.</p> <p>On 1/21/16 at 2:14 p.m., CNA #12 indicated therapy "walks us through" how to apply the splints and "we sign off on training."</p> <p>A policy for "Nursing Rehabilitation/Restorative Care" was provided by the Director of Nurses on 1/21/16 at 12:30 p.m. The policy indicated, but was not limited to, "...Definition: 1.) Measurable objectives and interventions must be documented in the care plan and in the clinical record. 2.) Evidence of periodic evaluation by a licensed nurse must be present in the clinical record...Use of the Restorative Log: The restorative log shall be initiated and very the amount of time (minutes) involved in performance when the procedure or activity is practiced...."</p> <p>This Federal tag relates to Complaint</p>			

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F 0312 SS=D Bldg. 00	<p>IN00190948.</p> <p>3.1-38(b)(6)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review, observation, and interview, the facility failed to ensure that 2 residents, totally dependent on staff for bathing, received necessary services to maintain good grooming related to soiled fingernails and toenails. This affected 2 of 4 residents reviewed for grooming. (Resident #E and Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on 1/19/16 at 9:42 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to, severe advanced Alzheimer's dementia, peripheral vascular disease, seizure disorder, rheumatoid arthritis, insulin dependent diabetes type 2, high blood pressure,</p>	F 0312	<p><b>F312</b></p> <p>It is the practice of the facility to ensure that if a resident is unable to carry out activities of daily living that they receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #E and #F have both had nail care. All residents who require assistance with nail care could be affected. All residents checked and with no concerns noted. Weekly and PRN nail care has been added to treatment administration record for all residents who require assistance with nail care. DON or designee will audit treatment administration records and 5 random resident's nails weekly x3 months then every other week x3 months (Attachment #6). All audit tools will</p>	02/12/2016	

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	<p>history of stroke with right side deficit, incapacitated with pain, osteoporosis, anxiety, depression, chronic kidney disease, irregular heartbeat/palpitations, difficulty swallowing, and dehydration.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 11/28/15, indicated Resident #F was severely impaired in cognitive skills for daily decision making, rarely/never made decisions, was totally dependent on two of staff for bed mobility, did not walk, and required assist of one staff for eating and hygiene.</p> <p>A care plan, dated 11/7/14, and last revised on 12/4/15, indicated Resident #F was at risk for skin breakdown related to immobility, diabetes, peripheral vascular disease, and episodes of incontinence. The goal was "Skin will remain intact through review date." Interventions included, but were not limited to, Shower twice a week, full sponge bath if unable to tolerate shower. The CNA was to inform the nurse whenever the shower was not completed.</p> <p>On 1/19/16 at 9:20 a.m., Resident #F was observed sitting up in bed, with the head of her bed up 30 degrees. CNA #2 indicated she was going to lower the head of her bed and turn Resident #F onto her</p>		<p>be reviewed by Quality Assurance committee and any recommendations will be followed.</p> <p>All nursing staff will be educated on nail care.</p>	

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	<p>side. CNA #2 indicated Resident #F has been sitting up since she ate breakfast, about an hour and a half. CNA #4 entered the room to assist CNA #2 to turn the resident. Both hands were clenched and CNA #4 opened the hands; the fingernails were long, jagged and discolored.</p> <p>2. Resident #E's record was reviewed on 1/19/15 at 11:20 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to, insomnia, aggressive behaviors and agitation, high blood pressure, chronic obstructive pulmonary disorder, Alzheimer's dementia, history of decubitus ulcers, osteoarthritis, anxiety, bipolar disorder, delusions and behavioral disturbance, and psychosis.</p> <p>A significant change MDS, dated 12/4/15, indicated Resident #E was severely cognitively impaired, and was totally dependent of one person for hygiene and bathing.</p> <p>On 1/19/16, at 8:18 p.m., a family member indicated his fingernails are soiled, then a few minutes later asked how his fingernails could be dirty if he doesn't feed himself and get anything under the nails.</p>			

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F 0314	<p>During an observation, on 1/20/16 at 11:05 a.m., Resident #E was in bed and his fingernails were jagged and soiled with a yellow/brown substance. Both palms had a foul odor. A family member was in the room at this time.</p> <p>A Policy and Procedure for "Nail Care" was provided by the Director of Nurses on 1/22/16 at 4:07 p.m. The Policy indicated, but was not limited to, "Purpose: Cleanliness and good grooming contribute to the dignity and self-esteem of every Resident. Policy: Nails should be kept short, clean, and free of rough edges. Nails should be groomed weekly, and as indicated...Procedure...3. Check fingers and nails for color, swelling, cuts, or splits. Check hands for extreme heat or cold. Report any unusual findings to nurse before continuing procedure...8. Gently remove dirt from around and under each fingernail with orange stick. 9. Clip nails straight across then file in a curve...."</p> <p>This Federal tag relates to Complaint IN00190948.</p> <p>3.1-38(a)(3)(E)</p>			
	483.25(c)			

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SS=J Bldg. 00	<p><b>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></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, record review and interview, the facility failed to ensure residents at risk for pressure ulcer development received interventions to prevent pressure ulcers. This resulted in Resident #F developing a stage 2 pressure ulcer that progressed to a stage 4, was referred to the wound clinic on 11/30/15 when the wound failed to heal, then required hospitalization on 1/20/16 for further treatment of the wound; Resident #J was found with a stage 3 wound under a brace; and Resident # E acquired 2 stage 2 pressure ulcers on his right ear from unpadded oxygen tubing.</p> <p>The immediate jeopardy began on 8/24/16 when Resident #F acquired a pressure ulcer while a resident of the facility. The Administrator and Director of Nursing were notified of the immediate jeopardy, related to pressure</p>	F 0314	<p><b>F314</b> It is the practices of this facility to ensure if aresident enters the facility without pressure sores do not develop pressuresores unless the individual's clinical condition demonstrates that they wereunavoidable. Reviewed facilities Policyand Procedure Resident #F returned from hospitalization on1/22/16. She had a blood transfusion of PRBCs, IV antibiotics and IV fluidswhile hospitalized. Resident's hemoglobin remains low at 9.2. Resident #F wasplaced on hospice on 2/3/16 with a diagnosis of Alzheimer's dementia. Thesacral pressure ulcer is Stage IV with treatment of "cleanse with normal salineapply polysporin ointment. Apply nickel thick amount of santyl, sprinkle flagylpowder into wound bed, pack loosely with slight moist kerlix and cover with ABDpad and secure with tape every day and as needed for soilage." The goal is tokeep pain at a tolerable level</p>	02/12/2016

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	<p>ulcers, on 1/21/16 at 4:20 p.m. The immediate jeopardy was removed on 1/22/16 at 5:55 p.m., but noncompliance remained at the lower scope and severity level of isolated no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on policies, reporting and documenting changes in skin condition.</p> <p>Findings include:</p> <p>1. Resident #F's record was reviewed on 1/19/16 at 9:42 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to, severe advanced Alzheimer's dementia, peripheral vascular disease, seizure disorder, rheumatoid arthritis, insulin dependent diabetes type 2, high blood pressure, history of stroke with right side deficit, incapacitated with pain, osteoporosis, anxiety, depression, chronic kidney disease, irregular heartbeat/palpitations, difficulty swallowing, and dehydration.</p> <p>Current physician's orders, dated 1/1/16 through 1/31/16, indicated diet orders for a pureed diet with no concentrated sweets and no added salt (started 1/18/15), 4 ounces applesauce three times a day with meals per her husbands request, and skim</p>		<p>and provide comfort measures. Resident #F is on a new alternating pressure relieving mattress. Resident #J has an order for an ankle foot orthotic to the left lower extremity. Resident #J's orthotic was readjusted by therapy on 1-18-2016. Resident #J's left ankle has a Stage III pressure ulcer. It is showing improvement with current treatment of "cleanse left lateral malleolus with normal saline. Apply pink polymem after applying skin prep to periwound and secure with tape every other day and as needed." Resident #J's orthotic is on a wearing schedule per MD orders. Resident #E Stage II wounds on right ear are healed. Preventative measures are in place with foam on oxygen tubing. All residents have the potential to be affected by this practice, no other residents were identified. Every resident's skin will be assessed within 4 hours of admission and twice weekly x3 months then weekly on an ongoing basis by a licensed nurse. Any new pressure areas will be documented and reported to MD and family will be notified per policy and procedure (See Attachment Skin Condition and Pressure Ulcer Assessment Policy and Procedure) (Attachment #1). Licensed nurses will check all dressings for placement and soilage. Any concerns will be addressed immediately. All pressure ulcers</p>	

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	<p>milk at meals. Supplements indicated: prostat 30 milliliters twice a day, a therapeutic vitamin with minerals once a day, and calcium carbonate 600 milligrams with 200 international units of vitamin D.</p> <p>Current physician's orders included the following treatments: Jobst stockings (compression stockings) to both legs; on in the morning and off in the evening, heel protectors to both heels at all times, float heels while in bed/recliner, lift to be utilized for surface to surface transfers, anchor Foley catheter to aid in wound healing, low air loss mattress (11/30/15), skin prep to left sesamoid (below left great toe) area and left heel 2 X a day (12/7/15)</p> <p>Braden scale assessments for predicting pressure ulcer risk, one dated 7/2/15 and one dated 9/2/15, indicated a total score of 12, which indicated a high risk for pressure ulcers.</p> <p>A quarterly Minimum Data Set Assessment (MDS) assessment, dated 9/3/15, indicated Resident #F was severely impaired in cognitive skills for daily decision making, rarely/never made decisions, was totally dependent on two of staff for bed mobility, did not ambulate, required assist of one staff for</p>		<p>will be assessed by a skin/woundnurse 2x weekly for 3 months then weekly on an ongoing basis. Any worsening areas will be documented and reported to MD and family will be notified within 24 hours. A treatment order will be obtained and appropriate interventions will be implemented and plan of care updated. All pressure areas will be reviewed by NP, wound nurse and DON weekly in the Weekly Wound Meeting (Attachment #2) and recommendations will be followed. CNA will complete shower sheets upon giving bath/showers. CNA will report any reddened or open areas to the nurse upon finding. Charge nurse will review and will take appropriate action. Shower sheets will be turned into wound nurse upon completion. Wound nurse will audit weekly x3 months then every other week x3 months. (Attachment #3) Licensed nurse will assess the skin of residents with braces, splints, and other equipment daily upon care. This will be documented on treatment administration record. DON or designee will audit treatment administration records weekly for accurate documentation. DON or designee will audit residents with equipment for type, areas noted, and action taken weekly for 3 months and then monthly thereafter. (Attachment #4).</p>	

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	<p>eating and bathing, was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had one stage two pressure ulcer that was not present upon admission.</p> <p>A significant change MDS assessment, dated 11/28/15, indicated Resident #F was severely impaired in cognitive skills for daily decision making, rarely/never made decisions, was totally dependent on two of staff for bed mobility, did not walk, required assist of one staff for eating and bathing, was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had two stage two pressure ulcers and one unstageable pressure ulcer with eschar (slough or dead tissue).</p> <p>A "Skin Condition Report" was initiated on 8/24/15, with a stage 2 (top layer of skin was gone) pressure ulcer on the sacral area that measured 1 centimeter by 1.5 centimeters, had no depth, was red in color with no drainage or odor present. This area was measured weekly, and on 10/12/15 the area was 2 centimeters by 2 centimeters and 0.1 centimeters in depth, was assessed as unstageable, was yellow in color, and had serous drainage and no odor.</p> <p>A "Physician Orders/patient Instructions"</p>		<p>Residents with pressure areas will be audited for appropriate treatment, physician and family notification and care plan updated weekly x3 months by DON or designee. (Attachment #5) All nursing staff will be educated on Skin Condition and Pressure Ulcer Assessment Policy and Procedure. All audit tools will be reviewed by Quality Assurance committee and any recommendations will be followed. <b>Requesting an IDR</b> The facility is requesting a Face to Face IDR of tag 314 with a scope severity of J. Through the IDR process the facility is seeking to have this tag deleted or in its alternative reduced. The facility will provide documentation to show evidence that the development of pressure ulcers were unavoidable for Resident #F.</p>	

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	<p>from a wound center, dated 11/30/15, indicated the diagnosis was an unstageable sacral ulcer, non healing, and the wound measurements were 8.6 cm (centimeters) by 3.7 cm by 1.6 cm depth, and indicated: "...low air loss bed, up in chair for meals only, turn side to side [every] 2 hours."</p> <p>A "Physician Orders/patient Instructions" from a wound center, dated 12/14/15, indicated: "...Keep weight off of wound."</p> <p>A "Physician Orders/patient Instructions" from a wound center, dated 12/21/15, indicated "...Not to be in chair [no] longer than 1 hour."</p> <p>On 1/22/16 at 3:44 p.m., the Director of Nurses indicated "When the wound center sends recommendations they would be entered as an order and put on the care plans."</p> <p>A care plan, initiated 8/24/15, indicated a focus of "[Resident #F] has pressure ulcer to coccyx development r/t (related to) immobility. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through next review date (12/11/15). Interventions: 30 ml (milliliters) prostat (high protein supplement) BID (twice a</p>			

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	<p>day) w/meds (with medications). Date initiated: 12/11/15. 4 oz (ounces) healthshake TID (three times a day) w/meds. Date initiated: 1/18/16. 4 oz pureed cottage cheese @ L&amp;S (lunch and supper). Date initiated: 12/11/15. Administer treatments as ordered and monitor for effectiveness. Date initiated: 8/24/15. Anchored Foley catheter Date initiated: 11/25/15. Assess/record/monitor wound healing Measure length, width and depth where possible. Assess and document status of wound perimeter, wound be and healing progress. Report improvements and declines to the MD. Date initiated: 8/24/15. Avoid positioning the resident on her back. Date initiated: 8/24/15. Educate the caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date initiated: 8/24/15. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date initiated: 8/24/15. Inform the resident/family/caregivers of any new area of skin breakdown. Date initiated: 8/24/15. Low air loss mattress to bed and pressure reducing cushion to WC. Date initiated: 8/24/15. Monitor dressing to ensure it is intact and adhering. Report</p>			

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	<p>loose dressing to nurse. Date initiated: 8/24/15. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date initiated: 8/24/15. Monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage. Date initiated: 8/24/15. Staff to lay [Resident #F] down after meals. Date initiated: 10/21/15. Supercereal @ B (breakfast). Date initiated: 1/18/16. The resident needs 2 person assistance to turn/reposition at least every 2 hours, more often as needed or requested. Date initiated: 8/24/15. The resident requires supplemental protein, vitamins, as ordered to promote wound healing. Date initiated: 11/25/15. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. Date initiated: 8/24/15. Wound clinic weekly. Date initiated: 11/25/15."</p> <p>On 1/19/16 at 9:20 a.m., Resident #F was observed sitting up in bed, with the head of her bed up 30 degrees. CNA #2 indicated she was going to lower the head of her bed and turn Resident #F onto her side. CNA #2 indicated Resident #F has been sitting up since she ate breakfast, about an hour and a half. CNA #4</p>			

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	<p>entered the room to assist CNA #2 to turn the resident. Resident #F had heel guards on both heels and her heels were not floated off the bed. Both hands were clenched and CNA #4 opened the hands; the fingernails were long, jagged and discolored. The incontinence pad under Resident #F was saturated, about 1/4 of the pad directly under the resident's buttocks, and CNA #4 indicated it was from the wound seeping. The wet incontinence pad was removed and a clean one placed under the resident. The dressing and adhesive covering over the wound on the sacrum was also wet. The CNAs turned the resident on her right side, placed a folded sheet between her knees, and raised the head of the bed up about 10 -15 degrees. The resident's heels were not floated off the bed and she was not wearing her compression stockings.</p> <p>During an observation, on 1/19/16 at 11:31 a.m., Resident #F remained on her right side, and LPN #3 indicated she was waiting for LPN #1 to do the wound treatment. Resident #F had not had the dressing changed after it was observed to be saturated.</p> <p>On 1/19/16 at 12:40 p.m., CNA #2 was observed feeding Resident #F while the resident was sitting up in bed with the</p>			

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	<p>head of the bed raised 30 - 35 degrees.</p> <p>During an anonymous interview, Resident #F was reported to have been observed sitting up in her wheelchair from 4:30 p.m. to 9:00 p.m. one night, and from 4:30 p.m. to 7:30 p.m. one night.</p> <p>During an interview, on 1/22/16 at 9:30 a.m., Resident #M indicated she has observed Resident #F sitting up for 3 to 4 hours at at time in her wheelchair.</p> <p>On 1/19/16 at 1:53 p.m., the dressing on the sacral area was changed by LPN #1 with assistance from LPN #3. The resident was laying on her left side, the saturated dressing was removed, and the packing inside the wound was removed. The wound was observed to be a stage 4 pressure ulcer, black inside an area that was approximately 3 inches by 3 inches round inside the wound and deep into the sacrum. The wound had yellow drainage with an odor that permeated the room. The inside of the wound was cleansed with normal saline and santyl ointment was applied to gauze that was then placed on the inside of the wound, packed with gauze, and covered with an adhesive coverall. LPN #1 used skin prep on the areas on the resident's left foot; the inner heel of the left foot had a stage 2 pressure</p>			

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	<p>ulcer, and the base of the left toe had an unstageable pressure that was approximately 1 centimeter by 2 centimeters. A folded sheet was placed between her knees, she was wearing the heel protectors, and her heels were not floated off the bed. When queried, LPN #1 indicated Resident #F's heels are supposed to be floated, left the room and brought a pillow in, then placed it under the lower legs to raise her heels up off the bed.</p> <p>During an interview, on 1/20/16 at 1:46 p.m., LPN #1 indicated if a dressing is saturated with drainage from a wound, the CNA should tell the nurse and she should go down and assess the dressing. LPN #1 indicated Resident #F's pressure area started in August 2015 as a stage 2 area, then progressed rapidly. The nurses had her check it, and the nurse practitioner was here on 10/19/15 and looked at it. 10/26/15 was the first date it was documented as unstageable. 11/30/15 was the first time Resident #F went to the wound care clinic; it was staged as unstageable and debrided there. Resident #F went to the wound clinic today (1/20/16) and they didn't do a culture, but the physician there said it was a possibility. LPN #1 also indicated Resident #F had been given zinc 220 milligrams and Vitamin C 500</p>			

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	<p>milligrams for 30 days.</p> <p>During an interview, on 1/21/16 at 1:40 p.m., CNA #2 indicated Resident #F should sit up no longer than an hour and a half, then would be laid down as soon as possible.</p> <p>During an interview, on 1/21/16 at 2:14 p.m., CNA #12 indicated Resident #F gets up for one meal now, she gets up for lunch, then lays down an hour to an hour and half when she finishes eating; "we lay her down."</p> <p>A "Physician Orders/patient Instructions" from a wound clinic, dated 1/20/16, indicated: "...Go to ER."</p> <p>Emergency Room notes for the hospital Resident #F was sent to, dated 1/20/16, indicated "Patient presents from [name of physician] office, [name of town], because of the report of this patient having increased findings of her sacral decubitus, he has been debriding this and has noticed a sudden change. Concern for sepsis as the patient also said change in mental status with this. Upon arrival patient is nonverbal she will not open her eyes to verbal command. She will however [call] out in pain when she is rolled on her side. Patient is febrile on arrival...Have spoken with [wound clinic</p>			

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	<p>physician]. Wound is not improving at all with debridement. It appears to me that the wound has enteral contents, possible rectal fistula...will not improve even with aggressive care to include diverting colostomy. In my opinion, patient best treated with comfort care/hospice...On re-exam patient's condition has not changed. She will not open her eyes to verbal stimuli...A culture of the wound is collected and sent to the lab. Patient's urinalysis is positive for infection, and this is another possible source...will admit the patient...sepsis due to unspecified organism...Disposition...Acute care...Condition: Serious."</p> <p>2. Resident #J's record was reviewed on 1/21/16 at 11:35 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated Resident #J was admitted with diagnoses that included, but were not limited to, memory loss, high blood pressure, stroke, dementia, and coronary artery disease. The physician's orders also indicated: Knee high TED (compression stockings) on in the morning and off in the evening and Geri-Hydrola Lotion 12%, apply topically to bilateral lower extremities at bedtime.</p> <p>Physician's orders dated 12/1/15 through</p>			

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	<p>12/31/15 and 1/1/16 through 1/31/16 failed to indicate an order for the brace on the left ankle/foot.</p> <p>During an interview, on 1/21/16 at 1:22 p.m., Physical Therapy Assistant #7 indicated CNAs were trained on how to put the brace on initially and how to fasten the strap. The CNAs were trained on tightening it more while he was walking due to his ankle would "roll out to the side." She said the strap that is on there is designed to pull his ankle into a more neutral position and as he progressed with his walking the tightening wasn't needed.</p> <p>On 1/20/16 at 12:56 p.m., with LPN #1 and LPN #5, Resident #J's left lateral ankle was observed and had an area about 1.5 cm by 1.5 cm with depth. A line of dried blood about 3/4 of an inch long had seeped from the wound and dried on the skin below the wound. The wound was cleansed with normal saline and a xeroform treatment covered with a foam dressing was applied. Dried blood was observed inside the padded area of the brace where his outer left ankle would touch.</p> <p>LPN #1 indicated at that time, Resident #J has been referred to physical therapy for evaluation of the brace on his shoe to</p>			

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	<p>see if it is causing the pressure area.</p> <p>Resident #J indicated, on 1/20/16 at 1:08 p.m. that his foot falls to the left if he doesn't wear the brace, and about 5 weeks ago when the CNAs took off his TED (compression stockings) hose at night, there was blood on them and after it happened a few times the CNAs let LPN #1 know. He indicated his brace was repaired yesterday.</p> <p>A "Weekly Wound Assessment" dated 1/18/16, indicated the onset of the wound was 1/18/16, the wound was acquired in facility, and was a stage 3 pressure ulcer when found.</p> <p>A "Skin observation tool" dated 1/11/16, indicated "Skin warm, dry and intact. No skin alterations to report at this time."</p> <p>"CNA Skin Check Forms", completed during showers or baths, dated 1/12/16 and 1/15/16, did not have any skin issues identified during the resident's shower/bath.</p> <p>A quarterly Minimum Data Set assessment (MDS), dated 11/20/15, indicated Resident #J was cognitively intact, required extensive assistance of one for bed mobility and transfers, required limited assistance for walking in</p>			

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	<p>his room and the hallway, had impairment on one side for functional limitation in range of motion, used a cane and a wheelchair, and was at risk for developing pressure ulcers.</p> <p>A care plan, dated 6/10/15 and last revised on 12/4/15 indicated a focus of: "[Resident #J] requires AFO (Ankle/Foot Arthrosis) brace left side for stabilization at all times. Goal: [Resident #J] will have AFO brace on left leg at all times except for bathing. Interventions: Ensure left leg brace is on. Drags foot without brace on. Report to nurse any discolored/open areas possibly caused by brace. Refer to therapy as needed for any changes in abilities or problems with brace. Remove brace for bathing and reapply. If you do not know how to apply brace, see nurse. Report to nurse if [Resident #J] refuses to wear left leg brace."</p> <p>During an interview, on 1/20/16 at 1:46 p.m., LPN #1 indicated she does skin assessments weekly and found the area; she spoke with physical therapy and they came out yesterday and adjusted a strap that was loose. She had not been informed of any skin problems; was told on Monday that it was a stage 3. It is on his affected side, he had a stroke and has had issues with that foot. She also</p>			

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	<p>indicated he hasn't had any skin issues for awhile; he was walking to and from the dining room and stretched the leather out. She said a stage 3 could have developed quickly especially because he wears a brace. He gets a lotion applied every night to his feet, and needs assistance to go to bed, and the CNAs take his compression stockings off.</p> <p>During an interview, on 1/21/16 at 4:40 p.m., CNA # 6 indicated she has observed blood a couple of times on Resident #J's TED hose, and she washed them out then reported it to the nurse. She indicated the area of blood was slightly larger than a quarter.</p> <p>During an interview, on 1/21/16, at 4:50 p.m., CNA #13 indicated she has observed blood.</p> <p>During an interview, on 1/22/16 at 9:43 a.m., Resident #J indicated 6 or 7 weeks ago, it would bleed when the CNAs took the TED hose off at night. He would see blood on the TED hose and it "had rubbed and bled at least 6 weeks."</p> <p>During an interview, on 1/22/16 at 10:08 a.m., the Director of Nurses indicated the brace was not on the current physician's orders.</p>			

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	<p>3. Resident #E's record was reviewed on 1/19/15 at 11:20 a.m. Current physician's orders, dated 1/1/16 through 1/31/16, indicated diagnoses that included, but were not limited to, insomnia, aggressive behaviors and agitation, high blood pressure, chronic obstructive pulmonary disorder, Alzheimer's dementia, history of decubitus ulcers, osteoarthritis, anxiety, bipolar disorder, delusions and behavioral disturbance, and psychosis.</p> <p>A significant change MDS, dated 12/4/15, indicated Resident #E was severely cognitively impaired, was at risk for pressure ulcer development, used oxygen therapy and did not require suctioning.</p> <p>A care plan, initiated on 3/4/15, indicated a focus of: "Risk for skin breakdown secondary to Pruritis, hx (history of) skin cancer, weight loss, and decrease mobility. Goal: Skin will remain free of breakdown thru next review.</p> <p>Interventions: Assist with ADL care to extent needed. Call light in reach. Diet per order. Meds as ordered. Monitor condition of skin during routine daily care. Report any discolored, open or sore areas to nurse. Notify Hospice of skin breakdown or concerns. Pressure relieving mattress on bed. Refer to dietitian PRN (as needed). Supplements</p>			

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	<p>as ordered. Therapy if ordered. Up in [specialty wheelchair] daily for meals as tolerated. Weekly skin assessment by a nurse."</p> <p>A "Skin Observation Tool" dated 1/18/16, indicated "beside right ear, scab lesion area, length 1 [centimeter] width 0.5 [centimeter] and 0.1 [centimeter] depth". The note on the "Skin Observation Tool" indicated: "Area beside right ear with dry scab. No redness or s/s infection. No exudate. Spoke with [Resident's family member] on 1-13-16 about area and condition."</p> <p>Current physician's orders included an order for "Oxygen @ 2 LPM (liters per minute) per N/C (nasal cannula) continuously for SOA (shortness of air) - check sats (oxygen saturation) every shift."</p> <p>During an observation, on 1/20/16 at 11:26 a.m., Resident #E was in bed, the head of his bed was up 35 degrees, his eyes were closed, his oxygen tubing was in place and across the tops of both ears. Over the right ear, where the oxygen tubing touched the skin, two small stage two open areas were observed; the open area closer to the top of his head had no drainage, and the open area closer to his ear was moist. The tubing laid on the</p>			

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	<p>moist open area and the tubing was not padded. A family member was present when these two open areas were observed.</p> <p>During an interview, on 1/20/16 at 1:46 p.m., LPN #1 indicated the areas on his ear were discovered today, he wears oxygen every day and has had the tubing covered with foam in the past; the nurses and CNA's usually monitor it.</p> <p>During an interview, on 1/21/16 at 12:58 p.m., Hospice CNA #14 indicated she has not observed the oxygen tubing padded where it touches his ears.</p> <p>A "Skin Condition and Pressure Ulcer Assessment Policy" was provided by the Director of Nurses on 1/21/16 at 9:35 a.m. The policy indicated, but was not limited to, "Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown and pressure or other ulcers and assuring interventions are implemented. Policy: It is the policy of this facility that pressure, other ulcers and skin problems will be assessed and measured at least every seven (7) days by a licensed nurse and recorded on the facility skin report form. Any significant changes between seven (7) day assessments will be recorded in the</p>			

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	<p>nursing progress notes and skin report record...5. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detail assessment. 6. If a resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock and groin areas. 7. Caregivers are responsible for promptly notifying the charge nurse of skin observations that include. g. any type of lesion...wound drainage..."</p> <p>The immediate jeopardy that began on 8/24/15 was removed on 1/22/16 at 5:55 p.m., when the facility educated staff on policies, reporting and documenting changes in skin condition, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been inserviced on policies, reporting and documenting changes in skin condition.</p> <p>This Federal tag relates to Complaint IN00190948.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F 0514 SS=D Bldg. 00	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 document in the Restorative log when a resident completed or refused Restorative services for 1 of 2 residents reviewed for Restorative services, (Resident #B).</p> <p>Findings include:</p> <p>Review of Resident B's record on 1/17/16 at 1:45 p.m., and indicated her diagnoses included but were not limited to, chronic venous embolism and thrombosis of deep veins of upper extremity, dementia, depression, anxiety, hypokalemia, insomnia, hypertension and tachycardia.</p>	F 0514	<p><b>F514</b></p> <p>It is the practice of this facility to maintain clinical records on each resident in an accepted professional standard and practice that are complete; accurately documented; readily accessible; and systematically organized. Resident #B is now receiving therapy. At the end of therapy Resident #B will be assessed and if appropriate will be placed on restorative nursing and will have a restorative log. All residents who require restorative nursing could be affected. Restorative logs will be put in place for all residents who require restorative nursing. All nursing</p>	02/12/2016

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	<p>Physical Therapy(PT)notes dated 12/15/15 at 3:28 p.m., indicated start of care 10/02/15 and end of care 12/15/15. "Short Term Goals...Patient will require 5 minutes of standing to decrease risk for falls, Status-Goal Not Met; Bed Mobility-Supine; Sit-The Patient will safely transition from supine to sitting position increasing to stand by assist, Status-Goal Met; Gait: distance-Patient will be able to ambulate safely 150 feet with contact guard assist utilizing a front wheeled walker, Status-Goal Not Met; Standing Balance: Grade: Standing balance will be... able to maintain balance without loss or upper extremity support, Status: Not Met; Strength: Lower Extremities: Overall: Patients bilateral lower extremities will improve to 4/5 good: full range of motion against gravity and moderate assistance to improve transfer and ambulation, Status: Goal Not Met; Long Term Goals: Bed Mobility-Transfers-Ambulation: Status: Goal Not Met.</p> <p>Discharge Plans and Instructions: Patient has reached maximum rehabilitation potential and is now being discharged from skilled services. Patient will remain in this skilled nursing facility with Restorative Nursing."</p> <p>Review of a document titled "Restorative Program...Program #1: At sink or in</p>		<p>staff will be educated on restorative nursing. Audit all restorative logs weekly x3 months then every other week x3 months. (Attachment #7) Results will be reviewed by Quality Assurance committee and any recommendations will be followed.</p>	

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	<p>shower Patient is able to wash her face, arms, chest and as much of lower body as she can. Praise for participating. Assistance as needed. Toileting: Patient to manage clothing, transfer with grab bar and can perform her own peri care. Transfers are contract guard assist to stand by assist. Goal: Patient will self perform with verbal cues and setup bath and toileting/peri care on daily basis at stand by assist-minimal assist level. Greater assistance with lower body... Program #2: Patient to ambulate to meals 2-3 times per day with the rollator, Patient required contract guard assist to stand and moderate to maximum encouragement. Patient will do it when encouraged. Use gait belt and wheelchair to follow. May walk anytime throughout day to meals, in hallway, to bathroom. Goal: To maintain Patient's ability to ambulate and prevent functional decline."</p> <p>1/21/16 at 11:40 a.m., review of Restorative Nursing Tracking Log for Resident #B was in CNA Activities of Daily Living log book. Restorative Nursing Tracking Log for Resident for December and January was not completed by CNA's.</p> <p>Review of CNA assignment sheet for Resident #B on 1/21/16 at 1:25 p.m., indicated Restorative Program was listed</p>			

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	<p>on the CNA assignment sheet but was not marked for Resident #B.</p> <p>1/22/16 at 2:05 p.m. review of Treatment Administration Record for December and January indicated no documentation for Resident #B's Restorative Program.</p> <p>Interview on 1/21/16 at 1:40 p.m., with Physical Therapy Assistant #7 indicated the Therapy Department writes the Restorative Program when the resident is ready to be discharged from Therapy. The Therapy Department trains the nursing staff and CNA's are trained and sign off on a sheet that they were trained. A copy of the training sheet is given to the Minimum Data Set (MDS) Coordinator, who follows up on it from a nursing perspective.</p> <p>1/21/16 at 1:55 p.m., an interview with CNA #8 indicated CNA's have a paper in the Activities of Daily Living book that indicates what Restorative Services the resident needs and said: "No, we don't document on Restorative, we let the nurse know if it was done or not and why."</p> <p>Interview on 1/21/16 at 2:40 p.m., with LPN #11 indicated "Restorative Services are usually on the CNA assignment sheet and Therapy does training with the</p>			

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	<p>CNA's. The nurse monitors her hall, sometimes Restorative is signed off in the Treatment Administration Record for ambulation on certain ones and splints are on it to sign off on as well."</p> <p>1/22/16 at 1:40 p.m., an interview with the MDS Coordinator#10 indicated "we are just getting Restorative started and I'm responsible for the coordination of the program. Restorative forms are in the Activites of Daily Living book for the CNA's to refer to. CNA's are to tell the nurse if Restorative Services were completed or refused and the nurse documents in the Treatment Administration Record."</p> <p>Interview on 1/22/16 at 3:20 p.m., with the Corporate Manager indicated Resident #B has no documentation on the Restorative log or documentation on the Treatment Administration Record.</p> <p>1/22/16 at 3:40 p.m., an interview with RN #9 indicated "CNA's don't document anywhere that I know of for Restorative."</p> <p>Review on 1/21/16 at 12:30 p.m., of a document provided by the Director of Nursing titled Nursing Rehabilitation/Restorative Care indicated "Definition: 1.) Measurable objectives and interventions must be documented in</p>			

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	<p>the care plan and in the clinical record.</p> <p>2.) Evidence of periodic evaluation by a licensed nurse must be present in the clinical record...Use of the Restorative Log: The restorative log shall be initiated and very the amount of time (minutes) involved in performance when the procedure or activity is practiced."</p> <p>This Federal tag relates to Complaint IN00190309.</p> <p>3.1-50(a)(2)</p>			