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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/16/2014 |
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| NAME OF PROVIDER OR SUPPLIER WOODLANDS THE | STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN 47304 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 8, 9, 10, 11, 12, 15, and 16, 2014</p> <p>Facility number: 000134 Provider number: 155229 AIM number: 100275430</p> <p>Survey team: Karen Lewis, RN-TC Tina Smith-Staats, RN Ginger McNamee, RN (9/8, 9/9, 9/10, 9/11, 9/16, 2014) Toni Maley, BSW (9/9, 9/10, 9/11, 9/15, 9/ 16, 2014)</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 7 Medicaid: 55 Other: 15 Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> | F000000 | The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 10/16/14 | |

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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| F000157 SS=D | <p>Quality review completed by Debora Barth, RN.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically</p> | | | | |

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| | <p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the resident's physician of significant weight loss which could have resulted in the need to alter treatment for 2 of 4 residents reviewed for weight loss (Residents #5 and #87).</p> <p>Findings include:</p> <p>1. Resident #5's closed clinical record was reviewed on 9/10/14 at 10:58 a.m. Resident #5's discharge diagnoses included, but were not limited to, acute renal failure, congestive heart failure and chronic obstructive pulmonary disease. Resident #5 had a, 7/11/14, physician's order for Lasix 40 mg (a diuretic) two times daily. Resident #5 had a, 7/21/14, physician's order for Metolazone 2.5 mg (a diuretic) Monday, Wednesday and Friday.</p> <p>Resident #5 had a, 6/20/14, care plan problem regarding the potential for weight loss. An approach to this problem was to report weight loss to the physician.</p> <p>Resident #5's weight on 7/1/14 was 191 pounds. Resident #5's weight on 8/6/14</p> | F000157 | <p>1. Resident # 5 no longer resides in facility. Resident # 87 has had the MD and family notified of the previous weight loss that had occurred prior on September 29th, 2014. There have been no negative outcomes.</p> <p>2. Other residents have the potential to be affected therefore residents with a significant weight gain or loss within the last 30 days from date of survey exit (09/16/14 through 10/16/14 have been audited for Md and family notification by nursing administration to assure compliance by 10/16/2014 with follow up if indicated.</p> <p>3. Nursing administration and or designee will in service licensed staff on the protocol and policy for physician and family notification related to weight loss or gain by 10/16/14.</p> <p>4. The DON or designee will audit 3 charts weekly for notification of weight loss or gain to the MD and family to assure compliance. Results will be reviewed by the PI committee for 12 months. The PI committee will determine</p> | 10/16/2014 | | | |

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| | <p>was 154 pounds, resulting in a 37 pound weight loss in one month. The clinical record lacked any documentation of the physician having been notified of Resident #5's 37 pound weight loss. Resident #5's weight on 8/18/14 was 150 pounds indicating a continuation in weight loss.</p> <p>During a 9/11/14, 8:55 a.m., interview, the Director of Nursing indicated she was unable to find any documentation that Resident #5's physician had been notified of the 8/6/14, thirty seven pound weight loss. When question she indicated although the resident was on a diuretic the physician should have been notified.</p> <p>2. Resident #87 clinical record was reviewed on 9/11/14 at 3:05 p.m. Resident #87's current diagnoses included, but were not limited to, dementia, hypertension and depression.</p> <p>Resident #87 had a current, 5/2/14, care plan need which indicated he was at risk for weight loss. An approach to this problem was to notify the physician of weight loss.</p> <p>Resident #87 had a, 7/7/14, Psychiatry note which indicated he had severe depression and was refusing to eat resulting in weight loss.</p> | | <p>the need for further audits.</p> <p>Date of Compliance Oct 16th, 2014</p> | | | | |

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| | <p>Resident #87 had a, 6/9/14, weight of 180 pounds. Resident #87 had a, 6/23/14, weight of 165 pounds (a loss of 15 pounds). Resident #87's record lacked documentation that his physician had been notified of his weight loss. During a 9/15/14, 2:30 p.m., interview the Director of Nursing indicated she was unable to find any documentation that Resident #87's doctor had been notified of the 6/23/14 15 pound weight loss. She additionally indicated the physician should have been notified and the communication documented.</p> <p>3. Review of an undated, current, facility policy "Changes in Resident's Condition or Status", which was left on the table by facility administrative personnel on 9/16/14 at 12:40 p.m., indicated the following:</p> <p>"The facility will notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. The following will outline the process.</p> <p>Procedure</p> <p>...b. There is significant change in the resident's physical, mental or emotional status...</p> <p>d. There is a need to alter the resident's</p> | | | |

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| F000248 SS=E | <p>treatment or medication significantly."</p> <p>3.1-5(a)(2)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents, who resided on a secured dementia unit, were offered an activity program which addressed their identified dementia needs for 4 of 27 dementia residents reviewed for activities. (Residents #77, #65, #71, and #60)</p> <p>Findings include:</p> <p>1. During observations of the Ivy Court Dementia Unit on 9/9/14 from 1:17 p.m. to 2:38 p.m., 9/11/14 from 12:54 p.m. to 3:49 p.m., 9/12/14 from 9:10 a.m., to 10:34 a.m., and on 9/15/14 at 1:20 p.m., the following was noted:</p> <p>On 9/9/14 at 1:17 p.m., the dining room (where activities were held on the secured unit) had chairs in the doorway which blocked the entrance to the room.</p> | F000248 | <p>1.Residents # 77, 65, and 60 have had their activity evaluations reviewed, along with care plans and care guides to assure appropriate programing is in place and occurring for these residents. Resident # 71 no longer resides in facility.</p> <p>2.Other residents on the secured dementia unit have the potential to be affected therefore a 100 % audit of the activity evaluations, care plans, care guides, and activity calendars have been completed by the activity director and the Social Service Director by October 16th, 2014 to ensure these residents are receiving appropriate activities and compliance.</p> <p>3.The activity director will in</p> | 10/16/2014 |

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| | <p>No activities were being provided on the secured unit. At 2:20 p.m., Resident #77 was invited to participate in the parachute activity. Resident #77 participated less than 2 minutes. No other residents participated in the parachute activity. At 2:30 p.m., Activity Assistant #4 put the parachute away. At 2:38 p.m., Resident #77 was rattling the handle of the exit door. At 2:40 p.m., no staff were visible. At 3:05 p.m., Resident #77 was walking up and down the hallway. At 3:12 p.m., staff was passing snacks to the residents in their rooms, the television was on in the dining room with one resident present drinking coffee.</p> <p>On 9/11/14 at 12:54 p.m., the dining room had chairs in the doorway which blocked the entrance to the dining room until 1:20 p.m. At 1:22 p.m., Activity Assistant #4 was sitting in the dining room. Resident #77 came into the room. CNA #5 came to the dining room and asked Activity Assistant #4 if she was doing an activity. Activity Assistant #4 replied "yes". CNA #5 said, "I will go and invite the other residents." Residents #77, #65, and #60 sat at a table and did crafts with Activity Assistant #4. Activity Assistant #4 was only interacting with residents if the residents made a comment or asked a question. At 1:39 p.m., Activity Assistant #4 left the dining</p> | | <p>service the activity staff on the protocol, policy, and the expectations to be initiated and followed through in relation to offering, encouraging, assisting, and engaging with residents in activities that are specific to meet their needs and provide their physical, mental and psychosocial well- being, as well as contribute to a higher quality of life, by October 16th, 2014.</p> <p>4.The Activity Director/designee will observe and validate 3 activities daily to ensure compliance. Results will be presented to PI x 12 months. The PI committee will determine the need for further audits.</p> <p>5.Date of Compliance October 16th, 2014</p> | | | | |

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| | <p>room. At 1:43 p.m., Resident #77 left the dining room. Activity Assistant #4 returned to the dining room at 1:49 p.m., with another resident. At 1:58 p.m., Activity Assistant #4 left the dining room. At 2:04 p.m., Resident #77 returned to the dining room, walked around a table and went back down the hallway. At 2:21 p.m., Resident #60 left the dining room. At 2:23 p.m., Resident #77 walked through the dining room, stopped at the television for a few seconds, pushed in the chairs, slid his hand down the counter top, and went back down the hall at 2:27 p.m. At 2:29 p.m., Resident #65 left the dining room. At 2:31 p.m., Resident #77 returned to dining room and walked around the room. At 2:38 p.m., LPN #6 had Resident #77 go with her to get something to drink. At 2:46 p.m., Resident #65 walked into the dining room, looked around and left the dining room. At 2:47 p.m., Activity Assistant #4 returned to the dining room and got the ring toss game out of the closet. Resident #77 walked in as Activity Assistant #4 was getting the ring toss game out. Activity Assistant #4 said "hi" to Resident #77, he responded and the Activity Assistant #4 left the room. Activity Assistant #4 returned with Resident #60 and another female resident in a wheelchair. At 2:55 p.m., Resident</p> | | | |

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| | <p>#65 walked in the dining room. Activity Assistant #4 asked if she would like to play ring toss, Resident #65 said "No, that is too much work," and left the dining room. Resident #60 and another female resident were the only residents playing ring toss. At 3:00 p.m., Resident #77 opened another male resident's door and entered his room. Residents' voices became loud and LPN #6 came down hall way and entered the resident's room and directed Resident #77 out of the room. Resident #65 came into dining room as LPN #6 was walking Resident #77 out with her. At 3:18 p.m., the ring toss game was put away. At 3:22 p.m., Activity Assistant #4 passed out snacks and drinks. At 3:40 p.m., Activity Assistant #4 left the dining room and returned at 3:48 p.m., with dice. A female resident in a wheelchair was the only resident to participate in the dice exercise activity. At 3:49 p.m., Resident #77 walked in the dining room, Activity Assistant #4 invited Resident #77 to play, Resident #77 continued to walk around table and left the dining room.</p> <p>The activities on the calendar for 9/11/14 were: 12:00 Working Puzzle 12:30 Quiet Time 1:30 Crafts 2:00 Games</p> | | | | |

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| | <p>2:30 Ring Toss 3:00 Snacks & Remembering 3:45 Dice Exercise 4:00 Nail Buff</p> <p>On 9/12/14 at 9:10 a.m., the dining room had chairs in the doorway which blocked the entrance to the dining room. Housekeeping staff was in the dining room. Resident #71 was in a chair in the lounge with her eyes closed. A female resident was sitting on a bench in the hallway. At 9:26 a.m., Activity Assistant #4 was pushing a female resident in her wheelchair to the dining room. CNA #5 asked if she was getting ready for an activity and Activity Assistant #4 responded "yes." CNA #5 asked Activity Assistant #4 which activity they were going to do. Activity Assistant #4 indicated "Remembering," and stated, "I have cards with pictures." CNA #5 said "Great, we will ask the residents and bring them down to the dining room." At 9:28 a.m., CNA #5 invited Residents #60, #65, and #71 (all in the lounge). Residents #65 and 60 started to walk toward the dining room. CNA #5 invited other residents. The CNA then assisted Resident #71 to her wheelchair and to the activity. At 10:34 a.m., 17 residents were sitting in the dining room. Some of the residents had empty glasses and napkins in front of</p> | | | | | | |

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| | <p>them. There were no staff in the dining room, and the residents were not interacting with one another.</p> <p>Activity Calendar for 9/12/14 10:00 Exercise Group 10:45 Laundry Day</p> <p>On 9/15/14 at 1:20 p.m., the dining room had chairs in the doorway which blocked the entrance to the dining room. Residents #60 and #65 were sitting in chairs and Activity Assistant #13 was sitting on the floor in the hallway playing cards in a hat. A female resident was sitting in her wheelchair in the hallway near the lounge. Resident #71 was sitting in a chair in the lounge with her eyes closed. Resident #77 was standing at the nursing station window running his hand over the window frame.</p> <p>2. The clinical record for Resident #77 was reviewed on 9/15/14 at 1:38 p.m. Diagnoses for Resident #77 included, but were not limited to, bipolar, psychosis, diabetes, and hypertension.</p> <p>Resident #77 had a current, 7/11/012, care plan problem regarding the behavior of wandering into others personal space. Approaches to this problem included, but were not limited to, "Address wandering behavior by walking with resident,</p> | | | |

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| | <p>redirect from inappropriate areas, engaging in diversional activity."</p> <p>Resident #77 had a current, 8/1/2012, care plan problem regarding elopement related to wandering. Approaches to this problem included, but were not limited to, "If resident is wandering or exit seeking, redirect resident to activities, offer snack and food, offer toilet."</p> <p>Resident #77 had a current, 9/11/2014, care plan problem regarding wandering and not showing interest in group activities. Approaches to this problem included, but were not limited to, "Staff will redirect him when he starts to leave group and Staff will praise him when he participates in group. "</p> <p>Resident #77 had a most current, 9/11/14, "Activities Evaluation" which indicated: "ACTIVITY PURSUIT PATTERNS AND PREFERENCES: Exercise-current interest Family/Friend Visits-current interest Group Discussion-current interest Music-current interest Religious Services-past interest Religious Studies-past interest Sing-Alongs-current interest Social/Parties-current interest Walking-current interest...."</p> | | | | | | |

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| | <p>During an observation on 9/9/14 at 2:20 p.m., Resident #77 participated in the activity provided for less than two minutes. During an observation on 9/9/14 at 2:38 p.m., Resident #77 was rattling the handle on the exit door. During an observation on 9/9/14 at 3:05 p.m., Resident #77 was walking up and down the hallway.</p> <p>During an observation on 9/11/14 at 2:04 p.m., Resident #77 came into the dining room and walked around a table and went back down the hallway. During an observation on 9/11/14 at 2:23 p.m., Resident #77 walked through the dining room, stopped at the television for a few seconds, pushed in the chairs, slid his hand down the counter top, and went back down the hall at 2:27 p.m. During an observation on 9/11/14 at 3:00 p.m., Resident #77 opened another male resident's door and entered his room. Residents' voices became loud and LPN #6 came down the hall way and entered the resident's room and directed Resident #77 out of the room.</p> <p>During an observation on 9/15/14 at 1:20 p.m., Resident #77 was standing at the nursing station window running his hand over the window frame.</p> <p>3. The clinical record for Resident #65</p> | | | | | | |

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| | <p>was reviewed on 9/15/14 at 1:46 p.m. Diagnoses for Resident #65 included, but were not limited to, dementia, psychosis, anxiety, and hypertension.</p> <p>Resident #65 had a current, 2/20/2012, care plan problem regarding risk for falls. Approaches for this problem included, but was not limited to, "Invite, encourage, remind, escort to activity programs consistent with resident's interest to enhance physical strengthening needs."</p> <p>Resident #65 had a current, 2/17/14, care plan problem for diagnosis of Alzheimer's and on a secured unit. Approaches for this problem included, but was not limited to, "Staff will encourage resident to attend and participate in groups and Praise resident when she attends and participates in groups."</p> <p>Resident #65 had a most current, 2/17/14, "Activities Evaluation" which indicated: "ACTIVITY PURSUIT PATTERNS AND PREFERENCES: Arts/Crafts-current interest Community Outings-current interest Cooking/Baking-current interest Exercise-current interest Family/Friend Visits-current interest Group Discussion-current interest</p> | | | |

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| | <p>Music-current interest Radio-current interest Religious Services-current interest Sing-Alongs-current interest Social/Parties-current interest Walking-current interest...."</p> <p>During an observation on 9/11/14 at 2:46 p.m., Resident #65 walked into dining room, looked around and left the dining room. During an observation on 9/11/14 at 2:55 p.m., Resident #65 walked in the dining room. Activity Assistant #4 asked if she would like to play ring toss, Resident #65 said "No, that is too much work," and left the dining room.</p> <p>4. The clinical record for Resident #71 was reviewed on 9/10/14 at 12:22 p.m. Diagnoses for Resident #71 included, but were not limited to, vascular dementia with depressed mood, psychosis, anxiety, and disorders of eating.</p> <p>Resident #71 had a current, 3/7/13, health care plan problem regarding purging self after meals. Approaches for this problem included, but were not limited to, "Provide diversional activities after a meal to dissuade her from going straight to the bathroom...."</p> <p>Resident #71 had a current, 1/24/14, health care plan problem of diagnosis of</p> | | | | | | |

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|--------------------|--|---------------|---|----------------------|
| | <p>Alzheimer's and on a secured unit. Approaches to this problem included, but were not limited to, "Staff will encourage resident to attend and participate and will praise resident when she does."</p> <p>Resident #71 had a most current, 10/14/13, "Activities Evaluation" which indicated: "ACTIVITY PURSUIT PATTERNS AND PREFERENCES: Arts/Crafts-current interest Beauty/Barber-current interest Cooking/Baking-current interest Exercise-current interest Family/Friend Visits-current interest Group Discussion-current interest Music-current interest Radio-current interest Reading-current interest Religious Services-current interest Sing-Alongs-current interest Social/Parties-current interest Walking-current interest...."</p> <p>During an observation on 9/12/14 at 9:10 a.m., Resident #71 was in a chair in the lounge with her eyes closed.</p> <p>During an observation on 9/15/14 at 1:20 p.m., Resident #71 was sitting in a chair in the lounge with her eyes closed.</p> | | | |

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| | <p>5. The clinical record for Resident #60 was reviewed on 9/15/14 at 1:42 p.m. Diagnoses for Resident #60 included, but were not limited to, Alzheimer's disease, dementia with behaviors, hypertension, and depression.</p> <p>Resident #60 had a current, 3/14/14, health care plan problem regarding falls. Approaches for this problem included, but were not limited to, "Invite, encourage, remind, escort to activity programs consistent with resident's interest to enhance physical strengthening needs."</p> <p>Resident #60 had a current, 1/24/14, health care plan problem regarding diagnosis of Alzheimer's with short term memory loss. Approaches for this problem included, but were not limited to, "Encourage resident to attend and participate in group activities and praise her when she does."</p> <p>Resident #60 had a most current, 9/4/14, "Activities Evaluation" which indicated: "ACTIVITY PURSUIT PATTERNS AND PREFERENCES: Arts/Crafts-current interest Bingo-current interest Community Outings-current interest Cooking/Baking-current interest Exercise-current interest</p> | | | | | | |

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| | <p>Family/Friend Visits-current interest Group Discussion-current interest Music-current interest Religious Services-current interest Sing-Alongs-current interest Social/Parties-current interest Television-current interest Walking-current interest...."</p> <p>During an observation on 9/11/14 at 1:22 p.m., Resident #60 participated in a craft activity until 1:45 p.m. Activity Assistant #4 left the dining room at 1:39 p.m., and did not engage Resident #60 when she returned to the dining room at 1:49 p.m. Activity Assistant #4 left the dining room again at 1:58 p.m. At 2:21 p.m., Resident # 60 left the dining room. From 1:45 p.m., to 2:21 p.m., Resident #60 did not have anything to do after completing her craft.</p> <p>During an observation on 9/12/14 at 9:10 a.m., Resident # 60 was sitting in the lounge with her eyes closed.</p> <p>6. During an interview with the Activities Director on 9/15/14 at 9:56 a.m., she indicated Activity Assistant #4 was not working today. She indicated last week was Activity Assistant's #4 first week working by herself. The Activities Director indicated the training provided new activity staff was "hands-on."</p> | | | |

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| | <p>Activity Assistant #4 was with Activity Assistant #13 for 3 days before doing any activities by herself. The Activities Director indicated she had no written orientation/training. She did have a book with descriptions of the activities.</p> <p>During an interview with Activity Assistant #13 on 9/15/14 at 12:20 p.m., she indicated she had worked here for four months. She indicated she had been hired to do activities on Hickory Hall and Southern Pines Hall. Activity Assistant #13 indicated the previous Ivy Court activity staff had trained her and that person had worked here approximately nine months when she started at the facility. Activity Assistant #13 indicated Activity Assistant #4 had been with her "a couple of days" and then began doing activities on her own. They did a couple of activities on each unit together. Activity Assistant #13 indicated all the training was "hands-on". She indicated there was a red binder with the descriptions of the activities. Activity Assistant #13 indicated if she had a questions she would go to her supervisor. She indicated she had instructed Activity Assistant #4 to call her if she had any questions and the supervisor was not in the facility.</p> <p>During an interview with CNA #5 on</p> | | | | | | |

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| F000250 SS=D | <p>9/15/14 at 12:56 p.m., she indicated she had worked here for two and a half years and worked full-time on Ivy Court. She indicated the residents on the secure unit did not have enough activities to do. She indicated the activity staff only involved 1-2 residents at a time. CNA #5 indicated activities help decrease behaviors from the residents. CNA #5 indicated there used to be a table and chairs in the "lobby" of the unit. The residents used to sit there and do games or puzzles when the dining room was being cleaned.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to provide diversional activities for residents with behavioral issues for 1 of 1 resident reviewed for behavior management. (Resident #77)</p> <p>Findings include: The clinical record for Resident #77 was reviewed on 9/15/14 at 1:38 p.m. Diagnoses for Resident #77 included, but were not limited to, bipolar, psychosis,</p> | F000250 | <p>1. Resident # 77 activity evaluation, behavior plan and interventions, care plan and care guide have been reviewed and updated to ensure appropriate interventions and programming is in place and occurring.</p> <p>2. Other residents on the behavior management program have the potential to be affected therefore a 100% audit of the activity assessments, behavior programs and interventions,</p> | 10/16/2014 | | | |

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| | <p>diabetes, and hypertension.</p> <p>Resident #77 had a current, 7/11/012, care plan problem regarding the behavior of wandering into others personal space. Approaches to this problem included, but were not limited to, "Address wandering behavior by walking with resident, redirect from inappropriate areas, engaging in diversional activity."</p> <p>Resident #77 had a current, 8/1/2012, care plan problem regarding elopement related to wandering. Approaches to this problem included, but were not limited to, "If resident is wandering or exit seeking, redirect resident to activities, offer snack and food, offer toilet."</p> <p>Resident #77 had a current, 9/11/2014, care plan problem regarding wandering and not showing interest in group activities. Approaches to this problem included, but were not limited to, "Staff will redirect him when he starts to leave group and Staff will praise him when he participates in group."</p> <p>Resident #77 had a most current, 9/11/14, "Activities Evaluation" which indicated: "ACTIVITY PURSUIT PATTERNS AND PREFERENCES: Exercise-current interest Family/Friend Visits-current interest</p> | | <p>care plans and care guides have been completed by the Activity Director and Social Service Director by October 16th, 2014 to ensure residents on the behavior program are receiving diversional activities as indicated by their plan of care.</p> <p>3.The Activity Director and Social Service Director will in service the activity and nursing staff by October 16th, 2014 on the policy and protocol for the behavior management program, and the expected follow thorough by staff to ensure these residents receive the appropriate interventions and approaches to meet their needs.</p> <p>4.The Social Service Director and or designee will validate 5 residents weekly on the behavior management program to ensure appropriate interventions and programming is in place and occurring. Results will be presented to PI for 12 months. The PI committee will determine the need for further audits.</p> <p>5.Date of Compliance: October 16th, 2014</p> | | |

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| | <p>Group Discussion-current interest Music-current interest Religious Services-past interest Religious Studies-past interest Sing-Alongs-current interest Social/Parties-current interest Walking-current interest...."</p> <p>During an observation on 9/9/14 at 2:20 p.m., Resident #77 participated in the activity provided for less than two minutes.</p> <p>During an observation on 9/9/14 at 2:38 p.m., Resident #77 was rattling the handle on the exit door.</p> <p>During an observation on 9/9/14 at 3:05 p.m., Resident #77 was walking up and down the hallway.</p> <p>During an observation on 9/11/14 at 2:04 p.m., Resident #77 came into the dining room and walked around a table and went back down the hallway.</p> <p>During an observation on 9/11/14 at 2:23 p.m., Resident #77 walked through the dining room, stopped at the television for a few seconds, pushed in the chairs, slide his hand down the counter top, and went back down the hall at 2:27 p.m.</p> <p>During an observation on 9/11/14 at 3:00</p> | | | |

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|---|--|---|---|----------------------|---|
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| | <p>p.m., Resident #77 opened another male resident's door and entered his room. Residents' voices became loud and LPN #6 came down the hall way and entered the resident's room and directed Resident #77 out of the room.</p> <p>During an observation on 9/15/14 at 1:20 p.m., Resident #77 was standing at the nursing station window running his hand over the window frame.</p> <p>Resident #77 was encouraged by staff to attend activities only two times during observations on 9/9/14, 9/11/14, and 9/15/14. Staff did not invite the resident to activities to reduce intrusive wandering.</p> <p>During an interview on 9/16/14 at 5:08 p.m., the Social Services Designee indicated she had no other information about Resident # 77 and his behaviors.</p> <p>Review of the current facility policy, revised 08/02, titled "BEHAVIOR PROGRAM POLICY AND PROCEDURE," provided by the Social Services Designee on 9/16/14 at 5:21 p.m., included, but was not limited to, the following:</p> <p>"Policy: This program is designed to accommodate individual needs, manage</p> | | | | |

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| F000282 SS=D | <p>behavioral symptoms and ensure regulatory compliance....</p> <p>...4. Care plans will be developed to address mood, behavior and other psychiatric symptoms exhibited by residents in order to reduce or eliminate these problems....</p> <p>...The goal will focus on maintaining the individual. Approaches will focus on prevention and how to intervene should symptoms occur...."</p> <p>3.1-34(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to identify and report bruising in accordance with facility protocol for 1 of 3 residents reviewed for bruising (Resident #100).</p> <p>Findings include:</p> <p>On 9/9/14, at 9:51 a.m., Resident #100 was observed with bruising on both her forearms and hands. Resident #100 was unable to provide information regarding how she acquired the bruises.</p> | F000282 | <p>1.Resident # 100 has had bruise reported to MD, family, and all appropriate parties' on 09/29/2014. No further bruising has occurred on resident 100 since survey exit. Bruising is now resolving. Please note this resident was on Plavix 75 mg daily since 11/2013. The resident received an order for geri sleeves on 09/11/2014 with care plan and care guide adjusted.</p> | 10/16/2014 | | | |

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| | <p>Resident #100's clinical record was reviewed in 9/11/14 at 1:08 p.m.</p> <p>Resident #100's current, diagnoses, included, but were not limited to, depression, heart disease and renal failure. Resident #100's record lacked any documentation of bruising. Resident #100 did not have an identified risk for bruising in her record or care plan.</p> <p>Resident #100 had a current, 5/16/14, Minimum Data Set (assessment) which indicated the resident had cognitive impairment and rarely made independent choices and required extensive assistance with activities of daily living.</p> <p>During a 9/11/14, 3:00 p.m., interview, the Director of Nursing indicated Resident #100 did not have a history of bruising.</p> <p>During a 9/11/14, 3:25 p.m., interview, the Director of Nursing indicated Resident #100 had received a shower the day before. She indicated the CNA should have identified the bruising during the shower and notify the nurse and completed a skin condition form. She indicated the CNA had not followed protocol.</p> <p>Review of a current, undated, facility</p> | | <p>2. Other residents have the potential to be affected therefore a 100% skin sweep will be conducted by nursing administration and documented on the pink bathing sheets by 10/16/14.</p> <p>3. Nurses and aides will be in-serviced on the appropriate protocol and policy related to the use of the pink bathing sheets, to whom and when to report skin issues and the appropriate follow up required by the nursing administration staff and or designee by October 16th, 2014.</p> <p>4. The pink bathing sheets will be validated daily with the current day's census to assure all residents have been reviewed by the charge nurses. The Don or designee will review 5 pink bathing sheets daily to assure compliance. Findings will be reviewed by the PI committee for 12 months. The PI committee will determine the need for further audits.</p> <p>Date of Compliance October 16th, 2014</p> | | | | |

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| F000309 SS=D | <p>policy titled "Skin Care Alert", which was provided by the Director of Nursing on 9/11/14 at 4:10 p.m., indicated the following: " the CNA during usual care, bath care ...The CNA should circle the location of any red, open, or dry areas and other skin concerns on the form..."</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure complete and appropriate communication between the facility and the dialysis center for 1 of 1 residents reviewed for dialysis (Resident #39).</p> <p>Findings include:</p> <p>Resident #39's clinical record was reviewed on 9/10/14 at 1:08 p.m. The resident's diagnoses included, but were</p> | F000309 | <p>1.The facility will use and accurately fill out the pre/post dialysis form.</p> <p>2.There are no other residents receiving dialysis in the facility currently.</p> <p>3.Nursing administration and or designee will in service and educate licensed staff on the protocol for the pre/post dialysis form to include what is required from the facility and the dialysis units by</p> | 10/16/2014 |

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| | <p>not limited to, hypertension, end stage renal disease, diabetes mellitus type 2, chronic respiratory failure and dementia with behaviors.</p> <p>The record indicated Resident #39 went out for dialysis on Mondays, Wednesdays and Fridays, order dated 6/5/14.</p> <p>The Pre/Post Dialysis Checklist, dated from 6/6/14 through 8/18/14, indicated the following:</p> <p>The Pre/Post Dialysis Checklist was not documented for 6/16/14, 6/20/14, 6/25/14, 6/30/14, 7/4/14, 7/11/14, 7/14/14, 7/16/14, 7/18/14, 7/28/14, 8/1/14, 8/4/14, 8/6/14 and 8/8/14</p> <p>Resident #39 had no documented pre dialysis vital signs for 6/6/14 and 6/30/14.</p> <p>Resident #39 had no documented post dialysis communication from the dialysis center for 6/13/13, 6/18/14, 7/7/14, 7/9/14, 7/30/14 and 8/18/14.</p> <p>Resident #39 had a, 12/20/13, care plan problem of Potential for complications related to hemodialysis for diagnosis of renal failure. The care plan indicated the facility should communicate with the dialysis center regarding medication, diet</p> | | <p>October 16th, 2014.</p> <p>4.Pre/Post dialysis sheets will be audited by the Don and or designee on residents who receive dialysis 3 times weekly for accurate completion. Findings will be reviewed by the PI committee for 12 months. The PI committee will determine the need for further audits.</p> <p>Date of Compliance: October 16th, 2014</p> | | | | |

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| | <p>and lab results.</p> <p>During an interview on 9/16/14 at 10:17 a.m., RN#12 stated, "Vital signs should be taken before they (the resident) leave. The assessment should be done and this also includes the dialysis site. The dialysis center weighs them pre dialysis. We send the sheet with them in the packet and the dialysis center is supposed to fill it out and return it with the resident. Sometimes we have to fax it to them because they don't send it back."</p> <p>During an interview on 9/16/14 at 11:20 a.m., the DON indicated the Pre section of the Pre/Post Dialysis Checklist should be completed by the nurse sending the resident to dialysis. She indicated the Post section of the Pre/Post Dialysis Checklist should have been completed by the dialysis center and returned to the facility with the resident. She further indicated if the facility did not receive the information, the nurse should have called the dialysis center and have the information faxed to the facility. After reviewing the Pre/Post Dialysis Checklist from the resident's chart, the DON verbalized the lack of documentation on both the part of the nurse and the dialysis center.</p> <p>The 1/1/07, policy titled "Clinical</p> | | | | | | |

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| F000312 SS=D | <p>Services Policies and Procedures, Nursing Volume 1 Treatments, Chapter 10: Dialysis" procedure was provided by the Director of Nursing on 9/15/14 at 8:49 a.m. The procedure indicated the day of dialysis as follows:</p> <p>"... Day of dialysis:...3: 3. If dialysis facility requires form(s) to be filled out and sent with resident , complete and send with resident...."</p> <p>3.1-37(a)</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 interview and record review, the facility failed to ensure residents received shower/baths to maintain personal hygiene for 1 of 1 residents who indicated she did not routinely receive showers (Resident #11).</p> <p>Findings include: During a 9/9/14, 12:58 p.m., interview, with Resident #11 who was deemed reliable during the stage one survey process, the resident indicated she did not</p> | F000312 | <p>1.Resident # 11 has now been receiving her showers as scheduled. Upon interview by ED on 09/30/14 she has no further concerns. 2.Other residents have the potential to be affected therefore nursing administration will complete an audit by October 16, 2014 of the pink bathing sheets and compare to shower sheets and the computerized documentation to assure</p> | 10/16/2014 |

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| | <p>always get her showers and she would like to have them.</p> <p>Resident #11's clinical record was reviewed on 9/11/14 at 10:15 a.m. Resident #11's current diagnoses included, but were not limited to, hypertension, depression and bipolar disorder.</p> <p>Resident #11 had an, 8/7/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident understood others and was understood by others, needed extensive assistance for personal hygiene and required the assistance of one staff member for showers.</p> <p>Resident #11 had a current, 5/8/14, care plan need regarding requiring assistance with activities of daily living. An approach to this need was to assist with showers twice weekly and as needed.</p> <p>Review of Resident #11's computerized shower record for September 1-15, August and July 2014 indicated the following:</p> <p>September 2014: Resident #11 had been given 1 bed bath and 1 shower during the 14 days of September, bed bath 9/2/14 (a 6 day period since a shower on 8/27/14) and shower 9/10/14 (an 8 day period).</p> | | <p>compliance of baths and showers for resident's and accurate documentation is in place.</p> <p>3.Nursing administration and or designee will in service licensed nursing staff and aides on the documentation requirements, how and whom to report refusals to, and the appropriate follow up in relation to showers and bathing for residents by October 16th, 2014. Charge nurses will speak with the resident if refuses and document in the clinical record as well.</p> <p>4.Nursing administration and or designee will review 10 pink bathing sheets, and validate that the computerized charting matches and is completed weekly. Any refusal will be reported to the Don and or designee and they will validate appropriate documentation in place for the refusal as well. Findings will be presented to PI committee for 12 months. The PI committee will determine the need for further audits.</p> <p>Date of Completion: October 16th, 2014</p> | | | | |

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| | <p>There was not documentation that Resident #11 had refused any baths/showers in September.</p> <p>August 2014: Resident #11 was given a bed bath on 8/6/14 (a 6 day period with no bath or shower). Resident #11 was given a bed bath on 8/12/14 (a 6 day period with no bath or shower). Resident #11 was given a shower on 8/20/14 (an 8 day period with no bath or shower). Resident #11 was given a bed bath on 8/22/14 and 8/23/18. Resident #11 was given a shower 8/27/14. There was no documentation that Resident #11 had refused any baths/showers in August.</p> <p>July 2014: Resident #11 had routine shower/baths July 1 to July 18. Resident #11 had a bed bath 7/18/14 and did not receive another bath/shower until July 28th (9 days). There was no documentation Resident #11 had refused any bath/shower in July.</p> <p>During a 9/15/14, 12:35 p.m., interview, CNA #1 indicated all showers were documented in the computerized record. She indicated if a resident refused showers the staff documented the refusal in the computer system as well.</p> <p>During a 9/15/14, 12:40 p.m. interview, CNA #2 indicated all showers and baths</p> | | | |

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| F000314 SS=G | <p>were documented in the computerized record. She indicated refusals were also documented in this record. She additionally indicated a CNA should let the nurse know if the resident was refusing showers/baths.</p> <p>During a 9/15/14, 12:45 p.m. interview, CNA #3 indicated all baths and showers were documented in the computerized record and refusal were also documented in this record.</p> <p>During a 9/15/14, 2:30 p.m., interview, the Director of Nursing was questioned about the lack of shower/bath documentation for Resident #11.</p> <p>During a 9/16/14, 10:50 a.m., interview, the Director of Nursing indicated she was unable to find any documentation that Resident #11 had received any showers/baths during the missing periods in July, August and September 2014.</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(D)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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</p> | | | | | | |

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| | <p>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 provide services to prevent the development of and promote the healing of pressure ulcers in 1 of 4 residents reviewed for pressure ulcers. This deficient practice resulted in the decline in healing of a pressure ulcer (Resident #35) having an increase in stage from 3 cm x 3 cm x 0.1 cm to size 1.2 cm x 2 cm, unstageable.</p> <p>Findings include:</p> <p>1. Resident #35's clinical record was reviewed on 9/15/14 at 2:37 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, hypertension, anemia and pseudophakia.</p> <p>During an observation on 9/15/14 at 8:33 p.m., LPN #14 removed the old dressing on the lower back of Resident #35. The area had a small amount of drainage noted. The peri wound area was dark and uneven. The wound bed was white with small amounts of pink noted.</p> <p>Review of physician orders indicated</p> | F000314 | <p>1. Resident's # 35 is receiving treatments as ordered by MD and had preventable measures in place.</p> <p>2. Other residents have the potential to be affected therefore the residents with pressure ulcers have had their clinical records audited by nursing administration and or designee by 10/03/2014 to assure their areas have not declined, treatments are in house and available, anti- pressure devices in place, RD follow up and dietary interventions in place as well.</p> <p>3. Nursing administration and or designee will in service licensed nursing and certified aides by October 16th, 2014 to ensure the policy and protocols are in place and being followed by nursing staff. This is to include keeping clean and dry, turning and repositioning, ordered treatments available, anti- pressure devices in place, dietary recommendations in place, and MD and family notification documented on any changes in wound status as well as licensed nursing to report any changes in wounds to wound nurse or nursing administration once noted.</p> | 10/16/2014 |

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| | <p>Resident #35 had an order for Allevyn to be applied daily to lower back for preventative dated 8/29/14 and renewed on 9/3/14. Review of physician orders indicated the order for Allevyn was changed on 9/14//14 to cleaning the lower back with normal saline, pat dry and apply Santyl to eschar then cover the area with Mepilex for 14 days. The dressing was to be changed daily.</p> <p>During an interview on 9/15/14 at 8:25 p.m., LPN #14 indicated there was no Santyl available to complete the dressing change as the physician had ordered.</p> <p>During an interview on 9/15/14 at 1:33 p.m., the Assistant Director of Nursing (ADON) indicated the facility had 3 pressure ulcers which had developed in house and one community acquired pressure ulcer. She indicated all but one of the in-house pressure ulcers were healing. Resident #35's pressure ulcer had declined and become unstageable.</p> <p>The Nursing Wound note, dated 8/29/14, indicated the resident was found to have an area of concern to her lower back. The area was red in color and measured 3 cm x 3 cm x <0.1 cm.</p> <p>Review of the Nursing Wound note, dated 9/5/14, indicated the resident was</p> | | <p>4.The DON will review and assess one wound weekly with the wound nurse to ensure validation of condition of wounds and ensure treatments are being completed per MD orders, the documentation is accurate and all steps in process being completed accurately. Findings will be presented to PI monthly x 12 weeks. The PI committee will determine the needs for further audits.</p> <p>5.Date of Compliance: October 16th, 2014.</p> <p>Informal Dispute Resolution Response to Regulation Cited F 314 483.25 (c) Treatment/Svsc to Prevent/Heal Pressure Sores We are disputing the citation of F 314 which stated 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 individuals 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. The guidance</p> | | | | |

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| | <p>found to have a stage 1 to her lower back red in color and measured 3 cm x 3 cm x 0 depth.</p> <p>The Nursing Wound note, dated 9/12/14, indicated the stage 1 pressure ulcer had declined in healing and had become unstageable with black eschar noted around the peri wound area and white eschar noted in the wound bed.</p> <p>Review of the Weekly Pressure Ulcer Tracking Report for September 2014 indicated the wound was discovered on 8/29/14.</p> <p>The resident had a, 9/4/14, care plan problem for Wound type/location Unstageable to lower back. The care plan indicated the nursing staff should observe for signs and symptoms of infection or delayed healing and report to physician; inspect skin during bathing, especially over bony prominences.</p> <p>The resident had a 4/4/14, care plan problem for Activities of Daily Living (ADL's): "Resident requires assist in completing ADL's related to decreased mobility, generalized weakness, incontinence, impaired cognition and behaviors." The care plan indicated the nursing staff should check the resident every 2 hours and as needed, provide</p> | | <p>used to determine an unavoidable pressure ulcer states that the resident developed a pressure ulcer and the facility did not do one or more of the following: evaluate the residents clinical condition and pressure ulcer risk factors, define and implement interventions that are consistent with resident needs, goals and recognized standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. We are specifically disputing that facility failed to provide services to prevent the development of and promote the healing of pressure ulcer on resident # 35. Resident # 35 had a stage 1 area noted on 08/29/2014 on her left upper buttock. Wound nurse notified the MD and family and an order was received for mepilex. The resident was being laid down after meals to relieve pressure, was receiving a treatment per MD order, her intakes were being monitored per attached documentation. Her intake's averaged 50- 100% and she was continuing to receive</p> | |

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| | <p>prompt peri care and chart all incontinent episodes.</p> <p>Review of Quarterly Minimum Data Set assessment, dated 7/4/14, indicated Resident #35's functional status was as follows: Bed mobility extensive assistance with one person physical assist. Transfers: extensive assist with one person physical assist Locomotion on unit: extensive assist with one person physical assist Locomotion off unit: extensive assist with one person physical assist Toilet use: extensive assist with one person physical assist Mobility device: wheelchair.</p> <p>Review of the Monthly Flow Report for August and September 2014, indicated Resident #35 was totally dependent, full staff performance, with one person physical assist for the activities of bed mobility, transfer, toilet use, personal hygiene and bathing.</p> <p>No further information was provided for the decline in Resident # 35's pressure ulcer.</p> <p>3.1-40(a)(1)</p> | | <p>med pass 120 ml BID. This resident had an anti-pressure mattress in place and a specific pressure reduction cushion in her w/c. The plan of care states she was to be checked every 2 hours for incontinence care, turned and repositioned, complete Braden scale which has been done as indicated, and complete weekly skin assessment and daily observation of skin during care. The md and family were notified when area became noted and a treatment order was received. The wound nurse evaluated weekly per protocol and documented this in the clinical record ongoing. On Sept 12th when noted change this was assessed, documented and new orders received for a change in treatment which indicates again assessment and evaluation of area, this area is improving , the eschar has decreased and is almost gone, and there have been no symptoms of infection.. On Sept 15th, 2014 the nurse attempted the ordered treatment of Santyl and the ointment was not available from pharmacy. The nurse</p> | | | | |

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| | | | called the MD immediately, got another order for treatment until the sanytl arrived and proceeded with that treatment as ordered. The resident did not miss any treatments and the treatment ordered for mepilex, promoted autolytic debridement therefore the debridement process was not delayed. Once the Santyl arrived the treatment was re-instated as such per order, and the Registered Dietician reviewed her condition as well on 09/17/2014, which indicates the facility did evaluate the residents clinical condition and pressure ulcer risk factors as well as monitored and evaluated the impact of the interventions and made changes as needed. The facility has also completed a significant change MDS on 09/19/2014 due to an overall decline in her mental, physical and psychosocial condition. Specific areas showing decline include ADL'S, cognition, activity level, and skin integrity currently she now is on Bactrim DS, Flagyl, and QID duoneb respiratory treatments. She has a pre | | |

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| F000328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS | | albumin of 12, and a chest x-ray done on the 26th of September shows a right lower lobe infiltrate. She is using O2 at 2/l per N/C , she has an air mattress now, Speech Therapy has downgraded her diet from Mechanical Soft with liquids to Pureed with honey thickened fluids. She has had an order for Palliative care since 06/25/2013 and yet this facility has been able to keep her at her highest level of functioning until recently. In closing, the facility did provide the services to prevent the development and promote the healing of this resident's pressure area as well as evaluated her clinical condition and pressure risk factors, defined and implemented interventions that are consistent with the resident's needs, goals, and recognized standards of practice; monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. Thank You for your consideration in this review. | | |

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| | <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interview the facility failed to ensure proper administration technique was use for providing tracheostomy care to 1 of 1 residents reviewed for tracheostomy care (Resident #39).</p> <p>Findings include:</p> <p>Resident #39's clinical record was reviewed on 9/10/14 at 1:08 p.m. The resident's diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus type 2, chronic respiratory failure, dementia with behaviors and Clostridium difficile.</p> <p>Review of the physician orders indicated Resident #39 had an order, dated 2/13/14, to change the inner cannula daily and as needed for her tracheostomy and was in isolation for Clostridium difficile.</p> <p>During an observation of tracheostomy care on 9/11.14 at 1:16 p.m., RN #7</p> | F000328 | <p>1.RN # 7 has been educated and had a competency check performed on tracheostomy care and hand washing by the SDC on September 29th, 2014.</p> <p>2. There are no other residents in facility with a tracheostomy therefore no other residents have the potential to be affected.</p> <p>3. The SDC will in service licensed staff on performing appropriate tracheostomy care and will complete tracheostomy and hand washing competencies on licensed staff by October 16th, 2014. In servicing will include infection control practices, hand washing as well as the appropriate procedure and protocol for performing tracheostomy care and changing of the cannula.</p> <p>4. The SDC and or designee will perform 4 competencies monthly once licensed</p> | 10/16/2014 |

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| | <p>gloved and gowned prior to bringing supplies for tracheostomy care into the resident's room and placed all the clean supplies on the bed. RN #7 stated she had washed her hands before coming into the room. RN #7 cleaned the area around the trach site and removed the old inner cannula while wearing clean gloves. RN #7 placed the contaminated supplies on the bed next to the clean supplies. RN #7 removed sterile gloves from the tracheostomy kit and put them on her hands over the soiled gloves. She then placed the new disposable inner cannula in the tracheostomy. RN #3 then removed the used supplies and placed them in the isolation waste container, removed her gloves, and washed her hands.</p> <p>During an interview on 8/11/13 at 1:54 p.m., RN #7 indicated she had been employed at the facility for approximately one year. She indicated she had been performing trach care for approximately 5-7 years. She indicated she had forgotten to bring a trash bag into the room with her and the over the bed table was too cluttered for setting up her supplies, so she used the bed. She also indicated the procedure was a clean procedure and the only sterile part was changing the inner cannula. RN #7 verbalized she usually used the double</p> | | <p>nursing completed, rotating shifts to ensure compliance r/t tracheostomy care and hand washing. Results will be presented to PI monthly x 12 months. The PI committee will determine the need for further audits.</p> <p>5.Date of Completion: October 16th, 2014</p> | | | | |

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| | <p>gloved method, placing the sterile gloves on over the soiled gloves.</p> <p>During an interview on 9/11/14 at 2:33 p.m., the DON indicated RN #7 did not follow procedure for providing trach care and changing the inner cannula. An undated policy titled "Respiratory Care Resources: Tracheostomy Care" was provided. The procedure for changing a disposable inner cannula was as follows:</p> <p>"...II procedure for disposable inner cannula ...C. aseptically open package for disposable inner cannula. D. Aseptically don sterile gloves..."</p> <p>An undated policy for hand washing titled "Life Care Centers of America, Inc. handwashing, Chapter 10" was also provided by the DON. The policy indicated the following: "...Wash Your Hands ...3. Hands should be washed: upon reporting on and off duty. Whenever a task may involve the exposure to blood or body fluids. After touching excretions (feces, urine, or material soiled with them) or secretions (from wounds, skin infections, etc.) before touching any resident again. After caring for an infected resident or touching contaminated items.</p> | | | |

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| F000353 SS=F | <p>Before touching wounds, feeding equipment, changing dressings, obtaining specimen collections, providing catheter care, and other invasive procedures.</p> <p>Before serving food.</p> <p>Before and after the use of sterile gloves, gowns, and masks.</p> <p>After handling the resident's belongings.</p> <p>Before entering and leaving an isolation area or room.</p> <p>After handling any articles removed from an isolation area...."</p> <p>3.1-47(a)(4)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of</p> | | | |

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| | <p>this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview and record review, the facility failed to provide adequate staffing to meet the needs of the residents. This deficient practice had the potential to effect 77 of the 77 residents living in the facility.</p> <p>Findings include:</p> <p>1. Interview with Resident # 7, on 9/9/14 at 9:30 a.m., indicated the resident had to "wait half an hour for the call light to be answered for pain medicine or ice."</p> <p>Interview with Resident # 80, on 9/9/14 at 1:45 p.m., indicated the resident believed there were not enough CNAs, especially when "I need to go to bathroom for bm (bowel movement). I have to use a lift and need 2 CNAS. Then either they can ' t find the lift or can ' t find a second CNA to spot during the transfer. They have had to clean me up because they take too long. I know it has happened 3 times. I have to use bowel stimulants and then can ' t control it. Evening shift is the worst but all shifts are short. "</p> <p>Resident # 22 was interviewed on 9/4/14 at 10:48 a.m. The resident stated, " I</p> | F000353 | <p>1.The daily staffing sheets produced and given to the surveyors did not include the hours that staff actually worked, it only included the staff scheduled without the open positions being covered.</p> <p>2.Other residents have the potential to be affected therefore an audit will be conducted by nursing administration, the ED, and SSD of residents to include if they have staffing or care concerns by 10/16/2014. If indicated follow up will be completed. Upon review of actual open positions as of 9/30/14 the facility only needs one part time aide for night shift all other positions have been filled.</p> <p>3.In-servicing and education will be completed by October 16th, 2014 by nursing administration and or SDC to address the importance of policy expectations and meeting residents needs to include toileting response, call light response, and shower process and expectations. The Ed/ DON and or designee will review daily staffing sheets to ensure enough staffing is scheduled to meet the resident's needs. If required nursing administration will continue when needed to assist in floor coverage to ensure needs are being met for the residents.</p> <p>4.ED/Social service/ and or</p> | 10/16/2014 | |

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| | <p>have had to wait a half hour to get changed after being incontinent and it is uncomfortable. I have been using the urinal more here lately but can ' t hold it very long. I have an overactive bladder. They had 5 or 6 CNA ' s leave in the past month. "</p> <p>2. Review of the Resident Council Meeting Minutes, on 9/15/14 at 10:18 a.m., indicated on 4/14/14 a concern regarding residents not receiving showers and bed sheets not being changed. These concerns were brought before the Council. Other concerns brought before the Council by unit were as follows: Southern Pines- making beds not good. Hickory and South water pass bad Response The facility's response to these concerns was to place all information in CNA Communication Binder. The facility was also to follow up concerns Monday through Friday for 1 month. Residents had no complaints regarding showers, bed sheet changing and water pass from 4/15/14 through 5/15/14.</p> <p>3. During an interview on 9/15/14 at 12:22 p.m., CNA #1 stated, "We had 4 CNA's walk out at the same time, same shift, same hall. We had to cover it. Some of us worked our days off. The majority us made sure the shifts were covered. They hired people to cover the</p> | | <p>Nursing administration will interview 5 residents and or responsible party weekly to identify any resident care/staffing concerns. Any concerns will be identified and logged in the facility resident Concern log with appropriate action and follow up. The resident Concern Log will be reviewed daily Monday through Friday at the standup meeting for completion. The Ed or designee will follow up with each resident and or responsible party to ensure their concerns have been resolved. Audit findings will be brought to PI x 12 months. The Pi committee will determine the need for further audits. Date of Compliance October 16th, 2014 Informal Dispute Resolution Response to Regulation Cited F 353 483.30(a) Sufficient 24-HR Nursing Staff per Care Plans We are disputing the citation of F 353 which stated the facility must provide services by sufficient numbers of each of the following types of personnel on a 24 hour basis to provide nursing care to all residents in accordance with residents care plans. Staff is defined as licensed nurses/ (RNS and or LPN/LVNS and nurse aides. During survey the 2567 cited on the evening shift HH only</p> | | |

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| | <p>open spots. The nurses and management help as well. Right now our numbers (census) are low so that helps."</p> <p>During an interview on 9/15/14 at 12:40 p.m., CNA #3 indicated she usually worked the day shift on the Hickory Hall and her assignment usually had 14-16 residents to care for. CNA #3 stated, "They are hiring people so I think we have enough. As long as there are 3 of us over here I feel like it is enough. With just two it gets to be too much. We have to do that about twice a week. Sometimes if there are just two of us they will pull people. It is hard to get all the care in with just two of us. The nurses are doing their own thing so it isn't like they can help with toileting or showers. I tell the nurses if I can't get the care done. I don't chart if I didn't have time to get things done. Over 5 residents require a lift. On average it takes 30 min's to provide care for residents requiring more than one assist. On an average we just have had 2 CNA's since August. I normally stay over almost everyday and pick up on my days off. If my replacement calls in then I have to stay over."</p> <p>During an interview on 9/15/14 at 12:50 p.m., CNA #5 from the Ivy Hall stated, "My assignment is 13 residents if we have 2 CNA's. Normally there are two</p> | | <p>had 2 aides when the facility actually had 3 aides and a nurse, on 09/09/14 stated SP hall and Ivy had only one aide when they really had one and a half on Southern Pine and a nurse, and Ivy Hall had an aide and a nurse as well, survey cited no aide on night shift for SP hall and there was aide and a nurse present, 09/10 survey states only one aide when in actuality they had 1FT aide, another worked 6.5 hours and a nurse was there as well, survey cites HH had 2.5 aides which us true but they also had 2 FT nurses on the hallway, on 09/11 survey cites evening shift SP hall had 1.5 aides but they had 2 fulltime aides and a nurse, IH had 1.5 aides when they had 2 and a nurse, HH 2 aides but again 2 nurses present to assist. On 09/12 survey cites IH one aide but they also had a nurse present to assist, HH 2 aides but 2 nurses also on floor, HH night shift one aide when they had 2 aides and a nurse. On 09/13/14 survey cited HH day shift 2 aides but there were 2 nurses also as well as a weekend manager who is a nurse that was at facility</p> | | | | |

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| | <p>aides. I worked twice last week alone. The nurses help out quite a bit. Normally all my work is done even if I am by myself. I always get the showers done. I have been here 2.5 years. Over the last 4 weeks I have worked alone maybe 5-6 times. Our staffing is just terrible right now. We had people quit. This is the worst turn over I have ever seen. Hickory is a very heavy hall. 3 were fired and 4 quit about one month ago. We do what we have to do. We have 3 new ones on the floor this week and I think they have a couple more in class right now. We have been working a lot of overtime. We are trying to pick up the best we can. There are 4 two person assist and it takes about 15-20 min's with 2 people to provide care like showers. I never do them alone I always get help."</p> <p>4. During an interview on 9/15/14 at 4:45 p.m., ADON indicated that recently within one week the facility lost 9 CNA's and they were currently hiring to replace the lost staff. She indicated the ideal staffing ratio for each hall per shift would have been as follows: Southern and Ivy Halls day shift one nurse and 2 CNA's. Hickory Hall day shift 2 nurses and 3 CNA's. Southern and Ivy Halls evening shift 1 nurse and 2 CNA's. Hickory Hall evening shift 2 nurses until 10:00 p.m. then 1 nurse and 3 CNA's.</p> | | <p>assisting, night shift southern Pines had 1.5 aides which is true but they also had a nurse, IH had 1.5 aides but a nurse was on the floor there as well, and HH had 2 aides but again a nurse was on staff on that hallway as well. On 09/14/14 day shift had 1 aide but the restorative aide assisted with care and a nurse on hall as well, HH had 2 aides but they also had 2 nurses, evening shift on IH 1.5 aides per survey but they did not include nurse on floor as well and the Assistant Director of Nursing who is a nurse, was on the floor working with the aides as well. HH had 2 aides as indicated in survey for evening shift but there was 2 nurses as well and night shift HH cited at one aide but had 1.5 and again a nurse on hall. Along with this the facility management team had been assisting on the floor during this time as well as 2 light duty aides who were passing water, making beds, and following their duty list. A summary is as follows 09/08/2014 total of 24 staff members for a census of 77 09/09/2014 total of 23 staff</p> | | | | |

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| | <p>Southern and Ivy Halls night shift 1 nurse and 1 CNA. Hickory Hall night shift 1 nurse and 2 CNA's. The ADON indicated they did work short staffed if they could not fill the open shifts.</p> <p>5. Review of the Resident Census and Conditions of Residents form, provided by the facility, dated 9/8/14, indicated the following: 73 of 77 residents required assist of one or two staff for toilet use. 71 of 77 residents required assist of one or two staff for transferring. 75 of 77 residents required assist of one or two staff for bathing. 66 of 77 residents were occasionally or frequently incontinent of bladder. 66 of 77 residents were on a urinary toileting program.</p> <p>6. Review of actual hours worked from 9/8 thru 9/14/14 indicated the following deviations from the ideal staffing: On 9/8 Hickory Hall on the evening shift was missing 1 CNA. On 9/9 Southern and Ivy Halls had 1 CNA. Hickory Hall had 2 CNA's. Southern Pine Hall on the night shift had no CNA. On 9/10 evening shift Southern Pine Hall had 1 CNA with 20 residents and Hickory Hall had 2.5 CNA's with 30 residents. On 9/11 evening shift Southern Pine Hall had 1.5 CNA's with 21 residents, Ivy Hall</p> | | <p>members for a census of 77 09/10/2014 total of 27 staff members for a census of 77 09/11/2014 total of 29 staff members for a census of 77 09/12/2014 a total of 31 staff members for a census of 77 09/13/2014 a total of 23 staff members for a census of 77 09/14/2014 a total of 24 staff members for a census of 77 This does not include the weekend manager for 09/13/and 09/14, who is an LPN nor does it include the ADON on 09/14/14. Resident # 7's medication sheet indicates he has Tylenol prn only for pain. He received a dose on 09/19/14 only which is after exit of survey. Resident has a dx of Schizophrenia and has multiple behavior issues including calling police multiple times and called the Indiana Supreme court. SSD reports his cognitive status fluctuates. Res # 80 had a care plan in place for negative adjustment and SSD reports this resident attempts to involve other residents in making negative statements or complaints related to facility and staff. Aide # 1 validated in the</p> | | |

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| F000371 SS=F | <p>had 1.5 CNA's with 26 residents and Hickory Hall had 2 CNA's with 31 residents. On 9/11 night shift Hickory Hall had 1 CNA with 31 residents. On 9/12 evening shift Ivy Hall had 1 CNA with 26 residents, Hickory Hall had 2 CNA's with 32 residents. Night shift Hickory Hall had 1 CNA with 32 residents. On 9/13 day shift Hickory Hall had 2 CNA's with 32 residents. Night Shift Southern Pine Hall had 1.5 CNA's with 21 residents. Ivy Hall had 1.5 CNA's with 26 residents and Hickory Hall had 2 CNA's with 32 residents. On 9/14 day shift Southern Pine Hall had 1 CNA with 20 residents. Hickory Hall had 2 CNA's with 32 residents. Evening shift Ivy Hall had 1.5 CNA's with 26 residents. Hickory Hall had 2 CNA's with 32 residents. Night shift Hickory Hall had 1 CNA with 32 residents.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> | | <p>survey that "the nurses and management help as well" Aide # 5 "the nurses help out quite a bit" In closing the facility did assure that they had sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plan of care. Thank You for consideration in this review.</p> | | | | |

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| | <p>Based on observation and interview, the facility failed to ensure food was prepared in a sanitary environment. This deficient practice had the possibility to effect 77 of 77 residents who are served meals prepared in the facility kitchen.</p> <p>Findings include:</p> <p>During the initial kitchen tour on 9/8/14 at 9:00 a.m., with the Director of Food Services, 9 one gallon partially used containers of milk were noted without open dates. The Director of Food services indicated the containers should have had open dates on them and the kitchen staff had known to date all open containers. One of the containers had a received date of 8/29/24. The floor had white debris noted on the floor on the grout. There was a brown dried flaky substance on the floor by the oven. A white powdery debris was noted on top of the milk refrigerator.</p> <p>During a kitchen tour on 9/11/14 at 10:44 a.m., there were dried bits of meat on the meat slicer. The Director of Food Services indicated the slicer had last been used for roast beef sandwiches served 9/10/14 for the evening meal. She indicated the slicer was not clean and washed it down at that time. The same white debris noted on the initial tour was</p> | F000371 | <ol style="list-style-type: none"> 1. Food containers have been dated correctly, floor cleaned, grout sanitized, debris removed from the top of the milk refrigerator, meat slicer cleaned, robo coupe cleaned. 2. Other residents have the potential to be affected. 3. Dietary staff in-serviced on 10/2/14 for proper dating procedure of containers, proper cleaning of meat slicer, robo coupe, and floor cleaning procedures in addition to other cleaning/sanitation procedures. The Cleaning schedule was updated to include the floor and duties assigned. 4. Cleaning tasks and sanitation checklist will be monitored 3 times a week for 12 weeks, 1 time a month for 3 months by the Dietary manager/designee and results reported to the PI. The PI committee will determine the need for further audits. 5. Systemic changes will be completed on 10/16/14 | 10/16/2014 | | | |

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| | <p>still on the floor. A paperclip was used to scrape the debris loose and was shown to the Director of Food Services. She indicated the floors were mopped daily and mechanically scrubbed on Wednesday nights. This cleaning did not appear on the cleaning schedule and was not documented. A copy of the cleaning schedule was provided.</p> <p>During a walk through tour of the kitchen on 9/12/14 at 8:07 a.m., dried food on front of robo coupe, food processor used to for altered textured diets, was noted. The food processor bowl was clean but had been reassembled wet. Water was noted in bottom of the bowl and on the inside of the lid. The Director of Food services verbalized the equipment should have been dried before being reassembled and the food processor should have cleaned after use.</p> <p>During an interview with the Director of Food Services, she indicated the kitchen floor had not been mechanically scrubbed on 8/10/14 due to staff issues.</p> <p>The cleaning schedule for September 2014 indicated the meat slicer was cleaned and the floors were swept and mopped twice daily, once in the a.m. and once in the p.m.</p> | | | |

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| F000441 SS=D | <p>3.1-21(a)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread</p> | | | |

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| | <p>of infection.</p> <p>Based on observation, record review and interview, the facility failed to ensure proper administration technique was used for providing tracheostomy care to 1 of 1 residents reviewed for tracheostomy care (Resident #39).</p> <p>Findings include:</p> <p>Resident #39's clinical record was reviewed on 9/10/14 at 1:08 p.m. The resident's diagnoses included, but were not limited to, hypertension, end stage renal disease, diabetes mellitus type 2, chronic respiratory failure, dementia with behaviors and Clostridium difficile.</p> <p>Review of the physician orders indicated Resident #39 had an order, dated 2/13/14, to change the inner cannula daily and as needed for the tracheostomy and was in isolation for Clostridium difficile.</p> <p>During an observation of tracheostomy care on 9/11/14 at 1:16 p.m., RN #7 gloved and gowned prior to bringing supplies for tracheostomy care into the resident's room and placed them on the bed. RN #7 stated she had washed her hands before coming into the room. RN #7 cleaned the area around the trach site and removed the old inner cannula while wearing gloves. RN #7 placed the used,</p> | F000441 | <p>1. Resident # 39 has had symptoms of infection. RN # 7 has been educated and had a competency check performed on tracheostomy care and hand washing by the SDC on September 29th, 2014.</p> <p>2. There are no other residents in the facility with a tracheostomy therefore no other residents currently have the potential to be affected.</p> <p>3. The SDC will in service licensed nursing staff on performing appropriate tracheostomy care including hand washing competencies on licensed staff by October 16th, 2014. In servicing will include infection control practices, hand washing as well as appropriate procedure and protocol for performing tracheostomy care and the changing of the cannula.</p> <p>4. The SDC and or designee will perform 4 competency checks monthly once licensed nurse completed rotating shifts to ensure compliance r/t tracheostomy care and hand washing. Results will be presented to PI monthly x 12 months. The PI committee will determine the need for further audits.</p> <p>5. Date of Compliance: October 16th, 2014</p> | 10/16/2014 | | | |

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| | <p>contaminated supplies on the bed next to the clean supplies. RN #7 removed sterile gloves from the tracheostomy kit and put them on over the soiled gloves. She then placed the new disposable inner cannula. RN #3 then removed the used supplies and placed them in the isolation waste container, removed her gloves and washed her hands.</p> <p>During an interview on 8/11/13 at 1:54 p.m., RN #7 indicated she had been employed at the facility for approximately one year. She indicated she had been performing trach care for approximately 5-7 years. She indicated she had forgotten to bring a trash bag into the room with her and the over the bed table was too cluttered for setting up her supplies. She also indicated the procedure was a clean procedure and the only sterile part was changing the inner cannula. RN #7 verbalized she usually used the double gloved method, placing the sterile gloves on over the soiled gloves.</p> <p>During an interview on 9/11/14 at 2:33 p.m., the DON indicated RN #7 did not follow procedure for providing trach care and changing the inner cannula. An undated policy titled "Respiratory Care Resources: Tracheostomy Care" was provided. The procedure for changing a</p> | | | |

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| | <p>disposable inner cannula was as follows:</p> <p>"...II procedure for disposable inner cannula</p> <p>...C. aseptically open package for disposable inner cannula.</p> <p>D. Aseptically don sterile gloves..."</p> <p>An undated policy for hand washing titled "Life Care Centers of America, Inc. Handwashing, Chapter 10" was also provided by the DON. The policy indicated the following:</p> <p>"...Wash Your Hands</p> <p>...3. Hands should be washed: upon reporting on and off duty.</p> <p>Whenever a task may involve the exposure to blood or body fluids.</p> <p>After touching excretions (feces, urine, or material soiled with them) or secretions (from wounds, skin infections, etc.) before touching any resident again.</p> <p>After caring for an infected resident or touching contaminated items.</p> <p>Before touching wounds, feeding equipment, changing dressings, obtaining specimen collections, providing catheter care, and other invasive procedures.</p> <p>Before serving food.</p> <p>Before and after the use of sterile gloves, gowns, and masks.</p> <p>After handling the resident's belongings.</p> <p>Before entering and leaving an isolation area or room.</p> | | | |

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| F000460 SS=D | <p>After handling any articles removed from an isolation area...."</p> <p>3.1-18(j)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation and interview, the facility failed to ensure privacy curtains were in place in each shared resident room for 3 rooms which had the potential to affect 6 residents. (Rooms #8, #9, and #27)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 9/9/14 at 7:59 a.m., room #8 was missing both privacy curtains. 2. During an observation on 9/9/14 at 3:24 p.m., room #9 was missing the privacy curtain for the bed by the door. 3. During an observation on 9/9/14 at 7:20 a.m., room #27 was missing the | F000460 | <ol style="list-style-type: none"> 1. Resident #8, #9, #27 privacy curtains were installed immediately by housekeeping staff. 2. All residents have the potential to be affected 3. Housekeeping staff in-serviced on 9/30/14 on the procedure to ensure that clean privacy curtains are in place after soiled curtains are removed. 4. 5 resident rooms will be monitored 3 times a week for 6 months and 1 time a month for 6 months by the Housekeeping supervisor/Designee to ensure privacy curtains are in place. Results will be reported to the PI committee. PI Committee will determine the need for further audits. 5. Systemic changes will be completed on 10/16/14 | 10/16/2014 | | | |

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| F000463 SS=D | <p>privacy curtain for the bed by the window.</p> <p>During an interview with the Housekeeping and Laundry Supervisor on 9/15/14 at 9:27 a.m., she indicated the housekeeping staff are supposed to put a privacy curtain up when they remove a privacy curtain to be cleaned. The undated "Space and Equipment" policy was left on the Conference room table on 9/16/14 at 12:40 p.m. The policy indicated the following: "Resident rooms must be designed and equipped for adequate nursing care, comfort and privacy of residents....Be designed or equipped to ensure full visual privacy for each resident.</p> <p>3.1-19(1)(6)</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents call lights were functional for 2 of 35 residents reviewed for functional call lights. (Resident #64/room #10 and</p> | F000463 | <p>1. Resident #64, #51 call lights were repaired immediately by maintenance. 2. All residents have the potential to be affected. Therefore, a 100% complete audit was completed on</p> | 10/16/2014 | | | |

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| | <p>#51/room #6)</p> <p>Findings include:</p> <p>1. During an observation of Resident #64's room (room #10) on 9/9/14 at 2:20 p.m., the call light would not sound after 2 separate attempts. LPN #15 was brought to the resident's room and pushed the call light 2 separate times. The call light did not sound. LPN #13 removed and re-inserted the call light from the wall. The call light did not sound. Both call lights were pushed and neither call light sounded. The Maintenance Supervisor was brought to the room and he was unable to get the call lights to sound. LPN #6 indicated Resident #64 would come out of her room and get a staff member if she needed something.</p> <p>2. During an observation of Resident #51's room (room #6) on 9/10/14 at 7:20 a.m., the call light would not sound after 2 separate attempts. LPN #6 was brought to the room and she pushed the call light 2 separate times. The call light did not sound. LPN #6 indicated Resident #51 did not use the call light, the staff anticipated the resident's needs.</p> <p>During an interview with the Maintenance Supervisor on 9/15/14 at 8:44 a.m., he indicated he checks the call</p> | | <p>9/30/14. No other call lights affected.</p> <p>3. All Staff is to be in-serviced by 10/16/14, for procedures when call light malfunctions are presented within the facility. When a call light malfunctions report immediately to the charge nurse, and complete a maintenance request form. Bells will be available for residents to signal the need for</p> <p>4. 5 rooms will be monitored 3 times a week for 6 months and 1 time a week for 6 months by the Housekeeping supervisor/Designee results to be reported to the PI committee. The PI committee will determine the need for further audits</p> <p>5. Systemic changes will be completed on 10/16/14 assistance until call light(s) are repaired. Rooms will be monitored daily by the housekeepers for the proper functioning of call lights noting any malfunction and reporting to the nurse immediately, maintenance on the request for repair form and the housekeeping supervisor.</p> | | | | |

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| F009999 | lights monthly and also prior to a resident moving into the facility. The undated, "Call Light Policy" was provided by the Director of Nursing on 9/15/14 at 10:09 a.m. The policy indicated the following: "...Purpose: To assure call system is in proper working order...10. Check all call lights daily and report any defective call lights to the charge nurse immediately. 11. Log defective call lights with the exact location in a facility maintenance log...." 3.1-19(u)(1) STATE RULES: 3.1-14 (t) EMPLOYEE PHYSICALS (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The results shall be recorded in millimeters of indurating | F009999 | 1.All new hired associates will have a physical signed by a physician or Nures Practitioner. 2. SDC in-serviced on 9/17/14 on the correct physical form to utilize. 3. Potential associates will have a physical completed prior to first day of employment. 4. All new associate personnel files will be audited monthly for 12 months to ensure that physicals are completed. Results will be reported to the PI committee. The PI committee will determine if further aduts are needed. 5. New associates will have physicals effective 10/16/14Tag 3. 1-14 (q) (7)1. All hew hired nursing associates will have specifif job skills orientation.2. SDC in-serviced on 9/17/14 on where | 10/16/2014 | | | |

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| | <p>with a date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employees starting work. The facility must ensure the following:</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure new employees had physicals prior to beginning work for 5 of 5 employee records reviewed for physical examinations (Activity Assistant #4, LPN #8, CNA #9, RN #10 and Dietary Aide #11).</p> <p>Findings include:</p> <p>Employee records were reviewed and finalized on 9/16/14 at 8:40 a.m. Five new employees were reviewed for physical examinations upon hire. The Following 5 employees did not have physical examinations in their employee records:</p> <p>a. Activity Assistant #4 - start date 9/2/14. b. Dietary Aide #11 - start date 7/8/14 c. RN #10 - start date 7/30/14 d. LPN #8 - start date 7/30/14 e. CNA #9 - start date 8/21/14</p> <p>During a 9/16/14, 9:10 a.m., interview,</p> | | <p>the job specific orientation checklists are located on the intranet.3. All new nursing department associates will have a specific orientation checklist completed during orientation on the floor.4. All new nursing department associate personnel files will be audited monthly for 12 months to ensure that job specific orientations are completed. Results will be reported to the PI committee for 12 months. The PI committee will determine if further audits are needed.5. New nursing department associates will have job specific orientations effective 10/16/14.</p> | | | | |

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| | <p>the Inservices Director indicated the corporate consultant had informed the facility pre-employment physicals were not required just TB testing was required. Therefore, the 5 new employees in question had not had physical examinations.</p> <p>3.1-14 (q)(7) EMPLOYEE ORIENTATION: (q)(7)Documentation of orientation to the facility and to the specific job skills.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure new employees had orientations to specific job skills for 5 of 5 new employees reviewed for employee orientation (Activity Assistant #4, LPN #8, CNA #9, RN #10 and Dietary Aide #11).</p> <p>Findings include:</p> <p>Employee records were reviewed and finalized on 9/16/14 at 8:40 a.m. Five new employees were reviewed for job specific orientation. The Following 5 employees did not have documentation of job specific orientation in their employee records:</p> | | | | | | |

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| NAME OF PROVIDER OR SUPPLIER WOODLANDS THE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN 47304 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | <p>a. Activity Assistant #4 - start date 9/2/14.</p> <p>b. Dietary Aide #11 - start date 7/8/14</p> <p>c. RN #10 - start date 7/30/14</p> <p>d. LPN #8 - start date 7/30/14</p> <p>e. CNA #9 - start date 8/21/14</p> <p>During a 9/16/14, 9:10 a.m. interview, the Inservice Director indicated the facility did not have documentation of job specific orientation for any of the 5 named employees nor did they have job specific documentation for any new employees hired in the past year.</p> | | | | |