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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155736 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/13/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MILL POND HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1014 MILL POND LN<br>GREENCASTLE, IN 46135 |
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| F000000            | <p>This visit was for the Investigation of Complaint #IN00162418.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint #IN00162418-Substantiated. Federal/State deficiency related to the allegation is cited at F314.</p> <p>Survey dates:<br/>January 5,6,7,8,9,12, and 13, 2015</p> <p>Facility number: 004550<br/>Provider number: 155736<br/>Aim number: 200526450</p> <p>Survey team:<br/>Laura Brashear, RN, TC<br/>Mary Weyls, RN<br/>Vicki Nearhoof, RN January 5, 6, 7, 8, 9, and 12, 2015<br/>Geoff Harris, RN January 5, 6, 7, 8, 9, and 12, 2015<br/>Jennifer Mcelwee, RN</p> <p>Census bed type:<br/>SNF: 21<br/>SNF/NF: 35<br/>Residential: 31<br/>Total: 87</p> | F000000       |   |                      |

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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| F000314<br>SS=G   | <p>Census payor type:<br/>Medicare: 21<br/>Medicaid: 17<br/>Other: 18<br/>Total: 56</p> <p>Residential sample: 7</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review competed 01/16/2015 by Brenda Marshall, RN.</p> <p>483.25(c)<br/>TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br/>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview, observation, and record review, the facility failed to evaluate alternate pressure reducing options and failed to ensure a timely repair/replacement of a broken recliner</p> | F000314   | All residents have the potential to be affected by the alleged deficient practice All nursing staff will be inserviced to ensure residents who enter the facility without pressure sores do not | 02/12/2015  |  |   |  |

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|                    | <p>for a resident whose preference was to sleep in a recliner. This deficient practice resulted in stage II pressure ulcers developing on the buttocks of a resident not identified at risk for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident A).</p> <p>Finding includes:</p> <p>During interview of Resident A on 1/12/15 at 10:35 a.m., the resident indicated her "bottom" was sore. The resident indicated she slept in her recliner because her back hurt and indicated the recliner had been broken since before Christmas. She indicated she was unable to recline the chair and her son told her he would call the company where the chair had been purchased. During the interview the resident was sitting in a wheelchair without a pressure relieving cushion. She patted the seat of the recliner and indicated her bottom was sore from sitting in the recliner all night without being able to recline.</p> <p>During interview of LPN #9, on 1/12/15 at 10:35 a.m., the nurse indicated she thought the resident's son was going to get a new chair for her. The nurse indicated the resident had a concern with her "bottom" and indicated the resident refused the waffle seat cushion that was</p> |               | <p>develop pressure sores unless the individuals condition clinically 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 All residents will be evaluated to ensure proper use of pressure reducing devices and assessment of each resident to ensure proper prevention in place DHS or designee will audit all pressure relieving devices daily to ensure proper functionality x 4 weeks then 3 residents per hall daily x 4 weeks then 3 residents monthly x 4 months. Then 3 residents monthly x 6 months Audit results will be forwarded to QA monthly x 6 months</p> |                      |

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|   | <p>offered.</p> <p>During interview of LPN #8, on 1/12/15 at 12:05 p.m., the LPN indicated "some time before Christmas" the resident's son indicated the chair's foot rest would not come up when he tried to recline the chair. The LPN indicated the son told him he was going to get the chair fixed and indicated he had not told any other staff about the broken chair.</p> <p>During interview of the wound nurse on 1/12/15 at 11:25 a.m., the nurse indicated the resident's chair was broken and she thought the resident's son was going to take care of fixing it. The wound nurse stated "I gave her a waffle cushion to sit on while in the wheelchair and in the recliner but she refused to use it. She also refused the offer of a bed."</p> <p>During observation on 1/12/15 at 11:25 a.m., the wound nurse assessed the resident's buttocks, the resident was observed with an open area on the upper, right, inner gluteal fold and another open area on the left buttock. The wound nurse indicated the areas were stage 2 pressure ulcers (Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured</p> |   |   |                      |   |

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|                    | <p>blister.)</p> <p>Prior to the observation, the resident was sitting in a wheelchair without a cushion. The resident stood to allow the observation.</p> <p>Resident A's clinical record was reviewed on 1/12/15 at 2 p.m. A diagnosis was noted of, but not limited to Diabetes Mellitus. A quarterly assessment dated, 8/20/14, indicated the resident was cognitively intact, required limited assist of one person for toileting and not at risk for developing a pressure ulcer.</p> <p>A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" was noted, dated 12/29/14, indicating a stage 1 [Stage I - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: - Skin temperature (warmth or coolness); - Tissue consistency (firm or boggy); - Sensation (pain, itching); and/or - A defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.] pressure area on the sacrum measuring 4 cm (centimeter) length by 11 cm width by 0 cm depth.</p> |               |   |                      |

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|                    | <p>A nurse's note, dated 12/30/14 at 10:00 a.m., indicated the resident was noted with a red area on the coccyx. The note indicated the wound nurse assessed the area and suggested the resident sleep in a bed instead of a recliner to relieve pressure from the coccyx area. The documentation indicated the resident refused and stated she couldn't sleep in a bed because it hurt her back. The record indicated the resident was given a waffle cushion to sit on while in recliner and/or wheelchair to relieve pressure.</p> <p>Documentation on 1/6/15 indicated a stage 1 pressure area on the resident's left buttocks measuring 2.0 cm by 2.0 cm by 0 cm and a stage 1 area on right buttocks measuring 2.0 cm by 2.0 cm by 0 depth.</p> <p>Documentation on 1/12/15 indicated a stage 2 pressure area on the right inside gluteal fold measuring 1 cm length by 0.2 cm width by 0.1 cm depth., a stage 2 pressure area on the left buttock measuring 1 cm length by 1 cm width by less than 0.1 cm depth. and a stage 1 pressure area to the right buttock measuring 1 cm length by 1 cm width by 0 depth.</p> <p>During interview of the wound nurse on 1/13/15 at 10 a.m., the wound nurse</p> |               |   |                      |

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|   | <p>indicated she had called the company where the resident purchased her recliner, and indicated the company planned to deliver a recliner for the resident on that date. The wound nurse indicated the only pressure reducing interventions offered since the stage one pressure area was identified on 12/30/14, were a waffle cushion and a bed.</p> <p>During review of a facility policy and procedure titled "WOUND STAGING AND IDENTIFICATION EDUCATIONAL INFORMATION" received on, 1/13/15 at 3 p.m., from the wound nurse, documentation indicated possible causes for non-healing wounds as "Continued pressure".</p> <p>This Federal tag relates to complaint IN00162418.</p> <p>3.1-40(a)(2)</p> |   |   |   |  |   |  |