

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155426	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804
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F000000	<p>This visit was for the Investigation of Complaint IN00123529 and Complaint IN00123562.</p> <p>Complaint IN00123529 Substantiated, federal/state deficiencies related to the allegations are cited at F279, F314 and F441.</p> <p>Complaint IN00123562 Substantiated, federal/state deficiencies related to the allegation are cited at F279 and F314.</p> <p>Survey dates: February 12 & 13, 2013</p> <p>Facility number: 000513 Provider number: 155426 AIM number: 100275360</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 177 Total: 177</p> <p>Census payor type: Medicare: 40 Medicaid: 114 Other: 23 Total: 177</p>	F000000	<p>We are requesting a desk review. We are also requesting consideration of 314 G to be reduced to a D level. Monitoring was in place prior to the development of pressure ulcers following our scheduled policy & procedure. Care plan interventions were in place prior to the development of pressure ulcers. It is not a Kindred Royal Oaks policy & procedure to use pink hearts on door frames to communicate pressure ulcers are present. Ulcers on Resident A's right lower extremity & left heel was not caused by pressure. Both were caused from Peripheral Artery Disease as documented by Dr. Puchalapalli. Both had been there for 2 weeks as per his documentation on 2-13-13. "Chronic Diabetic ulcers, non healing past 2 weeks due to Peripheral Artery Disease".</p>	

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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	<p>Sample: 3</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on 02/21/2013 by Brenda Nunan, RN.</p>			

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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observations, interview, and record review, the facility failed to update care plans with interventions specific to reducing pressure to areas with open wounds and failed to implement interventions listed in a care plan for 2 of 3 sampled residents reviewed for care plans (Resident A and B).</p> <p>Findings include:</p> <p>1. Resident A was observed on 02/12/13 at 11:05 a.m., receiving treatment to a dark purple, stage II,</p>	F000279	Resident A: Res A had a head to toe skin assessment completed 1/31/13 that identified a new stage 2 pressure ulcer on the resident's (R) ear caused from oxygen tubing, a new skin ulcer on the (R) lower extremity & (L) heel caused from Peripheral Artery Disease. Documentatin provided by Dr. Reddy S. Puchalapalli, M.D. was given to the ISDH complaint surveyor written 2/13/13 stating "Chronic Diabetic Ulcers, non healing past 2 weeks due to Peripheral Artery Disease". There were zero abnormal skin areas during the scheduled head to toe skin	03/15/2013	

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	<p>pressure ulcer on her right ear. According to a Weekly Pressure Ulcer Report, dated 02/12/13, the wound on the ear measured 0.5 cm (centimeters) x (by) 0.4 cm x < (less than) 0.1 cm (depth). A wound on the right lower extremity was observed and the weekly report indicated it measured 1.6 cm x 2.5 cm x < 0.1 cm. The wound was black in color (necrotic). A wound on the left heel was black in color and the pressure ulcer report indicated it measured 4.2 cm x 3.9 cm x 0 cm.</p> <p>During observations on the 300 hall on 02/13/13 at 11:30 a.m., hearts were observed on door frames of some resident rooms. CNA #1 indicated the heart represented the resident had pressure areas or was at risk for pressure areas. Resident A's door frame was missing a heart to show she had pressure areas.</p> <p>During an interview on 02/13/13 at 11:45 a.m., LPN #2 indicated Resident A's daughter found the pressure area on the right ear after accompanying the resident to a medical appointment on 01/31/13. LPN #2 indicated the facility completed a skin assessment on the same date and discovered additional areas on the resident's right outer</p>		<p>assessment 1/28/13 or during a skin inspection during a scheduled shower that was provided 1/29/13. Therefore, the abnormal skin condition developed between 1/29/13 and 1/31/13. The Resident's clinical record has been updated to include the diagnosis Peripheral Artery Disease. Care plan interventions in place PRIOR to 1/31/13: (provided to surveyor) 11/21/12 - turn & reposition every 2 hours 11/23/12 - Geo Mattress (pressure relieving mattress) 11/23/12 - weekly skin checks 11/29/12 - toilet/provide incontinence care every 2 hours & PRN 11/30/12 - notify nurse of red/open areas as needed 11/30/12 - monitor skin each bathing 12/17/12 - heel protectors to bilateral feet @ all times Care plan interventions specific to reducing pressure put in place 1/31/13: (provided to surveyor) 1/31/13 - Stat Guard 2 pressure relieving mattress 1/31/13 - Turn & reposition @ least every 2 hours 1/31/13 - Keep pressure off pressure ulcer (R) ear The Resident's care plan has been reviewed by the IDT along with the C.N.A. assignment sheet. The care plan interventions were all in place and did not require an update. The care plan interventions did not include the use of a paper heart icon on the resident's door frame for communication. The</p>		

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	<p>ankle and left heel She indicated weekly skin checks were completed and the CNA's observed skin during baths and incontinence care. The record indicated the facility did not identify the pressure ulcers prior to 01/31/13. The LPN indicated interventions for residents with pressure risks or pressure wounds included turning and repositioning every 2 hours. She indicated the facility did not document repositioning Resident A and did not have a system for ensuring a positioning schedule.</p> <p>During an interview on 02/13/13 at 11:48 a.m., LPN #2 indicated a heart on the door frame indicated the resident was at risk for or had a pressure ulcer. She indicated she did not know why Resident A's door frame lacked a heart signifying pressure risk/presence.</p> <p>Resident A's clinical record was reviewed on 02/12/13 at 10:10 a.m. The record indicated the resident had diagnoses which included, but were not limited to, diabetes, cerebrovascular accident with right hemiplegia, gastrostomy, aphasia, dysphagia, urinary tract infection, hypertension, and general pain.</p> <p>Resident A's most recent admission</p>		<p>communication on the C.N.A. assignment sheet indicated the resident is to wear heel protectors @ all times, turn/reposition every 2 hours, toilet/provide incontinence care every 2 hours & PRN, asst x 2 with bedpan. The I.D.T. has determined the use of a paper heart on the resident's door frame is not a necessary icon for communication. A paper heart was not & is not in our policies & procedures for communication to the C.N.A.s. Communication will continue to be via the care plan & the C.N.A. assignment sheets for consistency. The use of the paper heart has been discontinued in our nursing center. Oxygen is no longer necessary, therefore the oxygen tubing has been removed. C.N.A.s have continued to complete a head to toe skin inspection 2 times each week on Resident A's regularly scheduled shower days. Licensed Staff have continued to complete a weekly head to toe skin assessment on Resident A's regularly scheduled days. C.N.A.s continue to turn &/or reposition Resident A at least every two hours. Licensed nurses continue to observe repositioning during their tour of duty to ensure Resident A is being turned & repositioned at least every two hours. The ISDH complaint surveyor did not identify a lack of turning &/or repositioning the resident as care</p>		

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	<p>Minimum Data Set (MDS) assessment, dated 11/30/12, indicated the resident was severely cognitively impaired and was at risk for pressure ulcers.</p> <p>The Resident Weekly Skin Check Sheets, dated 01/07/13, 01/14/13, 01/21/13, and 01/28/13, indicated no open areas. No pressure areas were identified prior to 01/31/13.</p> <p>Shower Body Assessment Tools, used by the CNA's for any open, reddened, bruised areas or tears/cuts, dated 01/01/13, 01/04/13, 01/08/13, 01/11/13, 01/15/13, 01/18/13, 01/22/13, 01/25/13, 01/29/13 indicated, "ok" (no areas).</p> <p>Resident A's Weekly Pressure Ulcer Report, dated 01/31/13, indicated the wound on the right ear measured 0.8 cm (centimeters) x (by) 0.6 cm x < (less than) 0.1 cm (depth). The right lower extremity ulcer measured 4.2 cm x 2.6 cm x 0 cm. A wound on the left heel measured 4.2 cm x 3.9 cm x 0 cm.</p> <p>Resident A's Weekly Pressure Ulcer Report, dated 02/12/13, indicated the wound on the right ear was dark purple in color and measured 0.5 cm x 0.4 cm x < 0.1 cm (depth). The</p>		<p>planned @ least every 2 hours. The Unit Manager continues to use the C.N.A. assignment sheet to communicate Resident A's care plan interentions. Resident B: Review of Resident B's Treatment Administration Record (TAR) for the months of December 2012 - January 2013 - February 2013 has been completed by the Director of Nursing. There were initials on every date indicating treatments were provided to Resident B's right lower buttock every day. Other residents having the potential to be affected by the stated deficiency have been identified as any resident with an open wound. The I.D.T. will 1) review care plans of each resident with an open wound to ensure interventions are specific to reducing pressure to areas with open wounds 2) validate interventions are implemented as listed on the care plan 3) validate treatments are being provided. If a resident admits with or acquires a new open wound, the I.D.T. will review the resident's care plan during the weekly skin/nutrition meeting to ensure interventions are specific to reducing pressure to areas with open wounds. At the conclusion of the meeting @ least 2 members of the I.D.T. will validate that the interventions have been implemented as listed on the care plan including looking @ the TARs to ensure treatments</p>		

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	<p>record indicated the right lower extremity ulcer measured 1.6 cm x 2.5 cm x < 0.1 cm and was black in color (necrotic). The record indicated the wound on the left heel was black in color and increased in size to 4.2 cm x 5.3 cm x <0.1 cm.</p> <p>A physician's order, dated 12/15/12, indicated, "...HEEL PROTECTORS ON AT ALL TIMES EXCEPT FOR BATHING...." The care plan for altered skin integrity, dated 11/30/12 and 01/31/13, lacked the intervention for heel protectors.</p> <p>A care plan for altered skin integrity, dated 01/31/13, developed after pressure ulcers were identified, lacked interventions for a heart on the door frame to alert staff of the resident's pressure risk, lacked interventions specific to reducing pressure to the right lower extremity and left heel and lacked a system/schedule for ensuring repositioning every 2 hours.</p> <p>2. During observations on 02/13/13 at 11:20 a.m., LPN #1 was observed providing wound care to a stage II pressure ulcer on Resident B's right lower buttocks.</p> <p>Review of Resident B's clinical</p>		<p>are being provided. Any identified concerns will be corrected immediately with reeducation and/or progressive disciplinary action as indicated. A report will be submitted to the Quality Assurance Committee monthly by the Director of Nursing. The report will identify the findings of the I.D.T. during the weekly skin/nutrition meeting. The systemic changes will be completed by March 15, 2013. Addendum March 15, 2013: In services were provided to the licensed nurses & licensed Unit Managers addressing:</p> <ol style="list-style-type: none"> 1) care plan interventions to prevent pressure ulcers for resident's high risk per Braden's assessment 2) care plan interentions must be specific to reducing pressure to areas with ulcers 3) tracking residents @ risk for pressure ulcers using Braden's Score List 4) I.D.T. form to ensure resident high risk have care plan interventions that prevent pressure ulcers - ensure interventions are in place - ensure C.N.A. assignment sheets are updated 5) I.D.T. form to ensure residents with ulcers have care plan interventions that promote healing - are specific to reducing pressure to areas with ulcers - ensure interventions are in place - ensure C.N.A. assignment sheets are updated 6) ensure a list of residents with pressure ulcers are kept updated @ the nurse's station for shift to 				

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	<p>record, on 02/12/13 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited to, diabetes, anxiety, schizophrenia, mood disorder, schizoaffective disorder, chronic pain syndrome, and dementia with behaviors.</p> <p>Resident B's most recent MDS assessment, dated 12/10/12, indicated the resident was moderately cognitively impaired and needed extensive to total care with Activities of Daily Living (ADL's). The MDS assessment indicated the resident was at risk for pressure ulcers.</p> <p>Resident B's Weekly Pressure Ulcer Report indicated the right lower buttock pressure ulcer was found on 11/06/12 and measured 0.6 cm (centimeters) x (by)0.6 cm x < (less than) 0.1 cm.</p> <p>A Weekly Pressure Ulcer Report, dated 02/13/13, indicated the pressure ulcer increased in size and measured 1.6 cm x 1.1 cm x < 0.1 cm.</p> <p>A physician order dated 11/16/12, indicated, "...Clean wound R (right) lower buttocks with NS (Normal Saline), Apply silvadene & cover c (with) Mepilex dly (daily) until healed,</p>		<p>shift communication 7) a list of resident with weight lost is reveiwed by the I.D.T. weekly during the skin/nutrition meeting.The referenced lists & forms will be kept in the Skin/Nutrition meeting binder.The DNS will present a report to the Performance Improvement Committee montly until in compliance for at least 6 consecutive months.</p>		

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	<p>then DC (discontinue)..."</p> <p>Resident B's care plan for ulcer pain dated 11/06/12, indicated interventions which included, but were not limited to, documentation of treatment on the Treatment Administration Record (TAR) and treatment as ordered by the physician. The TAR dated November 2012, indicated treatments were not completed on 11/10/12, 11/12/12, 11/19/12, 11/28/12, and 11/30/12.</p> <p>This federal deficiency is related to Complaint IN00123529 and Complaint IN00123562.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observations, interview, and record review, the facility failed to monitor skin and ensure interventions to prevent a stage II pressure sore and failed to ensure updated care plans and interventions to promote healing of pressure wounds for 2 of 3 sampled residents reviewed for pressure ulcers (Resident A and Resident B).</p> <p>Findings include:</p> <p>1. Resident A was observed on 02/12/13 at 11:05 a.m., receiving treatment to a dark purple, stage II, pressure ulcer on her right ear. According to a Weekly Pressure Ulcer Report, dated 02/12/13, the wound on the ear measured 0.5 cm (centimeters) x (by) 0.4 cm x < (less than) 0.1 cm (depth).</p>	F000314	Resident A:Resident A had a head to toe skin assesment completed 1/31/13 that identified a new stage 2 pressure ulcer on the resident's (R) ear caused from oxygen tubing, and a new skin ulcer on the resident's (R) lower extremity & (L) heel caused from Peripheral Artery Disease. Documentation dated 2/13/13 provided by Dr. Reddy S. Puchalapalli, M.D. was given to the ISDH complaint surveyor stating "Chronic Diabetic Ulcers, non healing past 2 weeks due to Peripheral Artery Disease". There were zero abnormal skin areas during a head to toe skin assessment completed by a licensed nurse 1/28/13 or during a skin inspection during a shower that was provided 1/29/13. Therefore the 3 abnormal skin conditions developed between 1/29/13 and 1/31/13. The skin areas would have been identified without the family members notification on the next scheduled	03/15/2013			

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	<p>During observations on the 300 hall on 02/13/13 at 11:30 a.m., hearts were observed on door frames of some resident rooms. CNA #1 indicated the heart represented the resident had pressure areas or was at risk for pressure areas. Resident A's door frame was missing a heart to show she had pressure areas.</p> <p>Resident A's clinical record was reviewed on 02/12/13 at 10:10 a.m. The record indicated the resident had diagnoses which included, but were not limited to, diabetes, cerebrovascular accident with right hemiplegia, gastrostomy, aphasia, dysphagia, urinary tract infection, hypertension, and general pain.</p> <p>Resident A's most recent admission Minimum Data Set (MDS) assessment, dated 11/30/12, indicated the resident was severely cognitively impaired and was at risk for pressure ulcers.</p> <p>The Resident Weekly Skin Check Sheets, dated 01/07/13, 01/14/13, 01/21/13, and 01/28/13, indicated no open areas.</p> <p>Shower Body Assessment Tools, used by the CNA's for any open, reddened, bruised areas or</p>		<p>shower day 2/1/13. The Resident receives hygiene care between her every Tuesday & Friday scheduled shower which includes washing her face, hands, axilla & perineum. Her heel protectors were on at all times. The Resident's clinical record has been updated to include the diagnosis Peripheral Artery Disease. (provided to the surveyor) Care plan interventions in place prior to 1/31/13: (provided to the surveyor) 11/21/12 - turn & reposition every 2 hours 11/23/12 - Geo Mattress (pressure relieving mattress per manufacturers info.) 11/23/12 - weekly skin checks 11/29/12 - toilet/provide incontinence care every 2 hours & PRN 11/30/12 - notify nurse of red/open areas as needed 11/30/12 - monitor skin each bathing (showers Tues & Fri) 12/17/12 - heel protectors to bilateral feet @ all times Updated interventions specific to reducing pressure put in place 1/31/13: (provided to the surveyor) Resident A had 1 pressure ulcer on her (R) ear 1/31/13 - Stat Guard 2 pressure relieving mattress 1/31/13 - Turn & reposition @ least every 2 hours 1/31/13 - Keep pressure off pressure ulcer (R) ear The Resident's care plan has been reviewed by the IDT along with the C.N.A. assignment sheet. The care plan interventions were all in place and did not require an</p>				

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	<p>tears/cuts, dated 01/01/13, 01/04/13, 01/08/13, 01/11/13, 01/15/13, 01/18/13, 01/22/13, 01/25/13, 01/29/13 indicated, "ok" (no areas).</p> <p>Resident A's Weekly Pressure Ulcer Report, dated 01/31/13, indicated the wound on the right ear measured 0.8 cm (centimeters) x (by) 0.6 cm x < (less than) 0.1 cm (depth).</p> <p>Resident A's Weekly Pressure Ulcer Report, dated 02/12/13, indicated the wound on the right ear was dark purple in color and measured 0.5 cm x 0.4 cm x < 0.1 cm (depth).</p> <p>A care plan for altered skin integrity, dated 01/31/13, developed after pressure ulcers were identified, lacked interventions for a heart on the door frame to alert staff of the resident's pressure risk and lacked interventions specific to reducing pressure to the right lower extremity and left heel.</p> <p>During an interview on 02/13/13 at 11:45 a.m., LPN #2 indicated Resident A's daughter found the pressure area on the right ear after accompanying the resident to a medical appointment on 01/31/13. The record indicated the facility did not identify the pressure ulcers prior</p>		<p>update. The care plan interventions did not include the use of a paper heart icon on the Resident's door frame for communication. The communication on the C.N.A. assignment sheet indicated the residednt is to wear heel protectors @ all times, turn/reposition every 2 hours, toilet/provide incontinent care every 2 hours & PRN, asst x 2 with bedpan. (provided to the surveyor)The I.D.T. has determined the use of a paper heart on the resident's door frame is not a necessary icon for communication. A paper heart was not and is not a Kindred Royal Oaks policy & procedure for communication. (The surveyor did not ask the Director of Nursing for the policy & procedure). Communication will continue to be via the C.N.A. assignment sheets for consistency & during Nurse to C.N.A. change of shift report which includes information identifying residents with pressure ulcers. The use of the paper heart has been discontinued in our nursing center. Resident A no longer requires the use of oxygen, therefore the oxygen tubing has been removed. If the oxygen had been continued, the oxygen tubing (Hudson RCI) would have been changed to a soft tubing (Comfort Soft Plus) that is less likely to cause pressure. We have discontinued</p>	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TERRE HAUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 3500 MAPLE AVE TERRE HAUTE, IN 47804		
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	<p>to 01/31/13. The LPN indicated Resident A should have been turned and repositioned every 2 hours. She indicated the facility did not have a system to ensure/document the resident was repositioned every 2 hours.</p> <p>During an interview on 02/13/13 at 11:48 a.m., LPN #2 indicated a heart on the door frame indicated the resident was at risk for or had a pressure ulcer. She indicated she did not know why Resident A's door frame lacked a heart signifying pressure risk/presence.</p> <p>During an interview on 02/13/13 at 4 p.m., the Director of Nursing (DON) indicated a stage II pressure ulcer was identified on Resident A's right ear on 1/31/13 and indicated it was caused by the resident's oxygen tubing.</p> <p>2. During observations on 02/13/13 at 11:20 a.m., LPN #1 was observed providing wound care to a stage II pressure ulcer on Resident B's right lower buttocks.</p> <p>Review of Resident B's clinical record, on 02/12/13 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited</p>		<p>the use of the standard oxygen tubing throughout our nursing center and have replaced it with the soft tubing to prevent further pressure ulcer development from oxygen use.C.N.A.s have continued to complete a head to toe skin inspection 2 times each week on Resident A's regularly scheduled shower days.Licensed nurses have continued to complete a weekly head to toe skin assessment on Resident A's regularly scheduled days.C.N.A.s continue to turn & reposition Resident A at least every two hours.Licensed nurses continue to observe repositioning during their tour of duty to ensure Resident A is being turned & repositioned at least every two hours.The ISDH surveyor did not identify a lack of turning & repositioning Resident A as care planned at least every 2 hours.The Unit Manager continues to use the C.N.A. assignment sheet to communicate Resident A's care plan interventions.The licensed nurses followed our policy & procedure of monitoring & documenting daily on the Daily Monitoring/Pressure Ulcers form. The form was initiated 1/31/13 and did not have any omissions of assessment or documentation of assessment through the date the pressure ulcer healed on Resident A's (R) ear. The form was provided to the ISDH surveyor.RESIDENT B:Review of</p>		

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	<p>to, diabetes, anxiety, schizophrenia, mood disorder, schizoaffective disorder, chronic pain syndrome, and dementia with behaviors.</p> <p>Resident B's most recent MDS assessment, dated 12/10/12, indicated the resident was at risk for pressure ulcers.</p> <p>Resident B's Weekly Pressure Ulcer Report indicated the right lower buttock pressure ulcer was found on 11/06/12 and measured 0.6 cm x 0.6 cm x < 0.1 cm.</p> <p>A Weekly Pressure Ulcer Report, dated 02/13/13, indicated, the pressure ulcer increased in size and measured 1.6 cm x 1.1 cm x < 0.1 cm.</p> <p>Resident B's care plan for ulcer pain, dated 11/06/12, indicated interventions which included, but were not limited to, documentation of treatment on the Treatment Administration Record (TAR) and treatment as ordered by the physician.</p> <p>A physician order dated 11/16/12, indicated, "...Clean wound R (right) lower buttocks with NS (Normal Saline), Apply silvadene & cover c</p>		<p>Resident B's Treatment Administration Record (TAR) for the months of December 2012 - January 2013 - February 2013 has been completed by the Director of Nursing. There were initials indicating treatments were provided to Resident's B's (R) lower buttock each day. There were zero omissions. Our licensed nurses are initialing the TAR each time a treatment is administered to Resident B's (R) lower buttock. Other residents having the potential to be affected by the stated deficiencies have been identified as any resident residing in the nursing center. It is our policy to complete scheduled head to toe skin inspections during showers at least 2 times each week, to complete scheduled head to toe skin assessments at least weekly, and assessments of pressure ulcers daily until healed, develop care plans that prevent development of abnormal skin areas and care plans that promote healing of abnormal skin areas. 1) During the weekly skin nutrition meeting the I.D.T. will monitor and compare shower skin inspection sheets against weekly skin assessment forms and finally against the previous pressure ulcer and non-pressure ulcer weekly logs to ensure detection of skin changes are identified per our policy and procedure.2) During the weekly skin nutrition meeting the I.D.T. will review care</p>		

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	<p>(with) Mepilex dly (daily) until healed, then DC (discontinue)...."</p> <p>The TAR dated November 2012, indicated the physician ordered treatments were not completed on 11/10/12, 11/12/12, 11/19/12, 11/28/12, and 11/30/12. .</p> <p>This federal deficiency is related to Complaint IN00123529 and Complaint IN00123562.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>		<p>plans of residents that are considered high risk to develop pressure ulcers based on Braden scores, residents with weight loss and residents with abnormal skin areas. The review of residents with open wounds will include ensuring interventions are specific to reducing pressure to areas with open wounds.3) During the weekly skin nutrition meeting the I.D.T. will ensure care plan interventions have been added to the C.N.A. assignment sheets.4) At the conclusion of the skin nutrition meeting, members of the I.D.T. will go to the nursing units to a) validate that interventions are in place as care planned b) ensure licensed nurses and C.N.A.s are able to identify residents on their assignment that have abnormal skin areas/pressure ulcers. This information is communicated/shared during change of shift report.5) Resident A and Resident B both reside on the 300 hall. 300 hall is a 32 bed unit. A head to toe skin inspection was completed 2/14/13 for each resident residing on the 300 hall to ensure skin inspections, skin assessmens and care plan interventions were effective. There were zero new abnormal skin areas identified.If a resident admits with or acquires a new open wound, the I.D.T. will review the resident's care plan during the weekly skin/nutrition meeting to ensure interventions</p>		

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			are specific to reducing pressure to areas with open wounds. At the conclusion of the meeting at least 2 members of the I.D.T. will validate that the interventions have been implemented as listed on the care plan including looking at the TARs to ensure treatments are being provided. Negative findings will be corrected immediately with reeducation and/or progressive disciplinary action as indicated. Inservice education will be provided to Licensed Nurses to ensure they understand the expectation that the Treatment Administration Record must be initialed after each treatment is provided. A report will be submitted to the Quality Assurance Committee monthly by the Director of Nursing. The report will identify the findings of the I.D.T. during the weekly skin/nutrition meeting and unit rounds by I.D.T. members. The systemic changes will be completed by March 15, 2013.		

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F000441 SS=D	<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 of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	The nursing staff are washing their hands for at least 20	03/15/2013			

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	<p>ensure infection control in regard to effective hand washing for 1 of 3 residents reviewed for infection control [Resident B].</p> <p>Findings include:</p> <p>Resident B was observed during a dressing change to her right, lower buttock's on 02/13/13 at 11:20 a.m. LPN #1 washed her hands before the dressing change for 12 seconds and donned gloves. She removed the soiled dressing, then removed her gloves, and washed her hands for 7 seconds. LPN #1 donned another pair of gloves and cleaned the pressure sore with normal saline soaked gauzes. She removed the gloves, washed her hands for 16 seconds and donned another pair of gloves before drying the wound. LPN #1 removed the gloves, washed her hands for 15 seconds, and donned another pair of gloves and applied zinc oxide and a duoderm [hydrocolloid dressing] to the open area on Resident B's buttocks. LPN #1 removed her gloves and washed her hands for 18 seconds.</p> <p>Interview with the Staff Development Coordinator on 02/13/13 at 3:02 p.m., indicated the LPN should have washed her hands for 20 seconds</p>		<p>seconds to avoid transfer of microorganisms to other residents or environments. Other residents having the potential to be affected by the deficiency have been identified as any resident residing in the nursing center. The Infection Control Nurse is reeducating the current nursing staff to ensure hand washing is performed by rubbing hands together with vigorous friction for at least 20 seconds. (The amount of time it takes to sing "Happy Birthday" through twice.) The SDC is providing the same education during each new orientation group. The Infection Control Nurse or her designee will perform random observations of staff members while washing their hands to ensure the reeducation was effective. The random observations will be documented on a collection tool to be presented to the monthly Quality Assurance Committee. The random observations will be completed throughout the nursing center across all shifts. There will be a minimum of 25 observations each month. A report will be submitted to the Quality Assurance Committee monthly by the Infection Control Nurse. The report will be submitted monthly for at least 6 consecutive months until the Committee determines there is no longer a deficiency in hand washing. The systemic changes will be completed by March 15, 2013.</p>		

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	<p>according to the facility's policy.</p> <p>Review of the facility's policy entitled, "Hand Hygiene/Handwashing", dated 08/03/11, indicated, "Handwashing is the single most important procedure for preventing the spread of infection...Hand hygiene is to be performed: ...Intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments; ...Procedure...Rub hands together with vigorous friction for 20 seconds (The amount of time is [sic] takes to sing "Happy Birthday" through twice) or as designated by state regulations, covering all surfaces of the hands, exposed arms, fingertips, and between the fingers...."</p> <p>This federal finding is related to Complaint IN00123529 and Complaint IN00123562.</p> <p>3.1-18(l)</p>				