

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit resulted in an extended survey-Immediate Jeopardy.</p> <p>Survey Dates: July 9, 10, 11, 12, and 13, 2012 Extended Dates: July 14, 15, 16, and 17, 2012</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Heather Lay, RN - TC Janet Stanton, RN Melanie Strycker, RN</p> <p>Census Bed Type: SNF: 30 SNF/NF: 98 Total: 128</p> <p>Census Payor Type: Medicare: 19 Medicaid: 87 Other: 22 Total: 128</p> <p>Sample: 24 Supplemental Sample: 6</p>	F0000		

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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 23, 2012 by Bev Faulkner, RN</p>			

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F0157 SS=D	<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 update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the resident's physician regarding a change in the size of a pressure area in a timely manner. This deficient practice affected 1 of 8</p>	F0157	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth	08/08/2012			

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	<p>residents reviewed with pressure areas in a sample of 24 residents reviewed. [Resident #94]</p> <p>Findings include:</p> <p>On 7/10/12 at 10:30 A.M., Resident #94's record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, seizure disorder, history of vancomycin resistant enterococcus [in the urine], and an unstageable pressure wound [opened as a stage II on 3/8/12 and documented as an unstageable on 5/1/12].</p> <p>The skin assessments on the "Skin - Pressure Ulcer Evaluation" for the dates of 4/2/12 at 12:25 P.M. and 4/9/12 at 5:31 P.M., showed measurements in centimeters of 1.0 x 1.2 on 4/2/12 and 1.2 x 1.5 on 4/9/12.</p> <p>A "Skin - Pressure Ulcer Evaluation," dated 4/16/12 at 11:20 A.M., included, but was not limited to, "Length and width in centimeters: 2.0 x 2.5... Skin and Ulcer Treatments [marked]: Pressure reducing device for chair, pressure reducing device for bed, turning and repositioning, nutrition or hydration intervention to manage skin problems, and pressure ulcer care... Plan of Care [marked]: Continue current plan of care..."</p>		<p>in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 8-8-12.</p> <p>F 157 Notification of Change</p> <ol style="list-style-type: none"> The MD is aware of size resident's current pressure area. Residents with current open areas will be audited to determine that the physician has been notified of any change in size or condition of the area. MD(s) will be immediately notified if needed. The systemic changes will include: <ul style="list-style-type: none"> Pressure areas will be measured weekly and will be reviewed at the weekly risk meeting by the interdisciplinary team. This will include a review of change in size and notification of the physician. The nurses were provided education on 8-3-12 on the requirement of notifying the physician of any change in condition, treatment change and medication change of the resident. New orders will be at the clinical stand up meeting (Monday-Friday) for changes in 				

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	<p>No documentation of physician notification regarding the increase in size of pressure wound was located in Resident #94's clinical record regarding the increase in size of area from 4/9/12 to 4/16/12. Notification was made 8 days later [on 4/24/12] with a physician's order written for wound team to evaluate the resident.</p> <p>On 7/12/12 at 9:00 A.M., the facility Clinical Specialist #27 indicated she did not have any further documentation regarding physician notification.</p> <p>3.1-5(a)(3)</p>		<p>condition, treatment changes, and medication changes. Notification of physician is checked for compliance at the meeting.</p> <p>4. The Director of Nursing/designee will audit 5 charts daily (Monday-Friday) for one month, and then 5 charts weekly for 30 days and then monthly for an additional 8 months to equal 12 months.</p> <p>The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. The frequency and duration of reviews will be determined by the Committee.</p>		

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to report an allegation of</p>	F0225	F225 Investigate/Report Allegations/Individual 1. The Administrator is aware of the	08/08/2012			

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	<p>alleged abuse immediately to the facility Administrator. The deficient practice impacted 2 of 4 residents reviewed for alleged abuse violations from a sample of 24 residents reviewed. [Residents #51 and 128].</p> <p>Findings include:</p> <p>1. On 7/11/12 at 9:00 A.M., the facility Administrator provided the investigation of an allegation of verbal abuse that involved Resident #51.</p> <p>The investigation included, but was not limited to:</p> <p>"Incident Report Form: Incident Date: 1/13/12 at 8:30 A.M./9:00 A.M.... Residents Involved: [Resident #51]... Staff Involved: [CNA] #16 and CNA #17... Brief Description of Incident: On 1/18/12, we were made aware of an incident that occurred on 1/13/12. A CNA reportedly made the comment "Shut up and do what I say... I'm tired of your crap," to the resident [Resident #51]... Immediate Action Taken: Associates were suspended pending the outcome of the investigation. Family and physician were notified... Preventive Measures Taken: A head to toe assessment was completed..."</p>		<p>incidents for Residents #51 and #128. 2. During the survey, staff were provided education on the timeliness of reporting to the Administrator any abuse allegations directed toward a resident. 3. The systemic change includes:</p> <ul style="list-style-type: none"> · Staff were in-serviced on the Abuse policy that includes the Elder Justice Act and Reporting of a Crime against an elder. · A review of allegations of abuse and the grievance log will be reviewed at the daily stand up meeting. · Staff were educated on the requirement to notify the Administrator <u>immediately</u> of any suspected abuse. · The Abuse policy (including the Elder Justice Act) will be included in new employee orientation and will be reviewed semi-annually for all current employees. <p>The grievance log is compiled by the Social Services Department whenever a concern form is completed by any staff member of the facility. The concern forms are located at each nurses' station and are turned in to Social Services. Social Services forwards the concern form to the Administrator/DON for follow up and resolution as needed and then adds the concern and outcome to the Grievance Log. Nurses aides, as well as any other staff member, can</p>		

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	<p>A written statement from CNA #12, dated 1/18/12, included, but was not limited to, "[on 1/13/12] I was taking residents to the dining room for breakfast when I witnessed [Resident #51] wandering away from her table... I heard CNA #16 make a statement, 'I'm tired of you go back to your table so you can eat breakfast.' [Resident #51] turned around and went back to her table... CNA #17 was pushing other residents into the dining room and [Resident #51] asked CNA #17 to come to her... CNA #17 walked by [Resident #51] and said, "Shut up [Resident #51]... Other people in the dining room were CNA #18 and nursing students..."</p> <p>CNA #12 failed to immediately report the alleged verbal abuse that occurred on 1/13/12. She reported the alleged abuse 5 days later on 1/18/12.</p> <p>A written statement from CNA #16, dated 1/20/12, included, but was not limited to, "I was assisting residents [on 1/13/12] to the dining room for breakfast... I saw [Resident #51] was wheeling away from the dining room and I redirected her back to her table... After breakfast [Resident #51] followed me to the nurse's station as usual... On the way to the dining room, I said, '[Resident #51], we're tired of your dilly dallying,' in a joking manner... [Resident #51] replied,</p>		<p>complete the concern form as explained above and all staff will notify the Administrator/DON immediately of any allegation of abuse. The Administrator will review abuse investigations with each incident ongoing. 4. a. The DON/Designee will review any completed abuse investigations and the timeliness of reporting the incident to the Administrator reported during the week for 1 month; then every month for 3 months then monthly for 8 months to total 12 months of review of investigations. b. The DON and Staff Development Coordinator/Designee will present the results to the monthly QA meeting for review and recommendations by the Committee. c. The Committee will determine the frequency and duration of the reviews.</p>		

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	<p>'Your [sic] dilly dallying around... you can't talk to me like that...' I did not tell [Resident #51] to shut up... I would never talk to a resident in that manner...."</p> <p>A written statement from CNA #17, dated 1/20/12, included, but was not limited to, "I was working on 1/13/12... I was assisting residents to the dining room as normal... I agreed to stay on the floor to pass trays and feed the residents... I do not recall having an interaction with [Resident #51] that morning... I do not recall her waving and calling me to her... I did not tell [Resident #51] to shut up... [Resident #51] and I have a good relationship... I would not tell anyone to shut up...."</p> <p>A written statement from CNA #18, dated 1/20/12, included, but was not limited to, "I was working on 1/13/12... I assisted residents to the dining room for breakfast and remained in dining room... I did not hear anyone be inappropriate with a resident... I am not aware of anything that occurred, it was a good day...."</p> <p>A list of interviews with residents who resided on the same unit as Resident #51, dated 1/23/12, did not include any allegations of verbal abuse.</p> <p>Resident #51's interview, dated 1/23/12,</p>						

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	<p>no time, included, but was not limited to, "I like everyone. This is nice..."</p> <p>A document titled, "Just in Time Coaching," dated 1/23/12, no time, included, but was not limited to, "[CNA #16 and CNA #17].... Coaching Opportunity: Approach and perception, customer service... Corrective Action: Discussed and coached employee on customer service approach and perception of others...."</p> <p>On 7/12/12 at 3:15 P.M., Resident #51's record was reviewed. Diagnoses included, but were not limited to, weakness, fall history, diabetes mellitus type II, and depressive disorder.</p> <p>A quarterly "Minimum Data Set' assessment, dated 6/30/12, included, but was not limited to, "Brief Interview Mental Status [BIMS]: 3 [severe cognitive impairment]...."</p> <p>On 7/12/12 at 5:30 P.M., in an interview, CNA #12 indicated she did not report the allegation of verbal abuse that involved Resident #51, CNA #16 and CNA #17 related to being scared to report. She indicated she reported 5 days later because she felt she needed to report the verbal abuse. CNA #12 indicated she was inserviced on the facility abuse policy and</p>						

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	<p>procedures upon hire and re-educated on reporting any allegation of abuse after the incident of not reporting.</p> <p>2. On 7/10/12 at 2:20 P.M., the facility Clinical Specialist [Registered Nurse] #8 provided a "Incident Report Form" regarding Resident #128. At that time, in an interview, the Clinical Specialist #8 indicated the facility just reported to ISDH, on 7/9/12, an incident that involved Resident #128 who had complained in a care plan meeting that nursing staff were not speaking appropriately to her. She indicated the facility had started the investigation.</p> <p>The facility investigation included, but was not limited to:</p> <p>The "Incident Report Form" included, but was not limited to, "Incident Date: Week of July 3, 2012, night shift... Resident: [Resident #128]... Staff Involved: [Licensed Practical Nurse #19]... Brief Description of Incident: During Care Plan meeting with resident, husband, and daughter... the resident had several concerns... Daughter stated that [Resident #128] had related the way a nurse talked to her and treated her a few nights ago... Neither were able to pinpoint exact date but thought it was last week... Immediate Action Taken: Following a description of</p>						

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	<p>the nurse who could have worked on that hall... [LPN #19] was suspended pending investigation... Preventive Measures Taken: All other residents on the same hall will be interviewed to determine inappropriate care/treatment was given..."</p> <p>A written statement from Social Service #9, dated 7/9/12, included, but was not limited to, "Care plan meeting today to discuss [Resident #128's] progress and current needs... [Resident #128] voiced concern that she was having some difficulty swallowing pills and food... [Daughter] voiced a concern that [Resident #128] had related to the way a nurse talked to her and treated her a few nights ago... The situation is that the nurse came into her room in the middle of the night and put a pill into her mouth... [Resident #128] voiced that she could not swallow the pill... The nurse [LPN #19] got in her face and told her to take the stupid pill... Writer [Social Service #9] has reviewed this information with the DoN [Director of Nursing] and investigation has been started..."</p> <p>A written statement, dated 7/13/12, from Registered Nurse [RN] #21, included, but was not limited to, "Daughter [of Resident #128] came to nurse's station at approximately 3:15 P.M. [on 7/8/12] and stated she was very upset over some</p>						

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	<p>information that patient had given her... The nursing supervisor and on call manager went to the patient's room and spoke with the family... I was informed by [nursing supervisor] that family stated that someone shoved a pill down her throat during the night..."</p> <p>No documentation was located regarding the notification of the facility Administrator.</p> <p>A written statement, no date, from Unit Manager #20, included, but was not limited to, "On Sunday, 7/8/12 at approximately 9:00 P.M., I received a call from [LPN #19] stating that [Resident #128's] daughter was at the nurse's station with complaints of a nurse giving her mother a pill in the middle of the night that she had trouble swallowing causing her to have a sore throat..."</p> <p>On 7/12/12 at 2:45 P.M., Resident #128's record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, acute respiratory failure, and weakness.</p> <p>An admission "Minimum Data Set" assessment, dated 6/29/12, included, but was not limited to, "Brief Interview Mental Status [BIMS]: 15 [cognitively intact]..."</p>				

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	<p>A "Progress Notes" dated 7/8/12 at 3:15 P.M., included, but was not limited to, "[Resident #128's] daughter at nurses's station very upset about what she just heard from [Resident #128]... She stated that what resident told her was very disturbing... [Nursing Supervisor] informed her that she will come to the room and speak with her and her family... [Nursing Supervisor] and [On-call Manager] heard daughter's complaint... Apparently patient stated that nurse shoved a pill down her throat on night shift... Meeting [Care Plan Meeting] set up for tomorrow with management..."</p> <p>No documentation was located regarding notification of the facility Administrator.</p> <p>On 7/12/12 at 5:45 P.M., in an interview, the facility Administrator indicated he or the DoN were not made aware of the above incident on 7/8/12. He indicated he did not become aware of the allegation of physical abuse until the care plan meeting on 7/9/12 in the afternoon.</p> <p>3.1-28(c)</p>			
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F0226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Abuse Prohibition Policies were followed related to reporting alleged abuse immediately to the Administrator. This deficient practice affected 2 of 4 residents reviewed for allegation of abuse in a sample of 24 residents reviewed [Residents #51 and #128]. In addition, the facility failed to adequately train employees to understand the facility's Abuse Prohibition Policies. This deficient practice affected 3 of 9 employees interviewed for abuse.</p> <p>Findings include:</p> <p>1. On 7/11/12 at 9:00 A.M., the facility Administrator provided the investigation of an allegation of verbal abuse that involved Resident #51.</p> <p>The investigation included, but was not limited to:</p> <p>"Incident Report Form: Incident Date: 1/13/12 at 8:30 A.M./9:00 A.M.... Residents Involved: [Resident #51]...</p>	F0226	<p>F226 Development Abuse Neglect Policies 1. The Administrator is aware of the incidents for Residents #51 and #128. 2. During the survey, staff were provided education on the timeliness of reporting to the Administrator any abuse allegations directed toward a resident. 3. The systemic change includes:</p> <ul style="list-style-type: none"> · Staff were in-serviced on the Abuse policy that includes the Elder Justice Act and Reporting of a Crime against an elder. · A review of allegations of abuse and the grievance log will be reviewed at the daily stand up meeting. · Staff were provided education on the facility policy to notify the Administrator <u>immediately</u> of any suspected abuse. · The Abuse policy (including the Elder Justice Act) will be included in new employee orientation and will be reviewed semi-annually for all current employees. <p>The grievance log is compiled by the Social Services Department whenever a concern form is completed by</p>	08/08/2012			

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	<p>Staff Involved: [Certified Nursing Assistant [CNA] #16 and CNA #17... Brief Description of Incident: On 1/18/12, we were made aware of an incident that occurred on 1/13/12. A CNA reportedly made the comment "Shut up and do what I say... I'm tired of your crap," to the resident [Resident #51]... Immediate Action Taken: Associates were suspended pending the outcome of the investigation. Family and physician were notified... Preventive Measures Taken: A head to toe assessment was completed..."</p> <p>A written statement from CNA #12, dated 1/18/12, included, but was not limited to, "[on 1/13/12] I was taking residents to the dining room for breakfast when I witnessed [Resident #51] wandering away from her table... I heard CNA #16 make a statement, 'I'm tired of you go back to your table so you can eat breakfast.' [Resident #51] turned around and went back to her table... CNA #17 was pushing other residents into the dining room and [Resident #51] asked CNA #17 to come to her... CNA #17 walked by [Resident #51] and said, 'Shut up [Resident #51]...' Other people in the dining room were CNA #18 and nursing students...."</p> <p>CNA #12 failed to immediately report the alleged verbal abuse that occurred on</p>		<p>any staff member of the facility. The concern forms are located at each nurses' station and are turned in to Social Services. Social Services forwards the concern form to the Administrator/DON for follow up and resolution as needed and then adds the concern and outcome to the Grievance Log.</p> <p>Nurses aides, as well as any other staff member, can complete the concern form as explained above and all staff will notify the Administrator/DON immediately of any allegation of abuse.</p> <p>The Administrator will review abuse investigations with each incident ongoing.</p> <p>4. a. The DON/Designee will review any completed abuse investigations and the timeliness of reporting the incident to the Administrator reported during the week for 1 month; then every month for 3 months then monthly for 8 months to total 12 months of review of investigations. b. The DON and Staff Development Coordinator/Designee will present the results to the monthly QA meeting for review and recommendations by the</p>		

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	<p>1/13/12. She reported the alleged abuse 5 days later on 1/18/12.</p> <p>On 7/12/12 at 5:30 P.M., in an interview, CNA #12 indicated she did not report the allegation of verbal abuse that involved Resident #51, CNA #16 and CNA #17 related to being scared to report. She indicated she reported 5 days later because she felt she needed to report the verbal abuse. CNA #12 indicated she was inserviced on the facility abuse policy and procedures upon hire and re-educated on reporting any allegation of abuse after the incident of not reporting.</p> <p>2. On 7/10/12 at 2:20 P.M., the facility Clinical Specialist [Registered Nurse] #8 provided a "Incident Report Form" regarding Resident #128. At that time, in an interview, the Clinical Specialist #8 indicated the facility just reported to ISDH, on 7/9/12, an incident that involved Resident #128 who had complained in a care plan meeting that nursing staff were not speaking appropriately to her. She indicated the facility had started the investigation.</p> <p>The facility investigation included, but was not limited to:</p> <p>The "Incident Report Form" included, but was not limited to, "Incident Date: Week</p>		<p>Committee. c. The Committee will determine the frequency and duration of the reviews.</p>		

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	<p>of July 3, 2012, night shift... Resident: [Resident #128]... Staff Involved: [Licensed Practical Nurse #19]... Brief Description of Incident: During Care Plan meeting with resident, husband, and daughter... the resident had several concerns... Daughter stated that [Resident #128] had related the way a nurse talked to her and treated her a few nights ago... Neither were able to pinpoint exact date but thought it was last week... Immediate Action Taken: Following a description of the nurse who could have worked on that hall... [LPN #19] was suspended pending investigation... Preventive Measures Taken: All other residents on the same hall will be interviewed to determine inappropriate care/treatment was given...."</p> <p>On 7/12/12 at 2:45 P.M., Resident #128's record was reviewed. Diagnoses included, but were not limited to, end stage renal disease, acute respiratory failure, and weakness.</p> <p>An admission "Minimum Data Set" assessment, dated 6/29/12, included, but was not limited to, "Brief Interview Mental Status [BIMS]: 15 [cognitively intact]...."</p> <p>A "Progress Notes" dated 7/8/12 at 3:15 P.M., included, but was not limited to, "[Resident #128's] daughter at nurses's</p>						

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	<p>station very upset about what she just heard from [Resident #128]... She stated that what resident told her was very disturbing... [Nursing Supervisor] informed her that she will come to the room and speak with her and her family... [Nursing Supervisor] and [On-call Manager] heard daughter's complaint... Apparently patient stated that nurse shoved a pill down her throat on night shift... Meeting [Care Plan Meeting] set up for tomorrow with management..."</p> <p>No documentation was located regarding notification of the facility Administrator.</p> <p>On 7/12/12 at 5:45 P.M., in an interview, the facility Administrator indicated he or the DoN were not made aware of the above incident on 7/8/12. He indicated he did not become aware of the allegation of physical abuse until the care plan meeting on 7/9/12 in the afternoon.</p> <p>3. On 7/10/12 at 10:15 A.M., in an interview, Physical Therapy #13 indicated that if she witnessed verbal abuse or physical abuse she would remove the resident for their scheduled therapy session and report to her supervisor within 24 hours the abuse she witnessed.</p> <p>Physical Therapy employee #13 was unaware of the need to report any abuse</p>				

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	<p>allegation immediately to the facility Administrator or her supervisor.</p> <p>On 7/10/12 at 10:20 A.M., in an interview, CNA #14 indicated if she witnessed a co-worker verbally abusing or not speaking in an appropriate manner to a resident, she would go get the nurse on her unit to assist her before entering the room. She indicated she believed physical abuse was different in that she would probably go into the room before getting the nurse so she could stop the abuse. However, CNA #14 indicated she wasn't sure in that situation what she would do, it just depended.</p> <p>On 7/10/12 at 11:25 A.M., in an interview, CNA #15 indicated that if she witnessed physical abuse, such as hitting or verbal abuse such as yelling, she would go get the nurse on her unit first before entering the resident's room.</p> <p>CNA #14 and CNA #15 did not explain how they would appropriately protect a resident from abuse.</p> <p>4. On 7/9/12 at 12:30 P.M., the facility Administrator provided the facility's "Abuse Prevention" policies and procedures, dated 1/12.</p> <p>The facility "Abuse Prevention" included,</p>						

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	<p>but was not limited to, "Identifying and Recognizing Signs and Symptoms of Abuse: Our facility will not condone any form of resident abuse or neglect. To aid in abuse prevention, all personnel are to report any signs or symptoms of abuse/neglect to their supervisor who will report to the Administrator immediately... Reporting Abuse to: Administrator: Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etc, to immediately report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to the Administrator or Designee if the Administrator is unavailable...."</p> <p>3.1-28(a)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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 record review and interview, the facility failed to develop an elopement care plan for a resident with cognitive impairment who attempted elopement 6 days prior to successfully eloping from the facility. This deficient practice affected 1 of 4 residents reviewed for wandering behavior/elopements in the sample of 24 [Resident # 134]. The facility failed to develop a pressure area care plan for a resident with a new open area. This deficient practice affected 1 of 8 residents reviewed for pressure in a sample of 24 residents reviewed.</p>	F0279	<p>F279 Development Comprehensive Care Plans</p> <p>1. The Care Plan was updated for Resident #94 to reflect appropriate interventions related to her needs. Resident #134 no longer resides at the community.</p> <p>2. All current residents have been assessed related to an elopement potential and Care Plans updated to reflect interventions. Care Plans for residents with pressure ulcers were reviewed and updated as needed to determine that an appropriate intervention is present. No additional issues were identified.</p> <p>3. Systemic changes include:</p>	08/08/2012	

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	<p>[Resident #94]</p> <p>Findings include:</p> <p>1. On 7/12/12 at 3:30 P.M., Resident #134's closed record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, Alzheimer's disease, weakness, abnormal gait, and aftercare for hip fracture.</p> <p>A "Nurse's Progress Notes," dated 5/14/12 at 10:48 P.M., included, but was not limited to, "Patient [Resident #134] has not attempted to elope this shift... In report, it was reported that she had attempted in the A.M. [to elope]... Patient has been cooperative with nursing care... Patient able to ambulate well..."</p> <p>There was no documentation a care plan was developed after the attempted elopement on 5/14/12 and there was no documentation of a completed elopement assessment on 5/14/12.</p> <p>A "Nurse's Progress Notes," dated 5/20/12 at 12:19 P.M., included, but was not limited to, "Resident was witnessed by therapy walking out of main entrance into the parking lot... Resident was let out of the front door by a visiting delivery service... Therapy notified writer [Registered Nurse #3] and we approached</p>		<ul style="list-style-type: none"> · Staff were provided education on the Care Plans that were updated, specifically on the pressure ulcers and elopement interventions that were updated. · New treatment orders will be reviewed at the clinical meeting (M-F) to include the review of updates/additions made to the Care Plan. · Nurses have been provided education on the requirement to update the Care Plan for any resident who develops a pressure ulcer and/or when the intervention in place needs to be changed for more appropriate care and treatment of a resident. · Nurses have been provided education on the need to update the elopement assessment of any resident who exhibits behaviors or communicates the intent to exit the community. <p>4. a. The DON/designee will review 3 Care Plans of residents with pressure areas and/or residents who have been identified as an elopement risk each week for one month; then 5 times per month for 3 months and then an additional 8 months to total 12 months of monitoring.</p> <p>b. The results of the reviews will be presented at the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter. The frequency and duration of the</p>				

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	<p>resident in parking lot she had her walker and all personal belongings draped on top of the walker... Resident stated she was going to walk home... Resident was alert and oriented x 3 new [sic] her name where she was and time... Escorted resident back into the building... upset and resistant... placed on 15 minute checks... called daughter, paged MD, and notified weekend supervisor... Received order to [sic] motion sensor [sic] resident room along with 15 minute checks..."</p> <p>A "Nurse's Progress Notes," dated 5/20/12 at 2:10 P.M., included, but was not limited to, "[Dietary Aide #1] came down the hall and stated that a resident [Resident #134] was standing at the front door when she [Dietary Aide #1] went to clock out and that she let her [Resident #134] outside alone... when she [Dietary Aide #1] returned from clocking out she spotted the resident down in the parking lot... she [Dietary Aide #1] went back into the building to find the closest nursing station and sent to assist her... [Resident #134] had minor abrasions on knees and was guarding right arm... order obtained for x-ray... notified daughter... [daughter] sending daughter to sit with resident... resident placed immediately on 1 on 1 supervision..."</p> <p>On 7/13/12 at 1:00 P.M., the facility</p>		<p>reviews will be determined by the Committee.</p>				

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	<p>Clinical Specialist #27 indicated she did not have any further documentation of care plan development on 5/14/12 after her elopement attempt. The care plan was developed after the first attempt on 5/20/12.</p> <p>2. On 7/10/12 at 10:30 A.M., Resident #94's record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, seizure disorder, history of vancomycin resistant enterococcus [in the urine], and an unstageable pressure wound [opened as a stage II on 3/8/12].</p> <p>An "At risk for skin breakdown" care plan, dated 7/11/11, included, but was not limited to, "Problem: Start date: 7/13/11... [Resident #94] is at risk for skin breakdown due to incontinence and need for assist with bed mobility... Goal: Resident's skin will remain intact... Approach [with approach start date of 7/13/11]: Avoid shearing resident's skin during positioning, transferring, and turning... Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence's... Encourage fluids... Keep clean and dry as possible. Minimize skin exposure to moisture... Maintain head of bed at the lowest degree of elevation possible... Use pressure reducing cushion for pressure</p>			

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	<p>reduction when resident in chair... Use pressure reducing mattress for pressure reduction when resident in bed..."</p> <p>A "Resident Progress Notes," dated 3/8/12 at 5:00 P.M., included, but was not limited to, "OA [open area] noted to right sacral area. 2 x 1 x 0.2. Nurse Practitioner notified... N.O. [new order] received for thick layer of Dermaseptine [skin barrier], cover with Biatin foam dressing BID [2 times per day] and PRN [as needed] for soilage. D/C [discontinue] when healed... son notified..."</p> <p>Resident #94 had a hospital stay for a fractured femur on 3/24/12 through 3/29/12; however, the facility failed to develop a care plan regarding the actual open area discovered on 3/8/12.</p> <p>3.1-35(b)(1)</p>						

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F0282 SS=D	<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 follow physician orders and Care Plan interventions for incontinence care and positioning, for 1 of 1 resident who had a Stage II pressure ulcer, in a sample of 24 residents reviewed. [Resident #47]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 7/9/12 at 11:32 A.M., L.P.N. #4 indicated Resident #47 was totally dependent on staff for all care, received nutrition through a continuous gastrostomy tube feeding, required a mechanical lift for all transfers in and out of bed, and used a low air loss mattress. The nurse also indicated the resident had a Stage II pressure sore of the coccyx that was acquired in the facility, and a healed pressure sore area on one foot. The resident was observed at that time sitting in a semi-reclined geri-chair in the T.V. lounge area.</p> <p>The clinical record for Resident #47 was reviewed on 7/9/12 at 1:52 P.M.</p>	F0282	<p>F 282 Services By Qualified Persons Per Care Plan</p> <p>1. Resident #47 was provided incontinent care and was repositioned per the Care Plan. The nurses and CNAs providing the care for Resident #47 were provided education on care plan interventions provided to the Resident.</p> <p>2. Unit Managers made rounds to observe that incontinent care and repositioning was being provided to the residents. No other issues were identified.</p> <p>3. Systemic Change includes:</p> <ul style="list-style-type: none"> · Licensed nurses will conduct rounds throughout the shift to observe that residents are being repositioned and are receiving incontinent care as needed and will address any issues observed. · Education was provided to nurses and CNAs on the need for repositioning of residents and of the need to provide incontinent care following an episode. · New nurse orientation will include the nurse responsibility to supervise resident care with incontinent care and repositioning. <p>4. The Unit Manager/designee</p>	08/08/2012			

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	<p>Diagnoses included, but were not limited to, insulin-dependent diabetes, chronic kidney disease, adult failure to thrive with a gastrostomy tube, urinary incontinence with history of urinary tract infections, aphasia (inability to communicate), dysphagia (difficulty swallowing), anemia, and chronic obstructive pulmonary disease.</p> <p>A "Resident Care Record" form, identified by the Director of Nurses as the C.N.A. assignment sheet, was provided for Resident #47 on 7/12/12. The form indicated the resident required total ADL [Activity of Daily Living] care, was incontinent of bowel and bladder, was to be given incontinence care every 2 hours, was to be turned every 2 hours, was on a low air loss mattress, was to have feet and ankles "floated" [positioned off of surfaces], and to use small pillow/blanket at pressure points.</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "At risk for skin breakdown due to incontinence and need for assist with bed mobility." The interventions included, but were not limited to the following:</p> <p>"12/20/10--Float left ankle. 12/20/10--Keep bony prominences from direct contact with one another with</p>		<p>will monitor that rounds are conducted throughout the shift by the licensed nurses to observe that repositioning and incontinent care is being provided.</p> <p>The Director of Nurses will review the Unit Manager round audits weekly for 3 months and then monthly for 9 months to total 12 months.</p> <p>The results of the reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the Committee.</p>				

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	<p>pillows, foam wedges, etc. 12/20/10--Keep clean and dry as possible. Minimize skin exposure to moisture. 12/20/10--Keep linen clean, dry, and wrinkle free. 12/20/10--Provide incontinence care after each incontinent episode. 12/20/10--Turn and reposition every 2 hours."</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "Completely incontinent of both her bladder and bowel functions." The interventions included, but were not limited to, the following:</p> <p>"8/22/11--Staff will check before/after meal times, at bedtime, and every 2 hours at night providing incontinent care and brief changes as needed."</p> <p>On 7/11/12 at 8:30 A.M., the resident was observed sitting in a semi-reclined geri-chair in her room. From 9:15 to 11:20 A.M., the resident was continuously observed sitting in the semi-reclined geri-chair in her room. During that time period, the resident was not "off-loaded" [raised up off of her buttocks and coccyx for at least 5 minutes to relieve pressure on that area] at any time, or checked for incontinence and given incontinence care.</p>						

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	<p>In an interview on 7/11/12 at 9:30 A.M., L.P.N. #4 indicated Resident #47 had an open area of the coccyx, and two places on the right foot were healed. She indicated the resident "stays up [in the geri-chair] until after lunch," and then is transferred back into bed to be given incontinence and wound care.</p> <p>On 7/11/12 at 11:20 A.M., L.P.N. #4 and an unidentified C.N.A. went into the resident's room. The L.P.N. said "We're just readjusting her--she has been on her booty for" The C.N.A. placed a small soft stuffed animal under the resident's left upper arm, and another under her right ankle. The resident's right foot was observed to have been resting directly on the surface of the foot rest with no space between the heel skin and the foot rest. After placing the stuffed animal under the resident's foot, the heel was raised 1 inch above the surface. After completing this adjustment, the resident was wheeled in her geri-chair out to the T.V. lounge. The resident was not checked for incontinence or given incontinence care.</p> <p>On 7/11/12 at 2:10 P.M., R.N. #6 and L.P.N. #5 were observed while giving wound care treatment to Resident #47.</p> <p>The dressing over the pressure sore was crumpled and damp. When R.N. #6</p>						

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	<p>removed the dressing, the tape holding the dressing was observed to be stuck to the peri-wound area. The open area was approximately 3 centimeters in circumference with irregular edges, with a loss of the upper dermis/skin. There was a 1 inch peri-wound area around the whole circumference of the wound that was reddened, and appeared to be macerated [a softening or breaking down of tissue from constant dampness, which can be caused by exposure to anything wet]. The tape of the dressing had been stuck to this area. The resident's buttocks and perineum was shiny and wet, with reddened and macerated areas over the vulva and in the creases between the bilateral lower buttocks and upper thigh area. The right heel was observed to have intact skin, but had bright red to blue coloration throughout the entire heel skin area.</p> <p>After removing the dressing, R.N. #6 went into the bathroom to wash her hands. As L.P.N. #5 was assisting to hold the resident on her right side, the resident urinated a large amount of urine, which ran down across her perineal area and left buttock and buttock crease areas. The resident also began to strain to have a bowel movement, and a hard, formed stool was observed at the rectal opening.</p>						

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	<p>During the procedure, when R.N. #6 turned to obtain the Santyl ointment to place on the wound bed, the resident strained with the bowel movement, and urinated a large amount again. L.P.N. #5 continued to hold the resident to the right side, and had a direct view of the area.</p> <p>The resident continued to strain to have a bowel movement, and a small round marble size piece of stool dropped to the sheet. R.N. #6 then placed a large [ABD] dressing over the wound, and taped it in place. One piece of tape was applied down the middle of the dressing, so that both the bottom of the dressing and tape covered the resident's rectal area. R.N. # 6 picked up the piece of stool with a gloved hand, and discarded into a trash bag.</p> <p>No incontinence care was provided. The two nurses used the draw sheet to scoot the resident back up to the top of the bed, and repositioned her on her back. The draw sheet, which was wet with urine, was not changed.</p> <p>The July, 2012 physician order recap [recapitulation] sheet included, but was not limited to, the following order related to wound healing measures/medications: 7/20/11--Float heels with pillow when up in wheelchair.</p>						

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	<p>In an interview on 7/12/12 at 10:05 A.M., the Director of Nursing indicated she had been in the position of D.O.N. for a couple of months. She indicated the Staff Development Coordinator would have done observations of staff providing care, but the facility had not had anyone in that job position for the last 6-8 months. Someone had been hired to fill that job position 4 weeks ago. She indicated she felt the return demonstrations of care has been something that was lacking.</p> <p>3.1-35(g)(2)</p>				

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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, interview, and observation, the facility failed to assess a resident for pain and ensure a resident's pain was managed during a dressing change who was exhibiting signs of pain such as crying out and moaning during the dressing change. The deficient practice impacted 1 of 1 resident reviewed with complaints of pain during a dressing change in a sample of 24 residents reviewed. [Resident #94]</p> <p>Findings include:</p> <p>On 7/10/12 at 10:30 A.M., Resident #94's record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, seizure disorder, history of vancomycin resistant enterococcus [in the urine], and an unstageable pressure wound [opened as a stage II on 3/8/12].</p> <p>The last wound clinic note on 7/5/12, indicated Resident #94 had an unstageable coccyx wound measuring 3</p>	F0309	<p>F309 Provide Care Services for Highest Well Being 1. The nurses were reminded during survey to assess for pain daily and to be alert for the signs and symptoms of discomfort a resident is experiencing during wound and other treatments. 2. Unit Managers identified residents with wound and other treatments and reminded staff to assess for pain prior to, during and following treatments. 3. Systemic Changes include: · An in-service for licensed nurses was held to review the need to assess the residents prior to and following the provision of a wound treatment or other care and to administer pain medication as appropriate. · C.N.A.s were provided education on the need to report to the nurse if a resident is exhibiting or has communicated the presence of pain. · New nurse orientation will include education on assessing for pain prior to, during and following a wound</p>	08/08/2012			

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	<p>centimeters long x 2.1 centimeters wide x 0.6 centimeters deep.</p> <p>On 7/13/12 at 11:15 A.M., RN #25 was observed providing wound care to Resident #94. RN #25 did not assess the resident for pain prior to starting the dressing change. During the dressing change, RN #25 had cleansed the wound with a 4 x 4 gauze, during that time, the resident was crying and moaning out in pain and stated, "It hurts." RN #25 reassured the resident he was almost done with the dressing change; however he did not assess the resident for pain.</p> <p>On 7/13/12 at 11:30 A.M., in an interview, RN #25 indicated the resident had been given Tylenol during morning medication pass [9:00 A.M.]. He indicated she did have routine and PRN [as needed] pain medication scheduled daily.</p> <p>On 7/13/12 at 3:00 P.M., the facility Clinical Specialist [RN] #26 provided the Medication Administration Records [MARS] for Resident #94.</p> <p>The "MAR" for July 2012, included, but were not limited to, Acetaminophen 325 milligrams 2 by mouth every 4 hours for pain as needed marked as given on 7/13/12 at 9:00 A.M. and Ultram 25</p>		<p>or other treatment. Care Plans are reviewed for updates at any time an assessment occurs. As appropriate, the Care Plans are updated.</p> <p>4. The Unit Manager/ Designee will interview and observe 3 residents per week for 30 days and then monthly for 3 months to determine that pain interventions were provided prior to, during and following a wound or other treatment. The DON will review the interviews and observations completed by the Unit Managers for 30 days, then monthly for 3 months, then monthly for 8 months to total 12 months. Any concerns will be addressed by the DON. The results of the reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. The frequency and duration of the reviews will be determined by the Committee.</p>				

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	<p>milligrams by mouth every 8 hours, marked as given at 6:00 A.M. and 2:00 P.M. The MAR also included PRN [as needed] pain medication orders for Ultram 25 milligrams by mouth every 6 hours as needed for moderate pain..."</p> <p>RN #25 failed to assess Resident #94 when the resident verbalized pain during a dressing change and failed to assess Resident #94 for pain following the dressing change to ensure effective pain management.</p> <p>3.1-37(a)</p>			

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to provide incontinence care to 1 of 1 resident who had a coccyx pressure sore. This deficiency impacted 1 of 8 residents reviewed for pressure sores in a sample of 24 residents. [Resident #47]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 7/9/12 at 11:32 A.M., L.P.N. #4 indicated Resident #47 was totally dependent on staff for all care, received nutrition through a continuous gastrostomy tube feeding, and required a mechanical lift for all transfers in and out of bed. The nurse also indicated the resident had a Stage II pressure sore of the coccyx that was acquired in the facility. The resident was observed at that time sitting in a semi-reclined geri-chair in the T.V. lounge area.</p> <p>The clinical record for Resident #47 was reviewed on 7/9/12 at 1:52 P.M. Diagnoses included, but were not limited to, insulin-dependent diabetes, chronic</p>	F0312	<p>F 312 ADL Care Provided for Dependent Residents</p> <p>1. Resident #47 was provided incontinent care and was repositioned per the Care Plan. The nurses and CNAs providing the care for Resident #47 were provided education on care plan interventions provided to the Resident.</p> <p>2. All incontinent residents and those with dressing changes have been identified by Unit Managers. Unit Managers have observed that the care for these identified residents is being provided.</p> <p>3. Systemic Change includes:</p> <ul style="list-style-type: none"> · Unit Managers will observe by random rounds that incontinent residents are receiving incontinent care. · A wound in-service was provided to the licensed nurses to include protecting the wound during the dressing change. · CNAs and nurses were provided education on the need for timely incontinent care. · New nurse orientation will include dressing change technique that also includes protecting the wound from urine/feces during the 	08/08/2012			

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	<p>kidney disease, adult failure to thrive with a gastrostomy tube, urinary incontinence with history of urinary tract infections, aphasia (inability to communicate), dysphagia (difficulty swallowing), anemia, and chronic obstructive pulmonary disease.</p> <p>A "Resident Care Record" form, identified by the Director of Nurses as the C.N.A. assignment sheet, was provided for Resident #47 on 7/12/12. The form indicated the resident required total ADL [Activity of Daily Living] care, was incontinent of bowel and bladder, was to be given incontinence care every 2 hours, and was to be turned every 2 hours.</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "At risk for skin breakdown due to incontinence and need for assist with bed mobility." The interventions included, but were not limited to the following:</p> <p>"12/20/10--Keep clean and dry as possible. Minimize skin exposure to moisture. 12/20/10--Keep linen clean, dry, and wrinkle free. 12/20/10--Provide incontinence care after each incontinent episode.</p> <p>A Care Plan entry, updated 4/26/12,</p>		<p>dressings.</p> <p>New nurse orientation and CNAs orientation will include the need for nurses to supervise that residents are receiving incontinent care and the CNAs will be provided education on the techniques and timeliness of providing incontinent care to the residents.</p> <p>4. The Unit Managers will observe 5 dressing changes and randomly observe for incontinent care 5 days per week for 12 weeks then once monthly for 9 months to ensure compliance is maintained with the dressing change.</p> <p>The Director of Nurses will review the Unit Manager round and dressing change audits three times a week for 30 days, then monthly for 3 months the monthly for 8 months to total 12 months.</p> <p>The results of the reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the Committee.</p>				

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	<p>addressed a problem of "Completely incontinent of both her bladder and bowel functions." The interventions included, but were not limited to, the following:</p> <p>"8/22/11--Staff will check before/after meal times, at bedtime, and every 2 hours at night providing incontinent care and brief changes as needed."</p> <p>On 7/11/12 at 8:30 A.M., the resident was observed sitting in a semi-reclined geri-chair in her room. From 9:15 to 11:20 A.M., the resident was continuously observed sitting in the semi-reclined geri-chair in her room. During that time period, the resident was not checked for incontinence or provided incontinence care.</p> <p>On 7/11/12 at 11:20 A.M., L.P.N. #4 and an unidentified C.N.A. went into the resident's room. The L.P.N. said "We're just readjusting her--she has been on her booty for" After completing the adjustment, the resident was wheeled in her geri-chair out to the T.V. lounge. The resident was not checked for incontinence or given incontinence care.</p> <p>In an interview on 7/11/12 at 9:30 A.M., L.P.N. #4 indicated the resident "stays up [in the geri-chair] until after lunch," and then is transferred back into bed to be</p>						

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	<p>given incontinence and wound care.</p> <p>On 7/11/12 at 2:10 P.M., R.N. #6 and L.P.N. #5 were observed while giving wound care treatment to Resident #47.</p> <p>The dressing over the pressure sore was crumpled and damp. When R.N. #6 removed the dressing, the tape holding the dressing was observed to be stuck to the peri-wound area. The open area was approximately 3 centimeters in circumference with irregular edges, with a loss of the upper dermis/skin. There was a 1 inch peri-wound area around the whole circumference of the wound that was reddened, and appeared to be macerated [a softening or breaking down of tissue from constant dampness, which can be caused by exposure to anything wet]. The tape of the dressing had been stuck to this area. The resident's buttocks and perineum was shiny and wet, with reddened and macerated areas over the vulva and in the creases between the bilateral lower buttocks and upper thigh area.</p> <p>After removing the dressing, R.N. #6 went into the bathroom to wash her hands. As L.P.N. #5 was assisting to hold the resident on her right side, the resident urinated a large amount of urine, which ran down across her perineal area and left</p>				

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	<p>buttock and buttock crease areas. The resident also began to strain to have a bowel movement, and a hard, formed stool was observed at the rectal opening.</p> <p>When R.N. #6 turned to obtain the Santyl ointment to place on the wound bed, the resident strained with the bowel movement, and urinated a large amount again. L.P.N. #5 continued to hold the resident to the right side, and had a direct view of the area.</p> <p>The resident continued to strain to have a bowel movement, and a small round marble size piece of stool dropped to the sheet. R.N. #6 then placed a large [ABD] dressing over the wound, and taped it in place. One piece of tape was applied down the middle of the dressing, so that both the bottom of the dressing and tape covered the resident's rectal area. R.N. #6 picked up the small piece of stool with gloved hands, and discarded into a trash bag.</p> <p>No incontinence care was provided. The two nurses used the draw sheet to scoot the resident back up to the top of the bed, and repositioned her on her back. The draw sheet, which was wet with urine, was not changed.</p> <p>In an interview on 7/12/12 at 10:05 A.M.,</p>						

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	<p>the Director of Nursing indicated she had been in the position of D.O.N. for a couple of months. She indicated the Staff Development Coordinator would have done observations of staff providing care, but the facility had not had anyone in that job position for the last 6-8 months. Someone had been hired to fill that job position 4 weeks ago. She indicated she felt the return demonstrations of care has been something that was lacking.</p> <p>3.1-38(a)(3)</p>				

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to provide effective and timely treatment, services, and interventions to promote healing of facility acquired pressure ulcers for 2 residents whose Stage II pressure ulcers increased in size and became unstageable due to slough and eschar. This deficiency impacted 2 of 8 residents reviewed for pressure sores in a sample of 24 residents. [Resident #47 and #94]</p> <p>Findings include:</p> <p>1. In an interview during the initial orientation tour on 7/9/12 at 11:32 A.M., L.P.N. #4 indicated Resident #47 was totally dependent on staff for all care, received nutrition through a continuous gastrostomy tube feeding, required a mechanical lift for all transfers in and out of bed, and used a low air loss mattress. The nurse also indicated the resident had</p>	F0314	<p>F314 Treatment and Services to Prevent/Heal Pressure Sores</p> <p>1. Residents #47 and #94 are currently receiving appropriate treatments to assist in prevention and to promote healing of new pressure ulcers.</p> <p>2. All resident with pressure ulcer have been identified and the interventions in place have the appropriate measures to promote healing.</p> <p>3. Systemic changes include:</p> <ul style="list-style-type: none"> · The DON/designee will review the weekly pressure ulcer evaluations weekly during the At Risk Meeting, checking for an increase in size as well as provision of the appropriate treatment choice to promote healing of the pressure ulcer. · Wound education was provided for licensed nurses that included: <ol style="list-style-type: none"> 1. Staging of wounds 2. Measuring of wounds 3. Wound treatment 	08/08/2012

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	<p>a Stage II pressure sore of the coccyx that was acquired in the facility, and a healed pressure sore area on one foot. The resident was observed at that time sitting in a semi-reclined geri-chair in the T.V. lounge area.</p> <p>The clinical record for Resident #47 was reviewed on 7/9/12 at 1:52 P.M. Diagnoses included, but were not limited to, insulin-dependent diabetes, chronic kidney disease, adult failure to thrive with a gastrostomy tube, urinary incontinence with history of urinary tract infections, aphasia (inability to communicate), dysphagia (difficulty swallowing), anemia, and chronic obstructive pulmonary disease.</p> <p>A Significant Change M.D.S. [Minimum Data Set] assessment, completed on 8/19/11, indicated the resident had no speech, was rarely able to understand others and rarely was understood by others, was determined to have moderately impaired cognitive skills for daily decision-making by staff assessment, was totally physically dependent on 2 staff for all daily care, was always incontinent of both bowel and bladder, and had one Stage 4 unhealed pressure sore [the site was not identified].</p> <p>The most current Quarterly M.D.S.</p>		<p>4. Interventions</p> <p>5. Documentation of wounds</p> <p>6. The need to protect the wound during dressing from urine/feces.</p> <ul style="list-style-type: none"> · A Wound Guide was implemented to assist with treatment choices. · New nurse and CNA orientation will include appropriate wound treatments for the nurses and for both education will be provided to address protecting the wound from urine/feces. · CNAs were educated on the need to report changes in skin to the nurses. · CNAs were educated on the need to turn and reposition residents to avoid pressure on boney prominences and to maintain other interventions such as elevating to avoid pressure areas from developing and/or worsening. <p>4.</p> <p>Unit Managers will observe 5 dressing changes (per week for 12 weeks and then monthly for 9 months to total 12 months) administered by licensed nurse to observe for technique, resident was medicated if necessary and wound was protected from urine/feces during treatment.</p> <p>Unit Managers will also determine that the appropriate treatment choices are current.</p> <p>The DON will review the</p>				

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	<p>assessment, completed on 4/26/12, indicated no changes except the resident now had severe impairment in cognitive skills for daily decision-making, and had no unhealed pressure sores.</p> <p>The "Observations" section of the facility's electronic records included, but was not limited to, the following information:</p> <p>"5/1/12--No skin issues. Slight redness on bottom. Turn and re-position, pressure reduction mattress, chair cushion.</p> <p>6/5/12--Onset 5/31/12; coccyx. Acquired in-house. Stage II, 4.0 [length] by 6.2 [width] cm. [centimeters], no depth. Small amount serosanguinous exudate. Pressure reducing device for chair, pressure reducing device for bed, turning and repositioning program, heel protectors.</p> <p>6/25/12--Stage II coccyx, 5.0 by 7.0 cm., no depth. Small amount serosanguinous exudate. Wound bed yellow. Santyl and dry dressing. Pressure reducing device for bed, turning and repositioning program, Dietary/Nutritional supplements, elevate edematous/affected area, heel protectors.</p> <p>7/2/12--Coccyx/unstageable, 5.0 by 6.5 by</p>		<p>observation audits completed by the Unit Managers weekly for 30 days, the monthly for 3 months, then monthly for 8 months to total 12 months.</p> <p>The results of the reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. The frequency and duration of reviews will be increased as needed.</p>		

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	<p>0.2 [depth] cm. Small amount serosanguinous exudate, wound bed yellow. Pressure reducing device for bed, turning and repositioning program.</p> <p>A "Resident Care Record" form, identified by the Director of Nurses as the C.N.A. assignment sheet, was provided for Resident #47 on 7/12/12. The form indicated the resident required total ADL [Activity of Daily Living] care, was incontinent of bowel and bladder, was to be given incontinence care every 2 hours, was to be turned every 2 hours, was on a low air loss mattress, was to have feet and ankles "floated" [positioned off of surfaces], and to use small pillow/blanket at pressure points.</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "At risk for skin breakdown due to incontinence and need for assist with bed mobility." The interventions included, but were not limited to the following:</p> <p>"12/20/10--Avoid shearing resident's skin during positioning, transferring, and turning. 12/20/10--Float left ankle. 12/20/10--Keep bony prominences from direct contact with one another with pillows, foam wedges, etc. 12/20/10--Keep clean and dry as possible.</p>						

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	<p>Minimize skin exposure to moisture. 12/20/10--Keep linen clean, dry, and wrinkle free. 12/20/10--Provide incontinence care after each incontinent episode. 12/20/10--Turn and reposition every 2 hours. 12/20/10--Use pressure reducing mattress for pressure reduction when in bed."</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "At risk for pressure ulcers due to complete incontinence and need for staff to provide mobility." The interventions included the ones listed in the previous Care Plan entry, but were updated with a "Start Date" of 8/22/11. An additional approach was added for: "Use low air loss mattress for pressure reduction when resident in bed."</p> <p>A Care Plan entry, updated 4/26/12, addressed a problem of "Completely incontinent of both her bladder and bowel functions." The interventions included, but were not limited to, the following:</p> <p>"8/22/11--Staff will check before/after meal times, at bedtime, and every 2 hours at night providing incontinent care and brief changes as needed."</p> <p>The July, 2012 physician order recap</p>				

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	<p>[recapitulation] sheet included, but was not limited to, the following orders related to wound healing medications:</p> <p>6/6/12--ProStat 64 Liquid 30 ml. [milliliters] daily. 6/6/12--Vitamin C 500 mg. [milligrams] one daily. 6/6/12--Vitamin E 400 mg. one daily for 60 days. 6/6/12--Zinc 220 mg. one daily</p> <p>On 7/11/12 at 8:30 A.M., the resident was observed sitting in a semi-reclined geri-chair in her room. From 9:15 to 11:20 A.M., the resident was continuously observed sitting in the semi-reclined geri-chair in her room. During that time period, the resident was not "off-loaded" [raised up off of her buttocks and coccyx for at least 5 minutes to relieve pressure on that area] at any time.</p> <p>On 7/11/12 at 11:20 A.M., L.P.N. #4 and an unidentified C.N.A. went into the resident's room. The L.P.N. said "We're just readjusting her--she has been on her booty for" The C.N.A. placed a small soft stuffed animal under the resident's left upper arm, and another under her right ankle. The resident's right foot was observed to have been resting directly on the surface of the foot rest with no space</p>			

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	<p>between the heel skin and the foot rest. After placing the stuffed animal under the resident's foot, the heel was raised 1 inch above the surface. After completing this adjustment, the resident was wheeled in her geri-chair out to the T.V. lounge. At no time was the resident's bottom off-loaded from the seat of the geri-chair.</p> <p>In an interview on 7/11/12 at 9:30 A.M., L.P.N. #4 indicated Resident # 47 only had an open area of the coccyx, and two places on the right foot were healed. She indicated the resident "stays up [in the geri-chair] until after lunch," and then is transferred back into bed to be given incontinence and wound care.</p> <p>On 7/11/12 at 2:10 P.M., R.N. #6 and L.P.N. #5 were observed while giving wound care treatment to Resident #47.</p> <p>Upon entrance to the room, the resident was observed to be laying on her right side, with the head of the bed raised 35-40 degrees. There was a folded "draw" sheet under the resident, placed so the top was at the resident's waist area, and the bottom was at her upper thigh area. The sheet extended out to both sides of the bed.</p> <p>The dressing over the pressure sore was crumpled and damp. When R.N. #6 removed the dressing, the tape holding the</p>						

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	<p>dressings was observed to be stuck to the peri-wound area. The open area was approximately 3 centimeters in circumference with irregular edges, with a loss of the upper dermis/skin. The wound bed was clean, without slough, and red in color. There was a 1 inch peri-wound area around the whole circumference of the wound that was reddened, and appeared to be macerated [a softening or breaking down of tissue from constant dampness, which can be caused by exposure to anything wet]. The tape of the dressing had been stuck to this area. The resident's buttocks and perineum was shiny and wet, with reddened and macerated areas over the vulva and in the creases between the bilateral lower buttocks and upper thigh area. The right heel was observed to have intact skin, but had bright red to blue coloration throughout the entire heel skin area.</p> <p>After removing the dressing, R.N. #6 went into the bathroom to wash her hands. As L.P.N. #5 was assisting to hold the resident on her right side, the resident urinated a large amount of urine, which ran down across her perineal area and left buttock and buttock crease areas. The resident also began to strain to have a bowel movement, and a hard, formed stool was observed at the rectal opening.</p>			

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	<p>R.N. #6 returned to the bedside, prepared clean gauze with some normal saline, and dabbed at the wound bed. When she turned to obtain the Santyl ointment to place on the wound bed, the resident strained with the bowel movement, and urinated a large amount again. L.P.N. #5 continued to hold the resident to the right side, and had a direct view of the area.</p> <p>Using a Q-tip applicator, R.N. #6 applied the Santyl ointment to the wound bed. As she did so, the R.N. remarked "The orders say to apply the Santyl to the yellow [slough] areas, but there isn't any." Following the Santyl, the R.N. obtained another Q-tip applicator, placed some Dermaseptine on the end, and applied the cream to the peri-wound area. There was a glob of cream unevenly applied to the 3-6 o'clock peri-wound area, with only small amounts of the cream applied to the remainder of the peri-wound areas.</p> <p>The resident continued to strain to have a bowel movement, and a small round marble size piece of stool dropped to the sheet. R.N. #6 then placed a large [ABD] dressing over the wound, and taped it in place. One piece of tape was applied down the middle of the dressing, so that both the bottom of the dressing and tape covered the resident's rectal area. After applying the dressing, R.N. #6 picked up</p>						

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	<p>the small piece of stool with a gloved hand and discarded into a trash bag.</p> <p>No incontinence care was provided. The two nurses used the draw sheet to scoot the resident back up to the top of the bed, and repositioned her on her back. The draw sheet, which was wet with urine, was not changed.</p> <p>In an interview on 7/12/12 at 10:05 A.M., L.P.N. #4 indicated as the Unit Manager she only occasionally does direct observations of nursing staff performing dressing changes and other care.</p> <p>In an interview on 7/12/12 at 10:05 A.M., the Director of Nursing indicated she had been in the position of D.O.N. for a couple of months. She indicated the Staff Development Coordinator would have done observations of staff providing care, but the facility had not had anyone in that job position for the last 6-8 months. Someone had been hired to fill that job position 4 weeks ago. She indicated she felt the return demonstrations of care has been something that was lacking.</p> <p>The 2008 A.M.D.A. [American Medical Directors Association] "Pressure Ulcers in the Long-Term Care Setting, Clinical Practice Guidelines" manual defines a Stage II pressure ulcer as "Partial</p>				

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	<p>thickness loss of dermis [skin] presenting as a shallow open ulcer with a red pink ulcer bed, without slough [necrotic or avascular tissue in the process of separating from viable tissue. Usually soft, moist, and light in color; may be stringy]." An "Unstageable" ulcer is defined as "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar [thick, leathery, necrotic or devitalized tissue, frequently black or brown in color; skin that has lost its usual physical properties and biological activity; may be loose or may be firmly adhered to the wound.] in the wound bed."</p> <p>2. On 7/10/12 at 10:30 A.M., Resident #94's record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease, seizure disorder, history of vancomycin resistant enterococcus [in the urine], and an unstageable pressure wound [opened as a stage II on 3/8/12].</p> <p>Resident #94 was admitted to the facility on 11/11/10 without any sign or symptom of pressure wounds.</p> <p>An "At risk for skin breakdown" care</p>			

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	<p>plan, dated 7/11/11, included, but was not limited to, "Problem: Start date: 7/13/11... [Resident #94] is at risk for skin breakdown due to incontinence and need for assist with bed mobility... Goal: Resident's skin will remain intact... Approach [with approach start date of 7/13/11]: Avoid shearing resident's skin during positioning, transferring, and turning... Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominence's... Encourage fluids... Keep clean and dry as possible. Minimize skin exposure to moisture... Maintain head of bed at the lowest degree of elevation possible... Use pressure reducing cushion for pressure reduction when resident in chair... Use pressure reducing mattress for pressure reduction when resident in bed..."</p> <p>A quarterly "Minimum Data Set" assessment, dated 12/27/11, included, but was not limited to, "Brief Interview Mental Status [BIMS]" 7 [moderate cognitive impairment]... Transfer: 3/2 [extensive assistance of 1 staff person]... "</p> <p>There was no documentation of Resident #94 having a pressure area on the quarterly MDS completed on 12/27/11. Resident #94 was coded as yes to risk for pressure areas with the following treatments marked as used: pressure</p>						

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	<p>reducing devices for chair and bed and application of ointments.</p> <p>A "Resident Progress Notes," dated 3/8/12 at 5:00 P.M., included, but was not limited to, "OA [open area] noted to right sacral area. 2 x 1 x 0.2. Nurse Practitioner notified... N.O. [new order] received for thick layer of Dermaseptine [skin barrier], cover with Biatin foam dressing BID[2 times per day] and PRN [as needed] for soilage. D/C [discontinue] when healed... son notified...."</p> <p>No documentation was found of new interventions implemented after the area opened. Only new intervention was the ordered dressing change.</p> <p>A "Skin - Pressure Ulcer Evaluation," dated 3/8/12 at 5:00 P.M., included, but was not limited to, "OA to right sacral area... 2 x 1 x 0.2... Where acquired: In-House... Stage of ulcer: Stage II [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough]... Plan of Care: [No new interventions added]."</p> <p>A "Skin - Weekly Skin Inspection," dated 3/13/12 at 10:56 P.M., included, but was not limited to, "Treatment to sacral area...</p>						

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	<p>showing improvement... no other concerns [no measurements or description given]."</p> <p>A "Skin - Weekly Skin Inspection," dated 3/20/12 at 11:00 P.M., included, but was not limited to, "Risk factors [marked as risk]: Impaired Mobility, refusal of some aspects of care and treatment, cognitive impairment, exposure of skin to urinary and fecal incontinence, inability to respond meaningfully... No assessment of the wound was provided...."</p> <p>A "Resident Progress Notes," dated 3/24/12 at 9:00 A.M., included, but was not limited to, "Certified Nursing Assistant [CNA] stated while transferring resident from bed to wheelchair CNA's foot got tangled in phone cord... caused CNA's and resident's leg to tangle... resident taken by stretcher to hospital...."</p> <p>A "Resident Progress Notes," dated 3/29/12 at 5:29 P.M., included, but was not limited to, "Resident arrived by ambulance from [local hospital]... Resident has four surgical incisions to left leg... 2 centimeter pressure sore on coccyx [same pressure area resident had prior to admission to the local hospital]</p> <p>Resident #94 was in a local hospital for 5 days. The measurements of the pressure</p>			

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	<p>area remained the same on re-admission.</p> <p>A "Skin - Pressure Ulcer Evaluation" dated 3/29/12 at 9:22 P.M., included, but was not limited to, "Description: Admission: Where [Pressure] Acquired: Hospital [the pressure area was the same area being treated prior to discharge to hospital]... Location: Coccyx... Stage of Ulcer: Stage II... Length and Width: 2 centimeters... Skin and Ulcer Treatments [marked interventions]: Turning and repositioning program... Pressure ulcer care..."</p> <p>A "Open Area" care plan, dated, 3/30/12, included, but was not limited to, "Problem start date: 3/30/12... Resident has OA to coccyx... admitted with [resident had prior to 5 day stay at hospital]... Goal: OA to remain free of infection... Approach [with start date of 3/30/12: Apply treatment as ordered... Low air loss mattress... Supplements as ordered... Turn and reposition... Weekly skin inspections... [with start date of 5/9/12] Physical Therapy for estim [electrical stimulation treatment] as ordered..."</p> <p>The skin assessments on the "Skin - Pressure Ulcer Evaluation" for the dates of 4/2/12 at 12:25 P.M. and 4/9/12 at 5:31 P.M., showed improvement with</p>			
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	<p>measurements in centimeters of 1.0 x 1.2 on 4/2/12 and 1.2 x 1.5 on 4/9/12 as compared with the 3/29/12 measurement at 2 centimeters. However, the skin assessment on 4/16/12 at 11:20 A.M., showed an increase.</p> <p>A 'Resident Progress Notes" dated 4/12/12 at 4:02 P.M., indicated Resident #94 was started on antibiotic therapy for a urinary tract infection and placed on contact isolation for vancomycin resistant enterococcus in the urine.</p> <p>A "Skin - Pressure Ulcer Evaluation," dated 4/16/12 at 11:20 A.M., included, but was not limited to, "Length and width in centimeters: 2.0 x 2.5... Skin and Ulcer Treatments [marked]: Pressure reducing device for chair, pressure reducing device for bed, turning and repositioning, nutrition or hydration intervention to manage skin problems, and pressure ulcer care... Plan of Care [marked]: Continue current plan of care..."</p> <p>No documentation of physician notification regarding the increase in size of pressure wound was located in Resident #94's clinical record.</p> <p>There was no documentation of a skin assessment on 4/23/12 and 4/24/12; however, the following notes indicated</p>						

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	<p>the physician was notified and orders received on 4/24/12 [8 days after a noted increase in wound size].</p> <p>A "Resident Progress Notes," dated 4/24/12 at 4:55 P.M., included, but was not limited to, "New orders received for [wound team Nurse Practitioner] to evaluate stage II pressure ulcer on coccyx that resident was admitted with [Resident #94 had the pressure prior to her 5 day stay in the hospital and returned with the same measurements]... New wound care orders..."</p> <p>A "Wound, Ostomy, Continance Center Initial Evaluation," dated 5/1/12, no time, included, but was not limited to, "Subjective: [Resident #94] is a patient that is new to me... Objective: Upon assessment today, the left superior ischial tuberosity or the superior ischium, she does have a wound that measures 3.2 centimeters long x 3.15 centimeters wide x less than 0.1 centimeters deep... However, the wound base is necrotic... Today the wound base is 40% black, 40% yellow and 20% red... Assessment: Unstageable pressure ulcer left superior ischium... Plan: Discontinue foam dressing to her left buttocks... pre-albumin level... pillow placed between her knees and legs and no skin to skin contact... apply Santyl periwound for</p>			

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	<p>protection and cover with a dry dressing and change daily... anchor Foley... the patient is incontinent and there is no way that her wound is going to get better with her incontinence..."</p> <p>Resident #94's ulcer opened on 3/8/12 with a Stage II pressure wound measuring 2 centimeters that resulted in an unstageable pressure wound on 5/1/12 measuring in centimeters 3.2 long x 3.15 width x 0.1 deep.</p> <p>On 7/13/12 at 11:15 A.M., RN #25 was observed providing wound care to Resident #94. The right coccyx area was not measured at that time; however, the wound appeared round with a small amount of yellow colored tissue noted on the left upper side with surrounding pink tissue. There was no odor noted or drainage of the wound. RN #25 cleansed the area with a 4 x 4 gauze at which time the resident cried and moaned in pain.</p> <p>On 7/13/12 at 1:00 P.M., the facility Clinical Specialist #27 indicated she did not have any further documentation to provide for Resident #94. She aware of the concerns regarding Resident #94 developing a pressure area that worsened, the lack of care plan development, and no physician notification for 8 days.</p>						

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	<p>3. On 7/16/12 at 12:19 P.M., the Administrator provided a Policy/Procedure titled "Skin Care and Pressure/Non-Pressure Ulcer Management Program," and dated as revised April, 2011. Information included, but was not limited to, the following:</p> <p>"INTRODUCTION... Managing a skin prevention program is dependent upon many factors. There are certain clinical conditions along with limited mobility that may contribute to the development of pressure ulcers. These conditions may include, but are not limited to the following: 1. Urinary incontinence... 3. Diabetes 4. COPD... 12. Malnutrition/dehydration....</p> <p>There are also certain treatments that may contribute to pressure ulcer development. These treatments may include, but are not limited to, the following: ... 5. Head of be elevated majority of the day due to medical necessity....</p> <p>RISK INTERVENTIONS... 2. Turn and reposition on an every two hour schedule or per individual plan of care... 4. Use pillows or adequate positioning devices to avoid skin to skin contact... 6. Heel and elbow protectors may be utilized as appropriate to reduce friction. 7. Utilize</p>				

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	<p>measures to reduce pressure on heels. 8. Adequate cleansing, moisturizing, and protection of skin....</p> <p>SKIN CARE AND EARLY TREATMENT-- Cleanse: ... Cleanse skin after each episode of incontinence... Activity: Use proper positioning, transferring and turning techniques...."</p> <p>3.1-40(a)(1)</p>			

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F0323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review, interview, and observation, the facility failed to assess for elopement risk, develop interventions to prevent elopement and provide adequate supervision of a cognitively impaired resident with a known elopement attempt, resulting in the resident sustaining a fractured arm when the resident was let out of the building by a facility staff member. This affected 1 of 4 residents reviewed for wandering behavior/elopements in the sample of 24 [Resident # 134]. In addition, the facility failed to thoroughly investigate an elopement and develop interventions for prevention of future elopements for 1 of 6 residents reviewed for wandering behaviors/elopement in the supplement sample of 6. [Resident # 136]. The facility failed to identify and correct a non-functional exit door [employee entrance door]. This deficient practice had the potential to affect 3 of 4 residents reviewed for wandering behavior/elopements in the sample of 24 [Residents #51, 44, and 43] and 4 of 6 residents reviewed for wandering</p>	F0323	<p>F323 Free of Accident Hazards/Supervision/Devices</p> <p>1. Resident #136 was transferred to a facility with a secured unit on 7-19-12. Resident #134 no longer resides in the community.</p> <p>2. a. Elopement assessments were reviewed for all residents 7-13-12.</p> <p>b. Residents identified at risk for elopement had their picture taken and were added to the Elopement Book and books were placed at each reception desk and nurses stations.</p> <p>c. Care Plans were updated to reflect appropriate interventions.</p> <p>d. 15 Minutes checks of residents identified as an elopement risk were initiated pending doors being alarmed or secured.</p> <p>e. Residents identified at risk to elope were added to the C.N.A. assignment sheets.</p> <p>3. Systemic changes include:</p> <ul style="list-style-type: none"> · Staff were immediately in-serviced on the elopement policy. · Employees who are PRN, FMLA and/or on vacation will be 	08/08/2012	

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	<p>behaviors/elopement in the supplemental sample of 6 [Residents #136, 31, 52, and 34].</p> <p>The Immediate Jeopardy began on 5/20/12 when the facility failed to assess for elopement risk, develop interventions to prevent elopement and provide adequate supervision of a cognitively impaired resident with a known elopement attempt, resulting in the resident sustaining a fractured arm when the resident was let out of the building by a facility staff member. The facility Administrator, Associate Administrator, 3 Corporate Clinical Specialists [Registered Nurse], and the Corporate Vice President were notified of the Immediate Jeopardy on 7/13/12 at 4:15 P.M. The Immediate Jeopardy was removed on 7/16/2012, but the facility remained at the lowered scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings Include:</p> <p>Review on 7/9/12 at 9:00 A.M. of the facility reported incident included, but was not limited to, "Date received 5/22/12... Resident/Patient/Clients: [Resident #134]... Intake Detail: Date of Alleged: 5/20/12 at 2:10 P.M.... Brief</p>		<p>in-serviced prior to the beginning of the next scheduled shift.</p> <ul style="list-style-type: none"> · At the discretion of the DON/Designee, 1:1 checks of a resident who is actively exit seeking will be implemented if it is determined that 15 minute checks are not sufficient. · Employees on the Terrace (independent living) were in-serviced on Elopement Policy. · Elopement Books were also placed in the Terrace (independent living) and Davita (dialysis unit) to alert staff of residents at risk to elope · A meeting was held with Terrace residents to caution them from assisting Skilled residents out of any door(s). · New employees will be in-serviced on the elopement policy during their orientation and the elopement policy will be reviewed quarterly for current employees. · New admissions will be assessed for potential elopement at time of admission and updated should a change occur that represents an exit seeking concern. · Nursing progress notes will be reviewed by the Unit Managers to identify resident who has exhibited a recent 'exit seeking behavior by action and/or statements made. An elopement assessment will be updated and interventions implemented. <p>4.</p>				

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	<p>Description of Incident: Staff member [Dietary Aide #1] let resident [Resident #134] out key coded door... Staff member [Dietary Aide #1] thought resident was a visitor... Staff member [Dietary Aide #1] walked to other side of the building, upon returning staff member observed she [Resident #134] had fallen... Staff member [Dietary Aide #1] notified nursing personnel immediately... Type of Injury/Injuries: Received 3 minor abrasions... Immediate Action Taken: Head to toe assessment completed... Physician and family notified... One on one [supervision] initiated... Preventive Measures Taken: Supervisor [Registered Dietician #2] immediately inserviced staff member Dietary Aide #1]..."</p> <p>The facility failed to include in the report the resident's injury of fractured humerus.</p> <p>On 7/12/12 at 3:30 P.M., Resident #134's closed record was reviewed. Diagnoses included, but were not limited to, atrial fibrillation, Alzheimer's disease, weakness, abnormal gait, and aftercare for hip fracture.</p> <p>Resident #134 was admitted to the facility on 2/23/12 and discharged to local hospital on 5/20/12.</p> <p>An "Admission /Readmission Nursing</p>		<p>The DON/designee will audit 5 residents with those who have exhibited 'exit seeking' behaviors by action and/or statement made for an updated elopement assessment 5 times per week for 30 days, then monthly for 3 months, then monthly for 8 months to total 12 months of monitoring.</p> <p>The DON/Designee will present the findings at the monthly QA meeting for review and recommendations made by the Committee.</p> <p>The results these reviews will be discussed at monthly facility Quality Assurance Committee meeting for and the Committee will determine the frequency and duration of reviews.</p>				

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	<p>Assessment," dated 2/23/12 at 2:21 P.M., included, but was not limited to, "Resident [Resident #134] alert and oriented to person... Right hip fracture... Resident high fall risk and bed and chair alarms applied..."</p> <p>There was no documentation of an elopement assessment completed on admission.</p> <p>A "Fall Care Plan," dated 2/23/12, included, but was not limited to, "Problem: Resident [#134] is at risk for falls related to hip fracture... Goal: Resident will remain free from injury related to falls... Approach: Assist with ADLs [Activities of Daily Living] as needed... Bed and chair alarms... Cue/remind resident to use call lights to seek assistance as needed... Keep call light in reach at all times... Keep personal items and frequently used items within reach..."</p> <p>An admission "Minimum Data Set, assessment, dated 3/1/12, included, but was not limited to, "Brief Interview for Mental Status [BIMS] of 3 [severe cognitive impairment]... Transfer: 3/2 [extensive assistance requiring one person]... Ambulation of unit: 4/2 [total dependence requiring one person]...."</p>				

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	<p>There were no other "Minimum Data Set" assessments completed on Resident #134 to signify a change in condition.</p> <p>An "Impaired Decision Making Care Plan," dated 4/19/12, included, but was not limited to, "Problem:[Resident #134] has had episodes of impaired decision making ability... Goal: [Resident #134] will have no negative effects from her impaired decisions related to falls/injuries... Approach: Communicate routinely with MD, family, resident... Educate resident on potential negative effects from impaired decisions... Encourage [Resident #134] to participate in all aspects of her care... Encourage to utilize call light for assistance instead of trying to transfer independently... Praise for being compliant..."</p> <p>A "Nurse's Progress Notes," dated 4/19/12 at 11:49 A.M., included, but was not limited to, "Writer spoke with her [Resident #134] [daughter] via telephone today to answer the questions that [Resident #134] was unable to answer because of her cognitive dysfunction... [Resident #134] is going to [local facility's] secured unit on or around 6/1/12... will continue to work with [Resident #134] and her family on appropriate discharge planning..."</p>			

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	<p>A "Nurse's Progress Notes" dated 4/24/12 at 4:28 A.M., included, but was not limited to, "[Resident #134] up ad lib... continues with alarms to wheelchair... is reminded several times to remain seated in wheelchair due to resident's attempting to self transfer and has a risk of falls..."</p> <p>A "Nurse's Progress Notes," dated 5/11/12 at 1:12 A.M., included, but was not limited to, "Patient [Resident #134] continues to ambulate without staff spotting her... Patient has been educated multiple times regarding need for staff to be present while ambulating to relieve fall risk..."</p> <p>A "Nurse's Progress Notes" dated 5/11/12 at 10:48 P.M., included, but was not limited to, "Requires a lot of verbal redirection due to multiple unassisted transfers and unsteady gait... Personal safety alarm on and functioning..."</p> <p>A "Nurse's Progress Notes," dated 5/14/12 at 10:48 P.M., included, but was not limited to, "Patient [Resident #134] has not attempted to elope this shift... In report, it was reported that she had attempted in the A.M. [to elope]... Patient has been cooperative with nursing care... Patient able to ambulate well..."</p> <p>There was no documentation of</p>						

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	<p>immediate interventions placed after the attempted elopement on 5/14/12 and there was no documentation of a completed elopement assessment on 5/14/12.</p> <p>There was no documentation of notification of social service personnel regarding the attempted elopement on 5/14/12.</p> <p>A "Nurse's Progress Notes," dated 5/18/12 at 2:44 P.M., included, but was not limited to, "[Resident #134] continues to have severe cognitive deficit and her needs have to be anticipated and provided by nursing staff and family when they are available..."</p> <p>A "Nurse's Progress Notes," dated 5/20/12 at 12:19 P.M., included, but was not limited to, "Resident was witnessed by therapy walking out of main entrance into the parking lot... Resident was let out of the front door by a visiting delivery service... Therapy notified writer [Registered Nurse #3] and we approached resident in parking lot she had her walker and all personal belongings draped on top of the walker... Resident stated she was going to walk home... Resident was alert and oriented x 3 new [sic] her name where she was and time... Escorted resident back into the building... upset and resistant... placed on 15 minute</p>						

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	<p>checks... called daughter, paged MD, and notified weekend supervisor... Received order to [sic] motion censor [sic] resident room along with 15 minute checks..."</p> <p>A "15 Minute Monitoring Record," dated May 20, 2012, included, but was not limited to, "12:30 P.M. to 1:45 P.M.: Lounge... 2:00 P.M. to 2:15 P.M.: Resident Room... 2:30 P.M.: No documentation noted... 2:45 P.M. to 11:00 P.M.: Started 1 on 1..."</p> <p>A "Nurse's Progress Notes," dated 5/20/12 at 2:10 P.M., included, but was not limited to, "[Dietary Aide #1] came down the hall and stated that a resident [Resident #134] was standing at the front door when she [Dietary Aide #1] went to clock out and that she let her [Resident #134] outside alone... when she [Dietary Aide #1] returned from clocking out she spotted the resident down in the parking lot... she [Dietary Aide #1] went back into the building to find the closest nursing station and sent to assist her... [Resident #134] had minor abrasions on knees and was guarding right arm... order obtained for x-ray... notified daughter... [daughter] sending daughter to sit with resident... resident placed immediately on 1 on 1 supervision..."</p> <p>An 'Elopement Assessment,' dated</p>						

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	<p>5/20/12 at 2:30 P.M., included, but was not limited to, "Does the resident have a pertinent diagnosis: yes... Dementia... makes poor judgements, moderate difficulty redirecting... Is resident having difficulties with facility placement: yes... expresses wish to go home... Is resident at risk for elopement: yes... If a resident is considered at risk for elopement, consider the following interventions and update the resident's care plan and CNA [Certified Nursing Assistant] assignment sheet: [the boxes marked] Personal safety alarm device, frequent monitoring: 1 on 1 supervision, and motion sensor alarm to room door..."</p> <p>A "Nurse's Progress Notes," dated 5/20/12 at 10:41 P.M., included, but was not limited to, "X-ray results received and reported... Received new order to send [Resident #134] to [local hospital] emergency room... Daughter informed of x-ray results and order to send to hospital... Resident has been resting in bed calmly with CNA [Certified Nursing Assistant] at bedside... Neurological checks and vitals within normal limits... Norco [pain medication] given x 2 this shift... Right upper extremity immobilized... Noted blood pooling under skin with notable bruising to right shoulder..."</p>						

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	<p>On 7/12/12 at 5:30 P.M., the facility investigation of Resident #134's elopement on 5/20/12 was requested from the facility Administrator.</p> <p>On 7/13/12 at 9:30 A.M., the facility Administrator provided the investigation of the elopement on 5/20/12.</p> <p>The facility investigation included, but was not limited to:</p> <p>A "Radiology Report" dated 5/20/12, no time, included, but was not limited to, "[Resident #134]... Exam: Shoulder, 1 View, Right... Conclusion: Acute fracture and dislocation..."</p> <p>A written statement from Registered Dietician #2, dated 5/20/12, no time, included, but was not limited to, "[Dietary Aide #1] approached myself and stated she did something wrong... she knew she would get into trouble for and wanted to fess up now... She [Dietary Aide #1] stated she opened the front door to allow a resident [Resident #134] to go outside... [Dietary Aide #1] stated the resident was carrying several clothing items and she didn't know she was a resident... [Dietary Aide #1] was then notified that the resident fell outside, which is when she approached me [Registered Dietician #2]... After I [Registered Dietician #2]</p>						

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	<p>checked with the nursing supervisor and staff, I spoke with [Dietary Aide #1] one on one and told her under no circumstances should she allow a resident to go outside without a staff member... [Dietary Aide #1] received a copy of the elopement policy... She voiced understanding of the policy and received verbal counseling by myself for the incident...."</p> <p>A written statement from Dietary Aide #1, no date or time, included, but was not limited to, "On date of May 20, 2012 a resident [Resident #134] was at the door with a few of her shirts on hangers... not knowing I was not supposed to open the doors for residents, I had opened the door... I let her [Resident #134] out and finished walking across the parking lot to the dish room... It was around 2:40 P.M. when I had gotten in the other doorway by the time clock... another resident's family member came and had asked for help... a resident was down in the parking lot... I ran for help... it was barely a 3 minute lapse from the time I opened the door..."</p> <p>There were no other interviews provided in the elopement investigation.</p> <p>A "Staff Development" program attendance record, dated 5/21/12 through 5/26/12, included signatures of dietary</p>						

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	<p>staff for the program titled, "Elopement" with the policy and procedure for "Eloperments" attached.</p> <p>On 7/16/12 at 12:25 P.M., in an interview, the facility Administrator indicated the only other staff inserviced were those that were present in the facility on 5/22/12. He indicated he did not have further documentation regarding other staff being inserviced on elopement.</p> <p>At that time, the facility Administrator provided a document titled, "Sign in Sheet: Topics Discussed: Employee Morale, employees breakroom remodel, new team members, parking, elopement, resident abuse, questions and concerns..."</p> <p>The sign in sheet included, but was not limited to, signatures from administration, nursing, and housekeeping.</p> <p>On 7/13/12 at 1:15 P.M., in an interview with the facility Administrator, all information regarding Resident #134's elopement interventions and facility interventions placed after the 5/20/12 incident were requested.</p> <p>On 7/13/12 at 2:30 P.M., in an interview, the facility Administrator indicated there were no other documents to provide regarding the attempted elopement of</p>						

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	<p>Resident #134 on 5/14/12 and elopement of Resident #134 on 5/20/12.</p> <p>2. On 7/16/12 at 12:30 P.M., the clinical record for Resident #136 was reviewed. Diagnoses included, but were not limited to, cognitive deficit and cerebrovascular disease.</p> <p>Resident #136 was admitted to the facility on 1/19/2012.</p> <p>An elopement risk assessment, dated 1/19/2012, indicated Resident #136 was not an elopement risk.</p> <p>A quarterly elopement risk assessment, dated 7/3/2012, indicated Resident #136 was not an elopement risk.</p> <p>A quarterly "Minimum Data Set" assessment, dated 7/3/12, included, but was not limited to, "Brief Interview Mental Status: 1 [severe cognitive impairment]... "</p> <p>A "Progress Note," dated 7/3/12 at 1:31 P.M., included, but was not limited to, "[Resident #136] continues to prefer own routine... sister visits daily for several hours and will take him for walks outside and around the building..."</p> <p>There was no documentation of an</p>						

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	<p>attempted elopement prior to 7/5/12.</p> <p>A "Progress Note," dated 7/5/2012, at 1:00 P.M., included, but was not limited to, "[Resident #136] observed by staff in parking lot... Assessed, skin dry and intact with no signs or symptoms of perspiration, redness, or injuries..."</p> <p>A "Progress Note," dated 7/5/12 at 5:07 P.M., included, but was not limited to, "Resident placed in elopement book... it appears that a visitor may have held door for resident to enter the [Assisted Living] apartments as he was wandering this date and when he entered the area he then opened the door on the apartment side and was in the parking area [staff parking area]... he has not attempted to go near doors again... educated him on need for staff/family to be with him outdoors... currently on 15 minute checks... elopement care plan completed... MD notified... notified sister with care plan meeting to be held on 7/6/12 to discuss possibly memory care unit... she [sister] hopes facility will be able to continue placement..."</p> <p>Unable to locate documentation regarding Resident #136's previous wandering as described in the above progress note.</p> <p>An updated elopement risk assessment</p>				

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	<p>completed at 2:12 P.M., on 7/5/2012, indicated Resident #136 was at risk for elopement.</p> <p>On 7/16/12, at 12:20 P.M., the Director of Nursing [DON] provided the investigation of the incident. This included , but was not limited to the following information:</p> <p>A document titled, "Indiana State Department of Health Incident Report Form," dated 7/5/2012, included, but was not limited to the following:</p> <p>"Brief Description of Incident: Elopement. Nurse saw resident in parking lot outside Station 2 and brought back inside."</p> <p>"Immediate Action Taken: Assessed resident..."</p> <p>"Preventive measures taken: Started 15 minute checks on resident. Notified MD and family. Checked door at Station 2 to ensure locks appropriately. Elopement assessment updated. Care planned. Added picture of resident to Elopement Book."</p> <p>One staff interview indicated, "Resident spotted by writer in the parking lot 7-5-12 @ 1300 [1:00 P.M.]. Resident alone</p>						

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	<p>propelling himself in the wheelchair. Nurse assisted the resident back into the facility and notified unit manager." This statement was signed by LPN #7.</p> <p>During an interview on 7/16/2012 at 2:30 P.M., Clinical Specialist [RN] #8 indicated the facility had not implemented any interventions because they were not certain how the resident exited the facility. Clinical Specialist #8 indicated there should be a sign on the independent living door informing visitors not to allow residents through the door.</p> <p>3. The facility "Elopements" policy and procedures, dated 8/05, included, but was not limited to, "Policy: Nursing personnel must report and investigate all reports of missing residents... Procedures: Elopement risk Assessment: It is the policy of this facility to assess all residents upon admission, quarterly, and with significant changes for their elopement risk. Residents identified as being high risk for elopement will have a plan of care that identifies the risk and appropriate interventions..."</p> <p>4. On 7/14/2012 at 10:15 A.M., a tour of the facility to evaluate exit doors was initiated. The door at the employee entrance was observed. Next to the door was a functioning keypad. Social</p>				

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	<p>Services #9 indicated the door was only supposed to open when the correct code was entered on the keypad inside or on the keypad outside. The door contained a push-bar, but the door would not latch and therefore could not be closed tightly. At the top of the door was a magnetic closing device. Upon testing the door, it opened freely without depressing the push-bar or entering a code on the keypad. The magnetic closing device appeared to be hanging loosely from the doorframe. The Maintenance Director was notified. He indicated the door was not in that condition an hour ago and that he would fix it again.</p> <p>On 7/15/2012, at 2:15 P.M., this exit door was observed to still not latch. The door could be pushed open without depressing the push-bar or entering a code on the keypad.</p> <p>On 7/15/2012, at 2: 30 P.M. this exit door was observed. The door still was not latched but was securely held closed by the magnetic closing device.</p> <p>On 7/16/12 at 12:30 P.M., the facility Administrator provided a document titled, "Listing Of Residents That Are Potentially At Risk For Elopement," no date included on the document. In an interview, at that time, the facility</p>						

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	<p>Administrator indicated the document was a current list of residents at risk for elopement.</p> <p>The residents included on the list were Residents #136, 31, 52, 51, 34, 44, 43, 66, and 130.</p> <p>The residents who had access to the employee entrance door were Residents #136, 31, 52, 51, 34, 44, and 43.</p> <p>The Immediate Jeopardy that began on 5/20/12 was removed on 7/16/12 after the facility inserviced facility employees in all departments on the facility elopement policy, doors were observed alarmed or secured, residents identified as an elopement risk were added to the elopement book and Certified Nursing Assistant assignment sheets, new policies and procedures were put in place for residents who are actively exit seeking, signs to alert visitors to refrain from assisting a resident have been enlarged, and maintenance ensured and will continue to ensure that the doors are functioning properly, but non-compliance remained at the lowered scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>3.1-45(a)(1)</p>						

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F0371 SS=F	<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>Based on observation and interview, the facility failed to maintain equipment in a sanitary condition, and failed to label food and juices with a date of preparation or "use by" date; in 1 of 1 main kitchen area and 2 of 4 unit medication/pantry refrigerators. This deficiency had the potential to impact 124 of 124 residents who received food from the main kitchen.</p> <p>Findings include:</p> <p>1. During the initial Kitchen Sanitation tour on 7/9/12 at 10:30 A.M., multiple clean metal pans were observed stacked one on top of another and upside down on drying racks in a small room off the dishwashing area. Four pans were lifted from the middle of four different stacks, and the inside of the pans were observed to have water dripping from the inside wall surfaces.</p> <p>2. During the full Kitchen Sanitation tour on 7/10/12 at 2:45 P.M., with the Dietary Manager and Registered Dietician in</p>	F0371	<p>F 371 Food Procure, Store/Prepare/Serve- Sanitary</p> <p>1. Food without labels were discarded immediately and pitchers with no labels were emptied and reissued with the correctly dated label. Metal pans were all washed and dried and meat slicer was thoroughly cleaned. New supplies were dated and labeled.</p> <p>2. All kitchen areas and food services areas have been inspected. No other issues were identified.</p> <p>3. Systemic Changes includes: · Dietary Manager or designee will conduct rounds throughout the shift to observe that pitchers containing liquids are labeled and dated properly. · Dietary Manager will complete a 'Kitchen Food Service' audit form weekly. · Sanitation guidelines will be implemented. · In-services will be conducted with staff prior to 8/3/12 to review the importance of sanitation of the</p>	08/08/2012			

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	<p>attendance, the following was observed:</p> <p>A. The drying rack again had multiple clean metal pans stacked one on top of another and upside down on the rack. Three were observed to be wet and dripping water from the inside wall surfaces.</p> <p>In an interview, the Registered Dietician indicated staff were aware that the clean pans were to be dry on the inside before stacking them together.</p> <p>B. A meat slicer was observed on a lower shelf of a prep table. A large black plastic bag was partially pulled over the slicer. There was multiple crumbs and dust on the blade and platform used to hold the product for slicing. In an interview, the Dietary Manager indicated they use the meat slicer "a lot--almost every day."</p> <p>C. The stand-up refrigerator in the main kitchen area had two large metal pans filled with sandwiches. There was no label, and no date the sandwiches were prepared or to be used by.</p> <p>2. During a tour of the general environment on 7-9-2012, beginning at 1:05 P.M., the medication storage rooms/pantries were observed. In the medication storage room/pantry on the</p>		<p>kitchen area and the labeling and dating of food and liquid on a daily basis.</p> <p>4.</p> <p>The Administrator/designee will review the audits completed by the Dietary Manager three times a week for 30 days, then weekly for 3 months, then monthly for 8 months to total 12 months. The results of the reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee.</p>		

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	<p>800 Hall a refrigerator was observed to contain 2 pitchers containing a dark liquid. One of 2 pitchers did not contain a label.</p> <p>In an interview at that same time, LPN #23 indicated these pitchers contained iced tea that is served to the residents.</p> <p>3. In the medication storage room/pantry on the 200 Hall a refrigerator was observed to contain 2 pitchers; one containing a pink liquid; the other containing an orange liquid. Two of 2 pitchers did not contain a label.</p> <p>In an interview at that same time, LPN #24 indicated these pitchers contained juice that is served to the residents.</p> <p>"Retail Food Establishment Sanitation Requirements Title 410 IAC 724" effective 11/13/04 indicates the following:</p> <p>"SEC 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on one (1) of the temperature and time</p>			

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	<p>combinations specified as follows and the day of preparation shall be counted as day one (1):...."</p> <p>3.1-21(i)(2)</p>				

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F0425 SS=B	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded. This deficient practice affected 2 of 4 medication rooms in the facility and had the potential to affect 24 of 24 residents residing on the 200 Hall and 23 of 23 residents residing on the 500 Hall.</p> <p>Findings include:</p> <p>1. During a tour of the general environment on 7-9-2012, beginning at</p>	F0425	<p>F 425 Pharmaceutical Services/Accurate Procedures</p> <p>1. The expired medications were destroyed.</p> <p>2. The medication storage areas in the community were audited for any additional expired medications and no issues were identified. Refrigerators in the community were audited to determine that no other expired medications were found and no issues were identified.</p> <p>3. Systemic changes include:</p> <p>Nurses were educated to</p>	08/08/2012			

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	<p>1:05 P.M., the 500 Hall medication storage room was observed to contain a small refrigerator in which medications were stored. A 5 ml vial of Flulaval 2011/2012 Formula (an Influenza Virus Vaccine) was observed inside the refrigerator. The vial contained a label with an expiration date of June 2012.</p> <p>2. At 1:55 P.M., the 200 Hall medication storage room was observed to contain a small refrigerator in which medications were stored. Observed inside the refrigerator were 4 expired medications labeled for specific residents. The medications were as follows: Phenadoz (a medication used to treat hypersensitivity reactions or nausea) Suppository, 25 mg, "exp 11/29/11;" Phenadoz Suppository, 25 mg, "exp 1/24/12;" Phenadoz Suppository, 25 mg, "exp 8/24/11;" Promethazine (a medication used to treat hypersensitivity reactions or nausea) Suppository, 12.5 mg, "exp 4/7/12."</p> <p>In an interview at that time, Unit Manager #20 indicated the pharmacy comes to the facility every evening to deliver medications and retrieve expired medications.</p>		<p>observe the dates on medications and return to pharmacy or destroy the expired medications.</p> <ul style="list-style-type: none"> · Refrigerators in the community were audited to ensure no other expired medications were found. · A schedule will be implemented for the night nurse to conduct weekly checks of all areas related to expired medications. <p>4. The Unit Managers will audit the refrigerators in their Units weekly for 30 days and then monthly for 3 months, then monthly for 8 months to total 12 months and will document the findings on an audit form. The Director of Nursing will review the audits and will present the findings at the monthly Quality Assurance Committee meeting for 3 months and then quarterly thereafter for a total of 12 months. The Committee will determine the duration and frequency of the audits thereafter.</p>				

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	<p>On 7-11-2012, at 4:30 P.M., the facility's policy regarding disposal of expired medications was requested.</p> <p>On 7-12-2012, at 9:15 A.M., the Administrator provided a copy of the facility's "Drug Disposal" policy, no date indicated. This policy included, but was not limited to, the following information:</p> <p>"Discontinued drugs or those that remain in the facility after a resident's discharge or death (that are not house supplied or returned for credit) are to be destroyed by the facility. A record of their destruction shall be noted in the resident's medical record..."</p> <p>No other policy regarding expired medications was provided.</p> <p>3.1-25(o)</p>				

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F0465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to ensure shower chairs were maintained in safe, functional condition. This deficient practice affected 2 shower chairs in 1 of 4 shower rooms and had the potential to affect 23 of 23 residents who used this shower room in the facility population of 128.</p> <p>Findings include:</p> <p>1. During the quality of life assessment group interview on 7-11-2012, at 1:30 P.M., Resident #81 indicated she did not feel safe when using the shower chairs in the 500 Hall shower room. She indicated the chairs did not have locking wheels and she felt fearful that the chairs might "take off rolling" when she was in them.</p> <p>2. At 2:45 P.M., 2 of 2 shower chairs in the 500 Hall shower room were observed to not have locking wheels.</p> <p>During daily conference at 4:35 P.M., on 7-11-2012, the Administrator was informed of the condition of the 2 shower</p>	F0465	<p>F 465 Safe/FunctionalSanitary Comfortable Environment</p> <p>1. Rental shower chairs were ordered until 2 new shower chairs could be delivered. Identified shower chairs were discarded.</p> <p>2. Shower chairs throughout the rest of the facility were checked for proper functioning and no others were identified.</p> <p>3. Systemic Changes includes:</p> <p>a. Maintenance Director will complete the Environmental Observation Form weekly . Any identified equipment will be repaired or discarded.</p> <p>b. Staff will be in-serviced prior to 8/3/12 to review the need to observe signs of resident equipment that may need replaced or serviced by use of a 'Maintenance Repair Request' form located at the nurses stations throughout the community.</p> <p>c. Any equipment needs will be communicated to the maintenance Director or designee each morning at department head morning meeting unless communication is</p>	08/08/2012	

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	<p>chairs in the 500 Hall shower room.</p> <p>On 7-12-2012, at 9:15 A.M., the Administrator provided copies of invoices for 2 new shower chairs for review. In an interview at that time, the Administrator indicated the brakes on the shower chairs were not working and that new shower chairs had been ordered for the 500 Hall.</p> <p>3.1-19(f)</p>		<p>needed sooner for resident safety.</p> <p>4.</p> <p>The Associate Administrator will review the Maintenance Directors audits three times a week for 30 days, then weekly thereafter for 3 months, then monthly for 8 months.</p> <p>The results of the reviews will be discussed at the monthly Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a period of 12 months. The frequency and duration of the continued reviews will be determined by the committee.</p>		

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F9999	<p>STATE FINDINGS</p> <p>3.1-9 PERSONAL PROPERTY</p> <p>1. The facility must inventory, upon admission and discharge, the personal effects, money, and valuables declared by the resident at the time of admission. It is the resident's responsibility to maintain and update the inventory listing of the resident's personal property.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to complete a personal inventory of the personal effects at the time of admission for 1 of 24 residents reviewed. [Resident #44]</p> <p>Findings include:</p> <p>The electronic and paper clinical record for Resident #44 was reviewed on 7/11/12 at 9:35 A.M. The resident was admitted on 1/20/12 with diagnoses which included, but were not limited to, senile dementia, osteoarthritis, and syncope/collapse.</p> <p>An inventory of his personal effects,</p>	F9999	<p>9999 State Findings Personal Property</p> <p>1. An inventory sheet was completed for Resident #44.</p> <p>2. An audit was completed for all current residents to check for the inventory sheets. No issues were identified.</p> <p>3. Systemic changes include:</p> <ul style="list-style-type: none"> · The Unit Managers will be responsible to check that an inventory sheet has been completed on the new admissions. · If a new admission does not have an inventory sheet during the chart check, one will be completed. <p>4. Charts for new admissions are reviewed at the next clinical stand up meeting following admission and the inventory sheet will be reviewed for completion.</p> <p>The Director of Nursing will present a report on inventory sheet compliance at the facility Quality Assurance Committee meeting. Recommendations made by the Committee will be followed.</p> <p>9999 State Findings Personnel</p> <p>1. The two contracted Therapists have since had the physical exam and tuberculin skin tests completed.</p>	08/08/2012			

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	<p>brought in with him upon admission, was not found in the paper clinical record.</p> <p>In an interview on 7/11/12 at 10:05 A.M., R.N. #6 indicated the inventory sheets were completed in the electronic records, under "Admissions."</p> <p>An inventory was not found in the electronic records.</p> <p>During the daily conference on 7/11/12 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any documentation of a personal effects inventory completed on admission for this resident.</p> <p>On 7/12/12, a copy of a paper "Inventory of Personal Possessions" form was provided. The inventory sheet was dated as 7/11/12.</p> <p>3.1-9(g)</p> <p>3.1-14 PERSONNEL</p> <p>1. (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</p>		<p>2. An audit was conducted of employee files to ensure that the physical examinations and tuberculin tests were administered as required.</p> <p>3. Systemic changes include:</p> <ul style="list-style-type: none"> · The Rehab Manager will check that the physical examination and required tuberculin skin test(s) have been completed prior to working in the community. <p>4. The Rehab Manager will audit and report to the Director of Nursing prior to the orientation that all new employees have had the required physical examination completed and tuberculin skin test completed annually. The Director of Nursing will present the audits during the month Quality Assurance Committee meeting. The frequency and duration of the continued audit will be determined by the Committee.</p>				

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	<p>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 result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. the facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p>						

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	<p>This State Rule was not met as evidenced by:</p> <p>Based on record review, the facility failed to ensure that employees received the required physical examinations and screenings prior to beginning employment at the facility. This deficient practice affected 2 employees in a random sample of 17.</p> <p>Findings include:</p> <p>On 7-12-2012, the Director of Nursing (DON) provided a list of facility employees. A random sample of employees was selected for file reviews.</p> <p>1. On 7-16-2012, at 10:00 A.M., documentation of a pre-employment physical examination for Physical Therapy employee #10 was not found in the employee file.</p> <p>2. On 7-16-2012, at 10:10 A.M., documentation of the second step tuberculin skin test for Occupational Therapy employee #11 was not found in the employee file.</p> <p>On 7-16-2012, at 10:20 A.M., documentation of a pre-employment physical examination for Physical</p>						

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	<p>Therapy employee #10 and the second step tuberculin skin test for Occupational Therapy employee #11 were requested from the Administrator.</p> <p>No additional documentation was provided.</p> <p>3.1-14(t)(1)</p>				