

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155568	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2015
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NAME OF PROVIDER OR SUPPLIER  WILLIAMSPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 18,19, 22, 23, and 24, 2015</p> <p>Facility Number: 000449 Provider Number: 155568 AIM Number: 100290350</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 18 Medicaid: 38 Other: 15 Total: 71</p> <p>These deficiencies reflect State findings cited in accordance with 10 IAC 16.2-3.1</p>	F 0000	<p>Williamsport Nursing and Rehabilitation is respectfully requesting a paper compliance review for the federal and state citings for the survey which ended June 24, 2015. Please review the plan of correction submitted, with supporting documentation, to establish substantial compliance has been met and maintained as of July 15, 2015. Thank you in advance for your attention to this very serious matter.</p>	
F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>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 ensure recommended pressure reducing interventions were implemented for 1 of 1 resident reviewed with a pressure ulcers. (Resident #20)</p> <p>Finding includes:</p> <p>On 6/24/15 at 11:00 a.m., Resident #20 was observed asleep in his bed. The resident's bilateral heels were touching the mattress on the bed. The resident's left heel was observed to be wrapped in kerlix. Comfy c-boots were not worn by the resident during this observation.</p> <p>On 6/14/15 at 1:38 p.m., Resident #20 was observed in his room lying in bed. The resident's bilateral heels were touching the mattress on the bed. Comfy c-boots were not worn by the resident during this observation.</p> <p>During an interview on 06/24/2015 at 2:05 p.m., LPN #2 indicated the resident's heels shouldn't be touching the bed at any time. She indicated Resident</p>	F 0314	<p><b>F 314 D Level</b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A low air loss mattress was requested from hospice and was placed on the resident's bed on 06/24/2015. The "heels up" device was discontinued when the mattress was put into place. A care plan was put into place regarding the mattress and an ortho comfort boot to be worn by the resident to protect his heel. One on one education was provided to nursing and direct care staff regarding the new care plans and interventions by the Director of Nursing Services or designee.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> A daily CQI audit for two weeks will be completed by the Director of Nursing Services or designee to identify residents with decreased mobility, residents at risk for pressure ulcers, and current interventions. CQI audits will be completed daily for two weeks, weekly for four weeks, bi-weekly</p>	07/15/2015

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	<p>#20 was to be wearing his comfy c-boots at all times.</p> <p>The clinical record was reviewed on 6/19/15 at 11:03 a.m. Diagnoses included but were not limited to, impaired mobility, dementia, and muscle weakness. The most recent Minimum Data Set Assessment (MDS) was completed on 5/18/15. The assessment identified the resident as severely impaired in cognitive decision making skills.</p> <p>A physician order, dated 5/12/15, indicated Resident #20 was to wear comfy c-boot orthosis to bilateral lower extremities at all times except when bathing.</p> <p>A weekly skin sheet, dated 6/16/15, indicated Resident #20 had a stage 3 pressure ulcer to left heel that measured 3.3 cm (centimeters) in length, 1.5 cm in width, with a 0.1 cm depth. The pressure ulcer was identified on 12/19/14.</p> <p>A care plan for risk of skin breakdown, dated 6/20/12, and revised on 5/1/15, indicated, "...bilateral comfy orthosis boot at all times-may remove for hygiene...."</p> <p>A care plan for impaired skin integrity,</p>		<p>for six weeks, and then monthly for four months until compliance has been displayed for two consecutive monthly CQI audits.</p> <p><b>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</b></p> <p>Education was provided to staff through in-servicing in regards to identifying interventions on a profile and ensuring they are in place on a weekly basis. Director of Nursing Services or Designee will provide in-service training with staff and complete training by July 15, 2015. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Wound, and Change in condition CQI audits to be completed by Director of Nursing Services or Designee monthly for six months until compliance has been displayed for two consecutive monthly audits. <b>By what date will the systematic changes be completed?</b> July 15, 2015</p>	

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F 0315 SS=D Bldg. 00	<p>dated 12/19/14, and revised on 5/1/15, indicated, "...bilateral off loading boots...."</p> <p>A policy dated 2/2015, titled, "Skin Management Program", was provided by (Director of Nursing) DON on 6/25/15 at 11:20 a.m., The policy indicated, "...1. A plan of care will be initiated to include resident specific risk factors with appropriate interventions...."</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview, and record review, the facility failed to ensure</p>	F 0315	<b>F 315 D Level</b> What corrective action(s) will be accomplished for those residents found to	07/15/2015	

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	<p>services were provided to prevent possible urinary tract infections for 2 of 2 residents reviewed with a urinary catheter. (Residents #20 and #104)</p> <p>Findings include:</p> <p>1. On 6/19/15 at 9:37 a.m., Resident #20 was observed sitting in a wheelchair in his room. The drainage tube from the resident's indwelling urinary catheter was observed on the floor under his wheelchair.</p> <p>On 6/22/15 at 10:48 a.m., Resident #20 was observed sitting in a wheelchair in his room. The drainage bag from the resident's indwelling urinary catheter was observed on the floor under his wheelchair.</p> <p>On 6/23/15 at 9:15 a.m., Resident #20 was observed sitting in a wheelchair at the nurses' station on the 200 hall. The drainage bag from the resident's indwelling urinary catheter was observed on the floor under his wheelchair.</p> <p>On 6/23/15 at 11:11 a.m., Resident #20 was observed sitting in a wheelchair in his room. The drainage bag from the resident's indwelling urinary catheter was on the floor under his wheelchair.</p>		<p><b>have been affected by the deficient practice?</b> The catheter tubing for the resident affected was clipped to the bed and put into a basin on the floor and covered with a towel while the resident was in bed. Resident is in a bed in the low position, tubing placed in basin to ensure proper drainage while in bed and to prevent tubing from touching floor. When is wheelchair catheter bag and tubing placed in privacy bag attached to the wheelchair to prevent tubing from touching floor, when leg bag not in use. The care Staff is to be in-serviced about catheter tubing touching the floor, infection control issues and corrective action to be taken. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> This and any other residents with a catheter will be given the option to use a leg bag while out of bed to prevent tubing from touching the floor, or drainage bag will be placed with tubing in a privacy bag attached to his or her wheelchair. Director of Nursing Services or designee will complete a daily audit for two weeks audit of residents in the building with catheters for positioning of tubing and bag placement, then weekly for four weeks, bi-weekly for ten weeks, and then monthly for two months</p>	

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	<p>On 6/23/15 at 12:06 p.m., Resident #20 was observed sitting in a wheelchair in the main dining room. The resident's drainage tubing and bag from the resident's indwelling urinary catheter were observed on the floor under his wheelchair.</p> <p>On 6/23/15 at 3:00 p.m., Resident #20 was observed sitting in a wheelchair at the nurses' station on the 200 hall. The drainage bag from the resident's indwelling urinary catheter was observed on the floor under his wheelchair.</p> <p>On 6/24/15 at 1:32 p.m., Resident #20 was observed lying in bed in his room. The drainage bag from the resident's indwelling urinary catheter was on the floor under his bed.</p> <p>Resident #20's record was reviewed on 6/24/15 at 2:18 p.m. Diagnoses included, but were not limited to, urinary retention and prostate cancer. The most recent Minimum Data Set Assessment (MDS) was completed on 5/18/15. The assessment identified the resident as severely impaired in cognitive decision making skills.</p> <p>A care plan, dated 9/26/14, indicated the resident required an indwelling urinary catheter. The care plan indicated, "...do</p>		<p>until compliance has been displayed for two consecutive monthly audits. <b>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</b> Staff will be educated and trained by the Director of Nursing Services or designee about catheters being placed in bags and attached to the resident's wheelchair or bed frame to prevent tubing from touching the floor. Monthly in-service training will be provided to the staff with return demonstration to be completed for three months until compliance has been displayed for two consecutive monthly audits. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> The Director of Nursing Services or designee will complete a CQI audit regarding Catheters and Infection control monthly for six months until compliance has been displayed for two consecutive monthly audits. <b>By what date will the systematic changes be completed?</b> July 15, 2015</p>	

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	<p>not allow tubing or any part of the drainage system touch the floor...."</p> <p>2. During an observation on 6/19/15 at 12:00 p.m., Resident #104 was being transported in the 100 hall while seated in a wheelchair. The drainage tubing and bag from the resident's indwelling urinary catheter were observed dragging on the floor under her wheelchair.</p> <p>During an interview on 6/24/15 at 1:40 p.m., the Certified Nursing Assistant (CNA) #1 indicated the indwelling urinary catheter tubing and drainage bag shouldn't be touching the floor at anytime.</p> <p>Resident #104's record was reviewed on 6/24/15 at 2:18 p.m. A care plan, dated 6/17/15, indicated Resident #104 required an indwelling catheter and indicated, "...Resident will have catheter care managed appropriately as evidenced by: not exhibiting signs of urinary tract infection or urethral trauma...do not allow tubing or any part of the drainage system to touch the floor...."</p> <p>The most recent Minimum Data Set Assessment (MDS) was completed on 6/22/15 and identified the resident as cognitively intact in decision making skills.</p>			

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F 0323 SS=D Bldg. 00	<p>On 6/24/15 at 4:00 p.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON indicated there was not a facility policy about urinary catheter closed drainage system care. She indicated the indwelling urinary catheter drainage tubing and bag should not touch the floor at anytime and is a part of the residents' plan of care.</p> <p>3.1-41(a)(2)</p> <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. Based on observation, interview and record review, the facility failed to ensure precautions were implemented to prevent spillage of hot liquids for 1 of 1 residents reviewed with a history of spilling hot liquids on self. (Resident #49).</p> <p>Finding includes:</p> <p>During a lunch observation in the main dining room on 6/24/15 at 11:48 a.m.,</p>	F 0323	<b>F 323 D Level</b> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Education was provided to staff regarding adaptive equipment and the resident affected was provided hot liquids in a kennedy cup. Dietary Manager and Registered Dietician or designee reviewed all adaptive devices needed for meal service and updated tray cards and profiles to ensure accuracy.	07/15/2015

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	<p>Resident #49 was observed drinking coffee from an uncovered coffee mug. The resident's meal ticket was observed on the table and indicated a Kennedy (spillproof) cup was to be used for all hot liquids.</p> <p>On 6/24/15 at 11:56 a.m., the Dietary Manager indicated the coffee temperature was 166 degrees Fahrenheit.</p> <p>On 6/24/15 at 12:17 p.m., review of Resident #49's medical record indicated the following:</p> <p>The resident's diagnoses included, but were not limited to dementia and muscle weakness.</p> <p>A nurses' progress note dated 6/20/15 at 7:15 a.m., indicated the resident was drinking coffee in the main dining room when his cup fell into his lap. The resident complained of burning to his left inner thigh. The record indicated a 5 cm (centimeter) x 9 cm burst blister, pink in color with clear drainage noted.</p> <p>A physician's order, dated 6/20/15 at 10:39 a.m., indicated to apply Bacitracin to the affected area, apply non-stick pad and tape in place until healed. The Bacitracin was applied and the area was covered with nonstick pad and tape per</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> A master list has been created by the Dietary Manager and Registered Dietician or designee of all assistive devices ordered for Residents for use during meals. Master list will be updated regularly by the Dietary Manager or Designee and will include updating the tray cards used at meals. Director of Nursing Services or Designee will complete an audit in the dining room daily for four weeks, bi-weekly for eight weeks and then monthly for 3 months until compliance has been displayed for two consecutive monthly audits.</p> <p><b>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</b> Trays will be monitored when served using a two person system at each meal, starting with dietary and then nursing staff. Nursing Manager or Designee to audit trays and use of adaptive equipment daily for four weeks, then three times per week for one month, bi-weekly for three months, monthly for two months until compliance has been displayed for two consecutive monthly audits. In-service training to be provided to staff</p>	

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	<p>physician's order.</p> <p>A care plan, dated 6/21/15, indicated the resident was to use Kennedy cups for all hot beverages.</p> <p>A physician's order, dated 6/22/15 at 8:20 a.m., indicated to use a Kennedy cup for the resident's hot liquids for safety and skin integrity.</p> <p>The resident's 30-day Minimum Data Set Assessment (MDS), dated 6/3/15, indicated the resident had severe cognitive impairment and required extensive assistance with eating/self-performance and eating/support of one.</p> <p>On 6/24/15 at 1:40 p.m., during an interview, the Assistant Director of Nursing (ADON) indicated when Resident #49 spilled the hot coffee the nurse immediately performed first aid to the resident's left inner thigh and notified the physician for a treatment order. She indicated the resident's family was notified and they indicated the resident had no history of spilling drinks. The ADON indicated the Interdisciplinary Team (IDT) immediately instituted that lids were to be placed on the cups used for the resident's hot liquids. The ADON indicated the resident was referred to</p>		<p>members that serve from the kitchen and in the dining room, training to be completed on or before July 15, 2015. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> Director of Nursing Services or Designee will complete an audit in the dining room weekly for four weeks, bi-weekly for eight weeks and then monthly for 3 months or until compliance has been displayed for two consecutive monthly audits. <b>By what date will the systematic changes be completed?</b> July 15, 2015</p>	

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	<p>Occupational Therapy (OT) for assessment and recommendations of drinking hot liquids. She indicated she was not aware that the resident was not provided with a Kennedy cup for his coffee at the lunch meal. She indicated there had been no previous incidents of coffee being spilled with injury for the past 6 months.</p> <p>On 6/24/15 at 1:42 p.m., during an interview with the Dietary Manager, she indicated at the time of the spill incident they did not check the temperature of the coffee being served in the dining room. The Dietary Manager indicated dietary staff began letting the coffee stand for 30 minutes prior to being served after Resident #49 was burned. She indicated she had placed a call to the vendor, and the representative would come to the facility and adjust the temperature of the coffee machine. The Dietary Manager indicated the kitchen had the Kennedy cups in supply to be used by for the resident's hot liquids. She indicated it was the responsibility of the staff who served the resident his meal to ensure the hot liquids are placed into the Kennedy cup.</p> <p>On 6/24/15 at 12:00 p.m., a current copy of the resident's meal tickets for his breakfast, lunch and dinner meals dated 6/24/15, provided by the Dietary</p>			

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	<p>Manager, indicated the resident would be provided Kennedy cups for all hot liquids.</p> <p>A document titled, "Resident Profile," was provided by the ADON on 6/24/15 at 3:10 p.m. The document indicated under, "Problem Category," dated 6/21/15, "resident to use a Kennedy cup for all hot beverages."</p> <p>3.1-45(a)(1)</p>			