

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 2, 3, 4, 5, 6, & 9, 2013.</p> <p>Facility number: 000141 Provider number: 155236 AIM number: 100283660</p> <p>Survey team: Lora Brettnacher, RN -TC (December 2, 4, 5, & 9, 2013) Michelle Hosteter, RN (December 2, 3, 4, 5, & 6, 2013) Karen Hartman, RN (December 2, 3, 4, 5, & 6, 2013) Jeanna King, RN (December 2, 3, 4, 5, & 6, 2013) Brenda Nunan, RN (December 2 & 3, 2013)</p> <p>Census bed type: SNF: 10 SNF/NF: 125 Total: 135</p> <p>Census payor type: Medicare: 17 Medicaid: 81 Other: 37 Total: 135</p>	F000000	<p>This plan of correction is prepared and executed because it is required by the Provisions of State and Federal Regulations. Avon Health and Rehab. maintains that each deficiency does not jeopardize the health and safety of the residents, nor is it of such a nature as to limit our capability to provide adequate care.</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>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley on December 16, 2013.</p>				

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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and interview, the facility failed to ensure privacy for a resident when being examined by a nurse practitioner. (Resident #89)</p> <p>Findings include:</p> <p>During an observation on 12/2/13 at</p>	F000164	Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. The NP was immediately inserviced on patient rights and infection control. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	01/08/2014

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	<p>12:41 P.M., a Nurse Practitioner (NP) was assessing Resident #89 in the dining room. The NP was listening to the lung sounds, checking for edema, and palpating abdomen in the Hearth dining room. She also asked the resident questions regarding how he was feeling and about his recent hospitalization.</p> <p>When interviewing Resident #89 on 12/3/13 at 9:20 a.m. he indicated he prefers to be examined by a physician in privacy.</p> <p>3.1-3(o) 3.1-3(p)(2)</p>		<p>actions will be taken: 2. All residents being treated by this NP have the potential to be affected. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. 1:1 inservice was provided to NP immediately following the incident on resident rights to include dignity and infection control. ADM placed a call to NP's supervisor to notify them of the incident. Education will be provided to contract NP's and Medical Doctors related to residents rights to include dignity and privacy. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee to audit NP visits daily 5 times per week for 4 weeks then weekly for 8 weeks and then monthly times 3. Results of the audit will be forwarded to QA monthly for review.</p>		

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interview the facility failed to ensure a call light was in reach for 1 of 1 resident reviewed for call light accessibility. (Resident #96)</p> <p>Findings include:</p> <p>During an observation of Resident #96 on 12/3/13 at 11 a.m. Resident has a push call light, however it was not within the resident's reach. At this time, the resident indicated therapy and her came to conclusion it needs to be clipped to her pants for her to be able to use it. The call light was clipped to the quilt on the bed. Resident told me she would not be able to reach and use where it was at.</p> <p>In an interview with LPN # 1 on 12/3/13 at 11:10 a.m., she indicated the resident would not be able to reach the call light where it was at.</p> <p>In an observation on 12/5/13 at 11:15 a.m., Resident #96's call light was attached to the comforter on her bed</p>	F000246	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #96's call light was replaced with a longer cord and an easier touch to alert staff of her need for assistance. Nursing staff inserviced on therapy recommendations that the call light be attached to her pant leg. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. All residents have the potential to be affected. A 100% audit was completed to ensure appropriate length available for resident's reach. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. Nursing staff inserviced on use of call lights. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee will perform a daily audit 5X/week for 8 weeks, then weekly for 4 weeks, then monthly X2 to ensure</p>	01/08/2014	

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	<p>and the resident was unable to reach it. CNA # 2 indicated at this time the only thing she was aware of from therapy was they were working with the resident on getting her back in her electric chair. CNA # 2 indicated therapy tells them verbally of any thing they are working on as well as it is documented. The DON indicated therapy documents anything on the assignment sheet as well as the care tracker. (12/5/13 at 11:30 a.m.)</p> <p>In an interview with the Nurse Consultant on 12/6/13 at 1:30 p.m., she indicated the therapy department had not communicated to the nursing staff regarding the call light needing to be clipped to her pant leg.</p> <p>3.1-3(v)(1)</p>		<p>call lights are accessible to the resident. Results of the audit will be forwarded to QA monthly for review.</p>		

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F000282 SS=G	<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>A1. Based on observation, interview, and record review, the facility failed to follow the resident's plan of care for administer pain medication when staff was aware it was ordered and needed to prevent unnecessary pain during care for 1 of 2 residents observed with symptoms of pain (Resident #134). During care observation the resident cried out multiple times in pain.</p> <p>B2. Based on observation, interview, and record review, the facility failed to implement interventions in accordance with residents' plan of care to promote healing and prevent pressure ulcers and skin break down for 1 of 3 residents reviewed for pressure ulcers (Resident #134).</p> <p>Findings include:</p> <p>A1. During an observation on 12/5/2013 at 1:28 P.M., Certified Nursing Assistants (CNA) #31 and #32 were observed transferring Resident #134 with a mechanical lift from her chair to her bed. While she</p>	F000282	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1A. Resident #134's routine pain medication was increased to three times daily. Resident #134's pain assessment was updated. Discussed pain regime with Hospice nurse and added an anti-inflammatory and muscle relaxant medications. Current pain patch order discontinued and new pain patch order received. 1B. Resident #134's dressing to her foot was immediately applied as soon as staff noted it had fallen off. A cushion was placed to the seat of the BRODA chair and a sheet placed between her legs to prevent skin to skin contact. The intervention for heels to be floated was updated to state 'while in bed'. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2A. All residents receiving Hospice services have the potential to be affected. A 100% audit was completed on all Hospice residents to ensure that residents are receiving the appropriate pain medication. 2B.</p>	01/08/2014			

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	<p>extensive assistance for transfers and bed mobility, and had lower extremity impairment on both sides.</p> <p>A care plan dated 12/2/13, indicated Resident #134 had pain related to a history of a pelvic fracture with a goal for her to voice a level of comfort through the next review. The care plan indicated analgesia medication would be administered as ordered to meet this goal.</p> <p>A physician's order dated 10/2/2013 at 10:45 A.M., indicated Resident #134 had an order for Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 milligrams (mg) one tablet to be administered for moderate pain and two tablets for severe pain every 4 hours as needed.</p> <p>Behavior sheets dated 10/10/2013 at 1:13 P.M., 11/20/2013 at 2:05 P.M., and 12/4/2013 at 1:03 P.M., indicated Resident #134 was resistant to care and/or yelled and screamed out.</p> <p>The MARs for October, November, and December 1-6 were reviewed on December 6, 2013. The MAR for October 2013, lacked documentation Resident #134 was administered PRN pain medication. The Mar for</p>		face meeting .				

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	<p>November 2013, indicated Resident #134 was administered PRN pain medication on November 1, 2013 at 10:36 A.M., and November 29, 2013 at 1:15 P.M. The MAR for December 1-6, 2013 lacked documentation Resident #134 was administered PRN pain medication.</p> <p>A pain evaluation document dated 12/6/2013 at 10:37 A.M., indicated Resident #134 verbalized pain, had diagnoses which gave reason to believe she was in pain, the pain increased with movement, and medication relieved the pain.</p> <p>An untimed physician's progress note dated 12/6/2013, indicated, "...inadequate pain control reported yelling out...hurts "all over." Resident unable to pin point pain.... " This note indicated an order to increase Resident #134's schedule pain medication from twice a day to three times a day in addition to the as needed narcotic pain medication.</p> <p>During an interview on 12/5/2013 at 1:28 P.M., CNA #31 stated, "She is so constricted... It hurts her so bad.... Her little legs...[Resident #134 named] we are going to lift you... it is the only way we can get you in the bed... sorry (Resident #134 named)..."</p>			

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	<p>she doesn't want to be moved because her little legs hurt so bad... We have to pry her legs apart.... She does this every day. I hate doing it...."</p> <p>During an interview on 12/5/2013 at 1:40 P.M., LPN #30 indicated Resident #134 had scheduled pain medication which was administered at 7:30 A.M. and in the evening around 4:00 P.M. LPN #30 indicated Resident #34 also had PRN (as needed) narcotic pain medication ordered for pain and could be administered the pain medication every four hours if needed. LPN #30 indicated Resident #134 complained of pain when she was repositioned for care or transferred from one place to another. LPN #30 indicated Resident #134 was not given a lot of PRN pain medication because she only complained of pain when she was moved. LPN #30 indicated Resident #134 had to be transferred with a lift to get out of bed, to lie down after each meal, and for incontinent care all which required extensive moving. LPN #30 indicated she had planned to administer Resident #134 PRN pain medication prior to her being transferred to bed but she failed to do so. LPN #30 stated, "I planned on giving it to her before lunch but never</p>						

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	<p>got around to it."</p> <p>During an interview on 12/5/2013 at 1:46 P.M., the Director of Nursing (DON) was informed of the above observations. At this time documentation of pain assessments, medication administration records for October, November, and December 2013, the facility's pain management policy, and care plans for Resident #134 were requested. The DON indicated Resident #134 had an order for PRN pain medication and it should have been administered.</p> <p>During an interview on 12/9/2013 at 10:45 A.M., with the DON and the facility's wound care nurse (LPN #33) present, LPN #33 indicated the physician evaluated Resident #134 on 12/6/2013, and increased her scheduled pain medication from twice a day to three times a day. During this interview the DON indicated staff had reported Resident #134 was "doing much better" since the physician increased the pain medication on 12/6/2013.</p> <p>The facility's pain management policy dated 3/2012, indicated, "Pain Evaluation Purpose: 1. To establish guidelines to measure a resident's level of pain. 2. To provide optimal</p>				

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	<p>comfort through a pain control plan, which is established with the members of the health care team...."</p> <p>B1. During an observation on 12/5/13 at 11:10 A.M., Resident #134 was observed sitting in a broda chair with a pillow under her lower legs. Her feet were dangling-not elevated. Her left foot was bare. A pressure ulcer was observed on her left foot. A small amount of pink/reddish serous drainage was observed dripping down her left foot. Resident #134 was observed in a gown with her brief and thighs exposed. Her thighs and knees were touching one another. There was not a sheet in between her bare skin.</p> <p>During observations on 12/5/2013 at 11:37 A.M. and 12:04 P.M., Resident #134 was observed sitting in her chair. Her feet were dangling off the end of a pillow. They were not elevated She did not have a sheet between her bare legs and knees.</p> <p>During an observation on 12/5/2013 at 12:04 P.M. and 12:39 P.M., Resident #134 was observed seated in her chair, no sheet between her bare knees and/or thighs, and her feet were not elevated.</p>						

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	<p>During an observation on 12/5/2013 at 1:28 P.M., Certified Nursing Assistants (CNA) #31 and #32 were observed transferring Resident #134 with a mechanical lift from her chair to her bed. The chair she was transferred out of did not have a cushion in it. Resident #134 did not have a sheet between her bare legs.</p> <p>Resident #134's record was reviewed on 12/5/2013 at 9:56 A.M. Resident #134 had diagnoses which included, but were not limited to, dementia, abnormal posture, depression, weakness, osteoporosis, a history of pressure areas, and a current stage three pressure area..</p> <p>An annual MDS (minimum data set assessment tool) dated 6/13/2013, indicated Resident #134 was severely cognitively impaired, had long and short term memory loss, required extensive assistance for transfers and bed mobility, and had lower extremity impairment on both sides.</p> <p>A care plan dated 12/3/3013, indicated Resident #134 had a pressure ulcer present on her left bunion due to immobility and contractures. A goal indicated her pressure ulcer would show signs of healing and remain free from</p>						

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	<p>infection. Interventions indicated to meet this goal included: "Cleanse left foot bunion with wound cleanser...cover with foam and secure with kerlex every two days, cushion in wheelchair... limit time up in char, lie down after meals...."</p> <p>A care plan dated 12/3/2013 indicated Resident #134 was at risk for pressure ulcers related to immobility. A goal indicated she would have intact skin free by the next review. Interventions listed to meet this goal included: A cushion in the wheel chair, her heels were to be up, she was to be put to bed after each meal, and a sheet was to be placed between her bare knees and thighs when she was up in a chair.</p> <p>CNA flow sheets identified as current by the DON on 12/5/2013 at 12:06 P.M., indicated Resident #134 was to be put to bed after meals.</p> <p>During an interview on 12/03/2013 at 9:50 A.M., Licensed Practical Nurse (LPN) #30 indicated Resident #134 had a pressure ulcer on her left foot.</p> <p>During an interview on 12/5/2013 at 11:15 A.M., Licensed Practical Nurse (LPN) #30 was queried when she planned to change Resident #134's</p>				

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	<p>_____ dressing on her foot. She indicated she would change it after lunch around 1:00 P.M.</p> <p>During an interview on 12/5/2013 at 12:20 P.M., the facility wound nurse LPN #33 indicated she saw Resident #134 in her room without a dressing on her foot so she put a dressing on it. She stated, "I walked by the room and saw it wasn't on so I thought oops we better get it on. They cleaned her up this morning and it must have come off."</p> <p>During an interview on 12/5/2013 at 1:20 P.M., CNA #33 indicated the hospice aide put Resident #134 in her chair around 7:45 A.M. She indicated after breakfast staff took her to activities and then she was left reclined in her chair. She further indicated she had not attempted to put her back to bed but would after lunch. During an interview with CNA #33 and LPN #30 present, LPN #30 indicated Resident #134 was to be put to bed after each meal.</p> <p>During an interview on 12/5/2013 at 1:28 P.M., CNA #31 indicated Resident #134 did not have a cushion for her chair. CNA #31 stated, "She use to have something between her knees but she is so constricted they</p>						

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	<p>can't put it there anymore... I don't know how long it has been." She further indicated she did not put anything between Resident #134's legs because it was too painful for her.</p> <p>During an interview on 12/9/2013 at 9:45 A.M., the facility's consultant nurse indicated Resident #134 should of had a sheet between her bare legs, Resident #134 should of had a cushion in her chair, and staff should have informed the nurse her pressure ulcer dressing had fallen off and needed changed.</p> <p>3.1-35(g)(2)</p>			

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F000309 SS=G	<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 observation, interviews, and record review, the facility failed to administer pain medication as ordered to ensure residents were as free of pain as possible during care. This deficient practice resulted in unnecessary pain and suffering for 1 of 2 residents reviewed for pain management (Resident #134). During care observation the resident cried out in pain multiple times.</p> <p>Findings include:</p> <p>During an observation on 12/5/2013 at 1:28 P.M., Certified Nursing Assistants (CNA) #31 and #32 were observed transferring Resident #134 with a mechanical lift from her chair to her bed. While she was being transferred Resident #134 was observed to moan and cry out. During the transfer Resident #134 stated, "Don't, don't, don't, oh dear, oh dear, please don't do that. It hurts. Oh shoot. Don't do that. Oh no, oh no, oh no, oh no, oh no, oh no, oh no,</p>	F000309	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1A. Resident #134's routine pain medication was increased to three times daily. Resident #134's pain assessment was updated. Discussed pain regime with Hospice nurse and added an anti-inflammatory and muscle relaxant medications. Current pain patch order discontinued and new pain patch order received. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. All residents receiving Hospice services have the potential to be affected. A 100% audit was completed on all Hospice residents to ensure that residents are receiving the appropriate pain medication. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. An inservice was provided to the nursing staff on the policy and procedure for pain</p>	01/08/2014	

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	<p>oh no, oh no, no, oh no, oh no, oh no, no. I don't want to lay down. I don't want to lay down. I don't want to lay down. Oh no, oh no, oh no, oh no, oh no, oh no, oh no...They are so rough...." After Resident #134 was transferred to her bed CNA #31 and CNA #32 were observed to pull Resident #134's contracted legs apart so they could pull the brief through her legs. Resident #134 continued to moan and cry out until all care was finished and the head of the bed was elevated.</p> <p>Resident #134's record was reviewed on 12/5/2013 at 9:56 A.M. Resident #134 had diagnoses which included, but were not limited to, dementia, abnormal posture, depression, weakness, osteoporosis, and osteoarthritis.</p> <p>An annual MDS (minimum data set assessment tool) dated 6/13/2013, indicated Resident #134 was severely cognitively impaired, had long and short term memory loss, required extensive assistance for transfers and bed mobility, and had lower extremity impairment on both sides.</p> <p>A care plan dated 12/2/13, indicated Resident #134 had pain related to a history of a pelvic fracture with a goal</p>		<p>management and reporting resident's pain. Pain management to be reviewed during Hospice Care plan meetings to ensure residents are receiving appropriate type of pain medication. Progress notes will be reviewed daily during department head meeting. Pain medications will be administered as ordered and as needed to prevent unnecessary pain. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee will perform daily audits 5X/week for 8 weeks, then weekly X4, then monthly X2 to ensure residents receive necessary pain medication. I am requesting IDR of the severity "G" of this citation. Facility will provide supporting documents at face to face meeting..</p>				

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	<p>for her to voice a level of comfort through the next review. The care plan indicated analgesia medication would be administered as ordered to meet this goal.</p> <p>A physician's order dated 10/2/2013 at 10:45 A.M., indicated Resident #134 had an order for Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 milligrams (mg) one tablet to be administered for moderate pain and two tablets for severe pain every 4 hours as needed.</p> <p>Behavior sheets dated 10/10/2013 at 1:13 P.M., 11/20/2013 at 2:05 P.M., and 12/4/2013 at 1:03 P.M., indicated Resident #134 was resistant to care and/or yelled and screamed out.</p> <p>The MARs (Medication Administration Record) for October, November, and December 1-6 were reviewed on December 6, 2013. The MAR for October 2013, lacked documentation Resident #134 was administered PRN pain medication. The Mar for November 2013, indicated Resident #134 was administered PRN pain medication on November 1, 2013 at 10:36 A.M., and November 29, 2013 at 1:15 P.M. The MAR for December 1-6, 2013 lacked documentation</p>				

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	<p>Resident #134 was administered PRN pain medication.</p> <p>A pain evaluation document dated 12/6/2013 at 10:37 A.M., indicated Resident #134 verbalized pain, had diagnoses which gave reason to believe she was in pain, the pain increased with movement, and medication relieved the pain.</p> <p>An untimed physician's progress note dated 12/6/2013, indicated, "...inadequate pain control reported yelling out...hurts "all over." Resident unable to pin point pain.... " This note indicated an order to increase Resident #134's schedule pain medication from twice a day to three times a day in addition to the as needed narcotic pain medication.</p> <p>During an interview on 12/5/2013 at 1:28 P.M., CNA #31 stated, "She is so constricted... It hurts her so bad.... Her little legs...[Resident #134 named] we are going to lift you... it is the only way we can get you in the bed... sorry (Resident #134 named)... she doesn't want to be moved because her little legs hurt so bad... We have to pry her legs apart.... She does this every day. I hate doing it...."</p>				

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	<p>During an interview on 12/5/2013 at 1:40 P.M., LPN #30 indicated Resident #134 had scheduled pain medication which was administered at 7:30 A.M. and in the evening around 4:00 P.M. LPN #30 indicated Resident #34 also had PRN (as needed) narcotic pain medication ordered for pain and could be administered the pain medication every four hours if needed. LPN #30 indicated Resident #134 complained of pain when she was repositioned for care or transferred from one place to another. LPN #30 indicated Resident #134 was not given a lot of PRN pain medication because she only complained of pain when she was moved. LPN #30 indicated Resident #134 had to be transferred with a lift to get out of bed, to lie down after each meal, and for incontinent care all which required extensive moving. LPN #30 indicated she had planned to administer Resident #134 PRN pain medication prior to her being transferred to bed but she failed to do so. LPN #30 stated, "I planned on giving it to her before lunch but never got around to it."</p> <p>During an interview on 12/5/2013 at 1:46 P.M., the Director of Nursing (DON) was informed of the above observations. At this time</p>			

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	<p>documentation of pain assessments, medication administration records for October, November, and December 2013, the facility's pain management policy, and care plans for Resident #134 were requested. The DON indicated Resident #134 had an order for PRN pain medication and it should have been administered.</p> <p>During an interview on 12/9/2013 at 10:45 A.M., with the DON and the facility's wound care nurse (LPN #33) present, LPN #33 indicated the physician evaluated Resident #134 on 12/6/2013, and increased her scheduled pain medication from twice a day to three times a day. During this interview the DON indicated staff had reported Resident #134 was "doing much better" since the physician increased the pain medication on 12/6/2013.</p> <p>The facility's pain management policy dated 3/2012, indicated, "Pain Evaluation Purpose: 1. To establish guidelines to measure a resident's level of pain. 2. To provide optimal comfort through a pain control plan, which is established with the members of the health care team...."</p> <p>3.1-37(a)</p>				

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F000314 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 ensure residents who entered the facility without pressure ulcers did not develop pressure ulcers and residents who had pressure areas were provided treatment and services to promote healing for 2 of 3 residents reviewed for pressure ulcers (Resident #184 and Resident #134). Resident # 184 pressure ulcers were not assessed and timely treatment obtained to prevent the worsening of a documented "blister" to a Stage 3 ulcer.</p> <p>Findings include:</p> <p>1. Resident #184's closed record was reviewed on 12/9/2013 at 9:30 A.M. Resident #184 was admitted to the facility from an acute care hospital on June 14, 2013. Resident #184 had</p>	F000314	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Resident #184 no longer resides at the facility. Resident #134's dressing to her foot was immediately applied as soon as staff noted it had fallen off. A cushion was placed to the seat of the BRODA chair and a sheet placed between her legs to prevent skin to skin contact. The intervention for heels to be floated was updated to state 'while in bed'.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. All residents have the potential to be affected. A 100% audit was completed for those residents admitted over the past 2 weeks to ensure all treatments and preventative interventions are in place as necessary. What measures will be put into place or what systemic change will be</p>	01/08/2014			

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	<p>diagnoses which included, but were not limited to, osteomyelitis to his ankle and foot, traumatic amputation of right fifth toe, orthopedic aftercare following surgery, diabetes type II, and chronic mild kidney disease.</p> <p>An untimed admission assessment dated 6 /14/2013, indicated Resident #184 was admitted with two pressure ulcers to his coccyx.</p> <p>An untimed skin assessment dated 6/19/2013, indicated, "Stage 3 left ulcer present on admission. Seen by WCS today. 20% pale yellow slough 80% pale granulation amount of serous drainage no odor periwound is pale in color. Bilateral lower extremities with 3 plus edema...."</p> <p>An untimed and undated document, identified as "a report sheet" by the consultant DON on 12/9/2013 at 9:30 A.M., indicated Resident #184 had a "broken blister-Achilles L (left)."</p> <p>During an interview on 12/9/2013 at 9:30 A.M., with the Director of Nursing (DON)and the facility's consultant nurse present, the consultant nurse indicated the nurse who admitted Resident #184 failed to document skin break down on his left Achilles and because she was no longer</p>		<p>made to ensure that the deficient practice does not recur: 3. An inservice was provided to nursing staff on documentation and pressure ulcer prevention. Floor nurses will ensure dressings are intact each shift.Wound nurse to make wound rounds daily 5X/week to ensure interventions in place for wound prevention and treatment. The admission nurse will complete a head to toe skin assessment on the resident and place documentation per facility policy. MD will be notified of any skin issues and treatment orders obtained immediately. The wound nurse will perform a head to toe skin assessment on residents admitted Sunday through Friday, day shift. The Nurse Supervisor will complete a head to toe assessment on admission residents over the weekend.</p> <p>How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee will audit daily 5X/week for 8 weeks, then weekly X4, then monthly X3 to ensure preventative measures and dressings are in place. Results of the audit will be forwarded to QA monthly for review.I am requesting IDR of the severity "G" of this citation. Facility will provide supporting documents at Face to Face meeting..</p>				

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	<p>employed by the facility she was not available for an interview. She further indicated the ulcer was not observed until Monday, June 17, 2013 (four days after Resident #184 was admitted), when the wound nurse completed a skin assessment on him.</p> <p>During an interview on 12/9/2013 at 10:59 A.M., with the DON and the facility's wound nurse LPN #33 present, LPN #33 indicated she assessed Resident #184 on Monday, June 17, 2013 at which time she noted a dry dressing over his left ankle. She removed the dressing and noted a stage three pressure ulcer which measured 1.5 centimeters (cm) length X 2.5 cm width, X 0.2 cm depth. LPN #33 indicated the facility's protocol indicated the the admitting nurse was to do an initial skin assessment and notify a physician of any open areas to obtain orders. She further indicated her own responsibilities included performing skin assessments on all new residents regardless of the condition of their skin. LPN #33 indicated because it was the weekend when he was admitted she did not see Resident #184 until Monday. She indicated when she found the stage three pressure ulcer on his left Achilles she cleansed it, obtained an</p>			

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	<p>order for treatment, and notified the wound care specialist. During this interview the DON indicated the report received from the acute care hospital indicated Resident #184 had a broken blister on his left Achilles. She indicated hospital records alluded to an "old wound" to the area but was unable to find documentation to support Resident #184 was admitted to the facility with a pressure ulcer to his ankle.</p> <p>An undated document titled "PCC Wound Documentation Protocol" identified as current by the facility's nurse consultant on 12/9/13 at 11:38 P.M., indicated, "...On admission the admitting nurse will document any wounds or skin conditions on the Admission/Re-admission Observations. The wound nurse will complete the initial pressure and/or initial non-pressure skin reports within 24 hours of admission when a resident is admitted on Sunday-Thursday and with 72 hours of admission when a resident is admitted on Friday or Saturday.The admitting nurse will not stage areas, however they should describe the wound. The description should contain the measurements, a description of the periwound, a description of the wound bed....Initial</p>			

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	<p>Pressure Ulcer Report-To be completed by the nurse that found the pressure ulcer. Also completed upon admission, if there are pressure ulcers present on admission. Must be completed. The building may not simply choose not to use this form...."</p> <p>2. During an observation on 12/5/13 at 11:10 A.M., Resident #134 was observed sitting in a broda chair with a pillow under her lower legs. Her feet were dangling-not elevated. Her left foot was bare. A pressure ulcer was observed on her left foot. A small amount of pink/reddish serous drainage was observed dripping down her left foot. Resident #134 was observed in a gown with her brief and thighs exposed. Her thighs and knees were touching one another. There was not a sheet in between her bare skin.</p> <p>During observations on 12/5/2013 at 11:37 A.M. and 12:04 P.M., Resident #134 was observed sitting in her chair. Her feet were dangling off the end of a pillow. They were not elevated She did not have a sheet between her bare legs and knees.</p> <p>During an observation on 12/5/2013 at 12:04 P.M. and 12:39 P.M., Resident #134 was observed seated</p>						

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	<p>in her chair, no sheet between her bare knees and/or thighs, and her feet were not elevated.</p> <p>During an observation on 12/5/2013 at 1:28 P.M., Certified Nursing Assistants (CNA) #31 and #32 were observed transferring Resident #134 with a mechanical lift from her chair to her bed. The chair she was transferred out of did not have a cushion in it. Resident #134 did not have a sheet between her bare legs.</p> <p>Resident #134's record was reviewed on 12/5/2013 at 9:56 A.M. Resident #134 had diagnoses which included, but were not limited to, dementia, abnormal posture, depression, weakness, osteoporosis, a history of pressure areas, and a current stage three pressure area..</p> <p>An annual MDS (minimum data set assessment tool) dated 6/13/2013, indicated Resident #134 was severely cognitively impaired, had long and short term memory loss, required extensive assistance for transfers and bed mobility, and had lower extremity impairment on both sides.</p> <p>A care plan dated 12/3/3013, indicated Resident #134 had a pressure ulcer present on her left</p>						

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	<p>bunion due to immobility and contractures. A goal indicated her pressure ulcer would show signs of healing and remain free from infection. Interventions indicated to meet this goal included: "Cleanse left foot bunion with wound cleanser...cover with foam and secure with kerlex every two days, cushion in wheelchair... limit time up in char, lie down after meals...."</p> <p>A care plan dated 12/3/2013 indicated Resident #134 was at risk for pressure ulcers related to immobility. A goal indicated she would have intact skin free by the next review. Interventions listed to meet this goal included: A cushion in the wheel chair, her heels were to be up, she was to be put to bed after each meal, and a sheet was to be placed between her bare knees and thighs when she was up in a chair.</p> <p>CNA flow sheets identified as current by the DON on 12/5/2013 at 12:06 P.M., indicated Resident #134 was to be put to bed after meals.</p> <p>During an interview on 12/03/2013 at 9:50 A.M., Licensed Practical Nurse (LPN) #30 indicated Resident #134 had a pressure ulcer on her left foot.</p>						

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	<p>During an interview on 12/5/2013 at 11:15 A.M., Licensed Practical Nurse (LPN) #30 was queried when she planned to change Resident #134's dressing on her foot. She indicated she would change it after lunch around 1:00 P.M.</p> <p>During an interview on 12/5/2013 at 12:20 P.M., the facility wound nurse LPN #33 indicated she saw Resident #134 in her room without a dressing on her foot so she put a dressing on it. She stated, "I walked by the room and saw it wasn't on so I thought oops we better get it on. They cleaned her up this morning and it must have come off."</p> <p>During an interview on 12/5/2013 at 1:20 P.M., CNA #33 indicated the hospice aide put Resident #134 in her chair around 7:45 A.M. She indicated after breakfast staff took her to activities and then she was left reclined in her chair. She further indicated she had not attempted to put her back to bed but would after lunch. During an interview with CNA #33 and LPN #30 present, LPN #30 indicated Resident #134 was to be put to bed after each meal.</p> <p>During an interview on 12/5/2013 at 1:28 P.M., CNA #31 indicated</p>						

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	<p>Resident #134 did not have a cushion for her chair. CNA #31 stated, "She use to have something between her knees put she is so constricted they cant put it there anymore... I don't know how long it has been." She further indicated she did not put anything between Resident #134's legs because it was too painful for her.</p> <p>During an interview on 12/9/2013 at 9:45 A.M., the facility's consultant nurse indicated Resident #134 should of had a sheet between her bare legs, Resident #134 should of had a cushion in her chair, and staff should have informed the nurse her pressure ulcer dressing had fallen off and needed changed.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000371 SS=D	<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 Based on observation, interview, and record review the facility failed to ensure all areas of the kitchen were clean and items were stored in sanitary conditions for 2 of 2 kitchen observations.</p> <p>Findings include:</p> <p>The kitchen tour was completed on 12/2/13 at 10:30 a.m.</p> <p>In an observation during the kitchen tour, the walk-in refrigerator and walk in freezer fans had visible gray fuzzy debris on them. When wiped with a finger, the blades had a black residue which came off of them. In an interview at that time, the Dietary Manager indicated she was not aware of who was responsible for cleaning the fans.</p> <p>In an interview with the Nurse Consultant on 12/6/13 at 2:15 p.m., she indicated the maintenance department cleaned the area. She</p>	F000371	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Maintenance immediately cleaned the walk-in refrigerator and freezer. 1:1 counseling presented to dietary aide. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. All residents receiving meal service have the potential to be affected. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. Hand washing and infection control inservices have been presented to dietary staff members. Maintenance will follow scheduled fan cleaning and will keep a weekly log. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. Administrator/designee will monitor maintenance cleaning log weekly X8, then monthly X4 to ensure fans are clean within walk in refrigerator and freezer.</p>	01/08/2014	

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	<p>provided documentation at that time which indicated the last time it had been cleaned was November 11, 2013.</p> <p>In an observation on 12/2/13 at 12:00 through 12:45 p.m., Dietary Aide #3 was serving drinks in the Hearth dining room. She was observed rubbing her nose with her finger and then picking up a resident glass with the same finger and was touching the top rim of the glass. Dietary Aide #3 continued to touch the top rim of other resident's drinking glasses throughout the dining room as she served other residents their drinks. She was not observed washing her hands or sanitizing them.</p> <p>3.1-21(i)(3)</p>		Dietary Manager/designee will perform daily audits 5X/week for 8 weeks, then weekly X8, then monthly X2 to ensure no infection control issues present. Results of the audits will be forwarded to QA monthly for review.		

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F000406 SS=D	<p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation and interview the facility failed to ensure the therapy department communicated with the nursing staff regarding call light adaptation for 1 of 1 residents reviewed regarding call light use. (Resident #96)</p> <p>Findings include:</p> <p>During an observation of Resident #96 on 12/3/13 at 11 a.m., Resident #96 had a push call light. The resident had severe contractures of her right and left hands. The resident indicated it was not within her reach. The resident indicated therapy had discussed it with her and it needed to be clipped to her pants for her to be able to use it. The call light was clipped to the quilt on the bed.</p> <p>In an interview with LPN # 1 on</p>	F000406	<p>Corrective actions will be accomplished for those residents found to have been affected by the deficient practice: 1. Therapy notified nursing of the need for attaching call light to Resident #96's pants in order for accessibility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. Those residents receiving occupational therapy services have the potential to be affected. A 100% audit was completed to ensure communication occurred as necessary with nursing for those residents receiving occupational therapy. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. Therapy staff inserviced on communication with nursing. When the resident's treatment plan is completed,</p>	01/08/2014	

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	<p>12/3/13 at 11:10 a.m., she indicated the resident would not be able to reach the call light where it was at.</p> <p>In an observation on 12/5/13 at 11:15 a.m., Resident #96's call light was attached to the quilt on her bed and the resident was unable to reach it. CNA #3 indicated at this time the only thing she was aware of from therapy was they were working with resident on getting her back in her electric chair. CNA #3 indicated therapy tells them verbally of any thing they are working on as well as it is documented.</p> <p>The Director of Nursing indicated on 12/5/13 at 11:30 a.m., therapy would have any of their communication documented on the CNA assignment sheet as well as in the care tracker.</p> <p>In an interview with the Nurse Consultant on 12/6/13 at 1:30 p.m., she indicated the therapy department had not communicated to the nursing staff regarding the call light needing to be clipped to her pant leg.</p> <p>The Nurse Consultant provided documentation from the therapy department dated 12/2/13 which indicated, "...educate staff regarding proper positioning of call light...."</p>		<p>therapy will inservice nursing staff on therapy recommendations. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee to perform weekly audits X8, then monthly X4 to ensure therapy recommendations are shared with the appropriate nursing staff.</p>	

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	3.1-23(a)(1)			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F000441	Corrective actions will be accomplished for those residents	01/08/2014			

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	<p>ensure staff washed their hands between contact with residents. (Resident #96 and Resident # 98)</p> <p>Findings include:</p> <p>In an observation at 12:40 p.m., on 12/2/13, a Nurse Practitioner (NP) was examining Resident # 98. She touched the residents clothing, used her stethoscope to listen to heart and lung sounds, as well as lifting up pant legs to examine the lower extremities. The Nurse Practitioner then monitored the resident's blood pressure.</p> <p>The Nurse Practitioner then went to Resident #96 at the next table to examine her. She also took the same blood pressure cuff and examined Resident #96 as well as her stethoscope and monitored their blood pressure without washing hands or sanitizing hands.</p> <p>In an interview with the Director of Nursing and the Nurse Consultant on 12/6/13 at 1:30 p.m., they indicated the NP should have washed or sanitized her hands between examining each resident.</p> <p>The Nurse Consultant provided a policy titled "Handwashing" dated</p>		<p>found to have been affected by the deficient practice: 1. The facility was unable to correct the error made by the NP to not wash her hands prior to examining Resident #96. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: 2. All residents under the care of the NP have the potential to be affected. What measures will be put into place or what systemic change will be made to ensure that the deficient practice does not recur: 3. Hand washing inservice presented to the NP. It is the facility's expectation of the NP to wash hands between resident examinations. How will the corrective actions be monitored to ensure the deficient practice will not recur: 4. DON/designee will audit NP visits weekly X8 weeks, then monthly X4. Results of these audits will be forwarded to QA monthly for review.</p>	

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	4/2012, which indicated, "...When to Wash Hands (at a minimum)...Before and after each resident contact..." 3.1-18(l)			