

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/10/2012
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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
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F0000	<p>This visit was for the investigation of Complaints IN00112705, IN00113278 and IN00113716.</p> <p>Complaint IN00112705-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00113278-Substantiated. Federal/state deficiencies related to the allegations are cited at F 157, F 225, F 226 and F 514.</p> <p>Complaint IN00113716-Substantiated. Federal/state deficiencies related to the allegations are cited at F 157, F 309, F 328, and F 514.</p> <p>Survey dates: August 7, 8, 9, 10, 2012</p> <p>Facility number: 000307 Provider number: 155666 AIM number: 100285660</p> <p>Survey team: Ann Arney, RN TC Ellen Ruppel, RN</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor source:</p>	F0000	<p>This plan of correction is prepared and executed because the provisions of the state and federal law require it. This plan of correction shall not be deemed an admission to or agreement with the survey allegations. Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare Center further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance. Wesley Healthcare Center requests paper compliance for F157, F225, F226 F309, F328, and F514.</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>Medicare: 7 Medicaid: 38 Other: 12 Total: 57</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 8/14/12 Cathy Emswiller 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 interview and record review, the facility failed to notify the physician when there was a change in a surgical site (Resident #G) and when there were dietary recommendation to increase</p>	F0157	F157 1. I. It is the policy of Wesley Healthcare to appropriately assess, document and communicate Changes of Condition to the primary care provider as stated in the policy for	08/17/2012			

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	<p>enteral flushes (Resident #I). This deficiency affected 1 of 1 resident reviewed, who had a surgical incision and 1 of 3 residents reviewed, who received enteral flushes in a sample of 8.</p> <p>Findings include:</p> <p>1. The clinical record of Resident #G was reviewed on 8/8/12 at 2:15 p.m., and indicated the resident was admitted to the facility on 4/14/03 with diagnoses which included but were not limited to schizophrenia and coronary artery disease.</p> <p>Physician progress notes, dated 7/28/12, indicated Resident #G had a large sebaceous cyst on his mid upper back. The note indicated the abscess measured 10 cm with the central core measuring 5 cm.</p> <p>The physician progress note indicated "Large infected sebaceous cyst, drained & (and) exc'd (excised) as described above..."</p> <p>Physician orders, dated 7/28/12, indicated The sutures were to be removed in ten days, the resident was to receive Keflex (an antibiotic medication) 500 mg four times daily for ten days, and "call (Physician's Name) if any problems c (with) open area."</p>		<p>Managing Change of Condition, using the SBAR tool. II. It is the policy of Wesley Healthcare to transcribe telephone orders verbatim to the appropriate administration record including but not limited to MAR, TAR, Respiratory TAR, or Dialysis MAR. III. Nursing staff was in-serviced on 8/14/12 by the DON on proper assessment, documentation and communication of Changes of Condition as stated in the policy. IV. Nursing staff was in-serviced on 8/14/12 by the DON on proper technique for taking telephone orders, and carefully transcribing all orders onto appropriate administration record as stated in the policy. V. The nurse responsible for transcribing the physicians order to call if any problems occur, and the nurse responsible for faxing to notify the physician of a change of condition received a written teachable moment. VI. The DON or designee will monitor the 24 hr report and nurse's notes for proper continued assessment and notification of change of condition. If the 24 hr report or nurse's notes are found to be incomplete for proper ongoing assessment or notification of change in condition, the DON will identify the person responsible and reeducate that individual if applicable or begin progressive discipline. VII. The DON or designee will monitor all orders</p>		

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	<p>On 8/1/12 at 7:30 p.m., nursing notes indicated "area on back-chg (change) dsq (dressing). found-red area 18 cm x 13 cm, c (with) ridged area 3 m (sic) high-black c (with) purple edges-extends to red area warm to touch, localized...notified Dr by fax. afebrile"</p> <p>There was no documentation the physician responded to the evening fax or was consulted further about the surgical site until 8/2/12 at 1:00 p.m. (17 hours later).</p> <p>On 8/2/12 at 1:00 p.m., nursing notes indicated the treatment was changed and "area hard warm larg (sic) reddened/purple area found. (Physician's Name) notified per his wishes. (Physician's Name) instructed nurse to remove sutures, and open area and he would come in and check. Dr. came in doctor sterilly (sic) looking at wound which began to bleed copious amounts frank blood. Pressure applied (Physician's Name) gave order for res (resident) to be direct admitted to (Hospital's Name)..."</p> <p>On 8/9/12 at 8:45 a.m., the DON (Director of Nursing) indicated the physician should have been called on 8/1/12 when the red raised area was noted on Resident #G's back.</p> <p>2. The clinical record of Resident I was</p>		<p>for proper transcription to the appropriate administration record.</p> <p>VIII. The DON or designee will complete daily audits of the Physician's Telephone Orders, 24-hour report and nurse's notes for four weeks then daily audits of the 24-hour report and physician's orders ongoing.</p> <p>IX. The results of these audits will be reviewed in the monthly QA meeting. X. Date of completion is August 17, 2012.</p> <p>2. I. It is the policy of Wesley Healthcare that the physician will be notified of all dietary recommendations and any resulting orders will be followed verbatim. II. The previous DON was terminated on 8/1/12.</p> <p>XI. The current DON was oriented on 8/14/12 to notify the physician of all dietary recommendations and transcribe resulting orders as stated in the policy. XII. The DON or designee will monitor all orders for proper transcription to the appropriate administration record. XIII. The DON or designee will complete daily audits of the Physician's Telephone orders ongoing.</p> <p>XIV. The results of these audits will be reviewed in the monthly QA meeting. XV. Date of completion is August 17, 2012.</p>		

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	<p>reviewed, on 8/8/12 at 11:35 a.m., and indicated the resident had been admitted to the facility 6/25/12, with diagnose including, but not limited to: traumatic head injury, left subdural hematoma and seizure disorder.</p> <p>Review of dietary notes, dated 7/15/12, indicated the resident had been hospitalized 7/3/12 for pneumonia and dehydration. The note indicated he was on a gastrostomy tube feeding of Jevity 1.2 at 65 cc per hour, with 150 cc water flushes three times a day, providing 2355 cc of fluids daily. The note also indicated the dietician was recommending an increase of the flushes to 150 cc every 4 hours to make the total fluids 2460 cc per day.</p> <p>During an interview with LPN#12, on 8/8/12 at 2:30 p.m., she indicated the former Director of Nursing (DON) had "missed" the recommendation and the physician had not been notified of the suggested increase in fluids.</p> <p>The physician was notified, on 8/8/12 and ordered an electrolyte panel to determine if the resident was dehydrated. He ordered an increase in the flushes to every 4 hours. The electrolyte panel was done on 8/8/12, with results reported at 3:55 p.m., on 8/8/12. All electrolytes were</p>						

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	<p>within normal range.</p> <p>This Federal tag relates to complaint IN00113716 and IN00113278</p> <p>3.1-5(a)(3)</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 interview and record review, the facility failed to report an allegation of</p>	F0225	F225 I. It is the policy of Wesley Healthcare that all unusual occurrences, as defined by the	08/17/2012			

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	<p>neglect to the Indiana State Department of Health. This deficiencies affected 1 of 1 resident, whose family alleged neglect, in a sample of 8 and involved 1 of 3 incidents of alleged abuse and or neglect reviewed. (Resident #D)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #D was reviewed on 8/8/12 at 10:00 a.m. and indicated the resident was admitted to the facility on 4/11/12, with diagnoses which included but were not limited to, ventilator dependent respiratory failure, diabetes mellitus, enteral feedings, renal failure with dialysis and seizures. The resident was discharged to home on 6/7/12.</p> <p>The Minimum Data Set Assessment, dated 5/7/12, indicated Resident #D had severe cognitive impairment and required extensive assistance of two staff for dressing, hygiene and toileting.</p> <p>Social service notes, dated 6/4/12, indicated the Social Service Assistant met with Resident #D's family regarding a concern about Resident #D's care on 6/1/12. The note indicated the Director of Nursing was notified, a concern report was written with the family's note</p>		<p>Indiana State Department of Health's Reportable Unusual Occurrences Policy, will be reported to the Indiana State Department of Health Long Term Care Division within 24 hours. II. Nursing staff was in-serviced on 8/14/12 by the DON on unusual occurrences that should be immediately reported to the DON and Administrator. III. The previous DON was terminated on 8/1/12. IV. The current DON was oriented on 8/14/12 to report unusual occurrences, as defined by the Indiana State Department of Health's Reportable Unusual Occurrences Policy, to the Administrator and the Indiana State Department of Health's Long Term Care Division within 24 hours as stated in the policy. V. The Social Service Director was oriented on 8/14/12 by the DON on any concern reports or grievances with unusual occurrences should be immediately reported to the DON and Administrator. VI. The Executive Director or designee will complete daily customer satisfaction interviews on all interviewable residents as defined by,those residents with a BIMS score equal to or greater than 12 on their most recent MDS, for four weeks then weekly ongoing VII. The Clinical Interdisciplinary Team including the DON, ADON, MDS Coordinator, Executive Director, Dietary Manager and Social Service Director will now</p>				

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	<p>attached.</p> <p>A Concern Report, dated 6/4/12, indicated "Writer received letter from resident's daughter on 6/4/12. The letter was dated 6/3/12, it states horrible condition that family found resident in on 6/1/12. Writer was made aware of resident covered in feces through letter family wrote to DON (Director of Nursing)..." The concern report indicated the concern was referred to the DON for resolution.</p> <p>The family letter indicated they wanted to make the DON "aware of the neglect of my father on Friday June 1st 2012. We arrived to find him in his gerri-chair (sic) covered in feces!!..." The family note indicated the resident had on only a brief, had stool under his nails and had stool on his feeding tube. The note indicated the family felt Resident #D's care was "not acceptable."</p> <p>The allegation Resident #D received poor care was investigated by the DON, and statements were taken from the staff involved. The concern report was signed by the Administrator.</p> <p>There was no documentation the allegation of neglect was reported to the ISDH.</p>		<p>meet daily for a Quality of Care Meeting to discuss: all current resident or family grievances, concern reports, and daily customer satisfaction interviews. The Quality of Care Meeting will also discuss past resident or family grievances, concern reports, and customer satisfaction interviews to ensure a resolution.</p> <p>VIII. The Clinical Interdisciplinary Team will meet daily for a Quality of Care Meeting for four weeks then weekly ongoing. I. The results of these meetings will be reviewed in the monthly QA meeting. II. Date of completion is August 17, 2012.</p>				

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	<p>On 8/9/12 at 9:00 a.m., the MDS Coordinator, who was assisting the new DON, indicated the allegation of neglect had been investigated by the former DON but she had not reported the allegation to the ISDH.</p> <p>The MDS Coordinator indicated the allegation of neglect should have been reported.</p> <p>The Abuse and Neglect Resident's Rights policy & Procedure, undated, provided by the DON, was reviewed on 8/9/12 at 10:00 a.m., and indicated "...All incidents of abuse, neglect or misappropriate (sic) of Resident's property shall be investigated routinely by the Director of Nursing or designee... Any of the above incidents shall be reported to the Indiana Department of Health in a timely manner, as set forth by relevant state and federal regulations..."</p> <p>This Federal tag relates to Complaint IN00113278.</p> <p>3.1-28(c)</p>						

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F0226 SS=D	<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 interview and record review, the facility failed to follow their policy to report an allegation of neglect to the Indiana State Department of Health. This deficiencies affected 1 of 1 resident, whose family alleged neglect, in a sample of 8 and involved 1 of 3 incidents of alleged abuse and or neglect reviewed. (Resident #D)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #D was reviewed on 8/8/12 at 10:00 a.m. and indicated the resident was admitted to the facility on 4/11/12, with diagnoses which included but were not limited to, ventilator dependent respiratory failure, diabetes mellitus, enteral feedings, renal failure with dialysis and seizures. The resident was discharged to home on 6/7/12.</p> <p>The Minimum Data Set Assessment, dated 5/7/12, indicated Resident #D had severe cognitive impairment and required extensive assistance of two staff for</p>	F0226	F226 See F225	08/17/2012	

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	<p>dressng, hygiene and toileting.</p> <p>Social service notes, dated 6/4/12, indicated the Social Service Assistant met with Resident #D's family regarding a concern about Resident #D's care on 6/1/12. The note indicated the Director of Nursing was notified, a concern report was written with the family's note attached.</p> <p>A Concern Report, dated 6/4/12, indicated "Writer received letter from resident's daughter on 6/4/12. The letter was dated 6/3/12, it states horrible condition that family found resident in on 6/1/12. Writer was made aware of resident covered in feces through letter family wrote to DON (Director of Nursing)..." The concern report indicated the concern was referred to the DON for resolution.</p> <p>The family letter indicated they wanted to make the DON "aware of the neglect of my father on Friday June 1st 2012. We arrived to find him in his gerri-chair (sic) covered in feces!!..." The family note indicated the resident had on only a brief, had stool under his nails and had stool on his feeding tube. The note indicated the family felt Resident #D's care was "not acceptable."</p>				

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	<p>The allegation Resident #D received poor care was investigated by the DON, and statements were taken from the staff involved. The concern report was signed by the Administrator.</p> <p>There was no documentation the allegation of neglect was reported to the ISDH.</p> <p>On 8/9/12 at 9:00 a.m., the MDS Coordinator, who was assisting the new DON, indicated the allegation of neglect had been investigated by the former DON but she had not reported the allegation to the ISDH.</p> <p>The MDS Coordinator indicated the allegation of neglect should have been reported.</p> <p>The Abuse and Neglect Resident's Rights policy & Procedure, undated, provided by the DON, was reviewed on 8/9/12 at 10:00 a.m., and indicated "...All incidents of abuse, neglect or misappropriate (sic) of Resident's property shall be investigated routinely by the Director of Nursing or designee... Any of the above incidents shall be reported to the Indiana Department of Health in a timely manner, as set forth by relevant state and federal regulations..."</p> <p>This Federal tag relates to Complaint IN00113278.</p>						

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	3.1-28(c)			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, interview and record review, the facility delayed noting and implementing wound treatment orders and failed to notify the physician when there was a change in a surgical site resulting in a delay in treatment. This deficiency affected 1 of 3 residents, whose wound treatments were reviewed and 1 of 1 resident, who had a surgical incision, in a sample of 8. (Resident #F and Resident #G)</p> <p>Findings include:</p> <p>1. On 8/8/12 at 9:30 a.m., Resident #F, was observed in bed. The resident's skin was checked by the ADON (Assistant Director of Nursing) and she had a dressing on her right knee that was dated 8/7/12. No other open areas were observed.</p> <p>The clinical record of Resident #F was reviewed on 8/8/12 at 11:00 a.m. and indicated the resident was admitted to the</p>	F0309	<p>F309 1. I. It is the policy of Wesley Healthcare that all physicians' orders are to be followed verbatim, and if the order is unclear to ask for clarification from the physician. II. It is the policy of Wesley Healthcare to transcribe telephone orders verbatim to the appropriate administration record including but not limited to MAR, TAR, Respiratory TAR, or Dialysis MAR. III. Nursing staff was in-serviced on 8/14/12 by the DON on proper technique for taking telephone orders, carefully transcribing all orders onto appropriate administration record, and following physician's orders as stated in the policy. IV. The nurse responsible for transcribing the physicians order following the physician appointment received a written teachable moment. V. The nurses responsible for following the physicians order and administering the ordered treatment received a written teachable moment. VI. The DON or designee will monitor all orders for proper transcription to the appropriate administration</p>	08/17/2012			

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	<p>facility on 5/31/12, with diagnoses which included but were not limited to, multiple sclerosis, history of septic syndrome and acute renal failure.</p> <p>Admission wound sheets, dated 5/31/12, indicated the resident was admitted to the facility with multiple wounds, including but not limited to, areas on the right knee, left calf, right torso, right breast, left breast, and left side.</p> <p>Wound Clinic physician orders, dated 6/11/12 at 8:45 a.m., indicated the area on the left knee was to be treated with Santyl and Xeroform every day, the area on the right knee was to be treated with Bacitracin and Xeroform every day, abdominal areas were to be treated with Mycelex cream every day, and the right breast open areas were to be treated with Mycelex cream every day.</p> <p>There was no documentation the wound clinic orders were noted until 6/13/12, two days after they were ordered. On 6/13/12, at 11:00 p.m., nursing notes indicated new orders had been noted and received from the wound clinic.</p> <p>Although the treatments were noted on 6/13/12, there was no documentation on the June 2012 TAR (Treatment Administration Record) that the</p>		<p>record. VII. The DON or designee will monitor all administration records for proper documentation of medication and treatment administration. VIII. The DON or designee will complete daily audits of the MAR and TAR for four weeks then monthly ongoing. IX. The results of these audits will be reviewed in the monthly QA meeting. X. Date of completion is August 17, 2012.</p> <p>2. I. It is the policy of Wesley Healthcare to appropriately assess, document and communicate Changes of Condition to the primary care provider as stated in the policy for Managing Change of Condition, using the SBAR tool. II. It is the policy of Wesley Healthcare to transcribe telephone orders verbatim to the appropriate administration record including but not limited to MAR, TAR, Respiratory TAR, or Dialysis MAR. III. Nursing staff was in-serviced on 8/14/12 by the DON on proper assessment, documentation and communication of Changes of Condition as stated in the policy. IV. Nursing staff was in-serviced on 8/14/12 by the DON on proper technique for taking telephone orders, and carefully transcribing all orders onto appropriate administration record as stated in the policy. V. The nurse responsible for transcribing the physicians order to call if any problems occur, and the nurse</p>		

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	<p>treatments were started until 6/16/12, five days after they were ordered. The TAR indicated previous treatments to the areas continued through 5/14/12 and there were no treatments documented on 6/15/12.</p> <p>On 8/10/12 at 9:00 a.m., the ADON (Assistant Director of Nursing), who was the wound nurse, indicated she were unsure why there was a delay in noting and implementing the wound treatment orders from the wound clinic. She indicated Resident #F had a scabbed area on her right knee but all of the other areas had healed.</p> <p>1. The clinical record of Resident #G was reviewed on 8/8/12 at 2:15 p.m., and indicated the resident was admitted to the facility on 4/14/03 with diagnoses which included but were not limited to schizophrenia and coronary artery disease.</p> <p>Physician progress notes, dated 7/28/12, indicated Resident #G had a large sebaceous cyst on his mid upper back. The note indicated the abscess measured 10 cm with the central core measuring 5 cm.</p> <p>The physician progress note indicated "Large infected sebaceous cyst, drained & (and) exc'd (excised) as described above..."</p>		<p>responsible for faxing to notify the physician of a change of condition received a written teachable moment. VI. The DON or designee will monitor the 24 hr report and nurse's notes for proper continued assessment and notification of change of condition. If the 24 hr report or nurse's notes are found to be incomplete for proper ongoing assessment or notification of change in condition, the DON will identify the person responsible and reeducate that individual if applicable or begin progressive discipline. VII. The DON or designee will monitor all orders for proper transcription to the appropriate administration record. VIII. The DON or designee will complete daily audits of the Physician's Telephone Orders, 24-hour report and nurse's notes for four weeks then daily audits of the 24-hour report and physician's orders ongoing. IX. The results of these audits will be reviewed in the monthly QA meeting. X. Date of completion is August 17, 2012.</p>		

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	<p>Physician orders, dated 7/28/12, indicated The sutures were to be removed in ten days, the resident was to receive Keflex (an antibiotic medication) 500 mg four times daily for ten days, and "call (Physician's Name) if any problems c (with) open area."</p> <p>On 8/1/12 at 7:30 p.m., nursing notes indicated "area on back-chg (change) dsg (dressing). found-red area 18 cm x 13 cm, c (with) ridged area 3 m (sic) high-black c (with) purple edges-extends to red area warm to touch, localized...notified Dr by fax. afebrile"</p> <p>There was no documentation the physician responded to the evening fax or was consulted further about the surgical site until 8/2/12 at 1:00 p.m. (17 hours later).</p> <p>On 8/2/12 at 1:00 p.m., nursing notes indicated the treatment was changed and "area hard warm larg (sic) reddened/purple area found. (Physician's Name) notified per his wishes. (Physician's Name) instructed nurse to remove sutures, and open area and he would come in and check. Dr. came in doctor sterilly (sic) looking at wound which began to bleed copious amounts frank blood. Pressure applied (Physician's</p>						

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	<p>Name) gave order for res (resident) to be direct admitted to (Hospital's Name)..."</p> <p>On 8/9/12 at 8:45 a.m., the DON (Director of Nursing) indicated the physician should have been called on 8/1/12 when the red raised area was noted on Resident #G's back.</p> <p>This Federal tag relates to Complaint IN00113716.</p> <p>3.1-37(a)</p>						

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to provide respiratory treatments to 1 of 6 residents receiving respiratory care in a sample of 8. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #B was reviewed on 8/9/12 at 10:15 a.m., and indicated the resident was admitted to the facility on 6/21/12 with diagnoses which included but were not limited to respiratory failure, chronic kidney disease with dialysis and diabetes mellitus and dementia. The resident was transferred to the hospital on 6/22/12 and expired on 6/22/12.</p> <p>On 6/21/12 at 5:00 p.m., nursing notes indicated the resident was admitted to the facility at 4:45 p.m.</p>	F0328	<p>F328 I. It is the policy of Wesley Healthcare that all physicians' orders are to be followed verbatim. II. Respiratory Therapy staff was in-serviced on 8/14/12 by the DON on proper technique for taking telephone orders, carefully transcribing all orders onto appropriate administration record, and following physician's orders as stated in the policy. III. The Respiratory Therapist responsible for following the physicians order and administering the ordered treatment received a written teachable moment. IV. The Lead Respiratory Therapist or designee will monitor the administration record and all Ventilator Monitoring Records for proper documentation of medication and treatment administration. V. The Lead Respiratory Therapist or designee will complete bi-weekly audits of the Respiratory TAR and Ventilator Monitoring Records for four weeks then monthly ongoing.</p>	08/17/2012			

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	<p>Admission orders, dated 6/21/12, indicated, among other things, that Resident #B was to receive respiratory assessments with ventilator checks every six hours, tracheotomy care twice daily, Duoneb (albuterol/ipratropium, a pulmonary medication) 3 cc every six hours via inhaler, and Symbicort 160-4.5 mcg (a pulmonary medication) treatments twice daily.</p> <p>The June 2012 Respiratory Medication and Treatment record indicated the respiratory assessments and Duoneb treatments were to be done at 11:00 a.m., 5:00 p.m., 11:00 p.m. and 5:00 a.m. While the tracheotomy care and Symbicort treatments, were to be done at 11:00 p.m. and 11:00 a.m. On 6/22/12 11:00 a.m., the respiratory assessment, Duoneb treatment, tracheotomy care and ii Symbicort treatment were not documented as done.</p> <p>The Respiratory Assessment Sheet indicated the Resident received tracheotomy care on 6/21/12 at 10:40 p.m., and received a respiratory assessment, ventilator check and Duoneb treatment on 6/22/12 at 5:30 a.m. There was no documentation on the Respiratory Assessment Sheet indicating the resident received the Symbicort treatment, Duoneb treatment, tracheotomy</p>		<p>VI. The results of these audits will be reviewed in the monthly QA meeting. VII. Date of completion is August 17, 2012.</p>				

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	<p>care or respiratory assessment scheduled at 11:00 a.m. on 6/22/12.</p> <p>A dialysis flow sheet indicated Resident #B received dialysis in the facility on 6/22/12 beginning at 10:00 a.m. and concluding at 2:15 p.m.</p> <p>On 6/22/12 at 3:25 p.m., nursing notes indicated Resident #B was found not breathing and without vital signs. The nursing notes indicated they were unable to contact the resident's daughter but the daughter's husband, stated to continue CPR until he could reach his wife. The note indicated Resident #B's vent tubing was disconnected, the resident was bagged at 100% oxygen and chest compressions were initiated. Cardio pulmonary resuscitation continued until emergency medical staff arrived and assumed resuscitative efforts. Resident #B was transferred to the hospital at 3:30 p.m.</p> <p>Nursing notes, dated 6/22/12 at 3:40 p.m., indicated the daughter called back and stated to cease CPR but Resident #B had been transferred to the hospital.</p> <p>Hospital records indicate the resident arrived in the emergency room on 6/22/12 at 3:40 p.m. On 6/22/12 at 3:45 p.m., the resident's was asystole, the resident was determined to be DNR (Do Not</p>			

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	<p>Resuscitate), efforts were terminated with the time of death recorded at 3:45 p.m. The emergency room report indicated there would be no autopsy and indicated the coroner was not called. The final diagnosis was cardio pulmonary arrest.</p> <p>On 8/9/12 at 10:30 a.m., Respiratory Therapist #10, who worked on 6/22/12 was interviewed. The Respiratory Therapist indicated Resident #B's, 11:00 a.m., 6/22/12, vent check, treatments and respiratory assessment were not done and she was unsure why they had missed. She indicated she did go into dialysis to do respiratory treatments and assessments.</p> <p>On 8/9/12 at 2:30 p.m., RN #11, who provided resuscitation for Resident #B, was interviewed. She indicated his tracheotomy was not occluded, and she was able to advance the suction tubing, prior to initiating CPR. She indicated the ventilator was not alarming and was working properly before she disconnected the tubing to start bagging the resident with 100% oxygen.</p> <p>This Federal tag relates to Complaint IN00113716</p> <p>3.1-47(a)(6)</p>						

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interviews and record review, the facility failed to maintain a complete record of a fall investigation for one of four residents in a sample of eight, who sustained a fall. (Resident H).</p> <p>Findings include:</p> <p>During the orientation tour, on 8/7/12 at 10:30 a.m., Resident H was observed being returned to her room by therapy staff. The resident was slid forward in the chair and when queried about having foot rests for additional support, the resident indicated she did not want the leg rests or foot supports.</p> <p>The clinical record for Resident H was reviewed, on 8/7/12 at 2:50 p.m., and indicated the resident had been admitted</p>	F0514	F514 I. It is the policy of Wesley Healthcare that all incidents, including but not limited to falls, bruises, elopement, skin tears, and medication errors, will be investigated using the appropriate investigation packet to determine cause, and insure that reportable occurrences are recorded and monitored to facilitate compliance with state and federal laws. II. Nursing staff was in-serviced on 8/14/12 by the DON on the proper use of incident report packets and unusual occurrences that should be immediately reported to the DON and administrator. III. The previous DON was terminated on 8/1/12. IV. The current DON was oriented on 8/14/12 to investigate all incident report packets, document all findings, log all incidents by category every month, and maintain all records in the incident report binder as	08/17/2012			

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	<p>to the facility on 6/22/12, with diagnoses including, but not limited to: chronic respiratory failure, muscle weakness, and diabetes.</p> <p>Nurses notes, dated 6/25/12 at 8:15 a.m., indicated the resident had been found on the floor and was returned to bed by staff members, after an assessment. The note indicated the nurse had walked out of the room and was three doors away when the resident was heard falling again.</p> <p>When RN # 13 was queried, on 8/8/12 at 10:10 a.m., about the investigation of the incident, she indicated the former Director of Nursing (DON) had been responsible for the investigation and it was "missing" from the file where the investigations were kept. She indicated an investigation had been done, but could not be found.</p> <p>This Federal tag relates to Complaint IN00113278 and IN00113716.</p> <p>3.1-50(a)(1)</p>		<p>stated in the policy. V. The incident report binder will now be reviewed daily at Quality of Care Meeting by the Clinical Interdisciplinary Team to ensure all incidents are investigated, documented, logged, and the records are retained in the binder. I. The ADON or designee will complete daily audits of the incident report binder at the Quality of Care Meeting for four weeks then weekly ongoing. II. The results of these audits will be reviewed in the monthly QA meeting. III. Date of completion is August 17, 2012.</p>		