STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING 00 B. WING	01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the State Residential Survey. Survey dates: January 13, 14, 15, 19, 25, 2016 Facility number: 002724 Provider number: 155682 AIM number: 200309330 Census bed type: SNF: 11 SNF/NF: 39 Residential: 31 Total: 81 Census payor type: Medicare: 11 Medicaid: 28 Other: 11 Total: 50 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on February 1, 2016.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State Law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a complaint survey review concluding on January 25, 2016. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 2/16/2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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			

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	be taken. Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were reported timely to the Health Facility Administrator and the State Department of Health for 2 of 3 allegations reviewed. (Resident #300, Resident #33) Findings included: 1. During a confidential interview on 1/14/16 at 1:10 P.M., Resident #300 was observed sitting his/her chair at the residents bedside. At that time during a confidential interview Resident #300 indicated a night shift nurse had been verbally abusive to him/her. Resident #300 indicated the staff member would often yell at him/her when he/she used that call light. Resident #300 indicated the staff member would ask him/her "What the hell do you want?" Resident #300 indicated he/she had reported the allegation to another staff member and had been told "that's just the way she [the staff member] is. " The anonymous allegation of abuse was reported to the Health Facility Administrator on 1/14/16 at 1:10 P.M. The HFA indicated at that time there had been no allegations of abuse reported by staff at that time.	F 0225	The surveyor informed the campus that there was an anonymous allegation of abuse on 1/14/2016. There were no details shared with the ED other than it was an anonymous allegation. The ED immediately reported the anonymous allegation to the ISDH on 1/14/2016. On the follow up to the anonymous allegation the ED reported the abuse allegations of the other two residents identified in the investigation. Upon interviews the residents both stated that they did not feel they were abused. The nurse has been counseled and completed customer service trainings. COMPLETION DATE: 2/16/2016 All residents have the potential to be affected by the alleged deficient practice and therefore through in services, re education of staff, and audits the campus will assure all allegations of abuse are reported timely to the ED and the ISDH COMPLETION DATE: 2/16/2016 All campus staff have been in serviced regarding the definition of abuse and requirements of reporting all allegations of abuse and neglect immediately to the Executive Director. Systemic change is Campus to complete a quarterly in service concerning abuse and neglect procedural guidelines. COMPLETION DATE: 2/16/2016 ED/designee will administer a post test to 2 random campus	02/16/2016

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	2. On 1/19/16 at 1:45 P.M., the facility investigation was reviewed. The investigation included, but was not limited to, an interview with Resident #33 on 1/14/16 at 2:40 P.M., " Has anyone here ever treated you poorly or abused you? 'Yes-This morning lady was not nice, yells at my roommate [symbol for and] she yells at me' ... [name of RN #20] she a [sic] RN". The investigation lacked any documentation the State Department of Health had been notified and other staff members had been interviewed. The investigation also lacked documentation that RN #20 had been suspended pending a complete and thorough investigation being completed. 3. The facility provided a State Department of Health Incident report with follow up on 1/25/16 at 9:22 A.M. The incident report included, but was not limited to, 1/14/16 at 1:30 P.M., "...ISDH surveyor [name of surveyor] approached Executive Director at this time and reported an 'anonymous allegation of abuse' Staff to resident... no injury reported...Follow up: 1/19/16 All residents on health center interviewed and skin assessment completed. No injury were identified during skin sweep. Two residents stated concerns regarding		staff to verify understanding of abuse prevention procedure 5x a week x one month, 3x a week for 1 month, then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. COMPLETION DATE: 2/16/2016	

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	nurse..The residents wanted to remain anonymous...Nurse will complete two in-services related to customer service..." The document lacked any documentation of the names of the resident and staff members involved in the allegation. 5. During an interview with the HFA on 1/25/16 at 10:10 A.M., she indicated during the investigation of the anonymous allegation of abuse. Resident #33 had reported he/she and Resident #16 had been verbally abused by RN #20. The HFA indicated the allegation of abuse had not been reported to the State Department of Health. She indicated RN #20 had not been suspended and reported to work that evening at 10:00 P.M., where she was interviewed and allowed to return to work. During this interview the HFA indicated the facility had not done any other staff interviews as part of the investigation. 6. During a follow up interview with Resident #300 on 1/25/16 the resident indicated he/she had "gotten in to so much trouble" during the investigation and did not wish to get into more trouble. 7. A facility policy titled "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" dated 9/16/11 was reviewed on 1/14/16 at 4:00 P.M., it			

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	included but was not limited to "Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...ABUSE means the willful infliction of injury...intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged). This includes deprivation...This presumes the instance of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish...VERBAL ABUSE may include oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...staff to resident-any episode...Prevention...Encourage residents/family to report concerns, incidents, and grievances to staff...Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director...The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies...Protection...Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person			

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	reporting...Suspend suspected employee(s) pending outcome of investigation...Investigation... The Executive Director is accountable for investigating and reporting... " 3.1-28(c)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed ensure their abuse prohibition policy was implemented in regards to reporting allegations of abuse immediately to the Administrator and the State Department of Health, protection of residents reporting allegations and conducting a complete and through investigation for 2 of 3 allegations reviewed. (Resident #300, Resident #33) Findings included: 1. During a confidential interview on 1/14/15 at 1:10 P.M., Resident #300 was observed sitting his/her chair at the	F 0226	The surveyor informed the campus that there was an anonymous allegation of abuse on 1/14/2016. There were no details shared with the ED other than it was an anonymous allegation. The ED immediately reported the anonymous allegation to the ISDH on 1/14/2016. On the follow up to the anonymous allegation the ED reported the abuse allegations of the other two residents identified in the investigation. Upon interviews the residents both stated that they did not feel they were abused. The nurse has been counseled and completed customer service trainings. COMPLETION DATE: 2/16/2016 All residents have the potential to be affected by the alleged	02/16/2016

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	residents bedside. At that time during a confidential interview Resident #300 indicated a night shift nurse had been verbally abusive to him/her. Resident #300 indicated the staff member would often yell at him/her when he/she used that call light. Resident #300 indicated the staff member would as him/her "What the hell do you want?" Resident #300 indicated he/she had reported the allegation to another staff member and had been told "that's just the way she [the staff member] is " The anonymous allegation of abuse was reported to the Health Facility Administrator on 1/14/16 at 1:10 P.M. The HFA indicated at that time there had been no allegations of abuse reported by staff at that time. 2. On 1/19/16 at 1:45 P.M., the facility investigation was reviewed. The investigation included, but was not limited to, an interview with Resident #33 on 1/14/16 at 2:40 P.M., " Has anyone here ever treated you poorly or abused you? 'Yes-This morning lady was not nice, yells at my roommate [symbol for and] she yells at me' ... [name of RN #20] she a [sic] RN". The investigation lacked any documentation the State Department of Health had been notified and other staff members had been		deficient practice and therefore through systematic changes stated below the campus has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident policy. COMPLETION DATE: 2/16/2016 All Campus staff have been in serviced regarding the definition of abuse and requirements of reporting all allegations of abuse to the Executive Director. The ED, DHS, SS have been in serviced on how to complete a complete investigation in regards to an allegation of abuse. Systemic change is Campus to complete a quarterly in serviceED/Designee will administer a post test to 2 random campus staff to verify understanding of abuse prevention procedure 5X a week x 1 month 3x a week x 1 month then weekly thereafter with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.COMPLETION DATE: 2/16/2016	

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	interviewed. The investigation also lacked documentation that RN #20 had been suspended pending a complete and thorough investigation being completed. 3. The facility provided a State Department of Health Incident report with follow up on 1/25/16 at 9:22 A.M. The incident report included, but was not limited to, 1/14/16 at 1:30 P.M., "...ISDH surveyor [name of surveyor] approached Executive Director at this time and reported an 'anonymous allegation of abuse' Staff to resident... no injury reported...Follow up: 1/19/16 All residents on health center interviewed and skin assessment completed. No injury were identified during skin sweep. Two residents stated concerns regarding nurse..The residents wanted to remain anonymous...Nurse will complete two in-services related to customer service..." The document lacked any documentation of the names of the resident and staff members involved in the allegation. 4. During an interview with the HFA on 1/25/16 at 10:10 A.M., she indicated during the investigation of the anonymous allegation of abuse. Resident #33 had reported he/she and Resident #16 had been verbally abused by RN #20. The HFA indicated the allegation of			

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	abuse had not been reported to the State Department of Health. She indicated RN #20 had not been suspended and reported to work that evening at 10:00 P.M., where she was interviewed and allowed to return to work. During this interview the HFA indicated the facility had not done any other staff interviews as part of the investigation. 5. During a follow up interview with Resident #300 on 1/25/16 the Resident indicated he/she had "gotten in to so much trouble" during the investigation and did not wish to get into more trouble. 6. A facility policy titled "ABUSE AND NEGLECT PROCEDURAL GUIDELINES" dated 9/16/11 was reviewed on 1/14/16 at 4:00 P.M., it included but was not limited to "Trilogy Health Services, LLC (THS), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...ABUSE means the willful infliction of injury...intimidation, or punishment resulting in physical harm, pain or mental anguish (known and/or alleged). This includes deprivation...This presumes the instance of abuse of all residents, even those in a coma, cause physical harm, or pain and mental anguish...VERBAL ABUSE may include			

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	oral, written or gestured language that includes disparaging and derogatory terms to the resident/patient or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability...staff to resident-any episode...Prevention...Encourage residents/family to report concerns, incidents, and grievances to staff...Staff is required to report concerns, incidents and grievances immediately to your manager and/or Executive Director...The Executive Director is responsible for: 1. Notification to the State Department of Health (per State guidelines) and other agencies...Protection...Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident and the person reporting...Suspend suspected employee(s) pending outcome of investigation...Investigation... The Executive Director is accountable for investigating and reporting... " 3.1-28(c)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's			

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	written plan of care. Based on observation, interview, and record review, the facility failed to ensure restorative services were provided according to the plan of care for 1 of 1 resident who met the criteria for review of range of motion. (Resident #10) Findings include: During an interview on 1/14/15 at 11:00 A.M., the MDS Coordinator indicated Resident #10 experienced contractures to the bilateral upper and lower extremities. The MDS Coordinator further indicated, at that time, Resident #10 did not use splints and did not receive range of motion services. During an observation of care on 1/15/16 at 9:38 A.M., Resident #10 was observed lying in bed with a left hand contracture. Resident #10 was observed to have bilateral upper and lower extremity impairment and to not be utilizing splints. The clinical record of Resident #10 was reviewed on 1/15/16 at 11:00 A.M. The record indicated the diagnoses of Resident #10 included, but were not limited to, severe dementia, cerebrovascular accident, and muscle	F 0282	Resident #10 currently does not reside in the campus COMPLETION DATE: 2/16/2016 All residents have the potential to be affected by the deficient practice and through alterations in the processes and in servicing will ensure services provided by the campus are provided by qualified persons in accordance with each resident's written plan of care. All resident's that have a contracture will be screened by therapy to review for splint needs and restorative program. In service with therapy staff and restorative nurse related to the development of a restorative program. Systemic change is therapy will bring all restorative plan of care to morning meeting to assure communication to nursing. COMPLETION DATE: 2/16/2016 DHS/Designee to audit three random residents to assure nursing staff following plan of care for restorative 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. COMPLETION DATE: 2/16/2016	02/16/2016

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	weakness. The Admission MDS [Minimum Data Set] assessment dated 6/3/15 indicated Resident #10 experienced severe cognitive impairment, bilateral range of motion impairment to the upper and lower extremities, and received Physical Therapy services. The most recent MDS assessment dated 1/6/16 indicated Resident #10 experienced severe cognitive impairment, bilateral range of motion impairment to the upper and lower extremities, did not receive restorative nursing services and did not use splints or receive range of motion services. The most recent Physician's Order Recap dated 12/16/15 included, but was not limited to, an order for, "...splint hands bilateral as tolerated DX: contracture manage [sic]..." A Restorative Care Program referral dated 6/11/15 indicated, "...joint contracture...will tolerate resting hand splint on LUE [left upper extremity] and RUE [right upper extremity] daily...perform gentle stretching of LUE and RUE prior to donning resting hand splint..."			

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	A Restorative Care Program referral dated 7/16/15 indicated, "...Diagnosis: Stiffness of joints, CVA [cerebrovascular accident]. Patient is discharged from PT effective 7/17/15. Goals for Restorative Program: ...Maintain ROM in BLEs [sic] [bilateral lower extremities] to prevent contractures and allow for optimal positioning...PROM and gentle stretching to BLE X [times] 10 reps [repetitions]..." During an interview on 1/19/16 at 11:00 A.M., OT #1 indicated Resident #10 was discharged from Occupational Therapy Services on 6/11/15 and Physical Therapy Services on 7/16/15 with referrals for restorative nursing services. OT #1 further indicated, at that time, she was not aware who was responsible for the restorative nursing program or how the program worked. During an interview on 1/19/16 at 11:15 A.M., the MDS Coordinator indicated she was responsible for the Restorative Nursing Program, she had not been made aware Resident #10 was referred for restorative nursing services, and Resident #10 did not receive restorative nursing services between 6/18/15 and 1/18/16. 3.1-42(a)(2)			

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F 0314 SS=G Bldg. 00	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 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. Based on observation, interview, and record review, the facility failed to ensure care was provided to a resident admitted with pressure ulcers, did not develop additional pressure ulcers for 1 of 3 residents who met the criteria for review of pressure. This deficient practice resulted in the resident experiencing Stage 2 pressure ulcers to the left hip, right buttock, and coccyx, blisters to the right axilla and right thigh, an Unstageable pressure ulcer to the left heel, a Stage 4 pressure ulcer to the right ankle, and a Stage 3 pressure ulcer to the left ischium. (Resident #10) Findings include: During an interview on 1/14/16 at 11:00	F 0314	Resident #10 no longer resides in this campus COMPLETION DATE: 2/16/2016 All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent the development of new pressure sores and provide care for current pressure ulcers in accordance with physician's orders. A skin sweep has been completed on all residents to assure accurate documentation of all wounds and proper pressure relieving interventions in place as ordered. COMPLETION DATE: 2/16/2016 All nursing staff have been in serviced concerning proper positioning, wound prevention techniques, and identification of residents at risk to develop a pressure ulcer. All nurses have	02/16/2016

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	155682	A. BUILDING 00 B. WING	01/25/2016

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	A.M., the MDS Coordinator indicated Resident #10 experienced a facility acquired Stage 3 pressure ulcer to the left ischium, a facility acquired Unstageable pressure ulcer to the right outer ankle related to the use of a pressure relieving boot for the right heel and was on complete bedrest. During an interview on 1/15/16 at 9:35 A.M., CNA #17 indicated Resident #10 had been repositioned at approximately 9:00 A.M. During an observation of care on 1/15/16 at 9:38 A.M. Resident #10 was observed lying in bed positioned towards the left side. During an interview, at that time, CNA #16 and CNA #17 indicated they were going to reposition Resident #10 for pressure ulcer care to be provided to the left ischium/buttock. CNA #16 and CNA #17 were observed to reposition Resident #10 to the right side by grasping a draw sheet underneath Resident #10 and pulling Resident #10 across the surface of the mattress. During the repositioning, the right ankle was observed to be covered with a dressing. CNA #16 and CNA #17 then indicated repositioning was complete and the right ankle was observed, at that time, to be in direct contact with the surface of the mattress. No further positioning of Resident #10		been in serviced on completion of skin circumstance forms and implementation and documentation of pressure relieving interventions. Systemic change is residents at high risk for development of pressure ulcer will be identified on the resident profile. Systemic change all newly acquired wounds will be discussed in morning clinical meeting with floor nurse present to ensure new interventions is implemented and communicated to staff who care for the resident COMPLETION DATE: 2/16/2016DHS/designee will complete a random audit on 3 different residents to assure pressure relief/and or devices are provided per the care plan 5x a week x 1 month 3x a week x 1 month then weekly with results forwarded to the QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/commentsCOMPLETION DATE: 2/16/2016	

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	was observed by CNA #16 and CNA #17. On 1/15/16 at 9:40 A.M., PTA (Physical Therapy Assistant) #1 was observed to enter the room of Resident #10 with the DON (Director of Nursing). During an interview, at that time, PTA #1 indicated she usually provided the weekday treatments to the left ischium/buttock wound, but was not going to provide care or assess the wound on the left ischium/buttock of Resident #10 at that time, because she had already performed the treatment for that day and had charged for the time. The DON then indicated the left ischial/buttock wound could not be visualized, at that time, but the unstageable wound on the right ankle could be assessed. The DON and PTA #1 were then observed to exit the room. On 1/15/16 at 9:46 A.M., the DON was observed to return to the room of Resident #10 and indicated she was going to perform pressure ulcer care to the right ankle of Resident #10. During an interview, at that time, the DON indicated the wound was initially observed on 1/6/16 as an Unstageable wound with 100% eschar. CNA #16 and CNA #17 were then observed to reposition Resident #10 to the left side and prop the right ankle with a pillow. The DON was observed to remove the			

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	dressing, and cleanse the right ankle wound. The wound was observed to be 2.2 cm (centimeters) in length and 1.3 cm in width. The wound was observed to contain 90% white/yellow slough and have a red peri-wound. The DON then indicated the threads of a screw were visible in the base of the wound and the wound would be re-classified as a Stage 4 pressure wound. The clinical record of Resident #10 was reviewed on 1/15/16 at 11:00 A.M. The record indicated Resident #10 was admitted to the facility on 5/27/15, was transferred to a local hospital on 6/15/15, and was re-admitted to the facility on 6/18/15 with diagnoses including, but not limited to, severe dementia, cerebrovascular accident, neuropathy, left hip and femur replacement, muscle weakness, and diabetes. The Admission MDS [Minimum Data Set] assessment dated 6/3/15 indicated Resident #10 did not have a terminal diagnosis, experienced severe cognitive impairment, bilateral range of motion impairment to the upper and lower extremities, was at risk for development of pressure ulcers, was admitted with 8 unhealed Stage 2 pressure ulcers and 1 unhealed Unstageable pressure ulcer, received Physical Therapy services, and			

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	required the extensive assist of two staff for bed mobility, personal hygiene, and toileting. The most recent Quarterly MDS assessment dated 1/6/16 indicated Resident #10 did not have a terminal diagnosis, experienced severe cognitive impairment, bilateral range of motion impairment to the upper and lower extremities, a facility acquired Stage 3 pressure ulcer and a facility acquired Unstageable pressure ulcer with eschar. The assessment further indicated Resident #10 was at risk for the development of pressure ulcers and had experienced healing of previous pressure ulcers. The Admission Physician Order Recap dated 6/18/15 included, but was not limited to, and order for "...Pressure reducing cushion to w/c [wheel chair]..." The Admission Orders lacked any orders related to pressure ulcer care. A Nursing Admission Assessment dated 6/18/15 indicated Resident #10 was admitted with a Stage 1 pressure ulcer to the right ankle, a Stage 2 pressure ulcer to the left heel, a Stage 1 pressure ulcer to the left great toe, a Stage 2 pressure ulcer to the left buttock, and a Stage 2 pressure ulcer to the mid coccyx.			

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The most recent Physician's Order Recap dated 12/16/15 included, but was not limited to, orders for, "...weekly skin inspection...turn et reposition every 2 hours...float heels on bed, pressure reducing cushion to w/c at all times; check placement q [every] shift, pressure reducing mattress to bed at all times, apply pressure reduction boots, off load heels, keep all pressure off wounds when positioning in bed and w/c...[brand name of protective sleeve] sleeves to all extremities when transfering [sic] with [brand name of mechanical lift] lift..."

The January 2016 Treatment Administration Record indicated the following:
"...apply pressure reduction boot...off load heels-6/1/15...keep all pressure off wounds when positioning in bed and w/c-6/13/15...float heels while in bed-6/18/15..."

A Care Plan for "Skin" dated 6/18/15 indicated interventions of, "turn and reposition for comfort and with care, Prevent skin from touching skin, elevate heels off surface, use lift sheet to reposition in bed, provide pressure relieving device...to bed...ensure resident is clean and dry....observe labs... provide vitamins and supplement per physician

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	order..." A Resident Conference note dated 6/23/15 indicated a new intervention of, "...chair cushion..." was implemented. A Resident Conference note dated 7/22/15 indicated a new intervention of, "...specialty mattress..." was implemented. A Pressure Ulcer Assessment dated 7/2/15 indicated the Stage 1 pressure ulcer on the right ankle was healed. The assessment further indicated the meaning of Stage 1 was, "...intact skin with non-blanchable redness..." A Pressure Ulcer Assessment dated 7/8/15 indicated the Stage 2 pressure ulcer to the mid coccyx was healed. The assessment further indicated the meaning of Stage 2 was, "...Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister..." A Pressure Ulcer Assessment dated 7/20/15 indicated the Stage 2 pressure ulcer on the left heel was healed. A Pressure Ulcer Assessment dated 7/20/15 indicated the Stage 1 pressure			

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	ulcer on the left great toe was healed. A Pressure Ulcer Assessment dated 8/1/15 indicated the Stage 2 pressure ulcer to the left buttock was healed. A Clinically At-Risk weekly follow up form dated 8/5/15 indicated, "Wounds healed at this time ...current interventions of pressure red. [reduction] cushion to w/c, staff assist with T/R [turn and reposition] Q [every] 2 hours and PRN [as needed], pressure reducing boots to offload pressure to heels..." A Care Plan for Skin dated 9/10/15 indicated a new intervention of, "...use a draw sheet for turning and repositioning me to decrease the probability of my getting shear or friction injuries..." A Skin Impairment Circumstance, Assessment, and Intervention form dated 9/12/15 indicated Resident #10 experienced a facility acquired Stage 2 pressure ulcer to the left ischium/buttock and lacked any documentation to indicate a new intervention for pressure relief was implemented. A Pressure Ulcer Assessment dated 9/24/15 indicated Resident #10 experienced a facility acquired Stage 2 pressure ulcer to the left hip on 9/18/15			

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	which had healed. A Weekly Clinically At Risk Follow Up form dated 10/8/15 indicated, "...Continue current interventions...." A Pressure Ulcer Assessment dated 10/13/15 indicated Resident #10 experienced a facility acquired Stage 2 pressure ulcer to the right buttock on 10/7/15 which had healed. A Weekly Clinically At Risk Follow Up form dated 10/15/15 indicated, "...Continue current interventions...Has new wound on Lt [left] heel..." A Care Plan for Skin dated 10/20/15 lacked any documentation to indicate new pressure relief interventions had been implemented related to the left heel. A Pressure Ulcer Assessment dated 10/30/15 indicated Resident #10 experienced a facility acquired Unstageable wound with eschar to the left heel on 10/13/15 which had healed. The assessment further indicated the meaning of Unstageable was, "...non-removable dressing, slough/eschar; suspected deep tissue injury in evolution..." A Weekly Clinically At Risk Follow Up			

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	form dated 11/5/15 indicated, "...continue current interventions...new area on coccyx..." A Resident Conference note dated 11/9/15 lacked any documentation to indicate new pressure relief interventions had been implemented related to the new area on the coccyx. An untimed Physician's Telephone Order dated 11/12/15 indicated an order was received for, "Patient to utilize pressure reducing air cushion..." A Weekly Clinically At Risk Follow Up form dated 11/19/15 indicated, "...continue current interventions...open area continues with slough..." The form lacked any documentation to indicate which wound contained slough. A Care Plan for Skin dated 11/18/15 indicated a new intervention of, "...air bed..." was implemented. A Physician's Telephone Order dated 11/19/15 at 1:00 P.M. indicated an order was received for, "...PT [Physical Therapy] eval [evaluation] r/t [related to] Stage 3 area" The order lacked any documentation to indicate the location of the Stage 3 area.			

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	A Pressure Ulcer Assessment dated 12/1/15 indicated Resident #10 experienced a facility acquired Stage 2 pressure ulcer to the coccyx on 11/5/15 which had healed. A Skin Impairment Circumstance Assessment and Intervention form dated 12/5/15 indicated Resident #10 experienced a facility acquired Stage 2 pressure blister to the right axilla and lacked any documentation to indicate a new intervention for pressure relief was implemented. A Weekly Clinically At Risk Follow Up form dated 12/3/15 indicated, "...continue current interventions... A Monthly Nursing Assessment dated 12/16/15 indicated no new interventions for pressure relief were implemented. A Skin Impairment Circumstance, Assessment, and Intervention form dated 12/23/15 indicated Resident #10 experienced a facility acquired Stage 2 blister to the right thigh and lacked any documentation to indicate a new intervention for pressure relief was implemented. A Weekly Clinically At Risk Follow Up form dated 12/31/15 indicated,			

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	"...continue current interventions..." An untimed Nursing note dated 1/6/16 indicated, "...new area noted on Rt. [right] ankle with Eschar..." The note lacked any documentation to indicate new interventions for pressure relief to the left ischium/buttock or right ankle were implemented. A Skin Impairment Assessment dated 1/7/16 indicated Resident #10 experienced a facility acquired Stage 2 blister to the right axilla on 12/5/15 which had healed. A Skin Impairment Assessment dated 1/7/16 indicated Resident #10 experienced a facility acquired Stage 2 blister to the right thigh on 12/23/15 which had healed. A Care Plan for Skin dated 1/7/16 lacked any documentation to indicate new pressure relieving interventions were implemented after 9/10/15. A Weekly Clinically At Risk Follow Up form dated 1/7/16 indicated, "...Wound is not exhibiting s/s [signs/symptoms] of healing or appears to be worsening. See below for updated interventions...new unstageable area noted on Rt outer ankle, awaiting albumin level, letter of			

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	unavoidability." The form lacked any documentation to indicate new pressure relief interventions were implemented. The most recent Complete Metabolic Profile laboratory report dated 1/7/16 indicated the total protein level was 6.9 g [gram]/dl [deciliter] with the therapeutic level identified as 6.0-8.2 g/dl. The report further indicated the albumin level was 3.5 g/dl with the therapeutic level identified as 3.4-4.8 g/dl. and BUN [Blood Urea Nitrogen] 31 mg [milligrams]/dl with the therapeutic level 8-23 mg/dl. and Creatinine 0.8 mg/dl with a therapeutic level identified as 0.4-1.1 mg/dl. A Physician Pressure Ulcer Letter of Unavoidability dated 1/7/15 at 12:15 P.M. indicated, "...Despite routine preventative care such as turning and proper positioning, application of pressure reduction or relief devices, good skin care, and maintaining adequate nutrition and hydration this resident is at high risk for skin breakdown...Clinical conditions this resident exhibits that make the likelihood of this pressure ulcer unavoidable include, but are not limited to, resident immobility and...diagnosis [sic] Diabetes...Chronic bowel incontinence...head of bed elevated the majority of the time due to medical			

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	necessity tube feeding 6p [6:00 P.M.]-6a [6:00 A.M.] pale skin...muscle wasting..." A Pressure Ulcer Assessment dated 1/11/16 indicated Resident #10 experienced a facility acquired Stage 2 pressure ulcer on the left buttock/ischium that measured,"...2.3 cm [centimeters] in length...2.5 cm width...0.1 cm depth..." with a red wound bed on 9/12/15. The assessment further indicated, the wound contained "50% slough" on 9/29/15 and "Stage 3...70% slough..." on 10/7/15. The assessment indicated the meaning of Stage 3 was, "...Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss..." The Assessment lacked any documentation to indicate new interventions were implemented to provide pressure relief to the left buttock/ischium were initiated until 10/7/15, "...bedrest until wounds improved [sic]..." The Pressure Ulcer Assessments dated 10/13/15 through 1/11/16 were reviewed and lacked any documentation to indicate new pressure relief interventions were implemented. A Pressure Ulcer Assessment dated 1/13/16 indicated Resident #10 experienced a facility acquired Unstageable pressure ulcer with 100%			

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	black/brown eschar with an intact peri-wound on the Rt [right] outer ankle on 1/6/16. The assessment indicated the right ankle wound exhibited a red peri-wound on 1/13/16 and lacked any documentation to indicate a new intervention to provide pressure relief to the right ankle was implemented until 1/13/16. The assessment further indicated the meaning of Stage 4 was, "...Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or schar [sic] may be present on some parts of the wound bed. Often includes undermining and tunneling..." A Nursing note dated 1/14/16 at 10:35 A.M. indicated, "..Charge Nurse...came to discuss unstageable area on Rt ankll [sic] . Residents [sic] daughter...at bedside, she shared that resident had fractured the ankle and had a stent placed as well has repair pinned. POA wants the pressure reducing boot removed from Rt foot. She will allow the foot to be elevated...POA also shared that residents [sic] perfusion in that extremity was compromised and that she had a stent placed...discussed residents [sic] co-morbidities that compromise the ability to heal...discussed the letter of unavoidability..." A Care Plan for "Alteration in...skin			

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	integrity" dated 1/14/16 lacked a comprehensive list of current wounds or interventions and lacked any documentation new interventions for pressure relief to left ischium or the right ankle were implemented. An untimed Physician's Telephone Order dated 1/14/16 indicated an order was received for, "...Keep Rt L [lower] leg on pillow..." During an observation of care on 1/19/15 at 9:00 A.M., Resident #10 was observed lying in a supine position in bed with pillows behind the left back. PTA #1 indicated she was going to perform pressure ulcer care to the Stage 3 pressure ulcer on the left ischium of Resident #10. During an observation, at that time, PTA #1 and RN #5 were observed to reposition Resident #10 to the right side by grasping a draw sheet underneath Resident #10 and pulling Resident #10 across the surface of the bed. The left ischium wound was observed, at that time, to measure 2.1 cm X 1.8 cm X 0.9 cm with yellow slough, undermining, rolled edges, and areas of maceration on the peri-wound. The right ankle was observed to be covered with a dressing and in direct contact with inner surface of a u-shaped air-filled pillow on the surface of the bed. During an interview, at that			

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	155682	A. BUILDING 00 B. WING	01/25/2016

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	time, RN #5 indicated the u-shaped pillow was utilized to provide pressure relief to the left heel. An untimed PT Daily Treatment Note dated 1/19/15 indicated, "...Left ischial wound...wound measurement 2.1 X 1.8 X 0.9...maceration of wound edges from 4 oclock [sic] to 7 oclock [sic] with remaining edges pink in color. Wound edges are rolled and noted undermining from 9oclock [sic] to 2 oclock [sic]. Wound bed at 85% yellow necrosis prior to sharps [sic] debridement with 80% remaining after completion of sharps [sic] debridement..." During an interview on 1/19/16 at 11:15 A.M., the MDS Coordinator indicated Resident #10 had not experienced a change in condition since admission. During an interview on 1/19/16 at 11:30 A.M., the DON indicated the Stage 4 pressure wound to the right ankle and the Stage 3 pressure wound to the left ischium were unavoidable. The DON further indicated no Skin Impairment Circumstance form could be provided related to the Unstageable pressure wound initially observed on 1/6/16, but it had been documented in a nursing note that same day. The DON then indicated, skin inspections were completed for each			

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	resident weekly. A Weekly Clinically At Risk Follow Up form dated 1/21/16 indicated, "...wound is not exhibiting s/s of healing or appears to be worsening. See below for updated interventions..." The form lacked any documentation to indicate new pressure relief interventions were implemented. During an interview on 1/25/16 at 9:00 A.M., the DON indicated no documentation could be provided to indicate the albumin level was monitored between 6/18/15 and 1/6/16, no documentation could be provided to indicate the attending physician had visualized the wound, and Resident #10 had not been referred to a wound specialist for follow-up because the resident was being treated by PT. A Policy and Procedure for "Letter of Unavoidability Guidelines" provided by the RNC (Regional Nurse Consultant) #1 on 1/25/16 at 11:00 A.M. indicated, "...To provide physician certification of unavoidable wounds due to resident condition despite proper implementation of care interventions...2. Staff will make every effort to identify and implement care interventions to prevent skin breakdown..."			

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	A Policy and Procedure for "Wound Risk Assessment Guideline" provided by the RNC #1 on 1/25/16 at 11:00 A.M. indicated, "To provide guidelines for the identification of risk factors predisposing residents to skin breakdown...5. Recognized risk factors shall have care plan interventions/approaches identified and put in place to mitigate the risks to the extent possible." A Policy and Procedure for "Monthly Nursing Assessment and Data Collection" provided by the RNC #1 on 1/25/16 at 11:00 A.M. indicated, "6. The nurse completing the form shall identify the risk factors and follow the care plan intervention for minimizing and/or eliminating safety concerns. a. Care plan interventions should be reviewed and evaluated for effectiveness and modified as indicated. b. Interventions should be specific to the resident and target the impact of the risk to the individual..." A Policy and Procedure for "Guidelines for Circumstance and Reassessment Forms" provided by the RNC #1 on 1/25/16 at 11:00 A.M. indicated, "...4. New approaches or interventions should be evaluated and added as a care plan update...Approaches/interventions already in effect should not be listed again..."			

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	During an interview on 1/25/15 at 11:30 A.M. the RNC #1 indicated the Wound Risk Assessment policy was the comprehensive policy followed by the facility, specific interventions could be located on the Admission/Monthly Nursing assessments or the Skin Impairment Circumstance, wound prevention was basic nursing knowledge, and no specific policy could be provided for Pressure Ulcer Prevention. 3.1-40(a)(1)			
F 0318 SS=G Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview, and record review, the facility failed to ensure restorative nursing services were provided for 1 of 1 resident who met the criteria for review of range of motion. This deficient practice resulted in Resident #10 experiencing increased	F 0318	Resident #10 currently does not reside in the campus COMPLETION DATE: 2/16/2016 All residents have the potential to be affected by the deficient practice and through alterations in the processes and in servicing will ensure services provided by the campus are provided by	02/16/2016

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	contractures of the left knee and new contracture of the right knee. (Resident #10) Findings include: During an interview on 1/14/15 at 11:00 A.M., the MDS [Minimum Data Set] Coordinator indicated Resident #10 experienced contractures to the bilateral upper and lower extremities. The MDS Coordinator further indicated, at that time, Resident #10 did not use splints and did not receive range of motion services. During an observation of care on 1/15/16 at 9:38 A.M., Resident #10 was observed lying in bed with a left hand contracture. Resident #10 was observed to have bilateral upper and lower extremity impairment and to not be utilizing splints. The clinical record of Resident #10 was reviewed on 1/15/16 at 11:00 A.M. The record indicated the diagnoses of Resident #10 included, but were not limited to, severe dementia, cerebrovascular accident, and muscle weakness. The Admission MDS assessment dated 6/3/15 indicated Resident #10 experienced severe cognitive impairment,		qualified persons in accordance with each resident's written plan of care. All resident's that have a contracture will be screened by therapy to review for splint needs and restorative program. In service with therapy staff and restorative nurse related to the development of a restorative program. Systemic change is therapy will bring all restorative plan of care to morning meeting to assure communication to nursing. COMPLETION DATE: 2/16/2016 DHS/Designee to audit three random residents to assure nursing staff following plan of care for restorative 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. COMPLETION DATE: 2/16/2016	

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	bilateral range of motion impairment to the upper and lower extremities, required the extensive assist of two staff for bed mobility, hygiene, and toileting, and received Physical Therapy services. The most recent MDS assessment dated 1/6/16 indicated Resident #10 experienced severe cognitive impairment, bilateral range of motion impairment to the upper and lower extremities, did not receive restorative nursing services and did not use splints or receive range of motion services. The most recent Physician's Order Recap dated 12/16/15 included, but was not limited to, an order for, "...splint hands bilateral as tolerated DX: contracture manage [sic]..." A Restorative Care Program referral dated 6/11/15 indicated, "...joint contracture...will tolerate resting hand splint on LUE [left upper extremity] and RUE [right upper extremity] daily...perform gentle stretching of LUE and RUE prior to donning resting hand splint..." The Admission Nursing Assessment dated 6/18/15 indicated Resident #10 experienced a left hand contracture and included, but was not limited to, an			

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	intervention of ROM [range of motion] per protocol. An OT (Occupational Therapy) Plan of Care dated 6/19/15 indicated, "...Discharge plan...Pt [patient] will discharge from OT able to tolerate splints for positioning of BUE [bilateral upper extremities] and prevention of contractures...underlying impairments: Pt LUE rigid with contractures noted..." A Resident Conference dated 6/23/15 indicated, "...OT [Occupational Therapy] with positioning/splint mgt [management]...was using splint; gradually increasing...PT: working on ROM in legs...still has tightness in legs..." A PT-Therapist Progress note dated 7/2/15 indicated, "...Pt has demonstrated improved ROM of bilateral ankles and left knee since initiation of skilled PT services...has demonstrated improved joint mobility since initiation of skilled services...PT...Prognosis For Further Progress: Good due to increased ROM..." An OT-Therapist Progress note dated 7/2/15 indicated, "...prior level of function 6/19/15...is at risk for new contractures and worsening of existing contractures..."			

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	A PT-Therapist Progress note dated 7/14/15 indicated, "...Pt. [patient] would benefit from implementation of nursing restorative program ...to continue maintaining joint mobility at max [maximum] level....Pt continues with BLE contractures...which warrants continued PT to establish a restorative program which will help to maintain joint mobility and alignment...Pt has been able to maintain joint mobility without further progression of flexion contractures...focus on implementing restorative program for ROM [range of motion] to BLE to maintain joint mobility and alignment...will implement nursing restorative program for continued maintenance of joint mobility..." An OT-Therapist Progress note dated 7/15/15 indicated, "...Caregivers have been inconsistent with proper donning/doffing of bilateral hand splints and management of wearing schedule..." A Restorative Care Program referral dated 7/16/15 indicated, "...Diagnosis: Stiffness of joints, CVA [cerebrovascular accident]. Patient is discharged from PT effective 7/17/15. Goals for Restorative Program: ...Maintain ROM in BLEs [sic] [bilateral lower extremities] to prevent contractures and allow for optimal			

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	positioning...PROM [passive range of motion] and gentle stretching to BLE X [times] 10 reps [repetitions]..." A PT-Therapist Progress and Discharge Summary dated 7/17/15 indicated, "...The patient demonstrates PROM of LLE [left lower extremity] knee from 55 to 130 degrees...Pt has demonstrated improved ROM of bilateral ankles and left knee...would benefit from restorative nursing program for ROM to BLE's to maintain maximal joint mobility and prevent further contractures...Recommendations made for nursing restorative program for PROM to maintain joint mobility and prevent further contractures...at risk for joint contracture...d/c [discharge] from PT with recommendations made for nursing restorative program..." The summary lacked any documentation related to the right lower extremity. An OT-Therapist Progress & Discharge Summary dated 7/17/15 indicated, "...Patient discharged to SNF with recommendations including continue with splints (restorative program established) and positioning techniques..." A Monthly Nursing Assessment dated 12/16/15 indicated Resident #10			

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	experienced contractures and lacked any documentation to indicate Resident #10 received range of motion services or used splints. The Plan of Care dated 1/14/16 lacked any documentation related to contractures or restorative nursing services. During an observation of care on 1/19/16 at 9:30 A.M., PTA [Physical Therapy Assistant] #1 was observed to not be able to move the bilateral knee joints of Resident #10 during repositioning. PTA #1 stated, at that time, the bilateral lower legs were, "really contracted". CNA #5 was then observed to not be able to move the bilateral upper extremities shoulder or elbow joints during repositioning. RN #5 then indicated Resident #10 was admitted with contractures of the bilateral upper and lower extremities. During an interview on 1/19/16 at 11:00 A.M., OT #1 indicated Resident #10 was discharged from Physical Therapy Services on 7/17/5 and referred for restorative nursing services on 7/16/15. OT #1 further indicated, at that time, she was not aware who was responsible for the restorative nursing program or how the program worked, and provided a restorative nursing referral.			

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	During an interview on 1/19/16 at 11:15 A.M., the MDS Coordinator indicated she was responsible for the Restorative Nursing Program, she had not been made aware Resident #10 was referred for restorative nursing services, and Resident #10 did not receive restorative nursing services between 6/18/15 and 1/18/16 or use splints on the bilateral upper extremities after Occupational Therapy ended in July of 2015. An untimed PT Daily Treatment Note dated 1/25/16 indicated, "...L [left] knee 135-80 degrees (-80 degrees from full knee extension)...R [right] knee 135-25 degrees (-25 degrees from full knee extension)..." The PT daily treatment notes indicated Resident #10 experienced a 25 degree loss of extension in the left and right knee between 7/16/15 and 1/25/16. During an interview on 1/25/16 at 2:00 P.M., OT #1 indicated the documentation reflected Resident #10 experienced decreased range of motion in the bilateral lower extremities since being discharged from therapy service. A Policy and Procedure for "Nursing Restorative and Functional Maintenance Program" provided by the DON [Director of Nursing] on 1/25/16 at 8:05 A.M.			

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	indicated, "...To promote Restorative and Functional Maintenance Nursing Programs to enable residents to attain or maintain the highest level of functioning regarding physical...well-being... 7. Restorative programs will be delivered according to the established program plan..." 3.1-42(a)(2)			
F 0371 SS=F Bldg. 00	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 dishwasher temperatures were appropriate and food handling practices by staff were performed to ensure sanitary food preparation for 2 of 2 days of dietary observations. Findings include: 1. On 1/13/16 at 9:27 A.M., the initial kitchen tour began with the Assistant Food Manager (AFM). The walk in	F 0371	The residents suffered no ill effects from the alleged deficiencies. Dietary staff were in serviced on proper dish machine procedures, proper food handling related to hand washing, and proper food storage.COMPLETION DATE: 2/16/2016All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus procures food from sources approved or considered satisfactory by Federal, State, or local authorities and stores,	02/16/2016

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	refrigerator was observed to have 2 crates containing 18-1/2 gallons of chocolate milk sitting directly on the floor. On 1/13/16 at 9:37 A.M., the AFM indicated the 1/2 gallons of milk were usually on another crate and not placed directly on the floor. 2. On 1/19/16 at 9:44 A.M., during kitchen tour the dishwasher was observed in use. The Food Service Manager (FSM) indicated at that time the wash temperature should be 150 F (Fahrenheit) or higher and the rinse should be 180 F or higher. A tray of soiled flatware was placed thru the dishwasher at that time. The dial of the wash cycle was at 130 F when the wash cycle began and it remained at that temperature thru out the wash cycle. The dial of the wash cycle had condensation inside the dial making temperature readings difficult to read. The FSM put the flatware thru the wash cycle again and the wash cycle temperature increased to 134 F. The FSM at that time indicated, earlier that morning dishwashing staff had drained all the water out of the dishwasher and then refilled the dishwasher water due to the water was observed to be cloudy. The FSM indicated the wash cycle water temperature was below the required 150 F. The FSM indicated she was calling the facility maintenance staff for		prepares, distributes, and serves food under sanitary conditionsCOMPLETION DATE: 2/16/2016All dietary employees have been in serviced on proper dish machine guidelines as well as proper food handling with regards to hand washing. Systemic changes are all employees in serviced on proper dish machine guidelines including temperature logging. All employees in serviced on proper hand washing guidelines. All employees will complete a competency check off for hand washing and glove usage now and annually thereafter.COMPLETION DATE: 2/16/2016ED/Designee will complete unannounced audit of kitchen for proper hand washing, and not items stored on the floor in the refrigerator and spot check of dish machine temperatures along with checking temperature logs for completion 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments. COMPLETION DATE 2/16/2016	

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	assistance. 3. On 1/19/16 at 10:00 A.M., Maintenance Staff #1 was in the kitchen checking the dishwasher temperatures. Maintenance staff #1 agreed the inside dials of the wash and rinse cycles had condensation which made it difficult to read temperature measurements. Maintenance Staff #1 indicated now the dishwasher wash temperature was 150 F and the rinse temperature was 205 F. 4. On 1/19/16 at 10:45 A.M., the FSM provided documentation of the dishwasher machine temperatures for meal times from 1/3/16-1/19/16 (breakfast meal only). The dishwasher temperatures were in the correct range (150 F or higher for wash and 180 F or higher for rinse) except : on 1/3/16 no dishwasher temperatures were recorded for breakfast or lunch, on 1/5/16 evening dishwasher temperatures were not recorded, on 1/6/16 the evening dishwasher temperature was 146 F, on 1/7/16 no noon meal dishwasher temperatures had been recorded and the evening dishwasher wash temperature was 145 F, on 1/8/16 evening meal dishwasher temperature was recorded as 130 F, on 1/10/16 no noon meal dishwasher temperatures had been recorded, on 1/11/16 no evening meal			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dishwasher temperature had been recorded, on 1/14/16 noon meal dishwasher temperatures had not been recorded and wash cycle temperature on evenings recorded as 140 F, and on 1/16/16 no evening meal dishwasher temperatures had been recorded. 5. On 1/19/16 at 10:45 A.M., Maintenance Staff #1 was observed leaving the kitchen area. At that time Maintenance Staff #1 indicated the wash temperature of the dishwasher had increased to 155 F. He also indicated staff would be rewashing previous dishes when the wash temperatures had been too low. 6. On 1/19/16 at 11:20 A.M., during observation with Dishwasher Staff #1 flatware placed thru dishwasher had a wash temperature of 142 F. Dishwasher Staff #1 also indicated difficulty reading the temperature measurement due to condensation in the washing and rinse dials of the dishwasher. Maintenance Staff #1 indicated he was shutting the dishwasher down. Maintenance Staff #1 indicated the facility leased the dishwasher. He also indicated the dishwasher company staff had been at the facility on 1/4/16. 7. On 1/19/16 at 11:55 A.M., during			

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	155682	A. BUILDING 00 B. WING	01/25/2016

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	noon meal preparation Cook #1 was observed taking food from the oven for a temperature check. Cook #1 holding cloth pads in each hand removed the hot food from the oven. Cook # 1 was observed to drop one of the cloth pads on the floor while removing a pan of food. She picked the cloth pad off the floor and continued to remove the pan of food from the oven without hand washing or obtaining a clean pad for food handling. 8. On 1/19/16 at 11:58 A.M., Cook #1 while using a digital thermometer to check the temperature of a food item dropped the thermometer on the kitchen floor. Cook #1 was observed to pick up the thermometer and place the thermometer on a sink area. Cook #1 then asked for a different thermometer to continue checking food temperatures. Cook #1 received a clean thermometer and continued checking food temperatures without handwashing. 9. A facility policy entitled "Dishmachine Guideline" (revision date 4/25/13) was received and reviewed. The policy included but was not limited to, "... Check that temperatures are appropriate: High Temp- Wash temp should be 150 -160 [symbol for degrees] F; Rinse temp should be 180 - 185 [symbol for degrees] F..."			

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	10. On 1/25/16 at 8:35 A.M., the FSM was interviewed regarding inappropriate dishwasher temperatures observed last week. The FSM indicated on 1/19/16 the dishwasher company staff member was at the facility had indicated there was a problem with the floating switch of the dishwasher and a dishwasher part had to be ordered. She indicated the facility used disposable products (paper and plastic dishes and flatware) on 1/20/16, 1/21/16, and 1/22/16. The FSM indicated the dishwasher part has been replaced and now the dishwasher was working correctly. The FSM indicated at that time the dishwasher wash temperature needed to be 150 F or higher and rinse dishwasher temperature needed to be 180 F or higher. At that time the facility policy which indicated a high temperature wash of 150-160 F and a rinse temperature of 180-185 F was reviewed with the FSM. The FSM indicated she would ask about the policy. The FSM was also made aware at that time of lack of handwashing during meal preparation on 1/19/16 regarding thermometer and cloth pads dropped on the floor. The FSM indicated at that time she understood the problem. 11. On 1/25/16 at 8:54 A.M., the FSM provided a policy entitled, "Guidelines			

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	for Handwashing (revised 03/2013)." The policy included but was not limited to, " 3. Health Care Workers shall wash hands at times such as: a. On reporting to work; before/after eating; after smoking, toileting, blowing nose, coughing, sneezing, handling hair, etc..." 3.1-21(i)(2) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for the State Residential Survey. Resident Census: 31 Resident Sample: 7 Woodmont Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State Law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a complaint survey review concluding on January 25, 2016. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 2/16/2016.	