

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G320	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2012
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NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1855 WESTWOOD DR MOUNT VERNON, IN 47620
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W0000	<p>This visit was for a fundamental recertification and state licensure survey. This visit resulted in an extended survey (Health Care Services).</p> <p>Dates of Survey: 3/28, 3/29, 3/30, 4/2 and 4/5/12</p> <p>Facility Number: 000838 Provider Number: 15G320 Aim Number: 100243770</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, RN, Public Health Nurse Surveyor III (4/2/12)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on April 5, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility's healthcare services met the nursing/health needs of a client.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored, assessed and/or conducted timely assessments of client #2's open area on the client's buttocks. The governing body failed to exercise general policy and operating direction over the facility by failing to ensure the facility's nursing services ensured facility staff documented and/or accurately documented changes with an open area/wound, contacted nursing services when the client demonstrated a change of condition/health status, and failed to develop and/or put in place specific protocols/risk plans in regard to the open area/wound. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services</p>	W0104	<p>Historically, the Rehabilitation Center has provided effective nursing care. Due to lack of experience related to wound care, as an agency it appears we are not currently meeting the standard in this area. We pride ourselves in providing the best care to our clients. Realizing through the survey process that we are not adequate in wound care currently, motivates us to seek the required information, training, and policies to effectively address this area and elevate our standards immediately.</p> <p>In regard to client # 2's wound, IDT met immediately after the survey process to put additional measures in place to ensure comprehensive, thorough wound care. IDT met to develop the specific risk protocol for client #2. This more specific protocol includes instruction as to what contributing factors must be monitored (i.e. diabetes, decreased pain perception, sedentary, supervised hygiene, etc.), as well as specific interventions (i.e. bed rest with rotation from left side to right side, diet supplements, current medications and treatment for wound care, staff training,</p>	05/05/2012			

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	<p>trained and/or monitored staff for competency in regard to wound care and/or proper documentation in regard to the client #2's wound. Please see W331.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services trained staff in regard to client #2's wound care/decubitus ulcer, and to monitor staff to ensure competency in regard to care of client #2's wound. Please see W342.</p> <p>9-3-1(a)</p>		<p>nurse/medical monitoring, and staff instruction as to what signs/symptoms equate notification of the nurse/doctor). This protocol was immediately in-serviced to group home management and residential assistants by RCDS nursing staff to ensure thorough understanding and implementation. The nurses are in the group home every other day to monitor the wound and change the dressing. Progress with the wound will be noted by the nurses in their notes. The nurses are also monitoring staff implementation of the corrective interventions to ensure progressive wound healing. Client # 2 continues to work with the wound clinic as well for follow-along care related to his ulceration. Currently, wound clinic care is being scheduled on a bi-monthly basis and any changes made to the current treatment regimen is being trained on and implemented by RCDS nursing staff as applicable.</p> <p>All nursing staff were immediately retrained in regard to wound care, including their role in ensuring that comprehensive, thorough wound care is completed and documented. This retraining included specifics related to the nurses role in monitoring, assessing, and/or conducting timely assessments related to wounds. The nurses were also retrained on their role in ensuring</p>		

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			<p>staff are trained and clearly understand how to document on the pressure tracking sheet, as well as instruction/training to staff as to when the nurse/doctor must be contacted related to a change of status with the wound. The nurses also now understand their role in ensuring a specific protocol/risk plan is developed, implemented, and in-serviced to all staff in a timely manner related to wound care. The nurses were also retrained on ensuring they attend all IDT meetings related to medical issues as their input is vital to ensure appropriate medical care. Lastly, the retraining included instruction on the nurse's role with training related to all areas of medical care. The nurses will train staff related to medical issues (i.e. monitoring, documenting, treating, and prevention) and/or monitor for accuracy of wound care, as well as ensure appropriate wound documentation.</p> <p>Administration met to discuss systemic changes related to skin integrity issues and wounds. A Wound Care Policy was developed to ensure comprehensive care and follow through. The policy will ensure that the facilities nursing services</p>		

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			<p>monitor and assess skin issues timely, ensure staff are documenting wound care accurately, ensure staff training related to signs/symptoms that equate change and notification of the nurses, ensure effective risk plans are implemented and followed, and complete training and monitoring of staff for competency related to wound care. All professional staff, nurses, and direct care staff were trained in regard to the Wound Care Policy.</p> <p>Beyond implementation of the wound care policy, we also have provided a wound care training DVD to all staff which included administration, professional staff, nurses, and direct care staff. Also, administration has set up a professional training with a wound care nurse from a local hospital. This training will be recorded in order to ensure all staff have access to the information. These training DVD's will be incorporated into employee orientation to ensure new staff are familiar with wound care immediately upon hire. Also, current employees will be required to view the DVD's immediately, as well as on a recurring annual basis to ensure quality care on an on-going basis related to wound care.</p> <p>Beyond the development of the Wound Care Policy and wound</p>		

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			<p>care trainings, administration and nursing staff also met to develop acute/chronic high-risk protocols related to wound care. These protocols will include specific contributing factors (i.e. mobility, nutrition, medical conditions, etc.) and interventions (i.e. positioning, diet, medications, staff training, etc.). The listing of these specific probes in combination with the high-risk protocol will ensure the IDT evaluates all contributing factors, as well as interventions, when dealing with individual client wounds.</p> <p>Additionally, administration will begin conducting bi-monthly meetings with the nursing coordinator to ensure wound care is being monitored and implemented correctly. This meeting will ensure corrective action related to wound care is maintained on an on-going preventative basis within all nine group homes.</p> <p>As previously stated, the Rehabilitation Center has a long history of providing effective nursing care. Lack of expertise in the area of wound care has evidenced some shortcomings. As an agency, we pride ourselves on providing outstanding client care. We feel the corrective and preventative measures put in place will elevate our standard of care related to wounds and ensure future adequacy in this</p>		

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 1 of 4 sampled clients (#2). The facility's health care services failed to meet the nursing needs of a client in regard to a stage 3 Decubitus Ulcer. The facility's health care services failed to ensure nursing staff trained and/or monitored facility staff in regard to wound care.</p> <p>Findings include:</p> <p>1. The facility's nursing services failed to monitor, assess and/or to conduct timely assessments of client #2's open area on the client's buttocks. The facility's nursing services failed to ensure facility staff contacted nursing services when the client demonstrated a change of condition/health status, documented and/or accurately documented changes with the open area/wound, and failed to develop and/or put in place specific protocols/risk plans in regard to the open area/wound. The facility's nursing services failed to ensure facility staff were trained and/or demonstrated competency in regard to wound care and/or</p>	W0318	<p>Historically, the Rehabilitation Center has provided effective nursing care. Due to lack of experience related to wound care, as an agency it appears we are not currently meeting the standard in this area. We pride ourselves in providing the best care to our clients. Realizing through the survey process that we are not adequate in wound care currently, motivates us to seek the required information, training, and policies to effectively address this area and elevate our standards immediately.</p> <p>In regard to client # 2's wound, IDT met immediately after the survey process to put additional measures in place to ensure comprehensive, thorough wound care. IDT met to develop the specific risk protocol for client #2. This more specific protocol includes instruction as to what contributing factors must be monitored (i.e. diabetes, decreased pain perception, sedentary, supervised hygiene, etc.), as well as specific interventions (i.e. bed rest with rotation from left side to right side, diet supplements, current medications and treatment for wound care, staff training, nurse/medical monitoring, and</p>	05/05/2012

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	<p>documentation in regard to the client's wound. Please see W331.</p> <p>2. The facility's nursing services failed to train staff in regard to client #2's wound care/decubitus ulcer and failed to monitor staff to ensure competency in regard to care of client #2's wound. Please see W342.</p> <p>9-3-6(a)</p>		<p>staff instruction as to what signs/symptoms equate notification of the nurse/doctor). This protocol was immediately in-serviced to group home management and residential assistants by RCDS nursing staff to ensure thorough understanding and implementation. The nurses are in the group home every other day to monitor the wound and change the dressing. Progress with the wound will be noted by the nurses in their notes. The nurses are also monitoring staff implementation of the corrective interventions to ensure progressive wound healing. Client # 2 continues to work with the wound clinic as well for follow-along care related to his ulceration. Currently, wound clinic care is being scheduled on a bi-monthly basis and any changes made to the current treatment regimen is being trained on and implemented by RCDS nursing staff as applicable.</p> <p>All nursing staff were immediately retrained in regard to wound care, including their role in ensuring that comprehensive, thorough wound care is completed and documented. This retraining included specifics related to the nurses role in monitoring, assessing, and/or conducting timely assessments related to wounds. The nurses were also retrained on their role in ensuring staff are trained and clearly</p>		

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			<p>understand how to document on the pressure tracking sheet, as well as instruction/training to staff as to when the nurse/doctor must be contacted related to a change of status with the wound. The nurses also now understand their role in ensuring a specific protocol/risk plan is developed, implemented, and in-serviced to all staff in a timely manner related to wound care. The nurses were also retrained on ensuring they attend all IDT meetings related to medical issues as their input is vital to ensure appropriate medical care. Lastly, the retraining included instruction on the nurse's role with training related to all areas of medical care. The nurses will train staff related to medical issues (i.e. monitoring, documenting, treating, and prevention) and/or monitor for accuracy of wound care, as well as ensure appropriate wound documentation.</p> <p>Administration met to discuss systemic changes related to skin integrity issues and wounds. A Wound Care Policy was developed to ensure comprehensive care and follow through. The policy will ensure that the facilities nursing services monitor and assess skin issues</p>		

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			<p>timely, ensure staff are documenting wound care accurately, ensure staff training related to signs/symptoms that equate change and notification of the nurses, ensure effective risk plans are implemented and followed, and complete training and monitoring of staff for competency related to wound care. All professional staff, nurses, and direct care staff were trained in regard to the Wound Care Policy.</p> <p>Beyond implementation of the wound care policy, we also have provided a wound care training DVD to all staff which included administration, professional staff, nurses, and direct care staff. Also, administration has set up a professional training with a wound care nurse from a local hospital. This training will be recorded in order to ensure all staff have access to the information. These training DVD's will be incorporated into employee orientation to ensure new staff are familiar with wound care immediately upon hire. Also, current employees will be required to view the DVD's immediately, as well as on a recurring annual basis to ensure quality care on an on-going basis related to wound care.</p> <p>Beyond the development of the Wound Care Policy and wound care trainings, administration and</p>		

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			<p>nursing staff also met to develop acute/chronic high-risk protocols related to wound care. These protocols will include specific contributing factors (i.e. mobility, nutrition, medical conditions, etc.) and interventions (i.e. positioning, diet, medications, staff training, etc.). The listing of these specific probes in combination with the high-risk protocol will ensure the IDT evaluates all contributing factors, as well as interventions, when dealing with individual client wounds.</p> <p>Additionally, administration will begin conducting bi-monthly meetings with the nursing coordinator to ensure wound care is being monitored and implemented correctly. This meeting will ensure corrective action related to wound care is maintained on an on-going preventative basis within all nine group homes.</p> <p>As previously stated, the Rehabilitation Center has a long history of providing effective nursing care. Lack of expertise in the area of wound care has evidenced some shortcomings. As an agency, we pride ourselves on providing outstanding client care. We feel the corrective and preventative measures put in place will elevate our standard of care related to wounds and ensure future adequacy in this area.</p>	

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the facility's nursing services failed to meet the nursing needs of the client. The facility's nursing services failed to monitor, assess and/or to conduct timely assessments of the client's open area on the client's buttocks. The facility's nursing services failed to ensure facility staff contacted nursing services when the client demonstrated a change of condition/health status, and failed to ensure staff documented and/or accurately documented changes with the open area/wound. The facility's nursing services failed to develop and/or put in place specific protocols/risk plans regarding the client's decubitus ulcer/wound. The facility's nursing services failed to ensure facility staff were trained and/or monitored for competency in regard to wound care and/or documentation in regard to the client's wound.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/28/12 at 12:24 PM. The facility's 3/14/12 reportable incident report</p>	W0331	<p>Historically, the Rehabilitation Center has provided effective nursing care. Due to lack of experience related to wound care, as an agency it appears we are not currently meeting the standard in this area. We pride ourselves in providing the best care to our clients. Realizing through the survey process that we are not adequate in wound care currently, motivates us to seek the required information, training, and policies to effectively address this area and elevate our standards immediately.</p> <p>In regard to client # 2's wound, IDT met immediately after the survey process to put additional measures in place to ensure comprehensive, thorough wound care. IDT met to develop the specific risk protocol for client #2. This more specific protocol includes instruction as to what contributing factors must be monitored (i.e. diabetes, decreased pain perception, sedentary, supervised hygiene, etc.), as well as specific interventions (i.e. bed rest with rotation from left side to right side, diet supplements, current medications and treatment for wound care, staff training, nurse/medical monitoring, and</p>	05/05/2012	

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	indicated "[Client #2] was seen at the wound clinic today. He had an abscess area on his buttocks in January, ...which had resolved. However, due to his diabetes and the area, location being on his buttocks, he has had some flare-ups with the same area. [Name of doctor], [client #2's] G.P. (General Practitioner), has been seeing him routinely and advising treatment as needed. However, he decided that due to the continued flare-ups and lack of consistent resolution, he needed to be seen at the wound clinic for further recommendations. [Client #2] was seen today at the wound clinic and the doctor recommended the continued use of his pressure relief regimen, which has been in place to aid healing (i.e. repositioning regularly and use of Roho cushion when he is seated to relieve pressure on that area). The doctor also recommended the use of Promogran, Aquacel AG, and Lyofoam A (wound treatments) to be applied every other day. [Name of doctor] had ordered Bactroban and this ointment has been discontinued and the new treatment will begin. All staff will be made aware of the changes to [client #2's] treatments. [Client #2] goes about his normal routine but is encouraged to reposition himself routinely and he also takes his Roho cushion with him for his use in all settings...."		staff instruction as to what signs/symptoms equate notification of the nurse/doctor). This protocol was immediately in-serviced to group home management and residential assistants by RCDS nursing staff to ensure thorough understanding and implementation. The nurses are in the group home every other day to monitor the wound and change the dressing. Progress with the wound will be noted by the nurses in their notes. The nurses are also monitoring staff implementation of the corrective interventions to ensure progressive wound healing. Client # 2 continues to work with the wound clinic as well for follow-along care related to his ulceration. Currently, wound clinic care is being scheduled on a bi-monthly basis and any changes made to the current treatment regimen is being trained on and implemented by RCDS nursing staff as applicable. All nursing staff were immediately retrained in regard to wound care, including their role in ensuring that comprehensive, thorough wound care is completed and documented. This retraining included specifics related to the nurses role in monitoring, assessing, and/or conducting timely assessments related to wounds. The nurses were also retrained on their role in ensuring staff are trained and clearly				

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	<p>A 3/22/12 follow-up report indicated "[Client #2's] wound is healing well. He returned to the wound clinic on 3-19-12, and [name of doctor] is very pleased with the progress. He would like to see him back in two weeks. The wound has been diagnosed as a decubitus ulcer; however, prior to this diagnosis at wound clinic, the GP believed the area to be an abscess (sic). We will continue to follow along with the wound clinic to ensure [client #2's] wound heals efficiently...."</p> <p>The facility's 1/12/12 reportable incident report indicated client #2 had an area on his buttock. The reportable incident report indicated "Not sure how he got the area. Staff indicated he may have been sitting on a stool that was putting pressure on that area."</p> <p>Client #2's record was reviewed on 3/29/12 at 1:05 PM. Client #2's Skin Breakdown Tracking Sheets indicated the following in regard to an area on client #2's buttock:</p> <p>-1/10/12 one half (1/2) inch open area with "pus/yellow" drainage. The entry indicated the nurse was called.</p> <p>-1/11/12 1/2 inch open area with "pus/(yellow)" drainage</p>		<p>understand how to document on the pressure tracking sheet, as well as instruction/training to staff as to when the nurse/doctor must be contacted related to a change of status with the wound. The nurses also now understand their role in ensuring a specific protocol/risk plan is developed, implemented, and in-serviced to all staff in a timely manner related to wound care. The nurses were also retrained on ensuring they attend all IDT meetings related to medical issues as their input is vital to ensure appropriate medical care. Lastly, the retraining included instruction on the nurse's role with training related to all areas of medical care. The nurses will train staff related to medical issues (i.e. monitoring, documenting, treating, and prevention) and/or monitor for accuracy of wound care, as well as ensure appropriate wound documentation.</p> <p>Administration met to discuss systemic changes related to skin integrity issues and wounds. A Wound Care Policy was developed to ensure comprehensive care and follow through. The policy will ensure that the facilities nursing services monitor and assess skin issues</p>				

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	<p>-1/12/12 1/2 inch open area with "pus/ (yellow)" drainage</p> <p>-1/13/12 1/2 inch open area with "pus/ (yellow)" drainage Client #2's tracking sheets indicated no additional documentation in regard to the client's open area/wound until 2/20/12.</p> <p>-2/20/12 Client #2 had an "eraser size" area on upper buttocks. The 2/20/12 entry indicated "...Is Skin Open? No...." The 2/20/12 entry indicated drainage was present and the change was reported to the nurse.</p> <p>-2/21/12 Eraser size area with drainage but not open.</p> <p>-2/22/12 Eraser size area, no drainage and not open.</p> <p>-2/23/12 "...pin hole" area, no drainage and not open.</p> <p>-2/24/12 "closing" and no drainage</p> <p>-3/2/12 An open area the size of an eraser with no drainage and no odor. The entry did not indicate client #2's change of condition/open area was reported to the nurse.</p>		<p>timely, ensure staff are documenting wound care accurately, ensure staff training related to signs/symptoms that equate change and notification of the nurses, ensure effective risk plans are implemented and followed, and complete training and monitoring of staff for competency related to wound care. All professional staff, nurses, and direct care staff were trained in regard to the Wound Care Policy.</p> <p>Beyond implementation of the wound care policy, we also have provided a wound care training DVD to all staff which included administration, professional staff, nurses, and direct care staff. Also, administration has set up a professional training with a wound care nurse from a local hospital. This training will be recorded in order to ensure all staff have access to the information. These training DVD's will be incorporated into employee orientation to ensure new staff are familiar with wound care immediately upon hire. Also, current employees will be required to view the DVD's immediately, as well as on a recurring annual basis to ensure quality care on an on-going basis related to wound care.</p> <p>Beyond the development of the Wound Care Policy and wound care trainings, administration and</p>				

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	<p>-3/3/12 "...large eraser" size open area with no drainage and no odor.</p> <p>-3/4/12 "...pencil eraser open area with no drainage and no odor.</p> <p>-3/5/12 "...Nickel" size open area with "Blood" drainage and no odor. The 3/5/12 entry indicated the nurse called.</p> <p>-3/6/12 "...whole area about Tennis ball size, pus draining, peeling." The entry indicated the open area was the size of a nickel and the wound was draining "Blood." The note did not indicate the nurse was called/informed.</p> <p>-3/7/12 Client #2 had an open area. "...Size of area (measure) tennis ball blood whole area..." with no odor present.</p> <p>-3/8/12 Open area the size of a "half dollar...Whole Area bloody..." with no drainage. The entry indicated the wound was also "peeling." The entry did not indicate the client's change in condition/wound was reported to the nurse.</p> <p>-3/9/12 Open area the size of a half dollar. The entry indicated "...area not as bloody..." and no odor was present.</p> <p>-3/10/12 Open area the size of a half</p>		<p>nursing staff also met to develop acute/chronic high-risk protocols related to wound care. These protocols will include specific contributing factors (i.e. mobility, nutrition, medical conditions, etc.) and interventions (i.e. positioning, diet, medications, staff training, etc.). The listing of these specific probes in combination with the high-risk protocol will ensure the IDT evaluates all contributing factors, as well as interventions, when dealing with individual client wounds.</p> <p>Additionally, administration will begin conducting bi-monthly meetings with the nursing coordinator to ensure wound care is being monitored and implemented correctly. This meeting will ensure corrective action related to wound care is maintained on an on-going preventative basis within all nine group homes.</p> <p>As previously stated, the Rehabilitation Center has a long history of providing effective nursing care. Lack of expertise in the area of wound care has evidenced some shortcomings. As an agency, we pride ourselves on providing outstanding client care. We feel the corrective and preventative measures put in place will elevate our standard of care related to wounds and ensure future adequacy in this area.</p>				

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	dollar with bloody drainage and no odor. -3/11/12 Open area the size of a half dollar with bloody drainage and no odor. -3/12/12 Open area the size of a half dollar with bloody drainage and no odor. -3/13/12 Open area the size of a half dollar with bloody drainage and no odor. -3/14/12 Open area the size of a half dollar with bloody drainage and no odor. -3/14/12 (second entry) indicated "...No drainage thru (through) bandage...." The entry indicated RN #1 wrote "Wound clinic-dsg (dressing) applied." -3/15/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/16/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/17/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/18/12 Open area the size of a half dollar with no odor and "half dollar size blood thru bandage...."				

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	-3/19/12 Open area the size of a half dollar with bloody drainage and no odor. The 3/19/12 entry noted RN #1 documented "Wound Clinic."			
	-3/20/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/21/12 Open area the size of a half dollar with bloody drainage and no odor. A second entry/check indicated there was no drainage after the client received a bath.			
	-3/22/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/23/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/24/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/25/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/26/12 Open area the size of a half dollar with bloody drainage and no odor.			
	-3/26/12 second and third entries/checks indicated the client had an open area the size of a half dollar with bloody drainage and odor. The entries did not indicate the			

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	<p>change of condition/odor was reported to the nurse.</p> <p>-3/27/12 Open area the size of a half dollar with bloody drainage and odor.</p> <p>-3/28/12 Open area the size of a half dollar with bloody drainage and odor. A second entry/check indicated client #2 had "...thin dark drainage...."</p> <p>-3/29/12 Open area the size of a half dollar with "...thin, dark drainage..." and odor.</p> <p>A sticky note by RN #1 attached to the 3/18/12 to 3/24/12 tracking sheet indicated "Don't remove dressing when observe(sic) for any drainage on dressing & (and) any changes in surrounding area."</p> <p>Client #2's physician's orders and/or Doctor's Referral For Consultation forms (reviewed 3/29/12 1:05 PM) indicated the following:</p> <p>-1/12/12 "Drainage & erythema (redness) Buttock PE (physical examination) Ulceration (with) surrounding erythema superior to anus. t/x (treatment) Bacitracin (antibiotic ointment) & Duricef (antibiotic)."</p> <p>-1/28/12 (decrease) erythema, no drainage</p>			

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	<p>or ulceration. Continue with bacitracin bid (two times a day)."</p> <p>-3/1/12 "open areas on buttock...skin ulcer (with) 2 (degree) cellulitis t/x bactroban cream tid (three times a day). Bactrim (antibiotic) DS bid x (times) 2 weeks, Duricef 500, bid x 2 weeks."</p> <p>-3/8/12 "reduced (sic) erythema & drainage but large open area. Need refer wound clinic. Finish full course AB (antibiotic) continue Bactroban."</p> <p>Client #2's 3/14/12 Wound Services Visit Record indicated client #2's coccyx wound measured 35 mm (millimeters) in length, 50 mm in width and 3 mm in depth. The 3/14/12 report indicated a culture was taken of client #2's wound as the client had a "moderate amount of yellow drainage." The report indicated client #2 was to return to the wound clinic on 3/19/12.</p> <p>Client #2's 3/19/12 Wound Service dictated note indicated client #2's "...sacral pressure ulceration breakdown..." was evaluated and debridement was done of the wound. The dictated note indicated "...At this time, we are going to continue Promogran, Aquacel AG (wound treatments) with a cover roll type dressing. He has a Roho cushion.</p>			

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	<p>Continue to offload this area. I have talked with the group home supervisor here today and advised to possible (sic) deflate the cones on the Roho cushion directly where he sits to help with further offloading of pressure on this area. Everything appears to be stable at this time. I will see back in 2 weeks." The 3/19/12 Doctor's referral For Consultation indicated "Length 5 mm, Width 38 mm and depth 2 mm" of the wound.</p> <p>Client #2's 3/29/12 Doctor's Referral Consultation note indicated "There is a sacral decubitus through epidermis & (and) dermis into the subcutaneous fat (stage 3). This is debrided. Culture: Ps (Pseudomonas) aeruginosa & staphylococcus not aureus (sic). Rec: (recommend) (1) Debrided. (2) Promogran, aquacel AG, gauze square changed BID (two times a day). (3) Total bed Rest. Cipro (antibiotic) 500 mg (milligrams) po (by mouth) BID x (times) 14 days...." The 3/29/12 Wound Services Routine Visit record indicated client #2's pressure ulcer was 18 mm (millimeters) in length, 40 mm in width and 5 mm in depth. The wound sheet indicated the following was present in client #2's wound: -odor -moderate amount of yellow drainage -Fibrin (whitish protein produced in</p>			

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	<p>response to bleeding) present -Necrotic/eschar (dead tissue) -Erythema (redness) and Maceration (softening of the tissue) The wound service record indicated "Pt (patient) should remain in bed, off buttocks, Stay (sic) out of wheelchair and recliner. Do not go to work. Begin Cipro. Continue to apply Promogran to wound; moistened with normal saline until dissolved, Aquacel AG and foam dressing." A 3/17/12 Culture Wound report indicated "...Culture Result Few Pseudomonas Aeruginosa Scattered Staphylococcus Species, Not Aureus...." The report indicated client #2 had an "...Associated Diagnoses (sic) Infected Wound...."</p> <p>Client #2's 12/9/11 doctor's progress note indicated client #2 was treated for boils on his buttock in 12/11.</p> <p>Client #2's 4/1/12 (4/2/12 8:35 AM review) Physician's orders indicated client #2's diagnoses included, but were not limited to, Insulin Dependent Diabetes Mellitus, MRSA (Methicillin Resistant Staphylococcus Aureus) Colonization and Suprapubic Catheter Placement.</p> <p>Client #2's nurse notes (3/29/12 1:05 PM review) indicated the following (not all inclusive):</p>						

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	<p>-1/11/12 "Staff observed 1/8 redness in area of (between) upper fold of buttock-yesterday AM it was reported drainage coming from area-Staff instructed to clean (with) N/S (non-saline) & apply Bacitracin then cover & keep off area-yesterday in pm (late aftn) (afternoon), HM (Home Manager) reported 1/2" (inch) open area (with) purulent, bloody drainage & erythema (with) warmth surrounding-Dr. notified & ordered Duricef & Bactrim DS series.</p> <p>-This date, half-moon 2" area of mild redness @ (at) midline of upper buttock fold lt (left) & 2" area half moon shaped bright red area RT (right) (upper) buttock fold @ midline-serosanguineous drainage present on dsq (dressing)-1/2" open area is surrounded by hypertrophied li (light) black firm skin- additionally top layer of skin missing from apprx (approximately) 1/2" x 1/2" area on Rt buttock? Possibly from paper tape- also on Rt buttock a circular area (with) serous drainage below above described areas-Dr. to assess tomorrow in AM. Pressure tracking forms in place."</p> <p>-1/18/12 Client #2 saw the doctor on 1/12/12 and diagnosed with "...ulceration or abscess superior to anus-antibiotic series were to be continued. This date much improvement-granulation occurring</p>						

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	<p>@ site of ulceration- erythema resolved as well as hypertrophy/necrosis surrounding abscess site- bright red area, approx silver dollar size, Rt area of Rt buttock, is present-...possibly result of sitting on donut pillow improperly...."</p> <p>-1/25/12 "[Name of doctor] assessed yesterday-(decreased) erythema (without drainage or ulceration- to con't (continue) applying Bacitracin 2 x/day. Returned to work today (with) donut (pillow)."</p> <p>-2/1/12 "...Area on Buttock resolved...."</p> <p>-2/20/12 "Client has wound @ midline buttock reported by staff. 'Tip of eraser' @ midline beneath upper folds of buttocks @ site of previous ulceration, white area @ midline beneath upper folds of buttocks (sic) upper (sic) buttock fold exteriorly reddened (with) sm (small) bleeding-area cleaned & bacitracin applied. On 2/21/12 order for Skin Prep to buttock Tid (three times a day) x 2 weeks; bacitracin to be applied to reddened area."</p> <p>-3/7/12 "On 2/29, staff noted wound worsened. [Name of doctor] 3/1-diagnosed ulcer (with) 2 (degree) cellulitis & ordered Duricef & Bactrim DS Series + (plus) Bactroban application TID- Will see again tomorrow- This date,</p>			

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	<p>coccyxgeal area @ midline has white exudate (with) adjacent areas bilat (bilateral) (with) excoriation including serosanguineous drainage...Addendum: Using Roho Cushion currently instead of donut pillow-overlay mattress on order...." The 3/7/12 note indicated the facility's nurse did not assess/observe the wound timely.</p> <p>-3/14/12 "[Name of doctor] assessed 3/8 (decreased) erythema & drainage but lge (large) open area referred to Wound Clinic-seen this AM by [name of doctor] -35 mm L (length), 50 mm W (wide), 3mm D (depth). Pressure ulcer on coccyx diagnosed-debrided today/culture obtained...staff also instructed only to remove gauze dsg (dressing) to check site TID & observe for any drainage on dsg & any changes to surrounding area,...."</p> <p>-3/21/12 Client #2's wound on buttock was debrided at the wound clinic. The note indicated the facility's dietician came in and assessed the client and ordered additional protein to diet to aid in wound healing. The 3/21/12 note also indicated client #2's open area was "...approx half dollar size, clean with white exudate- no surrounding redness."</p> <p>-3/28/12 "HM reported 3/26 (increased) drainage from wound-instructed Mgmt</p>						

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	<p>(management) to share observations with Wound Clinic- to be seen tomorrow...Dr, aware...."</p> <p>-3/28/12 "...Addendum: I (RN #1) observed coccygeal dsg- lge amt (amount) thin, dark drainage on gauze covering...excoriation of skin below dressing was noted. No c/o (complaints of)- denies discomfort...."</p> <p>Client #2's Monthly Repositioning Logs for January 2012, February 2012 and March 2012 indicated client #2 was encouraged to reposition himself every 2 hours. The repositioning logs indicated client #2 was being repositioned by walking, use of a Roho Cushion, sitting on his buttocks, laying on his buttocks, sitting and/or laying on his right/left sides.</p> <p>Client #2's Interdisciplinary Team (IDT) meeting notes indicated the following (not all inclusive):</p> <p>-1/11/12 Client IDT met to discuss the area on client #2's coccyx. The IDT note indicated "...Repositioning was implemented immediately to ensure he was off the affected area....A donut was also implemented to relieve pressure from the area while sitting." The IDT note indicated no nursing staff was present at the IDT meeting.</p>			

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	<p>-1/12/12 IDT met to review the client's doctor appointment. The note indicated "...A donut was also implemented to relieve pressure from the area while sitting." The IDT note indicated no nursing staff was present at the IDT meeting.</p> <p>-3/5/12 "Discussion: IDT discussed [client #2's] ulceration and the proactive treatments that is being implemented the following things are being done at this time (sic). There is a tracking form, Roho Cushion, medication, repositioning during waking hours and assure goody hygiene as well as hourly walks...."</p> <p>-3/12/12 Client #2's IDT discussed his wound clinic appointment. The note indicated client #2 would continue his "...current pressure relief regimen..." with new treatments to start. The IDT note indicated the facility staff had been inserviced on the updates of the new treatments. The 3/12/12 IDT note indicated no nursing staff was present at the IDT meeting.</p> <p>-3/27/12 Client #2 was to be encouraged to sit up straight in his chair. The IDT note indicated client #2 would need to reposition himself every 2 hours and to walk hourly. The IDT note indicated staff</p>						

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	<p>were to ensure the client's Roho Cushion was present in the client's chair and the Roho cushion was adjusted on 3/27/12 when recommended on 3/19/12 by the Wound Clinic to relieve pressure on the buttock. The IDT note indicated no facility nurse was present at the IDT meeting.</p> <p>The facility's inservice/training record were reviewed on 4/2/12 at 8:35 AM. The facility's 3/5/12 and 3/12/12 Inservice Signature Forms indicated staff #1 conducted training/in-services in regard to client #2's ulceration and wound care. The 3/5/12 and/or 3/12/12 inservice records indicated the facility's nurse did not provide initial training and/or competency based training in regard to providing skilled wound care for client #2.</p> <p>Client #2's (reviewed 4/0212 8:35 AM) updated 3/5/12 Impaired Skin Integrity Protocol indicated the client had a skin integrity protocol in place for "...sitting for long periods of time...." The 3/5/12 protocol indicated the following Individualized Interventions:</p> <p>"...Roho Cushion to ambulate @ (at) frequent, routine intervals Tracking Record in place</p>						

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	<p>Wound Clinic Follow along To be repositioned regularly; 'Repositioning' in place Pressure reducing mattress utilized."</p> <p>Client A #2's 3/5/12 updated Skin Integrity Protocol indicated the nursing services failed to develop a specific protocol in regard to the client's open wound/Decubitus Ulcer which specifically indicated how client #2 was to be repositioned, bathed, toileted, what changes to report to the nurse to prevent client #2's Decubitus ulcer from worsening.</p> <p>The facility's Daily Medical Meeting Notes were reviewed on 4/2/12 at 8:45 AM. The facility's 3/30/12 note indicated client #2 had a "...stage 3 decub (decubitis ulcer), friction/movement impeding healing...."</p> <p>Interview with staff #1 on 3/29/12 at 2:40 PM indicated client #2 had a stage 3 ulcer on his buttock. Staff #1 indicated the area was initially treated for an abscess in 1/12. Staff #1 stated when staff #1 looked at the area on 3/26/12, the area "looked worse" and the client was returned to the Wound Clinic today, 3/29/12. Staff #1 indicated client #2 was to be on bed rest and was started on Cipro for the infected wound and another</p>						

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	<p>culture was taken on 3/29/12. Staff #1 indicated client #2 was ambulatory and was able to reposition himself, but would chose to sit on his buttocks. Staff #1 indicated facility staff reminded client #2 to stand and walk every hour for repositioning if sitting. Staff #1 stated "He is very non-compliant." Staff #1 stated as of 3/29/12, client #2 was to be "bed bound" and repositioned on his right and left sides only. Staff #1 indicated the group home's nurse visited the group home 1 time a week and the facility staff looked at client's buttock 3 times a day. Staff #1 indicated client #2's wound was cultured on 3/19/12 but they just received the results on 3/29/12 when he went to the wound clinic. Staff #1 indicated she (staff #1) and staff #2 were shown how to do the treatments by the wound care clinic. Staff #1 indicated she showed another staff person how to do the treatments/care. Staff #1 indicated she was not a nurse/medical professional.</p> <p>Interview with staff #1, administrative staff #1 and RN #2 on 3/30/12 at 11:35 AM indicated client #2 was being treated for a stage 3 decub at the wound clinic. RN #2 and staff #1 indicated client #2's decub had gotten bigger. RN #2 indicated she was covering for RN #1 who actually had the group home. RN #2 indicated she would be taking over the group home on</p>			

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	4/2/12. RN #2 indicated client #2 had different areas on his buttocks open up. RN #2 indicated one would close up and then another one would open up. RN #2 indicated the nursing notes did not clearly specify how many and/or which decub was being documented on. RN #2 indicated the area was first thought to be an abscess, but when it did not go away, it was thought to be a pressure area and the client's doctor sent client #2 to a wound clinic for treatment. When asked what the 3/17/12 culture report meant, RN #2 stated "Infected." RN #2 indicated the facility did not receive the results until 3/29/12 when staff took client #2 to the wound care clinic. When asked if the results should have been received sooner, RN #2 stated "Yes." RN #2 indicated the facility's nurses should have called the wound clinic for the results. RN #2 stated the wound clinic was measuring client #2's wound and the 3/19/12 wound clinic report indicated client #2's wound was "deep." When asked why the facility stopped documenting on an 1/2 inch open wound on 1/13/12, RN #2 indicated she thought the wound was healed. RN #2 indicated the wound tracking sheet should have been continued if the wound still had an 1/2 inch open area. RN #2 indicated the nurse should be called each time there was a change. When asked who provided training in regard to the				

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	<p>wound care, RN #2 and staff #1 indicated the wound care clinic showed staff #1 and staff #2 how to do the wound care treatments and changes. RN #2 indicated facility staff learned general wound care when they were first hired and went through the state's Core A and B curriculum for passing medications. RN #2 and staff #1 indicated facility staff changed the bandages on client #2's wound every other day. RN #2 and staff #1 indicated the facility's nurses did not conduct any wound care and/or treatments training with the group home staff. RN #2 indicated the facility's nurses should be going to the group home to assess clients as needed. When asked why staff were documenting client #2's wound was a Tennis ball size on 3/6/12, RN #2 and staff #1 stated it had to be the "whole affected area." RN #2 indicated the Skin Prep was stopped once the area re-opened and another medication was started. RN #2 indicated the facility's nurses visited client #2's group home 1 time a week.</p> <p>Interview with RN #1 and administrative staff #1 on 4/2/12 at 8:30 AM indicated client #2 was a Diabetic who was insulin dependent. RN #1 indicated client #2 was treated for an abscess prior to the pressure ulcer. RN #1 stated "There was some question whether it was a pressure area." When asked if the RN was contacted in</p>			

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	<p>regard to all the changes with client #2's wound, RN #1 stated, she received "verbal reports" from staff and she documented the reports in the nursing notes and discussed with client #2's doctor at their daily meeting. When specifically asked if the RN was informed, assessed and/or documented client #2's change of conditions on 3/2, 3/6 and 3/8/12, RN #1 indicated she did not go to the home and assess the client's wound each time staff called to inform her of a change with client #2's Decub/wound. RN #1 indicated she only went to the group home once a week on Wednesdays. RN #2 indicated client #2's area on his buttock had healed and then a new area opened on 2/20/12. RN #1 indicated client #2 had other open areas on his buttocks at different times. RN #1 indicated the nurse's notes did not clearly indicate the client had different open areas on the client's buttock. RN #1 stated "He (client #2) has different lesions." RN #1 indicated the wound from 2/20/12 was healed on 2/22/12 and then another area opened. RN #1 indicated she could not locate where she was informed of the 3/2/12 eraser size area that appeared. When asked about the tennis ball size open area, RN #1 indicated the staff probably measured the entire area of the wound and not just the open area. When asked if RN #1 had any</p>			

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	<p>concerns with how the staff were documenting on the wound tracking sheet, RN #1 indicated she questioned some of the documentation. RN #1 indicated she did not train and/or instruct staff on how and/or what they were to document on the tracking sheet in regard to client #2's wound. When asked if RN #1 reviewed the wound tracking sheets daily, RN #1 stated "No." RN #1 indicated client #2's wound had gotten worse and now the client was on bed rest except for toileting, showering and meals. RN #1 indicated the wound clinic " Doctor thought friction may be causing some problems with wound care." RN #1 indicated the facility was repositioning the client every 2 hours and having the client get up and walk every hour to stay off his buttocks. RN #1 indicated client #2 was also refusing to cooperate with staying off his buttocks prior to the 3/29/12 wound clinic visit. When asked if any additional protocols had been put in place, other than the 3/5/12 updated skin integrity sheet, RN #1 stated "No." RN #1 stated the skin integrity protocol was "generic" RN #1 stated she was told to write "generic protocols." RN #1 indicated client #2 should not get the area wet and staff were only bathing him every other day when the bandages were changed. RN #1 indicated after the 3/29/12 wound care visit, client #2's</p>			

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	bandages would be changed two times a day. RN #1 indicated client #2's area would need to be protected to keep from getting wet. RN #1 indicated facility staff were not assisting client #2 to wipe/clean himself to prevent contamination of the wound/dressing as the client was "independent" in toileting before. RN #1 indicated staff #1 and staff #2 were trained by the wound clinic on client #2's wound care and bandages. RN #1 indicated she did not train any staff and/or monitor the staff for competency who were conducting the skilled care of client #2's wound/Decub ulcer. RN #1 indicated she assessed client #2's wound on his buttock on 4/1/12. RN #1 stated the area on client #2's buttock was 2 inches by 4 inches with "granulation, moist, no drainage from wound, but there was drainage on the dressing." RN #1 indicated there was also some scabbing, some erythema and a "mild odor" from the wound. RN #1 indicated the facility's nurses did not measure client #2's wounds. RN #2 indicated the wound care center did the measurement and the nurses only determined if the wound was improving "Just by looking." RN #1 indicated client #2 was to be repositioned every 2 hours from his right to his left side. RN #1 indicated client #3 was not to sit and/or lay on his buttock.			

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W0342	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on interview and record review for 1 of 4 sampled clients (#2), the facility's nursing services failed to train staff in regard to wound/decubitus ulcer care and failed to monitor staff to ensure competency in regard to care of wounds.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/28/12 at 12:24 PM. The facility's 3/14/12 reportable incident report indicated "[Client #2] was seen at the wound clinic today. He had an abscess area on his buttocks in January, ...which had resolved. However, due to his diabetes and the area, location being on his buttocks, he has had some flare-ups with the same area. [Name of doctor], [client #2's] G.P. (General Practitioner), has been seeing him routinely and advising treatment as needed. However, he decided that due to the continued flare-ups and lack of consistent</p>	W0342	<p>Historically, the Rehabilitation Center has provided effective nursing care. Due to lack of experience related to wound care, as an agency it appears we are not currently meeting the standard in this area. We pride ourselves in providing the best care to our clients. Realizing through the survey process that we are not adequate in wound care currently, motivates us to seek the required information, training, and policies to effectively address this area and elevate our standards immediately.</p> <p>In regard to client # 2's wound, IDT met immediately after the survey process to put additional measures in place to ensure comprehensive, thorough wound care. IDT met to develop the specific risk protocol for client #2. This more specific protocol includes instruction as to what contributing factors must be monitored (i.e. diabetes, decreased pain perception, sedentary, supervised hygiene,</p>	05/05/2012			

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	<p>resolution, he needed to be seen at the wound clinic for further recommendations. [Client #2] was seen today at the wound clinic and the doctor recommended the continued use of his pressure relief regimen, which has been in place to aid healing (i.e. repositioning regularly and use of Roho cushion when he is seated to relieve pressure on that area). The doctor also recommended the use of Promogran, Aquacel AG, and Lyofoam A (wound treatments) to be applied every other day...."</p> <p>A 3/22/12 follow-up report indicated Client #2's "...wound has been diagnosed as a decubitus ulcer...."</p> <p>Client #2's record was reviewed on 3/29/12 at 1:05 PM. Client #2's Skin Breakdown Tracking Sheets indicated the following in regard to an area on client #2's buttock (not all inclusive):</p> <p>-3/2/12 An open area the size of an eraser with no drainage and no odor. The entry did not indicate client #2's change of condition/open area was reported to the nurse.</p> <p>-3/3/12 "...large eraser" size open area with no drainage and no odor.</p> <p>-3/4/12 "...pencil eraser" open area with</p>		<p>etc.), as well as specific interventions (i.e. bed rest with rotation from left side to right side, diet supplements, current medications and treatment for wound care, staff training, nurse/medical monitoring, and staff instruction as to what signs/symptoms equate notification of the nurse/doctor). This protocol was immediately in-serviced to group home management and residential assistants by RCDS nursing staff to ensure thorough understanding and implementation. The nurses are in the group home every other day to monitor the wound and change the dressing. Progress with the wound will be noted by the nurses in their notes. The nurses are also monitoring staff implementation of the corrective interventions to ensure progressive wound healing. Client # 2 continues to work with the wound clinic as well for follow-along care related to his ulceration. Currently, wound clinic care is being scheduled on a bi-monthly basis and any changes made to the current treatment regimen is being trained on and implemented by RCDS nursing staff as applicable.</p> <p>All nursing staff were immediately retrained in regard to wound care, including their role in ensuring that comprehensive, thorough wound care is completed and documented. This retraining</p>	

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	<p>no drainage and no odor.</p> <p>-3/5/12 "...Nickel" size open area with "Blood" drainage and no odor. The 3/5/12 entry indicated the nurse called.</p> <p>-3/6/12 "...whole area about Tennis ball size, pus draining, peeling." The entry indicated the open area was the size of a nickel and the wound was draining "Blood." The entry did not indicate the nurse was called/informed.</p> <p>-3/7/12 Client #2 had an open area. "...Size of area (measure) tennis ball blood whole area..." with no odor present.</p> <p>-3/8/12 Open area the size of a "half dollar...Whole Area bloody...." with no drainage. The entry indicated the wound was also "peeling." The entry did not indicate the client's change in condition/wound was reported to the nurse.</p> <p>-3/9/12 Open area the size of a half dollar. The entry indicated "...area not as bloody..." and no odor was present.</p> <p>-3/10/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/11/12 Open area the size of a half dollar with bloody drainage and no odor.</p>		<p>included specifics related to the nurses role in monitoring, assessing, and/or conducting timely assessments related to wounds. The nurses were also retrained on their role in ensuring staff are trained and clearly understand how to document on the pressure tracking sheet, as well as instruction/training to staff as to when the nurse/doctor must be contacted related to a change of status with the wound. The nurses also now understand their role in ensuring a specific protocol/risk plan is developed, implemented, and in-serviced to all staff in a timely manner related to wound care. The nurses were also retrained on ensuring they attend all IDT meetings related to medical issues as their input is vital to ensure appropriate medical care. Lastly, the retraining included instruction on the nurse's role with training related to all areas of medical care. The nurses will train staff related to medical issues (i.e. monitoring, documenting, treating, and prevention) and/or monitor for accuracy of wound care, as well as ensure appropriate wound documentation.</p> <p>Administration met to discuss systemic changes related to skin</p>		

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	-3/12/12 Open area the size of a half dollar with bloody drainage and no odor. -3/13/12 Open area the size of a half dollar with bloody drainage and no odor. -3/14/12 Open area the size of a half dollar with bloody drainage and no odor. -3/14/12 (second entry) indicated "...No drainage thru (through) bandage...." -3/15/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/16/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/17/12 Open area the size of a half dollar with no odor and "No drainage thru bandage...." -3/18/12 Open area the size of a half dollar with no odor and "half dollar size blood thru bandage...." -3/19/12 Open area the size of a half dollar with bloody drainage and no odor. -3/20/12 Open area the size of a half dollar with bloody drainage and no odor.		integrity issues and wounds. A Wound Care Policy was developed to ensure comprehensive care and follow through. The policy will ensure that the facilities nursing services monitor and assess skin issues timely, ensure staff are documenting wound care accurately, ensure staff training related to signs/symptoms that equate change and notification of the nurses, ensure effective risk plans are implemented and followed, and complete training and monitoring of staff for competency related to wound care. All professional staff, nurses, and direct care staff were trained in regard to the Wound Care Policy. Beyond implementation of the wound care policy, we also have provided a wound care training DVD to all staff which included administration, professional staff, nurses, and direct care staff. Also, administration has set up a professional training with a wound care nurse from a local hospital. This training will be recorded in order to ensure all staff have access to the information. These training DVD's will be incorporated into employee orientation to ensure new staff are familiar with wound care immediately upon hire. Also, current employees will be required to view the DVD's immediately, as well as on a				

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	<p>-3/21/12 Open area the size of a half dollar with bloody drainage and no odor. A second entry/check indicated there was no drainage after the client received a bath.</p> <p>-3/22/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/23/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/24/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/25/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/26/12 Open area the size of a half dollar with bloody drainage and no odor.</p> <p>-3/26/12 Second and third entries/checks indicated the client had an open area the size of a half dollar with bloody drainage and odor. The entries did not indicate the change of condition/odor was reported to the nurse.</p> <p>-3/27/12 Open area the size of a half dollar with bloody drainage and odor.</p> <p>-3/28/12 Open area the size of a half dollar with bloody drainage and odor. A</p>		<p>recurring annual basis to ensure quality care on an on-going basis related to wound care.</p> <p>Beyond the development of the Wound Care Policy and wound care trainings, administration and nursing staff also met to develop acute/chronic high-risk protocols related to wound care. These protocols will include specific contributing factors (i.e. mobility, nutrition, medical conditions, etc.) and interventions (i.e. positioning, diet, medications, staff training, etc.). The listing of these specific probes in combination with the high-risk protocol will ensure the IDT evaluates all contributing factors, as well as interventions, when dealing with individual client wounds.</p> <p>Additionally, administration will begin conducting bi-monthly meetings with the nursing coordinator to ensure wound care is being monitored and implemented correctly. This meeting will ensure corrective action related to wound care is maintained on an on-going preventative basis within all nine group homes.</p> <p>As previously stated, the Rehabilitation Center has a long history of providing effective nursing care. Lack of expertise in the area of wound care has evidenced some shortcomings. As an agency, we pride ourselves</p>	

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	<p>second entry/check indicated client #2 had "...thin dark drainage...."</p> <p>-3/29/12 Open area the size of a half dollar with "...thin, dark drainage..." and odor.</p> <p>Client #2's 3/29/12 Doctor's Referral Consultation note indicated "There is a sacral decubitus through epidermis & (and) dermis into the subcutaneous fat (stage 3). This is debrided. Culture: Ps (Pseudomonas) aeruginosa & staphylococcus not aureus (sic). Rec: (recommend) (1) Debrided. (2) Promogran, aquacel AG, gauze square changed BID (two times a day). (3) Total bed Rest. Cipro (antibiotic) 500 mg (milligrams) po (by mouth) BID x (times) 14 days..." The 3/29/12 Wound Services Routine Visit record indicated client #2's pressure ulcer was 18 mm (millimeters) in length, 40 mm in width and 5 mm in depth.</p> <p>The facility's inservice/training records were reviewed on 4/2/12 at 8:35 AM. The facility's 3/5/12 and 3/12/12 Inservice Signature Forms indicated staff #1 conducted training/in-services in regard to client #2's ulceration and wound care. The 3/5/12 and/or 3/12/12 inservice records indicated the facility's nurse did not provide initial training and/or</p>		<p>on providing outstanding client care. We feel the corrective and preventative measures put in place will elevate our standard of care related to wounds and ensure future adequacy in this area.</p>				

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	<p>competency based training in regard to providing skilled wound care for client #2.</p> <p>The facility's Daily Medical Meeting Notes were reviewed on 4/2/12 at 8:45 AM. The facility's 3/30/12 note indicated client #2 had a "...stage 3 decub (decubitus ulcer), friction/movement impeding healing...."</p> <p>Interview with staff #1 on 3/29/12 at 2:40 PM indicated client #2 had a stage 3 ulcer on his buttock. Staff #1 indicated she (staff #1) and staff #2 were shown how to do the treatments by the wound care clinic. Staff #1 indicated she showed another staff person how to do the treatments/care. Staff #1 indicated she was not a nurse/medical professional.</p> <p>Interview with staff #1, administrative staff #1 and RN #2 on 3/30/12 at 11:35 AM indicated client #2 was being treated for a stage 3 decub at the wound clinic. RN #2 indicated the wound tracking sheet should have been continued if the wound still had an 1/2 inch open area. RN #2 indicated the nurse should be called each time there was a change. When asked who provided training in regard to the wound care, RN #2 and staff #1 indicated the wound care clinic showed staff #1 and staff #2 how to do the wound care</p>						

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	<p>treatments and dressing changes. RN #2 indicated facility staff learned general wound care when they were first hired and went through the state's Core A and B curriculum for passing medications. RN #2 and staff #1 indicated facility staff changed the bandages on client #2's wound every other day. RN #2 and staff #1 indicated the facility's nurses did not conduct any wound care training and/or treatments with the group home staff. When asked why staff was documenting client #2's wound was a Tennis ball size on 3/6/12, RN #2 and staff #1 stated it had to be the "whole affected area."</p> <p>Interview with RN #1 and administrative staff #1 on 4/2/12 at 8:30 AM indicated client #2 was a Diabetic who was insulin dependent. When asked about the tennis ball size open area, RN #1 indicated the staff probably measured the entire area of the wound and not just the open area. When asked if RN #1 had any concerns with how the staff were documenting on the wound tracking sheet, RN #1 indicated she questioned some of the documentation. RN #1 indicated she did not train and/or instruct staff on how and/or what they were to document on the tracking sheet in regard to client #2's wound. RN #1 indicated staff #1 and staff #2 were trained by the wound clinic on client #2's wound care and bandages.</p>			

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	<p>RN #1 indicated she did not train any staff and/or monitor the staff for competency who were conducting the skilled care of client #2's wound/decubitus ulcer.</p> <p>9-3-6(a)</p>			