

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155618	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER MANOR CARE HEALTH SERVICES SUMMER TRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 12999 N PENNSYLVANIA ST CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaint IN00145429.</p> <p>Complaint IN00145429 - Substantiated. Federal/State deficiencies related to the allegations are cited at F151, F157, F224, F282, and F314.</p> <p>Survey dates: March 12, 13 & 14, 2014</p> <p>Facility number: 001149 Provider number: 155618 AIM number: 200145500</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 48 SNF/NF: 30 Residential: 75 Total: 153</p> <p>Census Payor Type: Medicare: 17 Medicaid: 30 Other: 106 Total: 153</p> <p>Sample: 6</p>	F000000	<p>The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following Plan of Correction. The Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on March 24, 2014.</p>				

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F000151 SS=D	<p>483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL</p> <p>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.</p> <p>Based on record review and interview the facility failed to ensure the rights of a resident were not impeded, in that when a family member requested a resident to be transported to the local area hospital for evaluation and treatment, the facility failed to respect the rights of the resident for 1 of 6 sampled residents. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 03-12-14 at 12:20 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, schizophrenia, debility, and pyelonephritis. The resident had a colostomy.</p> <p>A review of the record indicated the resident returned to the facility after a hospitalization on 01-02-14. A review of the nurses progress notes dated 01-02-14 at 21:32 (9:32 p.m.) through 02-26-14 the resident's condition</p>	F000151	<p>F 151 SS=D Right to Exercise Rights- Free of Reprisal</p> <p>It is the practice of this center to comply with F-151: Right to Exercise Rights- Free of Reprisal</p> <p><u>What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident A no long resides at the center.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- All residents have the potential to be affected by this deficient practice.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient</u></p>	04/13/2014	

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	<p>declined. The family member was unaware the resident had an unstageable pressure ulcer to her coccyx and pressure areas to bilateral heels until 02-25-14 and that on 02-26-14, the family member indicated she wanted the resident to be transferred to the local area hospital for evaluation and treatment.</p> <p>During an interview on 3//14/14 at 8:32 a.m., the family member indicated she questioned whether the resident should be sent to the hospital that night (02-25-14) and the "nurse told me that [resident] was stable and there wasn't anything the hospital could do that they couldn't do at Summer Trace. It was very cold that night, about 1 degree outside, and I didn't want to expose her to the cold, but the next morning I wanted her to go to the hospital."</p> <p>"On Wednesday [02-26-14] I told them I wanted her sent to the hospital. They wanted to debate it. The Case Worker, the Head Nurse and the Wound nurse all came at me at once. The wound nurse came in and said 'this is what we're doing for your mom's wound.' I never met this woman before or talked to her and didn't know anything about the wound until the night before. They didn't</p>		<p><u>practice does not recur?</u></p> <ul style="list-style-type: none"> - Licensed Nursing Staff will be re-educated on Resident Rights including the Right to Exercise Rights-Free of Reprisal. <p>Social Services Staff will be re-educated on Resident Rights including the Right to Exercise Rights-Free of Reprisal.</p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <ul style="list-style-type: none"> - Director of Nursing or designee will conduct 5 Random interviews per week with residents and/or family members in regards to are their rights being respected to validate Residents Rights are being honored. Any finding will be addressed as found. Monitoring to validate compliance with system corrections will continue until 4 weeks of negative findings have been observed, then monthly X3 months, then on-going as identified through the centers QA&A process. <p>Observations will be recorded in the QAA monitoring tool and corrections will be completed by the Administrative Director of Nursing/designee.</p> <p>The results of the audit will be submitted to the QA&A Committee for further review and</p>		

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	<p>want me to take mom to the hospital. The Case Worker got in my face and said, 'if you take your mom to the hospital they'll want to put in a feeding tube in her - is that what you want ?' I'll never forget her words. I said, 'well I might.' The nurse told me I couldn't take mom to the hospital without a physician order. I told them to call the ambulance or I would call."</p> <p>A review of the progress notes dated 02-26-14 at 8:57 a.m., indicated "Patient's daughter here in facility requesting patient to be sent out to [name of local area hospital] for wound evaluation and treatment. Daughter already aware of new orders from yesterday but stating she saw wound lost night and want her to be sent to hospital for further treatment. Spoke with NP [nurse practitioner] for [name of physician] regarding request and okay to send patient to hospital for eval [evaluation] and tx. [treatment]."</p> <p>Progress notes dated 02-26-14 at 10:03 a.m., indicated the "Dtr. [daughter] refusing to have patient's soiled drsg [dressing] changed stating they will do it that <sic> hospital. Unit manager and administrator aware of transfer."</p>		<p>recommendations.</p> <p><u>By what date the systemic changes will be completed:</u></p> <p>- 4/13/2014</p>	
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	<p>Social Services notation dated 02-26-14 at 11:08 a.m. "left message for pt's [family member] that pt. [patient] was being sent to [name of local area hospital] due to family insistence."</p> <p>During an interview on 03-14-14 at 11:20 a.m., a concerned friend of the family member indicated she witnessed the conversation between the nurse and (name of family member - daughter of the resident). She further indicated the family member was concerned that the resident was unresponsive and the nurse said "oh no don't take her to the hospital - she's stable." The next day, (name of family member) called me, and said they were arguing with her about transferring (name of resident) to the hospital. I was on the telephone and could hear them telling her that she couldn't take her mother to the hospital because the was no doctor's order. Then they told her she would have to pay for the ambulance. (Name of family member) indicated she didn't care if she had to pay for the ambulance. They were aware I was on the phone and heard the conversation.</p> <p>During an interview on 03-14-14 at 12:00 p.m., the Administrator</p>				

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	<p>indicated the resident did not have to have a physician order to go to the hospital, but "I did check to see if [name of physician] was in the building or his NP, that maybe they could take a look at the resident and take care of her here."</p> <p>A review of the facility policy on 03-14-14 at 12:15 p.m., titled "Discharge: Other Institution or Non-Emergency Acute Setting," indicated the following:</p> <p>"Purpose: to provide safe departure from center to other institution or acute care setting."</p> <p>"Procedure: 1. Verify physician's order."</p> <p>This Federal tag relates to Complaint IN00145429.</p> <p>3.1-3(a)(2)(A)</p>						

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F000157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to ensure a physician and family member were immediately notified, in that when a resident acquired a pressure ulcer to</p>	F000157	<p>F157 §483.10(b)(11) NOTIFICATION OF CHANGES (INJURY/DECLINE, ROOM, ETC)</p> <p>It is the practice of this center to</p>	04/13/2014	

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	<p>the coccyx, and bilateral heels, the nursing staff failed to ensure the physician was notified timely for possible intervention when a pressure ulcer progressed in size and appearance with necrotic tissue, odor and increased draingage and the development of new pressure ulcers to the residents heels and failed to ensure a concerned family member was notified for the development and continued deterioration and possible family decision for additional intervention for 1 of 6 sampled residents. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 03-12-14 at 12:20 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, schizophrenia, debility, and pyelnephritis. These diagnoses remained current at the time of the record review. The record indicated the resident had a colostomy.</p> <p>A review of the record indicated the resident returned to the facility after a hospitalization on 01-02-14. A review of the nurses progress notes dated 01-02-14 at 21:32 (9:32 p.m.), indicated the resident was</p>		<p>comply with F-157: NOTIFICATION OF CHANGES (INJURY/DECLINE, ROOM, ETC)</p> <p>Corrective action which will be accomplished for those resident(s) affected by the deficient practice.</p> <p>Resident "A" no longer resides at the center.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>Residents who develop pressure ulcers and/or experience a change in condition or status of their pressure ulcers. These identified like residents will be comprehensively reviewed and assessed and their individual physicians and families will be notified of the residents current wound status and related treatment orders.</p> <p>Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.</p> <p>Licensed nurses will receive in-service education regarding physician and family notification for residents that develop</p>		

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	<p>"readmitted to Summer Trace this evening. Resident is resting well and seems to be adjusting pleasantly to the facility. Resident is alert and oriented times 2. Colostomy is intact. Lungs are clear per auscultation. Bowel sounds present. Skin is warm to touch and normal in color."</p> <p>Further review of the record indicated a physician order dated 01-02-14 to "cleanse open area with normal saline and apply dry sterile dressing till [until] assessed by wound nurse."</p> <p>Additional record review indicated the following: "01-03-14 at 9:15 a.m.,...Has 3 cm [centimeter] by 1 cm open area on coccyx, stage 2 without drainage...Incontinent of urine. Has colostomy with brown stool noted. Screamed aloud when turned. Resident has incontinence dependency on staff for all adl's [activities of daily living]. Family and MD [Medical Doctor] aware."</p> <p>"01-07-14 at 21:45 [9:45 p.m.] No ulcers or incisions <sic> present."</p> <p>"01-10-14 at 8:07 a.m. Resident has open area on coccyx measuring 4 [cm] by 2.5 cm. Wound bed is red tissue. No drainage and is shear like</p>		<p>pressure ulcers and/or experience changes in condition or status of those pressure ulcers.</p> <p>Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.</p> <p>The Administrative Director of Nursing or Designee will complete audits to ensure compliance with facility guidelines 5 times weekly. . Monitoring to validate compliance with system corrections will continue until 4 weeks of negative findings have been observed, then monthly X3 months, then on-going as identified through the centers QA&A process. Observations will be recorded in the QAA monitoring tool and corrections will be completed by the Administrative Director of Nursing/designee.</p> <p><i>The results of these audits will be reviewed by the facility's Quality Assessment and Assurance Committee to determine continued compliance and make recommendations for further corrective action as needed.</i></p> <p><u>By what date the systemic changes will be completed:</u></p>		

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	<p>is <sic> formation. Family and MD area of area. No drainage noted."</p> <p>"01-13-14 at 10:24 a.m. Coccyx wound present."</p> <p>"01-20-14 at 8:20 a.m. Area on coccyx measures 4 [cm] by 3 cm. Area has beefy red tissue noted. Resident is incontinent of urine and frequently wet. Area is most likely moisture associated."</p> <p>"01-21-14 at 21:54 [9:54 p.m.] No ulcers or incisions."</p> <p>"01-23-14 at 15:14 [3:14 p.m.] Coccyx wound present."</p> <p>"01-25-14 at 11:15 a.m. DSG [dressing] changed to coccyx earlier. Wound bed white with not <sic> drainage noted. New dsg. applied without difficulty."</p> <p>A physician order was not obtained until 01-27-14 for "Santyl [a medication used in wound debridement], apply to coccyx topically Q [every] HS [bed time] for wound. Cleanse coccyx with normal saline - apply Santyl. Moist gauze then apply dry dressing daily."</p> <p>Nurses note dated 02-03-14 at 12:40</p>		4/13/2014				

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	<p>p.m., indicated "Area on coccyx <sic> measures 3 [cm] by 4 cm. Area is necrotic and unstageable. Has foul odor. Did complain of discomfort when turned. Family and MD aware of area."</p> <p>"02-04-14 at 19:36 [7:36 p.m.] Wound continue <sic> to have foul odor with drainage noted. Wound has in center some necrotic tissue with surrounding areas being pinkish/red. Resident is alert with confusion noted."</p> <p>"02-10-14 at 17:47 [5:17 p.m.] Ulcer on coccyx is being changed daily."</p> <p>"02-12-14 at 7:08 a.m. Resident has open area on coccyx measuring 5 [cm] by 3 [cm] by 3 cm. Area remains with necrosis and slough. Large amount of foul greenish yellow drainage noted on old dressing. Due to slough and necrosis area not yet stageable. Area has foul odor. Resident did not complaint of pain when area touched but did hollar out when turned over."</p> <p>"02-12-14 at 17:46 [5:46 p.m.] coccyx wound has no change."</p> <p>"02-13-14 at 21:14 [9:14 p.m.] coccyx wound has no change."</p>				

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	<p>"02-15-14 at 13:15 [1:15 p.m.] DSG to coccyx dry and intact this a.m."</p> <p>"02-17-14 at 18:47 [6:47 p.m.] Ulcer on coccyx is still present and necrotic. Dressing changed tonight, Santyl applied as ordered."</p> <p>"02-18-14 at 8:03 a.m. Resident has large necrotic area on coccyx. Area measures 7 [cm] by 6 [cm] by 5 cm. Not able to stage yet due to large amounts of eschar tissue. Area is deep."</p> <p>"02-18-14 at 20:17 [8:17 p.m.] Aids notified me this evening of two large blisters on resident's heels. One appears to be blood filled. The other seems to be clear. Allevy <sic> patches were put on bilaterally with heels floated with pillow. Skin sheet completed and placed in book."</p> <p>The record lacked physician notification for possible intervention.</p> <p>"02-19-14 at 14:17 [2:17 p.m.] Examined both heels. Removed allevyn and left heel is dark in collar <sic>, slightly fluid filled and measures 6 cm by 6 cm. Right heel has clear fluid filled area measuring 8 cm by 8 cm. Heels floated off bed.</p>			
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	<p>Cried when nonskid slippers removed but did not cry, flich <sic> or groan when heels touched."</p> <p>"02-22-14 at 00:24 [12:24 a.m.] Pressure area to coccyx that is being treated with Santyl and wet-dry dressing. Area is malodorous."</p> <p>"02-23-14 at 20:18 [8:20 p.m.] Resident seemed more weak this evening, and less responsive to cues. Resident usually responds to questions and she did very little this evening."</p> <p>"02-24-14 at 3:47 a.m. Pt. [patient] is is <sic> not A & O [alert and oriented], only responds with moans when being repositioned during the shift. Pt. had denied to open mouth or swallow any medications. Generalized weakness presnt <sic> in all extermitities <sic>. Foul order <sic> present to coccyx wound & no improvement noted. Has made MD aware of this awaiting CB [call back] from NP [nurse practitioner]."</p> <p>"02-25-14 at 5:40 a.m. Right heel has dark area, prior old blister, intact. Left heel is also dark, partially filled blister measuring 5 [cm] by 4 cm. coccyx has large area filled with dark tissue measuring 7 [cm] by 6 [cm] by</p>						

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	<p>5 cm. Can feel coccyx bone when area probed. Has large amount of foul smelling drainage noted. Family and MD aware of areas."</p> <p>The record indicated a physician order dated 02-25-14 and instructed the nursing staff to perform "wound culture on coccyx for wound infection, UA [urinalysis] C & S [culture and sensitivity], cleanse left heel with normal saline and apply Allevyn dressing every 72 hours. cleanse right heel with normal saline and apply Allevyn dressing every 72 hours."</p> <p>"02-26-14 at 8:57 a.m. Patient's daughter here in facility requesting patient to be sent out to [name of local area hospital] for wound evaluation and treatment. Dtr. [daughter] already aware of new orders from yesterday but stating she saw wound last night and wants her to be sent to hospital for further treatment. Spoke with NP for [name of physician] regarding request and okay to send patient to hospital for eval. [evaluation] and tx. [treatment]."</p> <p>During an interview on 03-13-14 at 1:50 p.m., the wound care nurse indicated she did not notify the resident's family for notification of</p>				

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	<p>changes for any resident who resided on the first floor, but did not notify the resident family members of those residents who resided on the second floor. "Those nurses [who worked on the first floor] do that." Resident "A" resided on the first floor of the facility.</p> <p>During an interview on 03-14-14 at 8:32 a.m., a concerned family member indicated she had been told about a small red spot on the resident's back. The family member indicated she noticed a difference in the resident's responsiveness on 02-25-14, and when she inquired about the resident's condition, the licensed nurse said the resident was "fine."</p> <p>The family member further indicated another family member had been told by a staff member on Tuesday (02-25-14) there was "something we needed to see." The family member indicated the resident was turned to her side and an odor came from the resident that filled the room. "The stench was horrific, and I couldn't believe what I was seeing. I could see gauze and it looked saturated with fluid. The drainage was greenish brown and the odor terrible. I didn't know if the drainage was coming from the pouch [colostomy</p>			
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	<p>bag]."</p> <p>The family member indicated she questioned whether the resident should be sent to the hospital that night but the "nurse told me that [resident] was stable and there wasn't anything the hospital could do that they couldn't do at Summer Trace. It was very cold that night, about 1 degree outside, and I didn't want to expose her to the cold, but the next morning I wanted her to go to the hospital."</p> <p>During interview the family member indicated the facility didn't give her a chance to make a decision about further treatment for the resident. "I was only told about a little red spot. Had I known, I would have liked the chance to at least know about what was going on and what were our options for her care. If anyone came to me and said we need to do something I would have done it. I didn't know anything about the ulcer or her heels. At no time did anyone red flag me about this thing on my [resident's] back."</p> <p>Review of the facility policy on 03-13-14 at 9:30 a.m., titled "Change in Condition: when to report to the MD/NP/PA [Medical Doctor - Nurse</p>				

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	<p>Practitioner - Physician Assistant]," indicated the following:</p> <p>"...Immediate Notification - Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and [underscored], a marked change in relation to usual symptoms or signs, or [underscored] unrelieved by measures already prescribed...</p> <p>Non-Immediate Notification - new or worsening symptoms that do not meet above criteria...</p> <p>Confusion - Immediate - abrupt significant change form usual, or a change in level of consciousness. Non-Immediate - abrupt persistent change from usual with no other significant symptoms...</p> <p>Consciousness, altered - Immediate - Sudden change in level of consciousness or responsiveness. Non-Immediate - Gradual but persistent recent change in level of consciousness or responsiveness...</p> <p>Pressure sore - Immediate New onset T [temperature] > [greater than] 100.5 [degrees] F [Fahrenheit] in someone with Grade 2 or higher score. Non-Immediate New onset Grade 2 or higher pressure sore, OR</p>			

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	<p>progression of pressure sore despite interventions...."</p> <p>This Federal tag relates to Complaint IN00145429.</p> <p>3.1-5(a)</p>			
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F000224 SS=G	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview the facility failed to ensure neglect did not occur, in that when a resident was identified with a pressure area the facility failed to ensure the resident received appropriate treatment and services as the pressure ulcer continued to deteriorate and the nursing staff failed to recognize the extensive wound which resulted in the resident being transported to the local area hospital for treatment for 1 of 6 sampled residents reviewed for pressure ulcers, and which resulted in death. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 03-12-14 at 12:20 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, schizophrenia, debility, and pyelonephritis. These diagnoses remained current at the time of the</p>	F000224	<p>F224 §483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>It is the practice of this center to comply with F-224: PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>Corrective action which will be accomplished for those resident(s) affected by the deficient practice. Resident "A" no longer resides at the center.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents with pressure ulcers that receive treatment and services for those pressure ulcers have the potential to be affected. Those identified residents have been reviewed and provided a comprehensive assessment of their current wound status and related treatment orders. Their physicians and families have been notified of the current status and related treatment orders.</p> <p>Measures the facility will take</p>	04/13/2014			

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	<p>record review. The resident had a colostomy.</p> <p>A review of the record indicated the resident returned to the facility after a hospitalization on 01-02-14. A review of the nurses progress notes dated 01-02-14 at 21:32 (9:32 p.m.), indicated the resident was "readmitted to Summer Trace this evening. Resident is resting well and seems to be adjusting pleasantly to the facility. Resident is alert and oriented times 2. Colostomy is intact. Lungs are clear per auscultation. Bowel sounds present. Skin is warm to touch and normal in color." The assessment lacked any concern related to a pressures ulcer.</p> <p>A review of the resident's MDS (minimum data set) assessment, dated 01-09-14 indicated the resident had 1 stage 2 pressure ulcer. The assessment further indicated, "[Resident] currently has moisture <sic> associated skin damage."</p> <p>The resident's plan of care, dated 01-03-14, indicated "has open area on coccyx." Interventions included "follow up care with physician as ordered, report evidence of infection such as purulent drainage, swelling, localized heat, increased pain etc.</p>		<p>or systems the facility will alter to ensure that the problem will be corrected and will not recur.</p> <p>Nursing leadership and the wound nurse received education regarding the following:</p> <ul style="list-style-type: none"> · Skin Practice Guidelines. · Documentation Guidelines <p>Licensed nurses will receive in-service education regarding the following:</p> <ul style="list-style-type: none"> · Physician and family notification for residents that develop pressure ulcers and/or experience changes in condition or status of those pressure ulcers · Skin Practice Guidelines · Documentation guidelines · Orders management and following treatment orders <p>Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent.</p> <p>The Administrative Director of Nursing or Designee will complete audits to ensure compliance with facility guidelines 5 times weekly . Monitoring to validate compliance with system corrections will continue until 4 weeks of negative findings have been observed, then monthly X3 months, then on-going random monthly monitoring as identified through the centers QA&A process. Observations will be recorded in the QAA monitoring tool and corrections will be</p>		

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	<p>Notify physician prn [as needed]."</p> <p>The "clinical assessment report for pressure ulcer," dated 01-03-14 indicated the resident "has open area measuring 3 cm [centimeters] by 1 cm, stage 2 [partial thickness loss] moisture associated." The resident "requires staff assistance to move, is confined to a bed/chair all or most of time, needs special mattress/seat cushion, requires regular schedule for turning, is persistently wet from incontinence/wound drainage/perspiration, was immobile and had cognitive loss."</p> <p>The clinical record indicated a physician order dated 01-02-14 to "cleanse open area with normal saline and apply dry sterile dressing till [until] assessed by wound nurse." This assessment lacked measurements or a description of the area to be treated.</p> <p>The Nurses Progress notes indicated the following: "01-03-14 at 9:15 a.m.,... Has 3 cm [centimeter] by 1 cm open area on coccyx, stage 2 without drainage... . Incontinent of urine. Has colostomy with brown stool noted. Screamed aloud when turned. Resident has incontinence dependency on staff for</p>		<p>completed by the Administrative Director of Nursing/designee. The results of these audits will be reviewed by the facility's Quality Assessment and Assurance Committee to determine continued compliance and make recommendations for further corrective action as needed.</p> <p>Completion Date: April 13th, 2014.</p>		

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	<p>all adl's [activities of daily living]. Family and MD [Medical Doctor] aware."</p> <p>"01-07-14 at 21:45 [9:45 p.m.] No ulcers or incisions <sic> present."</p> <p>"01-10-14 at 8:07 a.m. Resident has open area on coccyx measuring 4 [cm] by 2.5 cm. Wound bed is red tissue. No drainage and is shear like is <sic> formation. Family and MD area of area. No drainage noted."</p> <p>"01-13-14 at 10:24 a.m. Coccyx wound present."</p> <p>"01-20-14 at 8:20 a.m. Area on coccyx measures 4 [cm] by 3 cm. Area has beefy red tissue noted. Resident is incontinent of urine and frequently wet. Area is most likely moisture associated."</p> <p>"01-21-14 at 21:54 [9:54 p.m.] No ulcers or incisions."</p> <p>"01-23-14 at 15:14 [3:14 p.m.] Coccyx wound present."</p> <p>"01-25-14 at 11:15 a.m. DSG [dressing] changed to coccyx earlier. Wound bed white with not <sic> drainage noted. New dsg. applied without difficulty."</p>						

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	<p>A physician order was not obtained until 01-27-14 for Santyl [a medication used in wound debridement], "apply to coccyx topically Q [every] HS [bed time] for wound. Cleanse coccyx with normal saline - apply Santyl. Moist gauze then apply dry dressing daily."</p> <p>Nurses note dated 02-03-14 at 12:40 p.m., indicated "Area on coccyx <sic> measures 3 [cm] by 4 cm. Area is necrotic and unstageable. Has foul odor. Did complain of discomfort when turned. Family and MD aware of area."</p> <p>"02-04-14 at 19:36 [7:36 p.m.] Wound continue <sic> to have foul odor with drainage noted. Wound has in center some necrotic tissue with surrounding areas being pinkish/red. Resident is alert with confusion noted."</p> <p>"02-10-14 at 17:47 [5:17 p.m.] Ulcer on coccyx is being changed daily."</p> <p>"02-12-14 at 7:08 a.m. Resident has open area on coccyx measuring 5 [cm] by 3 [cm] by 3 cm. Area remains with necrosis and slough. Large amount of foul greenish yellow drainage noted on old dressing. Due to slough and necrosis area not yet</p>						

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	<p>stageable. Area has foul odor. Resident did not complaint of pain when area touched but did hollar out when turned over."</p> <p>"02-12-14 at 17:46 [5:46 p.m.] coccyx wound has no change."</p> <p>"02-13-14 at 21:14 [9:14 p.m.] coccyx wound has no change."</p> <p>"02-15-14 at 13:15 [1:15 p.m.] DSG to coccyx dry and intact this a.m."</p> <p>"02-17-14 at 18:47 [6:47 p.m.] Ulcer on coccyx is still present and necrotic. Dressing changed tonight, Santyl applied as ordered."</p> <p>"02-18-14 at 8:03 a.m. Resident has large necrotic area on coccyx. Area measures 7 [cm] by 6 [cm] by 5 cm. Not able to stage yet due to large amounts of eschar tissue. Area is deep."</p> <p>"02-18-14 at 20:17 [8:17 p.m.] Aids notified me this evening of two large blisters on resident's heels. One appears to be blood filled. The other seems to be clear. Allevy <sic> patches were put on bilaterally with heels floated with pillow. Skin sheet completed and placed in book."</p>			

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	<p>The record lacked physician notification for possible intervention.</p> <p>"02-19-14 at 14:17 [2:17 p.m.] Examined both heels. Removed allevyn and left heel is dark in collar <sic>, slightly fluid filled and measures 6 cm by 6 cm. Right heel has clear fluid filled area measuring 8 cm by 8 cm. Heels floated off bed. Cried when nonskid slippers removed but did not cry, flich <sic> or groan when heels touched."</p> <p>"02-22-14 at 00:24 [12:24 a.m.] Pressure area to coccyx that is being treated with Santyl and wet-dry dressing. Area is malodorous."</p> <p>"02-23-14 at 20:18 [8:20 p.m.] Resident seemed more weak this evening, and less responsive to cues. Resident usually responds to questions and she did very little this evening."</p> <p>"02-24-14 at 3:47 a.m. Pt. [patient] is is <sic> not A & O [alert and oriented], only responds with moans when being repositioned during the shift. Pt. had denied to open mouth or swallow any medications. Generalized weakness presnt <sic> in all extermities <sic>. Foul order <sic> present to coccyx wound & no</p>			
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	<p>improvement noted. Has made MD aware of this awaiting CB [call back] from NP [nurse practitioner]."</p> <p>"02-25-14 at 5:40 a.m. Right heel has dark area, prior old blister, intact. Left heel is also dark, partially filled blister measuring 5 [cm] by 4 cm. Coccyx has large area filled with dark tissue measuring 7 [cm] by 6 [cm] by 5 cm. Can feel coccyx bone when area probed. Has large amount of foul smelling drainage noted. Family and MD aware of areas."</p> <p>The record indicated a physician order dated 02-25-14 and instructed the nursing staff to perform "wound culture on coccyx for wound infection, UA [urinalysis] C & S [culture and sensitivity], cleanse left heel with normal saline and apply Allevyn dressing every 72 hours. cleanse right heel with normal saline and apply Allevyn dressing every 72 hours."</p> <p>"02-26-14 at 8:57 a.m. Patient's daughter here in facility requesting patient to be sent out to [name of local area hospital] for wound evaluation and treatment. Dtr. [daughter] already aware of new orders from yesterday but stating she saw wound last night and wants her</p>						

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	<p>to be sent to hospital for further treatment. Spoke with NP for [name of physician] regarding request and okay to send patient to hospital for eval. [evaluation] and tx. [treatment]."</p> <p>During an interview on 03-13-14 at 1:50 p.m., the wound care nurse indicated she did not notify the resident's family for notification of changes for any resident who resided on the first floor, but did notify the resident family members of those residents who resided on the second floor. "Those nurses [who worked on the first floor] do that." Resident "A" resided on the first floor of the facility.</p> <p>During an interview on 03-14-14 at 8:32 a.m., a concerned family member indicated she had been told about a small red spot on the resident's back. The family member indicated she noticed a difference in the resident's responsiveness on 02-25-14, and when she inquired about the resident's condition, the licensed nurse said the resident was "fine."</p> <p>The family member further indicated another family member had been told by a staff member on Tuesday (02-25-14) there was "something we needed to see." The family member indicated the resident was turned and</p>				

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	<p>an odor came from the resident that filled the room. "The stench was horrific, and I couldn't believe what I was seeing. I could see gauze and it looked saturated with fluid. The drainage was greenish brown and the odor terrible. I didn't know if the drainage was coming from the pouch [colostomy bag]."</p> <p>The family member indicated she questioned whether the resident should be sent to the hospital that night (02-25-14) and the "nurse told me that [resident] was stable and there wasn't anything the hospital could do that they couldn't do at Summer Trace. It was very cold that night, about 1 degree outside, and I didn't want to expose her to the cold, but the next morning I wanted her to go to the hospital."</p> <p>The family member indicated the facility didn't give her a chance to make a decision about further treatment for the resident. "I was only told about a little red spot. Had I'd known, I would have liked the chance to at least know about what was going on and what were our options for her care. If anyone came to me and said we need to do something I would have done it. I didn't know anything about the ulcer</p>				

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	<p>on her heels. At no time did anyone red flag me about this thing on my [resident's] back."</p> <p>A review of the Skin Alteration Record for the area on the resident's coccyx indicated the following measurements and description of the ulcer:</p> <p>"01-02-14 measurements 3 cm [centimeters] in length and 3 cm in width - Edges approximated with clear serous drainage, and reddened skin surrounding the area."</p> <p>"01-09-14 measurements 4 cm in length by 2.5 cm in width - Edges approximated with clear serous drainage, and reddened skin surrounding the area."</p> <p>"01-16-14 measurements - no documentation. The resident continued with "Edges approximated with clear serous drainage, and reddened skin surrounding the area."</p> <p>"02-06-14 measurements 4 cm in length by 4 cm in width. The area was identified with 'slough [moist yellow or gray necrotic tissue],' with a moderate amount of clear serous drainage with a foul odor."</p> <p>"02-13-14 measurements 5 cm in</p>			

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	<p>length by 3 cm in width by 3 cm in depth. The area continued with slough and had a moderate amount of purulent [creamy white to yellow] drainage with a foul odor."</p> <p>"02-20-14 measurements 7 cm in length by 6 cm in width by 5 cm in depth. The area continued with slough and had a moderate amount of 'purulent [creamy white to yellow] drainage with a foul odor."</p> <p>A review of the "pressure ulcer healing chart" for the area on the resident's coccyx indicated the exudate was assessed as "heavy" from 02-12-14 through 02-25-14 and the "tissue type" was assessed as "necrotic" from 02-12-14 through 02-25-14.</p> <p>A review of the Skin Alteration Record for the area on the resident's heels indicated the following measurements and description of the bilateral heels:</p> <p>"02-18-14 measurements 6 cm in length by 5 cm in width - intact and edges approximated. No drainage."</p> <p>"02-25-14 right heel measurements - 5 cm in length by 3 cm in width and scant amount of clear serous</p>				

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	<p>drainage."</p> <p>"02-25-14 left heel open area - 5 cm in length by 4 cm in width dark pink/red tissue." The "pressure ulcer healing chart," dated 02-25-14 indicated the "tissue type" was "dark deep tissue."</p> <p>A review of the physician progress notes, dated 01-07-14, 01-09-14, 01-14-14, 01-17-14, 01-21-14, 02-13-14, through 02-19-14 lacked any documentation related to the resident pressure ulcer to the coccyx area or heels.</p> <p>The 02-19-14 physician progress notation indicated the resident had an "elevated white blood cell count of 15.5 (normal range of 4.5 to 10.8)," but then further indicated the resident had "no s/s [sign or symptom] of infection" even though the resident's ulcer was now assessed with a "moderate amount of purulent [creamy white to yellow] drainage with a foul odor."</p> <p>The record indicated the resident was sent to the local area hospital on 02-26-14. A review of the hospital record on 03-10-14 at 1:00 p.m., indicated the following:</p>						

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	<p>"Pre-arrival Summary - Coming from Summer Trace per family request to have coccyx wound evaluated. ECF [extended care facility] nurse reports that pt. [patient] wound was recently cultured but results not back yet. Also reports pt. has been 'more sleepy' for past 2 days."</p> <p>"Emergency Medicine - The patient presents with from ECF [extended care facility] with complaints of decreased LOC [level of consciousness] times one day and purulent material from her coccyx wound. Unknown duration of wound. Location: back. The character of symptoms is pain. The degree at onset was unknown, The degree at present is severe. Physical Examination: large wound to coccyx with foul smelling discharge. Differential Diagnosis: sepsis, urinary tract infection, cellulitis, soft tissue infection, abscess, colostomy with green stool." The physician ordered laboratory testing to include a complete blood count. The hospital testing of the white blood cell count on 02-26-14 indicated a result of 22.4 HI [high] [reference range 3.6 - 10.6]. "Impression and Plan" Stage IV [full thickness tissue loss with exposed bone, tendon or muscle - slough or eschar may be present on some</p>			

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	<p>parts of the wound bed - often includes undermining and tunneling]."</p> <p>The Emergency Department physician also ordered a "wound culture" of the coccyx. The "Final Report" of the wound culture indicated the resident had "3+ (many) eschera coli, 3+ (many) and Proteus mirabilis in the wound."</p> <p>"Supplemental info [information]: Patient resides at Summer Trace ECF [extended care facility], dx [diagnoses] of SIRS [systemic inflammatory response syndrome], sepsis, decreased responsiveness. Patient arrived with extensive coccyx wounds, wound care nurse consult. Leukocytosis, loose green stools, differential includes urinary tract infection, bacteremia."</p> <p>The physician progress "consult" note, dated 02-27-14 indicated the resident had a "CT [computed tomography] scan of her abdomen and pelvis showed soft decubitus ulceration over the sacrum extending to her bone. Assessment: 1. sepsis likely related to infected sacrococcygeal wound, 2. Deep sacrococcygeal wound with soft tissue gas in extension to sacral bone."</p>			
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	<p>An "Addendum" note, dated 02-28-14, indicated the "pt. has likely necrotizing infection of sacral ulcer extending throughout her left gluteal muscle. This is a life threatening infection which can only be treated with aggressive surgical debridement - pt. is not a candidate for this due to her age. Local wound care and abx [antibiotics] will not be able to treat this. Proteus and E. Coli in wound sensitive to Zosyn [an antibiotic] but without extensive debridement - care is likely futile. Extensive necrotic/dead tissue throughout very large stage IV ulcer with foul odor, extension of erythema along left buttock to posterior left thigh."</p> <p>The hospital "wound description" dated 02-27-14 indicated the following: "Left coccyx wound including erythema is approx. [approximately] 12 cm by 12 cm and actually open area 6 cm by 6 cm. Unable to visualize wound bed. Undermining of at least 7 cm noted from approx. [approximately] 5 - 8 and 11 - 2 o'clock. Wound edges black in color drainage is same color as stool draining from colostomy. Strong foul odor noted. Size: 6 cm by 6 cm by depth unknown but can easily palpate</p>						

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	<p>spinal processes, color black, tunneling, periwound macerated with erythema. Coccyx wound is very concerning. Would question infection to the bone based on black necrotic tissue that is visible along with extremely foul smelling drainage that has same appearance as the contents of the ostomy bag. Spent about 45 minutes speaking with [family member] about [resident]. She [family member] is very upset about the state of the wound on her [resident's] coccyx."</p> <p>"Right heel with approx. 4 cm by 6 cm round black to brown hard eschar covered and left heel approx. 3.6 cm by 5 cm roundish black to brown hard eschar covered. 1st metatarsal joint left 2nd toe with .3 cm dark eschar."</p> <p>During an interview on 03-14-14 at 11:00 a.m., the Nurse who first examined the resident in the Emergency Department at the local area hospital indicated she donned gloves and could palpate bone when assessing the ulcer. "There was dead necrotic tissue, and the drainage was dark and the body was trying to get rid of the dead tissue. The slough was a combination of dark and black. There was tunneling but I couldn't see the wound base,</p>			
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	<p>but when I reached in I could touch bone. I could take my hand and put it inside and tunneling was significant. I could take my index finger and go all the way around into the tunneling."</p> <p>A second hospital wound nurse who was also involved with the care of the resident was interviewed on 03-10-14 at 1:25 p.m. The nurse indicated, "It was one of the worst bed sores I've seen in my life. The edges were black and necrotic and inside of the wound was black. Stool was coming from the wound the same color and consistency coming from the colostomy. I could put my finger in the wound and could feel every single process of the spine. There was undermining towards the left hip and I could stick my index finger in there. Each heel had eschar and it was black. What blew me away was that the wound had stool in the cavity with stringy black slough. I could put my fist in it to give you a sense of how big it was."</p> <p>During an interview on 03-14-14 at 11:20 a.m., a family friend (who was a nurse and indicated she was a wound nurse) of the resident and daughter of the resident indicated she was with the resident's daughter in the Emergency Department on</p>			
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	<p>02-26-14. "I saw the wound on the coccyx. It had necrotic black tissue with yellow slough. The drainage was purulent and profusely odoriferous. The stench was horrific."</p> <p>The resident expired at the local area hospital on 03-04-14.</p> <p>This Federal tag relates to Complaint IN00145429.</p> <p>3.1-28(a)</p>			
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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure physician orders or plans of care were followed for 2 of 6 sampled residents. (Residents "B" and "C")</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 03-12-14 at 1:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, peripheral neuropathy and had a status post left below the knee amputation. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility on 01-27-14 after recent surgical amputation to the left extremity.</p> <p>A review of the MDS (minimum data set) assessment, dated 02-03-14 indicated the resident was at risk for developing pressure ulcers secondary to requiring assistance with bed mobility, having incontinent</p>	F000282	<p>F 282 SS=D Services by Qualified Persons/Per Care Plan</p> <p>It is the practice of this center to comply with F-282: Services by Qualified Persons/Per Care Plan</p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>- Resident B no long resides at the center.</p> <p>Resident C s physician orders and medical record were reviewed.</p> <p>Resident C currently has all treatments & pressure ulcer prevention interventions in place per physician order.</p> <p><u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</u></p> <p>- Residents that have pressure ulcers and Surgical Wounds have the potential to be affected by this</p>	04/13/2014	

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	<p>and having current skin alterations and ulcers. "Skin is currently intact with deep tissue ulcer on right heel and necrotic tissue on right foot."</p> <p>The current plan of care, dated 03-12-14 indicated the resident had "alteration in skin integrity with deep tissue injury at right heel and right great toe and moisture related skin issues on upper thighs related to diabetes, impaired mobility, incontinence and PVD [peripheral vascular disease]." Interventions to this plan of care included "administer treatment per physician orders."</p> <p>A review of the nurses progress notes, dated 01-31-14 at 10:46 a.m., indicated, "Right foot assessed due to crying out when moved. Blister on heel found, skin sheet created. N.O. [new order] from NP [nurse practitioner] for allevyn to be applied to toe and heel Q [every] 3 days. Writer unable to locate allevyn in facility, wrapped with kerlix and elevated off bed with pillow. Pedal pulses weak."</p> <p>A review of the clinical record lacked documentation of the physician order. In addition, a review of the January 2014, and February 2014 treatment administration record indicated the</p>		<p>deficient practice.</p> <p>Residents with physician ordered pressure ulcer prevention interventions have been reviewed & verified for proper placement and usage.</p> <p>Residents with physician ordered treatments have been reviewed & verified for the proper treatments and usage per order.</p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>- Licensed Nursing Staff will be re-educated regarding Physician Orders Management and following treatment orders.</p> <p>Certified Nursing Aides will be re-educated on the role of the CNA in Skin Management (this training includes the use of the POC Task Kardex to identify existing and new skin prevention interventions that are in place for residents).</p> <p>Certified Nursing Aides were also provided with training by the vendor on specific skin prevention devices.</p>		

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	<p>resident did not receive the treatment as ordered by the physician until 02-03-13.</p> <p>In addition, the resident had a follow up appointment with the surgeon for the surgical wound on 02-12-14. The surgeon recommended "placing betadine soaked gauze over lateral incision daily, cover with roll gauze and stump shrinker."</p> <p>The record lacked a re-write of the physician order/recommendation on 02-12-14. During an interview on 03-13-14 at 10:10 a.m., wound care nurse #3 indicated she didn't know anything about the recommendation, "I only take care of pressure wounds not surgical wounds. The nurses should have added to the TAR [treatment administration record] per MD [Medical Doctor] order."</p> <p>2. The record for Resident "C" was reviewed on 03-13-14 at 12:20 p.m. Diagnoses included, but were not limited to, atrial fibrillation, depressive disorder, cellulites/abscess to buttocks. These diagnoses remained current at the time of the record review. The resident currently receives wound evaluation at a local wound care clinic.</p>		<p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put in place?</u></p> <p>- Director of Nursing or designee will track all physician ordered Treatments 5 days per week on all shifts to validate completion and orders are followed. Any finding will be addressed as found.</p> <p>Director of Care Delivery or designee will audit a minimum of 10 residents per week on random shifts to validate pressure ulcer prevention interventions are in place as ordered. . . Monitoring to validate compliance with system corrections will continue until 4 weeks of negative findings have been observed, then monthly X3 months, then on-going as identified through the centers QA&A process. Observations will be recorded in the QAA monitoring tool and corrections will be completed by the Administrative Director of Nursing/designee. Any findings will be addressed as found.</p> <p>The results of the audit will be submitted to the QA&A Committee for further review and recommendations.</p> <p><u>By what date the systemic changes will be completed?</u></p>				

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	<p>A review of the resident's MDS, dated 02-14-14 indicated the resident had an unstageable pressure ulcer to left buttocks - unstageable and measured 5.0 cm by 4.0 cm with slough present. The MDS documentation further indicated the resident "needs special mattress or seat cushion to reduce or relieve pressure." In addition the resident was assessed as incontinent, and had immobility. "Utilizes gel cushion in wheelchair and APM [antipressure mattress] on bed. Currently has 1 unstageable pressure ulcer and 1 deep tissue injury on heels and 1 unstageable ulcer on ischium. Being seen at [name of wound care clinic]."</p> <p>The resident's plan of care, dated 02-12-14 indicated the resident "Has open area on left buttock impaired mobility incontinence and two dark heels." Interventions included "Administer treatment per physician orders, use pillows and/or positioning devices as needed, special mattress on bed, encourage and assist as needed to turn and reposition: use assistive devices as needed."</p> <p>The wound care clinic report dated 02-17-14 instructed the facility nursing staff to use a "ROHO wheelchair cushion [a pressure relief</p>		4/13/2014				

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	<p>cushion] - do not use donut type devices."</p> <p>The subsequent wound clinic report dated 03-03-14 also indicated the need for "off loading - use wheelchair cushion. Do not use donut-type devices. ROHO. Use specialty mattress - low air loss alternating pressure mattress."</p> <p>During an observation on 03-13-14 at 11:00 a.m., the resident was observed lying in bed. The resident's "air mattress" controls had been turned to the "off" position. During interview licensed nurse #6 indicated she was unfamiliar with the current APM on the resident's bed.</p> <p>A subsequent observation on 03-13-14 at 12:40 p.m., the resident was seated in the wheelchair. The resident did not have the ROHO cushion to prevent pressure to the ischial area. Licensed nurse #5 verified the resident did not have the cushion as ordered.</p> <p>This Federal tag relates to Complaint IN00145429.</p> <p>3.1-35(g)(2)</p>			
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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview the facility failed to ensure a a resident who entered the facility with a reddened area, and a resident who acquired a pressure ulcer after being admitted to the facility received treatment and services to promote healing and prevention of the development of additional pressure ulcers for 3 of 6 sampled residents reviewed for pressure ulcers.</p> <p>The nursing staff failed to recognize the full extent of the wound and involvement of surrounding tissue and which extended in depth to resident "A's" spine. This deficient practice resulted in the death of the resident.</p> <p>(Residents "A", "B" and "C").</p>	F000314	<p>F314 §483.25(c) TREATMENT/SERVICES TO PREVENT HEAL PRESSURE SORES It is the practice of this center to comply with F-314: TREATMENT/SERVICES TO PREVENT HEAL PRESSURE SORES Corrective action which will be accomplished for those resident(s) affected by the deficient practice. Resident "A" no longer resides at the center. Resident "B" no longer resides at the center. Resident "C" continues to receive necessary treatment and services to promote healing, prevent infection and prevent new bed sores from developing as evidenced by current physician treatment orders, an individualized plan of care that includes necessary support and pressure redistribution surfaces and additional prevention interventions as necessary. How the facility will identify other residents having the potential</p>	04/13/2014	

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	<p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 03-12-14 at 12:20 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, schizophrenia, debility, and pyelonephritis. These diagnoses remained current at the time of the record review. The resident had a colostomy.</p> <p>A review of the record indicated the resident returned to the facility after a hospitalization on 01-02-14. The nurses progress notes dated 01-02-14 at 21:32 (9:32 p.m.), indicated the resident was "readmitted to Summer Trace this evening. Resident is resting well and seems to be adjusting pleasantly to the facility. Resident is alert and oriented times 2. Colostomy is intact. Lungs are clear per auscultation. Bowel sounds present. Skin is warm to touch and normal in color." The assessment lacked any concern related to a pressures ulcer.</p> <p>A "Clinical Assessment Report for Pressure Ulcer," dated 01-03-14 indicated the resident "has open area measuring 3 cm [centimeters] by 1 cm, stage 2 [partial thickness loss] moisture associated." The resident</p>		<p>to be affected by the same deficient practice. Residents with pressure ulcers or those that develop pressure ulcers have the potential to be affected. These identified like residents will have the comprehensive wound assessment completed. Their physicians and families will be notified of the current wound status. The treatment plan and individual plan of care will be revised as necessary to include the following:</p> <ul style="list-style-type: none"> · Appropriate dressing changes orders · Pressure ulcer prevention interventions <p>Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. Nursing leadership and the wound nurse received education regarding the following:</p> <ul style="list-style-type: none"> · Skin Practice Guidelines · Documentation Guidelines <p>Licensed nurses will receive in-service education regarding the following:</p> <ul style="list-style-type: none"> · Skin Practice Guidelines · Documentation guidelines · Orders management, transcription and following treatment orders · Medication management, 6 rights + 1 of medication administration · Dressing Change Guidelines <p>Certified Nursing Assistants will receive in-service education regarding the following:</p> <ul style="list-style-type: none"> · The Role of the CNA in Skin Management. <p>Quality Assurance Plans to monitor</p>		

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	<p>"requires staff assistance to move, is confined to a bed/chair all or most of time, needs special mattress/seat cushion, requires regular schedule for turning, is persistently wet from incontinence/wound drainage/perspiration, was immobile and had cognitive loss."</p> <p>A review of the resident's MDS (minimum data set) assessment, dated 01-09-14 indicated the resident had 1 stage 2 pressure ulcer. The assessment further indicated, "[Resident] currently has mositure <sic> associated skin damage."</p> <p>The resident's plan of care, dated 01-03-14, indicated "has open area on coccyx." Interventions included "follow up care with physician as ordered, report evidence of infection such as purulent drainage, swelling, localized heat, increased pain etc. Notify physician prn [as needed]."</p> <p>The clinical record indicated a physician order dated 01-02-14 "cleanse open area with normal saline and apply dry sterile dressing till [until] assessed by wound nurse." This assessment lacked measurements or a description of the area to be treated.</p>		<p>facility performance to ensure corrections are achieved and are permanent. The Administrative Director of Nursing or Designee will complete audits to ensure compliance with facility guidelines 5 times weekly to validate the system is sustained. Monitoring to validate compliance with system corrections will continue until 4 weeks of negative findings have been observed, then monthly X3 months, then on-going as identified through the centers QA&A process. Observations will be recorded in the QAA monitoring tool and corrections will be completed by the Administrative Director of Nursing/designee. The results of these audits will be reviewed by the facility's Quality Assessment and Assurance Committee to determine continued compliance and make recommendations for further corrective action as needed. Completion Date: April 13th, 2014.</p>		

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	<p>The Nurses Progress notes indicated the following:</p> <p>"01-03-14 at 9:15 a.m... Has 3 cm [centimeter] by 1 cm open area on coccyx, stage 2 without drainage... Incontinent of urine. Has colostomy with brown stool noted. Screamed aloud when turned. Resident has incontinence dependency on staff for all adl's [activities of daily living]. Family and MD [Medical Doctor] aware."</p> <p>"01-07-14 at 21:45 [9:45 p.m.] No ulcers or incisions <sic> present."</p> <p>"01-10-14 at 8:07 a.m. Resident has open area on coccyx measuring 4 [cm] by 2.5 cm. Wound bed is red tissue. No drainage and is shear like is <sic> formation. Family and MD area of area. No drainage noted."</p> <p>"01-13-14 at 10:24 a.m. Coccyx wound present."</p> <p>"01-20-14 at 8:20 a.m. Area on coccyx measures 4 [cm] by 3 cm. Area has beefy red tissue noted. Resident is incontinent of urine and frequently wet. Area is most likely moisture associated."</p> <p>"01-21-14 at 21:54 [9:54 p.m.] No ulcers or incisions."</p>			
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	<p>"01-23-14 at 15:14 [3:14 p.m.] Coccyx wound present."</p> <p>"01-25-14 at 11:15 a.m. DSG [dressing] changed to coccyx earlier. Wound bed white with not <sic> drainage noted. New dsg. applied without difficulty." A physician order was not obtained until 01-27-14 for Santyl [a medication used in wound debridement], "apply to coccyx topically Q [every] HS [bed time] for wound. Cleanse coccyx with normal saline - apply Santyl. Moist gauze then apply dry dressing daily."</p> <p>Nurses note dated 02-03-14 at 12:40 p.m., indicated "Area on coccyx <sic> measures 3 [cm] by 4 cm. Area is necrotic and unstageable. Has foul odor. Did complain of discomfort when turned. Family and MD aware of area."</p> <p>"02-04-14 at 19:36 [7:36 p.m.] Wound continue <sic> to have foul odor with drainage noted. Wound has in center some necrotic tissue with surrounding areas being pinkish/red. Resident is alert with confusion noted."</p> <p>"02-10-14 at 17:47 [5:17 p.m.] Ulcer</p>						

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	<p>on coccyx is being changed daily."</p> <p>"02-12-14 at 7:08 a.m. Resident has open area on coccyx measuring 5 [cm] by 3 [cm] by 3 cm. Area remains with necrosis and slough. Large amount of foul greenish yellow drainage noted on old dressing. Due to slough and necrosis area not yet stageable. Area has foul odor. Resident did not complaint of pain when area touched by did hollar <sic> out when turned over."</p> <p>"02-12-14 at 17:46 [5:46 p.m.] coccyx wound has no change."</p> <p>"02-13-14 at 21:14 [9:14 p.m.] coccyx wound has no change."</p> <p>"02-15-14 at 13:15 [1:15 p.m.] DSG. to coccyx dry and intact this a.m."</p> <p>"02-17-14 at 18:47 [6:47 p.m.] Ulcer on coccyx is still present and necrotic. Dressing changed tonight, Santyl applied as ordered."</p> <p>"02-18-14 at 8:03 a.m. Resident has large necrotic area on coccyx. Area measures 7 [cm] by 6 [cm] by 5 cm. Not able to stage yet due to large amounts of eschar tissue. Area is deep."</p>				

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	<p>"02-18-14 at 20:17 [8:17 p.m.] Aids notified me this evening of two large blisters on resident's heels. One appears to be blood filled. The other seems to be clear. Allevy <sic> patches were put on bilaterally with heels floated with pillow. Skin sheet completed and placed in book."</p> <p>The record lacked physician notification for possible intervention.</p> <p>"02-19-14 at 14:17 [2:17 p.m.] Examined both heels. Removed allevyn and left heel is dark in collar <sic>, slightly fluid filled and measures 6 cm by 6 cm. Right heel has clear fluid filled area measuring 8 cm by 8 cm. Heels floated off bed. Cried when nonskid slippers removed but did not cry, flich <sic> or groan when heels touched."</p> <p>"02-22-14 at 00:24 [12:24 a.m.] Pressure area to coccyx that is being treated with Santyl and wet-dry dressing. Area is malodorous."</p> <p>"02-23-14 at 20:18 [8:20 p.m.] Resident seemed more weak this evening, and less responsive to cues. Resident usually responds to questions and she did very little this evening."</p>			

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	<p>"02-24-14 at 3:47 a.m. Pt. [patient] is is <sic> not A & O [alert and oriented], only responds with moans when being repositioned during the shift. Pt. had denied to open mouth or swallow any medications. Generalized weakness presnt <sic> in all extremities <sic>. Foul order <sic> present to coccyx wound & no improvement noted. Has made MD aware of this awaiting CB [call back] from NP [nurse practitioner]."</p> <p>"02-25-14 at 5:40 a.m. Right heel has dark area, prior old blister, intact. Left heel is also dark, partially filled blister measuring 5 [cm] by 4 cm. coccyx has large area filled with dark tissue measuring 7 [cm] by 6 [cm] by 5 cm. Can feel coccyx bone when area probed. Has large amount of foul smelling drainage noted. Family and MD aware of areas."</p> <p>The record indicated a physician order dated 02-25-14 and instructed the nursing staff to perform "wound culture on coccyx for wound infection, UA [urinalysis] C & S [culture and sensitivity], cleanse left heel with normal saline and apply Allevyn dressing every 72 hours. cleanse right heel with normal saline and apply Allevyn dressing every 72 hours."</p>			

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	<p>"02-26-14 at 8:57 a.m. Patient's daughter here in facility requesting patient to be sent out to [name of local area hospital] for wound evaluation and treatment. Dtr. [daughter] already aware of new orders form yesterday but stating she saw wound last night and wants her to be sent to hospital for further treatment. Spoke with NP for [name of physician] regarding request and okay to send patient to hospital for eval. [evaluation] and tx. [treatment]."</p> <p>During an interview on 03-13-14 at 1:50 p.m., the wound care nurse indicated she did not notify the resident's family for notification of changes for any resident who resided on the first floor, but did notify the resident family members of those residents who resided on the second floor. "Those nurses [who worked on the first floor] do that." Resident "A" resided on the first floor of the facility.</p> <p>During an interview on 03-14-14 at 8:32 a.m., a concerned family member indicated she had been told about a small red spot on the resident's back. The family member indicated she noticed a difference in the resident's responsiveness and when she asked the staff if everything</p>			
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	<p>was alright, the staff assured her that everything was "fine."</p> <p>The family member further indicated another family member had been told by a staff member on Tuesday [02-25-14] there was "something we needed to see." The family member indicated the resident was turned to her side and an odor came from the resident that filled the room. "The stench was horrific, and I couldn't believe what I was seeing. I could see gauze and it looked saturated with fluid. The drainage was greenish brown and the odor terrible. I didn't know if the drainage was coming from the pouch [colostomy bag]."</p> <p>The family member indicated she questioned whether the resident should be sent to the hospital that night and the "nurse told me that [resident] was stable and there wasn't anything the hospital could do that they couldn't do at Summer Trace. It was very cold that night, about 1 degree outside, and I didn't want to expose her to the cold, but the next morning I wanted her to go to the hospital."</p> <p>During interview the family member indicated the facility didn't give her a</p>						

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	<p>chance to make a decision about further treatment for the resident. "I was only told about a little red spot. Had I known, I would have liked the chance to at least know about what was going on and what were our options for her care. If anyone came to me and said we need to do something I would have done it. I didn't know anything about the ulcer or her heels. At no time did anyone red flag me about this thing on my [resident's] back."</p> <p>A review of the Skin Alteration Record for the area on the resident's coccyx indicated the following measurements and description of the ulcer:</p> <p>"01-02-14 measurements 3 cm [centimeters] in length and 3 cm in width - Edges approximated with clear serous drainage, and reddened skin surrounding the area."</p> <p>"01-09-14 measurements 4 cm in length by 2.5 cm in width - Edges approximated with clear serous drainage, and reddened skin surrounding the area."</p> <p>"01-16-14 measurements - no documentation. The resident continued with "Edges approximated with clear serous drainage, and</p>						

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	<p>reddened skin surrounding the area."</p> <p>"02-06-14 measurements 4 cm in length by 4 cm in width. The area was identified with 'slough [moist yellow or gray necrotic tissue],' with a moderate amount of clear serous drainage with a foul odor."</p> <p>"02-13-14 measurements 5 cm in length by 3 cm in width by 3 cm in depth. The area continued with slough and had a moderate amount of purulent [creamy white to yellow] drainage with a foul odor."</p> <p>"02-20-14 measurements 7 cm in length by 6 cm in width by 5 cm in depth. The area continued with slough and had a moderate amount of purulent drainage with a foul odor."</p> <p>A review of the "pressure ulcer healing chart" for the area on the resident's coccyx indicated the exudate was assessed as "heavy" from 02-12-14 through 02-25-14 and the "tissue type" was assessed as "necrotic" from 02-12-14 through 02-25-14.</p> <p>A review of the Skin Alteration Record for the area on the resident's heels indicated the following measurements and description of the</p>			
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	<p>bilateral heels:</p> <p>"02-18-14 measurements 6 cm in length by 5 cm in width - intact and edges approximated. No drainage."</p> <p>"02-25-14 right heel measurements - 5 cm in length by 3 cm in width and scant amount of clear serous drainage."</p> <p>"02-25-14 left heel open area - 5 cm in length by 4 cm in width dark pink/red tissue." The "pressure ulcer healing chart," dated 02-25-14 indicated the "tissue type" was "dark deep tissue."</p> <p>A review of the physician progress notes, dated 01-07-14, 01-09-14, 01-14-14, 01-17-14, 01-21-14, 02-13-14, through 02-19-14 lacked any documentation related to the resident pressure ulcer to the coccyx area. The 02-19-14 notation indicated the resident had an elevated white blood cell count of 15.5 (normal range of 4.5 to 10.8), but then further indicated the resident had "no s/s [sign or symptom] of infection" even though the resident's ulcer was now assessed as necrotic with a "moderate amount of purulent drainage with a foul odor."</p>			
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	<p>The record indicated the resident was sent to the local area hospital on 02-26-14. A review of the hospital record on 03-10-14 at 1:00 p.m., indicated the following:</p> <p>"Pre-arrival Summary - Coming from Summer Trace per family request to have coccyx wound evaluated. ECF [extended care facility] nurse reports that pt. [patient] wound was recently cultured but results not back yet. Also reports pt. has been 'more sleepy' for past 2 days."</p> <p>"Emergency Medicine - The patient presents with from ECF [extended care facility] with complaints of decreased LOC [level of consciousness] times one day and purulent material from her coccyx wound. Unknown duration of wound. Location: back. The character of symptoms is pain. The degree at onset was unknown, The degree at present is severe. Physical Examination: large wound to coccyx with foul smelling discharge. Differential Diagnosis: sepsis, urinary tract infection, cellulitis, soft tissue infection, abscess, colostomy with green stool."</p> <p>The physician ordered laboratory testing to include a complete blood</p>				

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	<p>count. The hospital testing of the white blood cell count on 02-26-14 indicated a result of 22.4 HI [high] [reference range 3.6 - 10.6].</p> <p>"Impression and Plan" Stage IV [full thickness tissue loss with exposed bone, tendon or muscle - slough or eschar may be present on some parts of the wound bed - often includes undermining and tunneling]."</p> <p>The Emergency Department physician also ordered a "wound culture" of the coccyx. The "Final Report" of the wound culture indicated the resident had "3+ (many) escherichia coli, 3+ (many) and Proteus mirabilis in the wound."</p> <p>"Supplemental info [information]: Patient resides at Summer Trace ECF [extended care facility], dx. [diagnoses] of SIRS [systemic inflammatory response syndrome], sepsis, decreased responsiveness. Patient arrived with extensive coccyx wounds, wound care nurse consult. Leukocytosis, loose green stools, differential includes urinary tract infection, bacteremia."</p> <p>The physician progress "consult" note, dated 02-27-14 indicated the resident had a "CT [computed tomography] scan of her abdomen</p>						

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	<p>and pelvis showed soft decubitus ulceration over the sacrum extending to her bone. Assessment : 1. sepsis likely related to infected sacrococcygeal wound, 2. Deep sacrococcygeal wound with soft tissue gas in extension to sacral bone."</p> <p>An "Addendum" note, dated 02-28-14, indicated the "pt. has likely necrotizing infection of sacral ulcer extending throughout her left gluteal muscle. This is a life threatening infection which can only be treated with aggressive surgical debridement - pt. is not a candidate for this due to her age. Local wound care and abx [antibiotics] will not be able to treat this. Proteus and E. Coli in wound are sensitive to Zosyn [an antibiotic] but without extensive debridement - care is likely futile. Extensive necrotic/dead tissue throughout very large stage IV ulcer with foul odor, extension of erythema along left buttock to posterior left thigh."</p> <p>The hospital "wound description" dated 02-27-14 indicated the following: "Left coccyxgeal wound including erythema is approx. [approximately] 12 cm by 12 cm and actually open area 6 cm by 6 cm. Unable to</p>				

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	<p>visualize wound bed. Undermining of at least 7 cm noted from approx. [approximately] 5 - 8 and 11 - 2 o'clock. Wound edges black in color drainage is same color as stool draining from colostomy. Strong foul odor noted. Size: 6 cm by 6 cm by depth unknown but can easily palpate spinal processes, color black, tunneling, periwound macerated with erythema. Coccyx wound is very concerning. Would question infection to the bone based on black necrotic tissue that is visible along with extremely foul smelling drainage that has same appearance as the contents of the ostomy bag. Spent about 45 minutes speaking with [family member] about [resident]. She [family member] is very upset about the state of the wound on her [resident's] coccyx."</p> <p>"Right heel with approx. 4 cm by 6 cm round black to brown hard eschar covered and left heel approx. 3.6 cm by 5 cm roundish black to brown hard eschar covered. 1st metatarsal joint left 2nd toe with .3 cm dark eschar.</p> <p>During an interview on 03-14-14 at 11:00 a.m., the Nurse who first examined the resident in the Emergency Department at the local area hospital indicated she donned</p>			
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	<p>gloves and could palpate bone when assessing the ulcer. "There was dead necrotic tissue, and the drainage was dark and the body was trying to get rid of the dead tissue. The slough was a combination of dark and black. There was tunneling but I couldn't see the wound base, but when I reached in I could touch bone. I could take my hand and put it inside and tunneling was significant. I could take my index finger and go all the way around into the tunneling."</p> <p>A second hospital wound nurse who was also involved with the care of the resident was interviewed on 03-10-14 at 1:25 p.m. The nurse indicated, "It was one of the worst bed sores I've seen in my life. The edges were black and necrotic and inside of the wound was black. Stool was coming from the wound the same color and consistency coming from the colostomy. I could put my finger in the wound and could feel every single process of the spine. There was undermining towards the left hip and I could stick my index finger in there. Each heel had eschar and it was black. What blew me away was that the wound had stool in the cavity with stringy black slough. I could put my fist in it to give you a sense of how big it was."</p>			
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	<p>During an interview on 03-14-14 at 11:20 a.m., the family friend (a nurse who indicated she was a wound nurse) of the resident and daughter of the resident indicated she was with the resident's daughter in the Emergency Department on 02-26-14. "I saw the wound on the coccyx. It had necrotic black tissue with yellow slough. The drainage was purulent and profusely odoriferous. The stench was horrific."</p> <p>The resident expired at the local area hospital on 03-04-14.</p> <p>2. The record for Resident "B" was reviewed on 03-12-14 at 1:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, hypertension, peripheral neuropathy and had a status post left below the knee amputation. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility on 01-27-14 after recent surgery to the left extremity amputation.</p> <p>A review of the MDS, dated 02-03-14 indicated the resident was at risk for developing pressure ulcers</p>			
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	<p>secondary to requiring assistance with bed mobility, having incontinent and having current skin alterations and ulcers. "Skin is currently intact with deep tissue ulcer on right heel and necrotic tissue on right foot."</p> <p>The current plan of care, dated 03-12-14 indicated the resident had "alteration in skin integrity with deep tissue injury at right heel and right great toe and moisture related skin issues on upper thighs related to diabetes, impaired mobility, incontinence and PVD [peripheral vascular disease]." Interventions to this plan of care included "administer treatment per physician orders."</p> <p>A review of the nurses progress notes, dated 01-31-14 at 10:46 a.m. indicated "Right foot assessed due to crying out when moved. Blister on heel found, skin sheet created. N.O. [new order] from NP [nurse practitioner] for allevyn to be applied to toe and heel Q [every] 3 days. Writer unable to locate allevyn in facility, wrapped with kerlix and elevated off bed with pillow. Pedal pulses weak."</p> <p>A review of the clinical record lacked documentation of the physician order. In addition, a review of the January</p>						

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	<p>2014, and February 2014 treatment administration record indicated the resident did not receive the treatment as ordered by the physician until 02-03-13.</p> <p>3. The record for Resident "C" was reviewed on 03-13-14 at 12:20 p.m. Diagnoses included, but were not limited to, atrial fibrillation, depressive disorder, cellulites/abscess to buttocks. These diagnoses remained current at the time of the record review. The resident currently receives evaluation at a local wound care clinic.</p> <p>A review of the resident's MDS, dated 02-14-14 indicated the resident had an unstageable pressure ulcer to left buttocks - unstageable and measured 5.0 cm by 4.0 cm with slough present. The MDS documentation further indicated the resident "needs special mattress or seat cushion to reduce or relieve pressure." In addition the resident was assessed as incontinent, and had immobility. "Utilizes gel cushion in wheelchair and APM [antipressure mattress] on bed. Currently has 1 unstageable pressure ulcer and 1 deep tissue injury on heels and 1 unstageable ulcer on ischium. Being seen at [name of wound care clinic]."</p>				

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	<p>The resident's plan of care, dated 02-12-14, indicated the resident "Has open area on left buttock impaired mobility incontinence and two dark heels." Interventions included "Administer treatment per physician orders, use pillows and/or positioning devices as needed, special mattress on bed, encourage and assist as needed to turn and reposition: use assistive devices as needed."</p> <p>The wound care clinic report dated 02-17-14 instructed the facility nursing staff to use a "ROHO wheelchair cushion [a pressure relief cushion] - do not use donut type devices."</p> <p>The subsequent wound clinic report dated 03-03-14 also indicated the need for "off loading - use wheelchair cushion. Do not use donut-type devices. ROHO. Use specialty mattress - low air loss alternating pressure mattress."</p> <p>During an observation on 03-13-14 at 11:00 a.m. the resident was observed lying in bed. The resident's "air mattress" controls had been turned to the "off" position. During interview licensed nurse #6 indicated she was unfamiliar with the current APM on</p>			
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	<p>the resident's bed.</p> <p>A subsequent observation on 03-13-14 at 12:40 p.m. the resident was seated in the wheelchair. The resident did not have the ROHO cushion to prevent pressure to the ischial area. Licensed nurse #5 verified the resident did not have the cushion as ordered.</p> <p>This Federal tag relates to Complaint IN00145429.</p> <p>3.1-40(a)(2)</p>			
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