

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155243	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/24/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANS CARE AND REHAB-GREATER LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DR LAFAYETTE, IN 47905
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F0000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00114750.</p> <p>Complaint IN00114750- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 20, 21, 22, 23 and 24, 2012.</p> <p>Facility number : 000147 Provider number :155243 AIM number : 100266900</p> <p>Survey team: Michelle Hosteter RN- TC Michelle Carter RN- (08/22, 08/23, and 08/24, 2012) Rita Mullen RN</p> <p>Census bed type: SNF/NF : 133</p> <p>Census payor type: Medicare : 20 Medicaid : 84 Other: 29 Total: 133</p> <p>Sample : 24</p>	F0000	<p>This Plan of Correction is submitted to meet the requirements established by the state and federal regulations. Kindred Transitional Care and Rehabilitation of Greater Lafayette desires this Plan of Correction to be considered the facility's allegation of Compliance. Compliance is effective on September 14, 2012. Kindred Transitional Care and Rehabilitation of Greater Lafayette respectfully requests paper compliance with this Plan of Correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 29, 2012 by Bev Faulkner, RN</p>			

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F0282 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 record review and interview, the facility failed to follow a physician order regarding the duration of a PRN (as needed) Ativan (an anti-anxiety medication) 0.5 mg (milligrams) every 12 hours order. This resulted in the Ativan being given without a physician's order. This affected 1 of 14 residents reviewed for following physician's orders in a sample of 24. (Resident #71)</p> <p>Findings include:</p> <p>The clinical record of Resident #71 was reviewed on 8/20/12 at 2:00 P.M.</p> <p>A Physician's order, dated 12/1/11, indicated Ativan 0.5 mg [every] 12 hours PRN for ten days then re-evaluate. The order would end on 12/10/11.</p> <p>A Medication Administration Record, dated for the Month of December 2011, indicated Resident #71 received PRN Ativan 0.5 mg, once on 12/18/11 and once on 12/31/11. No times were indicated.</p>	F0282	<p>F282</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #71 had a physicians order, dated 12/1/11 which indicated Ativan 0.5mg every 12 hours PRN for 10 days. The physician was notified and the order was immediately discontinued on 8/20/12. Licensed nurses have been educated regarding following physician orders.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</b></p> <p>An audit was conducted for all timed orders from 8/20/12 to ensure each order has been re-evaluated by the resident's physician for continuation or discontinuation. Licensed nurses have been in-serviced on the policy regarding physician orders.</p>	09/14/2012			

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	<p>During an interview with LPN #1 on 8/2/12 at 11:20 A.M., she indicated the Ativan 0.5 mg every 12 hours PRN was just continued on without getting an order to continue, after the ten days were over.</p> <p>3.1-35(g)(2)</p>		<p><b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur.</b></p> <p>Licensed nurses have been in-serviced on the policy regarding physician orders. The DNS and/or designee will conduct random audits of 3 charts weekly x 90 days of timed orders to ensure ongoing compliance as demonstrated by documentation confirming that timed orders have been reevaluated timely.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>The DNS/and or designee to conduct random audits of 3 charts weekly x 90 days and report findings to the Performance Improvement Committee monthly x 90 days, and then quarterly to ensure ongoing compliance.</p>		

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F0309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to fully assess a resident upon returning from Hemodialysis (dialysis). This impacted 1 of 2 residents reviewed for assessment post dialysis in a sample of 24. (Resident #25)</p> <p>Findings include:</p> <p>The clinical record of Resident #25 was reviewed on 8/24/12 at 1:00 P.M.</p> <p>Diagnoses included, but were not limited to, end stage renal disease, diabetes and depression.</p> <p>A "Dialysis Log," dated for the month of August 2012, indicated Resident #25 received dialysis on Monday, Wednesday and Fridays. The form included sections for recording the post dialysis weight, assessment of the dialysis site, vital signs, and hourly checks for six hours.</p> <p>"Instructions included: Complete upon resident return for dialysis using codes a noted. Assess any changes and document</p>	F0309	<p><b>F309</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>The clinical record of resident # 25 has been reviewed to ensure that a post dialysis assessment has been completed. Licensed nurses have been educated regarding the policy and procedure for assessing residents receiving dialysis.</p> <p><b>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.</b></p> <p>The clinical record for all residents currently receiving dialysis has been reviewed by the DNS or designee to ensure each resident is properly assessed following each treatment. Licensed nurses have been in-serviced regarding the policy and procedure for assessing</p>	09/14/2012			

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	<p>in nurses' notes, contact physician and family as needed." No post dialysis weight was done and the site was not assessed for bruit or thrill as the form indicated should be done.</p> <p>A review of Nursing notes, for the Month of August 2012, did not indicate an assessment post dialysis had been done upon return from dialysis.</p> <p>During an interview with the Director of Nursing (DoN), on 8/24/12 at 2:30 P.M., she indicated the resident has a fistula and the dialysis center does not send paper work back with the resident receiving dialysis so there is no post dialysis weight. The nurses should be assessing for bruit and thrill.</p> <p>A Facility Policy for "Residents Receiving Dialysis," dated 10/31/09, received from the DoN, on 8/24/12 at 3:00 P.M., indicated the following:</p> <p>"Policy</p> <p>The center provides the necessary medical and nursing care and treatment to manage the resident's end-stage renal disease....</p> <p>Compliance Guidelines...</p> <p>2. Licensed nurses evaluate the resident's</p>		<p>residents receiving dialysis.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>Licensed nurses have been in-serviced regarding the policy and procedure for assessing residents receiving dialysis. The DNS and/or designee will review the clinical record of each resident currently receiving dialysis weekly x 90 days to ensure residents receiving dialysis are properly assessed following each dialysis treatment and to ensure ongoing compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>The DNS or designee will review the clinical record of residents currently receiving dialysis weekly x 90 days to ensure that the post dialysis assessment is complete and report the findings to the Performance Improvement Committee monthly x 90 days, then quarterly to ensure ongoing compliance.</p>		

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	<p>for signs and symptoms of infection/bacteremia, bleeding/hemorrhage, septic shock and /or excess/deficient fluids.</p> <p>3. Licensed nurses manage dialysis access site to maintain patency and adequate blood flow for dialysis...."</p> <p>3.1-37(a)</p>			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a resident received supervision during toileting for 1 of 4 residents reviewed for falls in a sample of 24. [ Resident #61]</p> <p>Findings include:</p> <p>The clinical record review for Resident #61 was completed on 8/24/12 at 8:30 A.M. Diagnoses included, but were not limited to, history of pelvic fracture October 2010, Osteopenia, and chronic constipation.</p> <p>The annual MDS (Minimum Data Set) 7/22/12 indicated Resident # 61 had moderate impairment of cognition. The MDS indicated for toilet use the resident was an extensive assist of one person physical assist. The MDS also indicated the resident had a fall with no injury.</p> <p>The Certified Nursing Aides, who assist Resident #61 filled out the ADL (Activities of Daily living) for March 16th through March 31st and April 10th</p>	F0323	<p>F323</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #61 has been identified as being affected by this deficient practice. Resident #61 clinical record has been reviewed and is care planned for assistance with toileting. Nursing staff has been educated regarding supervision of residents requiring assistance with toileting.</p> <p><b>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.</b></p> <p>Nursing staff has been in-serviced regarding supervision of residents requiring assistance for toileting and appropriate interventions post fall.</p> <p><b>What measures will be put into place or what systemic changes will be made to</b></p>	09/14/2012			

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	<p>through April 30th, indicated for toilet use the resident was an extensive assist of one person physical assist. This form indicated the type of help that each resident required for their daily activities, such as toileting and transfers.</p> <p>Resident #61's fall care plan, dated 9/28/11 with revision dates of 12/20/11, 3/13/12, and 5/8/12, indicated, "9/28/11 Keep call light in reach and remind resident to use for assist...Transfer with assist PRN...11/18/11 personal alarm on bed and wheelchair D/C'D (discontinued) 1/17/12 res educated c/o using call light for assist , PT (physical therapy) referral , note posted as reminder c/o use call light 4/17/12 Replace w/c (wheelchair) 4/25/12 personal alarm w/c..."</p> <p>A Patient Nursing Evaluation, dated 3/8/12, indicated, "...Bladder status screening. Frequently incontinent...Physically reliant on caregiver to go to the bathroom...difficulty to hold off going to the bathroom for two hours..."</p> <p>The nurses notes from 4/3/12 at 0500 (5 A.M.) indicated "...sometimes incont (incontinent) of bladder, mostly cont (continent) of bowel. Uses bedpan @ (at) noc (night) (sign for one) (assist) for transfers..." 4/17/12 at 14:30 ( 2:30 P.M.)</p>		<p><b>ensure that the deficient practice does not recur.</b></p> <p>Nursing staff has been in-serviced regarding supervision of residents requiring assist for toileting and appropriate interventions post fall. DNS and/or designee to audit 5 charts weekly x 90 days to ensure documentation is accurate and appropriate to ensure ongoing compliance. Post fall reviews with IDT meeting M-F then weekly x 2 weeks post fall to ensure interventions appropriate.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>DNS and/or designee will audit 5 charts weekly x 90 days and report findings to Performance Improvement Committee monthly x 90 days, then quarterly to ensure ongoing compliance.</p>				

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	<p>indicated, "...Resident's family notified of residents fall. (Sign for no) injuries noted from fall...Resident states she was trying to get up to use toilet and chair gave out..." April 25, 2012 at 10:30 A.M., indicated, "...Res's (residents) fall in her bathroom this a.m. (sign for no) injuries. Res(resident) trying to toilet self (sign for without) assist..." 4/25/12 at 1715 (5:15 P.M.) "...MAEW (moves all extremities well) unable to tolerate lt. (left) ankle edema noted to lt. ankle..." 2140 (9:40 P.M.) X-ray results back et (and) called to on call doctor ...and order obtained to transfer to (name of hospital)..."</p> <p>A change of condition form, dated 4/25/12, indicated, "...Fell (sign for with) unassisted transfer..."</p> <p>The x-ray report from 4/25/12 indicated "...Conclusion: Acute distal tibia and fibula shaft fractures..."</p> <p>In an interview with the Director of Nursing on 8/24/12 at 12:40 P.M., she indicated the resident only needed staff for transfers from bed to wheelchair and that the care plan for transfer with assist PRN (as needed) was for when the resident was weak. She indicated that physical therapy was to see the resident for evaluation after referral on 4/17/12 and that they did not get to the resident</p>			

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F0329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure indications for use were warranted prior to administering Ativan (an anti-anxiety) medication for 1 of 8 residents reviewed for inappropriate behaviors and psychoactive medications in a sample of 24. (Resident #55)</p> <p>Findings include:</p> <p>The clinical record of Resident #55 was reviewed on 8/22/12 at 5:15 P.M.</p>	F0329	<p>F329</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #55 was identified as being affected by this deficient practice. Resident #55 behavior monitoring flow sheet has been reviewed for appropriate interventions based on diagnosis and use of Ativan. Licensed</p>	09/14/2012	

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	<p>Diagnosis for Resident #55 included, but were not limited to, anxiety disorder, bipolar disorder, obsessive-compulsive disorder and insomnia.</p> <p>A quarterly Minimum Data Set assessment, dated 7/6/12, indicated a Brief Interview for Mental Status score of 11. (moderate mental impairment)</p> <p>A Care Plan, dated 5/8/12, indicated verbal aggression. Interventions included, but were not limited to, redirect, remove from area, 15 minute checks, 1:1 and do not sit near [name of resident].</p> <p>A "Monthly Behavior Monitoring Flowsheet," dated for the month of June 2012, indicated the behavior monitoring was for, verbal aggression, sleeplessness, saying her jaw was broken and physical aggression. There was one day, June 8, 2012, Resident #55 was verbally aggressive.</p> <p>A physician order, dated 6/22/12, indicated Ativan 0.5 mg (milligrams) by mouth every six hours PRN (as needed).</p> <p>A review of Nursing Notes, for the Month of June 2012, indicated behaviors were recorded on five days: June 22, 26, 28, 29 and 30, 2012.</p>		<p>nurses have been educated regarding documentation and appropriate interventions for PRN use of Ativan.</p> <p><b>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.</b></p> <p>All residents receiving PRN psychotropics have the potential to be affected. An audit has been completed of all residents with orders for PRN psychotropics for appropriate diagnosis and behavior monitoring flow sheets.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>Licensed nurses have been in-serviced regarding appropriate administration of PRN psychotropics and documentation of behaviors and use of non-pharmaceutical interventions prior to administration.</p> <p>SS and/or designee to review all new orders for appropriate diagnosis and behavior monitoring flow sheet and to update care plan to include non-pharmaceutical interventions.</p>	

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	<p>A review of the Medication Administration Record, dated for the Month of June 2012, indicated Resident #55 received Ativan 0.5 mg PRN on eight days: June 22, 23,25, 26, 27, 28, 29 and 30, 2012 with no documented behaviors warranting the use of Ativan on June 23, 25, and 27, 2012.</p> <p>During an interview with the Director of Nursing, on 8/23/12 at 9:00 A.M., she indicated behaviors are reviewed at the daily conference meeting so if the behavior monitoring sheets are not filled out we still know what behaviors are taking place, but behaviors should be on the behavior sheets or in the nursing notes.</p> <p>3.1-48(a)(3) 3.1-48(a)(4)</p>		<p>SS and/or designee to review 10 behavior monitoring flow sheets per week x 90 days for accurate and appropriate documentation to warrant use of PRN psychotropic and to review care plans to ensure non-pharmaceutical interventions in place to ensure ongoing compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>SS and/or designee will report results of findings of audits to the Performance Improvement Committee monthly x 90 days, then quarterly to ensure ongoing compliance.</p>		

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F0371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure prepared foods were properly covered and dated while stored in the kitchen refrigerator. This effected 1 of 1 kitchen and had the potential to effect 15 of 129 residents that consume meals at the facility.</p> <p>Findings include:</p> <p>During the kitchen tour with the Dietary Manager , on 8/20/12 at 9:45 A.M., items were found in the walk-in refrigerator not covered and not dated. Items included the following:</p> <p>3 - 6 oz. cups of pureed meat.</p> <p>1 - 6 oz. cup of slaw.</p> <p>1 - 6 oz. cup of ham salad.</p> <p>1 - 6 oz. cup of pureed fruit.</p> <p>9 - small lettuce salads.</p> <p>During an interview with the Dietary</p>	F0371	<p>F371</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>All items that were found in the walk-in refrigerator were immediately disposed of and dietary staff was educated on the policy and procedure for proper food storage.</p> <p><b>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.</b></p> <p>All residents have the potential to be affected therefore the Dietary manager and/or designee will conduct rounds daily M-F x 90 days and submit findings to the Executive Director.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>	09/14/2012			

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	<p>Manager, on 8/20/12 at 10:00 A.M., she indicated items in the refrigerator should be covered and dated. The salads had been made that morning for lunch service.</p> <p>3.1-21(i)(2)</p>		<p><b>practice does not recur.</b></p> <p>The Dietary manager, Registered Dietician, and dietary staff have been in-serviced regarding policy and procedure for proper food storage. The Dietary manager and/or designee will complete rounds daily M-F x 90days and submit findings to the Executive Director.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>The Dietary manager will complete rounds daily M-F x 90days and submit findings to the Executive Director. The Executive Director will review findings with the Performance Improvement committee monthly x 90days and quarterly thereafter to ensure ongoing compliance.</p>		

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F0514 SS=A	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure correct documentation of wound staging for 1 of 3 residents reviewed from the sample of 24. (Resident #89) In addition the facility failed to ensure the documentation of physician notification for 1 of 24 residents reviewed for accurate and complete documentation in the sample of 24 (Resident # 21).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #89 was reviewed on 8/22/12 at 5 P.M. Diagnoses included, but were not limited to, Diabetes Mellitus, renal failure, and C4 quadraplegia.</p> <p>Resident # 89 was admitted on 1/28/11</p>	F0514	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The clinical record of residents # 89 and # 21 has been reviewed to ensure accurate documentation regarding wound staging and MD notification. Nursing staff has been educated regarding the policy and procedure for documenting wound staging and documentation of MD notification.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</b>  An audit was conducted for all current residents with pressure</p>	09/14/2012			

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	<p>and was hospitalized and readmitted 3/7/11. The resident when readmitted on 3/7/11 had a Stage II pressure ulcer on his coccyx. The coccyx wound was staged at a Stage III on 7/25/11.</p> <p>The MDS (Minimum Data Set), dated 1/22/12, indicated the resident had a Stage III on his coccyx. The MDS, dated 7/8/12, indicated there resident had a Stage II on his coccyx.</p> <p>The documentation for wound care from the facility indicated the resident had a Stage III wound from 7/25/11 through 8/20/12 notes.</p> <p>The documentation from the wound care clinic treating the resident's wound, dated 6/6/12 through 8/20/12, indicated the wound on coccyx was a Stage IV.</p> <p>In an interview with the Director of Nursing on 8/23/12 at 9:30 A.M., she indicated they are using the MDS 2.0 in regards to how they document their wounds. She indicated after reading the more recent manual for the 3.0, they were not documenting the staging correctly.</p> <p>2. The clinical record of Resident #21 was reviewed on 8/21/12 at 10:45 A.M. Resident was admitted to the facility on 7/11/12.</p>		<p>areas to ensure that the documentation related to wound staging is accurate and that the MD has been notified of condition of wound.</p> <p><b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not occur.</b></p> <p>Nursing staff has been in-serviced regarding the policy and procedure for documenting wound staging and documentation of MD notification. The DNS and/or designee will conduct random audits weekly x 90 days of current residents with pressure wounds to ensure that the documentation is accurate and MD notification is documented to ensure ongoing compliance.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>The DNS/and or designee will report findings of the audits to Performance Improvement committee monthly x 90 days and then quarterly to ensure ongoing compliance.</p>		

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	<p>Diagnoses for Resident #21 included, but were not limited to, diabetes, high blood pressure and a stage II pressure ulcer.</p> <p>A Hospital Discharge Summary dictated, on 7/17/12, indicated an unstageable coccyx wound that was improving.</p> <p>A Nursing note, dated 7/12/12 at 12:06 A.M., indicated "Weekly Pressure Ulcer..site information: coccyx - Pressure: Length = 2.5, Width = 2, Depth = 0.2, - Stage II. Date of initial observation: 7/11/12....Admitted with area...."</p> <p>A Nursing Note, dated 8/3/12 at 6:26 A.M., indicated "...Area is slowly improving with current regimen...."</p> <p>A Nursing Note, dated 8/3/12 at 7:04 A.M., indicated "Res (resident) cont (continues) open area care on coccyx. Area shows no improvement at this time."</p> <p>A Nursing Note, dated 8/5/12 at 1:34 P.M., indicated "Area noted to outer left foot md notified and mepilex placed on wound for protection." There was no documentation the physician was updated on the condition of the pressure ulcer on the coccyx.</p>			

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	<p>A Late Entry Nursing Note, dated 8/23/12 at 3:05 P.M. for 8/5/12 at 3:30 P.M., indicated "After speaking with Resident re (regarding): wound and non-compliance with off loading, wound care nurse notified and MD. notified, no new orders at this time. Will cont with current tx (treatment) orders,..." This entry was made eighteen days after the physician was called.</p> <p>A Nursing Note, dated 8/8/112 at 1:18 A.M., indicated"Continues with area on coccyx, rash on left outer leg and abrasion of left outer foot. Coccyx area not improving at this time. Area has &gt; (greater than) 75% yellow slough to area..." There was no documentation the physician was notified.</p> <p>A Nursing Note, dated 8/9/12 at 7:48 A.M., indicated "Tx cont to coccyx area. No significant improvement to open area. Odor noted...." There was no documentation the physician was called.</p> <p>A Physician's order, dated 8/10/12, indicated "d/c (discontinue) tx to coccyx. Cleanse wound [with] NS (normal saline), apply santyl and polysporm powder, cover [with] moistened fluffed gauze then sacral mepilex...."</p> <p>A Late Entry Nursing Note, dated 8/23/12</p>						

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	<p>at 2:22 P.M., indicated "...when she did measurement on 8/9/12 she noted wound with no improvement and obtained orders for tx change and zinc, vit C and l-arginine."</p> <p>During an interview with the Director of Nursing, on 8/23/12 at 4:00 P.M., she indicated the M.D. was called, but the nurse didn't document the notification in the nursing notes. I had both nurses come in and make late nursing note entries.</p> <p>3.1-50(a)(1)</p>				