

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2016
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NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN 47274
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00199124.</p> <p>Complaint IN00199124 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: May 4, 5 and 6, 2016</p> <p>Facility number: 003342 Provider number: 155712 AIM number: 200403740</p> <p>Census bed type: SNF: 21 SNF/NF: 41 Residential: 26 Total: 88</p> <p>Census payor type: Medicare: 21 Medicaid: 25 Other: 16 Total: 62</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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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F 0157 SS=G Bldg. 00	<p>Quality review completed by 34233 on May 10, 2016.</p> <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>			

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	<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 notify the physician of changes related to one resident who sustained a fall which resulted in a total wound dehiscence (surgical complication in which a wound ruptures along a surgical incision) and new quadriceps tendon rupture of a previously approximated total right knee arthroplasty (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 5/4/2016 at 10:45 a.m. Diagnoses included, but were not limited to, hypertension, diabetes, and osteoarthritis. The resident was admitted to the facility, on 3/26/2016, for aftercare following an elective right knee total arthroplasty (orthopedic surgical procedure where the articular surface of a musculoskeletal joint is replaced) performed on 3/22/2016.</p> <p>Admission Minimum Data Set (MDS) assessment, dated 4/2/2016, indicated a Brief Interview for Mental Status of 15 out of 15; indicating the resident was cognitively intact. The resident required</p>	F 0157	<p>Submission of this plan of correction is not an admission by Covered Bridge Health Campus that the deficiencies alleged in this survey are accurate or depict the quality of services provided to the residents of this health care facility. This plan of correction is submitted timely in accordance with state and federal regulatory guidelines. This plan of correction is intended to serve as the health facility's credible allegation of compliance with state and federal regulatory requirements.</p> <ol style="list-style-type: none"> Resident B was discharged to the hospital from the physician appointment on 4/13/16 and did not return to the facility. All other residents have the potential to be affected. All nurses will be in serviced by 6/5/16 on the policy and procedure for physician notification, for resident assessments, and for changes in conditions/events related to falls or wounds. The in servicing will be conducted by the DHS, ADHS, UM, or Medical Records staff. All condition changes/events will be reviewed 5 time per week in the Clinical Care Meeting by the Interdisciplinary team to ensure change in condition events, fall 	06/05/2016

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	<p>extensive, 2+ physical assist for transfers and toileting.</p> <p>A Care Plan for Resident B, initiated 4/5/2016, indicated, "Problem: Resident has surgical wound to right knee following a right TKR [total knee replacement]...Approach: ...Record the amount, type, consistency, color, and odor of drainage from the wound if any...Report complications (e.g., ...hemorrhage...dehiscence..."</p> <p>Resident B's Orthopedic Follow-Up, dated 4/6/2016, indicated, "...Site: knee. Exam Site: Right. Exam: Clean, dry, intact, no erythema [redness], no purulence, no s/s infection....Patient is doing well...The wound looks good today."</p> <p>A Skin Integrity Event for Resident B, dated 3/26/2016, indicated, "...1. Incision present on admission? Yes. 2. Describe location of incision: rt [right] knee. 3. Length (cm) [centimeter]: Head to Toe (12 to 6 o'clock): 19 cm. 4. Width (cm): Side to Side (3 to 9 o'clock): 0 cm. 5. Depth (cm): 0 cm. Exudate [fluid from a wound]: No exudate. Wound Edges: Smooth. Well-approximated. Wound approximated with? Dermabond...Section 2: Incision Documentation (ongoing up to 10 weeks):</p>		<p>events and physician/family notifications are conducted timely.</p> <p>4. The DHS, ADHS, Unit Manager, or Medical Records will review each 24 hour Facility Activity Report 5 day per week to ensure follow up is conducted timely and all appropriate notifications to physicians and families have been conducted per policy and procedure for physician and family notification. On weekends and holidays the on call nurse will review each facility activity report to verify follow up and notifications are conducted. If concerns are identified the DHS and ED will be notified immediately for correction.</p> <p>The results of the audits will be reported, reviewed, and trended for compliance thru the campus Quality Assurance Committee will meet on a monthly basis. The review will continue monthly until substantial compliance has been achieved. Home Office Clinical Support Nurse will attend the monthly QA meeting for the next 3 months to review results of the audits and QA findings to provide additional monitoring and oversight to ensure ongoing compliance</p>	

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	<p>Re-assessment/measurement 1: Date: 3/28/2016: Incision length: 19 cm. Incision depth: 0 cm. Incision width: 0 cm. No exudate noted.</p> <p>Re-assessment/measurement 1: Date: 4/4/2016: Incision length: 19 cm. Incision depth: 0 cm. Incision width: 0 cm. No exudate noted..."</p> <p>Re-assessment/measurements for weeks three through 10 were blank. There was no evidence of additional documentation of wound measurements until the following Skin Integrity Report, dated 4/13/2016.</p> <p>Resident Progress Notes, dated 4/11/2016 at 9:18 p.m., indicated, "Resident picking at knee wound, causing bleeding; covered with telfa island dressing to protect at this time."</p> <p>Resident Progress Notes, dated 4/12/2016 at 9:30 a.m. (recorded as late entry 4/13/2016 at 11:40 a.m.), indicated, "[Surgeon] office notified of rt [right] knee bleeding in middle of incision line. No s/s [signs or symptoms of] infection noted..."</p> <p>Resident Progress Notes, dated 4/12/2016 at 3:56 p.m., indicated, "Call from [surgeon] office that resident needs to be seen tomorrow at 10 a.m..."</p>			

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	<p>Physical Therapy Daily Treatment Note, dated 4/12/2016 [no time], indicated, "Pt [patient] this am [sic] came to therapy with dressing on his R TKR [total knee replacement] site had blood saturated. Nursing notes she had just dressed his knee and again redressed the knee. Pt had an open area on his R [right] incision site that was draining blood. Pt notes that when he was transferring to the toilet last night he felt a 'twinge like I had been shot by a bullet'..."</p> <p>Resident Progress Notes, dated 4/13/2016 at 1:15 a.m., indicated, "CNA [Certified Nursing Assistant] came and got this nurse. Resident laying on back next to bed. Alert and oriented x 3...Resident stated he rolled over and slid out of bed. Assessed resident he was able to move all extremities. Denies pain or discomfort. 3 people to assist back in bed...[Spouse] and [primary physician] notified."</p> <p>Resident B's Skin Integrity Report, dated 4/13/2016 at 8:30 a.m., indicated, "...Description: Rt [right] knee surgical incision dehiscance [sic]...3. Length (cm) [centimeter]: Head to Toe (12 to 6 o'clock): 13 cm. 4. Width (cm): Side to Side (3 to 9 o'clock): 1.5 cm. 5. Depth (cm)... res [resident] to see surgeon this am, signee not comfortable disturbing wound/risk of increased bleeding..." The</p>			

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	<p>Skin Integrity Report did not indicate a mechanism of injury, cause for dehiscence, or any previous wound concerns.</p> <p>The following Resident Progress Notes, dated 4/13/2016 at 8:34 a.m., indicated, "...pressure dressing applied to RT knee to aid in reducing bleeding et [and] to keep covered to reduce risk of infection to dehisced rt tkr. edges of wound open 1.5 cm wide."</p> <p>Resident Progress Notes, dated 4/13/2016 at 9:32 a.m., indicated, "Res follow up fall with no injuries noted. Res ate breakfast in bed this am d/t [due to] incision complications..."</p> <p>Orthopedic Operative Note, dated 4/13/16 at 7:12 p.m., indicated, "Preoperative Diagnosis: Right knee wound dehiscence. Postoperative Diagnoses: 1. Right knee wound dehiscence. 2. Quadriceps tendon rupture. Procedure: Right knee incision and drainage with polyethylene exchange and quadriceps tendon repair and wound closure...Indication for Procedure: ...status post fall at the nursing home with right total knee wound dehiscence...It should be noted that the quadriceps tendon was completely avulsed off the superior aspect of the patella [knee bone]</p>			

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	<p>and there was a partial arthrotomy [creation of an opening in a joint that may be used in drainage] rupture distally...debride the knee of soft tissue debris...placed a new...polyethylene liner [plastic portion of artificial knee joint] into place. I repaired the arthrotomy rupture..."</p> <p>Resident B's Hospital Consultation Report, dictated by his primary care physician and dated 4/15/2016, indicated, "...Apparently on the early morning hours of the date of his presentation to [surgeon's office] on the 13th, he had a fall out of bed...The fall was not reported to my [sic] by the skilled nursing facility and did not learn on that until [surgeon] called me..."</p> <p>The Physical Therapy (PT) Director was interviewed on 5/4/2016 at 2:38 p.m. She indicated she saw Resident B just after breakfast and before therapy on 4/12/2016. She indicated Resident B described having right knee pain following being assisted to the bathroom 4/11/2016. She indicated that Resident B described a "twinge" and that it "felt like a bullet" when he transferred to the commode.</p> <p>Resident B's Orthopaedic Surgeon was interviewed on 5/5/2016 at 11:44 a.m.</p>			

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	<p>He indicated, "We got conflicting stories [from the facility]. Initially they said he had a little wound issue because he was picking at his wound or he might have bumped it at night. They didn't tell us he fell...even after he showed up here. They kept saying he may have bumped his knee. His knee was completely busted open. There is no way picking at it or bumping it would have gotten it to that level...The amount of damage done...his knee would have had to buckle underneath him...be hyperflexed.</p> <p>[Resident B] ruptured the native tendon under his knee cap. It was more violent than they described...more violent than rolling out of bed...No way that happened on transport [from facility to appointment]. It had to be a violent fall. The blood on the dressing was coagulated so it wasn't acute...." The surgeon described the right knee wound as "seven inches long, full thickness, down to the bone and metal implant."</p> <p>The Orthopaedic Surgeon's X-Ray Technician and Assistant was interviewed on 5/5/2016 at 11:52 a.m. She indicated she received a call on the facility 5/12/2016 and indicated, "They felt like he may have bumped his knee through the night and it was bleeding pretty good, but made it seem like it wasn't a big issue." When the surgeon's</p>			

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	<p>assistant called the facility to relay that the surgeon wanted to see the resident the following day, the assistant indicated, "The nurse said, 'Well I don't know why they told you he bumped it. He's picking it open.'" The assistant indicated, "When the resident turned up [for scheduled appointment on 4/13/2016 at 10 a.m.] we were in total shock [at the knee]. Nobody reported the fall. They stuck with the story that he may have bumped his knee until the doc called and said, 'There's no way.' Finally they said that he fell."</p> <p>On 5/5/2016 at 10:20 a.m., the Director of Nursing Services (DNS) indicated there was no fall event or fall investigation related to Resident B's documented fall on 4/13/2016 at 1:15 a.m.</p> <p>Resident B's son was interviewed on 5/5/2016 at 10:44 a.m. He indicated he visited his father almost daily after work and would arrive at the facility between 6:30 p.m. and 7:00 p.m. Resident B's son indicated when he arrived on 4/11/2016, his fathers sheets were "saturated with blood...looked like it was watered down, like with drainage." The son indicated there was a "scabbed area [on the resident's right knee] leaking fluid." He described the fluid as "running down his</p>			

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	<p>[Resident B's leg]...it just kept streaming down his leg and I kept wiping it...I brought it to her [nurse on duty] attention and she just didn't seem to care."</p> <p>Resident B's son described the drainage as "saturating a two-foot area on the sheets." Resident B's son indicated the nurse on duty indicated to him Resident B had been "picking at his knee." The right knee was not covered with any dressing or bandage and the sheets were not changed during the two hours Resident B's son was there. Resident B's son indicated he did not see his father picking at his knee and his father denied picking at his knee. Resident B's son indicated his father told him on 4/13/2016 about an incident on the commode which occurred on 4/11/2016. He indicated, "My dad told me he was in the bathroom...and she [staff assisting him] was rough. She told him, 'You need to work.' Then she twisted him and when she did, he [Resident B] said, 'It [right knee] popped and I screamed.' He said something about a 'twinge.' He said the nurse said, 'If something was really wrong, you'd scream a lot louder than that.'" Resident B's son indicated he was the Power of Attorney and first contact for his father. The facility did not notify him at any time of the wound dehiscence and did not notify him that his father had fallen. Resident B's son indicated he was</p>			

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	<p>not notified of his father's fall until he received a call from his mother around 6:30 a.m. on 4/13/2016 and she reported to him that the facility had just called her and indicated he had fallen and there was a "one inch dash in his knee where it was leaking and separated." Resident B's son indicated he met Resident B at the Surgeon's office for his scheduled 10:00 a.m. appointment on 4/13/2016. He indicated, "When the doc opened the bandage, we were all in shock. It was ten to twelve inches long and completely open. I could see the metal implant. [Surgeon] said the tendon was torn from the top of his knee cap."</p> <p>On 5/5/2016 at 3:28 p.m., the DNS indicated, "I would expect they [nursing staff] would send that information [regarding fall] with him to the appointment."</p> <p>On 5/5/2016 at 4:10 p.m., the Executive Director (ED) indicated the nurse did not check Resident B's surgical wound after the fall, but should have.</p> <p>Resident B was interviewed on 5/6/2016 at 10:10 a.m. via phone. The resident indicated one person frequently assisted him to the bathroom and indicated, "It was hard to get that many together. Every once in a while it would take quite</p>			

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	<p>a while to get just one." Resident B indicated he could not recall who assisted him with toileting on 4/11/2016, but did remember that it was one person. Resident B indicated, "I was taking therapy. I needed to go to the restroom...needed to get on the commode and she said, 'You're gonna [sic] have to help me more than you are' and I said, 'I can't.' She put her hands on my shoulder and spun me around and put me on the commode. I hollered [sic] because it hurt bad. It done something wrong. She said, 'If it was really hurt, you'd have yelled louder than that.' Resident B indicated he could not recall dates, but did recall blood on his his sheets. The resident indicated, "There was quite a bit of blood on them [sheets]. [They were] soaked all the way through and dripping." The resident indicated, "They [facility staff] were aware of that, but not too concerned." Resident B indicated he did not recall picking at his knee.</p> <p>On 5/6/2016 at 12:46 p.m., the DNS indicated she was not aware of the incident on the commode on 4/11/2016 until 5/4/2016 when she reviewed the PT note.</p> <p>On 5/6/2016 at 12:46 p.m., the ED and DNS were interviewed. The ED indicated, "We thought the dehiscence</p>			

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	<p>wasn't related to the fall. It [dehiscence] was an underlying issue. I think if he hadn't fallen that night, that wound still would have opened up." The DNS indicated, "Me too."</p> <p>A copy of the current Falls Management Program Guidelines Policy and Procedure was provided by the ED on 5/4/2016 at 4:12 p.m. The procedure indicated, "...3. Should the resident experience a fall the attending nurse shall complete the 'Fall Circumstance and Reassessment Form'...4. The staff member attending to the resident at the time of the incident should notify the attending physician or medical director..."</p> <p>A copy of the current Change in Condition Form Guidelines Policy and Procedure was provided by the ED on 5/5/2016 at 3:45 p.m. The purpose indicated, "To facilitate the thorough and consistent review and completion of the nursing process...documents the change in resident status, care plan update and notification of change. Procedure: 1. Upon assessment of a resident change in status, the nurse shall initiate the Condition Change Form in order to fully reflect and document the nursing process...3. The nurse will notify the physician..."</p>			

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F 0309 SS=G Bldg. 00	<p>A copy of the current Physician Notification Guidelines Policy and Procedure was provided by the DNS on 5/5/2016 at 3:45 p.m. The purpose indicated, "To ensure the resident's physician is aware of all...change in condition in a timely manner...1. Resident assessments for change in condition, suspected injury, event of unknown origin...should be completed in a timely manner. 2. The physician should be notified of...an immediate need by phone as soon as the results are known..."</p> <p>These Federal and State tags are related to Complaint IN00199124.</p> <p>3.1-5(a)(1) 3.1-5(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to accurately assess,</p>	F 0309	1. Resident B was discharged to the hospital from the physician appointment on 4/13/16 and did	06/05/2016

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	<p>document and notify the physician of changes related to a resident's wound dehiscence (surgical complication in which a wound ruptures along a surgical incision), which resulted in harm in that the resident experienced two accidents (during an improper transfer and fall), which resulted in a total wound dehiscence and new quadriceps tendon rupture of a previously approximated total right knee arthroplasty (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 5/4/2016 at 10:45 a.m. Diagnoses included, but were not limited to, hypertension, diabetes, and osteoarthritis. The resident was admitted to the facility, on 3/26/2016, for aftercare following an elective right knee total arthroplasty (orthopedic surgical procedure where the articular surface of a musculoskeletal joint is replaced) performed on 3/22/2016.</p> <p>Admission Minimum Data Set (MDS) assessment, dated 4/2/2016, indicated a Brief Interview for Mental Status of 15 of 15; indicating the resident was cognitively intact. The resident required extensive, 2+ physical assist for transfers and toileting.</p>		<p>not return to the facility.</p> <p>2. All other residents have the potential of being affected.</p> <p>3. The ED and DHS will be re-educated by Home office Clinical support Nurse on the policy for falls, with emphasis placed on completing fall investigations after an incident has occurred. All nursing staff will be re-educated by the Director of Health Services or ADHS by 6/5/16 on the policy and procedure falls, physician notifications, nursing assessment, change in condition and wound observation and documentation. All current residents with surgical incisions will have their incisions reassessed and documented in the medical record. The reassessments will be conducted by the DHS and ADHS. All direct care staff will be re-educated on following the ADL plan of care for residents with emphasis placed on assistance needed for transfers. The in servicing will conducted by the DHS and ADHS.</p> <p>4. Random unannounced observations of transfers being performed by the direct care staff will be conducted by the DHS, ADHS or unit manager until all direct care staff have been observed to verify understanding of the education provided. A</p>				

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	<p>Physician's Order's for Resident B indicated, "Start Date: 3/26/2016. Change telfa island dressing to right knee...once a day. D/C [discontinue date]: 4/7/2016..."</p> <p>A Care Plan for Resident B, initiated 4/5/2016, indicated, "Problem: Resident has surgical wound to right knee following a right TKR [total knee replacement]...Approach: ...Record the amount, type, consistency, color, and odor of drainage from the wound if any...Report complications (e.g., ...hemorrhage...dehiscence..."</p> <p>A Care Plan for Resident B, initiated 4/5/2016, indicated, "Problem: My ability to transfer, walk in room, walk in corridor, dress, eat, toilet, maintain personal hygiene, has deteriorated R/T Right total knee replacement...Approach: ...Provide extensive assist for ADL's [activities of daily living]..."</p> <p>A Care Plan for Resident B, initiated 4/6/2016, indicated, "Problem: I am at risk for falling R/T [related to] medication usage with side effects, and decreased mobility related to Right knee replacement...Approach: ...I require assist with transfers..."</p> <p>Resident B's Orthopedic Follow-Up,</p>		<p>minimum of 2 observations will be conducted on a daily basis for 6 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks. Re-education will be provided for staff if indicated.</p> <p>The DHS , ADHS or unit manager will randomly audit the weekly skin documentation on a minimum of 5 residents with wounds, including any surgical wounds daily for 6 weeks, then 3 times a week for 4weeks , then weekly for 4 weeks to verify the wounds are being assessed and documented per the policy and procedure for wound documentation.</p> <p>The DHS or ADHS will review each 24 hour Facility Activity Report daily in the Clinical Care Meeting to ensure that all notifications of change in condition and falls have been conducted. In addition, all falls will be reviewed in the daily Clinical Care Meeting 5 times per week to ensure a full investigation has been conducted and documented, and this will be conducted on an ongoing basis. On weekends and holidays the nursing administration on call will be notified of all falls to ensure all notifications and investigations are conducted. This will continue until substantial compliance has been achieved.</p> <p>The results of the</p>	

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	<p>dated 4/6/2016, indicated, "...Site: knee. Exam Site: Right. Exam: Clean, dry, intact, no erythema [redness], no purulence, no s/s infection...Patient is doing well...The wound looks good today."</p> <p>A Skin Integrity Even for Resident B, dated 3/26/2016, indicated, "...1. Incision present on admission? Yes. 2. Describe location of incision: rt [right] knee. 3. Length (cm) [centimeter]: Head to Toe (12 to 6 o'clock): 19 cm. 4. Width (cm): Side to Side (3 to 9 o'clock): 0 cm. 5. Depth (cm): 0 cm. Exudate [fluid from a wound]: No exudate. Wound Edges: Smooth. Well-approximated. Wound approximated with? Dermabond...Section 2: Incision Documentation (ongoing up to 10 weeks): Re-assessment/measurement 1: Date: 3/28/2016: Incision length: 19 cm. Incision depth: 0 cm. Incision width: 0 cm. No exudate noted. Re-assessment/measurement 1: Date: 4/4/2016: Incision length: 19 cm. Incision depth: 0 cm. Incision width: 0 cm. No exudate noted..." The completed/closed date indicated 4/9/2016. Re-assessment/measurements for weeks three through 10 were blank. There was no evidence of additional documentation of wound measurements until the following Skin Integrity Report,</p>		<p>audits/interviews will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee on a monthly basis. Home Office Clinical Support Nurse will attend the monthly QA meeting for the next 3 months to review results of the audits and QA findings to provide additional monitoring and oversight to ensure ongoing compliance.</p>	

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	<p>dated 4/13/2016.</p> <p>Resident Progress Notes, dated 4/11/2016 at 9:18 p.m., indicated, "Resident picking at knee wound, causing bleeding; covered with telfa island dressing to protect at this time."</p> <p>Resident Progress Notes, dated 4/12/2016 at 9:30 a.m. (recorded as late entry 4/13/2016 at 11:40 a.m.), indicated, "[Surgeon] office notified of rt [right] knee bleeding in middle of incision line. No s/s [signs or symptoms of] infection noted..."</p> <p>Resident Progress Notes, dated 4/12/2016 at 3:56 p.m., indicated, "Call from [surgeon] office that resident needs to be seen tomorrow at 10 a.m..."</p> <p>Physical Therapy (PT) Daily Treatment Note, dated 4/12/2016 [no time], indicated, "Pt [patient] this am [sic] came to therapy with dressing on his R TKR [total knee replacement] site had blood saturated. Nursing notes she had just dressed his knee and again redressed the knee. Pt had an open area on his R [right] incision site that was draining blood. Pt notes that when he was transferring to the toilet last night he felt a 'twinge like I had been shot by a bullet'..."</p>			

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	<p>Resident Progress Notes, dated 4/13/2016 at 1:15 a.m., indicated, "CNA [Certified Nursing Assistant] came and got this nurse. Resident laying on back next to bed. Alert and oriented x 3...Resident stated he rolled over and slid out of bed. Assessed resident he was able to move all extremities. Denies pain or discomfort. 3 people to assist back in bed...[Spouse] and [primary physician] notified."</p> <p>Resident B's Skin Integrity Report, dated 4/13/2016 at 8:30 a.m., indicated, "...Description: Rt [right] knee surgical incision dehiscence [sic]...3. Length (cm) [centimeter]: Head to Toe (12 to 6 o'clock): 13 cm. 4. Width (cm): Side to Side (3 to 9 o'clock): 1.5 cm. 5. Depth (cm)...: res [resident] to see surgeon this am, signee not comfortable disturbing wound/risk of increased bleeding..." The Skin Integrity Report did not indicate a mechanism of injury, cause for dehiscence, or any previous wound concerns.</p> <p>The following Resident Progress Notes, dated 4/13/2016 at 8:34 a.m., indicated, "...pressure dressing applied to RT knee to aid in reducing bleeding et to keep covered to reduce risk of infection to dehisced rt tkr. edges of wound open 1.5 cm wide."</p>			

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	<p>Resident Progress Notes, dated 4/13/2016 at 9:32 a.m., indicated, "Res follow up fall with no injuries noted. Res ate breakfast in bed this am d/t incision complications..."</p> <p>Orthopedic Operative Note, dated 4/13/16 at 7:12 p.m., indicated, "Preoperative Diagnosis: Right knee wound dehiscence. Postoperative Diagnoses: 1. Right knee wound dehiscence. 2. Quadriceps tendon rupture. Procedure: Right knee incision and drainage with polyethylene exchange and quadriceps tendon repair and wound closure...Indication for Procedure: ...status post fall at the nursing home with right total knee wound dehiscence...It should be noted that the quadriceps tendon was completely avulsed off the superior aspect of the patella [knee bone] and there was a partial arthrotomy [creation of an opening in a joint that may be used in drainage] rupture distally...debride the knee of soft tissue debris...placed a new...polyethylene liner [plastic portion of artificial knee joint] into place. I repaired the arthrotomy rupture..."</p> <p>Resident B's Hospital Consultation Report, dictated by his primary care physician and dated 4/15/2016, indicated,</p>			

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	<p>"...Apparently on the early morning hours of the date of his presentation to [surgeon's office] on the 13th, he had a fall out of bed...The fall was not reported to my [sic] by the skilled nursing facility and did not learn on that until [surgeon] called me..."</p> <p>The Physical Therapy Director was interviewed on 5/4/2016 at 2:38 p.m. She indicated she saw Resident B just after breakfast and before therapy on 4/12/2016. She indicated Resident B described having right knee pain following being assisted to the bathroom 4/11/2016. She indicated that Resident B described a "twinge" and that it "felt like a bullet" when he transferred to the commode.</p> <p>Resident B's Orthopaedic Surgeon was interviewed on 5/5/2016 at 11:44 a.m. He indicated, "We got conflicting stories [from the facility]. Initially they said he had a little wound issue because he was picking at his wound or he might have bumped it at night. They didn't tell us he fell...even after he showed up here. They kept saying he may have bumped his knee. His knee was completely busted open. There is no way picking at it or bumping it would have gotten it to that level...The amount of damage done...his knee would have had to buckle</p>			

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	<p>underneath him...be hyperflexed. [Resident B] ruptured the native tendon under his knee cap. It was more violent than they described...more violent than rolling out of bed...No way that happened on transport [from facility to appointment]. It had to be a violent fall. The blood on the dressing was coagulated so it wasn't acute..." The surgeon described the right knee wound as "seven inches long, full thickness, down to the bone and metal implant."</p> <p>The Orthopedic Surgeon's X-Ray Technician and Assistant was interviewed on 5/5/2016 at 11:52 a.m. She indicated she received a call on the facility 5/12/2016 and indicated, "They felt like he may have bumped his knee through the night and it was bleeding pretty good, but made it seem like it wasn't a big issue." When the surgeon's assistant called the facility to relay that the surgeon wanted to see the resident the following day, the assistant indicated, "The nurse said, 'Well I don't know why they told you he bumped it. He's picking it open.'" The assistant indicated, "When the resident turned up [for scheduled appointment on 4/13/2016 at 10 a.m.] we were in total shock [at the knee]. Nobody reported the fall. They stuck with the story that he may have bumped his knee until the doc called and said,</p>			

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	<p>'There's no way.' Finally they said that he fell."</p> <p>On 5/5/2016 at 10:20 a.m., the Director of Nursing Services (DNS) indicated there was no fall event or fall investigation related to Resident B's documented fall on 4/13/2016 at 1:15 a.m.</p> <p>Resident B's son was interviewed on 5/5/2016 at 10:44 a.m. He indicated he visited his father almost daily after work and would arrive at the facility between 6:30 p.m. and 7:00 p.m. Resident B's son indicated when he arrived on 4/11/2016, his fathers sheets were "saturated with blood...looked like it was watered down, like with drainage." The son indicated there was a "scabbed area [on the resident's right knee] leaking fluid." He described the fluid as "running down his [Resident B's leg]...it just kept streaming down his leg and I kept wiping it...I brought it to her [nurse on duty] attention and she just didn't seem to care."</p> <p>Resident B's son described the drainage as "saturating a two-foot area on the sheets." Resident B's son indicated the nurse on duty indicated to him Resident B had been "picking at his knee." The right knee was not covered with any dressing or bandage and the sheets were not changed during the two hours</p>			

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	<p>Resident B's son was there. Resident B's son indicated he did not see his father picking at his knee and his father denied picking at his knee. Resident B's son indicated his father told him on 4/13/2016 about an incident on the commode which occurred on 4/11/2016. He indicated, "My dad told me he was in the bathroom...and she [staff assisting him] was rough. She told him, 'You need to work.' Then she twisted him and when she did, he [Resident B] said, 'It [right knee] popped and I screamed.' He said something about a 'twinge.' He said the nurse said, 'If something was really wrong, you'd scream a lot louder than that.'" Resident B's son indicated he was the Power of Attorney and first contact for his father. The facility did not notify him at any time of the wound dehiscence and did not notify him that his father had fallen. Resident B's son indicated he was not notified of his father's fall until he received a call from his mother around 6:30 a.m. on 4/13/2016 and she reported to him that the facility had just called her and indicated he had fallen and there was a "one inch dash in his knee where it was leaking and separated." Resident B's son indicated he met Resident B at the Surgeon's office for his scheduled 10:00 a.m. appointment on 4/13/2016. He indicated, "When the doc opened the bandage, we were all in shock. It was ten</p>			

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	<p>to twelve inches long and completely open. I could see the metal implant. [Surgeon] said the tendon was torn from the top of his knee cap."</p> <p>On 5/5/2016 at 4:10 p.m., the Executive Director (ED) indicated the nurse did not check Resident B's surgical wound after the fall, but should have. He indicated a Fall Event Form and/or Change in Condition Form were not initiated, and the surgeon was not notified of the fall because the resident had an appointment to see the physician later that day.</p> <p>Resident B was interviewed on 5/6/2016 at 10:10 a.m. via phone. The resident indicated one person frequently assisted him to the bathroom and indicated, "It was hard to get that many together. Every once in a while it would take quite a while to get just one." Resident B indicated he could not recall who assisted him with toileting on 4/11/2016, but did remember that it was one person. Resident B indicated, "I was taking therapy. I needed to go to the restroom...needed to get on the commode and she said, 'You're gonna [sic] have to help me more than you are' and I said, 'I can't.' She put her hands on my shoulder and spun me around and put me on the commode. I hollered [sic] because it hurt bad. It done something wrong. She said,</p>			

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	<p>'If it was really hurt, you'd have yelled louder than that.' Resident B indicated he could not recall dates, but did recall blood on his his sheets. The resident indicated, "There was quite a bit of blood on them [sheets]. [They were] soaked all the way through and dripping." The resident indicated, "They [facility staff] were aware of that, but not too concerned." Resident B indicated he did not recall picking at his knee.</p> <p>On 5/6/2016 at 12:46 p.m., the DNS indicated she was not aware of the incident on the commode on 4/11/2016 until 5/4/2016 when she reviewed the PT note.</p> <p>On 5/6/2016 at 12:46 p.m., the ED and DNS were interviewed. The ED indicated, "We thought the dehiscence wasn't related to the fall. It [dehiscence] was an underlying issue. I think if he hadn't fallen that night, that wound still would have opened up." The DNS indicated, "Me too."</p> <p>A copy of the current Falls Management Program Guidelines Policy and Procedure was provided by the ED on 5/4/2016 at 4:12 p.m. The procedure indicated, "...3. Should the resident experience a fall the attending nurse shall complete the 'Fall Circumstance and</p>			

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NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W TIPTON ST SEYMOUR, IN 47274
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F 9999 Bldg. 00	<p>Reassessment Form'...4. The staff member attending to the resident at the time of the incident should notify the attending physician or medical director..."</p> <p>A copy of the current Change in Condition Form Guidelines Policy and Procedure was provided by the ED on 5/5/2016 at 3:45 p.m. The purpose indicated, "To facilitate the thorough and consistent review and completion of the nursing process...documents the change in resident status, care plan update and notification of change. Procedure: 1. Upon assessment of a resident change in status, the nurse shall initiate the Condition Change Form in order to fully reflect and document the nursing process...3. The nurse will notify the physician..."</p> <p>These Federal and State tags are related to Complaint IN00199124.</p> <p>3.1-37(a)</p> <p>Based on record review and interview, the facility failed to notify the state agency of a major accident with injury for one resident who sustained a fall which</p>	F 9999	<p>1. The resident was discharged to the hospital from the physician appointment and did not return to the facility.</p> <p>2. All other residents have a</p>	06/05/2016

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	<p>resulted in a total wound dehiscence (surgical complication in which a wound ruptures along a surgical incision) and new quadriceps tendon rupture of a previously approximated total right knee arthroplasty (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 5/4/2016 at 10:45 a.m. Diagnoses included, but were not limited to, hypertension, diabetes, and osteoarthritis. The resident was admitted to the facility on 3/26/2016 for aftercare following an elective right knee total arthroplasty (orthopedic surgical procedure where the articular surface of a musculoskeletal joint is replaced) performed on 3/22/2016.</p> <p>Resident Progress Notes, dated 4/13/2016 at 1:15 a.m., indicated, "CNA [Certified Nursing Assistant] came and got this nurse. Resident laying on back next to bed. Alert and oriented x 3...Resident stated he rolled over and slid out of bed. Assessed resident he was able to move all extremities. Denies pain or discomfort. 3 people to assist back in bed..."</p> <p>Resident B's Skin Integrity Report, dated 4/13/2016 at 8:30 a.m., indicated, "...Description: Rt [right] knee surgical</p>		<p>potential of being affected.</p> <p>3. The ED, DHS, and ADHS will be re-educated on the state reportable guidelines by the Divisional Vice President and/or Clinical Nurse Consultant by 6/5/16.</p> <p>4. Any event that occurs that meets the state reportable guidelines will be reported to the ISDH per policy. The Divisional Vice President and/or Clinical Nurse Consultant will be notified of any event that occurs that may meet guidelines so that it may be reviewed and submitted to ISDH as indicated.</p> <p>The results of the audits/interviews will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee monthly for a minimum of 6 months.</p>		

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	<p>incision dehiscence [sic]...3. Length (cm) [centimeter]: Head to Toe (12 to 6 o'clock): 13 cm. 4. Width (cm): Side to Side (3 to 9 o'clock): 1.5 cm. 5. Depth (cm)...: res [resident] to see surgeon this am, signee not comfortable disturbing wound/risk of increased bleeding...." The Skin Integrity Report did not indicate a mechanism of injury, cause for dehiscence, or any previous wound concerns.</p> <p>The following Resident Progress Notes, dated 4/13/2016 at 8:34 a.m., indicated, "...pressure dressing applied to RT knee to aid in reducing bleeding et [and] to keep covered to reduce risk of infection to dehisced rt tkr. [total knee replacement] edges of wound open 1.5 cm wide."</p> <p>Orthopedic Operative Note, dated 4/13/16 at 7:12 p.m., indicated, "Preoperative Diagnosis: Right knee wound dehiscence. Postoperative Diagnoses: 1. Right knee wound dehiscence. 2. Quadriceps tendon rupture. Procedure: Right knee incision and drainage with polyethylene exchange and quadriceps tendon repair and wound closure...Indication for Procedure: ...status post fall at the nursing home with right total knee wound dehiscence...It should be noted that the quadriceps</p>			

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	<p>tendon was completely avulsed off the superior aspect of the patella [knee bone] and there was a partial arthrotomy [creation of an opening in a joint that may be used in drainage] rupture distally...debride the knee of soft tissue debris...placed a new...polyethylene liner [plastic portion of artificial knee joint] into place. I repaired the arthrotomy rupture..."</p> <p>Resident B's Orthopaedic Surgeon was interviewed on 5/5/2016 at 11:44 a.m. He indicated, "We got conflicting stories [from the facility]...They kept saying he may have bumped his knee. His knee was completely busted open. There is no way picking at it or bumping it would have gotten it to that level...The amount of damage done...his knee would have had to buckle underneath him...be hyperflexed. [Resident B] ruptured the native tendon under his knee cap. It was more violent than they described...more violent than rolling out of bed...No way that happened on transport [from facility to appointment]. It had to be a violent fall. The blood on the dressing was coagulated so it wasn't acute..." The surgeon described the right knee wound as "seven inches long, full thickness, down to the bone and metal implant."</p>			

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	<p>On 5/5/2016 at 3:55 p.m., the ED indicated the fall was not reported to the State agency because the right knee was a surgical site and a pre-existing condition.</p> <p>On 5/6/2016 at 12:46 p.m., the ED and DNS were interviewed. The ED indicated, "We thought the dehiscence wasn't related to the fall. It [dehiscence] was an underlying issue. I think if he hadn't fallen that night, that wound still would have opened up." The DNS indicated, "Me too."</p> <p>A copy of the current Reportable Event Procedural Guidelines was provided by the Director of Nursing Services (DNS) on 5/5/2016 at 3:34 p.m. The procedure indicated, "1. Occurrences to be report [sic] include: ...e. injuries of unknown origin...i. significant injuries...iii. Large lacerations or contusions (of unknown origin or requires hospitalization > 23 hours).</p> <p>The State Agency Incident Reporting Policy, effective date 7/15/2015, indicated "...C. Types of incidents reportable under State laws only: MAJOR ACCIDENTS: Unexpected or unintentional events resulting in any fracture or any other outcomes that require medical attention beyond basic</p>			

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	<p>first aid or ER/Physician evaluation. Note: Includes injuries from improper care techniques. Examples: ...Injury that limits the ability of the resident to perform his/her normal activities..."</p> <p>This State tag is related to Complaint IN00199124.</p> <p>3.1-13(g)(1)(D)</p>				