STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIARWOOD HEALTH AND REHABILITATION CENTER	3640 N CENTRAL AVE INDIANAPOLIS, IN 46205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. Dates of Survey: January 8, 9, 10, 13, 14, 15, and 16, 2014 Facility number: 009569 Provider number: 155628 AIM number: 200139920 Survey team: Courtney Mujic, RN,TC Karina Gates, BHS Beth Walsh, RN Tom Stauss, RN Census bed type: SNF/NF: 79 Total: 79 Census payor type: Medicare: 6 Medicaid: 72 Other: 1 Total: 79 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on January 25, 2014, by Janelyn Kulik, RN.	F000000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review,	F000164	The following Plan of Correction constitutes our written allegation	02/15/2014

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	the facility failed to ensure a resident's privacy was maintained during wound treatment by his Nurse Practitioner for 1 of 1 resident randomly reviewed for privacy. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 1/13/14 at 2:00 p.m. The diagnoses for Resident #21 included, but were not limited to, cellulitis, abscess of leg, peripheral vascular disease, lower leg arthropathy, and hypertension. On 1/10/2014 at 11:40 a.m., an observation was made of Resident #21 sitting in his wheelchair in his room, with his NP (Nurse Practitioner) present. The NP was crouched on the floor removing the resident's lower left extremity bandage, which consisted of gauze and a mepilex border (all-in-one foam dressing that effectively absorbs and retains exudate and maintains a moist wound environment). The door to Resident #21's room was wide open. 3.1-3(i)		of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. It is the practice of this facility to ensure that residents have the right to personal privacy and confidentiality of his or her personal and clinical records.1. The Administrator closed the door at time of observation in order to provide privacy for the resident. A one to one in-service was completed with the vendor on dignity and privacy.2. All residents have the potential to be affected by this alleged deficiency.3. All nursing staff will be in-serviced on dignity, privacy and their role in educating and intervening when dignity or privacy issues arise with both employee and non employees.4. DON or designee will complete dignity and privacy auditing tool weekly x 4, and then ongoing monthly. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14	

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to provide activities as a substitute for missed weekly outings for 1 of 2 residents reviewed for activities out of 2 who met the criteria for activities. (Resident #4.) Findings include: Resident #4's clinical record was reviewed on 1/14/2014 at 2:20 pm. The resident's diagnoses included, but were not limited t,; infantile cerebral palsy, intellectual disabilities. An interview with a confidential family member of Resident #4, on 1/10/2014 at 10:45 am, indicated, "I don't know exactly what's going on, but she (the resident) used to have a social worker who would take her out on outings, like to the library. For the past year or so the social worker hasn't been coming, because of some reason. The facility has said that they are trying to do something	F000248	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Planof Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.1. The interview with the confidential family member was her 90 year old mother who is declining due to age. She has not been the person who comes to the care plan meetings or communicates with the staff and does not have the current information. The sister is the primary contact person chosen by the family. She is the one who attends the meetings and receives communication regarding the resident.The resident had not gone on outings for approximately two years when specialized service provider went out of business. Until this past June there were no agencies accepting clients. When the current agency met with the resident, she refused to go on outside activities. Although the surveyor documented observation	02/15/2014

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	about it, and that they are working on it. She doesn't really go to any activities in the facility. The facility doesn't provide her with books or music." A PASRR (Preadmission Screening and Resident Review) Level 2 assessment dated 1/4/2013, indicated, "Educational/vocational information:...She currently receives OBRA habilitation services. The listed outcome/goal is (Resident #4's name) would like to access the community on a weekly basis. She primarily visits the library during these outings. (Resident #4's name) mother and sister will sometimes meet her at the library. Recommendations: 2. (Resident #4's name) continues to benefit from encouragement to participate in facility-based group activities that she enjoys. 6. (Resident #4's name) continues to benefit from her ongoing participation in the OBRA Habilitation Services." An interview with the Social Services Assistant (SSA), on 1/14/2014 at 2:35 pm, indicated the resident had not gone out on her weekly outings with the specialized service provider. The SSA started working at the facility in June and the resident had not gone out since at least that point. The service provider had hired at least 2 new case managers for the		of resident in her room, at no time did they talk to the resident.The resident takes herself to every meal. She has social conversations with her table mates, staff and other residents. This resident loves soap operas and game shows. She can tell you all about all the characters in the show in the soap operas and their history from as much as 5 to 10 years ago. She can answer questions on the game show as well.This resident likes coloring books, strawberry shortcake etc. Her family this week, for her birthday brought her strawberry shortcake and coloring books.Although resident cannot read and her IQ is 57, her BIM score is 15 which shows her cognitively intact. The resident is independent with daily decisions where she chooses her own clothing, plans and organizes her day and seeks out staff when she needs assistance. Based on the above information we strongly feel that the resident's preference for activities be honored.A meeting was held with the resident, her mother, sister and facility staff. Resident was very clear that she did not want any services when it is cold. Sister said, "we should listen to the resident and let her make her own decisions, and that she has never steered herself wrong in the past". Resident does not want to be asked every day about activites because she says it	

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	resident since June. As of right now, (service provider company name) was still in the process of finding a new case manager for the resident. The SSA indicated she told the activity department a couple days ago they should be reading chapter books to the resident. The SSA feels this was the appropriate intervention for the resident's cognition level. The SSA believes the resident may be able to understand at about a 4th grade reading level. She isn't for sure, since there was no mental age recorded for the resident, but she believed the resident to be "high functioning". A care plan indicated, "Focus: Enjoys watches (sic) games shows, soap opera and looking at her coloring books. Goal: Resident will remain content with independent leisure pursuit of choosing through the next review. Interventions: Arrange for activity aide to visit and encourage resident to observe or designate activity. Assist resident in planning leisure-time activities. Encourage resident to plan own leisure-time activities. Establish daily routine with same activity/personnel/volunteers. Give resident verbal reminders of activity before commencement of activity. Offer schedule of activities for resident to select choices. Post personal activity		makes her feel like a baby. Activities will read to her when she desires.2. There are no other developmentally disabled residents in the facility.3. Interest survey was completed for the resident. Resident will be taken to any activity she wishes to attend. A special color coded activity calendar is being developed for the resident.4. The Activity Director/designee will audit particpation records of three residents weekly for eight weeks then ongoing monthly that residents attend activities of interest. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14 IDR:We request this citation be removed due to evidence presented above that clearly indicates this resident is independent and capable of making her own decisions.	

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	schedule in resident's room. Repect resident's choice in regard to limited/no activities." An activity progress note, dated 1/9/2014 at 1:29 pm, indicated, "Writer went in to talk to resident about doing activities with her if she would like for writer to read to her out of chapter books like Black Beauty. Resident stated that would be alright but prefer for writer just to read out of her books that she has. Writer asked if she would do this for awhile just to see if she night (sic) like that and she said she would try." An activity progress note, dated 1/10/2014 at 11:35 am, indicated, "Follow up to progress note dated 1/9/2014. Resident is developmentally disabled and prefers in room activities as opposed to group and facility activities. She has a history of refusing 1:1 activities, therefore writer met 1:1 with her in the privacy of her room to discuss appropriate activity options. She reports a desire to have out loud reading activities and requested that her books be read to her. The books she has a (sic) for infants and toddlers but that is her preference. In an effort to offer activity of her choice but one that is more appropriate to her cognition level writer offered to read her some chapter books. Resident was			

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	reluctant to this but agreed to try at least one book however she states that if she does not like the chapter books she would prefer her books such as Strawberry Shortcake and the Princess and the Frog. Care plan will be updated to address resident's preference of reading books below cognition level." An interview with the Activity Director (AD), on 1/14/2014 at 3:15 pm, indicated, she had not provided the resident with any new books or coloring books since 2 Christmas's ago, when she bought her a picture book called The Princess and the Frog, which was one of the resident's favorite books. Resident #4 loves that book. The AD indicated she does not really document the resident's activities, because she was independent in activities. Occasionally she would write down the resident's TVshows she watched. She got the idea to start reading to her once a week because the SSD told her she should about a week ago. Other than this, in the past, she had offered the resident to come to activities programs and outings but the resident always says no, she doesn't want to leave her room. She likes music, but doesn't want to leave her room to come listen to music guests. The resident hadn't had her case worker come for awhile, at least 6 months. When the outside company case worker used to			

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	come visit the resident she would take her on weekly outings. The outings usually were to the library, and sometimes to (name of fast food restaurant). The AD indicated she had offered for Resident #4 to come on the shopping trips to the dollar store, but she always refused to go. "(Resident #4's name) gets depressed easy in the winter." An observation of Resident #4, on 1/14/2013 at 2:08 pm, indicated she was sitting in her wheelchair in front of her TV in her room, she had in her hand an old tattered coloring book which she was looking at. An observation of Resident #4, on 1/15/2014 at 8:47 am, indicated she was leaving (in her w/c) dining room, propelling herself down the hallway. She stopped to talk with the Administrator and the AD. At 10:00 am, the resident was sitting in her room, and had all her coloring books spread out on her bed and she was looking through them. At 1:15 pm, she was ambulating down the hallway in her w/c with a coloring book in her lap. An interview with the Activity Assistant, on 1/15/2014 at 9:50 am, indicated she hadn't ever provided the resident with music in her room, and she didn't think the resident had a radio in her room. She could also turn on channel 2 on the TV			

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	and this would play music for the resident to listen to. An "Independent Pursuit Programming-(Resident #4's name)" document, provided by the RN Consultant, on 1/16/2014 at 10:00 am, indicated, "December 2013: 1st TV 2nd TV 3rd TV 4th TV 5th TV 6th TV 7th TV 8th TV 9th TV 10th Movie 11th TV 12th TV 13th TV 14th TV 15th TV 16th TV 17th TV 18th TV 19th TV 20th TV 21st TV 22nd TV 23rd TV 24th TV 25th TV 26th TV			

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	27th TV 28th TV 29th TV 30th TV 31st TV". 3.1-33(a) 3.1-33(b)(8)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			

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	Based on interview and record review, the facility failed to ensure a resident had a care plan regarding her use of an antipsychotic and associated behaviors and failed to develop a depression care plan for 2 of 19 residents reviewed for care plans. (Resident #42 and #36) Findings include: 1. The clinical record for Resident #42 was reviewed on 1/13/14 at 11:00 a.m. She was admitted to the facility on 10/2/13. The diagnoses for Resident #42 included, but were not limited to, explosive personality disorder. The January, 2014 MAR (medication administration record) for Resident #42 indicated she was receiving a total of 15 mg of olanzapine (antipsychotic medication) daily, 10 mg at bedtime and 5 mg in the morning. During review of her care plans, no care plan addressing her specific use of olanzapine or the reason for it's use could be found. During another review of Resident #42's care plans with the DON (Director of Nursing) and SSA (Social Services	F000279	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility to use the results of the resident assessments to develop, review and revise the residents comprehensive plan of care.1. Resident #36 and #42 care plans for psychiatric diagnosis were reviewed and updated based on most recent assessments.2. All residents receiving psychotropic medications have the potential to be affected. An audit of all residents receiving psychotropic medications has been completed and care plans updated as needed reflecting resident's psychiatric diagnosis, target behaviors and non-phamarcological interventions based on most recent assessments.3. Social Service consultant in-serviced the social service staff on care planning psychiatric diagnosis, targeted behaviors and non-pharmacological interventions.4. DON/designee will audit 5 resident care plans weekly x 4 then ongoing monthly for psychoactive medications, their assosciated behaviors and diagnosis. Any concerns will be	02/15/2014

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	Assistant) on 1/16/14 at 2:15 p.m., no care plan addressing her specific use of olanzapine or the reason for it's use could be found. The DON indicated Resident #42 "should have a care plan regarding zyprexa (name brand olanzapine) use and the targeted behaviors" for its use. The SSA indicated it was social services responsibility to create the care plan.		submitted to the QA committee for action.5. Date of compliance: 2-15-14	
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the physician's orders for wound care for 1 of 1 resident reviewed for venous ulcers and to ensure behaviors and side effects of psychoactive medications were adequately monitored for 1 of 5 residents reviewed for unnecessary medications and fall care plan interventions were followed for 1 of 3 residents reviewed for accidents. (Resident #21 and #63) Findings include: 1. The clinical record for Resident #21 was reviewed on 1/13 at 2:00 p.m. The diagnoses for Resident #21 included, but	F000282	The following Plan of Correction constitutes our written allegation of compliance for the defificiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. It is the practice of this facility to provide services by a qualified person in accordance with each residents written plan of care.1. For resident #21 the nurse identified has been counseled and the physician notified prior to identification of alleged deficiency by ISDH surveyors. Treatment supplies were also ordered for resident #21 and nurse educated to contact physician for interim	02/15/2014

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	were not limited to, cellulitis, abscess of leg, peripheral vascular disease, lower leg arthropathy, and hypertension. The Order Summary Report for Resident #21 indicated, "Apply tubi-grip to right lower leg. Keep on at all times, except bathing and dressing change every evening shift for wound healing." The order date and start date were 4/25/13 with no end date. The Order Summary Report had a second order for tubi-grip with a start date of 1/14/14 that indicated, "Apply 1 layer of tubi-grip to right lower extremity daily after dressing change completed one time a day for wound healing related to Unspecified peripheral vascular disease." An observation of Resident #21's right leg wound was made on 1/14/14 at 1:50 p.m. during his daily dressing change. The Wound Nurse felt his leg and stated, "It's warm". There were 5 pieces of gauze stuck to the wound area. The skin surrounding the wound was very dry and scaly. It covered an area wrapping completely around his lower leg between the ankle and 4 inches below the knee. The wound was the size of golf ball with a slight odor. There was greenish, yellow moderate drainage. The Wound Nurse indicated there was no tubi-grip available at this time.		orders and/or hold orders as needed. Resident #63 had his bed replaced, and the previous bed repaired prior to being put back in use. Care plan was updated in regards to specific intervention and individualized per residents needs. An order to observe side effects of psychoactive medication was added during survey.2. All residents receiving treatments, at risk for falls, or receiving psychotropic medications have the potential to be affected. An audit of all treatment orders and available supplies was completed. An audit was completed on all residents with recent falls to ensure care plans were up to date and interventions in place. An audit was also completed in regards to all residents who received psychotropic medications and having orders for observation of side effects.3. Nurses were in-serviced on wound care, following care plans and observation of side effects of psychoactive medications.4. DON/designee will audit 5 residents wound treatments weekly x 4 then ongoing monthly for compliance with treatment orders. DON/designee will audit 5 residents records who are on psychoactive medications for side effects monitoring weekly x 4 then ongoing monthly.DON/designee will audit 5 residents records that fall interventions are being	

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NAME OF PROVIDER OR SUPPLIER BRIARWOOD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3640 N CENTRAL AVE INDIANAPOLIS, IN 46205	

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	During an interview with the Wound Nurse and DON (Director of Nursing) on 1/16/14 at 11:40 a.m. regarding the last time Resident #21 had tubi-grip applied as ordered, the Wound Nurse indicated, "He did not have any tubi-grip on Monday (1/13/14). I asked therapy, nursing, supplies and I could not get any tubi-grip for him. I don't know when he ran out, but he had at least been out since 1/13 (1/13/14)." Regarding who was responsible for reordering supplies to ensure residents had what was needed for their treatment, she indicated, "Honestly, I'm not sure who's responsible for ordering supplies. I'm not sure if it's me, the Wound Nurse, Supply Person or a combination of us. I'm still learning the processes myself, so I'm not sure what the process is."		followed weekly x 4 then ongoing monthly.Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14	
F000309 SS=D	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.			
	Based on observation, interview and record review, the facility failed to perform the treatment as ordered to a resident's leg wounds resulting in severe maceration of his right lower leg for 1 of	F000309	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that deficiency exists or that one	02/15/2014

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	1 resident reviewed for venous ulcers. (Resident #21) Findings include: The clinical record for Resident #21 was reviewed on 1/13 at 2:00 p.m. The diagnoses for Resident #21 included, but were not limited to, cellulitis, abscess of leg, peripheral vascular disease, lower leg arthropathy, and hypertension. On 1/10/2014 at 11:40 a.m., an observation was made of Resident #21 sitting in his wheelchair in his room, with his NP (Nurse Practitioner) present. The NP was crouched on the floor removing the resident's lower left extremity bandage, which consisted of gauze and a mepilex border (all-in-one foam dressing that effectively absorbs and retains exudate and maintains a moist wound environment). The door to the room was wide open. During a conversation between Resident #21's NP and LPN #6 at the nurses station on 1/10/14 at 11:44 a.m. regarding Resident #21, the NP stated, "No mepilex. Just use kerlix. It's macerating his skin. It can't drain. I'm going to put the order in the computer now." The NP left the nurses station and returned one minute later and stated to LPN #6, "The		was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility that residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordnace with the comprehensive assessment and plan of care.1. The nurse identified has been counseled and the physician notified prior to identification of the alleged deficiency by the ISDH surveyors.2. All residents receiving treatments have the potential to be affected. An audit of all treatment orders and available supplies was completed.3. Licensed nurses were in-serviced on wound care policy and a skills validation for all nurses on dressing changes was completed.4. DON/designee will complete wound treatment audit tool for 5 residents with wounds weekly x 4 then ongoing monthly. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14 We request the IDR to dispute the severity of the F-tag (G-level) citation. Evidence of supporting documentation will be presented during the face to face IDR hearing.	

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	order is already there. I wrote the order the way I want it. You have to make sure the orders are being communicated between staff at shift change." During an interview with LPN #6 on 1/10/13 at 2:36 p.m. regarding Resident #21, she indicated, "I changed the dressing yesterday and put the 4x4 bandage on his foot under the kerlix for additional support...the order does not ay to use it. My understanding is the NP does not want the 4x4 bandage used. I'm not sure why she doesn't want it on there. I missed that." The Order Summary Report for Resident #21 indicated, "Silvaden Cream 1% (Silver Sulfadiazine) Apply to left leg topically every day shift related to CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT Cleanse open area to left leg with saline, pat dry, apply silvadene, cover with aquacel Ag, and wrap with kerlix, change daily." The order was dated 1/3/14 with a start date of 1/4/14. It also indicated, "Silvaden Cream 1% (Silver Sulfadiazine) Apply to right leg topically every day shift related to CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT Cleanse open areas to right leg with saline, pat dry, apply silvadene, cover with aquacel Ag, and wrap with kerlix, change daily." The			

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	order was dated 1/3/14 with a start date of 1/4/14. An interview was conducted with Resident #21's NP on 1/13/14 at 12:09 p.m. regarding the dressing change she performed on Resident #21's leg wounds on 1/10/14. She indicated she saw the skin was macerated on both wounds. It covered "most of the shin area and wrapped around the ankle on the right leg. There were big open areas, full thickness and the skin around it was red from drainage." Regarding the type of dressing used, she indicated, "At the time it was mepilex border. I did not order that to be on there. I didn't want it on there because it causes drainage to stay on the wound. When that happens it causes maceration and for the skin to not heal properly. It's kind of like being in a hot tub for a long time." Regarding how her 1/10/14 observation compared to her previous observation of Resident #21's leg wounds, she indicated, "I saw this wound a month prior. It looked like it was getting better, so I was surprised how much worse they'd gotten. I spoke to the old wound care nurse a couple weeks ago about (name of Wound Doctor),and he said he'd give him a call. I don't know if he ever did because that wound care nurse, (name of previous Wound Nurse), was let go. It seemed like the confusion			

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	was that the old wound nurse purchased a package of materials with (Name of Resident #21's) name on it, and it had mepilex in there. (Name of previous Wound Nurse) did mention about making packets, so he probably made the packet with the mepilex...My guess is nursing had been using the mepilex since my 1/3/14 order. I'm really happy (Name of current Wound Nurse) is here and not to necessarily trust the wounds are being taken care of." Regarding how her 1/10/14 observation of Resident #21's leg wound compared to her previous observation a month prior, she indicated, "At the time with the maceration, it looked significantly worse, more drainage and a smell. There was no smell a month ago. When I took his sock off, he seemed to be in a little pain. It doesn't seem to hurt him as much as it should. On the left, it was a lot smaller area, on the dorsal lateral foot. Unfortunately, it had mepilex over it as well. It was macerated because of the mepilex." An observation of Resident #21's right leg wound was made on 1/14/14 at 1:50 p.m. The Wound Nurse felt his leg and stated, "It's warm". There were 5 pieces of gauze sticking to the wound area. The skin surrounding the wound was very dry and scaly. It covered an area wrapping			

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	completely around his lower leg between the ankle and 4 inches below the knee. The wound was the size of golf ball with a slight odor. There was greenish yellow, moderate drainage. 3.1-37(a)			
F000314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review the facility failed to measure and Stage a resident's pressure ulcers per facility policy, ensure a resident's Stage IV pressure ulcer was securely wrapped to prevent direct	F000314	The following Plan of Correction consitutes our written allegation of compliance of the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	02/15/2014

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	contact with and soilage through her sock, ensure appropriate infection control practice was maintained during dressing changes, provide necessary care to ensure proper wound healing and prevention, and follow a plan of care for multiple pressure ulcers resulting in Stage IV pressure ulcer development for 5 of 5 residents reviewed for pressure ulcers. (Residents #42, 37, 118, 100 and 111) Findings include: 1. Resident #100's clinical record was reviewed on 1/14/2014 at 11:20 am. Diagnoses included but were not limited to, diabetes, congestive heart failure, cellulitis (skin infection) of bilateral (both) lower legs. An Admission/Readmission Data Collection Tool, dated 8/11/2013 at 16:22 (4:22 p.m.), indicated, "2. Skin observations: Using the diagram, indicate all marked areas on body- section were blank. Other open lesion specify: lower left leg-erupted blistering of skin, one area on front of leg, two on back of leg. 6. Foot observations: 8. Describe any open lesions on feet" the section was blank. An Admission/Readmission Data Collection Tool, dated 8/11/2013 at		the requirements established by the State and Federal law.It is the practice of this facility that residents who enter the facility without pressure sores do not develop pressure sores unless clinical conditions demonsrate that they are unavoidable, and residents with pressure sores receive the necessary treatment and services to promote healing, prevent infections and preven new sores from developing.1. Per Hospice documentation resident #100 developed pressure sores that were unavoidable. Resident no longer resides at facility and no further action could be taken. Resident #43, #37, #118 and #111 were assessed by Wound Care Certified Nurse and Wound Care Certified Nurse Practitioner. Orders, care plans and resident care sheets were updated based on those assessments. Orders and updated interventions were put in place as per the plan of care.2. All residents with wounds have the potential to be affected. Residents with wounds were assessed by the Wound Care Certified Nurse and Wound Care Certified Nurse Practitioner. Orders, care plans and resident care sheets were updated based on those assessments. Orders and updated interventions were put in place as per the plan of care.3. All licensed nurses were in-serviced on wound care policy, documentation on admission skin assessment, braden scale and	

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	18:00 (6:00 p.m.), indicated, "Section 2. Skin Observations: Using the diagram, indicate all marks on body (e.g. pressure ulcers...)" this section was blank. Admission Braden Scale for Predicting Pressure Sore Risk, dated 8/13/2013, indicated, "Score 20: no risk." A care plan, dated 7/31/2013, indicated, "Potential/Actual alteration in skin integrity r/t cellulitis of bilateral lower legs and heel. Interventions:...Observe/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration, etc to MD (Medical Doctor)." A care plan, dated 10/8/2013, indicated, "Focus: Pressure ulcer present on left heel and right heel r/t history of ulcers. Goals: Pressure ulcer will show signs of healing and remain free from infection through review date. Interventions: Administer treatments as ordered and assess for effectiveness. Assess wounds weekly. Encourage use of bed rails, trapeze bar, etc. for resident to assist with turning. Follow facility policies/procedures for the prevention of/treatment of skin breakdown. Heels up while in bed. Observe nutritional status. Serve diet as ordered. Monitor and record		accuracy of wound documentation.4. DON/designee will complete wound audit tool that reviews all parts of wound care for 5 residents weekly x 4 and then ongoing monthly. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14 We request the IDR to dispute the severity of the F-tag (G-level) citation. Evidence of supporting documentation will be presented during the face to face IDR hearing.	

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	meal intake. Pressure reducing mattress. Provide supplemental protein, amino acids, vitamins." A 10/21/2013 MDS assessment indicated, "Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? Yes. Stage 4 Pressure Ulcers: 2. Were pressure ulcers present on the prior assessment: No." A care plan meeting note, dated 9/4/2013, indicated, "Bilateral heels and legs are breaking down and receiving treatment..." An interview, with the DON, on 1/13/2014 at 11:14 am indicated, when a new wound is noted, the nurses chart in the electronic chart, initial pressure or an initial non-pressure ulcer skin report. Then they should continue to document daily and the wound nurse should document a weekly summary." The first mention of any wound to Resident #100"s heels was on 9/19/2013. On 9/19/2013 at 4:00 pm, the 'Daily wound documentation' indicated, "1. Wound location(s): left and right lower leg and heels. 9. MD notified? No." On 9/20/2013 at 5:31 pm, the 'Daily wound documentation' indicated, "1.			

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	Wound location(s): left and right lower leg and heels. 9. MD notified? No." On 9/21/2013 at 5:31 pm, the 'Daily wound documentation' indicated, "1. Wound location(s): (blank). 9. MD notified? No." On 9/23/2013 at 5:31 pm, the 'Daily wound documentation' indicated, "1. Wound location(s): both feet. 9. MD notified? No." On 9/24/2013 at 11:31 am, the 'Daily wound documentation' indicated, "1. Wound location(s): right and left heel. 9. MD notified? No." On 9/25/2013 at 4:00 pm, the 'Daily wound documentation' indicated, "1. Wound location(s): both feet and heels. 9. MD notified? No." On 9/26/2013 at 6:00 pm, the 'Daily wound documentation' indicated, "1. Wound location(s): both lower extremities and heels. 9. MD notified? No." A 'Non-pressure ulcer skin condition progress report', dated 9/27/2013 at 7:23 am, indicated, "Type of Skin Condition: other. Description: left heel-covered with eschar, 2 cm x 1.5 cm, no drainage or			

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	odor. Right heal covered with dry eschar, 4 cm (x) 2.5 cm, no drainage or odor. Treatment/Recommended Changes: Cleanse heels with wound cleanser. Cover with foam and wrap with kerlix. Change daily. MD notified? No. Comments: Eschars on both heels result of excessive fluid from cellulitis opening up skin and damage underneath skin surface." An interview with the RN consultant, on 1/14/2014 at 10:59 am, indicated, "I didn't know about the Stage IV's until I went in her room the day she was discharged and the smell was awful. This lady was very non-compliant in general. The nurse should have filled out an "initial pressure ulcer report" when the bilateral heel wounds were first identified. At that time the wound nurse also should have notified the MD, which he did not do. I'm not sure why he didn't notify the MD on 9/20/2013, when the wound first appeared. I'm not sure why the treatment recommendations from 9/27/2013 weren't followed. The resident went out to the hospital and then ended up at a different LTC facility. On 9/27/2013, where the wound nurse documented 'eschar' he should have filled out a pressure ulcer report, because eschar is present with pressure ulcers. The wound nurse also should have, at			

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	that point, notified the MD to get the recommendation to be written by MD order." An MD order, dated 10/8/2013 at 3:00 pm, indicated, "Cleanse left and right heels with wound cleanser. Apply santyl (a debridement agent to clean the wound) to wound bed and cover with aquacel, wrap with kerlix, change daily every evening shift for wound healing. D/C (discontinue) dated 10/15/2013 at 8:34 am." An MD order, dated 10/16/2013 at 7 am, indicated, "Santyl ointment 250 unit/gm. Apply to bilateral heels topically every day shift for wound healing. Cover with aqualcel ag and cover with foam dressing. Wrap with kerlix." A (hospital name) operative note, dated 10/24/2013 at 10:56 am, indicated, "Date of Operation: 10/23/2013. Indications for procedure: The patient has been admitted to (name of hospital) for sepsis and gangrene to her bilateral heels...She was found to have extensive gas gangrene to her left heel and osteomyelitis (bone infection) to her right and left calcareous (heels)...I discussed the need for surgical incision and drainage of both of her heels to try to release the abscess bacteria within the feet, to try to help with her			

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	sepsis. I discussed the surgery in detail and also discussed that the patient will most likely need 1 (one) , if not both, legs amputated in the future." A (hospital name) discharge summary note, dated 11/6/2013, indicated, "Date of admission: 10/21/2013. Date of discharge: 11/6/2013. Hospital course: 1. Sepsis secondary to osteomyelitis. The patient had a heel necrotic ulcer...The patient had initial debridement on 10/23/2013 by Podiatry, but recommended to have amputation of the left foot. The patient underwent for procedure on 10/28/2013 with left BKA (below the knee amputation)...7. Acute kidney injury, with iron-deficiency anemia and anemia of chronic disease on top of that. Blood loss likely from the wound. Received transfusion 10/22/2013 and also received iron infusion for 3 doses..." An interview with the RN consultant, on 1/14/2014 at 3:45 pm, indicated the resident only had a total of 3 Braden score assessments completed, all in August. No other Braden score assessments could be found. An interview with LPN #21, on 1/14/2014 at 4:00 pm, indicated he is the night shift unit manager, he remembers			

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	155628		01/16/2014

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	the resident, but it was a long time ago. He doesn't remember being the one who found she had wounds on her heels. He doesn't remember what the wounds looked like. If he were to find a new area on a resident he would do two things. He would notify the MD and also the wound nurse. The wound nurse would then take over from there and get orders for the wound.			
F000323 SS=D	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 observation, interview, and record review the facility failed to ensure a resident interventions were in place to prevent a fall for 1 of 1 residents reviewed for falls. (Resident #63) Finding include: On 1/14/14 at 3:02 p.m. during an observation of Resident #63, he was lying in bed. The resident's bed was observed with the breaks unlocked. The bed moved freely on the floor. The clinical record for Resident #63 was reviewed on 1/13/14 at 2:57 p.m. The resident's diagnoses included, but were	F000323	The followinf Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility that the residents environment remain as free of accident hazards as is possible, and each resident receives the adequate supervision and assistance devices to prevent accidents.1. Bed for resident #63 was changed out at time of survey.2. All residents with falls have the potential to be affected. All residents care plans for falls in	02/15/2014

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	not limited to, altered mental status, difficulty in walking, muscle weakness (generalized), lower limb amputation. A Nursing Progress Note dated 12/25/13 indicated Resident #63 had a fall on 12/25/13. An inter-disciplinary team progress note dated 12/26/13 indicated Resident #63 fell as he was attempting to reposition in bed due to "bed brakes no (sic) being locked and functioning appropriately..." On 1/14/14 at 3:58 p.m. the Maintenace Director indicated, Resident #63's was not properly locked. He indicated the bed should have rubber grips on the four free elements of the bed and that those devices were not present. He also indicated the beds would not lock appropriately unless those grips were on the bed feet and that no resident should have a bed which was function in the present condition. On 1/14/14 at 4:01 p.m., CNA #12 indicate, Resident #63 had a bed switch around "Christmas time" of 2013. A falls care plan indicated the following interventions: ".....Keep bed in locked position...." 3.1-45(a)(1)		the past 30 days with interventions were reviewed.3. Nursing staff have been in-serviced on following the care plan interventions.4. DON/designee will audit 5 residents records for fall interventions to ensure they are being followed weekly x 4 and then ongoing monthly. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14	

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F000329 SS=D	3.1-45(a)(2) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. Based on observation, interview and record review, the facility failed to follow through with the psychiatric treatment plan for 1 of 5 residents reviewed for unnecessary medications. (Resident #42) Findings include: The clinical record for Resident #42 was reviewed on 1/13/14 at 11:00 a.m. She was admitted to the facility on 10/2/13.	F000329	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility that the residents drug regimen is free from unnecessary drugs.1. Resident #42 is scheduled to be seen by the Psychiatrist on the	02/15/2014

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	The diagnoses for Resident #42 included, but were not limited to, explosive personality disorder. The January, 2014 MAR (medication administration record) for Resident #42 indicated she was receiving a total of 15 mg of olanzapine (antipsychotic medication) daily, 10 mg at bedtime and 5 mg in the morning. During an interview with the DON (Director of Nursing) and the Nurse Consultant on 1/16/13 at 1:32 p.m. regarding Resident #42's olanzapine use and the behaviors the antipsychotic was targeting, the DON indicated, "I've never seen any behaviors on her." The Nurse Consultant indicated, "I've never seen any behaviors." At this time, the DON reviewed her clinical record and indicated Resident #42 had one episode of "yelling and screaming" on 10/16/13, but "that is the only behavior sheet I see." She further indicated Resident #42 had been receiving her current dose of 15 mg daily of olanzapine since her 10/2/13 admission. At this time, she provided a copy of Resident #42's 10/25/13 Initial Psychiatric Assessment. The 10/25/13 Initial Psychiatric Assessment for Resident #42 indicated, "10/16/13: behavioral note, no specifics		next visit.2. All residents have the potential to be affected. The last three months of the psychiatrist notes have been audited to ensure all residents have been seen within the recommended followup time frame.3. A tracking system has been implemented to ensure Psychiatrist's followup are completed per their recommendations.4. DON/designee will audit 5 psychiarist visit progress notes for timeliness of followup visits weekly x 4 then ongoing monthly. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14	

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	known. Staff reported pt (patient) has (sic) (symbol for 'with') confusion but no behaviors reported. Chief Complaint: 'My feet are hurting.' History of Presenting Illness: ...seen for initial assessment and for evaluation of dementia with psychosis. Pt says she came to hospital as her feet are hurting. Pt denied being sad, depressed. Says she is eating good. No problems with sleep....Denied being anxious/nervous. Mental Status Examination: Appearance: fair, Attitude: cooperative, Affect: restricted...Thought Process: coherent, Thought Content: Patient denied SI (suicidal ideation)/HI (homicidal ideation)/ AH (auditory hallucinations)/ VH (visual hallucinations). Recommendations: 1) Continue current medications 2) Monitor for progress and s/s (signs/symptoms) Treatment Plan: 1) Follow-up 4-6 weeks for ongoing medication management and symptoms evaluation. 2) If any side effects or issues arise, please feel free to contact this provider to address any issues/concerns. 3) Continue other psychotropic medications at current dosages. Will formally evaluate for dose reductions in the future." During an hour long observation on 1/14/14 at 10:45 a.m. of Resident #42's dressing changes to her wounds, no			

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	behaviors were observed. She was very pleasant and cooperative. During an observation on 1/16/13 at 1:45 p.m. of Resident #42 participating in therapy, no behaviors were observed. She was very pleasant and cooperative. An interview was conducted with the DON on 1/16/14 at 1:35 p.m. regarding Resident #42's 10/25/13 treatment plan to follow up in 4 to 6 weeks for ongoing medication management and symptoms evaluation. She indicated she wasn't sure if there was any follow up and didn't see anymore psychiatric notes in her clinical record after the 10/25/13 Initial Assessment. During review of Resident #42's Treatment Plan from her 10/25/13 Initial Psychiatric Assessment with the SSA (Social Services Assistant) and the DON on 1/16/14 at 2:15 p.m., the SSA indicated, "I interpret this as she should have been seen in 4-6 weeks." Regarding why Resident #42 was not seen in 4-6 weeks and who's responsibility it was to follow up with psychiatric recommendations, the SSA indicated, "We don't have a process in place to track it." 3.1-48(a)(4)			

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F000441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.			

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	(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview and record review, the facility failed to maintain a sanitary environment during wound care for 2 of 5 residents reviewed for wound care (Resident #42 and #111), to place a resident in contact isolation after the resident was placed on an anti-viral medication for a rash of unknown origin (Resident #67) and to maintain a facility infection control monitoring/tracking program. This had the potential to affect 79 of 79 residents in the facility. Findings include: 1. The clinical Record for Resident #42 was reviewed on 1/13/14 at 11:00 a.m. The diagnoses for Resident #42 included, but were not limited to, pressure ulcers. An observation of Resident #42's dressing changes to her pressure ulcers was made on 1/14/14 at 10:15 a.m. CNA #20 was observed to pick up a disposable pad off the floor and place it onto the clean wound supply work area. LPN #7	F000441	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility to establish and maintain an infection control program designed to provide a safe, sanitaty and confortable environment and help prevent the developement and transmission of disease and infections.1. Resident #67 had been placed in isolation prior to identification by surveyors. Resident #42 alleged allegation occurred in the past. CNA #20 and LPN #3 were counseled on infection control and reinstating a clean field if contaminated. Resident #111 alleged allegation occurred in the past and unable to correct. Assigned a new staff member to monitor the infection control program.2. All residents have the potential to be affected.3. All nursing staff in-serviced on isolation policy, procedure and	02/15/2014

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	told her to not put it there, and to place it in the trash if it had been on the floor. She then threw it away. The Wound Nurse was in the restroom at this time. When the Wound Nurse returned from the restroom, no one informed her the disposable pad was placed from the floor onto the wound supply work area. She continued with the dressing changes utilizing the supplies from the now contaminated wound supply area. During an interview with the Wound Nurse on 1/14/14 at 12:31 p.m. regarding the above observation she indicated, "If I had known, it would have been a contaminated field, and I would have gotten new supplies.."		infection control basics.4. DON/designee will make environmental/care rounds that include infection control issues weekly. This will be be ongoing. Any concerns will be submitted to the QA committee for action.The infection control monitoring report will be present to the QA committee monthly.5. Date of compiance: 2-15-14	
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on interview and record review,	F000514	The following Plan of Correction constitutes our written allegation of compliance for the deficiencies	02/15/2014

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	the facility failed to ensure complete and accurate documentation regarding wound care for 1 of 6 residents reviewed for wound care. (Resident #42) Findings include: The clinical record for Resident #42 was reviewed on 1/13/14 at 11:00 a.m. She was admitted to the facility on 10/2/13. The diagnoses for Resident #42 included, but were not limited to: pressure ulcers. The January MAR (medication administration record) for Resident #42 was not signed off on for the following pressure ulcer treatments on the following days: Bacitracin Ointment 500 Unit/GM Apply to left outer lower extremity topically twice daily on 1/8/14 at 9:00 a.m. and 1/9/14 at 9:00 a.m. Bacitracin Zinc Ointment to right lower leg topically every shift on 1/2/14 day shift, 1/8 day shift and 1/9 day shift. Wound cleanser and Aquacel Ag ribbon to coccyx every Monday, Wednesday and Friday day shift on Wednesday, 1/8/14. Wound cleanser and Aquacel Ag to left		cited. Submission of the Plan of Correction is not an admission that a deficieny exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law.It is the practice of this facility to maintain the clinical records on each resident in accordance with the accepted prefessional standards and practices that are complete, accurately documented, readily accessible and systemically organized.1. Resident #42 alleged deficient practice occurred in the past.2. All residents have the potential to be affected. The alleged practice occurred in the past and cannot be corrected.3. All nurses have been in-serviced on the MAR/TAR completion.4. DON/designee will complete the MAR/TAR audit 5 x per week for holes in documentation. Any concerns will be submitted to the QA committee for action.5. Date of compliance: 2-15-14	

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	lateral foot on 1/8/14 and 1/9/14. Santyl Ointment 250 mg to left foot every day shift on 1/2/14, 1/8/14 and 1/9/14. During an interview with the Nurse Consultant on 1/14/14 at 1:41 p.m. regarding the missing pressure ulcer treatment documentation, she indicated there shouldn't be blanks on the MAR because there's codes to use if the resident cannot get the treatment for some reason. During another interview with the Nurse Consultant on 1/15/14 at 11:49 a.m. she stated, "I think the holes in the MAR are a matter of not signing off, but they were done." 3.1-50(a)(2)			