

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155524	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
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NAME OF PROVIDER OR SUPPLIER GLENBURN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441
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F0000	<p>This visit was for the Recertification and Licensure survey.</p> <p>Survey dates: January 23, 24, 25 and 26, 2012</p> <p>Facility number:000230 Provider number: 155524 AIM number: 100275000</p> <p>Survey team: Melinda Lewis, RN, TC Sharon Whiteman, RN Marla Potts, RN (January 23, 24 and 25, 2012)</p> <p>Census bed type: SNF/NF-117 SNF-8 Total-125</p> <p>Census payor type: Medicare: 13 Medicaid: 81 Other: 31 Total: 125</p> <p>Sample: 24 Supplemental sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>	F0000	<p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements under state and federal law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	16.2. Quality review completed 1/31/12 Cathy Emswiller RN			
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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure a physician was immediately notified when a resident developed an open area, or had changes in wounds for 4 of 24 residents reviewed for notification, in the sample of 24. Resident #119, 112, 74 and 200.</p>	F0157	What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #200 no longer resides in Glenburn Home. Staff initiated skin assessments on all Residents. Resident # 112 was noted to have a new area of	02/25/2012			

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	<p>Findings include:</p> <p>1. During the initial tour on 1/23/12 at 9:30 a.m., Resident #119 was identified by the Director of Nursing as alert and oriented, having a pressure ulcer on her bottom, and in the facility for therapy.</p> <p>Resident # 119 clinical record was reviewed on 1/23/12 at 12:00 p.m. Diagnoses included but was not limited to a fractured fibula (leg). Nursing notes indicated: 1/7/12 0900 (9 A.M.) Res...getting shower today. noted small spot found open on buttock .4 by .4 mm will have wound nurse evaluate..."</p> <p>Nurses notes indicated the wound nurse evaluated the area on 1/9/12 at 8 a.m.. The note indicated : "Resident has a .3 by .2 by less than .1 stage 2 from shearing to upper right buttocks with a peely (sic) periwound... complaints of pain 5/10 (pain was rated as 5 out of 10 total for severity) no order, MD (medical doctor) updated and treatment order requested." The weekly pressure ulcer healing assessment, indicated the area was .3 by .2 by less than .1 cm. A telephone physician's order dated 1/19/12 indicated "may use calazime paste to buttock BID (2 times daily) times 14 days then reevaluate.</p>		<p>excoriated on Right Buttocks and coccyx areas. Physician notified and new orders were received. A turn Q mattress was also placed resident's #112 bed. Resident #119 was noted to have a new area on the coccyx. Physician was notified and new orders were received. Resident #74 was assessed with no new areas noted. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this practice. Glenburn will no longer employ a designated wound nurse. Staff will be educated that when new areas are noted that the nurse of that resident will be responsible for informing the Physician and Responsible Party. New Physician orders will be processed in a timely manner. Unit managers will be responsible for doing Bi-weekly skin assessments. Any new areas or areas that are not improving will be reported to the Physician and Responsible Party. Unit Managers will be doing weekly wound rounds and completing measurements and any physician notifications that are required. What Measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be educated on the new skin assessment</p>				

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	<p>The clinical record lacked evidence of having called a physician until the wound nurse did so on 1/9/12, 2 days after the open area was first observed.</p> <p>2. Resident #112 was identified on the initial tour of the facility on 1/23/12 at 9:30 A.M. by the Unit Manager, as having an open skin area on her right outer calf. Resident #112's clinical record was reviewed on 1/23/12 at 2:00 P.M. Diagnoses included but were not limited to diabetes and right sided hemiparesis (paralysis).</p> <p>The skin wound logs indicated 5/26/11 right outer malleolus...wounds are closed. The log had entries each week with the next entry concerning the right outer ankle 6/17/11 with " dark pink in color 8.5 by 2 by 0 with .4 by .6 brown discoloration." "6/24/11 right outer ankle dark pink are with 8 by 3 with dark red brown discoloration 2 by .5 1 by 1 ..." "7/1/11 right outer ankle see pressure/vascular log."</p> <p>Physician orders indicated sure prep was ordered to the right outer ankle two times daily on 5/26/11. The June 2011 treatment record indicated this was completed on 6/9/11, with "reeval (reevaluate)" written on the sheet. A</p>		<p>procedure. The Director of Nursing and Charge nurse will be notified immediately when new areas are found. The Charge Nurse then will notify the Physician and Responsible Party immediately. C.N.A.'s have been provided a triplicate skin reporting booklet that will allow and track when the areas are found and when the charge nurse was notified. One copy will be given to the charge nurse and a copy to the Director of Nursing to ensure a follow up is completed. How the corrective Action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Wound rounds will be completed weekly The corrective actions will be monitored through an audit tool that will identify the proper compliance with Wound identification and Physician notification monthly. The monthly reports will be given at the Quarterly QA meeting. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been meet the audit tool will become a quarterly audit. What date the systemic Changes will be completed? 2.25.12</p>				

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	<p>telephone physician order indicated sure prep was again ordered on 6/24/11 to the right outer ankle.</p> <p>Documentation was lacking of the physician having been notified of the findings on 6/17 of the wound assessment, or of any treatment to the area from 6/10 through 6/24/11.</p> <p>Nurses notes indicated: "6/24/11 1435 (1:35 A.M.)...new order sure prep wipes to right outer ankle bid (2 times daily) routinely to toughen skin..." "6/25/11 0600 (6 a.m.) area on right heel weeping fluid. sure prep wipe treatment done to outer ankle..." "6/25/11 1430 (2:40 p.m.) area on right ankle weeping clear watery fluid applied sure prep, covered with optifoam and kerlix (dressings) res stated if felt better to be covered." "6/28/11 0720 11 -7 nurses brought it to this writers (wound nurse) attention that resident has drainage soaked gauze wrap on right foot and has odor for sure prep every shift. So writer went to assess right ankle area. res has an open area to right outer malleolus 2 by 1 by less than .1 with red wound bed and moderate serous yellow drainage and an open area to right outer upper ankle that is 1 by 2 by less than .1 with red wound bed...I believe both are caused from brace that resident wears. her foot is turned in more we have</p>						

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	<p>already removed her EZ boots at night. Both areas had a moderate amount of serous drainage noted...doctor updated, new treatment orders requested..." A telephone physician order dated 6/28/11 indicated 7:30 p.m. new order for 2 wounds on right ankle, discontinue sure prep change to antibiotic ointment with cuticerin and cover with optifoam and kerlix also for prostat 30 ml two times daily to aid in wound healing.</p> <p>The facility lacked evidence of having updated the physician of the worsening wound observed on 6/25 until 6/28/11 when the wound nurse did so.</p> <p>3. The clinical record for Resident # 74 was reviewed on 1/23/12 at 10:00 A.M. The record indicated Resident # 74 had diagnoses that included but were not limited to possible cancer and renal insufficiency. The MDS [minimum data set] assessment, dated 12/21/11, indicated Resident # 74 had no cognitive deficits. Resident # 74 was independent with bed mobility, required extensive assistance with transfers and toilet use. Resident # 74 did not ambulate. Resident # 74 had a stage IV pressure ulcer.</p> <p>A Nurses Note, dated 1/19/12 at 12:30 P.M., indicated "dry thick scab like tissue adhered to sock; when sock removed this scab came out of R heel wound leaving an</p>						

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	<p>open area 1.3 x [by] 0.8 x 0.7 no drainage no odor. Wound nurse and Unit manager examined. Res [resident] also has red sl [slightly] raised rash bil [bilateral] arms and face is flushed. Unit manager examined."</p> <p>A Nurses Note, dated 1/19/12 at 12:35 P.M., indicated "Wound bed is pale pink with small amount of tan eschar intact 0.2 x 0.2 to R heel. Dr (name) notified."</p> <p>In an interview with the Director of Nursing, on 1/23/12 at 2:55 P.M., she stated the Wound Nurse had left a message at the physician office on 1/19/12 regarding the area to the right heel but had not received an answer yet and had called him again today.</p> <p>A Nurses Note, dated 1/23/12 at 1500 (3:00 P.M.), indicated "Dr (name) returned call in regards to R heel wound. N.O. left to cover wound with dry gauze et [and] kerlix wrap daily et let wound stay dry. If wound starts to drain MD wants us to notify him. UM [unit manager] aware of orders."</p> <p>4. The closed record for Resident # 200 was reviewed on 1/24/12 at 10:00 A.M. The record indicated Resident # 200 had diagnoses that included but were not limited to weakness and gait dysfunction.</p>				

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	<p>The MDS [minimum data set] assessment, dated 12/30/11, indicated Resident # 200 had moderately impaired cognition. Resident # 200 required extensive assistance of one with bed mobility, transfers, and toilet use. Resident # 200 had a stage II pressure sore.</p> <p>The Nurses Notes, dated 12/23/11 at 1735 (5:35 P.M.), indicated "...Small opening on coccyx measured wound nurse to see also..."</p> <p>The Nurses Notes, dated 12/23/11 at 2300 (11:00 P.M.), indicated "...Wound on coccyx had drsg [dressing] 1/2 off with blood on drsg. Assessed wound on coccyx to be at 0.5 x [by] 0.5 x 1. Cleansed, atb [antibiotic] ointment applied and dressed with telfa and medflex as nsg [nursing] measure..."</p> <p>The Nurses Notes, dated 12/27/11 at 7:00 A.M., indicated "After further investigation per wound nurse of open area found on coccyx (pressure) on admission, area is not on coccyx it is R [right] inner buttocks. Coccyx is clear with skin intact. R inner buttocks has a superficial St [stage] II 0.4 x 0.3 x < [less than] 0.1 with dk [dark] pink wound bed et pink blanching peri wound. no pain no odor no drainage. MD updated for tx</p>				

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	<p>[treatment] orders..."</p> <p>In an interview with the Wound Nurse, on 1/25/12 at 1:00 P.M., she indicated she had faxed the physician on 12/27/11 and had not received a response by 1/3/12. She further indicated she had notified the Director of Nursing via email that Resident # 200 had went 7 days without treatment to her open area.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>			
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F0281 SS=D	<p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff obtained a physician order before treating an abscess on 1 of 24 resident's reviewed for nursing care in a sample of 24. (Resident #14)</p> <p>Findings Include:</p> <p>On 01/24/12 at 10:00 a.m. CNA #23 and CNA #24 were observed to provide incontinence care on Resident #14. The resident was observed to have a dried scab area on her left inner breast with slightly reddened area surrounding the scab.</p> <p>Interview of the Wound Nurse on 01/24/12 at 10:50 a.m. indicated the Wound Nurse assessed Resident #14 and noted a "great big raised and draining" area. The Wound Nurse indicated the area was "large and stuck out" and Resident #14 looked like she was in pain so she squeezed the area and it drained white/yellow pus.</p> <p>Review of Resident #14's clinical record on 01/23/12 at 3:05 p.m. indicated the following:</p>	F0281	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The area noted on Resident #14 is currently healed. Bactrim DS was started on 11/15/11, orders were received on 11/17/11 for hot compress to wound, and then on 11/18/11 resident #14 was sent to the hospital for further eval. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this practice. Skin assessments have been completed on all residents with no areas as stated above noted. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All staff will be educated on a new skin assessment policy and procedure that prohibits manipulation of any type skin lesion without a physician's order. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? These skin issues will be monitored through the biweekly skin assessments. There will be a monthly QA audit</p>	02/25/2012			

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	<p>Resident #14 had diagnoses which included, but were not limited to, late stage Alzheimer disease and Psychosis.</p> <p>A nurse's note dated 11/15/11 at 10:00 a.m. indicated, "During skin assessment (sic) wound nurse noted a black head on (l) [left] breast medial aspect that was raised this week. Wound nurse applied warm water to area & squeezed area in the process getting about 15 cc [milliliters] of yellow & white pus from area c [with] a core hard at average 0.3 x 0.3 (centimeters) size (sic). Bed (wound bed) is 2 x 2 (centimeters) reddened (sic) area now that will probably bruise c a 0.1 x 0.1 hole at distal end. MD updated on area. Charge Nurse updated et will notify family.</p> <p>A nurse's note, dated 11/15/11 at 1:00 p.m. indicated, "....Also Bactrim DS (antibiotic medication) BID [twice daily] x 7 days r/t [related to] area between breasts found by skin nurse..."</p> <p>A nurse's note, dated 11/15/11 at 9:40 a.m. indicated, "ATB [Antibiotic] started d/t [due to] area on breast. Area raised et red. 0 [No] s/s [signs/symptoms] of adverse reactions. 0 s/s of pain or discomfort...."</p> <p>A nurse's note, dated 11/17/11 at 9:30</p>		<p>that will be reported at the Quarterly QA meetings. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been met the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>				

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	<p>p.m. indicated, "MD [Medical Doctor] in to see Res [Resident #14]. N.O. [New Order] to [symbol for increase] ATB & to use hot compress to wound on left breast for 1/2 hour q [every] 4 hours for a total of 72 hours.</p> <p>A nurse's note, dated 11/17/11 at 9:30 p.m. indicated, "Res cont [continues] on ATB for cellulitis (inflammation of cellular or connective tissue) (sic) see Note from MD.</p> <p>Review of Physician Sheet notes, dated 11/17/11, indicated, "...Blackhead/pimple area R [right] medial lower breast was 'popped' by staff. Yellow white drainage noted...Area became red - Bactrim DS started...[family member] called us today. Red raised area c [with] much larger red firm area to this lateral sebaceous cyst c infection l [left] breast. Local heat [symbol for increase] antibiotic dose - will arrange surgery consult.</p> <p>A nurse's note dated 11/18/11 at 11:40 a.m. indicated, "Phoned Dr... concerning res [resident #14] temp [temperature] and [symbol for change] in LOC [level of consciousness]. Res refused to open mouth for meds [medications] and drinks. Dr.... stated he would call (local hospital) then call this nurse back."</p>				

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	<p>A nurse's note dated 11/18/11 at 12:15 p.m. indicated, "Dr... called this nurse c [with] order to send res to (local hospital) for direct admit to third floor.</p> <p>A hospital "History and Physical" form, dated 11/19/11, indicated, "...The patient (Resident #14) is a nursing home resident with dementia. The staff noted a red, raised area several days ago and this area was 'popped' by a nursing home employee at that time. A yellowish-white discharge was obtained. The area of redness was spread laterally. The initial lesion was in the medial breast. Bactrim DS one twice a day was started on 11/16/11. The area continued to enlarge....Assessment: 1. Cellulitis, left breast. 2. Sebaceous cyst (cyst filled with a fatty secretion) may be the underlying lesion. 3. Dementia...."</p> <p>A "Patient Transfer Form," dated 11/24/11, indicated the resident was at the hospital from 11/18/11 to 11/24/11....Final Diagnosis...infected cyst left breast...Left breast with iodoform packing - changed 11/24/11...."</p> <p>A nurse's note dated 11/24/11 at 8:00 p.m., indicated, "Res arrived to facility at 1900 (7:00 p.m.) via ambulance gurney....Physician's orders sent with res....6 cm [centimeter] incision on lt [left] breast c [with] iodoform (packing)</p>			
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	<p>et covered c bandaid...."</p> <p>Review of Tabor's Cyclopedia Medical Dictionary 16th Edition indicated, "....Sebaceous cyst....One should never attempt to drain such a cyst without taking every precaution against infection."</p> <p>3.1-35(a)(1)</p>				

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F0309 SS=D	<p>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 observation, interview, and record review, the facility failed to ensure nursing staff obtained a physician order before treating an abscess on 1 of 24 resident's reviewed for nursing care in a sample of 24. (Resident #14)</p> <p>Findings Include:</p> <p>On 01/24/12 at 10:00 a.m. CNA #23 and CNA #24 were observed to provide incontinence care on Resident #14. The resident was observed to have a dried scab area on her left inner breast with slightly reddened area surrounding the scab.</p> <p>Interview of the Wound Nurse on 01/24/12 at 10:50 a.m. indicated the Wound Nurse assessed Resident #14 and noted a "great big raised and draining" area. The Wound Nurse indicated the area was "large and stuck out" and Resident #14 looked like she was in pain so she squeezed the area and it drained white/yellow pus.</p> <p>Review of Resident #14's clinical record</p>	F0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The area noted on Resident #14 is currently healed. Bactrim DS was started on 11/15/11, orders were received on 11/17/11 for hot compress to wound, and then on 11/18/11 resident #14 was sent to the hospital for further eval. How other residents having the potential to be affected by teh same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this practice. Skin assessments have been completed on all residents with no areas as stated above noted. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? All staff will be educated on a new skin assessment policy and procedure that prohibits manipulation of any type skin leision without a physician's order. The Policy titled "Skin Integrity: Weekly Skin Assessment" was updated. How the corrective action(s) will be monitored to ensure the deficient</p>	02/25/2012			

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	<p>on 01/23/12 at 3:05 p.m. indicated the following:</p> <p>Resident #14 had diagnoses which included, but were not limited to, late stage Alzheimer disease and Psychosis.</p> <p>A nurse's note dated 11/15/11 at 10:00 a.m. indicated, "During skin assessment (sic) wound nurse noted a black head on (l) [left] breast medial aspect that was raised this week. Wound nurse applied warm water to area & squeezed area in the process getting about 15 cc [milliliters] of yellow & white pus from area c [with] a core hard at average 0.3 x 0.3 (centimeters) size (sic). Bed (wound bed) is 2 x 2 (centimeters) redden (sic) area now that will probably bruise c a 0.1 x 0.1 hole at distal end. MD updated on area. Charge Nurse updated et will notify family.</p> <p>A nurse's note, dated 11/15/11 at 1:00 p.m. indicated, "....Also Bactrim DS (antibiotic medication) BID [twice daily] x 7 days r/t [related to] area between breasts found by skin nurse..."</p> <p>A nurse's note, dated 11/15/11 at 9:40 a.m. indicated, "ATB [Antibiotic] started d/t [due to] area on breast. Area raised et red. 0 [No] s/s [signs/symptoms] of adverse reactions. 0 s/s of pain or</p>		<p>practice will not recur, i.e.what quality assurance program will be put into place? These skin issues will be monitored through the biweekly skin assessments and weekly wound rounds. There will be a monthly QA audit that will be reported at the Quarterly QA meetings. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been meet the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>		

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	<p>discomfort...."</p> <p>A nurse's note, dated 11/17/11 at 9:30 p.m. indicated, "MD [Medical Doctor] in to see Res [Resident #14]. N.O. [New Order] to [symbol for increase] ATB & to use hot compress to wound on left breast for 1/2 hour q [every] 4 hours for a total of 72 hours.</p> <p>A nurse's note, dated 11/17/11 at 9:30 p.m. indicated, "Res cont [continues] on ATB for cellulitis (inflammation of cellular or connective tissue) (sic) see Note from MD.</p> <p>Review of Physician Sheet notes, dated 11/17/11, indicated, "...Blackhead/pimple area R [right] medial lower breast was 'popped' by staff. Yellow white drainage noted...Area became red - Bactrim DS started...[family member] called us today. Red raised area c [with] much larger red firm area to this lateral sebaceous cyst c infection l [left] breast. Local heat [symbol for increase] antibiotic dose - will arrange surgery consult.</p> <p>A nurse's note dated 11/18/11 at 11:40 a.m. indicated, "Phoned Dr... concerning res [resident #14] temp [temperature] and [symbol for change] in LOC [level of consciousness]. Res refused to open mouth for meds [medications] and drinks.</p>						

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	<p>Dr.... stated he would call (local hospital) then call this nurse back."</p> <p>A nurse's note dated 11/18/11 at 12:15 p.m. indicated, "Dr... called this nurse c [with] order to send res to (local hospital) for direct admit to third floor.</p> <p>A hospital "History and Physical" form, dated 11/19/11, indicated, "....The patient (Resident #14) is a nursing home resident with dementia. The staff noted a red, raised area several days ago and this area was 'popped' by a nursing home employee at that time. A yellowish-white discharge was obtained. The area of redness was spread laterally. The initial lesion was in the medial breast. Bactrim DS one twice a day was started on 11/16/11. The area continued to enlarge....Assessment: 1. Cellulitis, left breast. 2. Sebaceous cyst (cyst filled with a fatty secretion) may be the underlying lesion. 3. Dementia....."</p> <p>A "Patient Transfer Form," dated 11/24/11, indicated the resident was at the hospital from 11/18/11 to 11/24/11....Final Diagnosis...infected cyst left breast...Left breast with iodoform packing - changed 11/24/11...."</p> <p>A nurse's note dated 11/24/11 at 8:00 p.m., indicated, "Res arrived to facility at 1900 (7:00 p.m.) via ambulance</p>			
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	<p>gurney....Physician's orders sent with res....6 cm [centimeter] incision on lt [left] breast c [with] iodoform (packing) et covered c bandaid...."</p> <p>Review of Tabor's Cyclopeda Medical Dictionary 16th Edition indicated, "...Sebaceous cyst....One should never attempt to drain such a cyst without taking every precaution against infection."</p> <p>3.1-37(a)</p>			
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F0314 SS=G	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents at risk of pressure ulcers did not develop pressure ulcers, Resident # 57 developed a stage 4 pressure area to his heel and Resident # 112 developed a stage 2 pressure area to her right outer ankle and the facility failed to ensure changes in the residents skin was promptly called to the physician and new interventions implemented when areas changed, Resident # 74's physician was not notified when there was a change in his wound, Resident # 52 did not receive proper pressure relief to prevent two stage 2 pressure sores from developing and Resident # 200 did not receive a treatment to her pressure sore for 7 days after the facility was aware of the open area, for 5 of 6 residents reviewed for pressure in the sample of 24. Resident #74, 57, 52, 200, 112</p> <p>Findings include:</p> <p>1. On the initial tour with Unit Manager #</p>	F0314	<p>What corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #200 no longer resides in the facility. Resident's # 52, 57, and 74 had skin assessments completed. No new areas were found. All pressure reductions interventions were reviewed for proper use. Resident #112 had a skin assessment completed and new excoriation was found on the R buttock and coccyx. The physician was informed and new orders were received. A Turn Q Mattress was applied to resident #112's bed. An ankle brace worn by resident #112 is removed every shift to look for skin impairment. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by this practice. All residents had a skin assessment completed immediately. New areas were noted and the physician's of the residents were notified with orders received as</p>	02/25/2012			

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	<p>1, on 1/23/12 at 9:45 A.M., she indicated Resident # 57 was interviewable, had a history of falls, and had a pressure sore to his right heel.</p> <p>On 1/24/12 at 2:15 P.M., Resident # 57 was observed to be in bed. Resident # 57's right heel was observed to have a quarter sized area with a approximately 20% of the wound base observed to have a yellow exudate.</p> <p>The clinical record for Resident # 57 was reviewed on 1/23/12 at 11:00 A.M. The record indicated Resident # 57 had diagnoses that included but were not limited to pain and history of right hip fracture. The MDS [minimum data set] assessment, dated 10/26/11, indicated Resident # 57 had moderately impaired cognition. Resident # 57 was dependent on two staff for bed mobility and toilet use. Resident # 57 required extensive assistance of two with transfers. Resident # 57 did not ambulate. Resident # 57 had a stage IV pressure ulcer. The admission MDS assessment, dated 5/10/11, indicated Resident # 57 had no pressure ulcers but was at risk to develop a pressure ulcer.</p> <p>A care plan, dated 5/16/11, indicated a problem of "Risk for impaired skin integrity R/T [related to] urinary</p>		<p>necessary. All residents have since had two skin assessments completed every week. All C.N.A.'s have been educated to use a triplicate skin sheet to notify the charge nurse and Director of Nursing about new areas they might find during ADL Care. These notification tools will be used to track the time the area was found to when the charge nurse was notified. Charge nurses have been educated to notify the physicians and responsible parties immediately. The DON will use the third copy to track physician notification. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Glenburn is not going to employ a single person to be responsible as a wound nurse. Unit Managers will resume the responsibility of completing skin assessments Bi-weekly and will do the wound rounds weekly. C.N.A.s have been given triplicate skin sheets to notify nursing staff when new areas are found. A copy will be given to the charge nurse and Director of Nursing. This will allow the tracking of when the areas are found and when the charge nurses are notified. The charge nurses have been educated to assess the area and notify the physician and responsible party immediately. The third copy will be given to the Director of Nursing for tracking appropriate</p>				

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	<p>incontinence occas [occasionally] other: decreased mobility." The interventions included but were not limited to "Weekly skin inspections by licensed nurse."</p> <p>The Nurses Notes, dated 7/20/11 at 9:30 A.M., indicated "Resident c/o [complains of] "burning" in R [right] leg at this time. Upon assessment, this writer noted a 3.0 cm x [by] 3.5 cm necrotic area with 0.5 cm bright red ring around outside of area to R heel. R heel is soft mushy with brown wrinkled skin noted at 5:00 on wound. Also, L [left] heel appears to be red, soft, mushy. Notified MD for treatment orders. Also EZ boots applied..."</p> <p>The Nurses Notes, dated 7/20/11 at 1315 (1:15 P.M.), indicated "Res [resident] has a 4 x 4 x 0 dk [dark] purple red soft deep tissue injury pressure wound to R heel. Periwound is pink et blanching. c/o [complains of] pain 6/10 (pain rated a 6 on a scale of 1 to 10 with 10 being the most intense pain) to heel. EZ boots on while in bed. Nonskid socks on while up in w/c, no shoes until wound is healed except for therapy. MD updated. Tx [treatment] requested. Boost given TID [three times daily]. Spoke with dietary about high cal [calorie] high protein diet."</p> <p>The Nurses Notes, dated 7/20/11 at 1420</p>		<p>physician notification. The Policy titled "Skin Integrity: Weekly Skin Assessment" was updated. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? These skin issues will be monitored through the biweekly skin assessments and weekly wound rounds. There will be a monthly QA audit that will be reported at the Quarterly QA meetings. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been meet the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>				

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	<p>(2:20 P.M.), indicated "N/O [new order] rec'd [received] granulex to bil [bilateral] heels a shift x [times] 14 days then reeval [re-evaluate]. EZ boot on while on bed heels floated nonskid socks while up in w/c no shoes until wound healed..."</p> <p>A care plan, dated 7/20/11, indicated a problem of "Resident has a pressure ulcer on Rt [right] heel D/T [due to] pressure area staged as deep tissue injury at this time. 8-11-11 wound is st [stage] IV." The interventions included but were not limited to "TX's [treatments] as ordered. Pressure reducing mattress on bed. Pressure reducing pad in w/c. Head to toe skin assessment. Labs as ordered. Enc [encourage] resident to consume 75-100% of meals/snacks. Keep skin C & D [clean and dry] if incontinent episodes. Turning and repositioning program. Watch for effectiveness of / response to TX ordered. Notify physician as needed. Bil [bilateral] heels floated while in bed. Nonskid socks wore at all times. Boost TID [three times daily]. 7/27/11 waffle mattress on bed. 8/8/11 Foot cradle on bed. No shoes worn until wound healed."</p> <p>In an interview with the Wound Nurse, on 1/25/12 at 10:45 A.M., she indicated Resident # 57's deep tissue injury was caused by the pressure from his heels being on the mattress.</p>				

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	<p>A Weekly Pressure Ulcer Healing Assessment, dated 7/27/11, indicated "Deep Tissue Injury 4 x [by] 6 x 0...Purple nonblanching fluid filled intact blister soft. Peri wound pink et blanching. No drg [drainage]. No odor. Denies pain but c/o burning to heel. Tx cont [continues] as ordered. Heels floated..."</p> <p>A Pain Assessment, dated 7/29/11, indicated "...Pain is constant R [right] heel...burning sensation, aching R foot/leg...date of onset/years of duration: 7/20/11...Cause of pain in this site-ulcer..."</p> <p>A Weekly Pressure Ulcer Healing Assessment, dated 8/11/11, indicated "Stage 4 3.3 x 3.8 x ?...Deep tissue injury wound is now a St [stage] IV due to black eschar over wound bed with moisture from 11 o' clock to 1 o' clock. Periwound and edges are dk [dark] pink, dry et blanching. no drg. c/o burning to heel. MD aware Tx cont..."</p> <p>In an interview with the Wound Nurse, on 1/25/12 at 1:00 P.M., she indicated she could not find any documentation regarding the physician notification of the change in wound.</p> <p>A Weekly Pressure Ulcer Healing</p>			
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	<p>Assessment, dated 1/17/12, indicated "Stage 4 1.2 x [by] 2 x 0.4...wound bed pink moist with 5% yellow to center deepest part is in center of 0.4 cm. Peri wound pink et [and] blanching no pain no drg [drainage] no odor. Tx [treatment] cont [continues]. Wound edges callous area was debrided per therapy...No change."</p> <p>2. Resident #112 was identified on the initial tour of the facility on 1/23/12 at 9:30 A.M. by the unit manager, as having an open skin area on her right outer calf. Resident #112 was observed on 1/24/12 at 12:30 p.m. Her right ankle was observed to turn inward, with a large wound on the underneath side of her lower leg/ ankle area. The base was red with dark on the outer edges.</p> <p>Resident #112's clinical record was reviewed on 1/23/12 at 2:00 P.M. Diagnoses included but were not limited to diabetes and right sided hemiparesis (paralysis).</p> <p>A care plan, dated 6/28/11, indicated a problem of "Resident has a pressure ulcer on right upper outer malleolus, stage 2, 7/7/11 stage 2 now , 7/14/11 wound is a stage 4 now with eschar noted, 9/15/11 area opened into two separate wounds</p>						

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	<p>now, upper wound is wound A, lower wound is wound B...interventions included: cushioned dressing between skin and brace to right foot until wound is healed, prevalon cushion boot on right foot at all times, turn and repositioning program</p> <p>The Weekly pressure ulcer healing assessments, indicated "date of onset 4/26/11 right outer malleolus, 5/5/11 stage 3 1.4 by .5 by less than .1, 5/26/11, area closed with epithelization and scar tissue to site, sure prep (a coating that protects the skin from breakdown, contains alcohol) to help toughen the skin.</p> <p>The skin wound logs indicated 5/26/11 right outer malleolus...wounds are closed. The log had entries each week with the next entry concerning the right outer ankle 6/17/11 with " dark pink in color 8.5 by 2 by 0 with .4 by .6 brown discoloration." "6/24/11 right outer ankle dark pink are with 8 by 3 with dark red brown discoloration 2 by .5 1 by 1 ..." "7/1/11 right outer ankle see pressure/vascular log."</p> <p>Physician orders indicated sure prep was ordered to the right outer ankle two times daily on 5/26/11. The June 2011</p>						

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	<p>treatment record indicated this was completed on 6/9/11, with "reeval (reevaluate)" written on the sheet. A telephone physician order indicated sure prep was again ordered on 6/24/11 to the right outer ankle.</p> <p>A right ankle radiology report dated 6/18/11 indicated "there is not acute bony abnormality...there is mild diffuse osteopenia, there is some vascular calcification."</p> <p>Documentation was lacking of the physician having been notified of the findings on 6/17 of the wound assessment, or of any treatment to the area from 6/10 through 6/24/11.</p> <p>Nurses notes indicated: "6/24/11 1435 (1:35 A.M.)...new order sure prep wipes to right outer ankle bid (2 times daily) routinely to toughen skin..." "6/25/11 0600 (6 a.m.) area on right heel weeping fluid. sure prep wipe treatment done to outer ankle..." "6/25/11 1430 (2:40 p.m.) area on right ankle weeping clear watery fluid applied sure prep, covered with optifoam and kerlix (dressings) res stated if felt better to be covered." "6/28/11 0720 11 -7 nurses brought it to this writers (wound nurse) attention that resident has drainage soaked</p>						

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	<p>gauze wrap on right foot and has odor for sure prep every shift. So writer went to assess right ankle area. res has an open area to right outer malleolus 2 by 1 by less than .1 with red wound bed and moderate serous yellow drainage and an open area to right outer upper ankle that is 1 by 2 by less than .1 with red wound bed...I believe both are caused from brace that resident wears. her foot is turned in more we have already removed her EZ boots at night. Both areas had a moderate amount of serous drainage noted...doctor updated, new treatment orders requested..." A telephone physician order, dated 6/28/11, indicated 7:30 p.m. new order for 2 wounds on right ankle, discontinue sure prep change to antibiotic ointment with cuticerin and cover with optifoam and kerlix also for prostat 30 ml two times daily to aid in wound healing.</p> <p>The facility lacked evidence of having updated the physician of the worsening wound observed on 6/25 until 6/28/11 when the wound nurse did so.</p> <p>The weekly pressure ulcer assessments indicated; "date of onset 6/28/11 right outer malleolus (wound B) stage 2 2 by 1 by less than .1, red moist wound bed with dark pink blanching moist periwound moderate yellow dressing...padding done to area between skin and brace" and "date</p>				

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	<p>of onset 6/28/11 right outer ankle upper aspect (wound A) 1 by 2 by less than .1 stage 2..." The wound sheets indicated wound a healed on 12/1/11. Wound B was documented as a stage 3 on 7/7/11 with 2 by 1.4 cm, unknown depth, stage 4 on 7/14/11. Wound B continued through 1/18/12 documented as stage 4 (a full thickness of skin and subcutaneous tissue is lost, exposing muscle and or bone.) 4.5 cm by 2.3 c.m. by .1 cm depth, red moist wound bed with pink blanching periwound small amount of bright red bloody drainage, no odor no pain, treatment continues...mist treatment (sent out to hospital for weekly), improved..."</p> <p>A right leg arterial ultrasound, dated 7/19/2011 indicated "abnormal Doppler signal, but no visible evidence of a significant stenosis or obstruction. "</p> <p>During interview with the wound nurse on 1/24/12 at 11:00 A.m. she indicated the resident wore a brace to help support her ankle and provided information on the brace worn. She indicated she did not know when the resident wore the brace and could provided no documentation of the braces use. A physical therapy note, dated 10/09, indicated "fitted with ankle brace." A copy of a ortho lower ankle support, with Resident #112's name of it, indicated "ankle support needed when in</p>						

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	<p>weight bearing (sic)." The product information indicated " fits right or left foot, dual rigid v stirrup straps provide lateral and medial stability for reduced inversion and eversion movements..include 2 horseshoe foam pads." The picture of the product showed it would go over the foot and a few inches above the ankle, the back of the product would have covered the area on the residents right outer ankle. The wound nurse indicated on 1/25/11 at 9:30 A.M. that a podiatrist had stopped the black ankle support, but then started a clear plastic support that went under her foot and up the back of her leg, she provided a telephone order dated 9/30 which indicated to discontinue the brace to right foot and apply protective boots. She indicated she thought the brace referred to in this order was the clear plastic brace ordered by the podiatrist. The facility could find no documentation of this original order or of when this brace was used.</p> <p>During interview with the wound nurse on 1/24/11 at 1:30 P.M. she indicated the area on the residents right outer ankle was a recurrent problem and provided documentation that this area had been open as a stage 3 on 1/5/2010 and continued to have been opened through 9/14/10 when it had healed.</p>						

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	<p>3 On the initial tour with the Assistant Director of Nursing, on 1/23/12 at 9:15 A.M., she indicated Resident # 74 was interviewable and had a wound to his heel that he had for years.</p> <p>The clinical record for Resident # 74 was reviewed on 1/23/12 at 10:00 A.M. The record indicated Resident # 74 had diagnoses that included but were not limited to possible cancer and renal insufficiency. The MDS [minimum data set] assessment, dated 12/21/11, indicated Resident # 74 had no cognitive deficits. Resident # 74 was independent with bed mobility, required extensive assistance with transfers and toilet use. Resident # 74 did not ambulate. Resident # 74 had a stage IV pressure ulcer.</p> <p>A Care plan, dated 5/26/11, indicated a problem of "Resident has a pressure ulcer on Rt [right] heel D/T [due to] Stage IV area is a reoccurring wound over an old Stage IV wound site. Res [resident] has had a lot of problems with this heel wound and it is almost unavoidable."</p> <p>A Weekly Pressure Ulcer Healing Assessment, dated 1/9/12, indicated "...R [right] heel...area closed per MD orders..."</p> <p>A statement from the physician, dated</p>						

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	<p>1/9/12, indicated "In regards to (Resident # 74) right heel wound, even though area continues to be covered with eschar, the wound is the best it's going to be due to tissue loss from old wound and history osteomyelitis. This wound will not completely close, nor heal and debridement is not recommended at this time. So I am going to say that this wound to right heel is basically healed. It is my understanding that a licensed nurse will be inspecting and assessing this area on a weekly basis and will inform me of any new concerns to wound site."</p> <p>A Nurses Note, dated 1/19/12 at 12:30 P.M., indicated "dry thick scab like tissue adhered to sock; when sock removed this scab came out of R heel wound leaving an open area 1.3 x [by] 0.8 x 0.7 no drainage no odor. Wound nurse and Unit manager examined. Res [resident] also has red sl [slightly] raised rash bil [bilateral] arms and face is flushed. Unit manager examined."</p> <p>A Nurses Note, dated 1/19/12 at 12:35 P.M., indicated "Wound bed is pale pink with small amount of tan eschar intact 0.2 x 0.2 to R heel. Dr (name) notified."</p> <p>A Care plan, dated 1/19/12, indicated a problem of "Resident has a pressure ulcer on Rt heel old wound reopened R/T</p>			
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	<p>[related to] Stage IV."</p> <p>In an interview with the Director of Nursing, on 1/23/12 at 2:55 P.M., she stated the Wound Nurse had left a message at the physician office on 1/19/12 regarding the area to the right heel but had not received an answer yet and had called him again today.</p> <p>A Nurses Note, dated 1/23/12 at 1430 (2:30 P.M.), indicated "Dr (name) office phoned per (name) wound nurse for tx [treatment] to heel open area. To return call today with N.O. [new order]."</p> <p>A Nurses Note, dated 1/23/12 at 1500 (3:00 P.M.), indicated "Dr (name) returned call in regards to R heel wound. N.O. left to cover wound with dry gauze et [and] kerlix wrap daily et let wound stay dry. If wound starts to drain MD wants us to notify him. UM [unit manager] aware of orders."</p> <p>4. On the initial tour, with Unit Manager # 1, on 1/23/12 at 9:30 A.M., she indicated Resident # 52 was not interviewable and had an excoriation to her bottom.</p> <p>The clinical record for Resident # 52 was reviewed on 1/23/12 at 1:30 P.M. The record indicated Resident # 52 had</p>						

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	<p>diagnoses that included but were not limited to stroke and Alzheimer's disease. The MDS [minimum data set] assessment, dated 11/23/11, indicated Resident # 52 had moderately impaired cognition. Resident # 52 required extensive assistance of one with bed mobility, transfers, ambulation and toilet use. Resident # 52 had no pressure ulcers but was at risk to develop pressure ulcers.</p> <p>A care plan, dated 9/20/11, indicated a problem of "Risk for impaired skin integrity R/T [related to] urinary incontinence, thin/fragile skin, other: decreased mobility."</p> <p>A care plan, dated 1/16/12, indicated a problem of "Resident has a pressure ulcer on upper rt [right] buttocks wound A (top wound) R/T [related to] Stage II (from shearing)." The interventions included but were not limited to "Placed a 6 inch foam cushion in w/c. Encouraged to lay down on sides after each meal. In house barrier cream around open sheared area, on each shift as a preventative . Staff to reposition resident by standing while up in w/c. Resident is to be up in w/c only for 2 hours at a time as a preventative measure."</p> <p>A care plan, dated 1/16/12, indicated a problem of "Resident has a pressure ulcer</p>				

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	<p>on upper rt [right] buttocks wound B (bottom wound) R/T [related to] Stage II (from shearing)." The interventions included but were not limited to "Placed a 6 inch foam cushion in w/c. Encouraged to lay down on sides after each meal. In house barrier cream around open sheared area, on each shift as a preventative . Staff to reposition resident by standing while up in w/c. Resident is to be up in w/c only for 2 hours at a time as a preventative measure."</p> <p>The Nurses Notes, dated 1/16/12 at 10:30 A.M., indicated "Res [resident] has two open areas on R [right] buttock from shearing. We have a wound A- top wound et [and] Wound B- bottom wound of R buttocks. Res is up in w/c et is fidgety constantly shifting et scooting forward. I believe shearing was self inflicted. Old pressure reduced (sic) cushion in w/c was removed et a 6 inch foam cushion applied. This cushion will hopefully reduce discomfort to buttocks while sitting. Staff educated on repositioning resident while chair, there is an order for resident to resident to lay down after meals. Wound A is a 1 x 1.8x< [less than] 0.1 open area St [stage] II from shearing with red bed et dk pink dry peeling peri wound. no drg [drainage] no odor. Res [resident] c/o [complains of] pain 7/10 (7 out of 10 on a scale of 1 to 10 with a 10</p>						

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	<p>being intense pain) with touch only but refuses pain meds [medications]. Wound B is 0.1 x 0.4 x <0.1 open area from shearing with red dry bed et dk pink peeling peri wound. no drg no odor c/o pain 7/10 with touch only but ref [refused] pain meds. St II area too. Coccyx is closed by peeling et dk pink. In house calazime. MD updated on both areas et tx [treatment] requested. Res is on Boost TID [three times daily] to help nutrition status. Pressure reducing mattress on bed. Staff will keep turned Q [every] 2 hours."</p> <p>A physician order, dated 1/17/12, indicated "Opsite to area on coccyx. Change Q 3 days or prn/soiling [as needed]."</p> <p>5. The closed record for Resident # 200 was reviewed on 1/24/12 at 10:00 A.M. The record indicated Resident # 200 had diagnoses that included but were not limited to weakness and gait dysfunction. The MDS [minimum data set] assessment, dated 12/30/11, indicated Resident # 200 had moderately impaired cognition. Resident # 200 required extensive assistance of one with bed mobility, transfers, and toilet use. Resident # 200 had a stage II pressure sore.</p>						

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	<p>The Nurses Notes, dated 12/23/11 at 1735 (5:35 P.M.), indicated "...Small opening on coccyx measured wound nurse to see also..."</p> <p>The Nurses Notes, dated 12/23/11 at 2300 (11:00 P.M.), indicated "....Wound on coccyx had drsg [dressing] 1/2 off with blood on drsg. Assessed wound on coccyx to be at 0.5 x [by] 0.5 x 1. Cleansed, atb [antibiotic] ointment applied and dressed with telfa and medflex as nsg [nursing] measure..."</p> <p>A care plan, dated 12/23/11, indicated a problem of "Admitted to the facility with the following skin problems Other: burn Rt [right] femur." The interventions were "Treatments per MD order. Use pressure reducing/relieving mattress on bed prn [as needed]. Diet per order, dietary to assess protein and nutritional needs. Keep site clean and dry. Refer to wound team for follow-up prn. Follow all protocols per admission skin assessment."</p> <p>The Nurses Notes, dated 12/27/11 at 7:00 A.M., indicated "After further investigation per wound nurse of open area found on coccyx (pressure) on admission, area is not on coccyx it is R [right] inner buttocks. Coccyx is clear with skin intact. R inner buttocks has a superficial St [stage] II 0.4 x 0.3 x < [less</p>			

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	<p>than] 0.1 with dk [dark] pink wound bed et pink blanching peri wound. no pain no odor no drainage. MD updated for tx [treatment] orders..."</p> <p>In an interview with the Wound Nurse, on 1/25/12 at 1:00 P.M., she indicated she had faxed the physician on 12/27/11 and had not received a response by 1/3/12. She further indicated she had notified the Director of Nursing via email that Resident # 200 had went 7 days without treatment to her open area.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F0323 SS=D	<p>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.</p> <p>Based on observation, interview, and record review the facility failed to ensure nursing staff utilized a mechanical lift properly while transferring 1 of 1 resident reviewed for lift transfers in a sample of 24. (Resident #14)</p> <p>Findings Include:</p> <p>On 01/24/12 at 10:00 a.m. CNA #23 and CNA #24 were observed to transfer Resident #14 from the resident's wheelchair to her bed using a Guardian Hoyer mechanical lift. While transferring the resident approximately 3 feet, the base of the lift remained closed during the transfer from the wheelchair to the bed. After the transfer, CNA #23 read the instructions. CNA #24 indicated she had never been inserviced on transfers with mechanical lifts and CNA #23 indicated it had been a while since she had been inserviced on mechanical lift transfers.</p> <p>Manufacturers instruction's on the side of the lift indicated the base should have been adjusted to the widest possible setting.</p> <p>Review of Resident #14's clinical record</p>	F0323	<p>What corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 14 was transferred safely without any injury on 1.24.12. C.N.A. #23 and #24 were both immediately educated on the proper use of a lift. Then, on 1.24.12, Staff education began for the whole building on the proper use of a mechanical Lift. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the practice. Manufacturers guidelines on the lift state the base should be at its widest possible setting. All staff will be educated on the proper use of a mechanical lift as recommended by the manufacturers guidelines. Then, All staff will be checked off by demonstrating proper usage of a mechanical lift. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be monitored for proper usage of a mechanical lift by random observation. These finding will be reported on a QA tool. All new employees will be trained during</p>	02/25/2012			

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	<p>on 01/23/12 at 3:05 p.m. indicated the following:</p> <p>Resident #14 had diagnoses which included, but were not limited to, late stage Alzheimer Disease and Dementia with agitation.</p> <p>An MDS [Minimum Data Set] assessment, dated 10/26/11, indicated Resident #14 had severe cognitive impairment, did not walk, had impairment in lower extremity range of motion, and required extensive assistance of staff for transfers and care.</p> <p>3.1-45(a)(2)</p>		<p>General Orientation. All employees will be trained Bi-annually along with a check off return demonstration. How the corrective Action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Staff will be monitored for proper usage of a mechanical lift by random observation. These findings will be reported on a QA tool. Corrective actions, will be taken immediately for any deficient practice noted. Audits will be completed every month and reported at the quarterly QA meeting. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been meet the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>		

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F0332 SS=D	<p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation and record review, the facility failed to ensure an error rate of less than 5 % during a total of 40 medications observed being administered with 4 errors. This resulted in an error rate of 10%. (Resident #38, Resident #88, Resident #104, and Resident #102)</p> <p>Findings Include.</p> <p>1. On 01/24/12 at 3:45 p.m., LPN #20 was observed to administer 16 units of Novolog insulin subcutaneously in Resident #38 abdomen.</p> <p>Review of #38's clinical record on 01/25/11 at 10:00 a.m. indicated Resident ??? had diagnoses which included, but were not limited to insulin dependent Diabetes and shortness of breath.</p> <p>Resident #38 was observed to not be served supper until 5:15 p.m.</p> <p>2. On 01/24/12 at 4:10 p.m., RN #21 was observed to administer 12 units of Humalog 75-25 insulin subcutaneously in Resident # 88's abdomen.</p> <p>Review of Resident #88s clinical record on 01/25/12 at 10:07 a.m. indicated</p>	F0332	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 38, 88, 104, and 102 were monitored with no ill effects noted. All fast acting insulins will be given at mealtime as indicated on the MAR, instead of a specified time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the practice. All residents that receive fast acting insulins will be scheduled at mealtimes. With the deficient practice, insulins were scheduled for a particular time, as indicated on the MAR. All times have been change for the fast acting insulins to be given at mealtimes as now indicated on the MAR. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nursing Administration will monitor MAR's to make sure fast acting insulins are given "at mealtime". Nursing administration will do random observations of med passes to make sure the insulin is given as specified by the drug manufacturers guidelines. How the corrective action(s) will be monitored to</p>	02/25/2012			

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	<p>Resident #88 had diagnoses which included, but were not limited to insulin dependent Diabetes Mellitus.</p> <p>Resident #88 was observed to not be served supper until 5:15 p.m.</p> <p>3. On 01/24/12 at 4:45 p.m., LPN #22 was observed to administer 4 units of Novolog insulin subcutaneously in Resident #104's abdomen.</p> <p>Review of Resident #104's clinical record on 01/15/12 at 10:12 a.m. indicated Resident #104 had diagnoses which included, but were not limited to, insulin dependent Diabetes.</p> <p>Resident #104 was observed to not be served supper until 5:15 p.m.</p> <p>4. On 01/24/12 at 4:50 p.m., LPN #22 was observed to administer 8 units of Novolog insulin subcutaneously in Resident #102's abdomen.</p> <p>Review of Resident #102's clinical record on 01/25/12 at 10:15 a.m. indicated Resident #102 had diagnoses which included, but were not limited to Diabetes Mellitus Type II and Dementia.</p> <p>Resident #102 was observed to not be served supper until 5:16 p.m.</p>		<p>ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? This corrective action will be monitored through QA audit tools. Audits will be completed monthly and will be reported at the Quarterly QA meeting. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been meet the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>				

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	<p>Review of Nursing Spectrum Drug Handbook 2006 indicated Novolog insulin should be given 15 minutes before meals because of it's rapid onset of action.</p> <p>Review of Nursing Spectrum Drug Handbook 2006 indicated Humalog 75/25 should be given 15 minutes before meals to avoid hypoglycemia (low blood sugar).</p> <p>3.1-25(b)(9)</p>			
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F0498 SS=D	<p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on observation, interview, and record review the facility failed to ensure nursing staff utilized a mechanical lift properly while transferring 1 of 1 resident reviewed for lift transfers in a sample of 24. (Resident #14)</p> <p>Findings Include:</p> <p>On 01/24/12 at 10:00 a.m. CNA #23 and CNA #24 were observed to transfer Resident #14 from the resident's wheelchair to her bed using a Guardian Hoyer mechanical lift. While transferring the resident approximately 3 feet, the base of the lift remained closed during the transfer from the wheelchair to the bed. After the transfer, CNA #23 read the instructions. CNA #24 indicated she had never been inserviced on transfers with mechanical lifts and CNA #23 indicated it had been a while since she had been inserviced on mechanical lift transfers.</p> <p>Manufacturers instruction's on the side of the lift indicated the base should have been adjusted to the widest possible setting.</p>	F0498	<p>What corrective Action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 14 was transferred safely without any injury on 1.24.12. C.N.A. #23 and #24 were both immediately educated on the proper use of a lift. Then, on 1.24.12, Staff education began for the whole building on the proper use of a mechanical Lift. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the practice. Manufacturers guidelines on the lift state the base should be at its widest possible setting. All staff will be educated on the proper use of a mechanical lift as recommended by the manufacturers guidelines. Then, All staff will be checked off by demonstrating proper usage of a mechanical lift. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be monitored for proper usage of a mechanical lift by random observation. These finding will be reported on a QA tool. All new</p>	02/25/2012			

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	<p>Review of Resident #14's clinical record on 01/23/12 at 3:05 p.m. indicated the following:</p> <p>Resident #14 had diagnoses which included, but were not limited to, late stage Alzheimer Disease and Dementia with agitation.</p> <p>An MDS [Minimum Data Set] assessment, dated 10/26/11, indicated Resident #14 had severe cognitive impairment, did not walk, had impairment in lower extremity range of motion, and required extensive assistance of staff for transfers and care.</p> <p>3.1-14(i)</p>		<p>employees will be trained during General Orientation. All employees will be trained Bi-annually along with a check off return demonstration. How the corrective Action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? Staff will be monitored for proper usage of a mechanical lift by random observation. These findings will be reported on a QA tool. Corrective actions, will be taken immediately for any deficient practice noted. Audits will be completed every month and reported at the quarterly QA meeting. This will be completed for two Quarterly QA meetings. The committee will then determine if compliance has been met. If compliance has been met the audit tool will become a quarterly audit. By what date the systemic changes will be completed? 2.25.12</p>		