

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155621	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PINE HAVEN HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3400 STOCKER DR EVANSVILLE, IN47720		
(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	
F0000	<p>This visit was the Post-Survey Revisit (PSR) to the Investigation of Complaints IN00089836, IN00089626, and IN00089748 completed on May 5, 2011.</p> <p>This visit included the PSR to the Investigation of Complaint IN00088724 completed on April 14, 2011.</p> <p>This visit included the Investigation of Complaint IN00090882.</p> <p>Complaint IN00089836- Not Corrected. Complaint IN00089626- Not Corrected. Complaint IN00089748- Not Corrected.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: June 13, 14, 15, and 16, 2011</p> <p>Facility number: 000442 Provider number: 155621 AIM number: 100266510</p> <p>Survey team: Anne Marie Crays, RN</p> <p>Census bed type: SNF: 38 SNF/NF: 61 Total: 99</p>	F0000	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 29, 2011 to the complaint survey conducted on June 16, 2011. We respectfully request that you review this information, request any further information you may require, and then consider a desk review.</p>		

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

TITLE

(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>Census payor type: Medicare: 20 Medicaid: 45 Other: 34 Total: 99</p> <p>Sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 20, 2011 by Bev Faulkner, RN</p>				

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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 observation, interview, and record review, the facility failed to notify a physician and family promptly of a pressure ulcer on a resident's left heel, for 1 of 4 residents reviewed for physician and family notification of pressure ulcers, in a sample of 8. Resident D</p>	F0157	<p>F157 It is the practice of this facility to assure that the physician and family are notified appropriately in accordance with the guidelines at the first sign of skin breakdown. The corrective action taken for those residents found to be affected by the deficient practice</p>	06/29/2011	

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	<p>Findings include:</p> <p>On 6/13/11 at 9:50 A.M., during the initial tour, LPN # 1 indicated Resident D had a pressure area on his left heel.</p> <p>The clinical record of Resident D was reviewed on 6/14/11 at 9:20 A.M.</p> <p>The resident was readmitted to the facility on 6/4/11, after being hospitalized from 6/2/11 to 6/4/11.</p> <p>A Nurses' Admission Record, dated 6/4/11, indicated, "Skin Problems...G. Unstageable area red 2 x 3 [centimeters]...." An anatomical drawing indicated "G" was on the left heel area. Further documentation of the left heel pressure area in the clinical record was lacking until 6/6/11. Documentation of family notification of the pressure area was lacking in the clinical record.</p> <p>A Nurse's Note, dated 6/6/11 at 2:15 P.M., indicated, "...[Left] heel [with] unstageable pressure ulcer. Heel floated at all times...."</p> <p>A Physician's order, dated 6/7/11 at 8:00 A.M., indicated, "Skin prep to [left] heel Q [every] shift x 21 days. Multipodous boot to [left] heel to relieve pressure. May remove for bathing."</p>		<p>include: Resident D's physician and family have been notified appropriately. Other residents that have the potential to be affected have been identified by: All residents with any type of skin breakdown have been reviewed to assure that physicians/families have been notified appropriately. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nurses have been in-serviced related to the importance of physician/family notification regarding significant changes, including the presence of skin breakdown. As the interdisciplinary team is reviewing any type of skin breakdown or any other type of significant change, they are reviewing all documentation to assure that the physician/family was notified appropriately. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to review skin issues, and to assure that the physician/family have been notified in accordance with the regulation. The tool will randomly review 5 residents (if applicable) with known skin breakdown. Nursing Administration, or designee, will complete this audit weekly x3,</p>				

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	<p>On 6/14/11 at 9:30 A.M., LPN # 1 provided a "Skin Ulcer Documentation" form for Resident D. The form indicated, "Pressure, Location: (L) heel. Date 6/6/11, Stage: Unstageable, Length x Width, 2 x 3, Depth, < 0.1...Tissue Type, eschar [black, scabbing]...When physician notified/saw, yes.</p> <p>6/13/11...Length x Width .2 x .2, .3 x .3...color tan, tissue type, closed..."</p> <p>On 6/14/11 at 9:30 A.M., during interview, LPN # 1 indicated the resident was readmitted from the hospital with the pressure ulcers on his heel. LPN # 1 indicated the resident was readmitted to the facility on a Saturday, and the areas on his left heel were measured on a Monday. LPN # 1 indicated the nurse who readmitted the resident was a "PRN [as needed] person," and did not routinely work at the facility. LPN # 1 indicated the nurse should have notified the physician and obtained a treatment order, and started the "skin sheets." LPN # 1 indicated she may have put the wrong date when she notified the physician of the pressure areas on Tuesday 6/7, because she thought she notified him on Monday 6/6.</p> <p>On 6/14/11 at 9:45 A.M., Resident D's left heel was observed to have two intact</p>		<p>monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: June 29, 2011</p>		

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	<p>tannish areas, with no surrounding redness. LPN # 1 indicated the areas were almost healed, and the resident received "skin prep" to each of the areas.</p> <p>On 6/15/11 at 10:45 A.M., the Assistant Director of Nursing [ADON] provided the current facility policy on "Pressure Ulcer Prevention & Management," dated 10/08. The policy included: "Policy, To ensure that a resident...who has an ulcer receives care and services to promote healing and to prevent additional ulcers...Procedure, ...Notify the physician for treatment orders and implement...Notify the resident's responsible party of the condition change and physician orders received...."</p> <p>3.1-5(a)(1)</p>				

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F0225	F225 It is the practice of this facility to assure that any form of abuse is reported to the Administrator immediately and that any personnel involved are removed from the schedule	06/29/2011	

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			<p>pending investigation. The corrective action taken for those residents found to be affected by the deficient practice include: There have been no further abusive incidents reported since the surveyor exited. Resident I has shown no negative impact related to the documented incident. LPN #2 has been individually educated related to the following of facility policy. Other residents that have the potential to be affected have been identified by: Potentially all residents could be affected. However, there have been no allegations or observations of incidents of abuse with any other residents since the surveyor exited. The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include: The policy related to how to appropriately intervene related to any allegation of abuse has been reiterated with all nursing staff members. The in-service was designed to assure a thorough understanding of the policy including the reporting of abuse to the facility Administrator and assuring that any personnel against which the allegation was made are removed from duty pending the investigation. The corrective action taken to monitor performance to assure compliance through quality assurance is: An</p>		

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	<p>Based on interview and record review, the facility failed to ensure a staff member [RN # 1] accused of abuse by Resident I was immediately sent home, and was instead allowed to continue her shift for 5 hours, potentially affecting 39 residents residing on the North and South units on which the staff member worked, in a sample of 5 Units, and 1 of 3 residents reviewed for abuse in a sample of 8.</p> <p>Findings include:</p> <p>On 6/13/11 at 10:30 A.M., the Administrator provided a "Facility Incident Reporting Form," sent to the</p>		<p>updated Performance Improvement Tool will be utilized to review the proper following of the abuse policy, including removing any employees from the schedule pending investigation based on the allegation that has been made. The tool will be utilized to review any allegation of abuse. The Administrator, or designee, will complete this audit as any allegations occur for the next 6 months. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: June 29, 2011</p>		

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	<p>Indiana State Department of Health on 6/10/11. The form included: "...Brief Description of Incident:...At 2:50 am [sic] another aide responded to resident's call light and resident stated that nurse had hit her. Night supervisor notified of allegations...." An accompanying statement, dated 6/10/11, indicated, "...At 2:50am [sic] [CNA # 2] responded to resident's call light and states that resident told her 'that lady hit me again' and that a tall guy was with her. [LPN # 2], night supervisor was notified and spoke with nurse involved as well as resident. [LPN # 2] reports resident was 'pleasant and smiling' at this time...At approx 9:00 a.m., this administrator, the ADON, and the social worker met regarding the incident...No other alert/oriented residents had complaints of mistreatment...SW [social worker] also spoke with resident today and resident did not appear to have memory of any incident last night...[RN # 1] will be notified that she may return to work as scheduled."</p> <p>A facility "Employee Counselling [sic] Form," dated 6/11/11 and documented with LPN # 2's name, indicated, "...Type of Occurrence: Failure to immediately initiate suspension of staff member when knowledge was received of physical abuse allegation...Solution Discussed: Abuse policy review - with special focus on</p>				

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	<p>Reporting Procedures 'Any staff member alleged to have abused a resident will immediately be suspended from further time worked. The individual in charge of the staff member will initiate the suspension...'</p> <p>On 6/14/11 at 12:05 P.M., the Administrator provided documentation that RN # 1 worked from 6/9/11 at 11:01 P.M. until 6/10/11 at 8:03 A.M.</p> <p>On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she notified her night supervisor at approximately 3:00 A.M., on 6/10/11 that Resident I had complained of RN # 1 hitting her. RN # 1 indicated she did not go into that resident's room for the remainder of her shift, but did work the remainder of her shift.</p> <p>On 6/15/11 at 8:45 A.M., the Assistant Director of Nursing provided the revised facility policy on "Abuse Prohibition," revised 2/11. The policy included: "...Purpose, To ensure that all allegations of abuse are investigated fully for possible substantiation...The alleged staff member will be relieved from his/her duties pending investigation..."</p> <p>This Federal Tag relates to Complaints IN00089836 and IN00089748.</p>						

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	This deficiency was cited on 4/14/11 and 5/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-28(c)				

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F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F0226	F226 It is the practice of this facility to assure that any form of abuse is reported to the administrator immediately and that any personnel involved are removed from the schedule pending investigation in accordance with facility policy. <i>The corrective action taken for those residents found to be affected by the deficient practice include:</i> There have been no further abusive incidents reported since the surveyor exited. Resident I has shown no negative impact related to the documented incident. LPN #2 has been individually education related to the following of facility policy. <i>Other residents that have the potential to be affected have been identified by:</i> Potentially all residents could be affected. However, there have been no allegations or observations of incidents of abuse with any other residents since the surveyor exited. <i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:</i> The policy related to how to appropriately intervene related to any allegation of abuse has been reiterated with all	06/29/2011	

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	Based on interview and record review, the facility failed to implement their policies on abuse prohibition, in that a staff member [RN # 1] accused of abuse by Resident I was not immediately sent		nursing staff members. The in-service was designed to assure a thorough understanding of the regulation including the reporting of abuse to the facility Administrator and assuring that any personnel against which the allegation was made are removed from duty pending the investigation. The corrective action taken to monitor performance to assure compliance through quality assurance is: An updated Performance Improvement Tool will be utilized to review the proper following of the abuse policy, including removing any employees from the schedule pending investigation based on the allegation that has been made. The tool will be utilized to review any allegation of abuse. The Administrator, or designee, will complete this audit as any allegations occur for the next 6 months. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: June 29, 2011		

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	<p>home, and was instead allowed to continue her shift for 5 hours, potentially affecting 39 residents residing on the North and South units on which the staff member worked, in a sample of 5 Units, and 1 of 3 residents reviewed for abuse in a sample of 8.</p> <p>Findings include:</p> <p>1. On 6/15/11 at 8:45 A.M., the Assistant Director of Nursing provided the revised facility policy on "Abuse Prohibition," revised 2/11. The policy included: "...Purpose, To ensure that all allegations of abuse are investigated fully for possible substantiation...The alleged staff member will be relieved from his/her duties pending investigation...."</p> <p>2. On 6/13/11 at 10:30 A.M., the Administrator provided a "Facility Incident Reporting Form," sent to the Indiana State Department of Health on 6/10/11. The form included: "...Brief Description of Incident:...At 2:50 am [sic] another aide responded to resident's call light and resident stated that nurse had hit her. Night supervisor notified of allegations..." An accompanying statement, dated 6/10/11, indicated, "...At 2:50 am [sic] [CNA # 2] responded to resident's call light and states that resident told her 'that lady hit me again' and that a</p>						

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	<p>tall guy was with her. [LPN # 2], night supervisor was notified and spoke with nurse involved as well as resident. [LPN # 2] reports resident was 'pleasant and smiling' at this time...At approx 9:00 a.m., this administrator, the ADON, and the social worker met regarding the incident...No other alert/oriented residents had complaints of mistreatment...SW [social worker] also spoke with resident today and resident did not appear to have memory of any incident last night...[RN # 1] will be notified that she may return to work as scheduled."</p> <p>A facility "Employee Counselling [sic] Form," dated 6/11/11 and given to LPN # 2, indicated, "...Type of Occurrence: Failure to immediately initiate suspension of staff member when knowledge was received of physical abuse allegation...Solution Discussed: Abuse policy review - with special focus on Reporting Procedures "Any staff member alleged to have abused a resident will immediately be suspended from further time worked. The individual in charge of the staff member will initiate the suspension...."</p> <p>On 6/14/11 at 12:05 P.M., the Administrator provided documentation that RN # 1 worked from 6/9/11 at 11:01 P.M. until 6/10/11 at 8:03 A.M.</p>				

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	<p>On 6/16/11 at 6:25 A.M., during interview with RN # 1, she indicated she notified her night supervisor at approximately 3:00 A.M., on 6/10/11 that Resident I had complained of RN # 1 hitting her. RN # 1 indicated she did not go into that resident's room for the remainder of her shift, but did work the remainder of her shift.</p> <p>This deficiency was cited on 4/14/11 and 5/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This Federal Tag relates to Complaints IN00089836 and IN00089748.</p> <p>3.1-28(c)</p>				

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F0314 SS=D	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.	F0314	F314 It is the practice of this facility to assure that all residents receive the necessary care and services to prevent and treat pressure ulcers. <i>The corrective action taken for those residents found to be affected by the deficient practice include:</i> Resident D has an appropriate treatment in place and the area is improving. <i>Other residents that have the potential to be affected have been identified by:</i> All residents that currently have pressure ulcers have been reviewed to assure that proper treatments and services are in place to assist with the healing of wounds. <i>The measures or systemic changes that have been put into place to ensure that the deficient practice does not recur include:</i> Nurses have been in-serviced related to the prevention and/or treatment of	06/29/2011	

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			pressure ulcers. The in-service included assuring that treatments are obtained immediately at the earliest sign of skin breakdown. The in-service emphasized the need to review new admissions and re-admissions to assure that, if any areas are present, a treatment is obtained in a timely manner. Medical documentation for all new admissions and re-admissions will be reviewed by the interdisciplinary team to assure that appropriate interventions related to actual skin breakdown occur appropriately. The corrective action taken to monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that will be utilized to observe for the provision of wound care, assuring that treatment was obtained timely and to assure that the physician/family were notified appropriately. The tool will randomly review 5 residents (if applicable) to assure that proper interventions are in place related to the prevention and/or treatment of pressure ulcers, that treatments were obtained timely, and that the physician/family were notified timely. Nursing Administration, or designee, will complete this audit weekly x3, monthly x3, then quarterly x3. Any issue identified will be immediately corrected. The		

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	<p>Based on observation, interview, and record review, the facility failed to ensure a resident re-admitted from the hospital with a pressure ulcer to his left heel received prompt treatment to the area, for 1 of 4 residents reviewed with pressure ulcers, in a sample of 8. Resident D</p> <p>Findings include:</p> <p>On 6/13/11 at 9:50 A.M., during the initial tour, LPN # 1 indicated Resident D had a pressure area on his left heel.</p> <p>The clinical record of Resident D was reviewed on 6/14/11 at 9:20 A.M.</p> <p>A Care Plan, initially dated 5/10/11 and updated 5/23/11, indicated a problem of "At risk for pressure ulcer (moderate risk) Related To:...Edema, Disease process/condition...H/O [history of] pressure ulcers." The Interventions included: "Float heels."</p> <p>The resident was readmitted to the facility on 6/4/11, after being hospitalized from</p>		<p>Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The date the systemic changes will be completed: June 29, 2011</p>		

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	<p>6/2/11 to 6/4/11.</p> <p>A Nurses' Admission Record, dated 6/4/11, indicated, "Skin Problems...G. Unstageable area red 2 x 3 [centimeters]...." An anatomical drawing indicated "G" was on the left heel area. Further documentation of the left heel pressure area in the clinical record was lacking until 6/6/11.</p> <p>A Nurse's Note, dated 6/6/11 at 2:15 P.M., indicated, "...[Left] heel [with] unstageable pressure ulcer. Heel floated at all times...."</p> <p>A Physician's order, dated 6/7/11 at 8:00 A.M., indicated, "Skin prep to [left] heel Q [every] shift x 21 days. Multipodus boot to [left] heel to relieve pressure. May remove for bathing."</p> <p>On 6/14/11 at 9:30 A.M., LPN # 1 provided a "Skin Ulcer Documentation" form for Resident D. The form indicated, "Pressure, Location: (L) heel. Date 6/6/11, Stage: Unstageable, Length x Width, 2 x 3, Depth, < 0.1...Tissue Type, eschar [black, scabbing]...When physician notified/saw, yes.</p> <p>6/13/11...Length x Width .2 x .2, .3 x .3...color tan, tissue type, closed...."</p>				

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	<p>On 6/14/11 at 9:30 A.M., during interview, LPN # 1 indicated the resident was readmitted from the hospital with the pressure ulcers on his heel. LPN # 1 indicated the resident was readmitted to the facility on a Saturday, and the areas on his left heel were measured on a Monday. LPN # 1 indicated the nurse who readmitted the resident was a "PRN [as needed] person," and did not routinely work at the facility. LPN # 1 indicated the nurse should have notified the physician and obtained a treatment order, and started the "skin sheets." LPN # 1 indicated she may have put the wrong date when she notified the physician of the pressure areas on Tuesday 6/7, because she thought she notified him on Monday 6/6.</p> <p>On 6/14/11 at 9:45 A.M., Resident D's left heel was observed to have two intact tannish areas, with no surrounding redness. LPN # 1 indicated the areas were almost healed, and the resident received "skin prep" to each of the areas.</p> <p>On 6/15/11 at 10:45 A.M., the Assistant Director of Nursing [ADON] provided the current facility policy on "Pressure Ulcer Prevention & Management," dated 10/08. The policy included: "Policy, To ensure that a resident...who has an ulcer receives care and services to promote healing and</p>				

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	<p>to prevent additional ulcers...Procedure, An initial skin assessment will be done on each resident at the time of admission or readmission...If a pressure ulcer/wound is present, a 'Pressure Ulcer/Wound Documentation' form will be completed for each area with all parameters covered including: stage, size, depth, exudate [drainage]...Notify the physician for treatment orders and implement...Notify the resident's responsible party of the condition change and physician orders received. Notify the dietician for nutritional intervention that may be needed...Document the plan of care on the resident's care plan and implement...."</p> <p>According to "Stages of Pressure Ulcers," AMDA 2008: "<u>Unstageable</u>: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the ulcer bed.</p> <p>Note: Until enough slough or eschar is removed to expose the base of the ulcer, the true depth and therefore stage, cannot be determined...."</p> <p>This deficiency was cited on 5/5/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011

FORM APPROVED

OMB NO. 0938-0391

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	This Federal Tag relates to Complaint IN00089626. 3.1-40(a)(2)				