STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF SCOTTSBURG THE	1350 N TODD DR SCOTTSBURG, IN 47170

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F0000	This visit was for Investigation of Complaint IN00117976. Complaint IN00117976 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F314 and F325. Survey dates: 11/2/12 and 11/5/12 Facility number: 000478 Provider number: 155494 AIM number: 100290430 Survey team: Jennie Bartelt, RN Census bed type: SNF/NF: 66 Total: 66 Census payor type: Medicare: 7 Medicaid: 50 Other: 9 Total: 66 Sample: 4 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/13/12 Cathy Emswiller RN	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. Compliance date is November 23rd, 2012 The facility respectfully request paper compliance for this plan of correction.	

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

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

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to ensure the physician was notified timely of changes in drainage and a pressure ulcer's increased size and failure to improve. The deficient practice	F0157	F 157 Notifications of Changes It is the practice of this facility to provide the resident's physician and family/POA timely notification of significant changes to the resident's pressure ulcers.	11/23/2012

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	affected 1 of 4 residents reviewed related to physician notification in a sample of 4. (Resident B) Findings include: The clinical record for Resident B was reviewed on 11/2/12 at 1:35 p.m. The record indicated the resident was readmitted to the facility after hospitalization on 3/25/12. A Pressure Ulcer Condition Monitoring Sheet, dated 5/8/12, indicated a pressure wound to the resident's right gluteal fold was 1.8 cm X 1.4 cm X 0.2 cm, brownish in color, with slough and moderate, non-odorous drainage. (AMDA Clinical Practice guideline describes a Stage 2 pressure ulcer as "Partial thickness loss of dermis presenting as a shallow open ulcer wit a red pink ulcer bed, without slough," and a Stage 3 pressure ulcer as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss...." Therefore, the wound was a Stage 3 ulcer.) The Pressure Ulcer Condition Monitoring Sheet indicated the right gluteal fold wound descriptions as follows:		Actions Taken Resident B passed away on 10/31/12Others IdentifiedNo other residents were identified in this finding.All residents at risk for developing pressure areas could be affected by this finding.Measures TakenAll licensed nursing staff has been in-serviced on timely physician and family notification of significant changes in resident condition. Special focus of notification of changes in the condition of a resident wound was reviewed.Complete audit of all current residents' medical record was reviewed in the facility PAR (Patient at Risk) program. The Director of Nursing/Designee will review resident weekly skin assessments,treatments, and wound condition at the facility weekly PAR meetings to ensure physician and family/POA are notified timely of significant changes to the wound.The Director of Nursing/Designee will review24-hour reports and new physician orders daily in the facility department head meeting to ensure timely notification of significant changes was completed to the resident physician and family/POA.How MonitoredThe Director of Nursing/Designee will review resident weekly skin assessments, treatments, and wound condition at the facility weekly PAR meetings to ensure physician and family/POA are notified timely of significant	

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	5/19/12 - 1 X 1 X 0.2 cm., yellow color, no drainage, no odor. 5/23/12 - 1.7 X 1.8 X 1.6 cm, yellow color, moderate drainage, no odor. 6/9/12 - 1.3 X 1.9 X 0.3 cm, pink/red color, no drainage, no odor. 6/30/12 (no measurements indicated from 6/9 to 6/30/12) - 0.8 X 1.2 X 0.8 cm, pink/red color, scant serosanguineous drainage, description of odor not indicated. 7/7/12 - 0.8 X 1.2 X 0.8 cm., pink color, scant serosanguineous drainage, description of odor not indicated. 7/14/12 - 1.8 X 1.8 X 0.8 cm., light pink slough color, moderate green serosanguineous drainage, no odor. During interview on 11/5/12 at 10:55 a.m., the DON indicated she could not find that the physician was notified of the change in wound drainage on 7/7/12. Nurse's Notes for July 2012 did not indicate the physician was notified of the increased size of the wound as measured on 7/14/12. 7/21/12 - 1.6 X 1.4 X 0.8 cm, no color		changes to the wound. Any negative findings will be immediately addressed.The Director of Nursing/Designee will review24-hour reports and new physician orders daily in the facility department head meeting to ensure timely notification of significant changes was completed to the resident physician and family/POA.The Director of Nursing/Designee will report findings of the chart reviews to the Quality Assurance Committee on a monthly basis for 3 months. The findings will be discussed with the Medical Director at the quarterly Quality Assurance Meeting. Adjustments to the audit schedule will be recommended by the Quality Assurance Committee based on findings of the monthly/quarterly audit findings.5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. F157 The monitoring of the weekly skin assessments, treatments and wound conditions will be monitored on an ongoing basis at the weekly PAR meetings. The QA team will monitor monthly for 3 months then quarterly ongoing. Our date of compliance is 11.23.12.	

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	indicated, moderate greenish drainage, description of odor not indicated. On 7/21/12 a Physician's Telephone Order was obtained to change the treatment to the right gluteal wound to "Clean wound [with] NS [normal saline] to R gluteal fold, apply Santyl 3:1 to wound bed pack [with] calcium alginate cover [with]hypoallergenic tape [symbol for change] q [every] 3 days and prn." 7/28/12 - 1.8 X 1.7 X 0.7 cm, eschar pink edges dark wound bed color, no description of drainage or odor indicated. 8/4/12 - 1.8 X 1.6 X 0.7 cm, eschar pink edge, moderate greenish drainage, no description of odor indicated. A Physician's Progress Note, dated 8/4/12, indicated, "...R buttock wound - cont [continue] wound care - difficult to heal [secondary to] multiple medical problems & immobility [secondary to] advanced dementia." 8/12/12 - 1.7 X 1.6 X 0.7 cm, pink edge green inside, green drainage, no description of odor indicated. On 8/12/12 a Physician's Telephone Order was obtained to discontinue the Santyl treatment and change the treatment to the			

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	right gluteal fold to "Wet to dry drsg [dressing] once dly [daily] until healed." 8/18/12 - 2.3 X 2.0 X 1.3 cm, green color, no description of drainage or odor indicated. On 8/18/12, a Physician's Telephone Order was obtained to discontinue the wet to dry dressing and "Cleanse area [with] normal saline. Start Santyl to R gluteal fold cover with ABD pad or gauze [symbol for no] tape." 8/25/12 - 2.3 X 2.0 X 1.3 cm, green black color, green drainage, foul odor. 9/1/12 - 2.2 X 2.0 X 1.2 cm, green color, drainage description illegible, no description of odor indicated. 9/8/12 - 2.2 X 2.1 X 1.0 cm, green/yellow color, greenish/yellow drainage, no description of odor indicated. 9/14/12 - 2 X 2 X 1 cm, yellow color, yellow drainage, no odor. 9/22/12 - date but no description. 9/29/12 - 2.5 X 2.3 X 1.5, black/yellow color, yellow - bloody drainage, no odor. Nurse's Notes did not indicate further			

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	contact with the physician related to the wound treatment, and physician's orders did not indicate further changes to the wound treatment from 8/18 through 10/5/12 except as follows: On 8/29/12, a Physician's Telephone Order was obtained to increase the physical therapy visits to five times a week for wound care and electrical stimulation and sharp mechanical debridement. On 9/24/12, a Physician's Telephone Order was obtained for "Give Mighty Shakes between meals...Give ice cream [with] each meal." On 9/27/12, Physician's Telephone Orders were obtained for "F/C [Foley catheter] to BSD [bedside drainage] for wound healing." On 9/28/12, Physician's Telephone Orders were obtained for "Surgical consult for surgical debridement of wound with [name of physician]," and "PT [physical therapy] clarification order: Continue PT skilled service including use of HVPC to right lower gluteal area Stage 4 wound; sharp/mechanical debridement PRN." A physician's consult, dated 10/5/12, indicated, "Reason for Consultation:			

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	decubitus....Skin: Reveals a 2.5 X 2 cm deep ischial wound. Some eschar in a portion of the edge of it that is fairly thin with a diffuse exudate and a little bit of devitalized eschar....Impression: Patient with a fairly significant ischial wound that does not appear to be progressing very well. I think given the appearance of this, surgical debridement may be necessary, but I do not think it would be as effective as an aggressive wet to dry dakins mechanical debriding dressing change. My goal for this would be to improve the bed of the wound enough to start a wound vac which should increase her rate of healing somewhat. Of note, really as expected, her principal problem is going to be keeping up with the caloric intake and offloading this wound, as well. I think also we need to make sure that she is having no recurrence of her anemia and that her oxygen delivery is good, as well. I will start the therapies as mentioned and will proceed with that." This federal tag related to Complaint IN00117976. 3.1-5(a)(2) 3.1-5(a)(3)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on record review and interview, the facility failed to ensure the resident with history of pressure ulcers had a comprehensive plan to prevent recurrence and timely, effective treatment for a recurrent pressure ulcer. The facility failed to ensure the physician was notified timely of changes in drainage, and the pressure ulcer's increased size and failure to improve. The facility failed to ensure the resident was turned and repositioned in accordance with the care plan. The facility discontinued nutritional supplements and failed to administer other nutritional supplements as ordered. The facility failed to ensure a timely referral to the Registered Dietitian when the resident's wound declined. The deficient practice affected 1 of 3 residents reviewed related to pressure ulcers in a sample of 4. (Resident B) Resident B was readmitted to the facility on 3/25/12 without pressure ulcers. On 6/11/12	F0314	F314 It is the practice of this facility to ensure residents with history of pressure ulcers have comprehensive plan to prevent occurrence and timely, effective treatment for a recurrent pressure ulcer.1. Actions Takena. Resident B passed away on 10/31/12b. Complete audit of all current residents' medical record was reviewed in the facility PAR (Patient at Risk) program. All current residents at risk for skin breakdown had his/her care plan reviewed for appropriate treatment, nutritional supplements reviewed, and to ensure appropriate interventions are in place and followed. 2. Others Identifieda. No other residents were identified in this finding.b. All residents at risk for developing pressure areas could be affected by this finding.3. Measures Takena. All licensed nursing staff has been in-serviced on timely physician and family notification of significant changes	11/23/2012

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	Resident B had chronic Stage 3 and Stage 4 pressure ulcers. Findings include: During Initial Tour on 11/2/12 at 11:00 a.m., the Director of Nursing (DON) indicated Resident B had expired about two days earlier after living at the facility for ten years. During interview on 11/2/12 at 11:40 a.m., the DON indicated the Assistant Director of Nursing is responsible for the facility's wound management program and records. The DON indicated two Assistant Directors of Nursing had worked at the facility recently, and the second had left about two weeks ago during her 90-day probationary period. The DON indicated the DON is responsible for the wound program when there is no Assistant Director of Nursing. The clinical record for Resident B was reviewed on 11/2/12 at 1:35 p.m. The record indicated the resident was readmitted to the facility after hospitalization on 3/25/12. The Nursing Admission Assessment, dated 3/25/12, indicated in the Narrative Summary section, "Blanchable old area noted to R [right] cease of buttocks.		in resident condition. Special focus of notification of changes in the condition of a resident wound was reviewed.b. Dietary Manager was in-serviced on the use of nutritional supplements for residents at risk for skin breakdown and timely notification to the facilities dietician when there is a decline in a resident's wound.c. The Dietary Manger implemented new resident weight binders to improve the tracking of monthly and weekly weights. These binders will be reviewed weekly in the facility PAR program.d. All nursing staff has been in-serviced on turning and repositioning residents at risk for skin breakdown in accordance with the care plan.e. Complete audit of all current residents' medical record was reviewed in the facility PAR (Patient at Risk) program. All current residents at risk for skin breakdown had his/her care plan reviewed for appropriate treatment, nutritional supplements reviewed, and to ensure appropriate interventions are in place and followed. f. The Director of Nursing/Designee will review resident weekly skin assessments,treatments, and wound condition at the facility weekly PAR meetings to ensure physician and family/POA are notified timely of significant changes to the wound.g. The Dietary Manager will review weekly any resident who has a declining wound condition with	

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	[Symbol for no] redness or drainage noted...." (American Medical Directors Association (AMDA) Clinical Practice Guideline related to Pressure Ulcers in the Long-Term Care Setting describes a Stage 1 pressure ulcer as "Intact skin with nonblanchable redness of a localized area, usually over a bony prominence...." Therefore, the resident was readmitted without a pressure ulcer to the right gluteal area.) A Non-pressure Ulcer Condition Monitoring Sheet, dated 4/17/12, indicated the resident had an "Abrasion - non-pressure related" wound to the right gluteal fold, 1 cm by 0.5 cm, red in color with no drainage or odor. A notation on 5/5/12 indicated, "Appears to be opening more due to brief rubbing." A Physician's Telephone Order, dated 4/17/12, was obtained for "N.O. [new order] apply Purocol Plus [arrow pointing down - lower] R gluteal fold Q [every] shift until healed then D/C [discontinue]." During interview on 11/5/12 at 10:55 a.m., the DON indicated the nurse used the incorrect form (Non-pressure Ulcer Condition Monitoring Form) for the documentation of the right gluteal wound. She indicated the wound was a pressure ulcer.		the Dietician to ensure appropriate nutritional supplements are in place. h. The Director of Nursing/Designee will review 24-hour reports and new physician orders daily in the facility department head meeting to ensure timely notification of significant changes was completed to the resident physician and family/POA.4. How Monitoreda. The Director of Nursing/Designee will review resident weekly skin assessments, treatments, and wound condition at the facility weekly PAR meetings to ensure appropriate plan of care is in place,including but not limited to, physician and family/POA are notified timely of significant changes to the wound. Any negative findings will be immediately addressed.b. The Director of Nursing/Designee will review24-hour reports and new physician orders daily in the facility department head meeting to ensure timely notification of significant changes was completed to the resident physician and family/POA.c. The Director of Nursing/Designee will make rounds once daily at least five days weekly to ensure residents at risk for skin breakdown have appropriate interventions in place. These rounds will take place for 4 consecutive weeks with zero negative findings and prn thereafter. Any negative findings	

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	A Pressure Ulcer Condition Monitoring Sheet, dated 5/8/12, indicated the wound to the right gluteal fold was 1.8 cm X 1.4 cm X 0.2 cm, brownish in color, with slough and moderate, non-odorous drainage. (AMDA Clinical Practice guideline describes a Stage 2 pressure ulcer as "Partial thickness loss of dermis presenting as a shallow open ulcer wit a red pink ulcer bed, without slough," and a Stage 3 pressure ulcer as "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss...." Therefore, the wound was a Stage 3 ulcer.) A Physician's Telephone Order, dated 5/8/12, was obtained for "1. Cleanse wound to R buttock [symbol for with] wound cleanser. 2. Apply Mary's Magic Butt Cream around the wound. 3. Apply Santyl oint [ointment] directly to wound bed (approximately a nickel's thickness) q [every] shift & prn [as needed] for soiling or dislodgement, 4. Cover with abd [abdominal] pad. 5. D/C Puracol Plus." A Dietitian's Progress Record, dated 5/16/12, indicated, "Wound note: Res [resident] has wound that is nonhealing. Currently res is getting Ensure BID [twice		will be immediately corrected.d. The Dietary Manager will review weekly in the facility PAR meetings any resident who has a declining wound condition and/or significant weight losses/gains to ensure appropriate nutritional supplements are in place and the dietician has reviewed the nutritional plan of care. e. The Director of Nursing/Designee will report findings of the plan of care reviews for all residents at risk for skin breakdown to the Quality Assurance Committee on a monthly basis for 3months. The findings will be discussed with the Medical Director at the quarterly Quality Assurance Meeting. Adjustments to the audit schedule will be recommended by the Quality Assurance Committee based on findings of the monthly/quarterly audit findings.5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements. F314 The monitoring for the weekly skin assessments, treatments and wound conditions will be monitored ongoing through weekly PAR meetings. The QA team will monitor monthly for 3 months then quarterly ongoing. The Director of Nursing/Designee will round daily, 7 days a week on each shift. Our date of compliance is	

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	daily] & Beneprot [protein supplement] BID. On MVI [multivitamin]. Wt [weight] 5/12 96.4 # [pounds], 4/12 98.6 #, 2/12 97.8 #, 11/11 94.8#. Wt. fluctuates. Rec [recommend] d/cing [discontinuing] Beneprotein add Juven 2 packets/day to help [with] healing. Cont [continue] to encourage intake @ all meals. RD to follow as needed." A lab report, dated 5/17/12, indicated, "Albumin 3.3 L [low]" with the Normal Range of 3.5 to 5.0 grams per deciliter. A Physician's Telephone Order, dated 5/17/12, indicated, "1. D/C Ensure. 2. D/C Beneprotein 3. Start Juven 2 pkg [packages] QD [daily] wound healing. 3. Vitamin C tab 500 mg 1 po [by mouth] qd wound healing...." The physician's rewrite orders and Medication Administration Records for August, September, and October 2012 indicated the order originally received 5/17/12 was for one packet instead of two packets of Juven, and nurses' initials next to the entry for "Juven Revigo Pow [powder] orange, dissolve 1 packet in liquid & take by mouth once daily" indicated the resident received one packet of Juven daily, instead of the two packets ordered on 5/17/12 for wound healing.		11.23.12.	

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	Review on-line on 11/9/12 at 1:45 p.m. at http://www.abbottstore.com/juven+reg/juven-orange-085-oz-packet-30-pack/invt/57935p30 indicated, "Juven is a targeted therapeutic nutrition drink mix that has been clinically shown to support wound healing in as little as 2 weeks and helps build lean body mass (LBM) in as little as 4 weeks. Consume Juven twice daily...." Another Physician's Telephone Order, dated 5/17/12, indicated the physical therapist was to evaluate and treat three times a week for twelve weeks for wound care including electrical stimulation (HVPC - high voltage pulsed current) and sharp mechanical debridement as needed. A Physical Therapy Evaluation Note, dated 5/17/12, indicated, "Current status includes: Need for wound care management. Pt [patient] was wound free prior to existence of current wound. Pt...referred by nursing for wound care on right ischial tuberosity. Wound is stage 3 completely covered with necrotic tissues. Pt. has advanced Alzheimer's disease and is completely dependent on all functional skills including bed mobility and transfers. Pt. is non-ambulatory.... Pt. evaluated for wound care on right ischial tuberosity. Pt. developed stage 3 decubitus ulcer measuring 1.8 X 1.5 X 0.3 cm with good pinkish area of skin surrounding wound bed. Wound edges also looks healthy. Wound bed completely covered with necrotic tissues. Sharp/mechanical debridement performed to remove non-viable tissues. Use of HVPC to promote blood flow to wound bed." The Pressure Ulcer Condition Monitoring Sheet indicated the right gluteal fold wound descriptions			

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	as follows: 5/19/12 - 1 X 1 X 0.2 cm., yellow color, no drainage, no odor. 5/23/12 - 1.7 X 1.8 X 1.6 cm, yellow color, moderate drainage, no odor. 6/9/12 - 1.3 X 1.9 X 0.3 cm, pink/red color, no drainage, no odor. 6/30/12 (no measurements indicated from 6/9 to 6/30/12) - 0.8 X 1.2 X 0.8 cm, pink/red color, scant serosanguineous drainage, description of odor not indicated. 7/7/12 - 0.8 X 1.2 X 0.8 cm., pink color, scant serosanguineous drainage, description of odor not indicated. 7/14/12 - 1.8 X 1.8 X 0.8 cm., light pink slough color, moderate green serosanguineous drainage, no odor. During interview on 11/5/12 at 10:55 a.m., the DON indicated she could not find that the physician was notified of the change in wound drainage on 7/7/12. Nurse's Notes for July 2012 did not indicate the physician was notified of the increased size of the wound as measured on 7/14/12. 7/21/12 - 1.6 X 1.4 X 0.8 cm, no color indicated, moderate greenish drainage, description of odor not indicated. On 7/21/12 a Physician's Telephone Order was obtained to change the treatment to the right gluteal wound to "Clean wound [with] NS [normal saline] to R gluteal fold, apply Santyl 3:1 to			

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	wound bed pack [with] calcium alginate cover [with]hypoallergenic tape [symbol for change] q [every] 3 days and prn." 7/28/12 - 1.8 X 1.7 X 0.7 cm, eschar pink edges dark wound bed color, no description of drainage or odor indicated. 8/4/12 - 1.8 X 1.6 X 0.7 cm, eschar pink edge, moderate greenish drainage, no description of odor indicated. A Physician's Progress Note, dated 8/4/12, indicated, "...R buttock wound - cont [continue] wound care - difficult to heal [secondary to] multiple medical problems & immobility [secondary to] advanced dementia." 8/12/12 - 1.7 X 1.6 X 0.7 cm, pink edge green inside, green drainage, no description of odor indicated. On 8/12/12 a Physician's Telephone Order was obtained to discontinue the Santyl treatment and change the treatment to the right gluteal fold to "Wet to dry drsg [dressing] once dly [daily] until healed." 8/18/12 - 2.3 X 2.0 X 1.3 cm, green color, no description of drainage or odor indicated. On 8/18/12, a Physician's Telephone Order was obtained to discontinue the wet to dry dressing and "Cleanse area [with] normal saline. Start Santyl to R gluteal fold cover with ABD pad or gauze [symbol for no] tape." 8/25/12 - 2.3 X 2.0 X 1.3 cm, green black color, green drainage, foul odor. 9/1/12 - 2.2 X 2.0 X 1.2 cm, green color, drainage			

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	description illegible, no description of odor indicated. 9/8/12 - 2.2 X 2.1 X 1.0 cm, green/yellow color, greenish/yellow drainage, no description of odor indicated. 9/14/12 - 2 X 2 X 1 cm, yellow color, yellow drainage, no odor. 9/22/12 - date but no description. 9/29/12 - 2.5 X 2.3 X 1.5, black/yellow color, yellow - bloody drainage, no odor. Nurse's Notes did not indicate further contact with the physician related to the wound treatment, and physician's orders did not indicate further changes to the wound treatment from 8/18 through 10/5/12 except as follows: On 8/29/12, a Physician's Telephone Order was obtained to increase the physical therapy visits to five times a week for wound care and electrical stimulation and sharp mechanical debridement. On 9/24/12, a Physician's Telephone Order was obtained for "Give Mighty Shakes between meals...Give ice cream [with] each meal." On 9/27/12, Physician's Telephone Orders were obtained for "F/C [Foley catheter] to BSD [bedside drainage] for wound healing." On 9/28/12, Physician's Telephone Orders were obtained for "Surgical consult for surgical debridement of wound with [name of physician]," and "PT [physical therapy] clarification order: Continue PT skilled service including use of HVPC to right lower gluteal area Stage 4 wound; sharp/mechanical debridement PRN."			

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	The Quarterly Nutritional Re-evaluation, dated June [no specific date] 2012 and signed by the Dietary Manager (DM) indicated, "Resident's wt. is stable and intake is good. Will continue to monitor and refer to RD [Registered Dietitian] PRN [as needed]." The evaluation indicated the resident's diet was "Puree, ice cream w/ [with] all meals." A notation by the DM, dated 6/22/12, indicated, "Resident's wt. is stable at this time. Consumes 75-100% of most meals. Will continue to monitor and refer to RD PRN." The note did not address the resident's pressure ulcer. The next entry by the Registered Dietitian was 9/21/12, the annual RD Assessment. A PT (Physical Therapy) Recertification Note, dated 6/11/12, and signed by the physician on 6/23/12, included, but was not limited to, "Treatment Plan: Rehabilitation plan includes ...elec stim...for chronic stage III and IV pressure ulcers." A Determination of Clinically Unavoidable Skin Condition was signed by the DON on 6/11/12, and countersigned by the physician on 6/23/12. The form indicated the resident was at risk for a clinically unavoidable skin condition, if the resident had two or more of the listed diagnoses (Resident B had three) and received two or more or the listed treatments (Resident B had one). The form indicated the resident might have malnutrition/dehydration based on four lab values. The resident had two of the lab values checked, as follows: "Serum albumin below 3.4 g/dl (check what additional protein is being provided)" and HGB (hemoglobin) less than 12 mg per dl." No documentation on the form indicated additional protein was being provided. The serum albumin listed was 5/17/12 at 3.3, and the hemoglobin listed was 4/2/12 at 10.4.			

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	During interview on 11/5/12 at 10:30 a.m., the Dietary Manager indicated she thought the resident's Mighty Shakes and ice cream were discontinued in June 2012 because she was eating well and gaining weight. She also indicated when she started her job at the facility in June 2012, she noticed a lot of residents received supplements, instead of being provided good nutrition. She indicated she would locate the physician's order related to the discontinuation and subsequently provided a Physician's Telephone Order obtained on 6/23/12, for "D/C [discontinue] shakes & super pudding @ meals." The Monthly Record of Vital Signs and Weights indicated the resident's 2012 weights were as follows: March: 98.6 pounds, April 98.6 pounds, May 96.4 pounds, June 98.2 pounds, July 100.4 pounds, August 95.8 pounds, September 99.6 pounds, and October 90.2 pounds with reweight of 103 pounds. The Care plan Worksheet for "[Name of resident] received a puree diet at risk for weight loss," originally dated 11/10/10, and updated 2/2/11, 11/3/11, 3/26/12, 6/28/12, and 9/27/12, indicated the goal of "Consume 75% - 100% of most meals thru next review." Dates for revised interventions were not indicated. The intervention of "Health shakes at all meals" was lined through. The intervention of "Health shakes between meals" was lined through. The most recent update, 9/27/12, indicated in the problem list: "Puree diet, at risk for wt. loss. Goal: No significant wt. loss thru next review." In the same handwriting was the intervention: "Mighty Shakes TID [three times a day], super cereal @ breakfast, ice cream w/ [with] meals." During interview on 11/5/12 at 10:15 a.m., in			

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	regard to a follow-up albumin level after 5/17/12, the DON indicated she did not know if a repeat lab had been obtained and indicated, "We can only do what the doctor orders." Lab reports in the lab report section of the clinical record did not indicate additional albumin levels were obtained. The Registered Dietitian's Assessment, dated 9/21/12, indicated no albumin level after 5/17/12. During interview on 11/5/12 at 11:05 a.m., the DON indicated she did not know when the resident stopped having Mighty Shakes and ice cream. During interview on 11/5/12 at 11:45 a.m., the DON indicated the resident had lived at the facility for ten years and "she [Resident B] had always had the Mighty Shakes since I've been here [until the supplements were discontinued]." During interview on 11/5/12 at 11:20 a.m., the DON indicated the health shakes were discontinued on 6/28/12. During interview on 11/5/12 at 11:55 a.m., the Dietary Manager provided a nutritional list for Mighty Shakes. The list indicated the four ounce Mighty Shake provided: 200 calories, 6 grams of fat, and 6 grams of protein. The Care plan Worksheet for Pressure Ulcer Risk, originally dated 12/17/08, and updated every three months and most recently updated 9/27/12, indicated, "The resident is at risk for further development of pressure ulcers due to: decreased mobility, incontinence." Dates of updated interventions were not indicated but included "Mighty shakes" and "Juven." Another care plan, dated 5/17/12, indicated, "I have an open area in the following area: "R gluteal fold." Interventions included, but were not limited to: "Notify MD and responsible party of			

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	area....Observe for S/S [signs and symptoms] such as: redness, warmth, odor, drainage, elevated temp [temperature]. Notify MD and responsible party of noted signs and symptoms....Dietitian evaluation as indicated....5/7[sic]/12 Air mattress 5/7/12 T& R [turn and reposition] Q [every] 1 [symbol for hour] 5/12 Juven [protein supplement]/MVI [multivitamin]. 9/12 Dietary to see pt [patient] weekly. 8/12 Mighty shake...." Nurse's Notes for 6/17 through 10/31/12 indicated the resident was turned and repositioned every two hours instead of every hour, as planned, except on the following dates/times, when the Nurse's Notes indicated the resident was turned and repositioned every hour: 6/17/12 at 8:00 p.m., 6/22/12 at 4:00 a.m. and 8:00 p.m., 6/23/12 at 4:00 a.m., and 7/1/12 at 8:00 p.m. Entries on the Treatment Record for August and September 2012 indicated, "Turn & reposition q [every] 2 [symbol for hours]." Nurses' initials indicated the intervention was implemented on the 6:00 a.m. to 6:00 p.m. and 6:00 p.m. to 6:00 a.m. shifts. The Treatment Record for October 2012 indicated, "Turn & reposition q 2 [symbol for hours] FYI [for your information]. The entry was not signed by nurses. During interview on 11/5/12 at 10:30 a.m., the DON indicated no dietary notes indicated the resident was seen weekly. The DON indicated the Dietary Manager was part of the PAR (Patient at Risk) meetings. The DON indicated the PAR meeting information was not part of the clinical record. She provided the PAR information for Resident B. The Patient at Risk (PAR) Tracking Form notes indicated the following for Resident B:			

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	5/8/12 - "PT [physical therapy] to look at wound - new order." 5/16/12 - "Tx [treatment] working well - getting smaller...labs - albumin level ordered. Res. [resident] gets supplements...." 5/23/12 - "Res. continues to get supplements.... 6/27/12 - "D/C [discontinue] shakes & super puddings [with] meals - res. doing better...." The next entry in the record related to nutritional care was the RD Assessment dated 9/21/12, the annual assessment. The RD recommendations included, but were not limited to, "Add double meat @ bkft [breakfast]." The RD Assessment indicated the resident received "Juven 1 pk [package]." The Dietitian's Progress Record, dated 9/21/12, indicated: "Wound note: See yrly [yearly] assessment sheet for recommendations." During interview on 11/5/12 at 2:10 p.m., the Dietary Manager provided the resident's tray card and indicated the double meat portion at breakfast had not been added to the resident's nutritional plan. A physician's consult, dated 10/5/12, indicated, "Reason for Consultation: decubitus....Skin: Reveals a 2.5 X 2 cm deep ischial wound. Some eschar in a portion of the edge of it that is fairly thin with a diffuse exudate and a little bit of devitalized eschar....Impression: Patient with a fairly significant ischial wound that does not appear to be progressing very well. I think given the appearance of this, surgical debridement may be necessary, but I do not think it would be as effective as an aggressive wet to dry dakins			

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	mechanical debriding dressing change. My goal for this would be to improve the bed of the wound enough to start a wound vac which should increase her rate of healing somewhat. Of note, really as expected, her principal problem is going to be keeping up with the caloric intake and offloading this wound, as well. I think also we need to make sure that she is having no recurrence of her anemia and that her oxygen delivery is good, as well. I will start the therapies as mentioned and will proceed with that." This federal tag related to Complaint IN00117976. 3.1-40(a) 3.1-40(b) 3.1-40(c)			

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F0325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.			
	Based on record review and interview, the facility failed to ensure dietary interventions to improve wound healing for 1 of 3 residents reviewed related to pressure ulcers (Resident B) and address weight loss for 1 of 3 residents reviewed related to weight loss (Resident A). The deficient practice affected 2 of 4 residents reviewed related to nutrition in a sample of 4. (Residents A and B) Resident B experienced a decline in a pressure ulcer from no ulcer to a Stage 4 ulcer. Findings include: 1. The clinical record for Resident B was reviewed on 11/2/12 at 1:35 p.m. The record indicated the resident was readmitted to the facility after hospitalization on 3/25/12. The Quarterly Nutritional Re-evaluation, dated 3/26/12, indicated, "Resident	F0325	F 325It is the practice of this facility to ensure dietary interventions are in place to improve wound healing for residents who have skin breakdown.1. Actions Takena. Resident B passed away on 10/31/12b. Resident A plan of care was reviewed in the facility PAR program to ensure appropriate measures are in place as it relates to weight monitoringc. Complete audit of all current residents' medical record was reviewed in the facility PAR (Patient at Risk) program. All current residents at risk for skin breakdown and significant weight changes had his/her care plan reviewed for appropriate treatment, nutritional supplements reviewed, and to ensure appropriate interventions are in place and followed. 2. Others Identifieda. No other residents were identified in this finding.b. All residents at risk for developing pressure areas and/or weight fluctuations could be	11/23/2012

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	continues to demonstrate poor appetite. Receives numerous supplements to combat weight loss. Weight stable. Will continue to monitor and refer to RD [Registered Dietitian] PRN [as needed]." The resident's diet was listed as "Puree/Ice cream @ all meals." The next Dietary Note was dated 4/9/12, and indicated, "14 day complete. Will continue to monitor: on weekly weights X 2 more weeks to monitor." A Non-pressure Ulcer Condition Monitoring Sheet, dated 4/17/12, indicated the resident had an "Abrasion - non-pressure related" wound to the right gluteal fold, 1 cm by 0.5 cm, red in color with no drainage or odor. During interview on 11/5/12 at 10:55 a.m., the DON indicated the wound was a pressure ulcer. A Pressure Ulcer Condition Monitoring Sheet, dated 5/8/12, indicated the wound to the right gluteal fold was 1.8 cm X 1.4 cm X 0.2 cm, brownish in color, with slough and moderate, non-odorous drainage. A Dietitian's Progress Record, dated 5/16/12, indicated, "Wound note: Res [resident] has wound that is nonhealing. Currently res is getting Ensure BID [twice daily] & Beneprot [protein supplement] BID. On MVI [multivitamin]. Wt		affected by this finding.3. Measures Takena. Dietary Manager was in-serviced on the use of nutritional supplements for residents at risk for skin breakdown and timely notification to the facilities dietician when there is a decline in a resident's wound and/or significant weight changes.b. The Dietary Manger implemented new resident weight binders to improve the tracking of monthly and weekly weights. These binders will be reviewed weekly in the facility PAR program.c. Complete audit of all current residents' medical record was reviewed in the facility PAR(Patient at Risk) program. All current residents at risk for skin breakdown had his/her care plan reviewed for appropriate treatment, nutritional supplements reviewed, and to ensure appropriate interventions are in place and followed. d. The Dietary Manager will review weekly any resident who has a declining wound condition with the Dietician to ensure appropriate nutritional supplements are in place.e. The Dietary Manager will track all resident monthly weights to ensure any significant weight loss/gain is reviewed in the facility PAR program. Any resident with significant weight changes will be added to the facility PAR program which is reviewed weekly f. The Director of Nursing/Designee will review 24-hour reports and new	

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	[weight] 5/12 96.4 # [pounds], 4/12 98.6 #, 2/12 97.8 #, 11/11 94.8#. Wt. fluctuates. Rec [recommend] d/cing [discontinuing] Beneprotein add Juven 2 packets/day to help [with] healing. Cont [continue] to encourage intake @ all meals. RD to follow as needed." A lab report, dated 5/17/12, indicated, "Albumin 3.3 L [low]" with the Normal Range of 3.5 to 5.0 grams per deciliter. A Physician's Telephone Order, dated 5/17/12, indicated, "1. D/C Ensure. 2. D/C Beneprotein 3. Start Juven 2 pkg [packages] QD [daily] wound healing. 3. Vitamin C tab 500 mg 1 po [by mouth] qd wound healing...." A Physical Therapy Evaluation Note, dated 5/17/12, indicated, "Current status includes: Need for wound care management....Pt [patient] was wound free prior to existence of current wound. Pt...referred by nursing for wound care on right ischial tuberosity. Wound is stage 3 completely covered with necrotic tissues...." The physician's rewrite orders and Medication Administration Records for August, September, and October 2012 indicated the order originally received 5/17/12 was for one packet instead of two		physician orders daily in the facility department head meeting to ensure appropriate interventions are in place.4. How Monitoreda. The Dietary Manager will review weekly in the facility PAR meetings any resident who has a declining wound condition and/or significant weight losses/gains to ensure appropriate nutritional supplements are in place and the dietician has reviewed the nutritional plan of care.b. The Director of Nursing/Designee will review24-hour reports and new physician orders daily in the facility department head meeting to ensure timely notification of significant changes was completed to the resident physician and family/POA and appropriate plan of care is in place. c. The Director of Nursing/Designee will report findings of the plan of care reviews for all residents at risk for skin breakdown and significant weight changes to the Quality Assurance Committee on a monthly basis for 3 months. The findings will be discussed with the Medical Director at the quarterly Quality Assurance Meeting. Adjustments to the audit schedule will be recommended by the Quality Assurance Committee based on findings of the monthly/quarterly audit findings.5. This Plan of Correction constitutes our credible allegation of compliance with all regulatory	

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	packets of Juven, and nurses' initials next to the entry for "Juven Revigo Pow [powder] orange, dissolve 1 packet in liquid & take by mouth once daily" indicated the resident received one packet of Juven daily, instead of the two packets ordered for wound healing. Review on-line on 11/9/12 at 1:45 p.m. at http://www.abbottstore.com/juven+reg/juven-orange-085-oz-packet-30-pack/invt/57935p30 indicated, "Juven is a targeted therapeutic nutrition drink mix that has been clinically shown to support wound healing in as little as 2 weeks and helps build lean body mass (LBM) in as little as 4 weeks. Consume Juven twice daily...." The next note related to nutrition was the Quarterly Nutritional Re-evaluation, dated June [no specific date] 2012, and signed by the Dietary Manager (DM), which indicated, "Resident's wt. is stable and intake is good. Will continue to monitor and refer to RD [Registered Dietitian] PRN [as needed]." The evaluation indicated the resident's diet was "Puree, ice cream w/ [with] all meals." A notation by the DM, dated 6/22/12, indicated, "Resident's wt. is stable at this time. Consumes 75-100% of most meals. Will continue to monitor and refer to RD PRN." The note did not address the resident's pressure ulcer.		requirements. F325 Declining wound conditions, weight loss or gain will be reviewed weekly in the PAR meeting and monthly for 3 months by the Quality Assurance Committee then quarterly ongoing. Our date of compliance is 11.23.12.	

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	A Determination of Clinically Unavoidable Skin Condition was signed by the DON on 6/11/12, and countersigned by the physician on 6/23/12. The form indicated the resident was at risk for a clinically unavoidable skin condition, if the resident had two or more of the listed diagnoses (Resident B had three) and received two or more or the listed treatments (Resident B had one). The form indicated the resident might have malnutrition/dehydration based on four lab values. The resident had two of the lab values checked, as follows: "Serum albumin below 3.4 g/dl (check what additional protein is being provided)" and HGB (hemoglobin) less than 12 mg per dl." No documentation on the form indicated additional protein was being provided. The serum albumin listed was 5/17/12 at 3.3, and the hemoglobin listed was 4/2/12 at 10.4. During interview on 11/5/12 at 10:30 a.m., the Dietary Manager indicated she thought the resident's Mighty Shakes and ice cream were discontinued in June 2012 because she was eating well and gaining weight. She also indicated when she started her job at the facility in June 2012, she noticed a lot of residents received supplements, instead of being provided good nutrition. She indicated she would			

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	locate the physician's order related to the discontinuation and subsequently provided a Physician's Telephone Order obtained on 6/23/12, for "D/C [discontinue] shakes & super pudding @ meals." The Monthly Record of Vital Signs and Weights indicated the resident's 2012 weights were as follows: March: 98.6 pounds, April 98.6 pounds, May 96.4 pounds, June 98.2 pounds, July 100.4 pounds, August 95.8 pounds, September 99.6 pounds, and October 90.2 pounds with reweight of 103 pounds. The Care plan Worksheet for "[Name of resident] received a puree diet at risk for weight loss," originally dated 11/10/10, and updated 2/2/11, 11/3/11, 3/26/12, 6/28/12, and 9/27/12, indicated the goal of "Consume 75% - 100% of most meals thru next review." Dates for revised interventions were not indicated. The intervention of Healthshakes at all meals was lined through. The intervention of "Healthshakes between meals" was lined through. During interview on 11/5/12 at 11:20 a.m., the DON indicated the health shakes were discontinued on 6/28/12. The most recent update, 9/27/12, indicated in the problem list: "Puree diet, at risk for wt. loss. Goal: No significant wt. loss thru next review." In the same			

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	handwriting was the intervention: "Mighty shakes TID [three times a day], super cereal @ breakfast, ice cream w/ [with] meals." During interview on 11/5/12 at 10:15 a.m., in regard to a follow-up albumin level after 5/17/12, the DON indicated she did not know if a repeat lab had been obtained and indicated, "We can only do what the doctor orders." Lab reports in the lab report section of the clinical record did not indicate additional albumin levels were obtained. The Registered Dietitian's Assessment, dated 9/21/12, indicated no albumin level after 5/17/12. During interview on 11/5/12 at 11:05 a.m., the DON indicated she did not know when the resident stopped having Mighty Shakes and ice cream. She indicated she remembered the resident had stopped receiving them. During interview on 11/5/12 at 11:45 a.m., the DON indicated the resident had lived at the facility for ten years and "she [Resident B] had always had the Mighty Shakes since I've been here [until the supplements were discontinued]." During interview on 11/5/12 at 11:55 a.m., the Dietary Manager provided a nutritional list for Mighty Shakes. The list indicated the four ounce Mighty			

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	Shake provided: 200 calories, 6 grams of fat, and 6 grams of protein. The Care plan Worksheet for Pressure Ulcer Risk, originally dated 12/17/08, and updated every three months and most recently updated 9/27/12, indicated, "The resident is at risk for further development of pressure ulcers due to: decreased mobility, incontinence." Dates of updated interventions were not indicated but included "Mighty shakes" and "Juven." The next entry in the record related to nutritional care was the RD Assessment dated, 9/21/12. The RD "Evaluation of Needs/Recommendations/Interventions for Nutrition Care" indicated, "Annual assessment completed. Diet puree [with] intake fair to good @ meals. [Symbol for no] chewing or swallowing problems [with] current diet. Wt. very stable X 1 yr. Res has wound abd [sic] folds. Add double meat @ bkft. [breakfast]. Cont [continue] to encourage intake @ meals." During interview on 11/5/12 at 2:10 p.m., the Dietary Manager provided the resident's tray card and indicated the double meat portion at breakfast had not been added to the resident's nutritional plan. On 9/24/12, a Physician's Telephone			

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	Order was obtained for "Give Mighty Shakes between meals...Give ice cream [with] each meal." On 9/28/12, Physician's Telephone Orders were obtained for "Surgical consult for surgical debridement of wound with [name of physician]," and "PT [physical therapy] clarification order: Continue PT skilled service including use of HVPC [high voltage pulsed current] to right lower gluteal area Stage 4 wound; sharp/mechanical debridement PRN." Another care plan, dated 5/17/12, indicated, "I have an open area in the following area: "R gluteal fold." Interventions included, but were not limited to: "....Dietitian evaluation as indicated....5/12 Juven [protein supplement]/MVI [multivitamin]. 9/12 Dietary to see pt [patient] weekly. 8/12 Mighty shake...." During interview on 11/5/12 at 10:30 a.m., the DON indicated no dietary notes indicated the resident was seen weekly. The DON indicated the Dietary Manager was part of the PAR (Patient at Risk) meetings. The DON indicated the PAR meeting information was not part of the clinical record. She provided the PAR information for Resident B.			

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	The Patient at Risk (PAR) Tracking Form notes indicated the following for Resident B: 5/16/12 - "Tx [treatment] working well - getting smaller...labs - albumin level ordered. Res. [resident] gets supplements...." 5/23/12 - "Res. continues to get supplements.... 6/27/12 - "D/C [discontinue] shakes & super puddings [with] meals - res. doing better...." A physician's consult, dated 10/5/12, indicated, "Reason for Consultation: decubitus....Skin: Reveals a 2.5 X 2 cm deep ischial wound. Some eschar in a portion of the edge of it that is fairly thin with a diffuse exudate and a little bit of devitalized eschar....Impression: Patient with a fairly significant ischial wound that does not appear to be progressing very well. I think given the appearance of this, surgical debridement may be necessary, but I do not think it would be as effective as an aggressive wet to dry dakins mechanical debriding dressing change. My goal for this would be to improve the bed of the wound enough to start a wound vac which should increase her rate of healing somewhat. Of note, really as			

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	expected, her principal problem is going to be keeping up with the caloric intake and offloading this wound, as well. I think also we need to make sure that she is having no recurrence of her anemia and that her oxygen delivery is good, as well. I will start the therapies as mentioned and will proceed with that." 2. The clinical record for Resident A was reviewed on 11/2/12 at 1:00 p.m. The record indicated the resident was admitted from another facility on 7/27/12. The resident's diagnoses included, but were not limited to, multiple sclerosis, paranoia, schizophrenia with delusions, and neuropathy. A Dietary Note, dated 8/1/12, indicated, "New admit. Receives a regular diet. Intake is good. [Symbol for no] noted skin issues. Above ideal body wt [weight] BMI [basal metabolic index] 35 weekly wt. X 4 wks. Will monitor and refer to RD for assessment." The RD Assessment, dated 8/10/12, indicated, "New res admitted to facility. Current diet regular [with] intake adeq [adequate]. [Symbol for no] chewing or swallowing problems noted. Skin [symbol for no] pressure issues. Res is nutritionally stable at this time. Cont [continue] to monitor. RD to follow as			

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	needed." The Resident Care Plan, originally dated 8/4/12, indicated a regular diet, was updated on 9/4/12 to indicate a mechanical soft diet. The Goal included, but was not limited to, "Rd [resident] will have no significant weight change through next review." Interventions included, but were not limited to, "Weights as needed." A Physician's Telephone Order, dated 10/3/12, indicated, "Re: pt [patient] c/o [complains of] bilateral heels hurting. Skin prep to heels q [every] shift." A Care plan Worksheet, dated 10/5/12, indicated a Problem of "Intact blister" with interventions including, but not limited to "Air waffle boots." The Monthly Record of V/S [vital signs] and Weights for 2012 indicated monthly weights as follows: July - 224 pounds August - 220 pounds (1.7% loss in one month) September - 211 pounds October - 203.2 pounds, reweigh 201.9 pounds (9.86% loss in three months) (November weight was not documented at the time of clinical record review.)			

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	During interview on 11/5/12 at 2:40 p.m., the DON indicated the Dietary Manager tracks weights, and the resident is placed on weekly weights if a significant weight change is indicated. During interview at this same time, the Dietary Manager indicated she did not have weekly weights tracked for Resident A since the first four weeks after admission. The Dietary Manager indicated the resident "should have triggered," but she did not catch the significant change (from July to October 2012). The Dietary Manager indicated her tracking form only showed the weights for September (211 pounds) and October 2012 (201 pounds). She indicated the change between those two months was not significant. This federal tag related to Complaint IN00117976. 3.1-46(a)(1)			