

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
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NAME OF PROVIDER OR SUPPLIER  CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaint IN00129811.</p> <p>Complaint IN00129811 Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F314.</p> <p>Survey dates: June 10 &amp; 12, 2013</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF: 18 SNF/NF: 128 Total: 146</p> <p>Census Payor Type: Medicare: 19 Medicaid: 109 Other: 18 Total: 146</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410</p>	F000000		
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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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	IAC 16.2.  Quality review was completed by Tammy Alley RN on June 14, 2013.				

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F000282 SS=G	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview the facility failed to ensure physician orders were followed, in that when a resident who was identified with a pressure area, the nursing staff failed to follow the physician orders in regard to wound care, assessment by a local wound care company and appropriate treatment for 1 of 3 sampled residents. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 06-12-13 at 8:40 a.m. Diagnoses included but were not limited to anxiety, severe depressive disorder, end stage renal disease, pain, lupus and bradycardic arrest. These diagnoses remained current at the time of the record review.</p> <p>The resident was recently re-admitted to the facility on 05-21-13 after a hospitalization.</p> <p>A review of the resident's current plan of care, dated 05-21-13 indicated the</p>	F000282	<p><b>F282 483.20 (k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>It is the practice of this provider to provide or arrange services by qualified persons in accordance with each resident's plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B was re-admitted to the facility with a Stage II wound to the sacrum. The wound was assessed upon admission by the charge nurse and documented on the admission nursing assessment. An appropriate treatment order was initiated and completed by the charge nurse, as ordered per MD. The resident was assessed by the wound MD on 6/17/13; improvement was noted. The Wound MD will assess weekly and treatment changes will be followed, per order. The facility respectfully would like to clarify that the resident's wound had been treated per MD order since readmission and prior to assessment by the surveyor, and the resident told the surveyor, in</p>	06/30/2013			

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	<p>resident "is at risk for pressure ulcers, due to very limited mobility and fragile coccyx." Approaches to this "problem" indicated, "Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences, report any signs of skin breakdown (sore, tender, red, or broken areas)."</p> <p>Review of the physician orders, dated 05-21-13 instructed the nursing staff to "apply dermaseptin to area on coccyx two times a day. Resident should be seen by wound doctor on next visit per MD [medical doctor]."</p> <p>A physician progress note dated 06-06-13 indicated "Sent to hospital late last month after syncopal episode, found to have hemoperitoneum. Problems since her latest return include continued abd. [abdominal] pain, tho [though] she states this has improved a little, and LE [lower extremity] edema. She also has early skin breakdown on her coccyx, which is very painful. Imp [impression]/Plan: Painful pressure area on sacral bony prominence, will apply biatain foam for cushioning and ask wound team to see."</p> <p>A subsequent physician order, dated 06-06-13 indicated "Biatain foam to</p>		<p>front of the charge nurse, that the dressing had come off. The Interdisciplinary Team, including the dialysis team, the MD, and nurse managers, had met on Wednesday, 6/11/13, (prior to survey) to review the resident's treatment plan and orders. At that time the wound consult order was discontinued. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b> Residents that are admitted/readmitted from the hospital with wound treatment orders have the potential to be affected by the alleged deficient practice. The facility completed a 100% audit of residents readmitted within the past 30 days to ensure wound treatments were initiated, per MD order, upon admission. Resident skin assessments were completed by nurse managers and new orders were initiated, as needed.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> Re-education was provided to licensed nurses on following physician orders for wound care treatments upon admission/readmission, and documentation of wound measurements on 6/25/13, and</p>		

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	<p>sacral bony prominence - change every 48 hours - please ask wound team to see for wound."</p> <p>Observation on 06-12-13 at 9:30 a.m., with licensed nurse employee #3 in attendance, the resident was seated on the side of the bed, bent over holding her stomach. When interviewed the resident indicated "I didn't sleep at all last night the pain was so bad. I don't know if I can take this anymore." When interviewed about the pain, the resident indicated her coccyx area. During this observation the resident stood up with the assistance of licensed nurse employee #3, and the resident's coccyx area was observed. The area did not have a dressing, and there was an opened area to the resident's coccyx area."</p> <p>Interview on 06-12-13 at 11:20 a.m., the Administrator and Director of Nurses verified, the resident had not been assessed by the nursing staff for her pressure ulcer, the nursing progress notes lacked documentation of the area, without documentation of improvement or deterioration of the wound, and that the resident had not been evaluated or assessed by the local wound care team.</p>		<p>ongoing by the Director of Nursing Services, or designee. Re-education was provided to the nurse management team on the admission/readmission process including auditing new/re-admission charts for skin impairment, treatment orders, etc., as well as validating the charge nurse skin assessment upon admission, on 6/24/13, by the Director of Nursing Services.</p> <p>The systemic change includes</p> <p>a) Nurse managers review readmission/admission hospital transfer orders to ensure wound orders are implemented appropriately. b) Nurse managers will inspect resident skin within 24 hours of admission to validate new orders and the charge nurse admission skin assessment. MD will be notified, as needed. c) The interdisciplinary team with complete wound rounds weekly, measuring pressure wounds and reviewing the resident's individualized plan of care. Changes to the plan of care will be implemented, per MD order, as needed. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>DON/Designee will audit new admission/readmission charts to ensure wound care orders are being followed as ordered from the discharging facility. This</p>				

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	This Federal tag relates to Complaint IN00129811  3.1-35(g)(2)		review will be done for 100% of new admissions each week for 4 weeks. Following this initial 4 weeks, random review of a minimum of 80% of new admissions weekly for 16 weeks, and then 4 admissions monthly for an additional 9 months to total 12 months of audits to determine that new admission/readmission wound care orders are being followed, per physician order. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>Compliance Date:</b> 6/30/13		

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F000314 SS=G	<p><b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></p> <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, record review and interview the facility failed to ensure a resident who was identified with a pressure area, received appropriate treatment and services. This deficient practice involved the lack of nursing assessment, failure to follow the physicians orders, and resulted in a delay in the appropriate treatment for the pressure ulcer, and evaluation by wound care specialist as ordered by the physician for 1 of 3 residents reviewed for pressure ulcers in a sample of 3. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 06-12-13 at 8:40 a.m. Diagnoses included but were not limited to anxiety, severe depressive disorder, end stage renal disease, pain, lupus and bradycardic arrest.</p>	F000314	<p><b>F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b> This provider ensures, based on the comprehensive assessment of a resident, 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B was re-admitted to the facility with a Stage II wound to the sacrum. The wound was assessed upon admission by the charge nurse</p>	06/30/2013			

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	<p>These diagnoses remained current at the time of the record review.</p> <p>The resident was recently re-admitted to the facility on 05-21-13 after a hospitalization.</p> <p>A review of the resident's current plan of care, dated 05-21-13 indicated the resident "is at risk for pressure ulcers, due to very limited mobility and fragile coccyx." Approaches to this "problem" indicated "Conduct a systematic skin inspection weekly. Pay particular attention to the bony prominences, report any signs of skin breakdown (sore, tender, red, or broken areas)."</p> <p>Review of the physician orders, dated 05-21-13 instructed the nursing staff to "apply dermaseptin to area on coccyx two times a day. Resident should be seen by wound doctor on next visit per MD [medical doctor]."</p> <p>A review of the nursing progress notes lacked documentation related to the resident's ulcerated area during treatment changes or weekly as indicated in the plan of care.</p> <p>A physician progress note dated 06-06-13 indicated "Sent to hospital late last month after syncopal</p>		<p>and documented on the admission nursing assessment. An appropriate treatment order was initiated and completed by the charge nurse, as ordered per MD. The resident was assessed by the wound MD on 6/17/13; improvement was noted. The Wound MD will assess weekly and treatment changes will be followed, per order. The facility respectfully would like to clarify that the resident's wound had been treated per MD order since readmission and prior to assessment by the surveyor, and the resident told the surveyor, in front of the charge nurse, that the dressing had come off. The Interdisciplinary Team, including the dialysis team, the MD, and nurse managers, had met on Wednesday, 6/11/13, (prior to survey) to review the resident's treatment plan and orders. At that time the wound consult order was discontinued. <b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <p>Residents that are admitted/readmitted from the hospital with wound treatment orders have the potential to be affected by the alleged deficient practice. The facility completed a 100% audit of residents readmitted within the past 30 days to ensure wound treatments were initiated, per MD order,</p>		

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	<p>episode, found to have hemoperitoneum. Problems since her latest return include continued abd. [abdominal] pain, tho [though] she states this has improved a little, and LE [lower extremity] edema. She also has early skin breakdown on her coccyx, which is very painful. Imp [impression]/Plan: Painful pressure area on sacral bony prominence, will apply biatain foam for cushioning and ask wound team to see."</p> <p>A subsequent physician order, dated 06-06-13 indicated "Biatain foam to sacral bony prominence - change every 48 hours - please ask wound team to see for wound."</p> <p>Observation on 06-12-13 at 9:30 a.m., with licensed nurse employee #3 in attendance, the resident was seated on the side of the bed, bent over holding her stomach. When interviewed the resident indicated "I didn't sleep at all last night the pain was so bad. I don't know if I can take this anymore." When interviewed about the pain, the resident indicated her coccyx area. During this observation the resident stood up with the assistance of licensed nurse employee #3, and the resident's coccyx area was observed. The area did not have a dressing and there</p>		<p>upon admission. Resident skin assessments were completed by nurse managers and new orders were initiated, as needed.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b> _</p> <p>Re-education was provided to licensed nurses on following physician orders for wound care treatments upon admission/readmission, and documentation of wound measurements on 6/25/13, and ongoing by the Director of Nursing Services, or designee. Re-education was provided to the nurse management team on the admission/readmission process including auditing new/re-admission charts for skin impairment, treatment orders, etc., as well as validating the charge nurse skin assessment upon admission, on 6/24/13, by the Director of Nursing Services.</p> <p>The systemic change includes</p> <p>a) Nurse managers review readmission/admission hospital transfer orders to ensure wound orders are implemented appropriately. b) Nurse managers will inspect resident skin within 24 hours of admission to validate new orders and the charge nurse admission skin assessment. MD will be notified, as needed. c) The interdisciplinary team with complete wound rounds weekly,</p>				

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	<p>was an opened area to the resident's coccyx area.</p> <p>Interview on 06-12-13 at 11:20 a.m., the Administrator and Director of Nurses verified, the resident had not been assessed for her pressure ulcer, the nursing progress notes, lacked documentation of the area, and the resident had not been evaluated or assessed by the local wound care team as ordered by the physician.</p> <p>At 12:10 p.m. on 06-12-13 the Director of Nurses provided the assessment of the resident's pressure ulcer and included the measurements of the area and were documented as follows:</p> <p>"Date of onset: 05-21-13, Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), length 1.8 centimeters by 0.4 centimeters in width and a depth of 0.1 centimeters. Pale granulation tissue with no drainage."</p> <p>During the Exit Conference on 06-12-13 at 12:36 p.m., the Director of Nurses and the Administrator indicated the local Wound Care team come to the facility "weekly - on Monday's."</p>		<p>measuring pressure wounds and reviewing the resident's individualized plan of care. Changes to the plan of care will be implemented, per MD order, as needed. <b>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></p> <p>DON/Designee will audit new admission/readmission charts to ensure wound care orders are being followed as ordered from the discharging facility. This review will be done for 100% of new admissions each week for 4 weeks. Following this initial 4 weeks, random review of a minimum of 80% of new admissions weekly for 16 weeks, and then 4 admissions monthly for an additional 9 months to total 12 months of audits to determine that new admission/readmission wound care orders are being followed, per physician order. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. <b>Compliance Date:</b> 6/30/13</p>		

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	<p>Approximately 3 weeks had passed since the physician instructed the nursing staff to have the resident evaluated and treated by the Wound Care team.</p> <p>This Federal tag relates to Complaint IN00129811</p> <p>3.1-40(a)(2)</p>			