

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155038	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2012
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NAME OF PROVIDER OR SUPPLIER PARKVIEW NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 WHITERIVER BLVD MUNCIE, IN 47303
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F0000	<p>This visit was for the Investigation of Complaints IN00104421, IN00104543, and IN00105027.</p> <p>Complaint IN00104421 - Substantiated. Federal/state deficiencies related to the allegation cited at F202.</p> <p>Complaint IN00104543 - Substantiated. Federal/state deficiencies related to the allegation cited at F314.</p> <p>Complaint IN00105027 - Substantiated. Federal/state deficiencies related to the allegations cited at F225 and F226.</p> <p>Survey dates: March 6, 7, 8, 2012</p> <p>Facility number: 000013 Provider number: 155038 AIM number: 100266100</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF: 6 SNF/NF: 65 Total: 71</p> <p>Census payor type: Medicare: 10 Medicaid: 54 Other: 7 Total: 71</p>	F0000	F0000 Preparation and /or execution of this plan of correction does not constitute admis-sion or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or exe-cuted solely because it is required by the provision of federal and state law. Parkview Nursing Center desires this Plan of Correc-tion to be considered the facility's Allega-tion of Complianceand is effective 4-4-2012.	

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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	<p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/13/12 by Suzanne Williams, RN</p>			
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F0202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on record review and interview, the facility failed to ensure physician documentation of need for the immediate discharge of 1 (Resident A) of 2 residents in the sample of 7 reviewed for transfer/discharge.</p> <p>Findings include:</p> <p>Family member #1 of Resident (A) was interviewed by telephone at 4:40 p.m., 3/6/12. Family member #1 indicated Resident (A) was discharged by the facility 1 month ago due to a sexual act with another male.</p> <p>Family member #1 indicated placement in another facility had not been possible due to the facility's method of discharge.</p> <p>Family member #1 indicated she had enlisted the area ombudsman in attempts to get Resident (A) into a geri psych facility.</p>	F0202	<p>F202 Resident (A) is no longer a resident of the facility. A review of all active resident records revealed no other resident was affected. Medical Director and Nurse Practitioner, as well as facility nurses, will be inserviced/ instructed to use the written phrase "D/T resident may cause harm to himself or others, resident may be immediately dis-charged.....", upon documenting a discharge required d/t an abuse/safety related reason. All inservicing/training will be completed before 4-4-12 by DON (or designee). After completion of inservicing (4-4-12), all resident discharges will be monitored by DON (or designee), during Morning Staff Meetings as a corrective action for any residents identified as having the potential to be affected by this practice. Beginning 4-4-12, any resident being discharged from the facility in the next four months</p>	04/04/2012

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	<p>The closed record of Resident (A) was reviewed at 3:50 P.M., 3/7/12, and indicated a 5/2/11, admission with diagnoses of depression, anxiety, and hypertension.</p> <p>A 2/7/12, social services note indicated a possible sexual assault with police notification in accordance with the Elder Justice Act. Documentation indicated (Resident A) was to be monitored 1:1 until the morning and a discharge secured on 2/8/12.</p> <p>Documentation indicated the father of Resident (A) had been notified Resident (A) must be out of the facility by 2/8/12. Documentation on 2/8/12, at 10:00 A.M., indicated facility #2 had called and said they would not be able to admit Resident (A).</p> <p>Documentation at 1:10 P.M., 2/8/12 indicated Resident (A) was discharged to Family Members #1 and #2.</p> <p>A brochure from a local visiting nurse association was provided to the family.</p> <p>A 2/8/12, physician's order indicated a discharge to home with medications except narcotics.</p> <p>Documentation did not indicate a physician's statement of need for immediate discharge.</p> <p>During a 3/8/12, 11:20 A.M., interview,</p>		<p>(until 8-4-12), will be monitored and their pertinent discharge information will be "logged" to ensure compliance with current regulations through 8-4-12.</p> <p>Resident (A) is no longer a resident of the facility. A review of all active resident records realed no ther residents were affected by this practice.</p>				

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	<p>Social Services Director #1 (SSD #1) indicated Resident (A) had been very deliberate and explicit in describing what had occurred on 2/7/12. SSD #1 indicated she had contacted the police who took statements and chose not to remove Resident (A) from the facility. SSD #1 indicated 1:1 monitoring was in place until the 2/8/12, discharge. SSD #1 indicated the physician was contacted for a release order. SSD #1 indicated the facility had not requested the physician to document a need for immediate discharge.</p> <p>This federal tag relates to Complaint IN00104421.</p> <p>3.1-12(a)(5)(A)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <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> <p>Based on record review and interview, the facility failed to immediately investigate</p>	F0225	F225 The facility conducted the investigation regarding resident (C) on 3-9-12. The investigation	04/04/2012			

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	<p>an allegation of abuse and failed to report the allegation of abuse, and the thorough investigation, to the Indiana State Department of Health within 5 working days as required by Indian State Law for 1 (Resident C) of 3 residents in a sample of 7 reviewed for abuse.</p> <p>Findings include:</p> <p>The record of Resident (C) was reviewed at 10:45 A.M., 3/8/12. The 2/11/12, quarterly review of the minimum data set (MDS) indicated a cognitive assessment as alert.</p> <p>A 1/18/12, interdisciplinary team note indicated family had reported to the Director of Nursing (DoN) a staff member had been rough with care. Documentation indicated the unit manager and DoN had taken care of the issue.</p> <p>A copy of the reportable incident was requested on 3/8/12. The DoN provided a copy of a 1/17/12, report of concern which included an internal investigation of the allegation.</p> <p>During a 3/8/12, 12:45 P.M., interview, the DoN indicated the concern had not been reported to the Indiana State Department of Health because the allegation had not been validated.</p> <p>The DoN indicated she understood only substantiated allegations were reportable.</p>		<p>revealed no other residents who had the potential to be affected. All staff members will be in-serviced R/T the INITIAL steps of an alleged abuse situation as well as the entire abuse allegation procedure. Staff who fail to follow policy will receive immediate re-education up to disciplinary action/termination. All abuse allegations will be handled as set forth in the ISDH guidelines. A resident reporting any type of threat or abuse will be ensured to be safe from the said situation immediately. The allegation will be reported to an individual designated to complete an investigative report. An appropriate A/I Report will be completed for allegation of abuse, neglect, mistreatment, or injuries of unknown origin. A report of this nature will be investigated and the findings filed with the ISDH within 5 days. The facility will provide all ne-cessary corrective actions depending on the investiation results. A/I's will be reviewed in the Morning Staff Meeting (following the documentation of the allegation). Facility nurses are to be inserviced/trained to document accurately on the "electronic A/I System" (eAI) for timely & accurate re-porting of alleged/abuse. All abuse allegations will be reviewed by DON (or designee) , during the Morning Staff Meeting and then "logged" into a Log Book for</p>				

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	<p>A copy of the facility's revised January 2011, and February 2011, Prevention and Reporting:Resident Mistreatment, Neglect, Abuse, Injuries of Unknown Origin, and Misappropriation of Property Policy, was provided by the DoN 3/7/12.</p> <p>The introduction indicated all allegations that meet the definition of abuse and substantiated violations would be reported to state agencies and all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The corporation would take all necessary corrective actions depending on the result of the investigation.</p> <p>Point #2 under Identification indicated a review of the following to identify trends that may constitute abuse, or to monitor for indicators leading to abuse, neglect, and/or mistreatment: Resident concern reports, and accident and incident process forms. An accident/incident report was to be initiated upon identification of alleged abuse, neglect, mistreatment, or injuries of unknown origin.</p> <p>Point #7 under Investigation indicated the completed accident/incident report summary was to assist in identification of trends.</p>		<p>monitoring & tracking purposes. DON (or designee) will meet one time per week with resident (C)& family to provide a chance for them to share concerns and/or have questions answered, and staff will document any verbalized concerns and/or questions for review during Morning Staff Meetings beginning 4-4-12.</p>				

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	<p>Point #8 under Investigation indicated the results of all investigations were to be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation was verified, appropriate corrective action would be taken.</p> <p>This federal tag also relates to Complaint IN00105027.</p> <p>3.1-28(c) 3.1-28(d) 3.1-28(e)</p>				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure their Prevention and Reporting of Resident Mistreatment, and Abuse Policy was implemented for 1 (Resident C) of 3 residents in the sample of 7 who alleged physical abuse by a staff member.</p> <p>Findings include:</p> <p>The record of Resident (C) was reviewed at 10:45 A.M., 3/8/12. The 2/11/12, quarterly review of the minimum data set (MDS) indicated a cognitive assessment as alert.</p> <p>A 1/18/12, interdisciplinary team note indicated family had reported to the Director of Nursing (DoN) a staff member had been rough with care. Documentation indicated the unit manager and DoN had taken care of the issue.</p> <p>A copy of the reportable incident was requested on 3/8/12. The DoN provided a copy of a 1/17/12, report of concern which included an internal investigation of the allegation.</p>	F0226	<p>F226 Resident (C) remains a resident at the facility. A review of all other resident records revealed no othr residents affected. A/I Reports will be completed in accordance with facility policy and then reviewed in the Morning Staff Meetings by IDT and DON (or designee). Facility nurses will be educated/trained to input the applicable resident data into com-puterized A/I Reports (eAI's). Education will include the policy for initial /immediate steps to be taken for an allegation of abuse as well as the proper notification of manage-ment personnel. Staff who fail to follow the policy will receive immediate re-education up to disciplinary action/termination. All abuse allegations will be handled as set forth in the ISDH guidelines. A resident re-porting any type of threat or abuse will be ensured to be removed from said situation immediately. The allegation will be report-ed to an individual designated to complete an investigative report. An appropriate A/I Report will be completed for allegation of abuse, neglect, mistreatment, or injuries</p>	04/04/2012			

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	<p>During a 3/8/12, 12:45 P.M., interview, the DoN indicated the concern had not been reported to the Indiana State Department of Health because the allegation had not been validated. The DoN indicated she understood only substantiated allegations were reportable.</p> <p>A copy of the facility's revised January 2011, and February 2011, Prevention and Reporting:Resident Mistreatment, Neglect, Abuse, Injuries of Unknown Origin, and Misappropriation of Property Policy, was provided by the DoN 3/7/12. The introduction indicated all allegations that meet the definition of abuse and substantiated violations would be reported to state agencies and all other agencies including the local law enforcement, elder abuse agencies, and Adult Protective Services, as required. The corporation would take all necessary corrective actions depending on the result of the investigation.</p> <p>Point #2 under Identification indicated a review of the following to identify trends that may constitute abuse, or to monitor for indicators leading to abuse, neglect, and/or mistreatment: Resident concern reports, and accident and incident process forms. An accident/incident report was to be initiated upon identification of alleged</p>		<p>of unknown origin. A report of this nature will be investigated and the findings filed with the ISDH within five days. The facility will provide all ne-cessary corrective actions depending on the investigation results. A/I Reports will be reviewed in the Morning Staff Meeting (following the documentation of the allegation), by DON (or designee) and then "logged into" a Log Book to further track allegations/abuse throughout the next four months.</p>				

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	<p>abuse, neglect, mistreatment, or injuries of unknown origin.</p> <p>Point #7 under Investigation indicated the completed accident/incident report summary was to assist in identification of trends.</p> <p>Point #8 under Investigation indicated the results of all investigations were to be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation was verified, appropriate corrective action would be taken.</p> <p>This federal tag also relates to Complaint IN00105027.</p> <p>3.1-28(a)</p>				

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</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 record review and interview, the facility failed to provide interventions to prevent 1 (Resident B) of 3 residents in the sample of 7, reviewed for pressure ulcers, from developing an unstageable, necrotic pressure sore to a heel.</p> <p>This pressure sore was discovered in the local hospital emergency room when Resident (B) was sent for evaluation and treatment of diaphoresis, and decreased mental status. This pressure sore required surgical debridement of dry gangrene which involved a circular dimensional surface of the heel and the surrounding tissue area.</p> <p>Findings include:</p> <p>Social Services (SS) Case Worker #1 at the local hospital was interviewed by telephone at 10:00 AM, 3/7/12, and indicated family members of Resident (B) were unhappy with the care provided at</p>	F0314	<p>F314 Resident (B) us no longer a resident of the facility.</p> <p>All active residents had an initial skin assessment on 3-7-12. Since that time there have been weekly skin assessments per faci-lity policy. Identified skin concerns were monitored by skin grids for healing and effectiveness of interventions on an ongoing basis. Facility interventions to monitor, treat, protect and/or prevent skin issues may relate to all active residents.</p> <p>The DON (or designee) will institute a review of any skin issues reported on a daily basis during the Morning Staff Meeting. Any skin issues will be assessed for cause, treatment, protection & prevention of further or additional</p>	04/04/2012			

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	<p>the facility.</p> <p>Hospital SS Case Worker #1 indicated the emergency room (ER) nurse had found open areas on the initial assessment of Resident (B). SS Case worker #1 indicated Resident (B) had been discharged to another facility the evening of 3/6/12, at the request of family.</p> <p>The facility record of Resident (B) was reviewed 3/7/12, at 10:10 A.M., and indicated a 10/15/08, admission with diagnoses including Alzheimer's dementia, depression, hypertension, chronic obstructive lung disease, and tremors.</p> <p>The current, 12/7/11, minimum data set (MDS) quarterly assessment indicated Resident (B) was cognitively alert, required extensive assistance with activities of daily living, including transfer to a wheel chair, and was at risk for pressure ulcers.</p> <p>Resident (B) was assessed as currently without unhealed pressure ulcers. The assessed skin/ulcer treatments included pressure reduction devices for bed and chair and a turning, re-positioning program.</p> <p>The 2/12/12, Braden risk assessment scale for pressure ulcers indicated a score of 14, moderate risk.</p> <p>The 2/21/12, plan of care indicated frequent urinary incontinence with use of</p>		<p>skin issues.</p> <p>The facility will institute a weekly IDT review of any reported skin issues to assess for additional causes, treatments, or additional preventions.</p> <p>The facility will institute formal audits of both turning/repositioning and of incontinent care daily.</p> <p>These audits will be completed by nursing and/or other members of the IDT daily through 8-4-12.</p> <p>The IDT will then re-evaluate to decide whether to continue or to discontinue the audits after 8-4-12.</p> <p>Log Book to further track allegations/abuse throughout the next four months (4-4-12).</p> <p>The HFA, DON, SSD, or designated individual, will be</p>	

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	<p>an adult pull-up brief.</p> <p>The 2/12/12, skin integrity assessment: prevention and treatment plan of care indicated a concern of a pressure ulcer risk with goals of remaining free of open areas, and being cooperative with position changes.</p> <p>Interventions included use of a commercial moisture barrier cream and absorbent adult incontinence products that wicked and held moisture; no massage of reddened bony prominences; no do-nut type devices; protection of heels, and avoidance of dry skin. Documentation did not indicate if Resident (B) required assistance with turning and re-positioning, nor a specific intervention of how to protect the heels.</p> <p>The 2/25/12, 9:00 A.M., nursing note, documented by Licensed Practical Nurse (LPN#1) indicated a check of the vital signs, temperature-98 degrees, and oxygen saturation (O 2 sat) level of 90% on 2 liters of oxygen by nasal cannula. A respiratory treatment was given which raised the O 2 sat level to 95%.</p> <p>Resident (B) was incontinent of bowel and bladder. Pedal (foot) pulses were present. Resident (B) verbalized not feeling well and requested a bed bath instead of a shower.</p> <p>A 2/25/12, 10:00 P.M., nursing note indicated assessment of vital signs and</p>		<p>notified of any allegations that meet the definition of abuse and any sub-stantiated violations will be reported to state agencies and all other appropriate agencies as required.</p>				

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	<p>lung sounds. Documentation indicated Resident (B) was not feeling well, ate little at dinner, and stayed in bed all evening. The skin was warm.</p> <p>The 2/26/12, 7:15 A.M., nursing note, documented by LPN #1, indicated assessment of vital signs with a decreased level of consciousness, and no response to verbal commands. The skin was wet, hot, and diaphoretic. The oxygen level was increased to 3 liters, a breathing treatment and Tylenol suppository were given (temperature not indicated).</p> <p>A 2/26/12, 7:45 A.M., nursing note indicated Resident (B) had not responded to the Tylenol suppository or respiratory treatment. Documentation indicated writer (LPN #1) believed Resident (B) had not responded well to the current Levaquin (antibiotic) therapy for pneumonia.</p> <p>911 was called for transfer to the local hospital emergency room (ER) for evaluation and treatment.</p> <p>Attempts were made to contact family member #1 twice, and report was called to the hospital.</p> <p>At 8:20 A.M., 2/26/12, the emergency medical services (EMS) arrived and transferred Resident (B) to the hospital. Documentation in the nursing notes indicated at 9:00 A.M., 2/26/12, the ER physician called to inquire if the facility had contacted the family. Documentation</p>			

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	<p>indicated the ER physician talked about end of life care, and indicated Resident (B) was septic and may not survive. The 2/26/12, facility transfer form indicated a full code status, a current history of pneumonia with decreased lung sounds, and a temperature of 102.8. The skin/wound care section of the form, which indicated high risk for pressure ulcer, with a yes or no check, and a space for documentation of a pressure ulcer, was blank</p> <p>On the morning of 3/7/12, the Director of Nursing (DoN) provided the 2/12, skin examination report sheets (shower assessment sheets) for Resident (B). The sheets contained a picture of the human body with word descriptive body parts which were to be checked if any pressure area was observed.</p> <p>The 2/22/12, sheet indicated zero red areas.</p> <p>Two sheets were enclosed for 2/25/12. The first indicated Resident (B) refused a shower.</p> <p>The second sheet, signed by LPN #1 to indicate assessment, had documentation a bed bath had been given. A circle with a diagonal line through it (zero) was drawn to the side of the form next to the picture of the body form.</p> <p>At 11:50 A.M. ,3/7/12, a visit was made</p>			

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	<p>to the area hospital, which was also a regional referral site, to review the 2/26 - 3/6/12, record.</p> <p>Documentation indicated the ER arrival time was 8:26 A.M., 2/26/12.</p> <p>At 9:56 A.M., 2/26/12, ER Registered Nurse (RN #1) documented a, "pressure ulcer to the right heel, dry, necrotic tissue, eschar." Measurements were not provided.</p> <p>The ER physician's report documentation included presence of a cellulitis with necrotic area to the right heel. Resident (B) was intubated in the ER and sent to the critical care area at 10:59 A.M., on 2/26/12.</p> <p>The initial impression was septicemia, cellulitis, and dehydration.</p> <p>Hospital Critical Care Manager #1 was present during the record review and indicated protocol required a total skin assessment on admission to the unit, with wound consult if necessary.</p> <p>The 2/26/12, 12:00 P.M., initial critical care skin assessment indicated the presence of a pressure ulcer to the right heel and right ankle with multiple deep tissue areas and scattered unstageable ulcers along the right lateral foot. The pressure ulcer to the right heel was described as black with dry necrosis and erythema about the surrounding tissue.</p> <p>The pressure ulcer to the right ankle was</p>				

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	<p>described as purple, red. Documentation also indicated a deep tissue pressure ulcer to the left heel, and a stage II to the right thumb.</p> <p>A 2/28/12, wound nurse consultation indicated a large, deep, tissue injury to the right heel measuring 7 by 7 centimeters(cm) with unstable eschar. Documentation also indicated 5 other areas along the right lateral foot up to the ankle, 1 by 1 cm. each. The wound nurse questioned if the areas could possibly be due to a device at the nursing facility.</p> <p>A 3/2/12, wound nurse consultation indicated a 7 by 6 cm. black eschar to the right medial heel, with an 8 by 2 cm. section on the right lateral foot of eschar covered wounds, and 2 wounds inside of the ankle, 1 by 1 cm. each. Documentation indicated all were eschar covered. A surgical consultation was sought.</p> <p>The 3/3/12, 3:15 P.M., operative note indicated a diagnosis of necrotic pressure ulcer of the right heel and lateral foot. Excisional debridement was made. The surgeon described dry gangrene involving an 8 by 8 cm. circular dimensional surface area of the right heel. Documentation indicated the tissue overlying the calcaneus (heel) was not viable. The surgeon documented to remove the tissue would leave exposed bone.</p>						

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	<p>The surgeon documented similar debridement of a 4 by 2 cm area along the right lateral foot. Documentation indicated pure dry gangrene. Documentation indicated the physician would speak with the family as whether further treatment would be desired in the event of a need for above the knee amputation.</p> <p>After return to the facility, a 3/7/12, 2:00 P.M., interview was conducted with RN Unit Manager #1. RN Unit Manager #1 indicated Resident (B) had worn sneakers and did not have a foot or leg device. After review of the record, RN Unit Manager #1 indicated Resident (B) did have a right leg splint ordered.</p> <p>LPN #1 was interviewed by telephone at 2:30 P.M., 3/7/12, and indicated she had not performed a total skin assessment on Resident (B). LPN #1 indicated she had care of Resident (B) on 2/25, and 2/26/12. LPN #1 indicated she recalled on 2/25/12, Resident (B) did not feel up to a shower and was given a bed bath. LPN #1 indicated she had assessed the skin and saw nothing. LPN #1 indicated on 2/26/12, Resident (B) had a temperature elevation, was shaking, and very diaphoretic. LPN #1</p>			

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	<p>indicated 911 was called and Resident (B) was sent to the hospital for evaluation. LPN #1 indicated Resident (B) always wore socks and sneakers. LPN #1 could not recall use of a leg splint. LPN #1 indicated Resident (B) had been able to self propel in the wheel chair until the decline on 2/25/12. LPN #1 recalled Resident (B) had been in bed most of the day on 2/25/12.</p> <p>LPN #1 indicated she had looked the resident up and down on 2/26/12, and saw nothing on the legs or feet. LPN #1 indicated Resident (B) was very ill and she was focused on his condition. LPN #1 indicated she could have over looked something.</p> <p>At 2:35 P.M., 3/7/12, the DoN and Corporate RN #1 were advised of the concern of Resident (B) having an unstageable necrotic right heel pressure ulcer discovered in the ER, following transfer from the facility on 2/26/12. Corporate RN #1 inquired if the hospital had provided documentation on the right patient.</p> <p>Corporate RN #1 indicated on the last Braden (pressure ulcer risk) Resident (B) had been assessed at 14, moderate risk. Corporate RN #1 indicated facility documentation did not indicate the presence of a pressure ulcer and inquired why hospital documentation would be</p>			

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	<p>seen as accurate and facility documentation seen as inaccurate.</p> <p>RN Week-End Supervisor #1 was interviewed at 3:10 P.M., 3/7/12, and indicated she recalled being asked to assist with the transfer of Resident (B) on 2/26/12. RN Week-End Supervisor #1 indicated she had not done a skin assessment and was not sure if one was completed prior to the hospital transfer.</p> <p>CNA #1 was interviewed by telephone at 3:40 P.M., 3/7/12, and indicated she had done a bed bath on Resident (B) on 2/25/12. CNA #1 indicated she had lotioned the feet and did not see any areas.</p> <p>CNA #1 indicated she was pretty sure she had seen the heels, however, could not really recall.</p> <p>CNA #2 had been interviewed by telephone at 2:40 P.M., 3/7/12, and indicated she had care of Resident (B) on 2/26/12, noticed a change in condition after the shift report, and got LPN #1 to assess him.</p> <p>CNA #2 indicated Resident (B) usually stayed up most of the day, CNA #2 indicated Resident (B) stayed in bed over the 2/25-2/26/12, week-end. CNA #2 indicated Resident (B) was diaphoretic with sticky skin.</p>						

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	<p>CNA #2 indicated she was so concerned about the change in condition she probably did not look at the feet.</p> <p>At 12:15 P.M., 3/8/12, Corporate RN #1 provided copies of written statements from all staff who had cared for Resident (B). Twelve statements were provided. Nine of the statements did not indicate the date of care provided. All nine of the unknown dates of care statements indicated no areas observed.</p> <p>Statement #7, documented by LPN #2 indicated care the evening prior to the hospital transfer without observation of open areas on the coccyx or buttocks.</p> <p>Statement #8, documented by RN #1 indicated the writer was the charge nurse on the night shift prior to the 2/26/12, hospitalization and saw zero open areas.</p> <p>Statement #12, illegible signature (unknown CNA) indicated night shift prior to the 2/26/12, hospitalization with completion of a 5-6 A. M., bed check without visible sores on Resident (B).</p> <p>The facility's 4/09, revised Wound Prevention and Treatment Policy indicated the corporation strived to ensure a resident entering the center without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates unavoidable skin breakdown.</p>						

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	<p>The corporation also recognized even the most vigilant nursing care may not prevent the development and/or worsening of pressure ulcers in some residents. In those cases, intensive efforts will be directed at the following: managing risk factors, providing preventive interventions, and providing treatment.</p> <p>This federal tag also relates to Complaint IN00104543.</p> <p>3.1-40(a)(1)</p>			