

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/16/2015
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NAME OF PROVIDER OR SUPPLIER HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00168651 and IN00169541.</p> <p>This visit was in conjunction with the Post Re-visit (PSR) for a Recertification and State Licensure Survey and the Investigation of Complaint IN00162422 on January 29, 2015.</p> <p>This visit was in conjunction with the PSR for the Investigation of Complaint IN00163279 completed on January 29, 2015.</p> <p>Complaint IN00168651-Substantiated. Federal/State deficiencies related to the allegations were cited at F-314.</p> <p>Complaint IN00169541-Substantiated. Federal/State deficiencies related to the allegations were cited at F-309 and F-312.</p> <p>Survey dates: March 11, 12, 13, 15 and 16, 2015.</p> <p>Facility Number: 000070 Provider number: 155149 AIM number: 100266190</p> <p>Survey Team:</p>	F 000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after March 30, 2015. This provider respectfully requests a face to face Informal Dispute Resolution (IDR) for tags F309 as facility disagrees with scope and severity	
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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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F 309 SS=G Bldg. 00	<p>Sandra Nolder, RN-TC Michelle Hosteter, RN (March 11, 12, 13 and 16, 2015) Gloria Bond, RN (March 11, 12, 13 and 16, 2015)</p> <p>Census bed type: SNF: 5 SNF/NF: 96 Total: 101</p> <p>Census payor type: Medicare: 9 Medicaid: 70 Other: 22 Total: 101</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on March 23, 2015.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>			

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to assess a resident in regards to pain and bowel concerns, which resulted in severe pain and fecal impaction for 1 of 4 residents reviewed for care concerns. (Resident C)</p> <p>Finding included:</p> <p>On 3/11/15 at 3:30 p.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, constipation, depression, left sided stroke and congestive heart failure.</p> <p>On 3/11/2015 at 4:01 p.m., CNA #1 and LPN #2 were observed transferring resident via a stand up lift. The resident was taken to the bathroom and transferred via a stand up lift from the wheelchair to the toilet.</p> <p>On 3/11/2015 at 4:16 p.m., Resident C was grimacing indicating her bottom hurt. CNA #1 indicated she was not aware of any open areas on the resident's bottom. The resident indicated she had been having problems with her bowels lately and sometimes it felt as if she was going to have surgery when she had a bowel movement (BM). CNA #1 applied</p>	F 309	<p>Provider respectfully requests a face to face IDR as facility disagrees with scope and severity What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident C is assessed daily for pain and bowel concerns by the charge nurse and documented in the medical record. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. Executive Director and Nurse Managers reviewed Facility Activity Report including weekly summary and pain interview for the past 7 days to look for documentation of signs and symptoms of pain and bowel concerns and will be reassessed to determine if pain or bowel concerns are still present. If pain or bowel concerns were still present nurse managers assessed pain and bowel concerns, implemented interventions, and reevaluated effectiveness of intervention. 	03/30/2015

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	<p>barrier cream to the area. The resident indicated after the barrier cream was applied her bottom felt better. LPN #2 asked the resident, during transfer when she complained of pain, if she wanted to stop and she would say yes. They would stop, then when they needed to continue with care they asked her permission to start again and she would indicate it was all right.</p> <p>Resident C was observed on 3/12/2015 at 9:38 a.m., getting therapy to her left hand and the resident indicated to the therapist at that time she was having pain in her bottom. The therapist indicated she would reposition her.</p> <p>On 3/12/2015 at 10:35 a.m., the resident indicated to LPN #3 that her bottom was hurting.</p> <p>CNA #4 and CNA #5 were observed transferring Resident C on 3/12/2015 at 10:52 a.m., from her bed to the wheelchair and the wheelchair to the toilet. CNA #5 went to change the bedding and it was observed to have some bowel movement smearing on the incontinence pad.</p> <p>On 3/12/2015 at 11:12 a.m., CNA #4 and CNA #5 left Resident C on the toilet with the call light in her hand. CNA #5</p>		<ul style="list-style-type: none"> ·DON/Designee reviewed Medication Administration Record for residents who received PRN pain medication in the last 7 days to determine if pain was still present. If pain was still present nurse managers made sure assessment of pain was present and interventions were implemented and reevaluated for effectiveness of intervention. ·Licensed nurses will be in serviced on pain management program including pain assessment, bowel elimination program including bowel assessment by Director of Nursing Services Specialist/Designee by March 30, 2015. ·CNA's will be in serviced on Pain Management Program including reporting signs and symptoms of pain to Nurse and Bowel Elimination Program by Director of Nursing Services Specialist/Designee by March 30, 2015. ·Therapy staff will be in serviced Pain Management Program including pain assessment Director of Nursing/Designee by March 30, 2015. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Executive Director and Nurse Managers will review Facility Activity Report including weekly summary and pain interview daily 		

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	<p>indicated the resident had a few small pieces of hard BM in her brief. Resident C complained of pain in her bottom again. CNA #5 was observed leaving the resident and indicated she needed to get sheets for the bed due to their being food in the bed.</p> <p>On 3/12/2015 at 11:16 a.m., the resident was complaining off and on again of discomfort, CNA #5 asked at that time if she was all right. CNA #5 told her she was going to leave for a moment and get something else and ensured the resident had the call light in her hand. About 11:19 a.m., after CNA # 5 left the room , the resident started moaning loudly. She was also yelling to go get CNA #5 and calling out loudly while on the toilet.</p> <p>On 3/12/2015 at 11:21 a.m., the Clinical Consultant Specialist (CCS) came in and started helping her. CNA #5 and an unidentified CNA were assisting to clean up the resident. The resident's stools were observed as very dark in appearance.</p> <p>On 3/12/15 at 11:30 a.m., LPN #3 came into the room and asked the resident where she hurt. The resident told LPN #3 her tailbone hurt. LPN #3 indicated at that time, she had been in a couple of times this morning and the resident had</p>		<p>to look for documentation of signs and symptoms of pain and/or bowelconcerns and ensure that pain and/or bowel assessment were completed, interventions were implemented and reevaluated to ensure interventions wereeffective.</p> <ul style="list-style-type: none"> ·Nurse Managers will review Medication AdministrationRecord daily for residents who received PRN medication daily to determine ifpain was assessed, intervention was implemented and was reevaluated foreffectiveness. ·Licensed nurses will be in serviced on painmanagement program including pain assessment, location, and intensity and bowelelimination program including bowel assessment by Director of Nursing ServicesSpecialist/Designee by March 30, 2015. ·CNA's will be in serviced on Pain ManagementProgram including reporting signs and symptoms of pain to Nurse and BowelElimination Program by Director of Nursing Services Specialist/Designee by March 30, 2015. ·Therapy staff will be in serviced PainManagement Program including pain assessment Director of Nursing/Designee by March 30, 2015. How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, 	

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	<p>complained of pain and LPN #3 had repositioned her a couple of times.</p> <p>During an interview on 3/12/15 at 1:25 p.m., the CCS indicated a bowel assessment was completed. The CCS indicated the Physician's Assistant (PA) had indicated upon her assessment the resident had active bowel sounds and hard stool in her rectum. The CCS indicated the PA digitally removed the stool and had a large amount of soft stool. The CCS indicated the resident was also given an enema to assist in the removal of remaining soft stool and the resident's stool had a greenish tint to it, which was from the iron the resident received.</p> <p>On 3/12/2015 at 2:46 p.m., LPN #2 indicated if a resident complained of pain he would possibly do a pain assessment. He indicated he had not done a bowel assessment due to the fact that she had soft smearing in her brief and had indicated she had a bowel movement recently. He also indicated that the resident had soft smearing, which indicated she was not constipated. LPN #2 indicated the pain was more related to the high cushion on the toilet, which the family had requested be placed on the toilet, since the resident spent a lengthy amount of time sitting on the toilet. He</p>		<p>i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Pain Management CQI tool and Bowel Elimination tool will be completed by DNS/Designee weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 	

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	<p>also indicated this caused discomfort because of the way the resident was weak on the left side and the fact she had to be lifted higher in the transfer sling in order to get up on top of the toilet cushion. He indicated CNA #1 had not reported any pain to the nurse because he was in the room, but that aids were expected to report pain to the nurse. LPN #2 indicated he felt that the pain was more from the transfer and that was why he had tried to stop the transfer, but the resident had indicated to go ahead. LPN #2 also indicated the resident had problems with constipation in the past and that was one of the concerns the family had communicated to him upon admission.</p> <p>During an interview on 3/12/2015 3:08 p.m., the CCS indicated she expected the nurse to assess the resident if a resident complained of pain, when it was explained to her that the resident indicated she had pain feeling like she was going to have surgery when having a bowel movement.</p> <p>A progress note dated 3/12/15 at 11:45 a.m., indicated, "Resident was complaining of pain in her bottom while on toilet. Resident had just had pain medication within the last hour. After resident was transferred to bed, smear of</p>			

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	<p>dark stool noted on incontinence pad. Resident bowel sounds assessed and active in all quads. Abdomen distended and firm, but this is usual for resident per report of charge nurse. NP [Nurse Practitioner] in building and contacted to assess resident and notified of assessment.... " This progress note had a note to indicate it had been edited.</p> <p>The progress note dated 3/12/15 at 11:56 a.m., indicated, "...Per report of NP at bedside. Resident had soft stool in the rectal vault that was manually removed by the NP. She stated that stool did not appear black and tarry but greenish as she is on iron. She stated there was no indication for hemacult [test to check for blood in the stool] due to the color. Enema administered.... " This progress note had a note to indicate it had been edited. The original version indicated, "...Per report of NP at bedside. Resident has hard stool in the rectal vault that was manually removed by the NP. She stated that stool did not appear black and tarry but greenish as in she is on iron., She stated there was no indication for hemacult [sic] due to the color. Enema administered...."</p> <p>The progress note dated 3/12/15 at 12:07 p.m., indicated, "Present during assessment of resident pain and bowel</p>			

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F 312 SS=D Bldg. 00	<p>status. NP asked resident if she would like assistance in removing stool to rectum and resident consented. NP ordered enema due to soft stool higher up, Resident tolerated enema well with initial small results. No further complaints of pain after resident received enema...."</p> <p>The Physicians Assistant document titled, "HMC Comprehensive Assessment" dated 3/12/15 at 11:45 a.m., indicated, "...fecal impaction...patient complaining of rectal pain and constipation with associated abdominal pain-aching, bilateral lower quadrant, constant...physical exam...abdomen: positive bowel sounds, soft, tender to palpation large amount black green soft stool removed from rectal vault increased soft stool palpated higher up no bright red blood per rectum. Assessment: 1) Fecal impaction manual disimpaction performed fleets enema, add stool softener...."</p> <p>This Federal tag relates to complaint IN00169541.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>			

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	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was neat and clean in appearance for 1 of 3 residents reviewed for Activities of Daily Living. (Resident C)</p> <p>Findings include:</p> <p>On 3/11/15 at 3:30 p.m., the record review for Resident C was completed. Diagnoses included, but were not limited to, constipation, depression, left sided stroke and congestive heart failure.</p> <p>CNA #4 and CNA #5 were observed transferring Resident C on 3/12/2015 at 10:52 a.m., from her bed to the wheelchair and the wheelchair to the toilet. CNA #5 went to change the bedding and it was observed to have some food debris scattered on the bed.</p> <p>On 3/15/2015 at 11:15 a.m., CNA #5 was exiting the room at that time. Resident C had food crumbs at the foot of her bed and on the right side of the bed beside her and she had food debris and crumbs on her purple nightgown. She started picking the food off her gown and</p>	F 312	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident C is checked by CNA's to ensure resident does not have food left on clothing or in bed after meals. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by this alleged deficient practice. Nursing staff will be inserviced by March 30, 2015 by Director of Nursing Services Specialist/Designee Resident Dignity including ensuring residents are free from food debris and spills on clothing and in bed after meals. Managers will be inserviced by March 30, 2015 by Executive Director/Designee on ensuring residents are free from food debris and spills on clothing and in bed after meals. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> A manager will be designated 	03/30/2015
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	<p>dropping the food on her bed at that time.</p> <p>On 3/15/2015 at 11:44 a.m., CNA #5 went into the resident's room at that time and asked her if she was going to get up for lunch. The Medical Records staff member came into the room at that time and indicated CNA #5 needed to attempt to get the resident up for lunch and CNA #5 indicated she was attempting to do this. The resident continued to have the purple gown on with the food debris and food crumbs on it when CNA #5 left the room.</p> <p>On 3/15/2015 at 3:50 p.m., the resident was sitting up in her wheelchair at the side of her bed and she had food crumbs and red juice dribbled on the front of her long sleeve white shirt. She had a brown substance under her bottom lip on the right side of her mouth. Her lunch tray was sitting on her table in front of her. She indicated at that time she had been done eating for a long while.</p> <p>On 3/15/2015 at 4:10 p.m., the resident was sitting at the side of her bed in her w/c with food crumbs down the front of her shirt with red drink dribbled down the front of her shirt. The resident had the brown substance under her bottom lip on the right side of her mouth. The lunch tray had been taken out of her room. The</p>		<p>to round after each meal on all units to ensure residents that dine in their rooms are free of food debris and spills on clothing and in bed after meals by completing bed board checklist.</p> <ul style="list-style-type: none"> ·Dining observation checklist will be completed after each meal to ensure residents are free from food debris and spills on clothing daily after each meal. ·Nursing staff will be inserviced by March 30, 2015 by Director of Nursing Services Specialist/Designee on resident dignity including ensuring residents are free from food debris and spills on clothing and in bed after each meal daily.. ·Managers will be inserviced by March 30, 2015 by Executive Director/Designee on ensuring residents are free from food debris and spills on clothing and in bed after meals. <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Dignity and Privacy CQI tool will be utilized by DNS/Designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 				

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F 314 SS=D Bldg. 00	<p>Interim Director of Nursing Services indicated at that time that she would expect the nursing staff to notice the resident required care and tend to her needs.</p> <p>This Federal tag relates to complaint IN00169541.</p> <p>3.1-38(a)(2)(A)</p> <p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure pressure ulcer prevention interventions were followed to prevent pressure ulcers from deteriorating and failed to follow Physician orders for the treatment of pressure ulcers for 2 of 3 residents reviewed for pressure ulcers. Resident F's coccyx pressure ulcer deteriorated from a Stage IV to an Unstageable pressure ulcer and the bilateral buttock pressure ulcers</p>	F 314	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident F no longer resides in this facility. ·Resident D no longer resides in this facility. ·LPN #3 was skills validated and will be observed performing dressing changes 1 x weekly. <p>How will you identify other</p>	03/30/2015

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	<p>deteriorated from a Stage II to Stage III pressure ulcers. (Resident F and D)</p> <p>Findings include:</p> <p>1. Resident F's record was reviewed on 3/13/15 at 10:32 a.m. Diagnoses included, but were not limited to, paraplegia, peripheral neuropathy, chronic foley secondary to neurogenic bladder and sacral pressure ulcer. The resident's record indicated the resident was admitted with two pressure ulcers and acquired one pressure ulcer in the facility.</p> <p>The resident's Medication Administration Record (MAR) dated February 2015, included, but was not limited to the following order, 2/13/15--Promod (A protein supplement for wound healing) 30 ml (milliliters) by mouth twice daily for 30 days. (To end on 3/13/15)</p> <p>The February 2015, MAR indicated the Nurses initials were circled every other day except 2/14/15 and 2/15/15 at 5 p.m., and there were no initials for those two dates. No documentation was found on the back of the MAR to indicate why the Nurses circled their initials and the Promod was not taken.</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents with pressure ulcers have the potential to be effected by the alleged deficient practice. ·All residents with pressure ulcers had medication administration record review and supplements were reviewed by nurse managers for documentation of refusal and then updated care plans accordingly. ·Clinical record and Physician Orders for all residents with pressure ulcers were reviewed by nurse managers to ensure that treatment administration records reflected current physician's orders. ·All readmissions for the last 30 days were reviewed by the IDT team to ensure that orders were reconciled and clarified from previous admission for wound prevention and healing interventions/supplements from previous admission. ·All residents with pressureulcers were reviewed by DNS/Designee to ensure interventions to preventpressure ulcers were in place and implemented per plan of care and physician'sorders. All changes or clarifications needed were clarified with physician,orders written, and care plan updated as 	

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	<p>The Nursing progress notes were reviewed from 2/13/15 to 2/20/15, at which time, the resident was admitted to the hospital. The record lacked documentation the resident had refused her Promod or why it was not given.</p> <p>Resident F was discharged to the hospital on 2/20/15, and readmitted to the facility on 2/26/15. The resident's readmission Physician orders had not included the order for the Promod 30 ml by mouth twice daily for 30 days, which should have been completed on 3/13/15.</p> <p>During an interview on 3/13/15 at 4:47 p.m., the Clinical Consultant Specialist (CCS) indicated there was no order found in Resident F's record for the Promod when she was readmitted back to the facility from the hospital on 2/26/15. She indicated the facility had not notified the Wound Physician to clarify the Promod order to ask if he wanted it restarted after the resident was readmitted. The CCS indicated she assessed the residents with wounds to assess their nutritional intakes, laboratory values, wound statuses, and previous supplement orders to determine whether or not the Nursing staff needed to call the Wound Physician to clarify if the wound healing supplements needed to be restarted after readmission to the facility. She indicated she had not</p>		<p>needed</p> <ul style="list-style-type: none"> ·Nursing staff will be in-serviced on the Skin Management Program, following residents care plan/profile, ensuring wound interventions are in place, turn schedule, Resident Refusal of Medication and Treatments Policy, Dressing Change (Incision or Wound) Policy, and following the plan of care by the DNS/designee by March 30, 2015. ·Licensed Nurses will be skills validated on Dressing Change (Incision and Wound) Skills Validation observed by DNS/Designee by March 30, 2015. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The DNS/Designee will review the Facility Activity Report and Physicians orders daily to identify wound healing and prevention interventions and update care plan and resident profile accordingly. ·Orders for all residents with pressure areas will be reviewed by DNS/Designee daily to ensure there are no transcription errors on the treatment administration record. ·All readmissions will be reviewed daily by the DNS/Designee to ensure that orders were reconciled and clarified with the physician from 	

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	<p>assessed Resident F to verify if the Wound Physician needed to be notified regarding her Promod after readmission to the facility.</p> <p>During an interview on 3/16/15 at 11:00 a.m., the Interim DNS indicated the Nurses initials circled on the MAR dated February 2015, for the Promod indicated Resident F had refused to take the supplement. She indicated the Nurses were to circle their initials and document on the back of the MAR the reason the resident had not taken the supplement, but the Nurses failed to do that on Resident F's February 2015, MAR. She indicated the resident had taken the Promod a couple of times, but generally refused it. She indicated the Wound Physician was addressing the Promod order on the Wound Care progress notes today when he visited.</p> <p>A "Resident Profile" document dated 3/13/15, indicated "...Problem Category: Pain Start Date: 10/15/14 Approach Description: Assist with positioning to comfort, turn and repositon every 2 hours... Problem Category: ADL Functional / Rehabilitation Potential: Start Date: 10/15/2014 Approach Description: Turn and reposition at least every 2 hours... Problem Category: ADL Functional / Rehabilitation Potential:</p>		<p>previous admission for wound prevention and healing interventions/supplements from previous admission.</p> <ul style="list-style-type: none"> ·ED /Designee and DON/Designee will read the facility activity report daily for documentation of refusals and update care plans accordingly. ·All residents with pressure ulcers will have a turn schedule implemented to ensure they are turned and repositioned every 2 hours, and by charge nurse by signing off on resident profile every 2 hours. ·Charge nurse will verify all interventions are in place by signing off on profile on every 2 hours. ·Nursing staff will be in-serviced on Dressing Change (Incision or Wound) and following the plan of care by the Director of Nursing Services Specialist/Designee by March 30, 2015. ·Licensed nurseswill be skills validated for dressing changes by DON/Designee by March 30, 2015. ·DNS/Designee will conduct rounds every 2hours to ensure residents with pressure ulcers have interventions in place perplan of care and physician's orders using resident profile sheets. <p>How the corrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place?</p>	

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	<p>Start Date: 10/23/14 Approach Description: *Resident has impaired skin integrity: pressure to coccyx, left buttock and right buttock... ADL Functional / Rehabilitation Potential: Start Date: 3/13/15 Approach Description: Float heels while in bed as resident tolerates."</p> <p>The resident had a Care Plan dated 10/22/14, which addressed the problem she had impaired mobility related to paraplegia. Approaches included "...10/22/14--turn and reposition every 2 hours and as needed."</p> <p>The resident had a Care Plan dated 10/15/14, which addressed the problem she had impaired skin integrity due to a pressure ulcer to her coccyx, left buttock and right buttock. The approaches included "3/13/15--Float heels while in bed as resident tolerates...10/15/14--Turn and reposition every 2 hours...."</p> <p>Resident F's record lacked a Care Plan for refusal of care and/or treatments.</p> <p>The Nursing progress notes were reviewed from 10/14/15 to 3/13/15, and indicated the resident had refused to have her wounds measured by the wound team one day, but then agreed on another day, refused her wound care at one time, then agreed later at another time, refused to</p>		<p>·DON/Designee willutilize Skin Management Program CQI, Refusal of Medication and Treatments CQItools will be utilized weekly x 4 weeks, monthly x 6 months, and quarterlythereafter for one year withresults reported to the Continuous Quality Improvement Committee overseen bythe Executive Director.</p> <p>·If 95% a threshold isnot achieved, an action plan will be developed to ensure compliance.</p>	

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	<p>lay down when requested by staff to complete her wound treatments, due to she was participating in activities, but allowed staff to complete her treatments after she had laid down. There was no documentation found in the resident's nursing progress notes, which indicated she had refused to be turned or repositioned until 3/15/15.</p> <p>A continuous observation was completed from 3/13/15 at 10:10 a.m. to 3/13/15 at 12:19 p.m., the following observations occurred:</p> <p>At 10:10 a.m., the resident was observed laying in bed on her back with pillows placed under her bilateral elbows and under her bilateral knees with her bilateral heels laying on the bed. Her breakfast tray was observed in front of her and she was drinking her milk from her tray. The head of her bed was raised 90 degrees.</p> <p>At 10:44 a.m., the Social Service Director (SSD) entered into the resident's room to talk to her and removed the breakfast tray. The SSD lowered the resident's head of her bed at the resident's request.</p> <p>At 11:30 a.m., the Medical Records staff member entered the resident's room to</p>			

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	<p>check on her and she repositioned her bilateral arms and legs. She offered to have a CNA come back and check and change and turn and reposition the resident at that time and the resident agreed.</p> <p>At 11:35 a.m., RN #7 entered the resident's room to discuss her excessive sleepiness with her. During that time the Weekend Supervisor entered the room and she and RN #7 assessed the resident for complaints of upper abdominal tightness. RN #7 spoke to the Physician's Assistant (PA) and indicated to the resident, the PA would come and visit her.</p> <p>At 12:03 p.m., CNA #8 entered Resident F's room and walked around the foot of her bed and walked back out of her room and indicated as she was exiting the room the resident was "dozing" off. CNA #8 had not attempted to wake Resident F to ask her if she wanted turned or repositioned.</p> <p>At 12:20 p.m., the Interim DNS (Director of Nursing Services) entered the room and observed the resident's bilateral heels on the bed. During an observation and interview, the Interim DNS indicated the resident's bilateral heels were on the bed. She indicated the</p>			

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	<p>resident should be turned every two hours and her heels should be positioned off the bed.</p> <p>During an interview on 3/13/15 at 12:35 p.m., the Medical Records staff member indicated she had repositioned Resident F's bilateral arms and legs, but she had not turned her. She indicated she had told Resident F's CNA to turn and reposition her and that was her expectation of the CNA.</p> <p>During an interview on 3/13/15 at 12:45 p.m., RN #7 indicated he and the Weekend Supervisor had turned and repositioned Resident F "just a while ago." He indicated the resident had been on her back and he and the Weekend Supervisor turned and repositioned her on her side. RN #7 indicated it had been over two hours since the resident had been turned and repositioned.</p> <p>During an interview on 3/16/15 at 1:10 p.m., the CCS indicated the resident had not had a Care Plan for refusal of care and/or treatments.</p> <p>The "Pressure Wound Skin Evaluation Report" dated 10/15/14, indicated the resident had a new open area to her coccyx (tailbone area) that originally started on 10/14/14, and was present on</p>			

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	<p>admission to the facility. The area was a Stage 4 (full thickness of the skin is lost, which exposed muscle and/or bone). The most severe tissue was granulation (can look reddened and irritated because of the numerous blood vessels) and the wound color was granulated (pink color and bumpy and uneven). The wound measured 3.2 x 3.5 x 1.2 cm (centimeters). No drainage from the wound.</p> <p>The "Pressure Wound Skin Evaluation Report" dated 10/15/14, indicated the resident had a new open area to her right buttock originally noted on 10/14/14, and was present on admission. The area was a Stage 2 (partial thickness loss of skin). The most severe tissue was granulation and the wound color was granulated. The wound measured 5.0 x 1.2 x 0.1 cm. No drainage from the wound.</p> <p>A Wound Care progress note dated 10/21/14, indicated the resident had a coccyx and right gluteal (buttock) wound present caused by pressure, which was longstanding. Wound #8, which was the coccyx wound was a Stage 4 pressure ulcer and had a status of not healed. The Initial wound measurements were 3.1 x 3.8 x 0.3 cm and there was a small amount of sero-sanguineous drainage with no odor. The wound margin was</p>			

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	<p>well defined. The wound bed was 76-100% bright red granulation. The periwound (the skin around the wound) skin was normal. Wound #9 was to the right buttock and was a Stage 3 (full thickness of skin was lost, which exposed the subcutaneous tissue and presented as a deep wound) pressure ulcer and had a status of not healed. The Initial wound measurements were 5.1 x 2.7 x 0.1 cm. There was a small amount of sero-sanguineous (watery-bloody drainage due to it contained serum and blood) drainage with no odor. The periwound skin was normal. The resident was not on any supplements. The additional orders were for offloading: wedge cushion or pillows for positioning in the bed and turn every two hours while in bed.</p> <p>The "Pressure Wound Skin Evaluation Report" dated 10/31/14, indicated the resident had a new area to her left buttock that was originally noted on 10/31/14 and was not present on admission. The wound was a Stage 2. The most severe tissue was granulation and the wound color was granulated. The wound measured 1.5 x 1.0 x 0.1 cm. There was no wound drainage.</p> <p>The Wound Care progress note dated 2/16/15, indicated the resident presented</p>			

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	<p>with pressure ulceration to her coccyx, right and left gluteal areas, which were longstanding. Wound #8 was located to the resident's coccyx area and was a Stage 4 pressure ulcer and had reached a status of not healed. The measurements were 3.6 x 2.0 x 0.2 cm.</p> <p>Hypergranulation (overgrowth of tissue, which would not allow healthy tissue to grow) was present. The wound had a scant amount of serosanguineous drainage without odor. The wound margin was thickened and rolled under. The wound bed was 76-100% bright red granulation. There had been no change noted in her wound progression. The periwound skin showed induration (inflammation and redness) and was friable (tissue that tears easily or bled when gently palpated or handled).</p> <p>Wound #9 was located to the resident's right buttock and was a Stage 3 pressure ulcer and had a status of not healed. The measurements were 5.5 x 1.7 x 0.2 cm. Hypergranulation was noted. The wound had a scant amount of serosanguineous drainage without an odor. The wound margin was thickened. the wound bed was 76-100% red granulation. The wound was improving. The periwound skin showed signs of induration and was friable. Wound #10 was located to the resident's left buttock and was a Stage 3 pressure ulcer. The wound had received</p>			

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	<p>a status of not healed. The measurements were 2.0 x 1.0 x 0.2 cm.</p> <p>Hypergranulation was present. The wound had a scant amount of serosanguineous drainage without odor. The wound margin was thickened. The wound bed was 76-100% bright red granulation and there was not change in the wound progression. The periwound skin showed signs of induration and was friable. The note indicated the resident was currently taking the dietary supplement Promod 30 ml by mouth twice daily and she would continue taking it for a protein supplement. The note indicated additional orders included turning the resident every two hours while in bed and floating her heels with pillows or a heels-up cushion under her calves while in bed.</p> <p>A "Pressure Wound Skin Evaluation Report" dated 2/19/15, indicated the resident had a Stage 4 pressure ulcer to her coccyx, which was an existing area. The wound was originally noted on 10/15/14, and was present on admission to the facility. The most severe type of tissue was granulation. The measurements of the wound were 3.6 x 2.0 x 0.2 cm. The wound color was 100% granulation with scant amount of serosanguineous drainage. The Interdisciplinary/Nutrition at Risk note</p>			

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	<p>for that date indicated the resident received Promod 30 ml twice daily.</p> <p>A "Pressure Wound Skin Evaluation Report" dated 2/19/15, indicated the resident had a Stage 3 pressure ulcer wound, which was an existing area to her right buttock, which was present on admission. The original date the area was noted was 10/15/14. The most severe tissue type was granulation. The wound measurements were 5.5 x 1.7 x 0.2 cm. The wound color was 100% granulation with a scant amount of serosanguineous drainage. The Interdisciplinary/Nutrition at Risk note for that date indicated the resident received Promod 30 ml twice daily.</p> <p>A "Pressure Wound Skin Evaluation Report" dated 2/19/15, indicated the resident had a Stage 3 pressure ulcer wound, which was an existing area to her left buttock, which was not present on admission. The area was originally noted on 10/31/14. The most severe type of tissue was granulation. The measurements were 2.0 x 1.0 x 0.2 cm. The wound color was 100% granulation with a scant amount of serosanguineous drainage. The Interdisciplinary/Nutrition at Risk note for that date indicated the resident received Promod 30 ml twice daily.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The Wound Care progress note dated 3/2/15, indicated the resident had coccyx, right and left gluteal wounds caused by pressure, which were long standing. Wound #8 was to the coccyx and was a Stage 4 pressure ulcer with a status of not healed. The measurements for the wound were 2.2 x 1.9 x 1.0 cm. Hypergranulation was noted. There was a small amount of sero-sanguineous drainage noted with no odor. The wound margin was well defined. The wound bed was 76-100% bright red granulation and was deteriorating (getting worse). The periwound skin was within normal limits. Wound #9 was to the right buttock and was a Stage 3 pressure ulcer and had a status of not healed. The measurements were 5.2 x 1.9 x 0.1 cm. The wound margin was well defined. The wound bed was 76-100% bright red granulation. There had been no change in the progression of the wound. Wound #10 was to the left buttock and was a Stage 3 pressure ulcer and had a status of not healed. The measurements were 1.7 x 2.0 x 0.1 cm. There was a small amount of serosanguineous drainage noted with no odor. The wound margin was attached to the base of the wound. The wound bed was 76-100% bright red granulation and there had been no change in the progression of the wound. The note</p>			

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	<p>indicated the resident was on these supplements at that time: Promod, MVI, Vitamin C and Zinc. The additional orders indicated, alternating pressure mattress with low air loss, ROHO or equivalent cushion in her wheelchair seat, wedge cushion or pillows for position in bed, turn every two hours while in bed, float heels with pillows or heels-up cushion under calves while in bed. The note indicated for Education: "Continue to encourage frequent turning to reduce risk of further pressure injury."</p> <p>The "Pressure Wound Skin Evaluation Report" dated 3/16/15, indicated the resident had a pressure area to the coccyx, which was an existing area. The wound was Unstageable (necrotic tissue, which was eschar/black dead tissue is present and staging was not possible until the eschar/black or slough tissue was removed). The most severe tissue type was slough (yellow or white tissue adhering to the ulcer bed) and the wound color was yellow. The wound measured 3.0 x 2.8 x 0.1 cm and had a moderate amount of serosanguineous drainage.</p> <p>During an interview on 3/11/14 at 4:05 p.m., Resident F indicated she had "sores on my bottom." She indicated the staff brought her meal trays to her, then picked them up, then she had not seen Nursing</p>			

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	<p>staff any other time generally throughout the shifts. She indicated the Nursing staff had not been turning her every two hours. She indicated her wounds had gotten worse, not better since she was admitted to the facility. She indicated she was admitted to the facility to receive wound care and to get her wounds healed up, so she was able to go home</p> <p>2. Resident D's record was reviewed on 3/12/2015 at 2:45 p.m. Diagnoses included, but were not limited to, paraplegia (paralysis of the lower half of the body with involvement of both legs) and pressure ulcers.</p> <p>The wound care center dated 3/11/2015, indicated the resident had one wound in the left lower quadrant of his abdomen. The wound was unstageable, and measured 2.5 cm (centimeter) in length, 2 cm in width and 1 cm in depth. A second wound was located on the sacrum (triangular shaped bone at the base of the spine) and was a stage 3 pressure ulcer and measured 2 cm in length, 0.6 cm in width and 0.6 cm in depth. The third wound was a stage 4 pressure ulcer located on the right ischium (the seat bone) and measured 1 cm in length, 0.2 cm in width and 1.5 cm in depth.</p> <p>The physician's orders for wound care,</p>			

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	<p>from the 3/11/2015 visit, indicated the following: "Please cleanse all wounds with Normal Saline or wound cleanser. Apply skin prep to periwound of all ulcers. Apply Medihoney gel to all the wounds (sacrum, ischium and abdomen) Cover with ABD pad. Secure with tape. Change daily."</p> <p>On 3/12/2015 at 2:52 p.m., LPN #3 was observed doing the wound care and dressing changes for Resident D's 3 wounds. After gathering the wound care supplies she entered the room and put clean gloves on. Then she laid out her supplies on a bedside table with a clean towel underneath them.</p> <p>Then she took scissors out of her pocket, without cleaning them, and cut strips of medfix (wound care tape) tape into 6 strips. She started with the resident's abdominal wound and after removing the old dressing to the resident's left lower abdominal wound and disposing of the old dressing, she washed and dried her hands. She donned clean gloves and applied Medihoney to the wound with a cotton tip applicator, dressed and taped the dressing. She then removed her gloves.</p>			

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	<p>Next LPN #3, cut bandage tape into 6 strips and an ABD (abdominal) dressing into a couple pieces. She then removed the dressing on the sacrum and right ischium and disposed of the old dressings, she then washed and dried her hands and donned clean gloves.</p> <p>Then she applied Medihoney to the sacral wound with a cotton tip applicator and dressed and secured it with tape. She did the same to the wound over the ischium. She dated and initialed the tape on the dressings.</p> <p>During an interview on 03/12/2015 at 3:35 p.m., LPN #3 indicated, she realized she had not cleaned the wounds with the normal saline as ordered. She had not realized she was supposed to apply skin prep to the periwound of all the ulcers.</p> <p>This Federal tag relates to complaint IN00168651.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			