

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/26/2014
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaint IN00159511. This visit resulted in a Partially Extended Survey - Immediate Jeopardy.</p> <p>Complaint: IN00159511 Substantiated. Federal /State deficiencies related to the allegations are cited at F157, F282, F314, F327.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: November 24 & 25, 2014 Partially Extended date: November 26, 2014</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</p> <p>Survey Team: Mary Jane G. Fischer RN TC Tammy Alley RN (11-25-14)</p> <p>Census Bed Type: SNF/NF: 73 Total: 73</p> <p>Census Payor Type: Medicare: 16 Medicaid: 40 Other: 17</p>	F000000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission 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 executed solely because it is required by the provisions of federal and state law.</p>	
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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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F000157 SS=D	<p>Total: 73</p> <p>Sample: 5 Supplemental sample: 10</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 December 1, 2014.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p>						

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	<p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview, the facility failed to ensure the resident's physician was notified for possible intervention in regard to impaired skin integrity, failed to ensure the physician was notified of decline in pressure ulcer condition failed to immediately notify the physician of a strong urine odor and poor color for 3 of 4 residents reviewed for physician notification in a sample of 15. (Resident's , "A", "F" and "D").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 11-24-14 at 9:40 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, history of urinary tract infection, dehydration and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p>	F000157	<p>F157 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged on 10/30/14. Resident F's physician was notified of wound status and new treatment orders were received on 11/24/14. Physician's progress notes 11/24/14, 11/26/14, 11/28/14 and 12/1/14 reflect wound status improvement. Resident D's physician was notified of urine status on 11/24/14 and new orders were received. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Nurse Managers completed head-to-toe skin assessments of all in-house residents on 11/24/14 and 11/25/14 to identify skin conditions in need of physician notification and treatment orders; physician notifications were made</p>	12/26/2014

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	<p>The resident was re-admitted to the facility on 09-26-14 at 6:40 p.m., after a hospitalization. A review of the "Nursing Admission Assessment," dated 09-26-14, indicated the resident was alert to person, had shortness of breath, with no recent history of nutrition, hydration or weight issues, was dependent for bathing, toileting, bed mobility, and no pressure or reddened areas.</p> <p>The assessment indicated the "Initial Skin Interventions," included "pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management."</p> <p>The resident's Braden Scale Assessment, dated 09-26-14, identified the resident at "high risk" for the development of pressure ulcers.</p> <p>A physician order, dated 09-26-14, indicated an order for Weekly Skin Assessments on Mondays. The clinical record lacked documentation of the nurses weekly skin assessments.</p> <p>A review of the "Shower Sheets," completed by the CNA's (certified nurses aide's), indicated the following: "10-08-14 - redness on upper back/buttocks."</p>		<p>and orders received accordingly. A Nurse Consultant evaluated residents with pressure ulcers on 12/9/14 to identify those wounds demonstrating changes that require modified treatment interventions and physician notifications were made and orders received accordingly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? By 12/26/14, Licensed Nurses will be re-educated by the Director of Nursing or designee regarding timely physician notification of changes, including new skin conditions, deteriorating wounds, and symptoms of urinary tract infection. By 12/10/14, Health Information Manager was re-educated by Director of Regulatory Compliance regarding auditing practice standards and tools. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Each week, a change-of condition audit will be completed by the Health Information Manger or designee to monitor compliance with timely physician notifications. Each week, the Director of Nursing or designee will be responsible for monitoring change-of-condition audits and coordinating compliance with physician notification as indicated. The Director of Nursing or designee</p>				

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	<p>"10-11-14 - redness on upper bath/buttocks." "10-18-14 - redness on upper backside." "10-22-14 - backside redness." "10-29-14 - backside redness - small area open."</p> <p>A review of the "Skilled Documentation Flow Sheets," related to "Special Skin Care Needs" and completed by the Licensed Nursing staff indicated the following:</p> <p>"October 11, 12, 13, and 18, 2014 - preventative skin care." The flow sheets lacked awareness by the nursing staff of the redness to the resident's upper back/buttocks."</p> <p>The record indicated the resident had a change in condition on 10-30-14 and was transported to the local area hospital for evaluation and treatment for suspected "seizure like activity."</p> <p>Review of the hospital "Adult Assessment Tool - Skin," dated 10-30-14, indicated, "multiple bruises, wound to left shin/shearing, bilateral heels DTI [deep tissue injury] reddened, coccyx 2 callused areas in wound bed, reddened, blanchable, reddened."</p> <p>The nursing staff failed to ensure this</p>		will be responsible for identifying patterns of non-compliance and reporting issues to the quarterly QA committee for problem analysis, remedial planning, and additional monitoring needs as indicated.	

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	<p>dependent resident received treatment and services for the noted skin breakdown, prior to being transferred to the local area hospital where the skin conditions were identified.</p> <p>2. The record for Resident "F" was reviewed on 11-24-14 at 3:15 p.m. Diagnoses included but were not limited to, cerebral palsy, a C6 (cervical) spinal cord injury, quadriplegia, and neurogenic bladder. At the time the resident was admitted to the facility the resident's skin was intact.</p> <p>The record indicated the resident's plan of care identified him with the potential for impaired skin integrity related to impaired mobility, required assist with turning and repositioning - two staff members. In addition the plan of care instructed the nursing staff to "Monitor for s/s [signs and symptoms] of infection daily - increased warmth of surrounding tissue, redness, swelling, pain, purulent drainage, foul odor. Notify MD if identified."</p> <p>During an interview on 11-24-14 at 3:15 p.m., the wound care nurse indicated the resident currently had an "acquired" pressure ulcer. "When we found it on 11-02-14, it was already Stage 2 [partial thickness loss of dermis presenting as a</p>			

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	<p>shallow open ulcer with a red pink wound bed without slough] ulcer."</p> <p>During an observation on 11-24-14 at 3:30 p.m., a request was made to observe the resident's pressure ulcer. A pungent odor permeated the resident's room. The resident agreed to the body assessment and indicated he was concerned that he had a pressure ulcer and wanted to do everything he could to aid in the healing of the ulcer. During this observation the resident indicated that he was unable to tell if he had a bowel movement "because I can't feel anything" and he was unable to turn himself from side to side. "I have to wait for the nurses to help me." The resident indicated he was concerned because "sometimes the nurses tell me there is not enough staff to keep me turned and sometimes they forget to change the treatment."</p> <p>During interview on 11-24-14 at 3:30 p.m., the facility wound care nurse indicated the resident had "already been evaluated during wound rounds this morning."</p> <p>A review of the "Pressure Ulcer Evaluation Record," dated 11-24-14 indicated the area measured 5.9 centimeters in length by 3.0 centimeters in width and 2.3 centimeters in depth. The area was assessed as a Stage 3 [full</p>			

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	<p>thickness tissue loss] pressure ulcer, with moderate drainage, serosanguineous with 75 % eschar and 25% granulation."</p> <p>With permission of the resident the wound care nurse turned the resident to his right side with the assistance of CNA #10. During this observation the resident had a dressing to his coccyx, which was dated 11-24-14. The wound care nurse identified the dressing as a "foam dressing with Santyl."</p> <p>The wound care nurse removed the soiled dressing, and the room was filled with a strong odor. The nurse indicated the area currently measured as a "Stage 3" pressure ulcer.</p> <p>After the completion of the assessment and upon exiting the resident room, CNA #10 indicated "I knew he had one [in regard to a pressure ulcer], but I didn't know it was that bad."</p> <p>A review of the physician progress notes dated 11-24-14, at 5:00 p.m., indicated the following:</p> <p>"Examined wound with State Surveyor. Pt. [patient] needs Santyl and turned every two hours. Stage 4 ulcer [Full thickness loss in which actual depth of the ulcer is completely obscured by</p>			

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	<p>slough - yellow, grey, green, tan or brown - and/or eschar - tan, brown of black - in the wound bed]."</p> <p>The nursing staff failed to immediately inform the physician for intervention after the resident was assessed during the "wound rounds" conducted in the morning of 11-24-14.</p> <p>3. The record for Resident "D" was reviewed on 11-24-14 at 11:50 a.m. Diagnoses included, but were not limited to dementia, hypertension, and hemiplegia due to a cerebral vascular accident. The resident had a suprapubic urinary catheter for a diagnosis of urinary retention.</p> <p>A review of the resident's current plan of care, originally dated 03-02-13, indicated the resident was at high risk for urinary tract infection due to indwelling catheter. An intervention to this plan of care included, "Monitor and notify MD [Medical Doctor] for fever, abdominal pain, tenderness, flank pain, altered mental status, malodor, hematuria or abnormal urine clarity/consistency."</p> <p>During an observation on 11-24-14 at 8:40 a.m., and although the resident was not in his room, the room had a strong pungent urinary odor.</p>						

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	<p>During a subsequent observation on 11-24-14 at 11:40 a.m., with licensed nurse # 6 in attendance the resident was observed lying in bed. The licensed nurse acknowledged the odor and checked the resident's catheter. The licensed nurse indicated the catheter was not leaking, but the urine in the catheter tubing was amber and the resident recently had a urinary tract infection. She indicated she would need to contact the physician.</p> <p>A review of the nurses notes, dated 11-24-14 at 7:00 p.m., the evening shift nurse documented, "Resident has very foul odor from urine. Resident has had no pain or distress. MD [Medical Doctor] and family notified." The licensed nurse received a physician order for a urinalysis with culture and sensitivity.</p> <p>A review of the urinalysis report, "drawn" on 11-25-14 at 11:01 a.m., and reported on 11-25-14 at 2:12 p.m., indicated the resident's urine was "amber in color, clarity - cloudy, and "packed with bacteria."</p> <p>Although licensed nurse #6 acknowledged the strong odor in the resident's room, and the need to</p>			

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	<p>immediately contact the physician, the nursing staff delayed contacting the physician for intervention for a resident with a history or urinary tract infections.</p> <p>4. A review of the facility policy on 11-24-14 at 3:30 p.m., titled "Pressure Ulcer, Prevention of," and undated, indicated the following:</p> <p>"Purpose: To prevent skin breakdown and development of pressure sores."</p> <p>"Documentation: Documentation may include: Date, time, approaches to prevent pressure ulcer development, Preventive equipment used, Condition of the resident's skin, Physician notification when change in skin condition is observed. If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective."</p> <p>5. A review of the facility policy on 11-24-14 at 11:30 a.m., dated October 2011, and titled, "Managing Change of Condition," indicated the following:</p> <p>"Objective: To appropriately assess,</p>			

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	<p>document, and communicate changes of condition (COC) to the primary care provider. To provide treatment and services to address changes in accordance with resident needs and existing Advance Directives."</p> <p>"Practice Standards: If the change in condition does not appear life-threatening, the following steps may be followed: 1. Select and complete each section of the appropriate COC SBAR [Situation - Background - Assessment - Request/ Notification/Response] or Report of Incident SBAR. If there is not an SBAR form which covers your observation, use the Acute COC SBAR tool. 2. Notify physician and responsible party of assessment findings. 3. Notify the Resident and/or responsible party of current status and subsequent actions/orders. 4. Document assessment findings and communications. 5. Report change of condition to DON [Director of Nurses], ED [Executive Director], and other members of the IDT [Interdisciplinary Team] per facility practice."</p> <p>This Federal tag relates to Complaint IN00159511.</p> <p>3.1-5(a)</p>				

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F000282 SS=E	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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 follow resident's physician orders and/or plans of care for 4 of 5 sampled and 1 of 10 supplemental sampled residents. (Resident's "A", "B", "D", "E" and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 11-24-14 at 9:40 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, history of urinary tract infection, dehydration and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p> <p>The resident was re-admitted to the facility on 09-26-14 at 6:40 p.m., after a hospitalization. A review of the "Nursing Admission Assessment," dated 09-26-14, indicated the resident was alert to person, had shortness of breath, with no recent history of nutrition, hydration or weight</p>	F000282	<p>F282 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged 10/30/2014. Resident B's flow rate was adjusted to match administration orders 11/26/14, and the physician was notified of rate discrepancy. Resident D's physician was notified of urine status 11/24/2014 and new orders were received. Resident D was formally evaluated by an Occupational Therapist on 12/3/14 and he is currently undergoing occupational therapy. Resident E's physician was notified of wound status and new treatment orders were received on 11/24/14. Resident F's wound was evaluated by a physician on 11/24/14 and new treatment orders were received.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be</p>	12/26/2014

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	<p>issues, was dependent for bathing, toileting, bedmobility, and no pressure or reddened areas.</p> <p>The assessment indicated the "Initial Skin Interventions," included "pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management."</p> <p>The resident's Braden Scale Assessment, dated 09-26-14, identified the resident at "high risk" for the development of pressure ulcers.</p> <p>The resident had a physician order, dated 09-26-14, for Weekly Skin Assessments on Mondays. The clinical record lacked documentation of the nurses weekly skin assessments.</p> <p>2. The record for Resident "B" was reviewed on 11-24-14 at 9:20 a.m. Diagnoses included, but were not limited to, failure to thrive, cerebral vascular accident with dysphagia and vascular dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident was recently readmitted to the facility on 11-05-14 after a hospitalization. A review of the hospital "History and Physical," dated 11-03-14, indicated the resident was admitted "with</p>		<p>taken? Nurse Managers completed skin assessments of all in-house residents on 11/25/14 to identify skin conditions in need of physician notification and treatment orders; physician notifications were made and orders received accordingly. A quality audit was completed of Residents receiving IV therapy on 12/1/14 to identify potential flow rate discrepancies. No further issues were identified. A reconciliation was completed of physician orthotic orders and plan of care will be completed. Care plans will be reviewed and updated as indicated; physician notifications will be made and orders received accordingly. Nurse Managers evaluated Resident's with Pressure Ulcers on 12/9/14 to identify wounds demonstrating changes that require modified treatment intervention physician notifications were made and orders received accordingly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? By 12/26/14, Licensed Nurses will be re-educated by the Director of Nursing or designee on carefully following physician's orders and/or plans of care for orthotics, infusion rates, and skin conditions. How will the corrective action(s) be monitored to ensure the</p>	

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	<p>hx.[history] history of end stage renal disease, dementia, COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure presented from nursing home by [family member] for altered mental status for 1 week. She has been progressively more sleepy and has not been eating or drinking will for 1 week. Dry mouth. Problems dehydration, acute hypernatremia, acute on chronic renal failure, altered mental status."</p> <p>A review of the resident's record indicated the resident had physician orders for a regular pureed diet with thin liquids, however the resident continued to refuse nutrition.</p> <p>The nursing progress notes, dated 11-23-14 at 7:00 p.m., indicated the resident had an increase in temperature - "101.7 degrees, denies pain - has been refusing meals however drinks plenty of water and supplements throughout the day. MD [Medical Doctor] notified."</p> <p>A review of a physician order dated 11-25-14 instructed the nursing staff for "labs and clysis fluids due to abnormal lab values. Lab notified of STAT BMP [basic metabolic profile] and pharmacy notified of order for D5W [dextrose 5% water] at 50 c.c. [cubic centimeters] per</p>		<p>deficient practice will not recur? Each week for 4 weeks, the Director of Nursing or designee will validate the completion of skin assessments and wound documentation; application of orthotics and intravenous infusion rates in accordance with physician's orders and care plans. The Director of Nursing or designee will be responsible for identifying patterns of non-compliance and reporting issues to the quarterly QA committee for problem analysis, remedial planning, and additional monitoring needs as indicated.</p>	

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	<p>hour."</p> <p>During an observation on 11-26-14 at 8:30 a.m., the resident was observed in bed with the subcutaneous fluids infusing via an infusion pump at 70 c.c. per hour.</p> <p>During a subsequent observation on 11-26-14 at 9:15 a.m., with licensed nurse #5 in attendance, the infusion rate had been changed to 75 c.c. per hour.</p> <p>During an observation on 11-26-14 at 9:30 a.m., the infusion pump was set at 75 c.c. per hour, with D5 1/2 NS (dextrose 5 % 1/2 normal saline) at 75 c.c. per hour.</p> <p>The resident did not received the prescribed subcutaneous hydration as prescribed by the physician. The Staff Development Coordinator/Wound Care Nurse indicated the physician would need to be notified.</p> <p>3. The record for Resident "D" was reviewed on 11-24-14 at 11:50 a.m. Diagnoses included, but were not limited to dementia, hypertension, and hemiplegia due to a cerebral vascular accident. The resident had a suprapubic urinary catheter for a diagnosis of urinary retention.</p>			

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	<p>A review of the resident's current plan of care, originally dated 03-02-13, indicated the resident was at high risk for urinary tract infection due to indwelling catheter. An intervention to this plan of care included, "Monitor and notify MD [Medical Doctor] for fever, abdominal pain, tenderness, flank pain, altered mental status, malodor, hematuria or abnormal urine clarity/consistency."</p> <p>During an observation on 11-24-14 at 8:40 a.m., and although the resident was not in his room, the room had a strong pungent urinary odor.</p> <p>During a subsequent observation on 11-24-14 at 11:40 a.m., with licensed nurse # 6 in attendance the resident was observed lying in bed. The licensed nurse acknowledged the odor and checked the resident's catheter. The licensed nurse indicated the catheter was not leaking, but the urine in the catheter tubing was amber and the resident recently had a urinary tract infection. She indicated she would need to contact the physician.</p> <p>A review of the nurses notes, dated 11-24-14 at 7:00 p.m., the evening shift nurse documented, "Resident has very foul odor from urine. Resident has had no pain or distress. MD [Medical</p>			

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	<p>Doctor] and family notified." The licensed nurse received a physician order for a urinalysis with culture and sensitivity.</p> <p>A review of the urinalysis report, "drawn" on 11-25-14 at 11:01 a.m., and reported on 11-25-14 at 2:12 p.m., indicated the resident's urine was "amber in color, clarity - cloudy, and "packed with bacteria."</p> <p>A review of the nurses notes on 11-26-14 at 10:00 a.m., indicated licensed nurse #6 did not immediately notify the resident's physician as she indicated.</p> <p>In addition the resident had a physician order dated 10-14-14 for "Splint/Brace/Immobilizer/Orthotic Splint left wrist/hand, left elbow. Left elbow [splint] on at 7:00 a.m. and off at 3:00 p.m."</p> <p>During an observation on 11-24-14 at 11:40 a.m., 12:35 p.m., and 12:50 p.m., the resident did not have the physician ordered splint on his left elbow.</p> <p>During an observation on 11-25-14 at 11:00 a.m., the resident did not have the splint on the left elbow.</p> <p>During an interview on 11-25-14 at 12:15</p>			

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	<p>p.m., the Occupational Therapist indicated the splint had not been discontinued by the therapy department.</p> <p>During an observation on 11-26-14 at 8:20 a.m., the resident was seated in a broda chair in a reclining position. The resident did not have the physician ordered splint.</p> <p>4. The record for Resident "E" was reviewed on 11-24-14 at 12:00 p.m. Diagnoses included, but were not limited to dementia, diabetes mellitus and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set (MDS) Assessment, dated 10-07-14 indicated the resident required extensive assistance and two+ staff members with transfer, bed mobility, and toileting, extensive assistance with 1 staff member for hygiene and dressing, was always incontinent of bowel and frequently incontinent of bladder.</p> <p>A review of the Braden Scale (a measurement to determine a resident's risk of pressure ulcers), dated 11-19-14 indicated this dependent resident was at "moderate risk."</p> <p>A review of the resident's plan of care,</p>						

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	<p>originally dated 10-19-12 and currently dated through 10-2014, indicated the resident had the potential for impaired skin integrity related to "impaired mobility, cognitive deficit's, incontinence and terminal/end stage disease."</p> <p>Interventions to this plan of care included pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm (morning and evening) care, maintain HOB (head of bed) in lowest possible position, notify MD (medical doctor) promptly of skin breakdown, refer to RD (registered dietitian) PRN (as needed) to evaluate diet/needs, bathe/shower per schedule, monitor incontinence, provide peri-care, and evaluate skin weekly.</p> <p>The resident's record indicated the resident had previously been an "inpatient" at a local area hospital and upon "readmission," on 11-12-14, was identified as alert to person and place, was dependent for bathing, eating, toileting and bed mobility, a Stage one pressure ulcer to the right buttocks with interventions which included pressure reducing mattress, chair or W/C (wheelchair) cushion and incontinence management.</p>				

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	<p>On 11-24-14 at 12:50 p.m., the wound care licensed nurse indicated the following assessment of the resident's buttocks after a request was made to see the residents buttocks.</p> <p>"Right buttocks measures 2.9 centimeters in length by 2.5 centimeters in width with a moderate amount of sero-sanguineous drainage with 50 % of eschar [tan, brown or black], 25% of slough and 25% of red granulation, and unstageable."</p> <p>"Left buttocks measures 4.0 centimeters in length by 2.5 centimeters in width, with 75 % of yellow slough and 25 % of red granulation tissue. It's a Stage 3 [full thickness tissue loss] pressure ulcer."</p> <p>"Coccyx - it's a stage two pressure ulcer [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough] with 100 % epithelial tissue and measures 1.5 centimeters in length by .5 centimeters in width by less that 0.1 in depth."</p> <p>A request was made to perform incontinent care for the resident in order to better observe the pressure ulcers. The licensed nurse obtained two wash cloths. One wash cloth was wet and the other wash cloth was dry. The nurse cleaned</p>			

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	<p>the resident's bilateral buttocks of stool and then indicated she needed to "remeasure" the resident's pressure ulcer to the right buttocks since the stool had been removed.</p> <p>After the nurse remeasured the area, she indicated the area measured larger than previously thought and now measured "4.5 centimeters length by 4.0 centimeters in width."</p> <p>The wound care nurse indicated, "we didn't know it had gotten this bad. That's the problem."</p> <p>5. The record for Resident "F" was reviewed on 11-24-14 at 3:15 p.m. Diagnoses included but were not limited to, cerebral palsy, a C6 (cervical) spinal cord injury, quadriplegia, and neurogenic bladder. At the time the resident was admitted to the facility the resident's skin was intact.</p> <p>A review of the hospital discharge summary dated, 10-24-14 indicated "due to patient's medical complexity, along with decreased functional mobility and self care, this patient continues to require 24 hour RN [Registered Nurse] to ensure and prevent skin breakdown, turn q [every] two hours to prevent skin breakdown."</p>			

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	<p>A review of the facility Braden Pressure Ulcer Risk assessment, dated 10-24-14, indicated the resident was at a 'moderate risk" in the development of pressure ulcers.</p> <p>The assessment indicated the resident had very limited sensory perception (2), occasionally moist (3), chairfast (2), very limited mobility (2), adequate nutrition (3), and a potential problem for friction/shear (2).</p> <p>A review of the resident's MDS, dated 10-31-14 indicated the resident was alert and oriented, required extensive assistance and 2 + staff members with transfers, dressing, and eating, and total care with 2+ staff members in regard to bed mobility, hygiene and toileting. The assessment indicated the resident had no pressure ulcers or skin concerns at the time of the assessment.</p> <p>The record indicated the resident plan of care identified him with the potential for impaired skin integrity related to impaired mobility, requires assist with turning and repositioning - two staff members. Interventions to this plan of care included, "Notify MD promptly of skin break down, monitor incontinence, encourage to reposition as able and</p>			

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	<p>observe skin integrity during am/pm care."</p> <p>During an interview on 11-24-14 at 3:15 p.m., the wound care nurse indicated the resident currently had an "acquired" pressure ulcer. "When we found it on 11-02-14, it was already Stage 2 ulcer."</p> <p>A review of the "change of condition" report, dated 11-20-14 indicated the area measured 0.7 cm in length by 0.7 centimeters in width and less than 0.1 centimeters in depth. A notation adjacent to these measurements indicated the area measured 1.0 centimeters in length by .5 centimeters in width. The wound care nurse measured the area the following day, 11-03-14 and indicated the area measured 1.5 centimeters in length by 1.0 centimeters in width by 1.0 centimeters in depth.</p> <p>The resident indicated he was concerned because "sometimes the nurses tell me there is not enough staff to keep me turned and sometimes they forget to change the treatment."</p> <p>A review of the Wound Care Specialist notation, dated 11-10-14 indicated the following: "Wound right buttock is a necrotic tissue unstageable pressure ulcer and has</p>			

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	<p>received a status of not healed. Unstageable ulcer due to significant deterioration - 100 % slough. The Wound Care Specialist ordered a ROHO [cushion] in wheelchair, an alternating pressure low air flow mattress, and to turn the resident every two hours." The notation alerted the nursing staff the resident had a "very right risk for further skin breakdown - diligent monitoring per facility staff will be essential."</p> <p>A review of the Wound Care Specialist notation, dated 11-17-14 indicated the following: "Alert and oriented to person, place and time, wound #1 buttocks now labeled sacrum is a necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. The wound is deteriorating. Significant deterioration. Pt concerned and asking what he can do to assist wound healing. Very high risk for further skin breakdown. Diligent monitoring per facility staff will be essential."</p> <p>On 11-24-14 at 3:45 p.m., the wound care nurse employed the advice from the facility physician. The physician assessed the resident's pressure ulcer and indicated, "It needs to be debrided." The resident conveyed to the physician he was aware of the odor, was not turned on a regular basis nor received the treatment</p>			

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F000314 SS=J	<p>to the pressure ulcer. The physician enforced the need for changing positioning and to receive the ordered treatment to the wound care nurse.</p> <p>A review of the physician progress notes dated, 11-24-14 at 5:00 p.m., indicated the following: Examined wound with State Surveyor. Pt. [patient] needs Santyl and turned every two hours. Stage 4 ulcer."</p> <p>This Federal tag relates to Complaint IN00159511.</p> <p>3.1-35(g)(2)</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 when a resident had previously been re-admitted to the facility after a hospitalization with a Stage 1 (intact skin with non-blanchable redness) pressure</p>	F000314	F314 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A head to toe skin assessment was completed and documented on a Skin Condition	12/26/2014

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	<p>ulcer, the facility failed to identify, monitor and treat the worsening of the pressure ulcer from the Stage 1 to a Stage 3 (full thickness tissue loss) and unstageable pressure ulcers (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed), (Resident E), failed to ensure prevention and treatment was provided to an acquired pressure to prevent worsening from a stage 2 to a Stage 4 (Resident F) and failed to ensure skin assessments and skin risk assessments were completed as indicated (Resident A and B) for 4 of 5 residents reviewed for pressure ulcers in sample of 5 and supplemental sample of 10.</p> <p>The Immediate Jeopardy began on 11-18-14 when the facility failed to monitor and treat known Stage 1 pressure ulcers that progressed to Stage 3 and Unstageable pressure ulcers without being aware the pressure ulcers progressed to Stage 3 [full thickness tissue loss] and Unstageable and acquired pressure ulcers had worsened to a stage 4 ulcer. The Administrator and the Director of Nurses were notified of the Immediate Jeopardy at 4:20 p.m., on 11-24-14.</p> <p>The Immediate Jeopardy was not</p>		<p>Report on 11/24/14 for Resident E, additionally the care plan was updated, A Change of Condition Pressure Ulcer Report (SBAR), a Pressure Ulcer Evaluation Record, a Nutritional Screening and Assessment completed, and treatment orders obtained. The physician assessed the resident on 11/24/14 and documented a progress note. A head to toe skin assessment was completed and documented on a Skin Condition Report on 11/24/14 for Resident F, additionally the care plan was updated, a Nutritional Progress Note completed and a Pressure Ulcer Evaluation Record completed and treatment orders obtained. The physician assessed the resident on 11/24/14 and modified the treatment plan. Skin assessment was completed on Resident B on 11/24/14. Braden Risk Assessments was updated on 11/25/14. Resident A was discharged on 10/30/2014.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? A head to toe skin assessment was completed and documented on a Skin Condition Report for all residents beginning the afternoon of 11/24/14 and was completed by 11/25/14. A Braden Skin Risk Assessment was completed on all residents 11/25/14 to identify Residents at risk and update care plans</p>	

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	<p>removed by the Exit date of the survey.</p> <p>Findings include:</p> <p>1. The record for Resident "E" was reviewed on 11-24-14 at 12:00 p.m. Diagnoses included, but were not limited to dementia, diabetes mellitus and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set (MDS) Assessment, dated 10-07-14 indicated the resident required extensive assistance and two+ staff members with transfer, bed mobility, and toileting, extensive assistance with 1 staff member for hygiene and dressing, was always incontinent of bowel and frequently incontinent of bladder.</p> <p>A review of the Braden Scale (a measurement to determine a resident's risk of pressure ulcers), dated 11-19-14 indicated this dependent resident was at "moderate risk."</p> <p>A review of the resident's plan of care, originally dated 10-19-12 and currently dated through 10-2014, indicated the resident had the potential for impaired skin integrity related to "impaired mobility, cognitive deficit's, incontinence and terminal/end stage disease."</p>		<p>accordingly. Repeat Braden Skin Risk Assessments were completed during the week of 12/01/14 for all residents and validated by nurse consultants, Stacy McNeelan, RN and Venus Mohr, RN. Residents with pressure ulcers were reviewed by the RD on 11/25/14 with recommendations documented. Additional RD assessments and reviews were completed on 12/5/14. Validation that recommendations were implemented occurred the week of 12/8/14. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? Training of LN and CNA's was initiated on the evening of 11/24/14. Training included: review of Covenant Care Skin Integrity Standard which details the practice that residents identified to be at risk for skin breakdown (Pressure Ulcers) will have a routine skin assessment and interdisciplinary (IDT) care plan process implemented to maintain and/or improve skin integrity. Staff was also educated on the use of the Early Warning Tool: Stop & Watch. Additionally, LN's were reeducated on how to thoroughly and accurately complete the Nursing Admission Assessment, the Skin Condition Report and a Change of Condition Pressure Ulcer (SBAR). All staff were educated on proper</p>	

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	<p>Interventions to this plan of care included "pressure reducing mattress to bed, pressure reducing cushion to wheelchair, apply lotion to skin following bathing, observe skin integrity during am/pm [morning and evening] care, maintain HOB [head of bed] in lowest possible position, notify MD [medical doctor] promptly of skin breakdown, refer to RD [registered dietitian] PRN [as needed] to evaluate diet/needs, bathe/shower per schedule, monitor incontinence, provide peri-care, and evaluate skin weekly."</p> <p>The resident's record indicated the resident had previously been an "inpatient" at a local area hospital and upon "readmission," on 11-12-14, was identified as alert to person and place, was dependent for bathing, eating, toileting and bed mobility, a Stage one pressure ulcer to the right buttocks with interventions which included pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management." The physician ordered the treatment of Calmoseptine to the affected area.</p> <p>A review of the nurses progress notes, dated 11-13-14 at 5:00 p.m., indicated the following: "Writer received call from dialysis stating</p>		<p>communication requirements. On 11/25/14, Susan Goodwin, PT and Advanced Physical Therapy Wound Management educated, provided training to all nurse managers on Skin/Wound Care Guidelines utilizing Medline skin care products, staging of wounds and wound treatment. Karen Kennedy-Evans, RN, FNP, APRN-BC, board member of NPUAP, a nationally recognized expert on wound care, provided on-site additional education to nursing staff on 12/02/2014 and 12/03/14 using training modules from the ISDH website. From 12/8/14 through 12/10/14, additional training for LN's was conducted by our contracted wound-care vendor, Medline's representative Deanna Hartnett, RN, CWCN in conjunction with Jennie Hylton, RN, nurse consultant. Training for LN included assessment, accurate staging and wound measurements, and proper treatment procedures. Return demonstration was conducted and competencies validated. CNA training has been provided on proper incontinence care with return demonstration and competencies documented, turning and repositioning, use of/and proper completion of shower sheets and Early Warning Tool: Stop and Watch. How will the corrective action(s) be monitored to ensure the deficient practice will not</p>	

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	<p>'resident had fell off stretcher during transport from dialysis. Resident had small abrasions at forehead but refused to go to ER [emergency room] for evaluation. Spoke with [name of individual] who reported that resident appeared OK with no complaints and EMT [emergency medical technicians] applied neck brace. Writer informed dialysis to send resident back to facility and informed DON [Director of Nurses] of incident.'</p> <p>"11-13-14 at 5:30 p.m., Resident returned to unit via stretcher and 2 attendants, noted neck brace and resident eyes open. C/O [complains of] 'little back pain.' Nurse Practitioner at facility and requested EMT to send resident to [name of local area hospital] ER for evaluation and treatment."</p> <p>"11-13-14 at 10:00 p.m., Writer <sic> called [name of local area hospital] for update and resident admitted for subdural hematoma due to transporting resident from dialysis and stretcher hit broken concrete and resident fell. Supervisor notified."</p> <p>The record indicated the resident returned to the facility on 11-14-14.</p> <p>A review of the hospital "transfer" note,</p>		<p>recur? By 12/25/14, head- to- toe skin assessments will be completed each week by Licensed Nurses and shower inspection sheets will be completed by Certified Nursing Assistants. The Director of Nursing or designee will be responsible for monitoring skin assessments/shower sheets and coordinating compliance with treatment administration practices when conditions are identified. By 12/25/14, the Health Information Manager or designee will audit clinical records each week of new admissions and Residents due for quarterly IDT review to monitor compliance with completing Braden Risk Assessments and skin risk care planning when indicated. The Director of Nursing or designee will be responsible for monitoring admission and quarterly review audits and coordinating compliance with Skin Risk Assessment and Skin Integrity Risk Care Planning. By 12/25/14, a Pressure Ulcer Management Report will be completed weekly by Nursing Managers or designee to monitor wound conditions, treatment efficacy, and physician notification needs. Weekly, the Director of Nursing, or designee will be responsible for monitoring Pressure Ulcer Management Reports and coordinating compliance with treatment administration practice. The</p>	

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	<p>lacked any documentation the resident had any pressure areas. The transfer notes lacked any instruction of preventative treatment for the previously identified Stage 1 (intact skin with non blanchable redness) pressure area to the buttock and the facility nursing staff failed to assess the resident upon return to the facility.</p> <p>A review of the facility "skilled documentation flow sheet," dated 11-15-14, lacked documentation of any "special care needs" which included preventative skin care, pressure ulcer care or other skin problems."</p> <p>The "skilled documentation flow sheet," dated 11-16-14, indicated the resident "needs" included "ostomy or stoma care and preventative skin care."</p> <p>Further review of the "skilled documentation flow sheets," dated 11-17-14, 11-18-14, 11-19-14, 11-20-14, 11-21-14, 11-22-14 and 11-23-14, continued to indicate the need for "preventative skin care."</p> <p>A review of the "Weekly Skin Assessment - Licensed Nurse to Complete," dated 11-17-14, indicated the resident had "no red or open areas, no tenting and mucous membranes were</p>		Director of Nursing or designee will be responsible for identifying patterns of non-compliance and reporting issues to the quarterly QA committee for problem analysis, remedial planning, and additional monitoring needs as indicated.	

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	<p>moist."</p> <p>A review of the Shower Sheets, dated 11-13-14, indicated the resident received a "bed bath" with no documentation of skin concerns. The Shower Sheet dated 11-15-14, also lacked documentation of skin concerns. No additional Shower sheets were provided for review.</p> <p>A review of the "Flow Sheet," for November 2014, indicated the resident received a bed bath on 11-16-14, 11-17-14 and 11-21-14, with no documentation of skin concerns.</p> <p>During an observation on 11-24-14 at 8:40 a.m., the resident was observed lying in bed on his back.</p> <p>An additional observation on 11-24-14 at 11:40 a.m., the resident was observed on his back. Upon entrance to the resident room, a pungent odor permeated the room.</p> <p>A request was made to perform a skin assessment and Licensed Nurse #6, requested permission of the resident, however the resident appeared unresponsive and unable to respond.</p> <p>The licensed nurse instructed the resident of the need to perform a body</p>			

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	<p>assessment. The resident did not respond. The licensed nurse indicated the resident was "usually not like this and before a previous hospitalization was able to respond, but I haven't been here for a couple of days."</p> <p>The licensed nurse again instructed the resident that she would turn him to his side in order to perform a body assessment.</p> <p>The licensed nurse pulled the bed linens down to the resident's knees and then in one movement turned the resident to his left side. The resident's incontinent brief was untaped along both sides and the incontinent brief was pulled down to the resident's thighs.</p> <p>The incontinent brief was soiled with stool. The resident's bilateral buttocks were observed with bilateral pressure areas along the right, left buttocks and coccyx area and a large area was covered with a dried thick cracked pink substance. The licensed nurse indicate she was unaware of the pressure areas and indicated she would "need to contact the wound care nurse."</p> <p>The licensed nurse reapplied and taped the soiled incontinent brief on to the resident and turned the resident in order</p>			

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	<p>for the resident to lay on his back. The licensed nurse indicated the wound care nurse was currently on her "lunch break and as soon as she returns I'll get her to look at the pressure areas."</p> <p>On 11-24-14 at 12:35 p.m., the resident remained on his back with the soiled brief.</p> <p>On 11-24-14 at 12:50 p.m., the resident remained on his back, when the wound care nurse came to the resident's room.</p> <p>During interview on 11-24-14 at 12:15 p.m., the wound care nurse indicated the resident returned from the "hospital with a Stage 1 pressure ulcer. We don't follow or measure the Stage 1 pressure ulcers because the floor nurses do a skin check weekly and the CNA's [certified nurses aide] complete a shower sheet two times a week, that way the resident's skin is checked three times a week."</p> <p>The licensed nurse requested the assistance of CNA #9 and the resident was turned to his left side. The resident's incontinent brief was "untaped," and the resident's bilateral buttocks were observed.</p> <p>The wound care nurse indicated the "pink dried lotion is calmoseptine. It's used to</p>			

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	<p>treat the Stage 1 pressure ulcers."</p> <p>A review of the Resident Treatment Administration Record for November 2014, indicated "apply calmoseptine to buttocks q [every] shift and PRN [as needed] for prevention 11:00 p.m. - 7:00 a.m.. The treatment record indicated the last time the resident received the Calmoseptine treatment was 11-22-14 on night shift and lacked documentation the resident received the treatment as ordered by the physician "every shift and PRN."</p> <p>The licensed nurse indicated the following assessment of the resident's buttocks:</p> <p>"Right buttocks measures 2.9 centimeters in length by 2.5 centimeters in width with a moderate amount of sero-sanguineous drainage with 50 % of eschar (tan, brown or black), 25% of slough and 25% of red granulation, and unstageable."</p> <p>"Left buttocks measures 4.0 centimeters in length by 2.5 centimeters in width, with 75 % of yellow slough and 25 % of red granulation tissue. It's a Stage 3 [full thickness tissue loss] pressure ulcer."</p> <p>"Coccyx - it's a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a</p>			
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	<p>red pink wound bed, without slough) with 100 % epithelial tissue and measures 1.5 centimeters in length by .5 centimeters in width by less that 0.1 in depth."</p> <p>A request was made to perform incontinent care for the resident in order to better observe the pressure ulcers. The licensed nurse obtained two wash cloths. One wash cloth was wet and the other wash cloth was dry. The nurse cleaned the resident's bilateral buttocks of stool and then indicated she needed to "re-measure" the resident's pressure ulcer to the right buttocks since the stool had been removed.</p> <p>After the nurse re-measured the area, she indicated the area measured larger than previously thought and now measured "4.5 centimeters in length by 4.0 centimeters in width."</p> <p>During an interview on 11-24-14 at 2:15 p.m., the wound care nurse indicated she enlisted the knowledge of another nurse (#5) who was employee at the facility and she (#5) made the determination, the area on the resident's right buttocks, the area that was previously identified as eschar was a "deep tissue injury rather than eschar, but the rest of the assessment is the same."</p>			

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	<p>During an interview on 11-24-14 at 12:50 p.m., licensed nurse #6 indicated the Calmoseptine lotion "must have been applied by the night shift "because I didn't apply it." During interview on 11-24-14 at 12:50 CNA #9 indicated "it was there when I came in this morning."</p> <p>During an interview on 11-24-14 at 2:15 p.m., the wound care nurse indicated she contacted the physician who ordered Santyl (a treatment for debridement of pressure ulcers) for the right and left buttocks and Calmoseptine for the area on the resident's coccyx.</p> <p>The wound care nurse indicated, "we didn't know it had gotten this bad. That's the problem."</p> <p>During an observation on 11-25-14 at 1:00 p.m., the resident was lying on his back in bed. The resident now had a low air loss mattress in place. Beneath the resident was a sheet which had been folded three times, which impeded the purpose of the low air loss mattress.</p> <p>2. The record for Resident "F" was reviewed on 11-24-14 at 3:15 p.m. Diagnoses included but were not limited to, cerebral palsy, a C6 (cervical) spinal cord injury, quadriplegia, and neurogenic</p>			

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	<p>bladder. At the time the resident was admitted to the facility the resident's skin was intact.</p> <p>A review of the hospital discharge summary dated, 10-24-14 indicated "due to patient's medical complexity, along with decreased functional mobility and self care, this patient continues to require 24 hour RN [Registered Nurse] to ensure and prevent skin breakdown, turn q [every] two hours to prevent skin breakdown."</p> <p>A review of the facility Braden Pressure Ulcer Risk assessment, dated 10-24-14, indicated the resident was at a 'moderate risk" in the development of pressure ulcers.</p> <p>The assessment indicated the resident had very limited sensory perception (2), occasionally moist (3), chairfast (2), very limited mobility (2), adequate nutrition (3), and a potential problem for friction/shear (2).</p> <p>A subsequent Braden Pressure Ulcer Risk Assessment, dated 11-25-14, all scores remained the same with the exception of "friction/shear" in which the licensed nurse indicated this area was a problem. The licensed nurse did not identify the resident's lack of mobility due to his</p>			

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	<p>quadriplegia.</p> <p>The licensed nurse failed to recognize the residents complete limitations with mobility and the score remained as "very limited" rather than "completely immobile" due to his diagnosis. The licensed nurse continued to assess the resident at "moderate risk" for pressure ulcers although he had an acquired stage four ulcer.</p> <p>A review of the resident's MDS, dated 10-31-14 indicated the resident was alert and oriented, required extensive assistance and 2 + staff members with transfers, dressing, and eating, and total care with 2+ staff members in regard to bed mobility, hygiene and toileting. The assessment indicated the resident had no pressure ulcers or skin concerns at the time of the assessment.</p> <p>The record indicated the resident plan of care identified him with the potential for impaired skin integrity related to impaired mobility, requires assist with turning and repositioning - two staff members. Interventions to this plan of care included, "Notify MD promptly of skin break down, monitor incontinence, encourage to reposition as able and observe skin integrity during am/pm care."</p>						

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	<p>During an interview on 11-24-14 at 3:15 p.m., the wound care nurse indicated the resident currently had an "acquired" pressure ulcer. "When we found it on 11-02-14, it was already Stage 2 ulcer."</p> <p>A review of the "change of condition" report, dated 11-02-14 indicated the area measured 0.7 cm in length by 0.7 centimeters in width and less than 0.1 centimeters in depth. A notation adjacent to these measurements indicated the area measured 1.0 centimeters in length by .5 centimeters in width. The wound care nurse measured the area the following day, 11-03-14 and indicated the area measured 1.5 centimeters in length by 1.0 centimeters in width by 1.0 centimeters in depth.</p> <p>During an observation on 11-24-14 at 3:30 p.m., a request was made to observe the resident's pressure ulcer. A pungent odor permeated the resident's room. The resident agreed to the body assessment and indicated he was concerned that he had a pressure ulcer and wanted to do everything he could to aid in the healing of the ulcer. During this observation the resident indicated that he was unable to tell if he had a bowel movement "because I can't feel anything" and he was unable to turn</p>			

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	<p>himself from side to side. "I have to wait for the nurses to help me."</p> <p>The resident indicated he was concerned because "sometimes the nurses tell me there is not enough staff to keep me turned and sometimes they forget to change the treatment."</p> <p>The wound care nurse turned the resident to his right side with the assistance of CNA #10. During this observation the resident had a dressing to his coccyx, which was dated 11-24-14. The wound care nurse identified the dressing as a "foam dressing with Santyl."</p> <p>The wound care nurse removed the soiled dressing, and the room was filled with a decaying odor. The nurse indicated the area currently measured as a Stage 3 pressure ulcer.</p> <p>After the completion of the assessment and upon exiting the resident room, CNA #10 indicated, "I knew he had one [in regard to a pressure ulcer], but I didn't know it was that bad."</p> <p>A review of the Wound Care Specialist notation, dated 11-10-14 indicated the following: "Wound right buttock is a necrotic tissue unstageable pressure ulcer and has</p>			

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>received a status of not healed. Subsequent wound encounter measurements are 4 centimeters in length by 3.5 centimeters in width by 0.2 centimeters in depth."</p> <p>The Specialist indicated the resident was "non ambulatory had paralysis, bowel incontinence with an "unstageable ulcer due to significant deterioration - 100 % slough. The Wound Care Specialist ordered a ROHO [cushion] in wheelchair, an alternating pressure low air flow mattress, and to turn the resident every two hours."</p> <p>The notation alerted the nursing staff the resident had a "very right risk for further skin breakdown - diligent monitoring per facility staff will be essential."</p> <p>A review of the Wound Care Specialist notation, dated 11-17-14 indicated the following: "Alert and oriented to person, place and time, wound #1 buttocks now labeled sacrum is a necrotic tissue (unstageable) pressure ulcer and has received a status of not healed. Subsequent wound encounter measurements are 5 centimeters in length by 4.5 centimeters in width by 0,2 centimeters in depth. There is a small amount of sero-sanguineous drainage noted which has a mild odor. The patient reports no wound pain due to the wound being insensate. The wound bed is 76 -</p>			
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	<p>100 % slough. The wound is deteriorating. Significant deterioration. Pt concerned and asking what he can do to assist wound healing. Very high risk for further skin breakdown. Diligent monitoring per facility staff will be essential."</p> <p>A review of the "Pressure Ulcer Evaluation Record," dated 11-24-14 indicated the area measured 5.9 centimeters in length by 3.0 centimeters in width and 2.3 centimeters in depth. The area was assessed as a Stage 3 pressure ulcer, with moderate drainage, serosanguineous with 75 % eschar and 25% granulation."</p> <p>On 11-24-14 at 3:45 p.m., the wound care nurse employed the advice from the facility physician. The physician assessed the resident's pressure ulcer and indicated, "It needs to be debrided." The resident conveyed to the physician he was aware of the odor, was not turned on a regular basis nor received the treatment to the pressure ulcer. The physician enforced the need for changing positioning and to receive the ordered treatment to the wound care nurse.</p> <p>A review of the physician progress notes dated, 11-24-14 at 5:00 p.m., indicated the following: Examined wound with</p>			

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	<p>State Surveyor. Pt. [patient] needs Santyl and turned every two hours. Stage 4 ulcer."</p> <p>3. The record for Resident "A" was reviewed on 11-24-14 at 9:40 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, history of urinary tract infection, dehydration and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p> <p>The resident was re-admitted to the facility on 09-26-14 at 6:40 p.m., after a hospitalization. A review of the "Nursing Admission Assessment," dated 09-26-14, indicated the resident was alert to person, had shortness of breath, with no recent history of nutrition, hydration or weight issues, was dependent for bathing, toileting, bed mobility, and no pressure or reddened areas.</p> <p>The assessment indicated the "Initial Skin Interventions," included "pressure reducing mattress, chair or W/C [wheelchair] cushion and incontinence management."</p> <p>The resident's Braden Scale Assessment, dated 09-26-14, identified the resident at "high risk" for the development of pressure ulcers.</p>			

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	<p>A review of the resident's Minimum Data Set Assessment (MDS), dated 10-03-14, indicated the resident had severe cognitive impairment, required extensive assistance with bed mobility, dressing, eating, hygiene, toileting, had no pressure or reddened areas and was incontinent of bowel and bladder. The assessment indicated the resident had weight loss.</p> <p>The 10-24-14 MDS assessment the resident's status was the same as the assessment dated 10-03-14.</p> <p>The resident had a physician order, dated 09-26-14, for Weekly Skin Assessments on Mondays. The clinical record lacked documentation of the nurses weekly skin assessments.</p> <p>A review of the "Shower Sheets," completed by the CNA's (certified nurses aides), indicated the following: "10-08-14 - redness on upper back/buttocks." "10-11-14 - redness on upper bath/buttocks." "10-18-14 - redness on upper backside." "10-22-14 - backside redness." "10-29-14 - backside redness - small area open."</p> <p>A review of the "Skilled Documentation</p>			
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	<p>Flow Sheets," related to "Special Skin Care Needs and completed by the Licensed Nursing staff indicated the following:</p> <p>"October 11, 12, 13, and 18, 2014 - preventative skin care." The flow sheets lacked awareness by the nursing staff of the redness to the resident's upper back/buttocks."</p> <p>The record indicated the resident had a change in condition on 10-30-14, and was transported to the local area hospital for evaluation and treatment for suspected "seizure like activity."</p> <p>A review of the "Acute Hospital Transfer Record," dated 10-30-14, indicated the resident was "dependent for transfers, ambulation, toileting, bathing, eating, and positioning. A pressure ulcer risk."</p> <p>This "Transfer Record" identified a bruise to the left lower leg, and a scab to the left ankle."</p> <p>Review of the hospital "Adult Assessment Tool - Skin," dated 10-30-14, indicated, "multiple bruises, wound to left shin/shearing, bilateral heels DTI [deep tissue injury] reddened, coccyx 2 callused areas in wound bed, reddened, blanchable, reddened."</p>			

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	<p>The nursing staff failed to ensure this dependent resident received treatment and services for the noted skin breakdown, prior to being transferred to the local area hospital where the skin conditions were identified.</p> <p>4. The record for Resident "B" was reviewed on 11-24-14 at 9:20 a.m. Diagnoses included, but were not limited to, failure to thrive, cerebral vascular accident with dysphagia and vascular dementia. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident's Braden Scale, dated 11-05-14 indicated the resident was not at risk for pressure ulcers.</p> <p>A review of the hospital "History and Physical," dated 11-03-14, indicated the resident was admitted "with hx.[history] history of end stage renal disease, dementia, COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure presented from nursing home by [family member] for altered mental status for 1 week. She has been progressively more sleepy and has not been eating or drinking will for 1 week. Dry mouth. Problems dehydration, acute hypernatremia, acute on chronic renal failure, altered mental status.</p>			

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	<p>The record indicated that from the time of re-admission to the facility on 11-05-14 through 11-24-14, the resident continued to refuse nutrition intake.</p> <p>A review of the nurses progress note, dated 11-23-14 at 7:00 p.m., indicated the resident "has been refusing meals...."</p> <p>The nursing staff failed to reassess the resident for the risk of pressure ulcers, until the notification of Immediate Jeopardy on 11-24-14. A subsequent review of the Braden Scale Assessment, dated 11-25-14, did not identify the resident's nutrition as "very poor," but rather as "probably inadequate."</p> <p>5. During an interview on 11-26-14 at 8:00 a.m., Licensed Nurse #13 indicated she was unfamiliar with the term "Braden Scale" or "Norton Scale." "The nurse does the weekly assessment and the CNA's do it on Shower days. It's up to the CNA's to let me know if there are any changes." When questioned if she was aware of any resident in her current assignment that had pressure ulcers or any skin concerns she indicated "No - I didn't hear anything in report."</p> <p>The licensed nurse indicated if a resident was on a special mattress it was "OK" to</p>			

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	<p>have a turn sheet. When questioned if the sheet could be folded the nurse responded "Yes."</p> <p>During an interview on 11-26-14 at 8:20 a.m., Licensed Nurse #12 indicated a "turn sheet could be folded" if a resident had a physician order for a special mattress.</p> <p>When questioned about the "Braden Scale" assessment, the licensed nurse indicated, "the Unit Manager's do that form."</p> <p>6. A review of the facility policy on 11-24-14 at 3:30 p.m., titled "Pressure Ulcer, Prevention of," and undated, indicated the following:</p> <p>"Purpose: To prevent skin breakdown and development of pressure sores."</p> <p>"Assessment Guidelines - may include, but are not limited to: Comorbid conditions, general condition of skin, impaired circulation pain, drugs that effect wound healing, cognitive impairment, urinary or fecal incontinence, nutritional status, hydration/fluid balance, terminal condition, weight (over/under ideal or usual body weight), bedfast, mobility status, including bed mobility, limitation</p>			

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	<p>in range of motion and deformities, deformities, indwelling catheter, use pressure ulcer risk assessment tools per facility procedure."</p> <p>"Procedure: 1. Assessment for risk of pressure ulcer development. a. Identify high and low risk residents. 2. Assess and identify complicating conditions that may contribute to pressure ulcer development. 3. Develop care plan to eliminate or minimize risk factors. a. Nutrition, b. Nutritional supplement, c. Hydration, d. Pressure relief, e. Resistance or refusal of care. 4. Apply moisture barrier gently to dry skin. 5. Change bed linen whenever wet of soiled. 6. Keep sheets dry and free of wrinkles and debris. 7. Use appropriate support surface in the resident's bed or chair. 8. Use pressure reducing or relieving devices as necessary...10. Establish a turning and positioning schedule in bed and chair to meet the resident's needs."</p> <p>"Documentation: Documentation may include: Date, time, approaches to prevent pressure ulcer development, Preventive equipment used, Condition of the resident's skin, Physician notification when change in skin condition is observed. If a pressure ulcer is present, the licensed nurse is responsible to record</p>			

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	<p>condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective."</p> <p>The Immediate Jeopardy began on 11-18-14 when the facility failed to monitor and treat known Stage 1 pressure ulcers that progressed to Stage 3 and Unstageable pressure ulcers without being aware the pressure ulcers progressed to Stage 3 and Unstageable and an acquired stage 2 ulcer had progressed to a stage 4. The Administrator and the Director of Nurses were notified of the Immediate Jeopardy at 4:20 p.m. on 11-24-14.</p> <p>The Administrator, Director of Nurses, and Corporate Nurse Consultant were notified on 11-26-14 at 11:30 a.m., the Immediate Jeopardy was not removed by the Exit date of the survey.</p> <p>This Federal tag relates to Complaint IN00159511.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>			

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F000317 SS=D	<p>483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.</p> <p>Based on observation, record review, and interview the facility failed to ensure a resident who had a limited range of motion due to a cerebral vascular accident received the appropriate services or application of splints for 1 of 1 resident reviewed for splints in a sample of 5. (Resident "D").</p> <p>Findings include:</p> <p>The record for Resident "D" was reviewed on 11-24-14 at 11:50 a.m. Diagnoses included, but were not limited to dementia, hypertension, and hemiplegia due to a cerebral vascular accident. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had a physician order dated 10-14-14 for "Splint/Brace/Immobilizer/Orthotic Splint left wrist/hand, left elbow. Left elbow [splint] on at 7:00 a.m. and off at 3:00 p.m."</p>	F000317	<p>F317 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident D was formally evaluated by an Occupational Therapist on and he is currently undergoing occupational therapy. The plan of care has been modified as indicated. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Range-of-motion screens were completed for in-house residents. Residents with contractures were referred to Occupational Therapy for evaluation of orthotic need or other contracture services as indicated. Nurse management will update/implement care plans based on therapy recommendations as indicated. What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? By 12/26/14,</p>	12/26/2014

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F000327 SS=G	<p>During an observation on 11-24-14 at 11:40 a.m., 12:35 p.m., and 12:50 p.m., the resident did not have the physician ordered splint on the left elbow.</p> <p>During an observation on 11-25-14 at 11:00 a.m., the resident did not have the splint on the left elbow.</p> <p>During an interview on 11-25-14 at 12:15 p.m., the Occupational Therapist indicated the splint had not been discontinued by the therapy department.</p> <p>During an observation on 11-26-14 at 8:20 a.m., the resident was seated in a broda chair in a reclining position. The resident did not have the physician ordered splint.</p> <p>3.1-42(a)(1) 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview and record review, when residents refused oral hydration, the facility failed to provide alternate hydration needs for one resident ("A"), which resulted in the resident requiring electrolyte fluids at the</p>	F000327	<p>Licensed Nurses will be re-educated by the Director of Nursing or designee on carefully following physician's orders for the application of orthotics/splints. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Once per week for 12 weeks, DON will monitor and validate splint application in accordance with physician's orders. The Director of Nursing or designee will be responsible for identifying patterns of non-compliance and reporting issues to the quarterly QA committee for problem analysis, remedial planning, and additional monitoring needs as indicated.</p> <p>F327 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident A discharged 10/30/2014. Resident B's flow rate was adjusted to match physician's</p>	12/26/2014	

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	<p>local area hospital and did not provide the physician prescribed amount of subcutaneous hydration for another resident ("B").</p> <p>This deficient practice affected 2 of 3 resident's reviewed for dehydration in a sample of 5. (Resident "A" and "B")</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 11-24-14 at 9:40 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes mellitus, history of urinary tract infection, dehydration and peripheral neuropathy. These diagnoses remained current at the time of the record review.</p> <p>The resident was re-admitted to the facility on 09-26-14 at 6:40 p.m., after a hospitalization. A review of the "Nursing Admission Assessment," dated 09-26-14, indicated the resident was alert to person, had shortness of breath, with no recent history of nutrition, hydration or weight issues, was dependent for bathing, toileting, bed mobility, and no pressure or reddened areas.</p> <p>The physician re-admission orders which indicated the resident had readmission orders which included included "daily weights - due to congestive heart failure,</p>		<p>administration orders 11/26/14, and physician was notified of the rate discrepancy. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken? Nurse managers will assess all residents for signs and symptoms of dehydration. Physicians will be notified and orders will be received and implemented as indicated. A quality audit was completed of Residents receiving IV therapy to identify potential flow rate discrepancies. No further issues were identified.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that deficient practices do not recur? By 12/26/14, Licensed Nurses and Certified Nursing Assistants will be re-educated on the importance of providing adequate fluids and reporting patterns of reduced oral intake. By 12/26/14, Licensed Nurses will be re-educated by the Director of Nursing or designee on signs and symptoms of dehydration and timely physician notification of changes in condition. By 12/26/14, Licensed Nurses will be re-educated by the Director of Nursing or designee on following physician's orders on infusion rates. How will the corrective action(s) be monitored to ensure the deficient practice will not</p>	

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	<p>and Lasix [a diuretic] 20 mg [milligrams] every day."</p> <p>A review of the MDS (Minimum Data Set) Assessment, dated 10-03-14 and also 10-24-14 indicated the resident had severe cognitive impairment, weight loss and did not have skin concerns.</p> <p>The nurses notes indicated the following: "09-26-14 at 6:40 p.m. - S/P [status post] UTI [urinary tract infection] and altered mental status. Alert to self. Skin cool and pale to touch. No open areas. Poor skin turgor. No tenting. No edema. Incontinent of urine."</p> <p>"09-27-14 at 4:33 p.m. lethargic. Incontinent of bowel and bladder."</p> <p>"09-28-14 at 8:50 p.m. Refuses to get out of bed. Fed per staff Poor intake fluids encouraged."</p> <p>"10-17-14 11:00 a.m. - taking bites."</p> <p>"10-20-14 [no time] Refused all meals today. Resident would not eat dinner for family as well, however will take meds [medications] and fluids with much encouragement."</p> <p>"10-20-14 at 8:00 p.m. - Refused dinner. Drinking fluid with much</p>		<p>recur? Weekly audits will be completed by the Health Information Manager or designee to monitor compliance with change-of-condition physician notifications. Each week, the Director of Nursing or designee will be responsible for monitoring change-of-condition audits and coordinating compliance with physician notification as indicated. Director of Nursing or designee will validate intravenous infusion rates in accordance with physician's orders. This audit will be conducted 3 times weekly for 4 weeks and then weekly thereafter until a pattern of substantial compliance is achieved. Director of Nursing or designee will be responsible for identifying patterns of non-compliance and reporting issues to the quarterly QA committee for problem analysis, remedial planning, and additional monitoring needs as indicated.</p>				

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	<p>encouragement. Resist care."</p> <p>"10-21-14 [no time] - Refused meals, Fluids 250 c.c. [cubic centimeters] this shift. Incontinent of bowel and bladder."</p> <p>"10-22-14 at 10:00 a.m. - Refused breakfast. Drank 200 c.c. orange juice."</p> <p>"10-25-14 at 12:30 p.m. - change of condition. BUE [bilateral upper extremity] twitch and biting <sic> tongue which started today. Recent change in function, intake and mental states."</p> <p>The nurses notes indicated the resident was currently diagnosed with pneumonia and a urinary tract infection and was started on Primaxin (an antibiotic). "IV [intravenous] atb. [antibiotic] initiated and noted BUE [bilateral upper extremity] twitching. Resident became unresponsive and biting on tongue. N.O. [new order] noted to d/c [discontinue] Primaxin and medication changed to levaquin."</p> <p>"10-26-14 at 1:00 p.m. - Refused meals. Took half meds. Drank 100 ml [milliliters] water approximately 100 ml of supplement. Stated that she just don't <sic> want to eat."</p>				

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	<p>"10-26-14 at 7:00 p.m. - States 'leave me alone' when meals are taken to room resident states, 'I don't want it.' However stated that she liked supplement."</p> <p>"10-28-14 at 11:00 a.m. - Continues to refuse meals. Drink <sic> 1/2 supplement. Fluids encouraged."</p> <p>"10-28-14 at 2:00 p.m. Refused lunch. Writer <sic> attempted to give glucerna [a nutritional supplement] but resident turned her head and acted as if falling asleep."</p> <p>"10-29-14 at 6:00 a.m. - Pt. [patient] has dry scabbed lips and tongue."</p> <p>"10-29-14 1:00 p.m. Continues to refuse meals and took sips of supplements today. Lower lip scabs came off. Healing well."</p> <p>"10-29-14 at 10:00 p.m. Resident refused all food and drink and meds. Stares at wall without looking at person talking. Slight eye movement toward person talking while shaking and talking very loudly in ear. No response to pain. Resident is mouth breathing intermittently. Mouth care given to remove dried blood."</p> <p>The record indicated the resident was</p>			

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	<p>transported to the local area hospital on 10-30-14 at 9:00 a.m., with a change in condition. The record indicated the resident had an elevated Sodium level at 149 and Blood Urea Nitrogen of 61.</p> <p>A review of the Hospital ER [emergency room] Nursing documentation, dated 10-30-14 indicated, "pt. [patient] comes from Pyramid Point where she had seizure around 9:00 a.m., was given Ativan around 11:00 a.m. and had another sz [seizure] last around 2-3 minutes around 1:00 p.m. Pt. unresponsive upon arrival. Pt has extension/flexion to pain. Pt unable to follow commands upon arrival EMS [emergency medical staff] stated the BP [blood pressure] was in the 70's, pt received 100 ml [normal saline] in route and has pressure upon arrival in the low 100's. Mucous Membranes - dry. Urine - tea colored."</p> <p>A hospital consultation notation, dated 11-12-14 indicated the resident's [family member] noted that the patient's appetite has been decreasing and she has been more confused."</p> <p>The Hospital "History and Physical," dated 10-30-14, indicated the resident had "dry mucous membranes - hypernatremia - suspect dehydration due</p>						

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	<p>to decreased PO [by mouth] intake."</p> <p>The Discharge Summary, dated 11-17-14 indicated that at the time of admission the resident had "multiple electrolyte abnormalities including hypernatremia, hypokalemia, hypoglycemia and hypocalcemia. She was repleted with electrolyte's. We did replete aggressively She improved however did have some electrolyte abnormalities for several days following her admission. These did eventually stabilize."</p> <p>2. The record for Resident "B" was reviewed on 11-24-14 at 9:20 a.m. Diagnoses included, but were not limited to, failure to thrive, cerebral vascular accident with dysphagia and vascular dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident was recently readmitted to the facility on 11-05-14 after a hospitalization. A review of the hospital "History and Physical," dated 11-03-14, indicated the resident was admitted "with hx.[history] history of end stage renal disease, dementia, COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure presented from nursing home by [family member] for altered mental status for 1 week. She has been progressively more sleepy and has</p>						

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	<p>not been eating or drinking will for 1 week. Dry mouth. Problems dehydration, acute hypernatremia, acute on chronic renal failure, altered mental status.</p> <p>The nursing admission assessment, dated 11-05-14 indicated the resident was alert to person.</p> <p>A review of the resident's record indicated the resident had physician orders for a regular pureed diet with thin liquids, however the resident continued to refuse nutrition.</p> <p>The nursing progress notes, dated 11-23-14 at 7:00 p.m., indicated the resident had an increase in temperature - "101.7 degrees, denies pain - has been refusing meals however drinks plenty of water and supplements throughout the day. MD [Medical Doctor] notified."</p> <p>A review of a physician order dated 11-25-14 instructed the nursing staff for "labs and clysis [subcutaneous fluids] due to abnormal lab values. Lab notified of STAT BMP [basic metabolic profile] and pharmacy notified of order for D5W [dextrose 5% water] at 50 c.c. [cubic centimeters] per hour."</p> <p>During an observation on 11-26-14 at</p>				

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	<p>8:30 a.m., the resident was observed in bed with the subcutaneous fluids infusing via an infusion pump at 70 c.c. per hour.</p> <p>During a subsequent observation on 11-26-14 at 9:15 a.m., with licensed nurse #5 in attendance, the infusion rate had been changed to 75 c.c. per hour.</p> <p>During an observation on 11-26-14 at 9:30 a.m., the infusion pump was set at 75 c.c. per hour, with D5 1/2 NS [dextrose 5 % 1/2 normal saline] at 75 c.c. per hour.</p> <p>With licensed nurse #14 in attendance, the nurse verified the infusion rate and the fluids and then pushed the "review" button on the infusion pump to indicate the amount of fluids already infused. During this observation, the infusion pump had an orange sticker with indicated the bag of fluids was started at 6:30 a.m. on 11-26-14. The licensed nurse indicated the amount infused since 6:30 a.m. was 195 c.c.</p> <p>During an interview on 11-26-14 at 9:40 a.m., the Unit Manager verified she received the first physician order for D5W at 50 c.c. per hour, "then the doctor called back and changed it to 75 c.c. per hour and change the fluids to D 5 1/2 NS [Dextrose 5% 1/2 normal saline]. That</p>			

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	<p>was around 4:30 p.m. I believe the first bag [fluids] was hung at 5:15 p.m. I went down to the room and titrated the flow myself."</p> <p>During an interview on 11-26-14, at 10:40 a.m., the Staff Development Coordinator/Wound Care Nurse indicated when she checked the "review" button on the infusion pump, it indicated the amount infused by 10:00 a.m. was 243 c.c. with 758 c.c. remaining.</p> <p>The resident did not received the prescribed subcutaneous hydration as prescribed by the physician. The Staff Development Coordinator/Wound Care Nurse indicated the physician would need to be notified.</p> <p>This Federal tag related to Complaint IN00159511.</p> <p>3.1-46(b)</p>			