

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2013
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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F000000	<p>This visit was for the Investigation of Complaints IN00123365 and IN00126974.</p> <p>Complaint IN00123365-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F166, F314, and F226.</p> <p>Complaint IN00126974-Substantiated. Federal/state deficiency related to the allegation is cited at F226.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: May 16 & 17, 2013</p> <p>Facility number: 000076 Provider number: 155156 AIM number: 100271060</p> <p>Survey team: Janet Adams, RN, TC Heather Tuttle, RN Cynthia Stramel, RN (May 17, 2013)</p> <p>Census bed type: SNF: 26 SNF/NF: 116</p>	F000000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. The Arbors would like to request a desk review for this survey.	

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

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

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	<p>Total: 142</p> <p>Census payor type: Medicare: 27 Medicaid: 91 Other: 24 Total: 142</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 401 IAC 16.2.</p> <p>Quality review completed on May 22, 2013, by Janelyn Kulik, RN.</p>			

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F000157 SS=D	<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> <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 record review and interview, the facility failed to notify the Physician of a change in the size of a pressure ulcer for 1 of 2 residents reviewed for pressure ulcers in the</p>	F000157	<p>PLAN OF CORRECTION F157 Notification of Changes Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of</p>	06/10/2013			

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	<p>sample of 5. (Resident #E)</p> <p>Findings include:</p> <p>The closed record for Resident #E was reviewed on 5/17/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, osteoarthritis, high blood pressure, and a history of a hip fracture. The resident was admitted to the facility on 12/28/12. The resident was discharged from the facility on 2/4/13.</p> <p>Review of the 12/28/12 admission Physician orders indicated there was an order to apply Silva-A (a medicated ointment) to the coccyx/buttock pressure ulcer every shift. A Physician's order was written on 1/26/13 to apply a dry sterile dressing to the right buttock every day and prn (as needed) for soilage.</p> <p>A Pressure/Stasis/Arterial /Diabetic Ulcer Assessment form was initiated on 12/28/12. The form indicated the resident had a Stage II (an ulcer with partial thickness loss of the dermis presenting as shallow open ulcer) pressure ulcer to the right inner buttock. The pressure ulcer measured 1.5 cm (centimeter) x 1.0 cm with no</p>		<p>guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice:</p> <p>RE is no longer a resident in the facility</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All residents with pressure ulcers were assessed by wound specialist on 5/22/13 and necessary assessments and order changes were done as necessary</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur:</p> <ul style="list-style-type: none"> · Nursing administration were in serviced on 5/20/13 regarding MD notification on significant wound changes · The DHS/designee will monitor skin books weekly and an audit tool will be used to report findings (see audit tool A). This will be performed for 6 months or until full compliance is obtained <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>The Quality Assurance Committee will review all findings monthly for trends and will make</p>		

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	<p>tunneling, undermining, or signs of infection. The tissue surrounding the wound was red with no exudate (drainage) noted.</p> <p>The following entries were made on the Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form: 1/2/13- measured 1.5 cm x 1.0 cm. x .1 cm The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/8/13- measured 1.0 cm x 1.0 cm. The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/15/13- measured 3.2 cm x 2.1 cm. The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/22/13- No documentation on this entry.</p> <p>1/30/13- measured 3.6 cm x 2.6 cm x 0.2 cm</p>		<p>recommendations to the plan of care as needed. QA & A will monitor for 6 months or until full compliance is met.</p>		

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	<p>The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>Review of a unit Wound Tracking Form indicated the right buttock wound measured 3.6 cm x 2.4 cm. on 1/22/13. There was no assessment of the ulcer on the form.</p> <p>Review of the 1/2013 Nursing documents indicated there was no documentation of Physician notification of the increase in size of the right buttock pressure ulcer.</p> <p>When interviewed in 5/17/13 at 2:00 p.m. Unit Manager #4 indicated there was no documentation of Physician notification of the increase in size of the pressure ulcer.</p> <p>The facility policy titled "Pressure Ulcer and Skin Condition Assessment Policy" was reviewed on 5/17/13 at 1:50 p.m. There was no date on the policy. Unit Manager #4 provided the policy and identified the policy as current. The policy indicated attending Physicians were to be notified within seven to fourteen days of the resident's lack of response to treatment. The policy also indicated</p>			

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	<p>changes the Physician were to be notified of included a significant increase in wound measurements.</p> <p>This federal tag relates to Complaint IN00123365.</p> <p>3.1-5(a)(3)</p>			

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to ensure resident grievances related to resident feeding voiced at a Resident Council meeting were relayed to the Nursing Department.</p> <p>Findings include:</p> <p>The 5/13/13 Resident Council meeting notes were reviewed on 5/17/13 at 11:00 a.m.. The meeting notes indicated residents in attendance voiced a concern related to feeding other residents.</p> <p>When interviewed on 5/17/13 at 11:15 a.m., the Activity Director indicated she writes the concerns that are voiced at Resident Council on Resident Concern forms and then gets them to the departments involved in the concerns. The Activity Director indicated resident's concerns were related to the meals when Restorative staff were not available to assist in feeding.</p> <p>When interviewed on 5/17/13 at</p>	F000166	<p>F166: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>F166: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice:</p> <p>The concern was given to nursing and resolved on May 17, 2013 The Activity Director was in-serviced on May 20, 2013, by Executive Director, to give all concerns from Resident Council to the appropriate department upon completion of Resident Council meeting.</p> <p>How the facility will identify other residents having the potential to be affected by the</p>	06/07/2013			

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	<p>11:00 a.m., the Director of Nursing indicated she had not been informed of the concerns voiced at the recent Resident Council meeting related to residents not being fed. The Director of Nursing indicated she should have been notified within 48 hours as per the policy.</p> <p>Review of the Resident Concern Resolution Procedure was reviewed on 5/16/13 at 9:30 p.m. The Director of Nursing provided the policy and identified the policy as current. The policy indicated concerns were to be addressed in 48 hours unless they involved abuse, neglect, or misappropriation of property, which were to be reported to the Executive Director immediately.</p> <p>This federal tag relates to Complaint IN00123365.</p> <p>3.1-7(a)(2)</p>		<p>same deficient practice: All concerns will be followed up by appropriate department within 48 hours of receipt (where possible) and resolution made.</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur: The Executive Director will be given copy of concerns/grievances upon completion of Resident Council meeting and monitor for completion and appropriate follow-up.</p> <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>Executive Director will report to Quality Assurance Committee, on a monthly basis compliance and time of resolution of concerns/grievances.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: The concern was given to nursing and resolved on May 17, 2013 The Activity Director was in-serviced on May 20, 2013, by Executive Director, to give all concerns from Resident Council to the appropriate department upon completion of Resident</p>		

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			<p>Council meeting. How the facility will identify other residents having the potential to be affected by the same deficient practice: All concerns will be followed up by appropriate department within 48 hours of receipt (where possible) and resolution made. Measures the facility will take to ensure that the problem will be corrected and will not recur: The Executive Director will be given copy of concerns/grievances upon completion of Resident Council meeting and monitor for completion and appropriate follow-up. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Executive Director will report to Quality Assurance Committee, on a monthly basis compliance and time of resolution of concerns/grievances.</p>	

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow their Abuse Policy related to obtaining references at the time of hire for 4 of 5 newly hired employees in the last 120 days. (Employees #1, #2, #3, and #4)</p> <p>Findings include:</p> <p>The facility employees files were review and 5/17/13 at 10:35 a.m. There were no reference checks completed for the following employees: Employee #1 : RN hired on 2/13/13 Employee #2: RN hired on 2/21/13 Employee #3: Dietary aide hired in 4/1/13 Employee #4: CNA hired on 3/13/13</p> <p>When interviewed on 5/17/13 at 1:00 p.m., the AIT (Administrator in Training) indicated there were no reference checks available for the above (4) employees.</p> <p>The facility policy titled "Prevention</p>	F000226	<p>F266: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: All records in questions have had references completed as of May 21, 2013. An audit of all hires in past 6 months was completed and checked for appropriate references.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: All new hires will have references completed before orientation is started and Human Resource Director will audit for completion and orientation for individual will not start until completed.</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur:</p>	06/07/2013			

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	<p>and Reporting of Suspected Resident/Patient Abuse and Neglect" was reviewed on 5/16/13 at 8:45 p.m. There was no date on the policy. The facility Administrator provided the policy and identified the policy as current. The policy indicated all potential employees were to be screened for a history of abuse, neglect, or mistreatment. The policy indicated the screening process included obtaining reference checks from previous/current employers.</p> <p>This federal tag relates to Complaints IN00123365 and IN00126974. 3.1-28(a)(1)</p>		<p>Executive Director or designee will be given new employee records to audit completion of references.</p> <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent</p> <p>Executive Director or designee will audit all new hire records for completion and will report to Quality Assurance Committee findings on a monthly basis until 6 months of 100% compliance.</p>		

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F000309 SS=D	<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 practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary treatment and services to prevent further injury of a dislocated wrist for 1 of 1 residents reviewed for injuries in the sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 5/17/13 at 9:00 a.m. The resident's diagnoses included, but were not limited to, dementia, right side weakness, fall, gout, and seizures.</p> <p>Review of Nursing Progress Notes dated 2/15/13 at 10:30 a.m., indicated the resident had complaints of pain to her left wrist. The resident's left wrist was observed to be swollen and red. The resident's Physician was notified and new orders were obtained for a mobile X-ray.</p>	F000309	<p>F309 Quality Of Care Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice: R#B had a head to toe assessment and range of motion assessment completed on May 29, 2013 with no adverse side effects noted related to splint application</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with splint orders were reviewed on 5/29/13 for the past 30 days. Deficiencies were corrected at this time</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur: · Licensed nurses were in serviced by DHS or designee related</p>	06/10/2013	

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	<p>Review of the mobile X-ray for the left wrist dated 2/15/13 indicated "Results: Mild dorsal subluxation of the distal ulna relative to the radius on the lateral view of the wrist. No acute fracture identified however. Conclusion: Questionable dorsal subluxation of the ulna at the radial ulnar articulation."</p> <p>Review of Nursing Progress Notes dated 2/15/13 at 7:15 p.m., indicated the results of the X-ray were phoned to the resident's Physician. At that time, the Physician indicated he wanted a splint to be applied to the resident's left wrist and to notify an Orthopedic Physician for consult. The nurse on duty indicated to the Physician the facility did not have any splints, but they could send to her to the Emergency Room for a splint to be applied. The Physician indicated he did not want the resident sent to the Emergency Room to obtain only a splint and have the resident charged all that money. The Physician then indicated to obtain an Orthopedic consult as soon as possible.</p> <p>The next documented entry in Nursing Progress Notes was on 2/15/13 at 9:00 p.m., which indicated the resident was given something for pain. The resident also had some lab</p>		<p>to therapy orders on 5/29/13, 5/30/13, and 5/31/13.</p> <ul style="list-style-type: none"> The DHS/designee will monitor the 24 hour reports on all units for any new therapy and adaptive equipment orders 7 days a week. An audit tool will be used (See audit tool B) to monitor therapy adaptive equipments. Findings will be discussed to QA&A monthly for the next 6 will monitor for 6 months or until full compliance is met.months <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>The Quality Assurance Committee will review all findings monthly for trends and will make recommendations to the plan of care as needed. QA & A</p>		

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	<p>work done. The only documented entry in Nursing Progress Notes for 2/16/13 was at 4:00 p.m., indicating new orders were obtained for a gout medication. There were no entries in Nursing Notes for 2/17/13.</p> <p>Review of the skin impairment circumstance assessment and intervention form dated 2/15/13 indicated the left wrist was assessed and the resident had complaints of pain. On 2/16/13 the resident's wrist was assessed and no interventions to immobilize the left wrist were documented. Further review of the skin impairment assessment form indicated more assessments of the left wrist were completed on all three shifts for 2/17 and 2/18/13. Again there was no documentation of any interventions to immobilize the left wrist and protect the wrist from further injury.</p> <p>Review of Nursing Progress Notes dated 2/18/13 at 10:30 a.m., indicated an appointment for the Orthopedic consult was obtained. The resident's appointment was for 2/19/13 at 10:45 a.m. Again there was no documentation in Nursing Notes indicating the resident's left wrist was immobilized.</p>			

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	<p>Review of the history and physical dated 2/19/13 by the Orthopedic Physician indicated the X-ray shows severe distal radius fracture that has shortened and angulated with subluxation of the distal radial ulnar joint. The plan was to place a removable cast to the left wrist. The resident should wear the cast at all times except for bathing.</p> <p>Interview with RN #1 on 5/17/13 at 12:00 p.m., indicated she had worked the weekend (2/16 and 2/17/13) after the resident's wrist was observed swollen. She indicated there was no splint in place on 2/16/13 however, on 2/17/13 she obtained a piece of cardboard and wrapped the resident's arm and wrist with Kerlix (a gauze wrapping) to make a splint for mobilization of the left wrist. She further indicated she had not documented any of the above information in the resident's clinical record. RN #1 further indicated she was unaware if the facility's Therapy Department had splints or not.</p> <p>Review of the 24 hour report sheet for 2/17/13 indicated 7-3 shift: "Temporary splint immobilize the wrist. 3-11 shift: splint kept falling off."</p>			

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	<p>Interview with the Assistant Director of Nursing (ADoN) on 5/17/13 at 12:35 p.m., indicated she was the Manager on duty for the weekend of 2/16 and 2/17/13. She further indicated she was unaware there were keys available to the Therapy Department. She indicated she was aware the Therapy Department had adaptive equipment but was not real sure what they had.</p> <p>Interview with the Rehab Program Director on 5/17/13 at 12:13 p.m., indicated all departments had keys to the therapy room and the Nursing Department had keys for the therapy room for "off hours". He further indicated there were all kinds of splints in the therapy room for use. He indicated they had inflatable splints that mold to the resident.</p> <p>3.1-37(a)</p>			

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview the facility failed to ensure the necessary treatment and services were rendered related to assessing and monitoring pressure ulcers before and after an increase in size of the ulcer for 1 of 3 residents reviewed for pressure ulcers in the sample of 5. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #E was reviewed on 5/17/13 at 10:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, osteoarthritis, high blood pressure, and a history of a hip fracture. The resident was admitted to the facility on 12/28/12. The resident was discharged from the facility on 2/4/13.</p>	F000314	<p>F314 pressure Sores</p> <p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>What corrective actions have been accomplished for those residents found to have been affected by the deficient practice:</p> <p>RE is no longer a resident in the facility</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>All residents with pressure ulcers sheet were reviewed on 5/30/13 with any deficiencies noted corrected at this time.</p> <p>Measures the facility will take to ensure that the problem will be corrected and will not recur:</p> <ul style="list-style-type: none"> Nursing administration were 	06/10/2013	

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	<p>The 1/4/13 Minimum Data Set (MDS) admission assessment indicated the resident had two Stage II pressure ulcers.</p> <p>Review of the 12/28/12 admission Physician orders indicated there was an order to apply Silva-A (a medicated ointment) to the coccyx/buttock pressure ulcer every shift. A Physician's order was written on 1/26/13 to apply a dry sterile dressing to the right buttock every day and prn (as needed) for soilage.</p> <p>A Pressure/Stasis/Arterial /Diabetic Ulcer Assessment form was initiated on 12/28/12. The form indicated the resident had a Stage II (an ulcer with partial thickness loss of the dermis presenting as shallow open ulcer) pressure ulcer to the right inner buttock. The pressure ulcer measured 1.5 cm (centimeter) x 1.0 cm with no tunneling, undermining, or signs of infection. The tissue surrounding the wound was red with no exudate (drainage) noted.</p> <p>The following entries were made on the Pressure/Stasis/Arterial/Diabetic Ulcer Assessment form: 1/2/13- measured 1.5 cm x 1.0 cm. x .1 cm The sections on the form to indicated</p>		<p>in serviced on 5/20/13 related to wound sheet documentations.</p> <p>The DHS/designee will monitor skin books 2x weekly and an audit tool will be used to report findings (See audit tool C). This will be performed for 6 months or until full compliance is obtained</p> <p>Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>The Quality Assurance Committee will review all findings monthly for trends and will make recommendations to the plan of care as needed. QA & A will monitor for 6 months or until full compliance is met.</p>				

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	<p>the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/8/13- measured 1.0 cm x 1.0 cm. The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/15/13- measured 3.2 cm x 2.1 cm. The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>1/22/13- No documentation on this entry.</p> <p>1/30/13- measured 3.6 cm x 2.6 cm x 0.2 cm The sections on the form to indicated the stage of the ulcer, the presence or absence of exudate, descriptions of the wound bed and the periwound areas were not completed.</p> <p>Review of a unit Wound Tracking Form indicated the right buttock wound measured 3.6 cm x 2.4 cm. on 1/22/13. There was no other documentation of the ulcer.</p>						

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	<p>Review of the 1/2013 Nursing documents indicated there was no documentation of the stage or any other assessments related to characteristics of the pressure ulcer from 12/28/12 through 2/4/13.</p> <p>When interviewed in 5/17/13 at 2:00 p.m. Unit Manager #4 indicated there was no other documentation of ongoing assessments of the resident's pressure ulcers from 12/28/12 through 2/14/13.</p> <p>The facility policy titled "Pressure Ulcer and Skin Condition Assessment Policy" was received from Unit Manager #4 on 5/17/13 at 1:50 p.m. The Unit Manager identified the policy as current. There was no date on the policy. The policy indicated pressure ulcers were to be assessed, monitored, and measured at least every seven days. The policy also indicated the Wound Assessment forms were to be completed weekly to monitor and assess the wounds.</p> <p>This federal tag relates to Complaint IN00123365.</p> <p>3.1-40(a)(2)</p>						

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