

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/10/2015
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00185872.</p> <p>Complaint IN00185872- Substantiated. Federal/State deficiencies related to the allegations were cited at F157, F282, and F309.</p> <p>Survey dates: November 9 & 10, 2015</p> <p>Facility number: 000224 Provider number: 155331 AIM number: 100267700</p> <p>Census bed type: SNF: 17 SNF/NF: 79 Total: 96</p> <p>Census payor type: Medicare: 27 Medicaid: 58 Other: 11 Total: 96</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>I respectfully request consideration for paper compliance. I am forwarding the signed 2567 along with additional supportive documentation related to our face to face request for an IDR for F-tag 309 via fax today (11-25-15) to 1-317-233-7322. Upon your request, we will provide additional supportive documentation of proof of inservicing, etc. after date certain. Please reference the attached 2567 as "Credible Allegation of Compliance" for a complaint survey conducted on November 9-10, 2015. 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 conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>Quality review completed by 26143, on November 15, 2015.</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> <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</p>			

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	<p>§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 notify a resident's responsible party of a change in condition, related to excoriation of the thigh and peri-area, for 1 of 3 residents reviewed for skin excoriation in a total sample of 6. (Resident #G)</p> <p>Finding includes:</p> <p>Resident #G's record was reviewed on 11/09/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia.</p> <p>The Initial Data Collection Tool, dated 10/10/15 at 3 p.m., indicated the resident's skin was warm and intact, had a bruise on the right inner arm, and an incision on the right hip. The area for excoriated skin was not checked, which indicated the resident had no excoriated skin.</p> <p>A Physician's Order, dated 10/14/15, indicated an order for Calmoseptine ointment (moisture barrier) to excoriation</p>	F 0157	<p>F 157 1. Documentation is present in the clinical record for resident "G" indicating that her skin excoriation was assessed and the responsible party and physician were notified of the area and the treatment plan on 11/10/15. 2. Utilizing the Skin Assessment tool, designated licensed nurses completed facility-wide skin assessments on 11/23/15 to identify skin conditions, ensure assessment documentation is present in the clinical record with an appropriate treatment plan in place and the physician and responsible party are notified. 3. Education specific to the Change of Condition policy guidelines and expectations will be developed by the Staff Development Coordinator and Director of Nursing and presented to licensed nurses by 12/9/15. 4. The DON and/or designees will utilize a Change of Condition audit tool to audit the 24 hour report, physician orders and resident progress notes for any indicators of a significant change in resident status seven days per week for six months to ensure changes in condition are</p>	12/09/2015

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	<p>on the inner thighs every shift until healed.</p> <p>The Nurses' Notes, dated 10/14/15, at 2:06 p.m. and 6:32 p.m., indicated the resident's Responsible Party had not been notified of the excoriation of the inner thighs and the new order for Calmoseptine ointment.</p> <p>A Physician's Order, dated 11/03/15, indicated an order for Nystatin cream (anti-fungal) to the excoriated areas on the groin and peri-area every shift.</p> <p>The Nurses' Notes, dated 11/03/15 at 3:15 a.m. and 10:26 a.m., indicated the resident's Responsible Party had not been notified of the excoriation of the groin and peri-area and the new order for Nystatin cream.</p> <p>During an interview on 11/10/15 at 8:31 a.m., the ADoN (Assistant Director of Nursing), indicated the Responsible Party had not been notified of the Calmoseptine, the Nystatin, and the excoriated areas.</p> <p>During an observation on 11/10/15 at 8:54 a.m., Resident #G was transferred from the wheelchair to the bed by CNA #1, QMA #2, and Physical Therapy Aide #3. CNA #1 and QMA #2 provided</p>		<p>addressed per policy. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QA/QI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. After six months, if audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/9/15</p>	

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F 0282 SS=D Bldg. 00	<p>incontinence care to the resident. During the observation, the ADoN indicated the resident's peri-area and inner thighs were bright reddish/pink.</p> <p>During an interview on 11/10/15 at 9:24 a.m., the ADoN indicated the area of excoriation was over 10 centimeters.</p> <p>An undated facility policy, titled, "Changes in Resident's Condition or Status", received from the DoN (Director of Nursing) as current on 11/10/15 at 10:23 a.m., indicated, "The facility will notify...representative (sponsor) of changes in the resident's condition and/or status..."</p> <p>This Federal Tag relates to complaint IN00185872.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure a Physician's</p>	F 0282	F 282 1. The identified resident is no longer at the facility. 2. Utilizing the Treatment Record	12/09/2015

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	<p>order was followed, related to a treatment for a red groin, for 1 of 3 residents reviewed for skin excoriation, in a total sample of 6. (Resident #D)</p> <p>Finding includes:</p> <p>Resident #D's record was reviewed on 11/09/15 at 11:04 a.m. The resident's diagnoses included, but were not limited to, after care knee joint replacement and congestive heart failure.</p> <p>A Physician's Order, dated 09/22/15, indicated Nystatin (anti-fungal) cream was to be applied to the resident's abdominal folds twice a day.</p> <p>The Treatment Administration Record (TAR), dated 09/15, indicated there were no initials to indicate the treatment for the Nystatin cream to the abdomen was completed as ordered by the Physician on the 3 p.m. to 11 p.m. shift on September 23, 24, 25, 26, 28, 29, and 30, 2015.</p> <p>During an interview on 11/10/15 at 12 p.m., the Skilled Unit Manager indicated the Nystatin cream had not been given as ordered due to there were no initials on the TAR.</p> <p>This Federal Tag relates to complaint IN00185872.</p>		<p>audit tool, designated licensed nurses completed facility-wide audits of treatment records by 11/19/15 to identify any lack of documentation that treatments were provided as ordered by the physician as indicated by the nurses initials on the treatment record and address any identified concerns. 3. Education specific to documentation requirements for treatments ordered by the physician and provided to the resident was developed by the Staff Development Coordinator and the Director of Nursing and presented to licensed nurses by 12/9/15. 4. The DON and/or designees will utilize the Treatment Record Audit tool to monitor treatment record documentation seven days per week for six months to ensure treatments were provided as ordered. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95% accuracy. After six months, if audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN</p>	

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F 0309 SS=G Bldg. 00	<p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary care and services to residents, related to not assessing the cause for the resident's increased pain and treating a resident's increased pain, after the Physician had decreased the resident's pain medication, the resident was moaning and groaning through out therapy treatments and was unable to tolerate the therapies as ordered due to the pain for 1 of 3 residents reviewed for therapy (Resident # D). The facility also failed to assess skin excoriations for 2 of 3 residents reviewed for excoriations, in a total sample of 6. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. Resident #D's record was reviewed on 11/09/15 at 11:04 a.m. The resident's</p>	F 0309	<p>12/9/15</p> <p>F 309 1. Documentation is present in the clinical record for resident "G" indicating that her skin excoriation was assessed and the responsible party and physician were notified of the area and the treatment plan on 11/10/15. Resident "D" is no longer a resident in the facility. The Physical Therapist and the Social Services Designee were educated on the need to ensure prompt communication with licensed nursing staff regarding any complaints of resident pain by 11/11/15. 2. Utilizing the Pain Assessment tool/Skin Assessment records, a facility-wide audit was completed by 11/23/15 by designated nurses to identify resident pain and/or excoriation and evaluate the current pain management plan/treatment plan. The nurse documenting the physician order for a treatment change on</p>	12/09/2015

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	<p>diagnoses included, but were not limited to, after care knee joint replacement and congestive heart failure.</p> <p>A 5-Day Minimum Data Set (MDS) assessment, dated 09/29/15, indicated the resident's cognition was moderately impaired, required extensive assistance with bed mobility, transfers, toileting, and hygiene, had pain frequently rated 8 out of 10 on a scale of 1-10, received Occupational Therapy for 6 days and Physical therapy for 7 days.</p> <p>A Physician's Orders, dated 09/22/19 (re-admission date from knee surgery), indicated Duragesic patch (narcotic pain medications) 25 mcg (micrograms), change patch every 72 hours and oxycodone-acetaminophen (narcotic pain medication) 10 mg (milligrams)- 325 g mg every four hours as needed for pain rated 5-10.</p> <p>A Physician's Progress Note, dated 09/23/15, indicated the resident had a "redo" of a right knee replacement with post operation infection in the knee, and the plan included pain control.</p> <p>A Physician's Order, dated 09/25/15, indicated to increase the Duragesic patch to 50 mcg, every 72 hours.</p>		<p>resident "G" was educated to include an assessment of the excoriation and contact with physician and POA in her charting on 11/24/15. 3. Education indicating the appropriate action to take when residents complain of pain and/or have a change in condition or changes in the treatment plan was developed by the Staff Development Coordinator and the Director of Nursing and will be presented to departments by 12/9/15. Education was also developed by the Staff Development Coordinator and the Director of Nursing specific to the facility Pain Management Policy and documentation requirements for changes in condition to be presented to licenses nurses by 12/9/15. 4. The DON and/or designees will utilize the Pain Management audit tool and Skin audit tool to review 24 hour reports, MD orders, progress notes and Interdisciplinary Communication data seven days per week for six months to ensure that resident pain/changes in condition/changes in the treatment plan are addressed per policy. The DON or designee will analyze trending data monthly and present a report of her findings at the monthly QAQI meetings and action plans developed for any negative trends. The criteria for determining that monitoring is no longer necessary will be 95%</p>	

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	<p>The Medication Administration Record, dated 09/15, indicated the resident received the oxycodone-acetaminophen for pain of the right lower extremity on the following dates:</p> <p>09/22/15 at 8 p.m. for pain rated at 7 and the medication was effective</p> <p>09/23/15 at 6 a.m. for pain rated at 7 and the medication was effective</p> <p>09/23/15 at 8:30 p.m. for pain rated at 8 and the medication was effective</p> <p>09/24/15 at 8 a.m. for pain rated at 8 and the medication was effective</p> <p>09/24/15 at 1 p.m. for pain rated at 8 and the medication was effective</p> <p>09/24/15 at 8 p.m. for pain rated at 8 and the medication was effective</p> <p>09/25/15 at 10 a.m. for pain rated at 8 and the medication was effective.</p> <p>A Physician's Order, dated 09/28/15 indicated to decrease the Duragesic patch to 25 mcg every 72 hours and discontinue the oxycodone-acetaminophen for pain. There were no other as needed pain medications ordered.</p> <p>Physical Therapy Treatment Notes, dated 09/23/15 through 10/01/15, indicated the resident was treated for therapeutic exercise, neuromuscular re-education and therapeutic activities.</p> <p>Physical Therapy Notes indicated:</p>		<p>accuracy. After six months, if audits do not meet this criteria, audits shall continue at the same schedule for an additional six months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN 12/9/15 THIS F-TAG IS BEING DISPUTED WITH A REQUEST FOR AN INFORMAL DISPUTE RESOLUTION FACE-TO-FACE HEARING TO REDUCE THE SCOPE AND SEVERITY OF THIS CITATION FROM A "G" RELATED TO PAIN AS ACTUAL HARM DUE TO EVIDENCE IN THE CLINICAL RECORD THAT INDICATES RESIDENT "D" WAS NOT EXPERIENCING SIGNIFICANT PAIN. WHILE THERAPY NOTES REFERRED TO "MOANING AND GROANING" DURING THERAPY SESSIONS, THE THERAPIST MAINTAINS AND HAS PROVIDED A SIGNED STATEMENT THAT THIS WAS NOT EVIDENCE OF PAIN, BUT RATHER FRUSTRATION AND LACK OF DESIRE TO PARTICIPATE IN THERAPY. IN RESPECT TO THE SOCIAL SERVICE DESIGNEE'S PROGRESS NOTE DATED 9-29-15, THIS DATA WAS PROVIDED IN RESPONSE TO MDS QUESTIONS DESIGNATED TO DETERMINE IF SYMPTOMS OF DEPRESSION WERE</p>	

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	<p>09/29/15- "...patient constantly moaning and groaning through tx (treatment) session..." The Note indicated the resident had 30 total minutes of therapeutic exercise and no neuromuscular re-education and therapeutic activities.</p> <p>09/30/15- "...patient constantly moaning and groaning through tx session. Refusing to perform any exer (exercise) stating she cant (sic)...Patient is unable to complete home program stating she cant (sic) doing anything today." The Note indicated the resident had 42 minutes of therapeutic exercise and no neuromuscular re-education and therapeutic activities.</p> <p>10/01/15- "...patient constantly moaning through the tx session. Refusing to perform any exer stating she cant (sic)..." The Note indicated the resident had 40 total minutes of therapeutic exercise and neuromuscular re-education and no therapeutic activities.</p> <p>A Nurses' Progress Note, dated 09/29/15 at 2:23 a.m. (resident in bed), indicated the resident had no complaints of pain or discomfort.</p> <p>A Nurses' Progress Note, dated 09/29/15 at 11:20 a.m., indicated the resident's</p>		<p>OBSERVED. DUE TO THE FACT THAT THE SOCIAL SERVICE DESIGNEE DOES NOT HAVE A NURSING BACKGROUND, SHE LACKS CLINICAL KNOWLEDGE TO ASSESS FOR PAIN AND COULD HAVE INTERPRETED RESIDENT "D's" RESPONSE AS INDICATING PAIN CAUSED HER FATIGUE, POOR APPETITE AND LACK OF SLEEP. SHE IS DIAGNOSED WITH DEPRESSION RELATED TO CHRONIC ILLNESS, PROLONGED RECOVERY FROM HER INTIAL KNEE REPLACEMENT SURGERY, INFECTION AND EXPLANTATION WITH A SUBSEQUENT REDO OF HER KNEE REPLACEMENT AT THE AGE OF 79. ON HER INITIAL ADMISSION PASRR SCREENING FORM LACK OF MOTIVATION AND WORRIES WERE IDENTIFIED AS SIGNS OF DEPRESSION. IN ADDITION, HER FAMILY HAD DECIDED TO HAVE RESIDENT "D" DISCHARGED HOME WITHIN THE NEXT FEW DAYS AFTER HER MEDICARE STAY DUE TO FINANCIAL CONCERNS AND THIS LIKELY CAUSED RESIDENT "D" TO FEEL OVERWELMED. PER RECORD REVIEW, RESIDENT "D" WAS RECEIVING DAILY NARCOTIC ANALGESICS AS ORDERED FOR PAIN THROUGH 9/24/15; HOWEVER,</p>	

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	<p>pain had not been assessed.</p> <p>A Social Service Note, dated 09/29/15 at 2:03 p.m., indicated, "...Resident stated that she has had trouble with sleeping due to pain. Resident stated that she has been feeling tired due to lack of sleep relating to pain. Resident stated that she has had poor appetite due to not being hungry relating to pain..." The Progress note did not indicate Nursing had been notified of the resident's concerns about the pain.</p> <p>A Nurses' Progress Note, dated 09/30/15 at 7:16 a.m. (resident in bed), indicated the resident had no complaints of pain or discomfort.</p> <p>A Nurses' Progress Note, dated 09/30/15 at 3:22 p.m., indicated the resident's pain had not been assessed.</p> <p>A Physician's Progress Note, dated 09/30/15, indicated the resident had increased complaints of pain from skin excoriation.</p> <p>A Nurses' Progress Note, dated 10/01/15 at 2:23 a.m. (resident in bed), indicated the resident had no complaints of pain or discomfort.</p> <p>A Nurses' Note, dated 10/01/15 at 3:09 p.m., indicated the resident complained</p>		<p>RESIDENT "D" HAD NOT REQUESTED ANALGESICS FROM 9/25/15 THROUGH 9/29/15 WHEN HER PRN OXYCODONE APAP ORDER WAS DISCONTINUED. UPON IDENTIFICATION OF PAIN TO HER PERINEAL AREA FROM URINE IRRITATING EXCORIATED SKIN, THE PHYSICIAN ORDERED AN INDWELLING CATHETER TO MANAGE OVERFLOW INCONTINENCE AND ZINC OXIDE WAS ORDERED TO THE PERINEAL AREA. IT IS FURTHER NOTED THAT THE AREA IDENTIFIED AS THE SOURCE OF HER PAIN WAS NOT HER ABDOMINAL FOLDS THEREFORE THE LACK OF CONFIRMATION THAT THIS PRESCRIBED TREATMENT WAS ADMINISTERED TO HER ABDOMINAL FOLDS WAS NOT A FACTOR RELATED TO HER PERINEAL DISCOMFORT.</p> <p>ATTACHMENTS: 1) THERAPIST STATEMENT 2) PHYSICIAN PROGRESS NOTES DATED 9/30/15 3) CATHETER ASSESSMENT DATED 9/30/15 4) PASRR PRESCREENING ASSESSMENT DATED 6/16/15 5) DEPRESSION SCREEN COMPLETED 6/16/15 6) MDS SECTION D DATED 9/29/15 7) TREATMENT SHEETS FOR SEPTEMBER IT IS OUR CONTENTION THAT RESIDENT</p>	

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	<p>of pain to the buttock. There was no assessment of the intensity of the pain.</p> <p>During an interview on 11/09/15 at 2:42 p.m., Physical Therapist #4 indicated the resident was, "ok" the first few minutes of the therapy then she would start moaning. The Physical Therapist indicated the resident was taken back to her room and she had informed the Nurse and the Social Service Director about the resident's moaning. She indicated she had informed the Nurse who was scheduled to take care of the resident, but was unable to provide a name. She indicated she had felt the moaning and groaning was more about the resident giving up and not pain.</p> <p>During an interview on 11/09/15 at 3:17 p.m., The Social Service Director indicated she had "stepped in" to encourage the resident. The Social Service Director indicated she had spoken to the resident's daughter about therapy and pain management prior to the moaning and groaning, and the daughter had wanted the resident to have less pain medications so the facility notified the Physician to decrease the pain medication. The Social Service Director indicated the resident had said the moaning was due to the wound on her buttock. the Social Service Director</p>		<p>"D" WAS PROVIDED AN APPROPRIATE PAIN MANAGEMENT PLAN. PAIN POST SURGERY WAS MANAGED WITHOUT THE NEED FOR PRN MEDICATION AFTER 9/24/15 PER DOCUMENTATION ON THE MAR. PAIN RELATED TO DISCOMFORT FROM PERINEAL IRRITATION WAS ADDRESSED WITH A TREATMENT PLAN THAT INCLUDED TOPICAL OINTMENT AND A CATHETER TO MANAGE OVERFLOW INCONTINENCE. THEREFORE, THE RESIDENT DID NOT EXPERIENCE "ACTUAL HARM" AS OUTLINED WITH THE F309 TAG.</p>		

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	<p>indicated she had informed the Nurse about the pain.</p> <p>During an interview on 11/10/15 at 12 p.m. with the Skilled MDS Coordinator, RN #5, the Skilled Unit Manager, the Social Service Assistant, and the Director of Nursing (DoN), the DoN indicated the resident had a Duragesic patch and was not sure if the resident realized she was moaning and groaning. The DoN indicated Physical Therapy had not informed the Nurse about the moaning and groaning and there had not been an assessment for the moaning and groaning. RN #5 indicated the resident had not been eating as well as she usually did. The Skilled Unit Manager indicated she had not been informed about the increased signs and symptoms of the pain. RN #5 indicated the Physician had assumed the pain was due to the knee surgery when he came in to see the resident on 09/30/15, and the resident had told him it was due to the excoriation on her buttock. RN #5 indicated the Physician had decreased the Duragesic patch due to the resident was lethargic. The Social Service Assistant indicated the family did not want the narcotic pain medications for the resident due to it made the resident, "loopy".</p> <p>A facility policy, dated 03/07, titled,</p>			

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	<p>"Pain Management Protocol", received from the DoN as current, indicated, "...To control/manage the pain a resident may be experiencing due to any disease process or an identified cause...Nursing staff will monitor and document the effectiveness of the pain management program in the resident medical record...as appropriate for the resident condition...Each resident who has been identified to have pain will have their pain assessed at least once per shift...Documentation of this assessment and vital signs will be placed on the Pain Flow Sheet..."</p> <p>An Initial Data Collection Tool, dated 09/22/15, indicated the resident had redness of the right leg and abdominal folds, bruises of the arms, surgical incision of the right knee, abrasion of the left buttock and a superficial pressure sore of the left buttock. Excoriated skin was checked, with no area indicated.</p> <p>A Physician's Order, dated 09/22/15, indicated zinc oxide cream (barrier) was to be used on the buttocks every shift and Nystatin (anti-fungal) cream was to be applied to the resident's abdominal folds twice a day.</p> <p>Nurses' Progress Notes, dated 09/23/15 at 2:32 a.m. through 09/26/15 at 4:03 a.m.,</p>			

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	<p>indicated an assessment of the resident's excoriation and abdominal fold redness had not been completed.</p> <p>A Nurses' Progress Note, dated 09/27/15 at 12:29 a.m., indicated treatments to the buttocks continued.</p> <p>Nurses' Progress Notes, dated 09/27/15 at 1:56 p.m. through 09/29/15 at 6:28 a.m. indicated an assessment of the resident's excoriation and abdominal fold redness had not been completed.</p> <p>A Nurses' Progress Note, dated 09/29/15 at 11:20 a.m., indicated treatment continued to the excoriation with each brief change.</p> <p>A Nurses' Progress Notes, dated 09/29/15 at 1:34 p.m., indicated an assessment of the resident's excoriation and abdominal fold redness had not been completed.</p> <p>A Physician's Progress Note, dated 09/30/15, indicated the resident had increased complaints of pain from skin excoriation of the buttocks and perineal regions.</p> <p>A Nurses' Progress Note, dated 09/30/15 at 3:22 p.m., indicated the Physician had examined the resident on rounds.</p>			

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	<p>A Nurses' Progress Note, dated 09/30/15 at 11:31 p.m., indicated an assessment of the resident's excoriation and abdominal fold redness had not been completed.</p> <p>A Nurses' Progress Note, dated on 10/01/15 at 3:09 p.m. indicated the resident was at an appointment with the Orthopedic Physician, outside of the facility.</p> <p>A Nurses' Progress Note, dated 10/01/15 at 3:26 p.m., indicated the resident had been transferred to the hospital Emergency Room from the Physician's office</p> <p>A Nurses' Progress Note, dated 10/01/15 at 11:38 p.m., indicated the resident was admitted into the hospital with sepsis and pneumonia.</p> <p>The Weekly Skin Integrity Data Collection form, dated 09/24/15 indicated the resident had right and left upper extremity bruises, a superficial pressure area on the left buttock and a surgical incision to the right knee. Excoriation of the skin had not been identified.</p> <p>The Weekly Skin Integrity Data Collection form, dated 10/01/15, indicated the resident had bruises on the right and left arms and left breast area,</p>			

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	<p>and incision on the right leg and redness of the buttocks and peri-area with treatment. There was not a thorough assessment of the redness of the buttock and peri-area.</p> <p>During an interview on 11/10/15 at 12 p.m. with the Skilled MDS Coordinator, RN #5, the Skilled Unit Manager, the Social Service Assistant, and the Director of Nursing (DoN), the Skilled MDS Coordinator indicated on the Admission Assessment, the excoriation box was checked but it was not indicated on the form where the excoriation was. The Skilled Unit Manager indicated there had not been an assessment of the redness of the resident's groin. The Skilled Unit Manager indicated she could not find an assessment of the resident's excoriation. RN #5 indicated she had looked at the excoriated area and the redness of the groin, but had not documented an assessment.</p> <p>2. Resident #G's record was reviewed on 11/09/15 at 2:51 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia.</p> <p>The Initial Data Collection Tool, dated 10/10/15 at 3 p.m., indicated the resident's skin was warm and intact, had a bruise on the right inner arm, and an</p>			

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	<p>incision on the right hip. The area for excoriated skin was not checked, which indicated the resident had no excoriated skin.</p> <p>A Physician's Order, dated 10/14/15, indicated an order for Calmoseptine ointment (moisture barrier) to excoriation on the inner thighs every shift until healed.</p> <p>The Nurses' Notes, dated 10/14/15, at 2:06 p.m. and 6:32 p.m., indicated the excoriation of the inner thighs had not been assessed.</p> <p>The Nurses' Progress Notes, dated 10/15/15 through 11/06/15, indicated the excoriation of the inner thighs had not been assessed.</p> <p>A Weekly Skin Integrity Data Collection form, dated 10/17/15, indicated the resident had a bruise on the right arm and was right hip post-op (operation). The area for rash, redness, and other had been left blank, which indicated the resident had no other skin concerns.</p> <p>The Weekly Skin Integrity Data Collection form, dated 10/23/15, indicated a bruise on the right arm and right hip post-op. The area for rash, redness, and other had been left blank,</p>			

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	<p>which indicated the resident had no other skin concerns.</p> <p>The Treatment Administration Records, dated 10/14/15 through 10/31/15 and 11/01/15 through 11/11/15, indicated the Calmoseptine ointment had been applied as ordered every shift</p> <p>A Physician's Order, dated 11/03/15, indicated an order for Nystatin cream (anti-fungal) to the excoriated areas on the groin and peri-area every shift.</p> <p>The Nurses' Notes, dated 11/03/15 at 3:15 a.m. and 10:26 a.m., indicated the excoriated areas on the groin and peri-area had not been assessed.</p> <p>The Nurses' Notes, dated 11/04/15 through 11/06/15 indicated the excoriated areas on the groin and peri-area had not been assessed.</p> <p>The Weekly Skin Integrity Data Collection form, dated 11/06/15, indicated a right hip healing surgical incision and redness of the peri-area.</p> <p>A Nurses' Note, dated 11/07/15 at 3:24 p.m., indicated, "...Per-area with excoriation barrier cream applied..."</p> <p>During an interview on 11/10/15 at 8:31</p>			

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	<p>a.m., the ADoN (Assistant Director of Nursing), indicated the excoriation areas had not been assessed.</p> <p>During an observation on 11/10/15 at 8:54 a.m., Resident #G was transferred from the wheelchair to the bed by CNA #1, QMA #2, and Physical Therapy Aide #3. CNA #1 and QMA #2 provided incontinence care to the resident. During the observation, the ADoN indicated the resident's peri-area and inner thighs were bright reddish/pink.</p> <p>During an interview on 11/10/15 at 9:24 a.m., the ADoN indicated the area of excoriation was over 10 centimeters.</p> <p>An undated facility policy, titled, "Post-admission Weekly Skin Assessments", received from the Director of Nursing as current on 11/10/15 at 10:23 a.m., indicated, "...On a weekly basis, a licensed professional searches for areas of skin that differ from surrounding tissue...The results of the skin assessment are documented on the Weekly Skin Integrity Data Collection form..."</p> <p>This Federal Tag relates to complaint IN00185872.</p> <p>3.1-37(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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