

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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F000000	<p>This visit was for the Investigation of Complaint IN00160337.</p> <p>Complaint: IN00160337 Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: December 10 & 11, 2014</p> <p>Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940</p> <p>Survey Team: Mary Jane G. Fischer RN TC</p> <p>Census Bed Type: SNF/NF: 150 Total: 150</p> <p>Census Payor Type: Medicare: 16 Medicaid: 101 Other: 33 Total: 150</p> <p>Sample: 6 Supplemental Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this Provider of any conclusion set forth in the statement of deficiencies. This Provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review for paper compliance in lieu of post survey visit on or after January 2, 2015.	

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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F000309 SS=D	<p>16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on December 16, 2014.</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 record review and interview the facility failed to ensure a resident's pain was managed effectively and failed to provide physician ordered medication in anticipation of a resident who had advanced cancer and a subsequent resident with a recent surgical incision. This deficient practice affected 2 of 4 residents reviewed for pain in a sample of 6. (Residents "C" and "A").</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 12-10-14 at 11:15 a.m. Diagnoses included, but were not limited to, advanced cancer, hepatitis C, cachexia and chronic obstructive pulmonary</p>	F000309	F309 - It is the consistent practice of this Provider to ensure each residents pain is managed and provides physician prescribed medication as ordered. I. What action the facility did to correct the alleged deficient practice for each client cited in the deficiency Resident C - no longer resides at facility Resident A - no longer resides at facility II. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents have the potential to be affected by the alleged practice. DNS/Designee reviewed	01/02/2015			

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	<p>disease. These diagnoses remained current at the time of the record review.</p> <p>At the time of admission the resident had physician orders for "Percocet [A Schedule 2 controlled pain medication], two tablets every four hours as needed for severe pain and a Fentanyl patch [A schedule 2 controlled pain medication], 1 patch every three days for chronic pain."</p> <p>A review of the Medication Administration Record for December 2014, indicated the last time the resident received the Percocet medication for pain control was on 12-09-14 at 9:00 a.m.</p> <p>A review of the Progress Notes, dated 12-09-14 at 1:30 p.m., indicated, "Resident is becoming less coherent. Resident is not oriented to time or place. Resident is very lethargic. Oxygen saturation is very low. NP [Nurse Practitioner] was notified and orders written."</p> <p>A review of the Physician Progress Note, dated 12-09-14 indicated the resident had stage 4 lung cancer with pain. "Spoke with [family member - POA [Power of attorney] - main goal of care is comfort. Increase Oxygen. Will leave script for prn [as needed] Roxanol and Ativan if needed."</p>		<p>residents who have narcotics prescribed for pain to ensure residents received medication as prescribed. DNS/Designee reviewed residents who had moderate to severe pain to ensure residents with pain were managed and controlled. Nursing staff re-educated on Providers pain policy/program. Nursing staff re-educated on December 30, 2014 by DNS/CEC on ordering of medications - including narcotics and use of EDK when meds not immediately available. III. Describe systemic changes the facility has made or will make to ensure that the alleged deficient practice does not recur. Licensed nursing completed Pain Assessments on residents by January 2, 2015. DNS/designee will review all new admissions to ensure residents receive pain medication as prescribed. Nursing staff were re-educated on pain policy, ordering of medications - including narcotics and use of EDK when medications are not immediately available. IV. Describe how the corrective actions will be monitored to ensure the alleged deficient practice will not recur To ensure compliance the Pain CQI will be completed by the DNS/Designee weekly x 4 weeks then monthly x 6. The result of these audits will be reviewed by the CQI committee overseen by the ED. If</p>				

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	<p>A review of the resident's record indicated the resident had the physician order dated 12-09-14 at 11:00 a.m., to "Increase O2 [oxygen] to 5 L [liters] per minute nasal cannula continuously for comfort. Roxanol [a controlled Schedule 2 narcotic use for pain] .5 ml [milliliters] every 30 minutes prn [as needed] for pain/air hunger. Lorazepam [a antianxiety medication] Intensol 0.25 ml SL [sublingual] every hour as needed for anxiety/restlessness."</p> <p>The original prescriptions for both medications were included in the residents record. A hand written notation at the right upper corner indicated, "Please send with auth [authorization] code."</p> <p>During an interview on 12-10-14, a concerned family member indicated, "We've been pleased except for last night [12-09-14] when we couldn't get the Morphine she needed [in regard to Resident "C"]. She was in a lot of pain and it took a long time to get the medication, my sister was very upset by the whole thing."</p> <p>During this interview the Unit Manager was in attendance and indicated there was a problem with obtaining the</p>		a threshold of 95% is not achieved, an action plan will be developed to assure compliance.				

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	<p>authorization code from the pharmacy in order to administer the pain medication to the resident. The Unit Manager indicated eventually she had to contact the nurse practitioner for intervention.</p> <p>Further review of the December 2014 Medication Administration Record indicated the resident received the Lorazepam at 8:19 p.m., and a review of the Emergency Drug Kit form for the removal of medications, dated 12-09-14, indicated the resident did not receive the pain medication Roxanol, until 7:45 p.m.</p> <p>A communication letter from the Pharmacy, dated 12-10-14, indicated "After looking into this, we received a fax [facsimile] for [name of Resident "C"] Ativan [Lorazepam] and Morphine [Roxanol] at 6:33 p.m. [12-09-14]."</p> <p>The nursing staff failed to ensure the resident had the prescribed pain medication for management of pain, until 7.5 hours after the Nurse Practitioner provided the nursing staff with orders for pain management/comfort.</p> <p>During an interview on 12-11-14 at 9:30 a.m., the Director of Nurses indicated the nurse thought she had faxed the prescription to the pharmacy but "we don't have proof of that. The nurses</p>			

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	<p>should fax the orders right away. I think her thought was that the resident was sleepy around 2:00 p.m., so she [Resident "C"] wouldn't need it."</p> <p>During an interview on 12-11-14 at 9:50 a.m., Licensed Nurse #3 indicated, "that day [12-09-14] she [Resident "C"] started doing worse. I called the NP and got orders. I remember she [Resident "C"] had a fall and she seemed to decline after that. On Tuesday [12-09-14] she started struggling with pain and I put the orders in the computer. I thought I faxed them to the pharmacy. I reported off to the evening shift nurse. I know she was trying to get the meds. [medications] and the authorization code. When we fax something we will get a form that tells us if the pharmacy received the fax or prescription."</p> <p>During an interview on 12-11-14 at 8:20 a.m., Licensed Nurse #5 indicated, "We usually receive the order and then call the NP to verify them. After they are verified the orders are entered into the computer. They automatically fax to the pharmacy. If there is a prescription for controlled meds we have to fax the hard script to the pharmacy. Then we actually have to wait for confirmation and the code to get in to the EDK [Emergency Drug Kit]."</p>						

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	<p>2. The record for Resident "A" was reviewed on 12-10-14 at 8:45 a.m. Diagnoses included, but were not limited to, history of lung cancer, osteoarthritis, chronic obstructive pulmonary disease and a recent total hip replacement surgery. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility physician orders included Oxycodone HCL [a Schedule 2 controlled pain medication], 5-325 mg [milligrams] - two tablets as needed for mild - moderate pain." A handwritten notation adjacent to the order from the discharging hospital indicated "will give 2 tabs [tablets] at 5:35 p.m., just prior to leaving the hospital."</p> <p>The hard copy of the original prescriptions were included with the discharge summary.</p> <p>A review of the Resident Progress Note, dated 11-14-14 at 9:37 p.m., indicated the resident "arrived at facility at 9:10 p.m. Writer came into room to meet and assess resident and resident requested I work on her meds first so her pain medicine would be available sooner. I did as resident requested after orienting her to the call light and making sure she had no</p>			
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	<p>needs at the moment."</p> <p>During an interview on 12-11-14 at 9:50 a.m., Licensed Nurse # 3 indicated "Yes I took care of her. She was admitted on Friday night and I worked the next day on the day shift. She said she was in pain. I had to fax the prescription to the pharmacy and get the authorization code. Pain was her main thing."</p> <p>During an interview on 12-10-14 at 12:20 p.m., the resident indicated, "I'm not a narcotic person but I needed my pain medications to be available. I finally received it after 11 hours. They could have called the NP or the Doctor to get the orders they needed for me. The pain medication should have been there but they didn't get it until the next day."</p> <p>A review of a notation from the local area pharmacy, dated 12-11-14 indicated the Pharmacy did not receive the "hard copy of the script" until 11-15-14 at 6:58 a.m., approximately 9 hours after the resident was admitted to the facility. A review of the November 2014 Medication Administration Record indicated the resident received the pain medication at 8:13 a.m., due to complaints of moderate right knee pain.</p> <p>A review of the Nurse Practitioner</p>						

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	<p>notation, dated 11-16-14 indicated the resident had "chronic pain," the the pain medication was increased from "as needed" to a scheduled medication every four hours.</p> <p>3. A review of the facility policy on 12-11-14 at 8:00 a.m., and titled "Pain Management," dated as revised 09-2013, indicated the following:</p> <p>"Policy: It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication , while keeping the resident as comfortable and pain free as possible."</p> <p>4. A review of the facility policy on 12-11-14 at 11:10 a.m., titled "Nursing Admission /Return Admission Procedure," dated as revised 06-2013, indicated the following:</p> <p>"Purpose: To provide a baseline and accurate documentation of the mental and physical condition of each resident admitted or readmitted to the facility and to assist the resident and family with</p>				

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	<p>adjusting to the facility. Admission procedures will be followed for all new admissions including respite care."</p> <p>"Physician orders: 1. Upon admission, physician orders must be obtained. 2. Transcribe the admission orders from the original orders sent from the hospital or physician's office. 3. Transcribe PRN medication orders to include dosage, route, frequency, and reason for use."</p> <p>"Verification of orders: The admitting nurse must call the attending physician to verify all orders upon admission."</p> <p>"Pharmacy notification: Pharmacy notified of new admit/readmit."</p> <p>5. A review of the Pharmacy Policy and Procedure Manual, on 12-11-14 at 2:40 p.m., instructed the nursing staff as follows:</p> <p>"Ordering Controlled/Scheduled 2 Medication"</p> <p>"Purpose: to establish guidelines regarding controlled/scheduled medications in accordance with federal and state regulations."</p> <p>"Procedure: Schedule 2 medications require a specific ordering procedure</p>			

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F000314 SS=D	<p>which is different than that for all other medications. The pharmacy is able to send Schedule 2 substances to the facility ONLY when the pharmacy has a valid prescription signed by the prescriber. When ordering a new Schedule 2 medication, the prescriber must write a separate prescription and fax the prescription to the pharmacy, prior to the scheduled 2 medication being delivered to the facility, except in an emergency situation.</p> <p>This Federal tag relates to Complaint IN00160337.</p> <p>3.1-37(a)</p> <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 observation, record review and interview the facility failed to ensure a resident received treatments for exiting pressure ulcers and failed to follow the facility policy in the treatment of pressure</p>	F000314	F314 - It is the consistent practice of this Provider to ensure residents receive treatments as ordered for existing pressures sores. I. What action the facility did to correct the alleged deficient	01/02/2015

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	<p>ulcers, in that when a resident had two pressures ulcers, the nursing staff failed to provide the treatment orders as indicated by the physician for 1 of 3 residents reviewed for wound care in a sample of 6 and failed to follow the facility policy for 1 of 4 supplemental sampled residents reviewed for wound care. (Resident "F" and "H").</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 12-11-14 at 11:45 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, and obesity. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's plan of care, dated 07-14-14 indicated the resident had "impaired skin integrity left ankle Stage 3 [full thickness tissue loss]." Interventions to this plan of care included, "Treatment as ordered."</p> <p>A subsequent plan of care, dated 09-23-14 indicated the resident had "impaired skin integrity right ankle - unstageable [full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed]." Interventions to this plan of care included, "Treatment</p>		<p>practice for each client cited in the deficiency Resident F - The resident dressing was immediately changed and dated as ordered. Nurse was provided 1:1 education regarding changing wound dressings as ordered. MD notified of wound and progress. Resident H - This resident wound dressing was changed timely as ordered. Nurse #3 just completed wound change. Nurse #3 followed up after surveyor rounds and properly dated the dressing per policy. Nurse #3 was provided 1:1 re-education regarding wound policy and proper dating of dressings. II. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and what actions the facility took to correct the deficient practice for any client the facility identified as being affected. All residents with physician orders for wound treatments and dressing changes have the potential to be affected by the alleged deficient practice. Wound rounds were completed by IDT (including RD, DNS, nursing managers and wound specialist) to ensure all treatments and dressings were changed and applied as directed by physician orders. Nursing staff completed skills validation for dressing changes. III. Describe systemic changes the facility has made or will make to ensure that the alleged deficient practice</p>				

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	<p>as ordered."</p> <p>The record indicated the resident was seen and treated by a local wound care specialist while at the facility.</p> <p>A review of the wound care specialist notations indicated the following:</p> <p>"Visit Report 12-02-14 - location: bilateral medial ankles. Duration: Present on admission 06-03-14; resolved briefly and reopened. Wound said to have been from surgical origin initially and thought to have reopened from friction from shoes. New open area to right inner ankle 09-21-14 (also said to have occurred from shoes). Modifying Factors: venous insufficiency with edema, DM [diabetes mellitus]. Wears his tubigrips. Patient states they 'feel and look better this week.'"</p> <p>"Wound left medial ankle is a Stage 3 pressure ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2.6 cm [centimeters] length by 1.5 cm width by 0.1 cm in depth. The wound is improving."</p> <p>"Wound right medial ankle is a necrotic tissue (unstageable) pressure ulcer and has received a status of Not Healed.</p>		<p>does not recur. Nursing staff re-educated on wound policy on Dec 30, 2014 by DNS and completed skills validation for dressing changes. Wound rounds will occur weekly by IDT team to ensure ongoing compliance of wound dressings and changes. DNS/Designee will review all residents with pressure wounds each day to ensure that treatments are provided as ordered and consistent with policy until compliance met. IV. Describe how the corrective actions will be monitored to ensure the alleged deficient practice will not recur Skills validation will occur monthly x 6 to ensure staff remain efficient with proper procedures. To ensure compliance the Wound CQI will be completed by the DNS/Designee weekly x 4 weeks then monthly x 6. The result of these audits will be reviewed by the CQI committee overseen by the ED. If a threshold of 95% is not achieved, an action plan will be developed to assure compliance.</p>		

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	<p>Subsequent wound encounter measurements are 0.6 cm in length by 0.7 cm in width by 0.1 cm in depth. The wound is deteriorating. There is a scant amount of sero-sanguineous drainage noted. General notes: debridement 12-02-14."</p> <p>The notation indicated the resident received debridement to the right medial ankle and the measurement post procedure were documented as "1.0 cm in length by 1.0 cm in width by 0.1 cm in depth."</p> <p>"Plan - left medial ankle - Iodosorb - cleanse wound(s) with NS [normal saline]. Pat dry. Apply Iodosorb to wound bed then cover with secondary dressing. Change daily and PRN [as needed], soiled. Apply tubigrips to bilateral lower extremities daily in a.m. and off at hs [bedtime]."</p> <p>"Right medial ankle - Iodosorb - cleanse wound(s) with NS [normal saline]. Pat dry. Apply Iodosorb to wound bed then cover with secondary dressing. Change daily and PRN [as needed], soiled. Apply tubigrips to bilateral lower extremities daily in a.m. and off at hs [bedtime]."</p> <p>"General notes: DC [discontinue] shoes - pt [patient] compliant with this."</p>			

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NAME OF PROVIDER OR SUPPLIER RIVERWALK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 295 WESTFIELD RD NOBLESVILLE, IN 46060
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	<p>"Visit Report 12-09-14 Wound left medial ankle is a Stage 3 Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2.6 cm in length by 1.3 cm in width by 0.1 cm in depth. There is a moderate amount of sero-sanguineous drainage noted which has no odor. The wound is improving."</p> <p>"Wound right medial ankle is a necrotic tissue (unstageable) pressure ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.9 cm in length by 0.7 cm in width by 0.2 cm in depth. There is a scant amount of sero-sanguineous drainage noted which has no odor. The wound is deteriorating."</p> <p>"Plan left medial ankle - Iodosorb - cleanse wound(s) with NS [normal saline]. Pat dry. Apply Iodosorb to wound bed then cover with secondary dressing. Change daily and PRN [as needed], soiled. Apply tubigrips to bilateral lower extremities daily in a.m. and off at hs [bedtime]."</p> <p>"Right medial ankle - Iodosorb - cleanse wound(s) with NS [normal saline]. Pat dry. Apply Iodosorb to wound bed then cover with secondary dressing. Change</p>			

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	<p>daily and PRN [as needed], soiled. Apply tubigrips to bilateral lower extremities daily in a.m. and off at hs [bedtime]."</p> <p>"Continue Iodosorb to left (improved). Right slightly larger (this is expected as are <sic> was debrided last week), plan resume enzymatic debridement with Santyl (treatment remains appropriate for current tissue type)."</p> <p>A review of the current physician orders indicated the following:</p> <p>"11-25-14 Iodosorb gel 0.9 % one application topical. Cleanse left inner ankle with normal saline and pat dry. Apply Iodosorb to wound bed. skin prep to periwound and cover and secure every day one time a day on day shift."</p> <p>"12-10-14 Santyl ointment one application topical. Cleanse wound to right ankle - pat dry. Apply Santyl to wound bed, cover with dry gauze and secure one time a day on day shift."</p> <p>An observation of the wounds and dressing changes were requested on 12-11-14 and the resident agreed.</p> <p>During an observation on 12-11-14 at 1:00 p.m., the following was noted:</p>			

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	<p>Left ankle - the nurse removed the tubigrip to the resident's lower leg. A dressing was observed on the left ankle and was dated 12-09-14. As the nurse removed the dressing a heavy thick yellow exudate was observed pouring from the ulcer and into the dressing. The wound care nurse indicated the ulcer remained a Stage 3 pressure ulcer and the measurements were currently 4.0 cm in length by 3.0 cm in width. The wound care nurse acknowledged the date on the dressing.</p> <p>Right ankle - the nurse removed the tubigrip to the residents lower leg. A dressing was observed on the right ankle and was dated 12-09-14. The ulcer had a yellow center and slight drainage was noted on the dressing. The wound care nurse measured the area and indicated the ulcer remained a Stage 3 ulcer and was 1.0 cm in length by 1.0 cm in width.</p> <p>On 12-11-14 at 1:40 p.m., the wound care nurse informed the Director of Nurses and the Administrator of the observations of the resident's ulcers and the date on the dressing. During an interview, the Director of Nurses acknowledged the wound to the left ankle had deteriorated since seen by the wound care specialist on 12-09-14.</p>			

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	<p>2. The record for Resident "H" was reviewed on 12-11-14 at 2:15 p.m. Diagnoses included, but were not limited to, dementia, hypertension, atrial fibrillation and septicemia. These diagnoses remained current at the time of the record review.</p> <p>The resident's record indicated the resident was admitted to the facility with a Stage 1 pressure ulcer - unstageable with eschar.</p> <p>A review of the resident's current plan of care, dated 11-25-14, indicated the resident had a "pressure wound to coccyx - admitted with." Interventions included "treatment as ordered."</p> <p>A review of the physician order, dated 11-24-14, instructed the nursing staff to apply "Santyl 250 unit per gram - one application topical two times a day at 9:00 a.m. and 5:00 p.m. Special instructions: cleanse area with normal saline and pat dry. Apply Veraseptine [barrier cream] to periwound. Santyl to wound bed. Cover with Hydrogel fluffed gauze and secure."</p> <p>During an observation on 12-11-14 at 2:00 p.m., the resident agreed to observe the dressing to the coccyx. The wound care nurse and staff nurse # 3 turned the</p>						

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	<p>resident to the right side. The resident had an undated dressing to the sacral area.</p> <p>A review of the facility skills validation policy on 12-11-14 at 2:20 p.m., titled "Dressing Change (Incision or Wound)," indicated the following: "16. Apply new dressing according to the physician orders." "17. Date and initial new dressing."</p> <p>This Federal tag relates to Complaint IN00160337.</p> <p>3.1-40(a)(2)</p>				