STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15E681		10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILDEGARD HEALTH CENTER INC	802 E 10TH ST FERDINAND, IN 47532

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F 0000 Bldg. 00	This visit was for Recertification and State licensure survey. Survey dates: October 5, 6, 7, 8, 2015 Facility number: 004429 Provider number: 15E681 AIM number: 200502439 Census bed type: NF: 17 Total: 17 Census payor type: Medicaid: 17 Total: 17 This deficiency also reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by #02748 on October 16, 2015.	F 0000	*Preparation and execution of this response and plan of correction does not constitute an 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. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual*	
F 0314 SS=G Bldg. 00	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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	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. Based on observation, interview, and record review, the facility failed to ensure a resident admitted to the facility without a pressure ulcer, did not develop a Stage 2 pressure ulcer and failed to ensure effective interventions were implemented to prevent the wound from deteriorating for 1 of 1 resident who met the criteria for review of pressure ulcers. This deficient practice resulted in Resident #5 experiencing a Stage 4 pressure ulcer. (Resident #5) Findings include: During an interview on 10/05/15 at 9:45 A.M., LPN #4 indicated Resident #5 experienced a facility acquired Stage 4 wound on the right upper mid back and required a wound vac. During an interview on 10/06/15 at 8:58 A.M., RN #2 indicated Resident #5 experienced a facility acquired wound on the right upper mid-back requiring the treatment of a wound vac. RN #2 then indicated the wound vac dressing would	F 0314	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Resident #5 was reassessed to include Wound Data Collection UDA October 8, 2015, and continues daily, Braden Scale on October 12, 2015, with a score of 17 and Wound RN Assessment UDA completed October 12, 2015, and continues weekly per policy. Resident #5 Care Plan was reviewed for appropriate interventions. The facility has continued use of pressure reducing devices as tolerated and accepted by resident in chairs, wheelchairs and in bed. **How will other residents, having the potential to be affected by the same deficient practice, be identified?** All residents have the potential to be affected by this deficient practice. All residents were re-assessed for risk of pressure ulcers. Braden Scales were completed on all 16 residents in the facility on October 13, 2015, and on one resident who returned to facility on October 14, 2015. 7 of 17 had a Braden score of 18 or lower. Skin Assessment UDA's were	11/07/2015

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	not be changed during the survey and the wound would not be available for observation. RN #2 further indicated, at that time, the wound was related to a pacemaker placement procedure performed to the left upper chest on 9/18/14. During an interview on 10/6/15 at 1:00 P.M., Resident #5 was observed sitting in a recliner with a horseshoe shaped pillow around a kyphotic area of the back. The back of the recliner was observed to be covered with sheepskin and a foam pillow was observed to not be in place on the back of the recliner. Resident #5 indicated, at that time, she experienced a wound on the kyphotic hump of her back, she utilized a wound vac, she was sitting on a foam pillow, and she could feel the kyphotic hump was in direct contact with the sheepskin surface of the recliner even with the horseshoe shaped pillow in place. Resident #5 further indicated, she was able to reposition self in the bed by using a grab bar, but was not physically able to completely lift the kyphotic hump off the surface of the bed during repositioning. The clinical record of Resident #5 was reviewed on 10/07/15 at 8:45 A.M. The record indicated Resident #5 was admitted to the facility on 5/6/08 with		completed on these 7 residents by October 23, 2015, and care plans were reviewed and updated if indicated. **What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur?** Re-education was provided by DNS for all licensed nurses on Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements Procedure, Care Planning and Learning Center Course Wound Assessment and Documentation on October 20, 2015. One prn nurse was not present, and re-education was completed October 23, 2015. DNS or designee will track pressure ulcers and report to QAPI Committee for further recommendation. **How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur?** The Director of Nursing or designee will audit the at risk residents for assessment, documentation and appropriate care plan interventions weekly x4 and monthly x3. Audits will be reviewed by the QAPI Committee at meeting for recommendations and if not 100% compliant x 3 months, committee will recommend further education and additional audits for another 3 months until 100% compliance is reached.	

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	diagnoses including, but not limited to, history of of sebaceous cyst, acquired postural kyphosis (an abnormally excessive convex curvature of the spine in the thoracic and sacral regions) and history of pressure ulcers to the kyphotic hump. The most recent Quarterly MDS assessment dated 6/15/15 indicated Resident #5 experienced no cognitive impairment, no rejection of care, required the extensive assistance of one staff for bed mobility and transfers, was at risk for the development of pressure ulcers, had a history of pressure ulcers, and experienced a, "...Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling..." that was not present upon admission/re-entry to the facility. The MDS assessment further indicated the wound measured that 3.0 cm [centimeters) X 1.5 cm X 0.5 cm and included, "...slough-yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous..." and the wound had worsened since the previous assessment. The most recent annual MDS assessment dated 8/31/15 indicated Resident #5			

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	experienced no cognitive impairment, no rejection of care, required the extensive assistance of one staff member for bed mobility and transfers, was at risk for the development of pressure ulcers, and experienced a facility acquired Stage 4 pressure wound. The Quarterly Braden Scale for Predicting Pressure Sore Risk assessments from 10/17/14 through 8/25/15 indicated Resident #5 was not at risk for the development of pressure ulcers. The Nursing Progress Notes from 9/18/14 at 9:00 A.M. through 9/18/14 at 3:45 P.M. indicated Resident #5 was away from the facility for 6.75 hours to have a pacemaker generator replaced in the left upper chest region. The notes lacked any documentation to indicate a skin assessment was performed upon the return of Resident #5 to the facility. The Nursing Progress Notes from 9/18/14 through 9/29/14 at 12:59 P.M. lacked any documentation a skin assessment was performed. A Nursing Progress Note dated 9/29/14 at 8:11 P.M. indicated, "...wound on back approx [approximately] 2 cm in circumference. Area is open with			

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	drainage present. Surrounding tissue is red and non blanchable. Drainage is serosanguinous. Wound is on thoracic spine [sic] is same place as healed wound..." The note lacked any documentation to indicate pressure relieving interventions to the right upper mid-back were implemented. The Nursing Progress Notes from 9/29/14 at 9:38 P.M. through 10/1/14 at 10:22 P.M. were reviewed any lacked any documentation to indicate pressure relieving interventions to the right upper mid-back were implemented. A Wound RN Assessment dated 9/29/14 indicated Resident #5 experienced a Stage 2 pressure ulcer on the right upper mid-back. The assessment lacked any documentation to indicate pressure relieving interventions to the right upper mid-back were implemented. (The skin impairment was observed 11 days after the pacemaker generator replacement in the left upper chest region) A Nursing Progress Note dated 9/30/14 at 6:49 P.M., indicated an order had been received for a Wound Care consultation. A Nursing Progress Note dated 10/1/14 at 1:30 P.M. indicated, "...This writer also			

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	examined wound to resident's back...Resident in recliner with u-shaped pillow inverted to back. When resident is lying back in recliner, this writer is able to place fingers back between the pillow and recliner. Very minimal contact between resident's back and the back of the recliner noted...Resident states she believes that the wound may have started from the camisoles that she wore after her pacemaker procedure..." (2 days passed before a pressure relieving intervention was implemented) An untimed Wound Care Center Progress note dated 10/8/14 indicated, "...seen for a mid back lateral wound that is secondary to trauma...The patient is at risk for developing a sore in this area secondary to...disposition, as well as pressure in this area..." A Wound Care Physician's Order form dated 10/8/14 at 9:30 A.M. indicated, "...Stage 3 pressure ulcer: mid-back complicated by imobility [sic], friction...Continue to utilize all pressure reduction measures, memory foam pillow to back while sitting up..." A Clinic Referral form dated 10/8/14 included, but was not limited to, orders for, "...continue with memory foam to back while in chair...offload..." The form			

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	included a handwritten notation dated 10:45 A.M. of, "noted" with the initials of RN #2. The Plan of Care dated 10/8/14 indicated Resident #5 had a history of skin impairment to the right upper back with a new interventions of, "...Make sure bras do not have a seam that could rub on back". The plan lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented. The Nursing Progress notes for 10/08/14 were reviewed and lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented. An RN Wound Assessment dated 10/09/14 indicated Resident #5 experienced a Stage 2 pressure wound to the right of the thoracic spine. The assessment lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented.			

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	A Nursing Progress note dated 10/11/14 at 8:41 P.M. indicated, "...states...trying to position self different in bed to help aliviate [sic]...any pressure to area on back..." A Nursing Progress note dated 10/22/14 at 1:55 P.M. indicated, "...addressed order of continuing to utilize all pressure reduction measures...Asked resident if [Resident #5] has been sleeping on ...back and...states...sleeps mostly on...side. Staff assists resident at hs [hour of sleep] to bed and positions ...on...side...uses the horseshoe shaped pillow to alleviate pressure...already has in place a pressure reducing mattress and a California fire code memory foam topper...has a memory foam pad to her chair in the dining room for meals and...wheelchair...Further discussion with nurse regarding [name of hospital]Physician Order Sheet that accompanied resident on 10/22 that stated that resident has a stage 3 pressure ulcer to mid back complicated by immobility and friction. This was the first time this diagnosis was seen by this writer and [name of RN #3]. Questioned this nurse as to why this was written now when [name of wound physician] wound care progress note on 10/8/14 stated that wound is secondary to trauma. (Resident had a generator change			

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	to...pacemaker...on 9/18/14 and developed the wound after procedure) Nurse stated it is listed as a stage [sic] 3 pressure ulcer on the 10/8/14 ...Physician Orders sheet written by the nurse. This writer stated that the 10/8 Physician's orders and the wound care center record were not sent to [name of facility] after that appointment. All [name of facility] received was [name of wound care physician] progress note. She stated she would fax the 2 documents to [name of facility] today. Also nurse stated that since the wound has slough over it, it is hard to determine the actual stage of the ulcer." The note lacked any documentation to indicate a memory foam pillow had been placed to backrest of the recliner or an intervention to reduce friction while repositioning in bed was implemented. A Care Plan dated 10/22/14 for, "...resident has potential for pressure ulcer development r/t [related to] requires assist to turn and reposition self..." with interventions of, "...Encourage/assist resident to use positioning bar on right side of bed...Provide pressure relieving device on bed and in chair...Notify nurse immediately of any new areas of skin breakdown, redness, blister, bruises, discoloration etc. noted during bath or daily care..." The plan lacked any			

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	documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented. A Care Plan dated 12/26/14 for "...Resident has actual impaired skin integrity R/T deep tissue injury secondary to surgical wound from pacemaker procedure..." included a new intervention of, "...Monitor location on right side of back for abnormalities and report to health care provider. Change dressing as ordered by physician, schedule appointments with wound center and arrange for transportation..." The plan lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented. A Care Plan dated 2/16/15 for, "...has actual impaired skin integrity pressure wound stage 3 r/t deep tissue injury secondary to surgical wound from pacemaker procedure and friction from bar". The plan lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction while repositioning in bed was implemented.			

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	A Wound Care Physician's Order form dated 5/27/15 at 10:00 A.M. indicated, "...Stage 4 pressure ulcer to mid-back... complicated by immobility, friction/shear..." A Wound Care Center Record dated 5/27/15 at 10:00 A.M. indicated, "...Wound #2...mid back spine...wound debrided down to joint capsule before blood/circulation achieved...off loading as before..." The Nursing Progress notes for 5/27/15 indicated Resident #5 was treated at the Wound Care Center and returned with new orders. The Progress notes lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction/shear while repositioning in bed was implemented. A Care Plan dated 6/25/15 for, "..has actual impaired skin integrity pressure wound stage 4 r/t etiology of deep tissue injury secondary to surgical wound from pacemaker procedure and friction from bra..." The plan lacked any documentation to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction/shear while repositioning in bed was implemented.			

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	During an interview on 10/7/15 at 9:30 A.M., the HFA (Health Facilities Administrator) indicated the Stage 4 wound on the right upper mid-back of Resident #5 was acquired after a surgical procedure was performed to left upper chest on 9/18/14. During an interview on 10/7/15 at 2:30 P.M., the DON (Director of Nursing) indicated no documentation could be provided to indicate a new pressure relieving intervention had been initiated after the discovery of the red area on the right upper mid back of Resident #5. During an interview on 10/08/15 at 8:15 A.M., the DON presented an Insurance Authorization Form dated 9/11/15 which indicated, "...Severe kyphosis with internal pressure being exerted on wound external pressure measures in place, has pressure reducing mattress with memory foam pad all chair used...have pressure reducing device in place.." During an interview, at that time the DON indicated, the horseshoe shaped pillow was not increasing the internal pressure on the kyphotic hump,and the memory foam pad was used on the mattress. During an interview on 10/08/15 at 11:27 A.M., the DON indicated Resident #5			

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	was at risk of pressure ulcer development r/t to kyphosis and limited mobility, The DON further indicated no documentation could be provided to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction/shear while repositioning in bed was implemented. During an interview on 10/8/15 at 11:00 A.M., the HFA indicated the facility followed the NPUAP (National Pressure Ulcer Advisory Panel) definitions and provided A Pressure Ulcer Stages/Categories resource. The resource indicated, "...Stage 1:...Intact skin with non-blanchable redness of a localized area usually over a bony prominence...may indicate "at risk" persons...Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sangiuinous filled blister...Stage 3: Full thickness tissue loss...Slough may be present but does not obscure the depth of tissue loss...Suspected Deep Tissue Injury...Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is			

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	painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detecting individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layer of tissue even with optimal treatment..." During an interview with on 10/8/15 at 11:15 A.M., the DON indicated Resident #5 was repositioned in bed with the extensive assistance of one staff, the use of a grab bar and pulling the upper body across the surface of the mattress. The DON further indicated Resident #5 would require the assistance of two staff to completely lift the kyphotic hump off the surface of the bed during repositioning. During an interview on 10/08/15 at 12:30 P.M., the HFA (Health Facilities Administrator) indicated no documentation could be provided to indicate an intervention of a memory foam pillow to back while sitting up or an intervention to reduce friction/shear while repositioning in bed was implemented. The most recent Wound Care Physician's			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILDEGARD HEALTH CENTER INC	802 E 10TH ST FERDINAND, IN 47532

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	Order form dated 9/30/15 at 10:30 A.M. indicated, "...Pressure Ulcer Stage 4...midback [sic]...all pressure reduction measures...continue...wound vac... The Guidelines for Pressure Ulcer Practice provided by the HFA on 10/08/15 at 11:30 A.M. indicated, "...Initial Risk Assessment ...Risk factors ...that increase a resident's susceptibility to develop or impact healing times of pressure ulcer. They include, but are not limited to: impaired/decreased mobility...history of a previous ulcer...Movement or Management of Tissue load...staff should implement resident-specific...positioning programs based upon an individualized assessment. This includes a consistent program for ...realigning the body ...Staff should collaborate with restorative nursing and therapy staff for resident presenting with positional challenges...staff should use support surfaces...to decrease ischemia of bony prominences..." The Policy and Procedure for Pressure Ulcers provided by the HFA on 10/08/15 at 11:30 A.M. indicated, "...will use prevention and assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition			

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	demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing..." 3.1-40(a)(1)			