

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155762	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/16/2015
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NAME OF PROVIDER OR SUPPLIER  FOREST PARK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 S L ST RICHMOND, IN 47374
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177421.</p> <p>Complaint IN00177421 -- Substantiated. Federal/State deficiencies related to the allegation are cited at F157, F282, F309 and F514.</p> <p>Survey dates: July 14, 15 and 16, 2015</p> <p>Facility number: 011387 Provider number: 155762 AIM number: 200853180</p> <p>Census bed type: SNF: 23 SNF/NF: 40 Residential: 21 Total: 85</p> <p>Census payor type: Medicare: 26 Medicaid: 29 Other: 9 Total: 64</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the isolated deficiencies cited during Indiana State Department of Health Recertification and State Licensure survey (date)2015. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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>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 interview and record review,</p>	F 0157	<b>Corrective actions accomplished for those</b>	08/15/2015

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	<p>the facility failed to ensure facility staff promptly notified the attending physician of a physician-ordered treatment not being readily available for a resident with a diabetic wound, for 1 of 3 residents reviewed for wounds in a sample of 4. This deficient practice has the potential to adversely affect the healing or improvement of a resident's wound area. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 7-14-15 at 5:35 p.m. Her diagnoses included, but were not limited to, uncontrolled diabetes, heel and midfoot ulcer (wound), morbid obesity and peripheral neuropathy. Review of Resident #B's physician orders indicated, on 6-29-15, a new order was received to modify the dressing change to her left foot to cleansing the wound with normal saline, then pack the ulcers with Dakin's Solution moistened gauze, then cover with dry gauze and secure with gauze wrap twice daily.</p> <p>In an interview with LPN #3 on 7-14-15 at 5:10 p.m., she indicated she had worked with Resident #B several times during her stay at the facility. She indicated she recalled approximately one week prior to Resident #B's transfer to</p>		<p><b>residents found to be affected by the alleged deficient practice:</b> Resident #B at time of survey was discharged from the facility.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> The Director of Health Services or Designee will audit all of the residents identified with wounds to ensure physician ordered supplies are in place to address their treatment.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Staff will be re-educated on the process to notify the physician if prescribed treatment is not available.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Resident with wounds will be reviewed during the Clinical Care Meeting once a week x 4 weeks, then monthly x 6 months to ensure residents with wound treatment orders have the proper treatment supplies and physician notification if treatment not available. The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assurance</p>				

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	<p>the local emergency room, the resident's dressing changes had been changed to one in which "Dakin's Solution" was to be used. LPN #3 indicated she recalled phoning the facility's pharmacy to inquire when the Dakin's Solution would be available, prior to being off of the work schedule for several days. She indicated the facility pharmacy indicated the solution was on back order and they were expecting to be available the following day. She indicated that since she could not locate the Dakin's Solution, she used normal saline in place of the Dakin's Solution. She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon documentation in the resident's Medication Administration Record (MAR), this would have occurred on/around 7-1-15, 2 days after the order had been issued.</p> <p>In an interview with RN #4 on 7-14-15 at 7:10 p.m., she recalled working with Resident #B, on 7-5-15, the evening before she was transferred to the local emergency room on 7-6-15. She indicated, "I do recall doing her dressing change to the heel. We did not have the Dakin's [solution] yet, so I used the normal saline." She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon interview</p>		Committee for a minimum of 6 months then randomly thereafter for further recommendation.		

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	<p>with RN #4 and documentation in the resident's Medication Administration Record (MAR), this would have occurred on 7-3-15, 4 days after the order had been issued, and/or 7-5-15, 6 days after the order had been issued.</p> <p>Review of the nursing notes did not reflect any documentation of the modification of the 6-29-15 dressing change order to substitute normal saline for the Dakin's Solution. The nursing notes did not reflect notification of the physician regarding the lack of Dakin's Solution and the substitution of normal saline for the Dakin's Solution.</p> <p>Review of Resident #B's MAR for July, 2015 indicated the dressing change to the left foot using the Dakin's Solution, dated 6-29-15, was conducted 9 times between 7-1-15 and 7-6-15, with one time not conducted as the resident was listed as "LOA," indicating she was on a leave of absence (out of the facility) and the second and third times, she was at the local hospital, as of early morning hours of 7-6-15. The MAR indicated LPN #3 signed off on this treatment, as ordered by the physician, on 7-1-15 for the evening shift and again on 7-5-15 for the day shift. The MAR indicated RN #4 signed off on this treatment, as ordered by the physician, on 7-3-15 and 7-5-15</p>						

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	<p>for the evening shift.</p> <p>In an interview with the facility's Wound Nurse on 7-15-15 at 12:50 p.m., she indicated she had conducted Resident #B's dressing change and wound measurement on 7-3-15. The Wound Nurse indicated she had Dakin's Solution available for that particular dressing change. She indicated this particular item, Dakin's Solution, is an item that is routinely stocked by the facility. She indicated she had checked the stock room prior to the interview and found one bottle of Dakin's Solution in the stock room. She added that the bottle was difficult to visualize, as it was located on an upper shelf. She indicated that pharmacy records indicated that a staff member had ordered the Dakin's Solution from the contracted pharmacy, as it was delivered on 7-7-15, after the resident had discharged from the facility.</p> <p>In an interview with LPN #5 on 7-15-15 at 1:05 p.m., she indicated she recalled Resident #B was admitted to the facility with a large bottle of Dakin's Solution and it was placed in the treatment cart and was labeled with her name on it. She indicated, "There would be no reason for anyone not to be able to find it." In an interview with LPN #5 on 7-15-15 at 3:30 p.m., she indicated she could not</p>			

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	<p>locate this bottle anywhere.</p> <p>In an interview with the Executive Director on 7-16-15 at 10:00 a.m., she indicated Resident #B's personal inventory record did not list the Dakin's Solution. She indicated facility staff had spoken with the Wound Center staff regarding the Wound Center providing a bottle of Dakin's Solution upon the change order on 6-29-15. or prior. She indicated the Wound Center staff indicated it would be a common practice for them to provide dressing change supplies, but they did not have any record of Resident #B receiving that particular item.</p> <p>On 7-16-15 at 12:20 p.m., the Executive Director provided a listing of medications returned to the contracted pharmacy for credit or destroyed by the facility after Resident #B's discharge on 7-6-15. There was no listing for Dakin's Solution on the forms provided.</p> <p>On 7-16-15 at 11:42 a.m., the Executive Director provided a copy of a policy entitled, "Physician Notification." This policy had an effective date of 12-6-2007, and was indicated to be the current policy utilized by the facility. This policy indicated, "Purpose: To ensure the resident's physician is aware of all</p>			

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F 0282 SS=D Bldg. 00	<p>diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...Attempts to notify the physician and their response should be documented in the resident record."</p> <p>On 7-16-15 at 11:42 a.m., the Executive Director provided a copy of a policy entitled, "Medication Orders/Prescriber [Physician] Medication Orders." This policy had an effective date of 9-1-2013, and was indicated to be the current policy utilized by the facility. This policy indicated, "The prescriber is contacted for direction when delivery of a medication will be delayed or the medication is not or will not be available."</p> <p>This Federal tag relates to Complaint IN00177421.</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 interview and record review, the facility failed to ensure facility staff followed the physician's orders for wound</p>	F 0282	F - 282  <b>Corrective actions</b>	08/15/2015			

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	<p>care for 1 of 3 residents reviewed for wounds in a sample of 4. This deficient practice has the potential to adversely affect the healing or improvement of a resident's wound area. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 7-14-15 at 5:35 p.m. Her diagnoses included, but were not limited to, uncontrolled diabetes, heel and midfoot ulcer (wound), morbid obesity and peripheral neuropathy. Review of Resident #B's physician's orders indicated, on 6-29-15, a new order was received to modify the dressing change to her left foot to cleansing the wound with normal saline, then pack the ulcers with Dakin's Solution moistened gauze, then cover with dry gauze and secure with gauze wrap twice daily.</p> <p>In an interview with LPN #3 on 7-14-15 at 5:10 p.m., she indicated she had worked with Resident #B several times during her stay at the facility. She indicated she recalled approximately one week prior to Resident #B's transfer to the local emergency room, the resident's dressing changes had been changed to one in which "Dakin's Solution" was to be used. LPN #3 indicated she recalled phoning the facility's pharmacy to inquire</p>		<p><b>accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #B at time of survey was discharged from the facility.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Director of Health Services and/or Designee will audit all residents identified with wounds by visually observing their treatment to ensure that wound care is appropriately completed as per the physician order.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Staff will be re-educated on the process id following prescribed treatment as it relates to wound care.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Resident with wounds will be reviewed during the Clinical Care Meeting once a week x 4 weeks, then monthly x 6 months to ensure staff compliance with prescribed orders. The results of the audit observations will be reported, reviewed and trended for compliance through the</p>	

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	<p>when the Dakin's Solution would be available, prior to being off of the work schedule for several days. She indicated the facility pharmacy indicated the solution was on back order and they were expecting to be available the following day. She indicated that since she could not locate the Dakin's Solution, she used normal saline in place of the Dakin's Solution. She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon documentation in the resident's Medication Administration Record (MAR), this would have occurred on/around 7-1-15, 2 days after the order had been issued.</p> <p>In an interview with RN #4 on 7-14-15 at 7:10 p.m., she recalled working with Resident #B, on 7-5-15, the evening before she was transferred to the local emergency room on 7-6-15. She indicated, "I do recall doing her dressing change to the heel. We did not have the Dakin's [solution] yet, so I used the normal saline." She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon interview with RN #4 and documentation in the resident's Medication Administration Record (MAR), this would have occurred on 7-3-15, 4 days after the order had been issued, and/or 7-5-15, 6 days after the</p>		campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	<p>order had been issued.</p> <p>Review of the nursing notes did not reflect any documentation of the modification of the 6-29-15 dressing change order to substitute normal saline for the Dakin's Solution. The nursing notes did not reflect notification of the physician regarding the lack of Dakin's Solution and the substitution of normal saline for the Dakin's Solution.</p> <p>Review of Resident #B's MAR for July, 2015 indicated the dressing change to the left foot using the Dakin's Solution, dated 6-29-15, was conducted 9 times between 7-1-15 and 7-6-15, with one time not conducted as the resident was listed as "LOA," indicating she was on a leave of absence (out of the facility) and the second and third times, she was at the local hospital, as of early morning hours of 7-6-15. The MAR indicated LPN #3 signed off on this treatment, as ordered by the physician, on 7-1-15 for the evening shift and again on 7-5-15 for the day shift. The MAR indicated RN #4 signed off on this treatment, as ordered by the physician, on 7-3-15 and 7-5-15 for the evening shift.</p> <p>In an interview with the facility's Wound Nurse on 7-15-15 at 12:50 p.m., she indicated she had conducted Resident</p>			

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	<p>#B's dressing change and wound measurement on 7-3-15. The Wound Nurse indicated she had Dakin's Solution available for that particular dressing change. She indicated this particular item, Dakin's Solution, is an item that is routinely stocked by the facility. She indicated she had checked the stock room prior to the interview and found one bottle of Dakin's Solution in the stock room. She added that the bottle was difficult to visualize, as it was located on an upper shelf. She indicated that pharmacy records indicated that a staff member had ordered the Dakin's Solution from the contracted pharmacy, as it was delivered on 7-7-15, after the resident had discharged from the facility.</p> <p>In an interview with LPN #5 on 7-15-15 at 1:05 p.m., she indicated she recalled Resident #B was admitted to the facility with a large bottle of Dakin's Solution and it was placed in the treatment cart and was labeled with her name on it. She indicated, "There would be no reason for anyone not to be able to find it." In an interview with LPN #5 on 7-15-15 at 3:30 p.m., she indicated she could not locate this bottle anywhere.</p> <p>In an interview with the Executive Director on 7-16-15 at 10:00 a.m., she indicated Resident #B's personal</p>						

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	<p>inventory record did not list the Dakin's Solution. She indicated facility staff had spoken with the Wound Center staff regarding the Wound Center providing a bottle of Dakin's Solution upon the change order on 6-29-15. or prior. She indicated the Wound Center staff indicated it would be a common practice for them to provide dressing change supplies, but they did not have any record of Resident #B receiving that particular item.</p> <p>On 7-16-15 at 12:20 p.m., the Executive Director provided a listing of medications returned to the contracted pharmacy for credit or destroyed by the facility after Resident #B's discharge on 7-6-15. There was no listing for Dakin's Solution on the forms provided.</p> <p>In an interview with the Executive Director on 7-16-15 at 10:00 a.m., she indicated the facility does not have a specific policy to address following physician's orders. She indicated that it is an understood expectation of all staff.</p> <p>This Federal tag relates to Complaint IN00177421.</p> <p>3.1-35(g)(2)</p>			

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F 0309 SS=D Bldg. 00	<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 ensure staff utilize the correct method for the application of elastic bandages/wraps to the lower extremities for 1 of 1 residents observed for the application of elastic bandages/wraps. This deficient practice has the potential to further diminish the blood flow to the lower extremities for a resident with PVD. (Resident #E)</p> <p>Findings include:</p> <p>During a care observation of Resident #E, with LPN #1 and with a Hospice Nurse on 7-16-15 at 9:30 a.m., LPN #1 was observed to remove the elastic bandages/wraps from both lower extremities, apply lotion to both lower extremities, then began to replace the elastic bandages/wraps with new ones. She was observed to begin wrapping the elastic bandages/wraps in a spiral fashion, beginning just below the left knee and moving downward, toward the toes. When she was halted at</p>	F 0309	<p><b>F -309</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> During the observed wrap application during the survey, the process was halted and clarified by the surveyor for distal to proximal application. The wrap was then re-applied distal to proximal.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Director of Health Services and/or Designee will audit all residents identified with elastic bandage/wraps by visual observations to ensure that bandage application is applied correctly and as per the physician order.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Staff</p>	08/15/2015			

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	<p>approximately the calf of the left leg and queried as to the rationale for performing this task in this manner, she explained, "This is how I was taught in nursing school." The Hospice Nurse, at this point, intervened and indicated to LPN #1, "Generally, [one] should start at the farthest point and go upward." LPN #1 was then observed to remove the elastic bandage/wrap and begin to apply the elastic bandages/wraps from the forefoot area of the left foot and place the elastic bandages/wraps in a spiral fashion towards the ankle and knee.</p> <p>In an interview with Physical Therapy Assistant (PTA) #2 on 7-16-15 at 11:05 a.m., he indicated the use of any wraps, such as elastic bandages/wraps or gauze-type wrap, should be done from the most distal area to the most proximal area. He further clarified this as meaning, on a leg, from the toes toward the thigh area. He explained this is done in order to help with one's circulation.</p> <p>In an interview with the Executive Director on 7-16-15 at 11:27 a.m., she indicated the facility had a recent inservice (education) program for staff in which the topic of application of elastic bandages/wraps was addressed. The Executive Director was unable to provide documentation of this inservice, except</p>		<p>will be re-educated on the process of applying elastic bandages/wraps.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Residents with elastic bandage/wrap orders will be observed randomly once a week x4 weeks, then monthly x6 to ensure staff compliance. The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>for the date of 5-26-15, on the elastic bandages/wraps application, prior to the exit date of the survey on 7-16-15.</p> <p>On 7-16-15 at 11:27 a.m., the Executive Director provided a copy of a procedure, entitled, "Ace Bandage, Application of." This procedure had a copyright date of 2012 and was indicated to be the current procedure in use by the facility. This procedure indicated, "Purpose...to reduce pain; to apply pressure; to reduce swelling; to facilitate return circulation from the extremities...Apply bandage smoothing in spiral or spiral-reverse method. Apply with even pressure taking care to avoid occlusion of arteries..."</p> <p>Resident #E's clinical record was reviewed on 7-15-15 at 11:05 a.m. His diagnoses included, but were not limited to, ischemic heart disease, hypertension, atrial fibrillation, edema and peripheral vascular disease. Review of the recapitulation orders for July, 2015 indicated a physician's order, dated 6-15-15, which indicated to apply Ace wraps (type of elastic bandage/wrap) to both lower extremities daily with the placement each morning and removal daily at bedtime.</p> <p>This Federal tag relates to Complaint IN00177421.</p>			

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F 0514 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the documentation for treatments for a resident with wound care is accurate and reflects the care provided by facility staff for 1 of 3 residents reviewed for wounds in a sample of 4. This deficient practice has the potential to adversely affect the healing or improvement of a resident's wound area. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 7-14-15 at 5:35 p.m. Her diagnoses included, but were not limited to, uncontrolled diabetes, heel and</p>	F 0514	<p><b>F - 514</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #B at time of survey was discharged from the facility.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> Director of Health Services and/or designee will audit all treatment documentation of residents identified with wound care orders to ensure the documentation is accurate and reflects the care</p>	08/15/2015			

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	<p>midfoot ulcer (wound), morbid obesity and peripheral neuropathy. Review of Resident #B's physician's orders indicated, on 6-29-15, a new order was received to modify the dressing change to her left foot to cleansing the wound with normal saline, then pack the ulcers with Dakin's Solution moistened gauze, then cover with dry gauze and secure with gauze wrap twice daily.</p> <p>In an interview with LPN #3 on 7-14-15 at 5:10 p.m., she indicated she had worked with Resident #B several times during her stay at the facility. She indicated she recalled approximately one week prior to Resident #B's transfer to the local emergency room, the resident's dressing changes had been changed to one in which "Dakin's Solution" was to be used. LPN #3 indicated she recalled phoning the facility's pharmacy to inquire when the Dakin's Solution would be available, prior to being off of the work schedule for several days. She indicated the facility pharmacy indicated the solution was on back order and they were expecting to be available the following day. She indicated that since she could not locate the Dakin's Solution, she used normal saline in place of the Dakin's Solution. She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon</p>		<p>provided by the assigned staff.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> Staff will be re-educated on the process of documentation of wound treatments as it relates to wound care.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> Resident with diabetic wounds will be reviewed during the Clinical Care Meeting once a week x 4 weeks, then monthly x 6 months to ensure residents with wound treatment orders have accurate documentation reflective of the care provided. Audit performed by the DHS and/or designee. The results of the audit observations will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>documentation in the resident's Medication Administration Record (MAR), this would have occurred on/around 7-1-15, 2 days after the order had been issued.</p> <p>In an interview with RN #4 on 7-14-15 at 7:10 p.m., she recalled working with Resident #B, on 7-5-15, the evening before she was transferred to the local emergency room on 7-6-15. She indicated, "I do recall doing her dressing change to the heel. We did not have the Dakin's [solution] yet, so I used the normal saline." She did not indicate she notified the physician of the lack of the Dakin's Solution. Based upon interview with RN #4 and documentation in the resident's Medication Administration Record (MAR), this would have occurred on 7-3-15, 4 days after the order had been issued, and/or 7-5-15, 6 days after the order had been issued.</p> <p>Review of the nursing notes did not reflect any documentation of the modification of the 6-29-15 dressing change order to substitute normal saline for the Dakin's Solution. The nursing notes did not reflect notification of the physician regarding the lack of Dakin's Solution and the substitution of normal saline for the Dakin's Solution.</p>			

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	<p>Review of Resident #B's MAR for July, 2015 indicated the dressing change to the left foot using the Dakin's Solution, dated 6-29-15, was conducted 9 times between 7-1-15 and 7-6-15, with one time not conducted as the resident was listed as "LOA," indicating she was on a leave of absence (out of the facility) and the second and third times, she was at the local hospital, as of early morning hours of 7-6-15. The MAR indicated LPN #3 signed off on this treatment, as ordered by the physician, on 7-1-15 for the evening shift and again on 7-5-15 for the day shift. The MAR indicated RN #4 signed off on this treatment, as ordered by the physician, on 7-3-15 and 7-5-15 for the evening shift.</p> <p>This Federal tag relates to Complaint IN00177421.</p> <p>3.1-50(a)(2)</p>			