

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155811	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/05/2016
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF AVON	STREET ADDRESS, CITY, STATE, ZIP CODE 10307 EAST COUNTY ROAD 100 NORTH INDIANAPOLIS, IN 46234
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 12/17/15. This visit included a PSR to the State Residential Licensure Survey completed on 12/17/15.</p> <p>Survey dates: February 4 and 5, 2016</p> <p>Facility number: 013085 Provider number: 155811 AIM number: 201279600</p> <p>Census bed type: SNF/NF: 56 NF: 2 Residential: 18 Total: 76</p> <p>Census payor type: Medicare: 40 Medicaid: 2 Other: 16 Total: 58</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 2/10/16 by 29479.</p>	F 0000		
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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 0314 SS=D Bldg. 00	<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, interview, and record review, the facility failed to identify, accurately assess, and obtain physician orders for wound treatments for 2 of 2 residents reviewed for pressure ulcers (Residents #274 and #273).</p> <p>Findings include:</p> <p>1. During an interview on 2/4/16 at 11:00 a.m., the Director of Nursing (DON) indicated Resident #274 was admitted to the facility with a pressure ulcer on her heel.</p> <p>Resident #274 ' s wounds were observed on 2/4/16 at 1:34 p.m., with Registered Nurse (RN) #20. The resident was lying on her back in bed with the head of the bed elevated. Her lower legs were elevated on a pillow and her heels hung</p>	F 0314	<p>F 314</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice?</p> <p>Residents #273 and 274 have been discharged from the facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>Review of all current residents skin condition and all new residents upon admission will be done by the DHS or designee to ensure the following: 1). Pressure related areas and other skin impairments are properly identified, assessed and documented per the campus policy.</p>	02/23/2016

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	<p>over the edge of the mattress. No wound dressings were observed and the resident was not wearing protective boots. A dime sized open wound was observed on the outer edge of Resident #274 ' s right heal. The wound bed was dry and was black and brown. The skin surrounding the wound was intact and pink. RN #20 indicated the center of the wound was hard and both of Resident #274's heels were "mushy." RN #20 washed Resident #274's feet with soap water, dried with towel, and applied Skin Prep (liquid film-forming dressing) to both heels. The RN indicated there were no orders for wound dressings. Protective boots were observed on Resident #274 ' s dresser.</p> <p>On 2/4/16 at 2:04 p.m., Resident #274's record was reviewed. The physician history and physical, dated 1/25/16, indicated Resident #274's had a stage 1 pressure area (an observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red,</p>		<p>2). Appropriate treatment is initiated per the MD order and the campus policy.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: A). Immediate implementation of treatment as indicated. B). Weekly Assessment with monitoring. C). Weekly Wound Rounds D). Thorough completion of skin Impairment Circumstance Form (Investigation, Assessment, Intervention).</p> <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>QAA monitoring tool will be completed by the DHS/Designee on pressure sores and interventions. This will be completed weekly times eight weeks and then monthly times 4 months. The results will be reviewed by QAA committee monthly until substantial compliance is achieved.</p> <p>Date to be completed</p> <p>2/23/16</p>	

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	<p>blue, or purple hues) to the coccyx (tailbone) and bruising on her left hand. The history and physical form did not indicate a pressure area on Resident #274's right heel and a physician ' s order, dated 1/25/16, did not include orders for pressure areas on the buttock or the left heel.</p> <p>An admission assessment, dated 1/25/16 at 2:36 p.m., indicated Resident #274 had skin impairment and the details were documented in the Pressure Wound Circumstance note. The " Pressure Wound Circumstance," dated 1/25/16, indicated Resident #274 had a stage 2 pressure ulcer on her right "lateral heel" 0.9 centimeters (cm) in length by 0.6 cm in width by 0.1 cm in depth. The noted stated, "The wound is healing, currently scabbed over 100%." The note indicated interventions of a pressure reducing device for the chair and bed, pressure ulcer care, application of dressing to feet, elevate edematous/affected extremity and heel protectors.</p> <p>The Nursing note, recorded as a late entry on 1/31/16 at 7:41 p.m. and dated 1/25/16 at 7:37 p.m., documented by the Wound Nurse, stated, " ...Resident admitted with a small scabbed area to her R (right) lateral heel, site measures 1.0 x 1.0 x <0.1 cm. There is no exudate present.</p>			

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	<p>New orders for skin prep BID (two times daily) to help promote further healing. Resident also noted with boggy, soft heels to receive skin prep BID to maintain intact skin. Resident noted with sacral dressing on admission, no open areas noted at this time. The bilateral buttocks and sacrum present blanching red, new orders received for Calazime cream to be applied every shift and PRN for incontinent episodes. Family and MD (physician) updated."</p> <p>The physician order report, dated 2/5/16, indicated weekly skin assessments were ordered 1/25/16, Calazime cream (skin protectant) to bilateral buttocks every shift and PRN (as needed) to promote skin integrity and skin prep to bilateral heels BID (twice daily) was ordered on 1/28/16. The report indicated Prevalon boots (heel protectors) were ordered to be worn while Resident #274 was in bed on 2/2/16. .</p> <p>The Medication Administration Record indicated wound treatments were done on 1/25/16, 1/26/16, or 1/27/16. The record indicated Skin Prep twice daily was implemented on 1/28/16.</p> <p>The nursing progress notes, dated from 1/25/16 to 1/28/16, did not indicate wound treatments were competed for</p>			

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	<p>Resident #274 ' s right heel.</p> <p>A care plan, dated 1/28/16, indicated Resident #274 was at risk for skin breakdown and skin integrity issues. Interventions include, but were not limited to, avoid shearing resident's skin, minimize skin exposure to moisture, maintain the head of the bed at the lowest degree of elevation possible, and turn and reposition as tolerated.</p> <p>During an interview, on 2/5/16 at 9:29 a.m., the Wound Nurse indicated Resident #274 was admitted with a scab on the right outer side of her heel and both heels were soft. She indicated the right heel wound was a stage 2 pressure ulcer. The wound nurse indicated she " could tell " there was depth, but couldn ' t ' see the wound bed because of dead tissue or a scab. She indicated pressure ulcers were considered unstageable when the wound bed was not visible because of dead tissue or a scab. The Wound Nurse indicated orders for wound treatment should have been obtained from the physician immediately for unstageable pressure ulcers. The Wound Nurse indicated preventative nursing measures were implemented, but no treatment was initiated until she received orders from the physician on 1/28/16. The Wound Nurse indicated she wrote a late entry on</p>				

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	<p>the nursing note, dated 1/25/16, and included the initial wound assessment from 1/25/16, the follow-up assessment of the wound from 1/28/16, and the treatment orders obtained on 1/28/16 within the same note.</p> <p>During an interview, on 2/5/16 at 9:29 a.m., the Director of Nursing (DON) indicated there were standing orders for wound treatments when residents were admitted with pressure ulcers or wounds. The DON indicated staff followed the standing orders until the Wound Nurse or the physician saw the wound and made specific wound treatment orders. On 2/5/16 at 3:14 p.m., the DON provided the form titled, "Standing and Admission Orders." The form stated, "Stage 2 Decubitus Ulcers...a. Cleanse the area gently with antibacterial soap and rinse...Cover with Alleevyn type dressing...Pressure reducing mattress under body QDay (every day) when in bed...Pressure reducing cushion under buttocks QDay when in chair...Consult Wound Team for further evaluation and management...Change Dressing Q (every) 3-5 days and PRN (as needed)...Report according to policy and procedure."</p> <p>During an interview on 2/05/16 at 11:05 a.m., Physician #21 indicated she assessed Resident #274 on 1/25/16 when</p>			

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R 0000 Bldg. 00	<p>she was admitted, but was not aware of the pressure ulcer on her right heel. She indicated she did not recall being told about Resident #274's right heel pressure until 1/28/16 after the wound team saw the area. She indicated she approved the treatment plan and indicated she had not seen the wound since 1/28/16.</p> <p>During an interview on 2/5/16 at 11:08 a.m., the DON indicated the orders for the wound treatment were not obtained until 1/28/16 and only preventative measures were in place as of 1/25/16.</p> <p>This Visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 12/17/16.</p> <p>Residential Census: 18 Sample: n/a</p> <p>Wellbrooke of Avon was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p>	R 0000		

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

PRINTED: 02/23/2016

FORM APPROVED

OMB NO. 0938-0391

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