

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2016
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NAME OF PROVIDER OR SUPPLIER  LAKEVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BEACHWAY DR INDIANAPOLIS, IN 46224
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Compliant IN00190839.</p> <p>This visit was in conjunction with a Recertification and State Licensure Survey.</p> <p>Complaint IN00190839 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: January 4, 5, 6, 11, 12, and 13, 2016.</p> <p>Facility number: 000032 Provider number: 155077 AIM number: 100273330</p> <p>Census bed type: SNF: 12 NF: 100 Total: 112</p> <p>Census payor type: Medicare: 11 Medicaid: 80 Other: 21 Total: 112</p> <p>Sample: 7</p>	F 0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p> <p>Please find enclosed the plan of correction for the survey ending January 13, 2016.</p> <p>The documentation serves to confirm the facility's allegation of compliance. Should additional information be necessary, feel free to contact me.</p> <p>Respectfully,</p> <p>Steve Kassen Administrator</p>	

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

TITLE

(X6) DATE

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

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F 0309 SS=G Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 1/19/16 by 29479.</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>A. Based on observation, record review, and interview the facility failed to ensure medication was administered to manage pain resulting in acute pain and the resident yelling out during wound treatments for 1 of 3 residents reviewed for pain management (Resident B).</p> <p>B. Based on record review and interview, the facility failed to ensure communication between the facility and the dialysis provider for 1 of 1 resident reviewed for dialysis (Resident #117).</p>	F 0309	<p>1. Resident #B was affected. Resident #B received pain medication as ordered 30 minutes prior to the dressing change. When resident #B complained of pain during the dressing change the skin area being dressed was secured and pain medication was immediately provided to the resident. Resident B was not observed to have verbal or non-verbal signs/symptoms of pain after the pain medication was administered. Resident #117 was affected. The resident was not</p>	01/27/2016

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	<p>Findings include:</p> <p>A. On 1/12/16 at 11:29 a.m., with Qualified Medication Aide (QMA) # 98, Certified Nursing Assistant (CNA) #97, CNA #86, Licensed Practical Nurse (LPN) #96, and LPN #99 present, Resident B's wound care was observed. Resident B was positioned on his right side. During the procedure at 11:46 a.m., Resident B screamed out three times. LPN # 96 indicated the resident was feeling pain. LPN #99 was heard telling Resident B she was trying to get the dressing change completed as fast as she could and indicated she did not know how often Resident B received pain medication. At 11:48 a.m., Resident B screamed out again and LPN #99 was heard telling LPN #96 the resident had PRN (as needed) pain medication and indicated to Resident B pain medication would be given as soon as she finished the "big" dressing change. LPN #99 continued with the wound care and at 11:50 a.m., stated, "This is going to be a bad part," and continued the wound care. At 11:52 a.m., Resident B screamed out "I hurt." LPN #99 indicated the resident would "probably get some medication" after the dressing change was completed. LPN #99 continued with wound care while Resident B yelled out again. At</p>		<p>harmd. The dialysis center had been contacted on multiple occasions to provide the facility with resident dialysis care documentation. The dialysiscenter provided such information to the facility.</p> <p>2.All residents requiring dressing changes or receivingdialysis have the potential to be affected. All residents receiving dressingchanges had a pain assessment completed to ensure pain was controlled withdressing changes. Should the resident require additional intervention tocontrol pain, the physician will be notified and orders followed. All nursingstaff will be in-serviced on pain control, to include stopping care immediatelyshould resident exhibit pain symptoms during care and implement interventionsfor pain control before continuing with said care. All residents receivingdialysis care have a specified binder for dialysis center communication whichis transported with them to and from the dialysis center. The dialysis centeris to provide communication to the facility in the binder. All nurses will bein-serviced on the dialysis binder use and necessary communication with thedialysis center.</p> <p>3.As a measure to ensure ongoing compliance the DON ordesignee will complete treatment change observations</p>	

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	<p>12:00 p.m., LPN #99 indicated Resident B was administered scheduled pain medication prior to the procedure and indicated she "tried" to do wound care around his "scheduled" or "PRN" medication. Resident B cursed and asked, "How would you feel?" when asked about his pain level. At 12:03 p.m. LPN #99 asked Resident B if he wanted pain medication and the resident indicated "yes." LPN #96 administered sublingual (under the tongue) pain medication 37 minutes after wound care began at 12:06 p.m., and without delays, wound care continued until 12:26 p.m. Resident B was not observed to have verbal or non-verbal signs/symptoms of pain after the pain medication was administered.</p> <p>Resident B's record was reviewed on 1/12/16 at 10:05 a.m. Resident B had diagnoses which included, but were not limited to, multiple sclerosis, urinary retention, chronic back pain, weakness, contracture, pressure ulcers.</p> <p>A pain care plan originally dated 5/13/15, and last updated on 1/11/16, indicated Resident B had the potential for pain in the following areas: general discomfort, buttocks, feet, back, and hands due to a diagnosis of multiple sclerosis, depression, pressure ulcers, chronic back pain, contracture, and complaints of "pain</p>		<p>daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing to ensure pain is controlled with dressing changes. Should the resident require additional intervention to control pain, the physician will be notified and orders followed. Additionally, the DON or designee will complete an audit on all residents receiving dialysis to ensure the dialysis center has provided communication to the facility weekly ongoing. Should the facility note that the dialysis binder is lacking communication documentation from the dialysis center, the dialysis center will be contacted to provide such documentation. The facility will document requests made to the dialysis center and records are provided to the facility timely.</p> <p>4. As a measure of quality assurance the DON or designee will review any findings and subsequent corrective action in the facility's quarterly quality assurance meeting. The plan will be revised as warranted.</p>	

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	<p>all over." A goal indicated he would have pain rated less than a 7 on a scale from 0-10, Interventions indicated staff would monitor for non-verbal signs of pain, asses his level of pain, and administer pain medication as ordered and monitor for efficacy.</p> <p>A physician's order, dated 12/14/15, indicated orders for Roxanol (narcotic pain medication/Morphine Sulfate 100 milligrams/5 milliliters solution, give 1 milliliters (20 milligrams) every hour as needed for pain/shortness of breath.</p> <p>A physician's order, dated 1/11/16, indicated orders for Roxanol (narcotic pain medication) 20 milligrams/milliliters, give 1.25 milliliters sublingual every 2 hours for pain.</p> <p>Resident B's medication administration record (MAR), dated January 2016, and Resident B's PRN flow sheet were reviewed on 1/12/16 at 12:30 p.m., with LPN #95 present. The MAR indicated Resident B was administered routine Roxanol pain medication at 6:00 a.m., 8:00 a.m., 10:00 a.m., and 12:00 p.m. There was no indication the resident had received additional pain medication until 37 minutes after the treatment began.</p>			

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	<p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 2.7 x 3.2 x 1.5, had moderate amount of serous drainage, 5.4 cm (centimeters) tunneling at 12:00. Wound associated pain was 8 out of 10 and the wound bed was red with red/dark edges.</p> <p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 4 x 3.3 x 1.5, had a moderate amount of serous exudates, with 2 cm tunneling/undermining at 11:00-12:00 locations of a clock face. The wound associated pain was rated a 5 out of 10, with a red wound bed and red wound edges.</p> <p>A pressure ulcer assessment record, dated 1/11/16, indicated the wound measured 5.7 x 3.7 x 3, had a moderate amount of serous exudates, 4 cm of tunneling/undermining located at 3:00-4:00 on a clock face, wound associated pain was rated 5 out of 10, with a red wound bed with red wound edges.</p> <p>During an interview on 1/12/16 at 12:30 p.m., LPN #95 indicated she administered Resident B's routine Roxanol pain medication at 10:00 a.m. and had not administered additional "as needed" pain medication.</p>			

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	<p>During an interview on 1/12/15 at 12:40 p.m., with the Director of Nursing, Administrator, and corporate nurse consultant present, the corporate nurse consultant indicated, if ordered, pain medication should have been administered prior to wound care.</p> <p>During an interview on 1/13/16 at 11:08, Physician #90 indicated he recently observed staff reposition Resident B and indicated he experienced pain and could not tolerate the repositioning. He went on to indicate he believed the most important thing was to keep him comfortable.</p> <p>A policy titled, "Pain Assessment," dated 10/2014, was provided by the DON on 1/12/2016 at 3:05 p.m., and indicated the following, "...Purpose: To identify those residents who utilize routine medications for pain or who utilize frequent PRN (as needed) pain medications in an effort to ensure adequate pain control is achieved...1. Upon admission, each resident shall be assessed for the presence of acute or chronic pain per the admission assessment. 2. If resident verbalizes pain, unaffected by the currently ordered pain medication, and/or exhibits non-verbal communication that pain is present, resident shall be</p>			

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	<p>identified through completion of regularly scheduled MDS' to ensure pain symptoms are evaluated and communicated to the physician...6. The care plan for the individual resident shall be reviewed to ensure pain management is addressed...."</p> <p>B. Resident #117's record was reviewed on 1/7/2016 at 12:17 p.m. The resident's diagnosis included, but was not limited to, end stage renal disease and the record indicated the resident received hemodialysis three days a week.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/2/2015 and did not indicate the dialysis center provided complete pre-vital and post-vital signs.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/7/2015 and did not indicate the dialysis center provided complete pre-vital and post-vital signs.</p> <p>A "Dialysis Center Communication Record Form" indicated Resident #117 received dialysis on 12/11/2015 and did not indicate the dialysis center provided complete pre-vital and post-vital signs.</p> <p>A "Transfer to Appointments Form"</p>			

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	<p>indicated Resident #117 received dialysis on 1/4/2016. The record lacked documentation the dialysis center provided a returned "Dialysis Communication Record Form" upon Resident #117's return to the facility. The record lacked documentation a "Transfer to Appointments Form" had been completed by the facility for his other dialysis appointments attended in January 2016.</p> <p>During an interview on 1/7/2016 at 9:41 a.m., Unit Manager #60 indicated Resident #117 received dialysis three times a week. A dialysis communication binder contained a "Dialysis Communication Record Form" for the dialysis center to complete and return to the facility with Resident #117. The binder also contained a "Transfer to Appointments Form" completed by the facility and sent with the resident to dialysis. The Unit Manager indicated the binder was not always returned to the facility with completed information and she could not provide communication documentation for all of Resident #117's dialysis appointments.</p> <p>During an interview on 1/11/2016 at 3:54 p.m., the Director of Nursing (DON) indicated the facility was responsible for sending the completed "Transfer to</p>				

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	<p>Appointments Form" to the dialysis center and ensuring the retrieval of the completed "Dialysis Communication Record Form" information from the dialysis center upon Resident #117's return to the facility. She indicated Resident #117 had attended all of his scheduled dialysis appointments for the month of January 2016.</p> <p>A policy titled, "Dialysis Coordination/Facility Services," dated 10/2014, was provided by the DON on 1/11/2016 at 9:00 a.m., and indicated the following, "...Purpose: to ensure effective communication between the facility and dialysis center providing service to the facility...facility personnel will communicate with the outpatient dialysis center in an effort to ensure the resident is rendered necessary care and services for the provision and maintenance of dialysis services...2. Facility personnel shall ensure that all appropriate medical and administrative information accompanies resident at the time of transfer or referral to the dialysis center...4. Unit manager/licensed nurse shall monitor the needs of the dialysis resident and review any notes/orders accompanying resident from the dialysis center upon arrival to the facility...."</p> <p>This Federal tag relates to complaint</p>			

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F 0314 SS=G Bldg. 00	<p>IN00190839.</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, interview, and record review, the facility failed to identify changes in skin condition and ensure effective pressure reducing interventions for 3 of 3 residents reviewed for pressure ulcers. This deficient practice resulted in a resident's existing pressure ulcers deteriorating to stage IV (full thickness tissue loss with exposed bone, tendon or muscle) or unstageable pressure ulcers and development of additional pressure ulcers on the buttocks and bilateral, medial knees. This deficient practice also</p>	F 0314	<p>1. Resident #B, C, and D were affected. Resident # B was only sitting up in the Broda chair for approximately an hour. The Broda chair's built in seat cushion has pressure redistribution and air flow properties. Resident B's cushioned knee dressings were in place. The blue foam knee protector was ordered and received on 1/12/16 and put into place that day. Resident B did not tolerate being positioned completely over on his side, thus pillows were used to redistribute pressure from side to side. The care plan did include that resident B was non-adherent with turning</p>	01/27/2016	

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	<p>resulted in a resident with a stage III pressure ulcer (full thickness tissue loss where bone, tendon or muscle is not exposed) on the right great toe worsening to an unstageable pressure ulcer and resulted in lack of wound healing for a resident with a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying tissue) to the right heel (Residents B, C and D).</p> <p>Findings include:</p> <p>1. During an observation on 1/11/15 at 4:00 p.m., Resident B was seated in a reclined broda chair by the C wing nursing station without a pressure reducing cushion in place. The resident had bilateral heel protectors on and his right and left knees had wound dressings in place. The knees were positioned against one another.</p> <p>During an observation on 1/12/16 at 11:29 a.m., with Qualified Medication Aide (QMA) # 98, Licensed Practical Nurse (LPN) #96, and LPN #99 present, Resident B's wounds were observed during a dressing change. QMA #98 and LPN #99 positioned Resident B on his left side. There was a stage IV pressure ulcer on the coccyx with a yellow and dark brown wound bed. The wound edges were reddened and yellow crusted.</p>		<p>and repositioning and treatment changes. Staff encouraged resident B to allow turning and repositioning and dressing changes as well as make him aware of risk for non-adherence as needed. A mirror was placed on the wall so that resident B could see his television when turned away from it. Resident B received hospice care due to end stage Multiple Sclerosis and interventions were in place as care planned. Resident B's open areas were unavoidable due to his terminal illness per his physician. Resident B has since past away. Resident C has an area to his right great toe thathas continued due to peripheral vascular disease. The area was listed asunstageable due to it being a scabbed area. The care plan was revised to notethe wound was vascular. Staff were immediately re-educated on resident C'sinterventions. Interventions are in place as ordered and care planned. ResidentD was admitted from the hospital with the pressure area with interventions inplace. Interventions were clarified and care planned accordingly. 2. All residents at risk for pressure areas have thepotential to be affected. Braden scoreswere updated on all residents. All residents' at high risk for pressure ulcerscare plans and assignment sheets were reviewed and revised as indicated toinclude</p>	

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	<p>No drainage was observed. The left buttock wound was a stage IV pressure ulcer with a yellow wound bed with a moderate amount of continuous brownish colored drainage. The wound edges were reddened. The right buttock wound was observed as a stage IV pressure ulcer with a yellow wound bed with some red tissue. No drainage was observed and the wound edges were intact. The right lower buttock wound was observed as an unstageable pressure ulcer with a dark brown center and yellow tissue surrounding the dark center.</p> <p>During an observation on 1/12/16 at 10:00 a.m., Resident B was positioned on his back on a low air loss mattress.</p> <p>During observations on 1/12/16 at 12:33 p.m., 12:50 p.m., and 1:00 p.m., Resident B was lying in bed on his back. His legs were covered with a thin sheet and a blue foam knee protector pad was at the end of the bed.</p> <p>During an observation on 1/12/16 at 1:08 p.m., with LPN #96 present, Resident B was observed on his back, foam knee protector was at the end of the bed. Resident B had a stage two pressure ulcer with yellow wound bed and reddened wound edges on his right inner knee and a stage two pressure ulcer with a yellow</p>		<p>appropriate interventions. Nurses were in-serviced on skin management including pressure ulcer prevention and treatment, care planning, and assessment. All CNA's were in-serviced on proper positioning and prevention of pressure ulcers. 3. As a measure to ensure ongoing compliance each resident will have a head to toe skin assessment completed weekly and as needed. If any new areas are noted the physician will be notified and a treatment order requested. The noted problem skin areas will be measured on a weekly basis. The status of all pressure ulcers will be reviewed weekly in SWAT meeting and if no improvement is noted after 2 weeks or the area had worsened, a change in the treatment regimen will be requested and implemented. Care plans and assignments sheets will be updated accordingly. Braden scale scores will be completed upon admission and weekly for four weeks, then quarterly, annually, and with any significant changes. All residents with pressure areas and residents at high risk for pressure areas will be observed by the DON or designee to ensure proper positioning with pressure reducing devices and that treatments are in place as ordered which will include varied times five times weekly for 30 days, then three times weekly for 30 days,</p>	

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	<p>wound bed and reddened wound edges on his left inner knee.</p> <p>During an observation on 1/13/16 at 10:14 a.m., with Certified Nursing Assistant (CNA) #92 present, Resident B was lying in bed on his back with a regular bed pillow positioned under his left hip. The pillow was compressed flat and did not position the Resident to reduce pressure to his coccyx and buttock wounds.</p> <p>Resident B's record was reviewed on 1/12/16 at 10:05 a.m. and indicated diagnoses which included, but were not limited to, multiple sclerosis, urinary retention, chronic back pain, weakness, and contractures.</p> <p>An admission assessment, dated 9/26/14, indicated Resident B was admitted to the facility without pressure ulcers.</p> <p>Laboratory tests results, dated 1/5/15, indicated Resident B had a total protein level of 6.8 gm/dL (reference range 6.0-8.2) and an albumin (helps tissue growth ad healing) of 3.7g/dl (reference range 3.2-5.7). The record lacked indication levels were monitored after this date.</p> <p>A hospice certification note, dated</p>		<p>then weekly for 30 days, then monthly. 4. As a quality measure, the DONor designee will review any finding and subsequent corrective action in the quarterly Quality Assurance meeting. The plan will be revised as warranted.</p>		

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	<p>1/12/15, indicated Resident B qualified for hospice due to his diagnosis of multiple sclerosis.</p> <p>A pressure ulcer assessment record, dated 3/25/15, indicated Resident B developed a stage III (full thickness loss) pressure ulcer which measured 5.0 x 5.0 x 0.1 (length X width X depth in centimeters) on his left buttock. The record indicated the wound was measured weekly and indicated the wound became unstageable and measured 6.0 x 6.0 with an undetermined depth on 5/1/15. The wound bed was "100 percent necrotic" and the wound edges were "red." On 5/28/15, the wound stage was documented as stage 3 and the wound measured 5.0 X 5.0 with 0.1 depths. The wound bed was "10 percent slough and 90 percent beefy red." On 6/12/15, the wound stage was documented as unstageable and measured 2.6 x 2.4 with the depth undetermined. The wound bed was "100 percent slough" and the wound edges were red. On 1/8/15, the wound stage was documented as stage IV and measured 3 x 3.2 x 5.2 with a moderate amount of serosanguineous drainage with no tunneling. Wound associated pain was rated 7 out of 10, the wound bed was red, and the wound edges were red. On 1/11/16, the wound measured 2.7 x 3.2 x 1.5, had moderate amount of serous</p>			

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	<p>drainage, 5.4 cm (centimeters) tunneling at 12:00. Wound associated pain was 8 out of 10 and the wound bed was red with red/dark edges.</p> <p>A pressure ulcer assessment record, dated 4/23/15, indicated Resident B developed an "unstageable" pressure ulcer which measured 4 x 2 x undetermined depth to his right buttock. The wound bed was 100 percent necrotic with red wound edges. The record indicated weekly wound measurements and indicated on 6/8/15 the wound stage was documented as stage III and measured 1.6 x 1.2 x undermined depth. The wound bed was 100 percent slough with red wound edges. On 6/12/15 the wound stage was documented as unstageable and measured 1.4 x 1.0 x undetermined depth. The wound bed was 100 percent slough with red wound edges. On 1/8/15, the wound stage was documented as stage IV and measured 5 x 3 x 3.6 with no tunneling. Wound associated pain was a 7/10 and the wound bed was red with red wound edges. On 1/11/16 the wound measured 4 x 3.3 x 1.5, had a moderate amount of serous exudates, with 2 cm tunneling/undermining at 11:00-12:00 locations of a clock face. The wound associated pain was rated a 5/10, with a red wound bed and red wound edges.</p>			

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	<p>A pressure ulcer assessment record, dated 10/16/15, indicated Resident B developed a stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a res-pink wound bed without slough) on his sacrum which measured 1.2 x 0.4 x less than 0.1. The wound had no tunneling and no pain. The wound bed was red and the wound edges had "redness." The record indicated wounds were measured weekly and on 12/18/15 the wound stage declined to a stage III and measured 2.5 x 2 x 0.2. Wound associated pain was rated at a 4/10. The wound bed was red and the edges were red. On 1/8/16, the wound stage declined to a stage IV and measured 3.9 x 3.6 x 2.8, had a moderate amount of serosanguinous drainage, no tunneling, wound associated pain rated 7/10, wound bed was red, and the wound edges were red. On 1/11/16 the wound measured 5.7 x 3.7 x 3, had a moderate amount of serous exudates, 4 cm of tunneling/undermining located at 3:00-4:00 on a clock face, wound associated pain was rated 5/10, with a red wound bed with red wound edges.</p> <p>A Minimum Data Set (MDS) assessment, dated 8/5/15, indicated Resident B was at risk for developing pressure ulcers and had one stage II pressure ulcer, 2 stage III pressure ulcers, and no stage IV pressure</p>			

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	<p>ulcers. The assessment indicated the resident was totally dependent on staff for bed mobility.</p> <p>A pressure sore care plan, initiated on 3/29/15, and last updated 10/30/15, indicated Resident B had a pressure ulcer. A goal indicated the pressure ulcer would decrease in size or heal by the next review. Interventions to meet this goal included: apply treatment as ordered, monitor per skin management program, monitor for signs/symptoms of infection, monitor for treatment efficacy and consult the physician if the ulcer did not improve. Additional interventions included pressure reducing devices to the bed and chair, low air loss mattress, encourage consumption of meals, fluids, and supplements, assist/encourage to turn and reposition at least every two hours and as needed, educate the resident and responsible party on factors of skin breakdown and interventions as needed, use the bed pad/sheets for bed mobility and positioning, and refer to incontinence, dietary, and pressure risk care plans. The record lacked indication Resident B refused interventions to prevent or promote healing of pressure ulcers.</p> <p>A pressure ulcer risk care plan, originally dated 5/13/15, and last updated 12/12/15,</p>			

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	<p>indicated Resident B was at risk for the development of pressure ulcers due to: dependence on staff for bed mobility, functional limitation in range of motion to bilateral upper extremities and bilateral lower extremities, bedfast, frequently slides down in bed, bowel incontinence, use of s/p (suprapubic) catheter, impaired cognition, use of psychotropic and narcotic pain medications, pain, increased pain with repositioning, use of oxygen, significant weight loss, current pressure ulcers, diagnosis of multiple sclerosis, chronic back pain, urinary retention, spinal cord lesions, depression, anxiety, weakness, coronary pulmonary disease, history of non adherence with turning and repositioning and treatment changes. A goal indicated he would be free from pressure ulcers by the next review. Interventions included: weekly head to toe skin assessments, observation of skin condition during care, notification of skin problems to the charge nurse for further assessment and possible physician notification, pressure redirecting cushion to chair, pressure reducing mattress to be, low air loss mattress, encourage and assist with turning and repositioning at least every two hours and as needed, application of preventative topical medication as ordered, monitor labs as ordered, encourage food and fluid intake, refer to dietician as indicated, dietary</p>			

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	<p>supplements as ordered, hospice visits as scheduled, educate him on the risks of non adherence as needed and encourage him to comply. The record lacked indication Resident B refused interventions to prevent or promote healing of pressure ulcers</p> <p>A physician's order, dated 10/23/15 at 2:30 p.m., indicated orders to position Resident B on his left and right side only. The order indicated, "not on his back."</p> <p>A physician's order, dated 10/30/15 at 2:30 p.m., indicated, "Reposition on side except meals (from side to side).</p> <p>A Minimum Data Set (MDS), dated 11/5/15, indicated Resident B was totally dependent on two staff for bed mobility, had range of motion limitations in upper and lower extremities, had unhealed pressure ulcers, was at risk for developing additional pressure ulcers, and did not exhibit behaviors of rejecting care.</p> <p>A Certified Nursing Assistant assignment sheet, dated 1/4/16, indicated Resident B was dependent for activities of daily living, confused at times, needed encouraged to lay on his side, turned every two hours, and checked every 30 minutes.</p>			

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	<p>An initial pressure ulcer assessment, dated 1/5/16, indicated Resident B developed a stage 2 pressure ulcer which measured 2 x 2.5 x less than 0.1 on his right knee and a stage 2 pressure ulcer which measured 1 x 0.9 x 0.1 on his left knee.</p> <p>An initial pressure ulcer assessment, dated 1/11/16, indicated Resident B developed a stage III pressure ulcer to his right lower buttock which measured 2 x 1.9 x 0.1, with a dark brown wound bed and red edges.</p> <p>An initial pressure ulcer assessment, dated 1/11/16, indicated Resident B developed a stage 1 pressure ulcer on his left heel which measured 2.5 x 5.5, had a dark red wound bed with red wound edges.</p> <p>A physician's order, dated 1/12/16, indicated an order for a knee abductor pillow to be placed on Resident B at all times with the exception of when care or/bathing was provided.</p> <p>A care plan, dated 1/11/16, and updated on 1/12/16, indicated Resident B had pressure ulcers located on his left and right buttocks, coccyx, left and right knees, lower right buttock, and his left</p>			

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	<p>heel. A goal indicated the pressure ulcers would decrease in size/heal without complications by the next review.</p> <p>Interventions to meet this goal included: administer treatments as ordered, monitor skin management program, monitor for signs and symptoms of infection, monitor for treatment efficacy and notify physician if not improving, pressure reducing devices to bed and the chair, encourage consumption of meals, fluids and supplements, assist/encourage to turn and reposition at least every two hours and as needed, turn on his left and right only, turn every two hours, dressing changes as ordered, notify hospice nurse as needed, bunny boots to bilateral feet, abductor pillow (knee) at all times "may remove for bathing and care."</p> <p>During an interview, on 1/11/2016 at 4:00 p.m., Licensed Practical Nurse #96 indicated the chair in which Resident B was seated did not have a pressure reducing cushion.</p> <p>During an interview, on 1/12/16 at 1:08 p.m., LPN #96 pointed to a foam cushion at the end of Resident B's bed and indicated she did not know when the resident got the foam cushion and indicated it was to prevent his skin from breaking down between his knees.</p>			

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	<p>During an interview on 1/13/16 at 10:14 a.m., CNA #92 indicated she was assigned to Resident B and indicated she repositioned Resident B every two hours. The CNA indicated Resident B wasn't supposed to be on his back "too much" and indicated she didn't want to position him on his side because he "wouldn't have anything to look at but the wall." She indicated she placed a pillow under his left hip to help relieve the pressure. She indicated she should "probably get more pillows" to help relieve the pressure and indicated Resident B complained of pain when she moved him, but he did not refuse repositioning.</p> <p>During an interview on 1/13/16 at 9:15 a.m., with the Director of Nursing and Corporate Nurse Consultant present, the Director of Nursing indicated preventative measures were in place prior to him developing pressure ulcers. The Corporate Nurse Consultant indicated the interventions in place to prevent Resident B from developing pressure ulcers did not prevent the Resident from developing pressure ulcers. She indicated she believed the facility had done everything they could to prevent the skin breakdown and indicated the pressure ulcers were "unavoidable." The Corporate Nurse Consultant indicated Resident B refused to be turned from side to side and</p>			

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	<p>indicated the facility documented times when the refused repositioning and indicated he had been provided with education regarding the risks of refusing repositioning. Documentation of the refusals was requested, but not provided before the survey was exited.</p> <p>During an interview on 1/13/16 at 11:08, Physician #90 indicated the only intervention that would have prevented pressure ulcers on Resident B's back side was to keep him off his back. He indicated in the past, when Resident B was obese, the facility staff had difficulty keeping him positioned off his back. The physician indicated Resident B declined nutritionally and had muscle wasting. He indicated the wound treatments ordered were appropriate and the only other possible intervention would be surgical repairs of the wounds. The physician indicated Resident B was on hospice and not a candidate for surgery. He indicated he recently observed staff reposition Resident B and indicated he experienced pain and could not tolerate the repositioning. He went on to indicate he believed the most important thing was to keep him comfortable. The physician indicated he believed pressure ulcers were unavoidable for residents who had end stage multiple sclerosis.</p>			

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	<p>During an interview, on 1/13/15 at 11:30 a.m., the Administrator indicated documentation which indicated Resident B had refused interventions to heal/prevent pressure ulcers was not available.</p> <p>2. During an interview on 1/5/2016 at 10:38 a.m., Licensed Practical Nurse (LPN) #61 indicated Resident C had an unstageable (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed) pressure ulcer to his right great toe.</p> <p>During an observation on 1/7/2016 from 2:05 p.m. to 2:17 p.m., Resident C was observed with his right great toe pressure ulcer positioned flat against his composure mattress before his dressing change. LPN #61 changed a dressing to Resident C's unstageable pressure ulcer to his right great toe. She measured the wound as 1.0 centimeter (cm) x 0.1 cm with depth unable to be determined. The wound was a pink scabbed area, with white slough visible at the edges encompassing the scab. Resident C was observed positioned on his left side with his bilateral legs contracted upward, as both legs laid on top of one another. The area of pressure to his right great toe was placed flat against the composure</p>			

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	<p>mattress upon completion of his dressing change. Resident C was not observed to have bunny boots applied to both feet before or after the dressing change. The resident's heels were not observed to be floated before or after the dressing change.</p> <p>During a continuous observation on 1/8/2016 from 9:29 a.m. to 10:53 a.m., Resident C was observed sitting up in his broda chair. Orthotic braces were applied to both legs without the abductor bar of the orthotics present. The area of pressure to his right great toe was observed lying against the brace to his left leg.</p> <p>During a dining observation on 1/08/2016 at 1:11 p.m., Resident C was sitting up in his broda chair with his brace orthotics placed on both legs. The abductor bar of the orthotics was not observed. The area of pressure to his right great toe was observed lying against his left foot.</p> <p>During an observation on 1/8/2016 from 2:38 p.m. to 3:11 p.m., Resident C was observed in bed positioned on his right side with his knees bent and legs contracted upward. His right foot was lying flat on the composure mattress with his left foot placed directly on top of his right foot. His left great toe was observed</p>			

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	<p>rubbing against the area of pressure to his right great toe. Resident C's pants were pulled down around his ankles. Resident C was not observed with soft boots to his feet or his heels floated. A pillow was not observed in between his contracted legs.</p> <p>During an observation on 1/8/2016 at 4:09 p.m., Resident C was observed lying in bed and positioned on his right side. His legs were bent with his knees toward the ceiling. His left foot was lying on top of his right foot flat on the composure mattress. His heels were not observed to be floated and soft boots were not observed on his feet.</p> <p>Resident C's record was reviewed on 1/7/2016 at 3:00 p.m. Resident C's diagnoses included, but were not limited to, dementia, aphasia, Chronic Obstructive Pulmonary Disease, seizure disorder, and history of Metachromic Leukodystrophy (accumulation of fats in nervous system cells).</p> <p>A Certified Nursing Assistant (CNA) Assignment sheet, dated 1/4/2015, indicated Resident C should be turned and repositioned every hour, laid down after meals, wear Bunny Boots while in bed, and wear orthotics to bilateral lower extremities.</p>			

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	<p>A Minimum Data Set assessment (MDS), dated 9/25/2015, indicated Resident C was totally dependent with assistance of 1 staff person with bed mobility, dressing, and locomotion on the unit. The resident was totally dependent and required assistance of 2 staff members for transfers. The record indicated Resident C was at risk of developing pressure ulcers, had an unstageable pressure ulcer with measurements of 0.2 cm x 0.2 cm, and did not have a venous or arterial ulcer present. The record indicated Resident C's skin and ulcer treatments included: pressure reducing device for chair, pressure reducing device for bed, pressure ulcer care, and applications of ointments/medications other than to feet. The record lacked indication Resident C received a turning and repositioning program or applications of dressings to feet (with or without topical medications).</p> <p>A Pressure Ulcer Risk care plan, dated 10/13/2015, indicated Resident C was at risk for the development of pressure ulcers due to: dependent on staff for bed mobility and all activities of daily living (ADL's) and transfers, current pressure ulcer to his right medial great toe, decreased mobility, impaired ROM (range of motion) in lower extremities and his history of healed pressure ulcers.</p>			

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	<p>The care plan goal indicated Resident C would be free from pressure ulcers by next review. Current interventions included: head to toe skin assessment at least weekly by a licensed nurse, staff to observe skin condition while providing care, pressure redirecting mattress to bed, treatment to pressure ulcers as ordered, Z-flow cushion to elevate heels and check each shift while in bed, encourage and assist resident with turning and repositioning at least every two hours and as needed, monitor labs as ordered, and avoid lying on right side.</p> <p>A Pressure Area care plan, dated 10/13/2015, indicated Resident C has a pressure area located on his right medial foot and right medial great toe. The care plan goal indicated Resident C's pressure areas will decrease in size or heal without complications through the next review. Interventions included: daily skin inspection by nursing assistants, head to toe skin assessments by licensed nurse weekly and as needed, provide pressure redistribution mattress to bed, monitor for treatment efficacy if area is not improving and consult with the physician for further instruction, and assist with turning and repositioning at least every two hours and as needed.</p> <p>A physician's telephone order, dated</p>			

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	<p>12/9/2015, indicated, "PT (physical therapy) to evaluate right great toe medial likely venous stasis ulcer."</p> <p>A Nurse Practitioner (NP) progress note, dated 12/9/2015, indicated, "Chief Complaint: Venous stasis ulcer...This is a new problem, is acute...Resident is a highly contracted male, bed bound, concern that ulcer is 2/2 (secondary) to PVD (peripheral vascular disease). Will request therapy to evaluate and monitor. Will observe but given patient's chronic condition, unlikely to improve. Interested in therapy's evaluation and care plan, problem unlikely to resolve quickly if at all, patient unlikely surgical candidate unless toe becomes necrotic...Diagnosis: Venous insufficiency (chronic) (peripheral) (PT to evaluate right great toe for possible venous stasis ulcer)..."</p> <p>A physician's telephone order, dated 12/11/2015, indicated, "Order clarification: 1. PT wound care eval [evaluation] completed. 2. PT skilled intervention not recommended at this time via electrical stimulation due to wound stage and status. 3. Nursing to perform saline flush, xeroform (wound dressing) application, cover with gauze daily and as needed for soilage. 4. Unit staff to strictly adhere with orthotic application as scheduled."</p>			

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	<p>A Physical Therapy Plan of Care (Evaluation Only), dated 12/11/2015 and signed by the physician on 12/18/2015, indicated, "...Reason for Referral: non healing pressure ulcer to right dorsal [back] aspect of 1st DIP [distal interphalangeal joint] of foot...Therapy Necessity: Wound care skilled intervention via electrical stimulation is not recommended at this time d/t (due to) current wound stage and status however wound care treatment to be performed by nursing is recommended...2. Strict adherence to orthotic application and schedule to alleviate progression of contractures and pressure wound and prevent new onset of contractures and pressure wound...Discharge Plans: RNP (Restorative Nursing Program) will be in place to delay progression and new onset contractures and pressure sores...Underlying Impairments Other: Pt (patient) presents with stage 2 pressure wound to dorsal 1st DIP of R [right] foot with 100% granular tissue [new connective tissue and tiny blood vessels that form on the surfaces of a wound during the healing process] measuring 1 cm x 0.9 cm x no depth with minimal exudate, no odor and intact periwound [tissue surrounding the wound]...."</p> <p>A physician's order, dated 12/18/2015,</p>			
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	<p>indicated, "...cleanse R (right) great toe medial with NS [normal saline], pat dry, Xeroform [dressing] application and cover with gauze and secure QD [daily] and PRN [as needed] for soilage."</p> <p>A Braden Scale for Predicting Pressure Ulcer Risk, dated 12/23/15, indicated Resident C had a score of 11, indicating he was at a high risk for skin breakdown.</p> <p>The Certified Nursing Assistant (CNA) Shower Book, dated January 2016, indicated Resident C was to receive showers on Wednesday and Saturday evenings. The record lacked documentation the CNAs had performed a skin assessment for Resident C during his assigned showers for 1/2/2016 and 1/6/2016.</p> <p>Resident C's Medication Administration Record (MAR), dated 1/1/2016 through 1/31/2016, was reviewed on 1/8/2016 at 9:39 a.m. The record lacked indication Resident C had received his dressing change to his right great toe on 1/1/2016, 1/3/2016, and 1/6/2016. The record lacked indication Resident C had worn his orthotics to his legs on 1/2/2016 from 4 p.m. to 8 p.m., 1/3/2016 from 12 a.m. to 4 a.m., 1/5/2016 from 4 p.m. to 8 p.m., 1/5/2016 from 12 a.m. to 4 a.m., 1/6/2016 from 7 a.m. to 11 a.m., 4 p.m.</p>				

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	<p>to 8 p.m., or 12 a.m. to 4 a.m., and 1/7/2016 from 4 p.m. to 8 p.m. The record lacked indication Resident C had used a Z-flow cushion to elevate his bilateral heels while in bed on 1/2/2016 from 3 p.m. to 11 p.m., 1/5/2016 from 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m., 1/6/2016 from 3 p.m. to 11 p.m., 11 p.m. to 7 a.m., and 1/7/2016 from 3 p.m. to 11 p.m. The record lacked indicated Resident C had been turned every 2 hours on 1/2/2016 from 4 p.m. to 10 p.m., 1/3/2016 from 12 a.m. to 6 a.m., 1/5/2016 from 12 a.m. to 6 a.m. and 4 p.m. to 10 p.m., 1/6/2016 from 12 a.m. to 6 a.m. and 4 p.m. to 10 p.m. The record lacked indicated Resident C had a weekly skin assessment performed on Wednesday, 1/6/2016, and a skin sheet had been charted. The record did not indicate a reason Resident C had not received the nursing measures or dressing change.</p> <p>An undated Weekly Skin Assessment, reviewed in the January 2016 Treatment Administration Record (TAR), indicated, "Directions: A head-to-toe assessment of each resident is to be completed. Should a new skin alteration be identified, the appropriate assessment and ongoing monitoring tool shall be initiated and noted below. Weekly assessment shall continue in an effort to identify any</p>			

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	<p>additional areas thereafter...." The record lacked documentation a weekly skin assessment had been performed by a nurse for Resident C during the month of January 2016.</p> <p>A Physician's Order sheet, dated 1/1/2016 through 1/31/2016, indicated the following Nursing Measures for Resident C: Z-flow cushion to elevate bilateral heels and check each shift while in bed, turn every 2 hours, weekly skin assessment every Wednesday and chart on skin sheet, patient to wear bilateral lower extremity (BLE) orthotics daily for four hours each shift, from 7 a.m. to 11 a.m., 4 p.m. to 8 p.m. and 12 a.m. to 4 a.m., for his diagnosis of contractures. The record lacked documentation of an order for Bunny Boots (soft boots) to be applied to Resident C's feet while in bed.</p> <p>A Podiatry Exam progress report, dated 1/6/2016, did not indicate Resident C had vascular conditions, cyanosis (poor circulation or inadequate oxygenatio of the blood), or claudication (condition in which cramping pain the the leg can be caused by obstruction of arteries).</p> <p>A Pressure Ulcer care plan, dated 1/7/2016, indicated Resident C had a pressure ulcer to his right great toe. The care plan indicated a goal for Resident</p>			

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	<p>C's ulcer to decrease in size/heal without complications by next review. The care plan included undated interventions of: treatment as ordered, monitor per Skin Management Program and SWAT (facility's wound monitoring) protocol, monitor for treatment efficacy, pressure reducing devices to bed and chair, assist/encourage to turn and reposition at least every two hours and as needed, Xeroform (dressing change) per order, boots on bilateral feet when braces are off.</p> <p>A Contracture care plan, dated 1/7/2016, indicated Resident C suffers with contractures to bilateral knees and is at risk for further contractures. The goal indicated Resident C will be free from further contractures. Undated care plan interventions include: ensure that splints are placed as per orders and patient to wear BLE Bilateral lower extremities) daily for four hours each shift for his contractures.</p> <p>An undated Restorative Program document was provided by the Physical Therapist (PT) #66 on 1/8/2016 at 1:55 p.m. This document indicated, "...Program #1 Special Instructions: Apply RLE (right lower extremity) and LLE (left lower extremity) splint daily. Leave on for 5 hours each shift then</p>			

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	<p>remove. The record indicated a picture with instructions that an abductor bar is to be placed medial (inside) the orthotics.</p> <p>A Wound Care Evaluation, dated 12/21/15, indicated Resident C had a stage 3 (full thickness skin loss) wound to his right greater toe, measuring 0.4 cm x 0.4 cm with depth of 0.1 cm. The date of the wound's onset was 8/8/2014 and had been facility acquired.</p> <p>SWAT program documentation titled, "Ongoing Assessment of Pressure Ulcer," measurements indicated Resident C's pressure ulcer to his right medial great toe had been identified as a Stage 3 pressure ulcer on 12/31/2014 with measurements of 0.7 cm x 0.4 cm and depth of 0.1 cm. The wound continued as a stage 3 pressure ulcer with increase in length and width until it progressed to an unstageable wound on 7/16/2015 with measurements of 2.6 cm x 2.8 cm and depth of 0.1 cm. The wound was then classified down as a stage 3 pressure ulcer on 7/24/2015 with measurements of 3 cm x 3 cm and depth 0.1 cm. Resident C's wound was classified down as a stage 2 (partial thickness loss of dermis) pressure ulcer on 8/14/2015 with measurements of 3 cm x 3 cm and depth less than 0.1 cm. The wound progressed to an unstageable pressure ulcer with</p>						

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	<p>measurements of 0.3 cm x 0.3 cm and depth unable to be determined on 9/3/15. Resident C's wound was classified on 10/8/2015 as a stage 2 pressure ulcer with measurements of 1.7 cm x 1.6 cm and depth less than 0.1 cm. From 10/16/2015 to 11/6/2015, measurements indicated Resident C's pressure ulcer to his right great toe was classified as a stage 2 pressure ulcer with depth unable to be determined. On 11/13/2015, the wound continued as a stage 2 pressure ulcer with measurements less than 0.1 cm x less than 0 .1 cm and no depth. The wound progressed to a stage 3 pressure ulcer on 12/18/2015 with measurements of 2.5 cm x 2.0 cm and depth of 0.2 cm. The wound progressed to an unstageable pressure ulcer on 12/22/2015 with measurements of 1 cm x 1 cm and depth unable to be determined. Resident C's pressure ulcer to his right great toe remained at an unstageable pressure ulcer on 12/30/2015 with measurements of 1 cm x 1 cm and depth unable to be determined.</p> <p>During an interview on 1/7/2016 at 2:17 p.m., LPN #61 indicated Resident C currently had a composure (therapeutic) mattress and used to have a low air loss mattress. She indicated he wore orthotic braces to his legs from 8 a.m. to 2 p.m. She indicated the staff experience</p>			

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	<p>difficulty floating his heels due to his contracted legs.</p> <p>During an interview on 1/8/2016 at 9:34 a.m., CNA #65 indicated Resident C had orders to wear his orthotic braces to his lower legs for 4 hours each shift. She indicated she did not float his heels with a Z-flow cushion while in bed and indicated his room did not contain a cushion to float his heels with. She indicated he is repositioned in bed every 2 hours and she did not always float his heels with a pillow while in bed. She indicated he had a pair of Bunny Boots in his closet and he did not wear them during the day shift. She indicated the CNAs monitor the residents' skin conditions during each shower day by filling out a skin sheet and placing it in the shower binder. She indicated the nurses monitor the skin sheets each shift.</p> <p>During an interview on 1/8/2016 at 10:33 a.m., Unit Manager (UM) #67 indicated she had not performed Resident C's wound measurements for the week. She indicated she had been unaware if that was a task assigned to her.</p> <p>During an interview on 1/8/2016 at 10:35 a.m., the Director of Nursing (DON) indicated she expected the UM to take measurements of Resident C's wound.</p>			

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	<p>She indicated there was not an assigned date during the week, as long as the measurements were taken by Friday each week. She indicated Resident C's pressure ulcer developed within the facility. She indicated the efficacy of the resident's current wound interventions were measured by the wound measurements and visual site of the wound and this would determine if the resident required new interventions to be put in place. She indicated Resident C's current interventions were turning and repositioning every 2 hours, a low air loss mattress, heels floated while in bed, pillow between his contracted knees while in bed, and Bunny Boots applied to both of his feet when his leg orthotics are off. She indicated the Bunny Boots are padded and protect Resident C's pressure area due to him rubbing his feet together and causing pressure to his right great toe. She indicated the NP had questioned circulation issues in December 2015, but Resident C had not received any diagnostic testing to address if circulation issues had been present. She indicated the pressure area to his right great toe had been a result of his feet rubbing together.</p> <p>During an interview on 1/8/2016 at 1:26 p.m., CNA #65 indicated Resident C's orthotics had been applied incorrectly without the abductor bar present. She</p>			

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	<p>indicated the abductor bar for his orthotics remained in his closet as he had worn his orthotics for the day shift.</p> <p>During an interview on 1/8/2016 at 1:36 p.m., RNA #86 indicated she had placed Resident C's orthotics to his legs without the abductor bar between 6 a.m. to 7 a.m. She indicated she had not placed the abductor bar to his orthotics because he had been lying in bed when she applied the orthotics.</p> <p>During an interview on 1/8/2016 at 1:53 p.m., PT #66 indicated Resident C's orthotics had been applied incorrectly without the abductor bar present. She indicated the orthotics required the abductor bar to ensure abduction (to draw away from the axis of the body) of his leg contractures and keep his legs from rubbing together.</p> <p>During an interview on 1/8/2016 at 2:38 p.m. CNA #65 indicated Resident C had his orthotics applied to his legs between 6 a.m. to 7 a.m. by Restorative Nursing Assistant (RNA) #68 and she had removed his orthotics at 2:18 p.m.</p> <p>During an interview on 1/11/2016 at 11:30 a.m., the DON indicated the UM who had performed Resident C's wound measurements to his right great toe had</p>			

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	<p>incorrectly staged the pressure ulcer from 10/16/2015 to 11/6/2015 and the wound measurements had not been updated with correct information. She indicated Resident C's pressure ulcer should have been classified as an unstageable pressure ulcer to his great toe, with depth unable to be determined.</p> <p>During an interview on 1/11/2016 at 11:23 a.m., the Nurse Consultant indicated Resident C's wound to his right great toe began from pressure. She indicated it was being considered a possible venous stasis ulcer due to the facility being unable to heal the pressure area.</p> <p>During an interview on 1/11/16 at 11:25 a.m., the DON indicated the staff had not provided Resident C with correct pressure reducing interventions with his orthotics applied incorrectly, heels not floated, and staff were unaware when Bunny Boots were to be placed on the resident. She indicated she expected her nursing staff to correctly document nursing measurements and dressing treatments in the MAR and TAR.</p> <p>During an interview on 1/11/16 at 4:09 p.m., the DON indicated Resident C's Z-flow cushion had ruptured and was unavailable for an uncertain amount of</p>			

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	<p>time. She indicated the Bunny Boots had been ordered for the resident to wear while in bed until his new Z-flow cushion arrived. She indicated there should have been an order for the nursing measure of the Bunny Boots in the MAR for nursing staff to have awareness of when Resident C was to wear the Bunny Boots and the Z-flow cushion order should have been removed. She could not provide a date when the Bunny Boots were implemented.</p> <p>During an interview on 1/11/2016 at 4:11 p.m., the NP indicated he and the facility had considered Resident C's wound to his right great toe as a pressure ulcer since August 2014. He indicated since Resident C's pressure ulcer had not been able to heal with the interventions of Bunny Boots, orthotic braces applied to his legs, heels off-loaded, and treatment changes the facility had attempted, he had considered the pressure ulcer a possible venous stasis ulcer that could be a result of PVD (peripheral vascular disease) or PAD (peripheral artery disease) in December 2015. He indicated he had referred Resident C to a podiatrist and wound care via the facility's therapy department to evaluate possible venous insufficiency to the open area. He indicated Resident C did not have a history of circulatory or venous</p>			

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	<p>insufficiency diagnoses and had not received a diagnostic evaluation of PVD or PAD. He indicated Resident C had not received wound care from the outpatient wound care facility that he utilized for residents with pressure ulcers in the facility.</p> <p>During an interview on 1/12/2016 at 11:56 a.m., PT #66 indicated the facility's therapy department was able to provide consultation and observation in determining whether an open area was the result of pressure or venous insufficiency. She indicated an open area that occurs in an area of muscle, such as the calf, would indicate venous insufficiency. She indicated an open area on a bony prominence that receives pressure, such as the heel or toe, would indicate a pressure ulcer.</p> <p>3. On 1/11/2016 at 10:30 a.m., Resident D was observed lying in bed on a regular mattress tilted on his right side with the head of the bed elevated approximately 45 degrees and he was slouched down in the bed with his head at the fold of the mattress. He had a cloth boot on his right foot covering his right ankle and his pants were pulled down around his ankles and covered his heels. Resident D was observed rubbing his legs together to kick his pants down.</p>			

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	<p>On 1/11/16 at 11:53 a.m., Resident D was sitting up in his wheelchair with a foam boot on his left foot and socks on his bilateral feet. Resident D wore only a sock on the right foot. Licensed Practical Nurse (LPN) #23 indicated the foam boot was a heel protector.</p> <p>On 1/11/16 from 1:09 p.m. to 1:12 p.m., Resident D was sitting in his wheelchair in front of his room. Resident D had socks on bilateral feet and a foam boot on the left foot. The right foot only had a sock on it. Resident D was observed to have both feet on the foot pedals, then he lifted both feet off of the pedals and placed them on floor behind the foot pedals. Resident D placed both feet back on the foot pedals before he lifted his right leg and placed it on top of his left knee.</p> <p>On 1/11/16 at 3:37 p.m., Resident D was laying on his back on his mattress with a protective boot on his right foot. His feet were lying against the mattress.</p> <p>On 1/12/16 at 9:56 a.m., Resident D's right heel wound was observed with Unit Manager (UM) #63. Resident D was lying on his left side on his mattress with his pants down to his knees. Both of his heels were lying against the mattress. A</p>			

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	<p>black protective boot was on his right heel, and blue foam boot was on his left heel. Resident D had socks on both feet under the boots. Unit Manager #63 removed the black boot and sock from his right foot. An area approximately the size of a quarter was noted on his right heel with a pink center. Black eschar (dead tissue) surrounded the sides of the open area and around the top. The black eschar on the top of the wound was approximately the size of a dime, and the eschar on the sides were approximately a quarter of an inch wide and half an inch in length. UM #63 applied skin prep to the wound, and placed his sock and protective boot back onto his foot.</p> <p>On 1/12/16 at 10:05 a.m., Resident D was lying on his left side on his mattress with protective boots on both feet and his boots lying against the mattress.</p> <p>On 1/12/16 at 11:21 a.m., Resident D was lying on his back on his mattress with protective boots on both feet and his feet flat against the mattress.</p> <p>On 1/12/16 at 12:53 a.m., Resident D was propelling his wheelchair down the hall with his feet. He had a black protective boot on his right heel and a blue foam boot on his left heel.</p>			

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	<p>On 1/12/16 at 2:35 p.m., Resident D was lying on his back on his mattress with protective boots on both feet and his feet lying against the mattress.</p> <p>On 1/13/16 at 11:20 a.m., Resident D was lying on his back with both feet in foam boots lying flat against the mattress.</p> <p>On 1/11/16 at 10:02 a.m., Resident D's record was reviewed. The form titled, "Admission/Re-admission Resident Assessment," dated 8/17/15, indicated Resident D had a deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying tissue) on his right heel. The form indicated "bunny" boots and skin prep were to be applied to both heels. The form indicated the resident required total assistance, was non-weight bearing, and needed a Hoyer lift.</p> <p>The form titled, "Non-Pressure related skin condition," initiated on 8/17/15, indicated Resident D had a suspected deep tissue injury (DTI) on his right heel that measured 2 centimeters (cm) by 3 cm.</p> <p>The form titled, "Initial Pressure Ulcer Assessment," dated 8/17/15 to 1/8/16, indicated Resident D's had a deep tissue injury (DTI) to his right heel. On 8/17/15,</p>			

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	Resident D's DTI measured 2 centimeters (cm) in length by 3 cm in width, and the depth could not be visualized. On 9/3/15, Resident D's DTI measured 10 cm in length by 4 cm in width, and the depth could not be visualized. On 9/9/15, the DTI measured 9 cm in length by 3 cm in width, and the depth could not be visualized. On 9/17/15, Resident D's DTI measured 8 cm in length by 2 cm in width, and the depth could not be visualized. On 10/2/15, the DTI measured 6 cm in length by 5 cm in width, and the depth could not be visualized. On 10/8/15, the DTI measured 3 cm in length by 3 cm in width, and the depth could not be visualized. On 10/23/15, the DTI measured 1.5 cm in length by 1.5 cm in width, and the depth could not be visualized. On 10/29/15, Resident D's DTI measured 1 cm in length by 1 cm in width, and the depth could not be visualized. On 11/25/15, Resident D's DTI measured 1.5 cm in length by 2 cm in width, and the depth could not be visualized. On 12/8/15, the DTI measured 1.5 cm in length by 1.8 cm in width, and the depth could not be visualized. On 12/18/15, the DTI measured 2 cm in length by 3 cm in width, and the depth could not be visualized. On 12/25/15, Resident D's DTI measured 2 cm in length by 3 cm in			

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	<p>width, and the depth could not be visualized. On 1/1/16, the DTI measured 2 cm in length by 3 cm in width, and the depth could not be visualized. On 1/8/16, Resident D's DTI measured 1.8 cm in length by 2.8 cm in width, and the depth could not be visualized.</p> <p>The lab results, dated 8/21/15, indicated Resident D had a low albumin level, and a normal protein level.</p> <p>The pressure ulcer risk care plan, initiated on 9/4/15, stated Resident D was "...at risk for the development of pressure ulcers due to:...Extensive assist with bed mobility...impaired cognition (sic)...Diabetes, HX (history) CVA (cerebrovascular accident), confined to bed and chair...Limited ROM (range of motion), left side weakness." Interventions did not include pressure reducing boots or to float his heels while in bed.</p> <p>The form titled, "Care Plan Conference Record," dated 9/8/15, indicated Resident D had a deep tissue injury to his left heel and he was dependent on staff for all activities of daily living and transfers.</p> <p>The dietary notifications form, dated 9/23/15, indicated Resident D had a deep tissue injury on his right heel. The form</p>			

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	<p>indicated Resident D was on a regular pureed diet, his weight was stable, and the physician had been notified of his low albumin level.</p> <p>The physician order, dated 10/2/15, ordered skin prep to the resident's right heel.</p> <p>The form titled, "Braden Scale for Predicting Pressure Ulcer Risk," dated 11/23/15 and 12/15/15, indicated Resident D had a score of 14 out of 18, and was at a moderate risk for developing pressure ulcers.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 11/24/15, indicated Resident D had a Brief Interview for Mental Status score of 9 out of 15, and had moderate cognitive impairment. The MDS indicated Resident D required extensive assistance of one person for bed mobility, locomotion, dressing, personal hygiene, and bathing. The MDS indicated Resident D required extensive assistance of two people for transfers. The MDS indicated Resident D had one unstageable pressure ulcer that was a suspected deep tissue injury.</p> <p>The form titled, "Care Plan Conference Record," dated 12/15/15, indicated Resident D's deep tissue injury to his left</p>			

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	<p>heel was healing and he was dependent on staff for all activities of daily living and transfers.</p> <p>The activities of daily living (ADL) care plan, revised on 12/15/15, stated Resident D required, "...up to total/2 assist in performing ADL's due to : Dementia (sic), weakness, risk for falls, Delirium, Cognitive loss, Moderately impaired vision, Abnormal lab level, use of psychotropic medications, limited ROM (range of motion), incontinence." The care plan indicated Resident #30 had diagnoses including, but not limited to: diabetes, history of cerebrovascular accident, altered mental status, and congestive heart failure.</p> <p>The physician order, dated 12/18/15, discontinued the dressing to Resident D's right heel due to the area being "closed/intact."</p> <p>The physician order summary, dated 12/28/15, discontinued the foam boot and sterile dressing to Resident D's right heel.</p> <p>The physician order summary, dated 12/28/15, indicated the following was ordered on 10/29/15, "float both heels while in bed."</p> <p>The form titled, "C.N.A. Assignment</p>			

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	<p>Sheets," dated 1/4/16, indicated Resident D required a Hoyer lift, had a concave mattress, and was to have his heels floated.</p> <p>During an interview on 1/11/16 at 1:24 p.m., Unit Manager #63 indicated Resident D had a deep tissue injury (DTI) to his right heel and it was acquired in the facility on 8/2/15. UM #63 indicated she was unsure how he had obtained the DTI because he was able to reposition himself. She indicated she thought the DTI was not found during his most recent readmission assessment, so the facility had to claim the wound as a facility acquired wound. She indicated the wound presented as a colored area of skin with a hard disc in the center and no open area. She indicated Resident D was to have padded boots on both heels in bed, and socks on bilateral feet and a boot on the right heel when he was up in the wheelchair.</p> <p>During an interview on 1/12/16 at 9:56 a.m., Unit Manager (UM) #63 indicated Resident D had a black protective boot for his right heel to relieve pressure from the wound. She indicated the blue foam boot on Resident D's left foot was only for preventative measures. UM #63 indicated Resident D was not wearing the black boot on his right foot on 1/11/16</p>			

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	<p>afternoon while he was in his wheelchair, and she had to track him down to put it on him.</p> <p>During an interview on 1/12/16 at 3:15 p.m., the Director of Nursing (DON) and the Nurse Consultant indicated they believed Resident D was admitted with the wound on his right heel from the hospital.</p> <p>During an interview on 1/12/16 at 3:28 p.m., Licensed Practical Nurse (LPN) #24 indicated the order for the heel dressing was discontinued not the protective boot. She indicated the order for the heel protector was in treatment administration record (TAR). LPN #24 indicated Resident D had an order to float his heels in bed.</p> <p>During an interview on 1/13/16 at 11:21 a.m., Certified Nursing Assistant (CNA) #25 indicated she was the CNA for Resident D and she was unaware Resident D had a wound on his foot or any interventions in place related to his wound.</p> <p>A Skin Management Program policy, dated 10/2013, and identified by the DON as current on 1/12/2016 at 3:05 p.m., indicated the following, "Policy: This facility will assess/identify the presence</p>			

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	<p>of risk factors that may contribute to the development of pressure ulcers and other skin alterations in an effort to prevent skin breakdown and/or further deterioration limited by the individuals' recognized pathology and pre-existing co-morbid conditions.</p> <p>Assessment/Documentation/Monitoring: A comprehensive head to toe assessment will be completed by a licensed nurse upon admission, readmission and at least weekly thereafter...See Weekly Skin Assessment (to be used for weekly skin assessments for all residents...Residents who receive assistance with bathing and/or peri-care will be observed daily by nursing staff and any observance of red areas, open areas, skin tears, bruises, rashes, abrasions, excoriations or other alterations in skin will be reported to the licensed nurse for further assessment...See Shower Observation Sheet: to be completed by the direct caregiver and given to licensed nurse on charge when a resident is assisted to bathe/shower...Residents who wear a device such as a splint, brace, immobilizer, etc. will have his/her affected limb(s) assessed daily by a licensed nurse due to greater risk of skin breakdown....</p> <p>This Federal tag relates to complaint IN00190839.</p>			

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