

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155702	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/10/2011
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NAME OF PROVIDER OR SUPPLIER  CARING HANDS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1850 MATADOR ST PERU, IN46970
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F0000	<p>This visit was for the Investigation of Complaint IN00098470.</p> <p>Complaint IN00098470 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309.</p> <p>Survey dates: 11/9-10/11</p> <p>Facility number: 003130 Provider number: 155702 AIM number: 200386750</p> <p>Survey team: Ellen Ruppel, RN</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 15 Medicaid: 49 Other: 13 Total: 77</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/15/11 by Suzanne</p>	F0000	<p>The following correction or any corrective action set forth herein does not constitute an admission or agreement by Caring Hands Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and corrective action are prepared and executed solely as provisions of Federal and State law. Caring Hands Health Care Center requests that this plan of correction be considered the facility's credible allegation of compliance.</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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F0309 SS=G	<p>Williams, RN</p> <p>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, interviews and record review, the facility failed to ensure a treatment for edema did not cause increased risk of tissue breakdown, due to lack of prior evaluation of the circulatory condition, for 1 of 1 resident (Resident C) being treated with compression wraps in a sample of 4. This resulted in deep tissue injuries and stage III and unstageable open areas to both of Resident C's feet.</p> <p>Findings include:</p> <p>The closed clinical record of Resident C was reviewed, on 11/9/11 at 11:10 a.m., and indicated the resident had lived in the facility since 2006. Her diagnoses included, but were not limited to: paranoid schizophrenia, hypertension, angina and paralysis agitans. The most current Minimum Data Set (MDS) assessment, dated 7/8/11, indicated the resident was confused and in need of extensive assistance for transfers. The assessment indicated no open skin areas were present.</p> <p>Physician's orders, dated 8/2/11 indicated</p>	F0309	<p><b>1. Resident C no longer resides at this facility. 2. All charts have been reviewed for Residents receiving compression therapy for edema management. No Residents have been identified as receiving compression therapy. 3. All licensed nursing staff and therapy department have been in-serviced on the new Compression Therapy Triple Check system that includes the following steps: a. Goal: To reduce edema. b. A physician order will be obtained for compression therapy. c. An Arterial Doppler test will be obtained prior to initiating compression therapy. d. The chart will be reviewed for evidence of an appropriate diagnosis. e. The licensed therapist will determine the appropriate product selection for compression therapy. f. The Triple Check Team, consisting of the Wound Care Nurse, DON, Therapist and Administrator will meet prior to the initiation of the</b></p>	12/05/2011
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	<p>the physical therapist had requested an arterial doppler study of both lower extremities.</p> <p>Physical therapy notes, dated 8/2/11 at 12:30 p.m., indicated, "Requires continued skilled edema management. Spoke to Nursing who is calling MD and explained her presence of Edema L (left) greater than R (right) and current use of TED (thrombo embolic deterrent) hose. Edema still present and she could benefit from management/lymph massage. Nursing to explain current medical condition to MD of chronic kidney disease and renal failure diagnosis. She has slightly shiny and hairless toes unable to determine capillary refill due to fungus. Nursing and PT (physical therapy) requested arterial doppler. Plan to order materials for edema wrapping and initiate after doppler results is (sic) appropriate and then secure correct garment and wearing schedule. Will write orders ect. after doppler and materials obtained and initiate goals as well at that time along with measurements."</p> <p>Nurses notes, dated 8/5/11 at 11:45 a.m., indicated, "Resident out for arterial doppler at approx (approximately) 0930 (9:30 a.m.) this day at (name of hospital) with Caring Hands bus. Appointment had been pushed back an hour for</p>		<p><b>compression therapy to ensure all above steps have been addressed appropriately and that there are no contraindications for use of the compression therapy. The Triple Check form will be signed off and maintained by the DON during the time the resident receives compression therapy. g. Any resident with a potential need for compression therapy will be evaluated using the Compression Therapy Triple Check method. 4. The results of the residents that are being evaluated for compression therapy will be presented to the QA Committee. Any recommendations made by the Committee will be followed. 5. Completion Date: 12-5-2011</b></p>		

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	<p>appointment at 1000 (10:00 a.m.) instead of 0900. Resident sent with transfer papers and bed hold. Resident back at facility at approx 1145 this day. No new orders. Tech (technician) at (name of hospital) had called (physician's name) office for clarification orders and arterial doppler was changed to venous doppler due to edema. Preliminary Lower Venous Findings show that all vessels compress consistent within normal study. Dr (physician's name) has been notified as well as therapy."</p> <p>Therapy notes, dated 8/17/11 at 9:27 a.m., indicated, "spoke to staff involved in care. Edema management to be initiated once supplies obtained from outside source. Contract pending. ABI (ankle brachial index, or arterial doppler) completed and NORMAL. Md (sic) authorized program. Will initiate with orders once appropriate."</p> <p>The note indicated a second time that the arterial doppler was normal. The test which had been done was a venous doppler, rather than an arterial one.</p> <p>Review of a faxed information sheet, dated 8/5/11 from the hospital to the facility and included in the resident's record, indicated the test which had been done was a lower venous study, and the preliminary results were normal.</p>			

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	<p>Therapy notes, dated 8/22/11 at 11:49 a.m., indicated the compression wraps had been applied.</p> <p>Nurses notes, dated 8/22/11 at 10:27 a.m., also indicated the edema management had begun with therapy and if the wraps became loose, nursing would apply double layer of tubigrip to the lower legs until physical therapy could reapply the wraps.</p> <p>Nurses notes, of 8/24/11 at 10:53 a.m., indicated physical therapy had been notified of red areas on top of the right foot and on the outer portion of the right foot near the little toe.</p> <p>Physical therapy notes, of 8/24/11 at 2:15 p.m., indicated petechia was observed on the foot and the wound team was aware. The note indicated no open area and a fluid filled blistered area was observed by the therapist. The entry indicated, "L (left) Lateral 5th stylus with slight errythema (sic) after wrap removal and noted fluid filled blister just distal to MCP (metacarpal) UNKNOWN (SUSPECT POSSIBLE FRICTION.)" The entry indicated the area would be inspected the next day and the wrappings would be stopped if the petechia worsened.</p>				

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	<p>The therapy note, of 8/25/11 at 12:27 p.m., indicated the petechia was not worse and had subsided slightly. The note indicated more padding was used for both feet.</p> <p>The next therapy note, dated 8/26/11 at 10:07 a.m., indicated the wraps would be padded with more layers and the tension decreased for the application for the weekend.</p> <p>Therapy notes, on 8/29/11 at 11:49 a.m., indicated "...Her skin does not tolerate the wrappings despite increased padding and significantly decrease tension on Friday's application." A second entry on 8/29/11 at 1:06 p.m., indicated, "Due to foot bruising (pressure deep tissue injury) the team determined the best support would be the B (bilateral) foot boots in place 24 hours and to ensure she does not cross her legs or apply pressure to her feet across the boney prominences. Suspect there are underlying issues causing this significant amount of discoloration and lab tests/values are being requested by MD and D/C (discontinuance) of wraps and compression this date....."</p> <p>During an interview with the wound nurse (LPN #3), on 11/9/11 at 12:40 p.m., she indicated the first she saw Resident C's feet was on 8/29/11 and she initiated a</p>				

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	<p>wound report. She provided the wound report which identified 9 areas of "suspected deep tissue injury." The areas were identified as:</p> <p>L (left) dorsal foot 3.8 centimeters (cm) long by 2.9 centimeters wide with no depth.</p> <p>L anterior ankle 4.7 cm by 0.3 cm with no depth</p> <p>R (right) dorsal foot 9.2 cm by 4.7 cm with no depth</p> <p>L gt (great) metatarsal 2.4 cm by 2.9 cm with no depth</p> <p>L 5th metatarsal 6.0 cm by 3.0 cm with no depth</p> <p>R gt metatarsal 2.0 cm by 2.0 cm with no depth</p> <p>R 5 th metatarsal 6.2 cm by 3.0 cm with no depth</p> <p>L Achilles 7.0 cm by 1.0 cm with no depth</p> <p>R Achilles 7.0 cm by 1.7 cm with no depth</p> <p>Physical therapy notes, dated 8/31/11 at 12:24 p.m., indicated, "Chart reviewed extensively by wound care nurse, myself and corporate liaisons (sic) after significant compromise noted in vessel study performed today. After review it was noted that study performed on 8-5-11 was actually a venous study. Wraps had already been discontinued. Plan after</p>				

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	<p>consultation is to continue with hematoma reduction on lateral border of foot and posterior section. Reportedly by wound care nurse the areas all look improved in color and the blistered area had indeed ruptured and drained but is intact in its covering. All goals currently on hold and management for bruising has become only needed skilled intervention at this time to prevent skin breakdown on BLE (bilateral lower extremities) ankle/feet areas. With much input determination of best plan of care and determination of course of care has been decided to focus on wound healing of deep tissue injury and then refocus on goal attainment with total cessation of edema management due to NON compressibility of the RLE (right lower extremity) and LLE (left lower extremity) at 79 from study performed at this date (8-31-11)."</p> <p>Nurses notes, dated 9/2/11 at 13:09 (1:09 p.m.) indicated "MD here to see resident, viewed bilateral lower extremities, slight edema noted, area to top of right foot purple in color, blister no longer intact, moderated (sic) amount of brown/yellow drainage noted, no foul odor noted, pedal pulses palpable bilaterally. area to right lateral foot near pinky toe, purple in color, not open, area to achilles tendon area right foot, purple/pink in color. skin prep applied to all areas, non stick versiva</p>				

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	<p>applied then wrapped foot loosely with kerlex. left foot area top of foot, pink/purple, not open, area noted to back of ankle as well, dark pink in color, skin prep applied to areas, covered with non stick versiva, wrapped loosely with kerlex. no signs of any pain, currently up in wc (wheelchair) only for meals and light PT/OT (physical therapy/occupational therapy), has air flow mattress as well."</p> <p>Nurses notes, dated 9/8/11 at 15:50 (3:50 p.m.), indicated the physician had been updated about the wounds and informed that the Left dorsal foot now was a stage III area. The entry indicated Santyl was ordered for daily application.</p> <p>Wound notes, dated 9/19/11 at 13:40 (1:40 p.m.), indicated the areas on the right dorsal foot and left dorsal foot were stage III, both with depths of less than 0.1 cm. The right 5th metatarsal and left 5th metatarsal were described as unstageable with black eschar and the right achilles area was also described as unstageable.</p> <p>During an interview with Physical Therapist #13, on 11/10/11 at 10:40 a.m., she indicated she had seen the faxed doppler study of 8/5/11, but had not noticed the test was a venous doppler</p>				

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	<p>rather than the arterial one needed prior to initiating a compression wrapping of Resident C's lower extremities. She indicated she would not have started the wraps if she had realized the doppler was not an arterial one.</p> <p>Review of an arterial doppler test, dated 8/31/11, indicated "Conclusions Lower Arterial Doppler *The ankle brachial index on the right indicated moderate arterial occlusive disease. *The ankle brachial index on the left indicated moderate arterial occlusive disease."</p> <p>The product information sheet for the Comprilan Compression Wrap system was provided by Therapist #8, on 11/10/11 at 10:00 a.m. The information sheet indicated a lower leg assessment including an ankle brachial index must be done prior to the use of the wraps and the contraindication for the use was, "1. Do not use in the presence of arterial insufficiency."</p> <p>Resident C was transferred to another facility, on 9/26/11. She was observed in the new facility, on 11/10/11 at 8:15 a.m., with the unit nurse of the current facility. The resident was sitting in a wheel chair with her feet supported by pressure relieving boots. According to the admission assessment at the new facility,</p>				

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	<p>which was reviewed with the unit nurse, on 11/10/11 at 8:30 a.m., the resident had been admitted on 9/26/11 with areas described as, "Back of R leg/foot sore/wound 5X2 cm yellow sloth. Top (R) foot wound 6x2 cm, R lateral foot sore/dry 2X0.5 cm. (L) outer foot blood blister /dry 2X1 cm. (L) top foot wound 1X2 cm c (with) yellow sloth..." The unit nurse indicated the family was considering hospice care for the resident.</p> <p>This federal tag relates to Complaint IN00098470.</p> <p>3.1-37(a)</p>				