

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/03/2015
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NAME OF PROVIDER OR SUPPLIER APERION CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180682.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00177352 completed on July 17, 2015.</p> <p>Complaint IN00180682 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F314.</p> <p>Survey dates: August 31, 2015 and September 2 & 3, 2015.</p> <p>Facility Number: 000025 Provider Number: 155064 AIM Number: 100274850</p> <p>Census Bed Type: SNF: 3 SNF/NF: 50 Total: 53</p> <p>Census Payor Type: Medicare: 6 Medicaid: 37 Other: 10 Total: 53</p> <p>Sample: 4</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0157 SS=G Bldg. 00	<p>Supplemental Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on September 8, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>			

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility failed to ensure immediate notification of the resident's legal representative and physician for intervention, when a resident had a pressure ulcer which deteriorated for 1 of 4 resident's reviewed for notification of change in condition. (Resident "B").</p> <p>This deficient practice resulted resulted in a delay of treatment, a decline in a resident's condition (Resident "B") where the resident was subsequently transported and admitted to Intensive Care of the local area hospital for sepsis, and treatment of a Stage Four Pressure ulcer.</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-31-15 at 1:00 p.m. Diagnoses included, but were not limited to, dementia with behaviors, dysphagia, depressive disorder, and hypothyroidism. These diagnoses remained current at the time of the record review.</p>	F 0157	<p>F157</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p>	09/21/2015

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	<p>The record indicated that at the time the resident was admitted to the facility the resident's skin was intact. The Initial Braden scale (a system used to identify resident's at risk for pressure ulcers), dated 05-19-15 indicated the resident was at risk for the development of pressure ulcers.</p> <p>The resident's plan of care, dated 07-21-15, instructed the nursing staff to "Observe/document/report to MD [Medical Doctor] PRN [as needed] changes in skin status. Appearance, Color, wound healing, s/sx [signs/symptoms] of infection, wound size (Length times Width times Depth), Stage."</p> <p>A review of the Interdisciplinary Progress Notes indicated the following:</p> <p>"07-20-15 20:40 [8:40 p.m.] - Coccyx reported as a pink intact area."</p> <p>"07-22-15 14:02 [2:02 p.m.] - Coccyx reported as a pink intact area per 07-20-15 skin note, not new. However orders indicate area to coccyx is open. Will ask nurse to clarify coccyx."</p> <p>"07-22-15 14:57 [2:57 p.m.] - DON [Director of Nurses] said coccyx is open, superficial. Treatment ordered. Will</p>		<p>Resident #B was discharged from the facility.</p> <p>2) How the facility identified other residents:</p> <p>Residents with pressure ulcers were assessed and documentation reviewed.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be re-educated regarding policy for timely notification of physician and responsible party for change in condition.</p> <p>4) How the corrective actions will be monitored:</p> <p>Documentation will be reviewed at</p>	

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	<p>review upcoming wound reports, expect it will heal quickly."</p> <p>"07-23-15 05:28 [5:28 a.m.] - ...Tx [treatment] to coccyx, drsg [dressing] intact, no further areas noted."</p> <p>"07-23-15 12:15 [12:15 p.m.] - Skin condition: superficial."</p> <p>"07-24-15 02:26 [2:26 a.m.] - Coccyx continues with tx. as ordered, no redness, or drainage to or around dressing, no c/o [complaints of] verbally, pleasant."</p> <p>"07-28-15 02:39 [2:39 a.m.] - Tx. to coccyx continues as ordered, no bleeding, mild drainage clear/light yellow, are cleaned and dried sterile technique/clean technique, tender to touch area, applied foam derma as ordered, tolerated."</p> <p>"07-29-15 01:28 [1:28 a.m.] - Skin concerns observed: coccyx - treatment in progress. Moist to dry dressing."</p> <p>"07-29-15 05:45 [5:45 a.m.] - Treatment continues to coccyx. Cleansed, applied moist dressing and covered with transparent dressing. Small amount of bloody drainage noted. Complaint of tenderness with touch. Slight odor noted."</p>		<p>least 3-5 times per week to ensure physician and responsible party were notified of change in condition in a timely manner.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 9-21-15</p>	

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	<p>"07-31-15 02:50 [2:50 a.m.] ...coccyx area pink with dk. [dark] brown area by open area, cleansed, wet to dry drsg. [dressing] and covered, tender to touch...."</p> <p>A review of the "Skin/Pressure Report dated 07-21-15 indicated, "new wound development, open area to coccyx - abrasion 7.0 cm [centimeters] by 2.0 cm. Acquired in house/pressure. Date first observed 07-20-15 - epithelial, granulation with no signs or symptoms of infection. Periwound intact. Treatment - Calmoseptine and foam."</p> <p>A physician order, dated 07-21-15 indicated, "cleans [sic] open area to coccyx with Normal Saline, pat dry. Apply small amount of Calmoseptine [a skin barrier treatment] ointment BID [two times a day] and PRN [as needed] for soilage until healed every day and night shift for open area." The order did not indicate the use of a foam dressing, wet to dry dressing or transparent dressing.</p> <p>Further review of the Skin/Pressure Reports indicated on 07-24-15 the area measured .5 cm by .2 cm by .1 cm and was assessed as a Stage Two [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink</p>			

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	<p>wound bed, without slough] pressure area.</p> <p>A review of the Skin/Pressure report dated 07-31-15, 7 days later, indicated the area was now assessed as a "Stage 4 [Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed and often include undermining and tunneling] pressure ulcer and measured 4.6 cm by 3.4 cm by .3 cm." The assessment indicated the area was "worsening, had granulation, with slough and was necrotic." The drainage was identified as "serosanguinous" and the "periwound was discolored."</p> <p>A subsequent review of the Skin/Pressure report, dated 08-07-15 indicated the pressure ulcer increased in size to "4.8 cm by 4.2 cm by .3 cm" and was assessed as a "Stage Four" pressure ulcer. The assessment indicated the area was "worsening, had slough and eschar with moderate amount of purulent drainage, discoloration and edema to the periwound and displayed with signs and symptoms of infection."</p> <p>The nursing staff failed to notify the physician for medical intervention, on 07-28-15 when the area was first noted</p>			

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	<p>with mild drainage, and then on 07-29-15 when the area was noted with bloody drainage, a slight odor and complaints of tenderness by the resident to the area, and subsequently did not report the area until it was assessed on 07-31-15 as a Stage Two pressure ulcer when the nurse documented the area had a dark brown area adjacent to the open area and the resident continued to complain of tenderness.</p> <p>Further review of the resident's clinical record indicated the resident had a change in condition and was transported to the local area hospital on 08-08-15.</p> <p>On 8-31-15 at 9 a.m., the ambulance report dated 8-8-15 was reviewed and indicated the resident had a temperature of 101.9 Fahrenheit, a pulse of 115 and respiration rate of 24. The report indicated that when the ambulance crew arrived at the facility, four nurses were "holding his hands to prevent them from shaking."</p> <p>A review of the Hospital record on 08-31-15 at 8:30 a.m., for the dates 8-8-15 through 8-19-15 indicated that upon arrival at the local hospital Emergency Room, the resident's white blood cell count was 19.8 (with a normal range of 3.3 to 10.5) and diagnosed with</p>			

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	<p>"multi organism sepsis with fever and decubitus ulcer overlying the lower sacrum and coccyx."</p> <p>A review of the hospital "Wound Care,"documentation indicated the resident "came from Aperion nursing facility and had decubitus ulcer to coccyx upon arrival to [name of local area hospital]. The wound has a strong odor and has eschar on it." The Wound Nurse indicated there was a "Large amount of purulent drainage. Photo and measurements completed." The documentation indicated the pressure ulcer measured "5 cm long by 3 cm wide and 5 cm deep with necrotic tissue."</p> <p>The hospital physician notation indicated, the resident presented to the hospital with a "deep infected sacral decubitus ulcer" and underwent a debridement procedure to the wound. "The size of the area treated [by debridement] was approximately 10 cm long by 7 cm wide by 3 cm deep with all necrotic devitalized tissue removed."</p> <p>During an interview on 09-02-15 at 2:00 p.m., the Wound nurse indicated the legal representative for the resident had not been notified of the pressure area, and the nursing staff had been communicating with the resident's spouse. "We thought</p>			

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	<p>she [in regard to the spouse] was the contact person and didn't know she had some dementia until later on. We talked with her almost daily."</p> <p>During a further interview on 09-03-15 at 10:00 a.m., the Wound Care Nurse verified the nursing staff did not follow the physician orders dated 07-21-15, "There are some areas that need to breath and not be covered."</p> <p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled, "Change in Condition Physician Notification Overview Guidelines," and dated 01-01-2014, indicated the following:</p> <p>"These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2. Medical care problems are communicated to the attending physician in a timely, concise, and thorough manner."</p> <p>"Nurse Responsibilities - The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention."</p>			

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	<p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled "Pressure Ulcer and Skin condition Assessment Policy," dated 01-01-2015, indicated the following:</p> <p>"Policy: It is the policy of this facility that pressure and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and recorded on the facility approved wound assessment form."</p> <p>"Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented."</p> <p>"Standards: ... 2. Residents identified by the Braden scale of being at risk of a skin breakdown will have a weekly skin assessment by a licensed nurse. 7. At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative and attending physician will be notified.... 14. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record. ... 18. The licensed nurse is responsible for notifying the</p>			

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F 0314 SS=G Bldg. 00	<p>attending physician, Director of Nursing and legal representative of any suspected wound infection. ... 21 A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible party will be notified by change nurse."</p> <p>The Federal tag relates to Complaint IN00180682.</p> <p>3.1-5(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure 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, record review and interview the facility failed to ensure resident's with pressure ulcers received the necessary treatment and services to promote healing and prevent infection for 3 of 3 resident's reviewed with pressure</p>	F 0314	<p>F314</p> <p>The facility requests paper compliance for this citation.</p>	09/21/2015			

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	<p>ulcers in a sample of 4. (Residents "B", "F" and "H").</p> <p>This deficient practice resulted in a decline in a resident's condition (Resident "B") which included sepsis, and a Stage Four Pressure ulcer which resulted in a hospitalization for the resident. The resident was admitted to the Intensive Care Unit underwent surgical debridement of the pressure ulcer.</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 08-31-15 at 1:00 p.m. Diagnoses included, but were not limited to, dementia with behaviors, dysphagia, depressive disorder, and hypothyroidism. These diagnoses remained current at the time of the record review.</p> <p>The record indicated that at the time the resident was admitted to the facility the resident's skin was intact. The Initial Braden scale (a system used to identify resident's at risk for pressure ulcers), dated 05-19-15 indicated the resident was "at risk" for the development of pressure ulcers. The clinical record contained an additional Braden Scale assessment, dated 05-19-15, where the resident was identified as "moderate risk" for pressure ulcers. A subsequent Braden scale dated</p>		<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #B has been discharged from the facility.</p> <p>Resident #F- Dressing and Prevalon boot was applied to left heel as ordered.</p> <p>Resident #H- Dressing was applied to coccyx as ordered.</p>		

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	<p>07-21-15 indicated the resident remained "at risk" with a score of "15."</p> <p>The resident's plan of care, dated 07-21-15, instructed the nursing staff to "Observe/document/report to MD [Medical Doctor] PRN [as needed] changes in skin status. Appearance, Color, wound healing, s/sx [signs/symptoms] of infection, wound size (Length times Width times Depth), stage."</p> <p>A review of the Interdisciplinary Progress Notes indicated the following:</p> <p>"07-20-15 20:40 [8:40 p.m.] - Coccyx reported as a pink intact area."</p> <p>"07-22-15 14:02 [2:02 p.m..] -Coccyx reported as a pink intact area per 07-20-15 skin note, not new. However orders indicate area to coccyx is open. Will ask nurse to clarify coccyx."</p> <p>"07-22-15 14:57 [2:57 p.m.]- DON [Director of Nurses] said coccyx is open, superficial. Treatment ordered. Will review upcoming wound reports, expect it will heal quickly."</p> <p>"07-23-15 05:28 [5:28 p.m.]- ...Tx [treatment] to coccyx, drsg [dressing] intact, no further areas noted."</p>		<p>2) How the facility identified other residents:</p> <p>All residents with pressure ulcers were assessed to ensure proper treatment/dressings and devices were in place as ordered.</p> <p>3) Measures put into place/ System changes:</p> <p>Treatment orders and care plan for all residents with pressure ulcers were reviewed to ensure appropriate treatment and interventions are in place as ordered.</p> <p>Licensed nurses will be re-educated regarding wound assessment, including physician notification of acute significant changes and infection, monitoring of wound dressing placement and timely replacement of dressing when dislodged.</p> <p>Wound nurse will observe pressure ulcers at least 3 times per week to</p>	

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	<p>"07-23-15 12:15 [12:15 p.m.] - Skin condition: superficial."</p> <p>"07-24-15 02:26 [2:26 a.m.]- Coccyx continues with tx. as ordered, no redness, or drainage to or around dressing, no c/o [complaints of] verbally, pleasant."</p> <p>"07-28-15 02:39 [2:39 a.m.] - Tx. to coccyx continues as ordered, no bleeding, mild drainage clear/light yellow, are cleaned and dried sterile technique/clean technique, tender to touch area, applied foam derma as ordered, tolerated."</p> <p>"07-29-15 01:28 [1:28 a.m.]- Skin concerns observed: coccyx - treatment in progress. Moist to dry dressing."</p> <p>"07-29-15 05:45 [5:45 a.m.] - Treatment continues to coccyx. Cleansed, applied moist dressing and covered with transparent dressing. Small amount of bloody drainage noted. Complaint of tenderness with touch. Slight odor noted."</p> <p>"07-31-15 02:50 [2:50 a.m.] ...coccyx area pink with dk. [dark] brown area by open area, cleansed, wet to dry drsg. [dressing] and covered, tender to touch...."</p>		<p>assess wound healing and progress.</p> <p>Facility has contacted a Wound Care Physician to provide wound consultations at the facility on a weekly basis.</p> <p>4) How the corrective actions will be monitored:</p> <p>Pressure ulcer treatment orders will be reviewed weekly to ensure orders are transcribed correctly.</p> <p>Residents with pressure ulcer dressings will be observed randomly at least 3x/week at varied times to ensure correct wound dressing and devices are in place as ordered.</p> <p>Documentation will be reviewed at least 3-5 times per week for all residents with pressure ulcers to ensure physician is notified of acute changes in a timely manner.</p>				

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	<p>"08-01-15 00:32 [12:32 a.m.] - Area to coccyx continues. Tx. as ordered. Tender to touch. Resident has discomfort to area, receives Tylenol [an analgesic] prn [as needed] monitoring fever and s/s of infection."</p> <p>"08-01-15 11:17 [11:17 a.m.] Wound bed black in color, strong odor noted. Mild drainage noted to area." The nurse notified the physician and received an order to culture the wound due to malodor and low grade temperature.</p> <p>"08-02-15 00:00 [12 a.m.] Malodorous with bloody serous drainage noted on old dressing but not in wound bed. Perimeter of wound black with reddish brown wound bed. Specimen obtained via culture swab."</p> <p>"08-02-15 18:15 [6:15 a.m.] - Culture needs to re done due to expired culture swab. Asked for lab tech [technician] to deliver culture swab so this writer can swab wound and send specimen to lab with this run. Per Lab. [Laboratory] they will contact dispatch to attempt to have lab tech. bring a culture swab."</p> <p>In addition the clinical record indicated the facility did not provide an anti pressure reducing device to the resident's bed or wheelchair until 08-02-15.</p>		<p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of compliance: 9/21/15</p>	

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	<p>"08-03-15 03:45 [3:45 a.m.]- Collected specimen via culture swab. Wound bed reddish brown, perimeters black. Small amount of serous drainage. Less odorous than yesterday. Complaint of tenderness with treatment."</p> <p>The culture result dated 8-6-15 indicated the area included organisms as Pseudomonas Aeruginose - Heavy Growth, Enterococcus Faecalis - Heavy Growth, and two Different Gram Negative Rod - Heavy Growth."</p> <p>The resident was started on the antibiotic Clindamycin 600 mg [milligrams] three times a day. However the facility was notified the organism was resistive to the antibiotic on 08-07-15.</p> <p>A review of the "Skin/Pressure Report dated 07-21-15 indicated, "new wound development, open area to coccyx - abrasion 7.0 cm [centimeters] by 2.0 cm. Acquired in house/pressure. Date first observed 07-20-15 - epithelial, granulation with no signs or symptoms of infection. Periwound intact. Treatment - Calmoseptine and foam."</p> <p>A physician order, dated 07-21-15 indicated, "cleans [sic] open area to coccyx with Normal Saline, pat dry. Apply small amount of Calmoseptine [a</p>			

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	<p>skin barrier treatment] ointment BID [two times a day] and PRN [as needed] for soilage until healed every day and night shift for open area." The physician order did not include the use of an occlusive dressing.</p> <p>Further review of the Skin/Pressure Reports, indicated on 07-24-15 the area measured ".5 cm by .2 cm by .1 cm" and was assessed as a "Stage Two [Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough] pressure area."</p> <p>A review of the Skin/Pressure report dated 07-31-15, 7 days later, indicated the area was now assessed as a "Stage 4 [Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed and often include undermining and tunneling] pressure ulcer and measured 4.6 cm by 3.4 cm by .3 cm." The assessment indicated the area was "worsening, had granulation, with slough and was necrotic." The drainage was identified as "serosanguinous" and the "periwound was discolored."</p> <p>The nursing staff failed to notify the physician for medical intervention, on</p>			

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	<p>07-28-15 when the area was first noted with mild drainage, and then on 07-29-15 when the area was noted with bloody drainage, a slight odor and complaints of tenderness by the resident to the area, and subsequently did not report the area until it was assessed on 07-31-15 as a Stage Two pressure ulcer when the nurse documented the area had a dark brown area adjacent to the open area and the resident continued to complain of tenderness.</p> <p>A subsequent review of the Skin/Pressure report, dated 08-07-15 indicated the pressure ulcer increased in size to "4.8 cm by 4.2 cm by .3 cm" and was assessed as a "Stage Four" pressure ulcer. The assessment indicated the area was "worsening, had slough and eschar with moderate amount of purulent drainage, discoloration and edema to the periwound and displayed with signs and symptoms of infection."</p> <p>Further review of the resident's clinical record indicated the resident had a change in condition and was transported to the local area hospital on 08-08-15.</p> <p>On 8-31-15 at 9 a.m., the ambulance report dated 8-8-15 was reviewed and indicated the resident had a temperature of 101.9 Fahrenheit, a pulse of 115 and</p>			

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	<p>respiration rate of 24. The report indicated that when the ambulance crew arrived at the facility, four nurses were "holding his hands to prevent them from shaking."</p> <p>A review of the Hospital record on 08-31-15 at 8:30 a.m., for the dates 8-8-15 through 8-19-15 indicated that upon arrival at the local hospital Emergency Room, the resident's white blood cell count was 19.8 (with a normal range of 3.3 to 10.5) and diagnosed with "multi organism sepsis with fever and decubitus ulcer overlying the lower sacrum and coccyx."</p> <p>A review of the hospital "Wound Care,"documentation indicated the resident "came from Aperion nursing facility and had decubitus ulcer to coccyx upon arrival to [name of local area hospital]. The wound has a strong odor and has eschar on it." The Wound Nurse indicated there was a "Large amount of purulent drainage. Photo and measurements completed." The documentation indicated the pressure ulcer measured "5 cm long by 3 cm wide and 5 cm deep with necrotic tissue."</p> <p>The hospital physician notation indicated, the resident presented to the hospital with a "deep infected sacral decubitus ulcer"</p>			

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	<p>and underwent a debridement procedure to the wound. "The size of the area treated [by debridement] was approximately 10 cm long by 7 cm wide by 3 cm deep with all necrotic devitalized tissue removed."</p> <p>2. The record for Resident "F" was reviewed on 08-31-15 at 2:15 p.m. Diagnoses included, but were not limited to, cerebral vascular disease, encephalopathy, dementia, hypertension atrial fibrillation and difficulty in walking. These diagnoses remained current at the time of the record review.</p> <p>The resident had routine wound care at a local area hospital prior to admission to the facility.</p> <p>At the time the resident was admitted to the facility, the Nursing Assessment indicated the resident had an area to the right shin and the left heel. The admission documentation, lacked an assessment or description of the two areas.</p> <p>An admission order, dated 08-11-15, indicated the area to the resident's heel was "necrotic/eschar - treatment Aquacel Ag cover with gauze and wrap with conform and change every three days."</p>			

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	<p>The "Pressure Report," dated 08-14-15 indicated the area to the left heel measured "1.0 cm by .5 cm - unstageable."</p> <p>A review of the resident's Minimum Data Set assessment, dated 08-18-15 indicated the resident had a pressure ulcer - was "at risk" for the development of pressure ulcers and the current pressure ulcer was "unstageable" with measurements of "1.0 cm by .5 cm by 0.0 cm and eschar."</p> <p>A review of the resident's current plan of care indicated the resident had a pressure ulcer to left heel related to immobility. Interventions to this plan of care included "Monitor dressing to ensure it is intact and adhering."</p> <p>A review of the documentation from the local hospital wound care center indicated the following:</p> <p>"08-11-15 - left calcaneous [heel] Hydrofera blue gauze and conform. Prevalon boots at night. Pressure Injury/Pressure Ulcer 1.6 cm. by 1.4 cm. by 0.2 cm. Small amount of exudate serosanguineous red/brown. Wound status - open" The area was debrided and the measurements post procedure were "1.7 cm. by 2.1 cm. by 0.2 cm. - Stage Two [Partial thickness loss of dermis</p>			

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	<p>presenting as a shallow open ulcer with a red pink wound bed, without slough.]."</p> <p>"08-18-15 - left calcaneous, Pressure Injury/Pressure Ulcer - Wound status 'open' - 1.3 cm. by 1.3 cm by 0.1 cm with serosanguineous drainage, red/brown in color with necrotic tissue." The area was debrided and post treatment the area measured "1.5 cm. by 2.0 cm by 0.3 cm. - Stage Three [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling]."</p> <p>"08-25-15 - left calcaneous [heel] Pressure Injury/Pressure Ulcer - Wound status 'open' 1.5 cm. by 1.2. cm. by 0.1 cm. Necrotic amount large (67 - 100 %). The area was debrided and post treatment the area measured "1.2 cm. by 1.5 cm. by 0.2 cm., with necrotic/eschar, fibrin/slough exudates,and subcutaneous tissue dedrided. Orders: "Hydrofera Blue/Gauze, Conform, tape, change daily. Prevalon boot left heel during day and at night. Protein supplement two times a day."</p> <p>During an interview on 09-02-15 at 9:35 a.m., the Wound Nurse indicated the resident was transported to the local area</p>			

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	<p>Wound Care Clinic on 09-01-15 for a scheduled appointment.</p> <p>A review of the Wound Care Physician Orders, dated 09-01-15, instructed the nursing staff to continue to use Hydrofera/gauze and conform as previously ordered. The physician also indicated the resident required Prevalon boots during day and/or left heel at night. The wound status was assessed as "open" and measured "2.0 cm. by 1.5 cm. by 0.1 cm." and was assessed as "Stage Three" with "large amount of necrosis - eschar." The area was again debrided and the measurements post debridement were "1.5 cm by 1.3 cm. by 0.2 cm."</p> <p>During an observation on 09-02-15 at 9:40 a.m., with the Wound Care Nurse in attendance, the resident was assisted from the wheelchair to bed. During this observation, the resident had bedroom slippers on. After the resident was positioned in bed, Licensed Nurse #6 pulled up the resident's left pant leg and removed the left sock. The pressure ulcer to the left heel lacked the physician ordered treatment/dressing.</p> <p>A request was made to measure the left heel pressure ulcer. The Wound Care Nurse indicated the area measured "1.6 cm. by 1.1 cm. by 0.0 - unstageable and</p>			

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	<p>necrotic."</p> <p>In addition, although the Wound Care center ordered the specialized pressure relieving Prevalon boot for the resident, the facility failed to provide the boot until 09-03-15.</p> <p>3. The record for Resident "H" was reviewed on 09-02-15 at 11:00 a.m. Diagnoses included, but were not limited to, a history of a fracture of the lower extremity, dementia, chronic pain, and hypertension. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set assessment, dated 06-12-15, indicated the resident required extensive assistance with bed mobiity/transfer, was always incontinent of bowel and bladder and had a Stage Two pressure ulcer.</p> <p>A review of the current Braden Scale assessment, dated 08-14-15, indicated the resident was assessed at High Risk for the development of pressure ulcers with a score of "12." The assessment indicated the resident's sensory perception was slightly limited, was assessed as very moist, chairfast, with very limited mobility, a nutrition problem and "problem with friction/shear."</p>			

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	<p>The physician order, dated 08-18-15, instructed the nursing staff to "cleanse coccyx wound with wound cleanser, pat dry, cover with bordered foam. Change every three days or as needed for soilage."</p> <p>A review of the facility "Pressure Ulcers/Wound Report, dated 08-28-15, indicated the pressure ulcer measured ".2 by .6 by 0.1 - Stage Two."</p> <p>During an observation on 09-02-15 at 9:45 a.m., with Licensed Nurse #7 in attendance as well as the Wound Care Nurse, the resident was assisted to bed and a body assessment was completed. Certified Nurse Aide #5 removed the resident's slacks, and then removed the incontinent brief. During this observation the pressure ulcer to the resident's coccyx lacked a dressing. The Certified Nurse Aide indicated when she prepared the resident for breakfast "early this morning, she [in reference to the resident] was wet and the dressing was not on her but lying inside the brief. I told the nurse but at the time she was busy with doing Accuchecks."</p> <p>Licensed Nurse #7 verified she had been informed by the Certified Nurse Aide.</p> <p>At the time of the observation, the</p>			

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	<p>Wound Nurse measured the area and indicated the area measured ".5 cm. [length] by .8 cms [width] with edges macerated and some necrosis."</p> <p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled "Pressure Ulcer Prevention," and dated 01-01-2014, indicated the following:</p> <p>"Purpose: To prevent and treat pressure sores."</p> <p>"Procedure: ... 2. Inspect the skin several times daily during bathing, hygiene, and repositioning measures. ... 9. Pressure reduction mattress may be used for moderate/high risk. Pressure relieving mattress will be used for residents at severe risk for break down. 10. Use pressure reducing pads in chairs (all types) to protect bony prominence's for residents identified as Moderate/High/Severe risk. 11. Use positioning devices to relieve all pressure from heels, toes and malleoli. ... NOTE: Daily skin checks will be done by CNAs [Certified Nurses Aides] during routine care."</p> <p>A review of the facility policy on 09-02-15 at 11:30 a.m., titled "Pressure Ulcer and Skin Condition Assessment Policy," dated 01-01-2015, indicated the</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>following:</p> <p>"Policy: It is the policy of this facility that pressure and other ulcers, (diabetic, arterial, venous) will be assessed and measured at least every seven (7) days by licensed nurse, and recorded on the facility approved wound assessment form."</p> <p>"Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown, pressure and other ulcers and assuring interventions are implemented."</p> <p>"Standards: ... 2. Residents identified by the Braden scale of being at risk of a skin breakdown will have a weekly skin assessment by a licensed nurse. ... 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. 5. If the resident receives a shower, it will be necessary to have the resident stand or be returned to bed to visualize the buttock area and groin. 6. Care givers are responsible for promptly notifying the charge nurse of skin observations, including: a. redness/swelling ... e. excoriations, f. wound drainage,... i. any type of lesion,...</p>				

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	<p>j. skin discolorations. 7. At the earliest sign of a pressure ulcer or other skin problem, the resident, legal representative and attending physician will be notified.... 14. When there are weekly changes which require physician and responsible party notification, documentation of findings will be made in the clinical record.... 16. Dressing which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall include the date and initials of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness and signs and symptoms of infection. ...18. The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative of any suspected wound infection. ... 21. A licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes. If observations are acute, physician and responsible party will be notified by change nurse."</p> <p>This Federal tag relates to Complaint IN00180682.</p> <p>3.1-40(a)(1) 3.1-40(b)(2)</p>			

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

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