

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaints IN00152377, IN00152386, and IN00152823.</p> <p>Complaint IN00152377- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F314.</p> <p>Complaint IN00152386- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F314, and F505.</p> <p>Complaint IN00152823- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F314.</p> <p>Survey dates: July 20, 21, & 22, 2014</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 115 Total: 115</p> <p>Census payor type:</p>	F000000	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by to 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 the provisions of federal and state law require it.</i></p> <p><i>We respectfully request a Desk Review of this Plan of Correction.</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000157 SS=D	<p>Medicare: 26 Medicaid: 68 Other: 21 Total: 115</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on July 28, 2014, by Janelyn Kulik, RN.</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</p>				

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	<p>consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Physician and family were notified of the development of a new pressure ulcer at the time it was observed for 1 of 3 residents reviewed for pressure ulcers in the sample of 5. (Resident #E and LPN#2)</p> <p>Findings include:</p> <p>On 7/20/14 at 9:45 a.m. Resident #E was observed in bed. The resident was awake. LPN #2 was present at this time and the resident's wound dressing were checked by the LPN. The resident had dressings in place to the left hip and left upper posterior thigh areas. The date of</p>	F000157	<p>F 157 483.10(b)(11) Notify of Changes (Injury/Decline/Room, Etc)</p> <p>1. Resident #E had dressings changed as ordered on 7/20/14. Family and MD were notified on 7/20/2014 regarding omission on 7/19/2014. Orders for wound care on Resident #E were clarified with MD on 7/21/2014 by the wound care nurse along with further clarification of wound measurements. Nurses involved in omissions were re-educated regarding providing care and treatment per facility policy and procedure.</p> <p>2. Residents with wounds could be affected by this practice. The family and MD will be notified immediately of any changes. All current treatments and dressing changes were audited by the wound care nurse and</p>	08/21/2014

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	<p>7/18 was written on both of the dressings. LPN #2 confirmed the dates on the dressings were 7/18.</p> <p>On 7/20/14 at 1:30 p.m., LPN #2 was observed completing wound care for Resident #E. The resident was in bed. The LPN removed the dressing to resident's left buttock area. There was a around open area to the outer left buttock area. The LPN measured the area indicated the area measures 5.9 cm (centimeters) x 4.9 cm . There was also an irregular shaped area to the side of the above open area. This open area was measured by the LPN also. The area measured 1.8 cm x 2.4 cm. The LPN proceeded to cleanse the round wound with wound wash and applied Santyl ointment to the area. The LPN then cleansed the irregular shaped area and also applied Santyl ointment to the area.</p> <p>The record for Resident #E was reviewed on 7/20/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to, Multiple Sclerosis, urostomy, insomnia, and urinary tract infection. The resident was sent to the hospital on 7/11/14 and was re-admitted to the facility on 7/15/14.</p> <p>The 7/2014 Medication Record indicated there was a Physician's order to cleanse</p>		<p>unit managers. Any discrepancy was addressed immediately and MD/family was notified.</p> <p>3. Wound rounds will be completed daily by the treatment nurse /unit manager/weekend supervisor or designee. Wound rounds will be audited by the Director of Nursing and/or designee for compliance daily and MD/Family notification per facility P&P. Any non compliance will result in re-education and counseling by the Director of Nursing/Wound Nurse and/or designee. (<i>Audit sheet #1 attached</i>). Nurses will be re-educated to facility P&P regarding wound care and MD/Family notification.</p> <p>4. Wound audits will be presented by the Director of Nursing in the monthly QA meeting for six (6) months or until 100% compliance is achieved.</p>				

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	<p>the left buttock with normal saline, apply Santyl ointment and Kallostad and cover with Meplex every day. This order was initiated on 7/16/14.</p> <p>No Physician orders for any new treatments were written on 7/20/14. There was a Physician order written on 7/21/14 at 10:15 a.m. to clean the left medial buttock wound with wound cleanser, apply Hydrogel and cover the area with a dry dressing every day. The order indicated the family was notified of the new order at this time.</p> <p>The 7/2014 Nursing Progress Notes were reviewed. There was no documentation of the Physician or the resident's family being notified of the new pressure area on 7/20/14.</p> <p>The 7/2014 Weekly Pressure Ulcer reports were reviewed. A Weekly Skin Pressure Ulcer report was initiated on 7/21/14 for an area to the left medial buttock. The report indicated this was a new onset pressure ulcer. The area was identified as a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed). The report indicated the pressure ulcer measured 2.0 cm x 1.0 cm.</p> <p>When interviewed on 7/20/14 at 1:51</p>						

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	<p>p.m., LPN #2 indicated she worked on 7/19/14 and was assigned to care for Resident #E. The LPN indicated she did not complete the treatment to the resident's left buttock area on 7/19/14. The LPN indicated the resident did not refuse the treatment yesterday. LPN #2 indicated another Nurse was going to do the treatment for her and she must have forgotten to do it. The LPN indicated she she applied the Santyl ointment to both the open areas on the left buttock area.</p> <p>When interviewed on 7/21/14 at the Wound Nurse indicated she had completed the resident's treatment to the left buttock area on 7/18/14. The Wound Nurse indicated there was only one open area to the left buttock area. The Wound Nurse indicated she obtained an order on 7/21/14 for the treatment to the left medial buttock after seeing the new area for the first time. The Wound Nurse indicated the Physician and family should have been notified of the new area to the left buttock area at the time it was first observed.</p> <p>The facility policy titled "Condition Change of a Resident" was reviewed on 7/20/14 at 12:29 p.m. The policy was dated 10/31/06. The Assistant Director of Nursing provided the policy and identified the policy as current. The</p>			

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F000314 SS=G	<p>policy indicated the Physician was to be notified of resident events and/or changes in the resident's condition.</p> <p>This Federal tag relates to Complaints IN00152386, IN00152377, and IN00152823.</p> <p>3.1-5(a)(2)</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 Physician ordered treatments were provided as ordered for 2 of 3 residents reviewed for Pressure Ulcers in the sample of 5. (Residents #D and #E) (LPN #1 and LPN #2).</p> <p>The facility also failed to ensure excoriated and red areas were monitored and treatments rendered as ordered resulting in the development of an Unstageable Pressure Ulcer and a Deep</p>	F000314	<p>F 314 3.1-5(a)(2) 483.25(c) Treatment/Svcs to Prevent/Heal Pressure Sores 1.Resident # D and # E dressing changes were performed on 7/20/2014 as ordered. Family and MD notified regarding the 7/19/14 omission on 7/20/14. Orders for wound care on all areas were clarified with MD on 7/21/14 by the wound care nurse. A completed skin check was completed on both residents to ensure accuracy for both residents affected with no</p>	08/21/2014

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	<p>Tissue Injury to the areas. (Resident #E) (LPN #1 and LPN #2)</p> <p>Findings include:</p> <p>1. On 7/20/14 at 9:45 a.m. Resident #E was observed in bed. The resident was awake. LPN #2 was present at this time and the resident's wound dressings were checked by the LPN. The resident had dressings in place to the left hip and left upper posterior thigh areas. The date of 7/18 was written on both of the dressings. LPN #2 confirmed the dates on the dressings were 7/18.</p> <p>On 7/20/14 at 1:30 p.m., LPN #2 was observed completing wound care for Resident #E. The resident was in bed. The LPN removed the dressing to resident's left buttock area. There was around open area to the outer left buttock area. The LPN measured the area and indicated the area measured 5.9 cm (centimeters) x 4.9 cm . There was also an irregular shaped open area to the side of the above open area. This open area was measured by the LPN also. The area measured 1.8 cm x 2.4 cm. The LPN proceeded to cleanse the round wound with wound wash and applied Santyl ointment to the area. The LPN then cleansed the irregular shaped area and also applied Santyl ointment to the area.</p>		<p>further concerns noted. Nurses involved in omissions were re-educated regarding providing care and treatment per facility policy and procedure.</p> <p>1. Residents with wounds could be affected by this practice. All current treatments and dressing changes were audited by the wound care nurse and unit managers. Any discrepancy was addressed immediately along with family and MD notification.</p> <p>1.Wound rounds will be completed daily by the treatment nurse /unit manager/weekend supervisor or designee. Wound rounds will be audited by the Director of Nursing and/or designee for compliance daily. Whole house skin checks will be performed weekly and findings of such documented in the PCC system accordingly. Shower sheets will be audited three times weekly by the Unit Managers and/or designee. (Audit sheet #1 attached). Any non compliance will result in immediate re-education and counseling by the Director of Nursing/Wound Nurse and/or designee. Nurses will be re-educated to facility P&P regarding wound care, treatment orders and documentation.</p> <p>1.All audits will be presented monthly by the Director of Nursing in the QA meeting for compliance for six (6) months and until 100% compliance is achieved.</p>	

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	<p>The record for Resident #E was reviewed on 7/20/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to, Multiple Sclerosis, urostomy, insomnia, and urinary tract infection. The resident was sent to the hospital on 7/11/14 and was re-admitted to the facility on 7/15/14.</p> <p>Review of the 5/16/14 Minimum Data Set Quarterly assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, and dressing. The assessment also indicated the resident was at risk for the development of pressure ulcers and did not have any Stage I or greater pressure ulcers at this time.</p> <p>A 4/30/14 Braden Scale for pressure ulcer risk indicated the resident's score was (17). A score of (17) indicated the resident was at risk for pressure ulcer development.</p> <p>A Care Plan initiated on 10/8/12 indicated the resident had the potential for skin and tissue alterations related to the need for assistance with ADL's (Activities of Daily Living), a history of pressure ulcers, and a Braden scale score indicating the resident was at high risk. The Care Plan was last updated with a</p>			

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	<p>goal date of 8/4/14. Care Plan interventions included for staff to turn and reposition the resident every two hours, assess skin weekly, and provide treatments as ordered by the Physician. A Care Plan initiated on 7/7/14 indicated the resident had an actual alteration in skin integrity related to an Unstageable ulcer to the left buttock and a Suspected Deep Tissue Injury wound to the left posterior thigh related to decreased mobility.</p> <p>The 7/2014 Medication Record indicated there was a Physician's order to cleanse the left buttock with normal saline, apply Santyl ointment and Kallostat and cover with Meplex every day. This order was initiated on 6/16/14.</p> <p>No Physician orders for any new treatments were written on 7/20/14. There was a Physician order written on 7/21/14 at 10:15 a.m. to clean the left medial buttock wound with wound cleanser, apply Hydrogel and cover the area with a dry dressing every day. The order indicated the family was notified of the new order at this time.</p> <p>The 7/20/14 Nursing Progress Notes were reviewed. There was no documentation of the Physician or the resident's family being notified of the</p>			

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	<p>new area on 7/20/14.</p> <p>Review of the 7/1/14 Physician Progress Note indicated the author was requested to look at the resident's buttock. The note indicated the residents buttock/coccyx area was "red", "raw", and "flaky". The progress note indicated the plan was to discontinue Calmoseptine and to change the treatment to apply Nystantin/Zinc 1:1 to the area every shift. The plan also indicated staff were to turn the resident side to side and to monitor.</p> <p>The 7/2014 Physician orders were reviewed. An order was written on 7/1/14 to discontinue Calmoseptine to the buttock and to start Nystantin 1:1 zinc oxide to the coccyx every shift. Another order was written on 7/5/14 to apply Santyl (a debriding ointment) on the red area on the coccyx and Nystantin 1:1 zinc oxide to the necrotic area [SIC]. Two orders were written on 7/7/14. The first order was to cleanse the left buttock with wound cleanser, apply Santyl/Bactroban 1;1 and cover with a foam dressing every day. The second order was to cleanse the left posterior thigh area with wound wash and cover with a foam dressing every three days.</p> <p>The 7/2014 Treatment Record was reviewed. The treatment for Nystantin</p>			

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	<p>1:1 zinc oxide was not signed out as completed on any shifts on 7/1/14 or 7/2/14. The treatment ordered on 7/5/14 was not signed out as completed on 7/5/14 or 7/6/14.</p> <p>The 6/2014 Weekly Skin Check sheets were reviewed. A Skin Check Sheet was completed on 6/13/14. There were no further Weekly Skin Sheets for June 2014.</p> <p>The 6/13/14 Weekly Skin Check Sheet indicated there were no skin conditions or changes, ulcers, or injuries</p> <p>The 7/2014 Weekly Skin Check Sheets were reviewed. The first sheet completed in July was dated 7/4/2014. This sheet indicated " no" was marked for any skin conditions or changes, ulcers, or injuries. The Comments section indicates no new areas were noted at this time and redness continued to the coccyx.</p> <p>There were no Non Pressure sheets available for the dates of 7/1/14 thru 7/10/14.</p> <p>The 6/2014 Nursing Progress Notes were reviewed. The last June entry made was entered on 6/22/14 at 11:09 a.m. This entry indicated the resident was alert and verbally responsive and his skin was warm and dry to touch.</p>			

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	<p>The 7/2014 Nursing Progress Notes were reviewed. The first entry was titled as a "late entry" 7/1/2014 at 8:50 a.m. The entry noted the Calmoseptine to the coccyx was discontinued and Nystatin Zinc Oxide 1:1 to the coccyx every shift was to be applied. There was no assessment of the coccyx area in this entry.</p> <p>The next entry was titled as a "late entry" at 6:50 p.m. The entry indicated there was a new order from the Nurse Practitioner for the area on the residents "left buttock" and "left posterior thigh." The entry also indicated on 7/1/14 the Nurse Practitioner assessed the area on the residents left buttock and left posterior thigh and wrote a treatment order for that area. On 7/5/14 while doing personal care a CNA called the writer into the room to look at the area. The area was red with dark areas. The writer called the Nurse Practitioner on call and treatment orders were changed to include Santyl on the "dark areas" with zinc oxide on the "red areas" noted with dark red areas.</p> <p>One entry was made on 7/6/14. This entry was made at 4:44 a.m. The entry indicated the resident was in bed and the dressing to the buttock was clean, dry,</p>			

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	<p>and intact. The next entry was made on 7/7/14 at 1:28 a.m. This entry indicated the resident was repositioned side to side every two hours and the dressing was intact to the wound.</p> <p>The next entry in the Nursing Progress Notes was entered by the Wound Nurse. The entry was made on 7/7/14 at 11:08 a.m. This entry indicated the resident was assessed and an Unstageable pressure ulcer was noted to the left buttock area with 90% slough and 10% DTI (deep tissue injury) and another DTI was noted to the left posterior thigh. The Nurse Practitioner was called and appropriate treatment orders were obtained for both areas.</p> <p>The July Weekly Pressure Ulcer Report were reviewed. There were two reports initiated on 7/7/14. The first report indicated the resident had an Unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough or eschar) pressure ulcer to the left buttock. The ulcer measured 10.0 cm x 5.5 cm. the report indicated 7/5/14 was the initial observation of the area.</p> <p>The second 7/7/14 Weekly Pressure Ulcer Report was reviewed. The report indicated a Suspected Deep Tissue Injury area was noted on the resident's rear left</p>			

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	<p>thigh area. The area measured 6.0 x 6.0 cm. The report indicated 7/5/14 was the initial observation of the area.</p> <p>The 7/2014 Weekly Pressure Ulcer reports were reviewed. A Weekly Skin Pressure Ulcer report was initiated on 7/21/14 for an area to the left medial buttock. The report indicated this was a new onset pressure ulcer. The area was identified as a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed). The report indicated the pressure ulcer measured 2.0 cm x 1.0 cm.</p> <p>The 7/2014 Laboratory test results were reviewed. A culture of the left buttock wound was obtained on 7/8/14. The results were reported on 7/11/14. The report indicated the wound culture was positive for a moderate amount of MRSA (Methicillin Resistant Staph Aureus) indicating an infection in the wound.</p> <p>A Resident Event Report Worksheet form was initiated on 7/21/14 at 10:00 a.m. The form was initiated by the Wound Nurse. The form indicated the resident developed a Stage II pressure ulcer to the left medial buttock. A Pressure Ulcer Investigation- In House Acquired form attached to the Event Report indicated the ulcer measured 2.0</p>						

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	<p>cm x 1.0 cm with no tunneling. The form indicated the section titled " Area Avoidable" was checked.</p> <p>A Resident Event Report Worksheet form was initiated on 7/5/14 at 5:00 p.m. The report indicated the resident developed a pressure area to the buttock. The attached Pressure Ulcer Investigation - In House Acquired form attached to the Event Report indicated pressure areas on the resident's left buttock measured 10 cm x 5 cm and an are to the left posterior thigh measured 6 cm x 6 cm. The form indicated the section titled " Area Avoidable" was checked.</p> <p>Review of the 7/2104 Daily Monitoring/Pressure Ulcers logs for Resident #E was reviewed. There was one log for the left hip pressure ulcer and one log for the left buttock pressure ulcer. The first entries on both of these logs were entered on 7/7/14.</p> <p>When interviewed on 7/20/14 at 1:51 p.m., LPN #2 indicated she worked on 7/19/14 and was assigned to care for Resident #E. The LPN indicated she did not complete the treatment to the resident's left buttock area on 7/19/14. The LPN indicated the resident did not refuse the treatment yesterday. LPN #2 indicated another Nurse was going to do</p>						

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	<p>the treatment for her and she must have forgotten to do it. The LPN indicated she applied the Santyl ointment to both the open areas on the left buttock area</p> <p>When interviewed on 7/21/14 at 8:55 a.m., the Wound Nurse indicated she completed the residents's treatment to the left buttock and left posterior thigh wounds on 7/18/14. The Wound Nurse indicated the resident had two open areas on 7/18/14 when she completed the treatments. The Wound Nurse indicated there was only one open area on the resident's left buttock area when she completed the resident's treatments on 7/18/14. The Wound Nurse indicated second area to the left buttock was not present on 7/18/14. The Wound Nurse indicated an Unstageable pressure ulcer was noted to the resident's left buttock area on 7/7/14 and a Suspected Deep Tissue injury was noted to the resident's left rear thigh on 7/7/14 and new treatment areas were obtained.</p> <p>When interviewed on 7/22/14 the Director of Nursing indicated no non-pressure skin sheets, pressure wound sheets, or any skin/wound assessments were initiated when Physician orders were obtained to start a new treatment to the coccyx area on 7/1/14 . The Director of Nursing indicated the treatment</p>			

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	<p>ordered was first signed out as completed on 7/3/14.</p> <p>Continued interview with the Director of Nursing indicated a new order was obtained on 7/5/14 to treat the necrotic and red areas to the left buttock with Santyl and Nystatin/Zinc. The Director of Nursing indicated the above ordered treatment was not signed out as completed on 7/5/14 and 7/6/14. The Director of Nursing indicated the treatments should have been completed as ordered. The Director of Nursing indicated the Wound Nurse assessed the left buttock and let posterior thigh areas on 7/7/14, initiated Pressure Ulcer Reports for wounds and the new treatment orders were obtained.</p> <p>The policy titled "Documentation and Charting Frequency Guidelines" was reviewed on 7/22/14 at 9:22 a.m. the policy was dated 8/31/12. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated Licensed Nurses were to document weekly progress notes for non-pressure skin conditions. The policy also indicated the documentation was to be completed on a Weekly Non Pressure Skin Conditions Report.</p> <p>2. On 7/20/14 at 9:25 a.m., Resident #D</p>			

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	<p>was observed in bed. LPN #1 was present in the room. The resident had a dressing in place to the left right buttock area. The date of 7/18 was written on the dressing. The resident had a dressing in place to the right heel area. The date of 7/18 was written on the dressing. There were initials written on the dressing. There was dried dark red drainage on the heel dressing.</p> <p>On 7/20/14 at 11:05 a.m., LPN #1 was observed providing wound care for the resident. The resident was sitting in a wheel chair in her room LPN#1 removed the kerlix wrap dressing from around the resident's right ankle area. The LPN then removed a small dressing from the wound area. There was dried yellow/tan colored drainage on the dressing. The resident had an open wound to the right heel. The open area was approximately 4 cm (centimeters) x 3 cm. the wound was dark in color. The resident stated "I was wondering why they don't change this every day" when the LPN was completing the treatment.</p> <p>The record for Resident #D was reviewed on 7/20/14 at 10:25 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer, chronic pain, depressive disorder, and quadriplegia.</p>			

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	<p>The July 2014 Treatment Record was reviewed. There was a Physician's order to cleanse the right heel with wound cleanser, apply Bactroban (an antibiotic ointment/Santyl (a debriding ointment) 1:1 and wrap with Kerlix one a day. The Treatment Record indicated the treatment was to be completed on the 6:00 a.m.- 2:00 p.m. shift daily. The right heel treatment was circled as not completed on 7/19/14. An entry on the back page of the Treatment Record indicated the resident was up in the wheel chair at 10:00 a.m. and she refused the right heel treatment at this time.</p> <p>The 4/15/14 Minimum Data Set Significant Change assessment indicated the resident BIMS (Brief Interview for Mental Status) score was 15. A score of 15 indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance of 2 or more staff members for bed mobility, transfers, and personal hygiene. The assessment also indicated the resident had one Stage III (full thickness tissue loss with no visible bone or tendon exposed) Pressure ulcer.</p> <p>The 7/14/14 Weekly Pressure Ulcer report indicated the resident had an Unstageable (Full thickness tissue loss in which the base of the ulcer is covered by</p>			

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	<p>slough or eschar in the wound) to the right heel. The pressure ulcer measured 2.9 cm x 4.1 cm with no depth. The 7/21/14 Weekly Pressure Ulcer report indicated the right heel pressure ulcer was Unstageable and measured 4.0 cm x 4.2 cm with no depth.</p> <p>A 6/19/14 Physician's Progress Note indicated the resident had an infected wound to the right foot. The Progress Note also indicated the wound culture was positive for Proteus Mirabilis (an infection). The Progress Note also indicated the resident was to be treated to IV (intra-venous) antibiotics.</p> <p>The 6/21/14 results of a wound culture obtained on 6/16/14 was positive for Proteus Mirabilis and MRSA (an infection).</p> <p>When interviewed on 7/20/14 at 10:20 a.m., LPN #1 indicated she had worked on 7/19/14 and was assigned to care for Resident #D. The LPN indicated she did not complete the dressing change to the the resident's right heel on 7/19/14. The LPN indicated the resident had been gotten out of bed by 10:00 a.m. on 7/19/14 and she had not completed the resident's treatments on 7/19/14.</p> <p>When interviewed on 7/21/14 at 3:00</p>			

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F000505 SS=D	<p>p.m., the Director of Nursing indicated the treatments should have been completed as ordered.</p> <p>This Federal tag relates to Complaints IN00152386, IN00152377, and IN00152823.</p> <p>3.1-40(a)(2)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings. Based on record review and interview the facility failed to notify the Physician of the results of a Urinalysis/Culture and sensitivity laboratory test in a timely manner for 1 of 3 residents review for Urinary Tract Infections in the sample of 5. (Resident #F)</p> <p>Findings include:</p> <p>The record for Resident #F was reviewed on 7/20/14 at 12:25 p.m. The resident's diagnoses included, but were not limited to, fibromyalgia, morbid obesity, chronic pain syndrome, and osteoarthritis.</p>	F000505	<p>F 505 3.1-40(a)(2) 483.75(j)(2)(ii) Promptly notify Physician of Lab results</p> <p>1.Resident #F medication was initiated on 7/17/2014. No further findings on Resident F.</p> <p>1.Residents receiving lab testing have the potential to be affected. A whole house lab audit was completed on 7/20 -7/21/2014 and findings corrected immediately. Nurses were re-educated to the lab process, notifications and documentation per facility P&P.</p> <p>1.A daily lab audit will be completed by the unit</p>	08/21/2014			

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	<p>Review of the 6/18/14 MDS (Minimum Data Set) Quarterly Assessment indicated the resident's BIMS (Brief Interview for Mental Status) was 15. A score of 15 indicated the resident's cognitive patterns were intact. The assessment also indicated the resident was always incontinent of bladder.</p> <p>The 7/2014 Physician orders were reviewed. An order was written on 7/11/14 for a Urinalysis and Culture & Sensitivity test to be completed.</p> <p>Review of the laboratory test result form indicated the urine specimen was collected by the laboratory on 7/12/14 . The culture was positive for greater than 100,000 colonies /milliliters of Eschericha Coli (a bacteria indicating infection.) The form indicated the results were faxed to the facility on 7/14/14 at 11:50 a.m. There was no Physician or Nurse Practitioner signature on the form.</p> <p>The 7/2014 Nursing Progress notes were reviewed. An entry made on 7/12/14 at 1:41 a.m. indicated the resident had an Urinalysis with Culture & Sensitivity done and staff were awaiting the results. The next entry was made on 7/17/14 at 1:24 a.m. This entry indicated there was a new order for the resident to receive Cipro (an antibiotic) 500 milligrams</p>		<p>managers/weekend supervisor for all ordered labs which will also include MD/Family notification. Lab will send facility all monthly routine orders for monitoring of completion and timely notification. Any discrepancies will be completed immediately and immediate education will be provided to nurses for these occurrences. Nurses will continue re-education to the lab process, notifications and documentation per facility P&P.</p> <p>1.The Director of Nursing and/or designee will review audits three times weekly to ensure compliance. The weekly audits will be completed in a 30 day process and reviewed by the Director of Nursing in the monthly QA meeting for a minimum of six (6) months until 100% compliance is achieved.</p>				

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	<p>orally every 12 hours x 7 days. The entry also indicated the Cipro was to be given for a UTI with e-Coli (Eschericha Coli). There was no documentation of any attempts to notify the Physician of the positive culture results between 7/14/14 and 7/16/14.</p> <p>The current 7/2014 Medication Record was reviewed. The Medication Record indicated the resident received the first dose of Cipro 500 milligrams on 7/17/14 at 8:00 a.m.</p> <p>When interviewed on 7/22/14 at 9:45 a.m., the Director of Nursing indicated the Physician should have been notified of the laboratory results at the time they were sent to the facility.</p> <p>The facility policy titled "Notifications" was reviewed on 7/20/14 at 12:29 p.m. The policy had an Original Date of 09/23/2003 and a Release Date of 04/28/13. The Assistant Director of Nursing indicated the policy was current.</p> <p>This Federal tag relates to Complaint IN00152386.</p> <p>3.1-49(f)(2)</p>			