

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/19/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN46142		
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F0000	<p>This visit was for Investigation of Complaints IN00100958 and IN00100763.</p> <p>Complaint IN00100958 Substantiated. Federal/State deficiency related to the allegation is cited at F463.</p> <p>Complaint IN00100763 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F279, F282 and F314.</p> <p>Survey dates: December 15, 16 & 19, 2011</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF/NF: 160 Total: 160</p> <p>Census payor type: Medicare: 38 Medicaid: 99 Other: 23 Total: 160</p>	F0000			

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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	<p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 12/20/11 Cathy Emswiler RN</p>				

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F0157 SS=D	<p>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 §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 physician, in that when a residents had a pressure ulcer with recent debridement, the facility nursing staff failed to immediately notify the resident's physician for possible intervention for 1 of 3 residents sampled</p>	F0157	F-157This plan of correction is the centers credible allegation of complaine. 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. This plan of correction is	01/12/2012

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	<p>with pressure ulcers in a total sample of 6. [Residents "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 12-15-11 at 1:20 p.m. Diagnoses included but were not limited to severe Parkinson's disease, a history of urinary tract infections, contractures, respiratory failure, dementia and aspiration. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had a tracheostomy and received the services of a local Wound Care physician.</p> <p>The record also indicated the resident had been followed by the Wound Care physician since 06-16-11.</p> <p>The "Wound Care Note/Reassessment," dated 10-20-11 indicated the resident's left ischium wound measured 5.0 by 2.7 by 0.3 centimeters, "unstageable" was "stable" with "drainage - no odor" was debrided.</p> <p>Other areas identified by the local Wound Care physician included the sacrum which measured 3.0 cm [centimeters] by 8.0 cm by 0.1 cm, and the left heel which measured 2.0 cm by 1.0 cm by 0.1 cm., both with drainage but no odor.</p>		<p>prepared and/or executed soley because it is required by the provisions of federal and state law. What corrective action will accomplished for those residents found to have been affected by the deficient practice.No corrective action for this resident as she no longer resides in this facility. The resident was treated for wounds while in the facility. The resident admitted with multiple wounds, including all that were present on DC to hospital. The resident was extremely compromised with health and nutrition. The wound MD completed wound debridement which resulted in increased drainage. The treatment was also changed to a calcuim alginate which promotes increased drainage. Looking at the entire clinical picture with chronic leukocytosis, antibiotic therapy and treatment in process the change of condition with the wound occurred on the night the resident presented with a fever. The facility followed the policy for contacting the primary MD. The increased drainage was an expected outcome. The wound specialist determined the inability to heal as unavoidable due to disease process. How other residents have the potential to be affected by the same practice will be identified and what corrective action will be taken. Every patient in the facility with a wound could have been affected. If the</p>		

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	<p>Further documentation in regard to the left ischium indicated the ulcer was classified as "traumatic" - Stage 3 now aggravated by pressure, so must be reclassified. Debrided to Stage 3. Must off load. Wound details post [debridement] length 5.4 cm width 3.0 by 0.6 cm."</p> <p>Instructions from the Wound Care physician included: "1. Call me immediately for evidence of infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>Review of a "Wound Progress Note/Reassessment," dated 10-27-11 indicated the resident's sacral wound measured 2.7 cm by 7.5 cm by 0.1 cm - drainage but no odor, the wound on the left ischium measured 4.7 cm by 2.3 cm by 0.4 cm "improving" with drainage and no odor, and the left heel which measured 2.0 cm by 1.0 cm by 0.1 cm.</p> <p>The "Wound Progress Note/Reassessment," dated 11-10-11 indicated the resident's left ischium measured 5.3 cm by 3.5 cm by 0.5 cm drainage but no odor, and the sacrum 5.4 cm by 8.0 cm by 0.1 cm drainage but no</p>		<p>physician circled the statement "Call me immediately for evidence of infection", they could have been affected. The facility Medical Director, follows in the facility 5 days per week. It has always been the standard to have the Medical Director's office follow between visits for wound care, as with Resident 'A'. The facility was under the impression that doing the right thing by having the physician that was in the facility follow up, was the best plan of care for the resident. Wound MD's practice has been advised the facility requests the wording on the form be changed to 'Follow up with MD for evidence of infection, etc.' The facility will be instructed (educated) to follow with wound MD for every wound. All wound drainage smells. It is a waste product of the body. Adding a product to the regimen to increase wound drainage, will cause increased odor due to increased amount. This was an expected outcome in this case. The wound MD is available for visits to the facility off his regular weekly visit and has accommodated the facility numerous times. The Licensed staff will contact as needed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur. Education will be provided to the nurses to call wound</p>		

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	<p>odor. The progress note lacked documentation related to the left heel.</p> <p>A subsequent notation by the Wound Care Specialist, dated 11-17-11 indicated the following: "Left hip [ischium] - 5.5 cm [centimeters] by 3.0 cm by 1.4 cm, Sacrum 2.6 cm by 8.6 cm by 0.1 cm both with drainage but no odor. A new area was identified on the resident's spine as a stage 3 and measured 1.6 cm by 0.9 cm by 0.1 cm., both identified with drainage but no odor." A handwritten notation indicated, "Stage 3, sacrum unstageable pressure ulcer hip - debrided to [Stage] 4. Stage 3 - spine."</p> <p>Instructions included: "1. Call me immediately for evidence of infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>During interview on 12-16-11 at 11:45 a.m. the Director of Nursing Services indicated the Wound Care Specialist physician came to the facility weekly, but the resident was not seen by the Wound Care Specialist the week of the Thanksgiving holiday [11-20-11].</p> <p>However, the record indicated the nursing staff on 11-22-11 [Tuesday], notified</p>		<p>MD with changes in condition. This was an expected change in condition. The unexpected change in condidtion was when the resident vomited and has a trach. The primary MD was immediately contacted and the resident was sent to the hospital. How the corrective action will be monitored to ensure the deficient practice will not recur. The facility Performance Improvement Committee, or designee, will review residents with wounds daily to ensure no change in condition related to the wound. The Unit Manager or designee will document accordingly. Justification for increased drainage will be explained in the medical record, by the treatments being used. NAR (nutrition at risk) will follow the residents with wound. The Performance Improvement committee will follow this process for a period of three months if substantial compliance is maintained. Monitoring and re-education will occur if compliance is not maintained for a consecutive period of three months. To discontinue monitoring of this citation, the PI committee will sustain compliance for three months.</p>		

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	<p>Nurse Practitioner #12, from a different physician service the of the following, "Nursing states increased drainage [related to the pressure ulcers]." The Nurse Practitioner documented "leukocytosis - could be secondary to wound. Wound care is following [related to the Wound Care Specialist physician]. Will start clindamycin [an antibiotic] 300 mg [milligrams] per gastrostomy feeding tube two times a day for five days." The Nurse Practitioner progress note was "blank" in the area provided for an assessment/documentation of the resident's skin/ulcers.</p> <p>A subsequent Nurse Practitioner [#11 also from the same physician service as Nurse Practitioner #12] progress note dated 11-28-11, indicated the resident's white blood cell count increased and further noted the resident had been treated with clindamycin "thru 11-27-11 secondary to wound drainage - continue with Wound Team."</p> <p>During an interview on 12-19-11 at 10:15 a.m., the Nurse Practitioner #11, with documentation as noted on 11-28-11, indicated she was "probably approached by the nursing staff of the resident's laboratory results. I didn't observe the resident's wounds. Sometimes the staff do get us involved, but they should confer</p>				

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	<p>with the Wound Care Specialist."</p> <p>Review of the "Resident Progress Notes," dated 11-22-11 at 10:10 p.m., the nurse documented the resident was "started on ATB [antibiotic] tonight." The 11-23-11 10:00 a.m. notation as well as 11-24-11 at 9:00 p.m. and 11-27-11 at 12:00 p.m. and 8:00 p.m. indicated the resident's "sacral and ischial wounds with foul smelling drainage."</p> <p>The record lacked documentation the nursing staff notified the Wound Care physician, as directed in the "Instructions," for possible intervention of the resident's wounds.</p> <p>Review of the facility policy on 12-19-11 at 9:25 a.m., titled "Notification," and dated 10-31-07 as "revised," indicated the following:</p> <p>"POLICY [bold type] - Staff informs the resident, consults with their attending physician, and notified the resident's surrogates when a significant change occurs in the resident's physical, mental or psychosocial status; treatment needs to be altered significantly."</p> <p>This Federal tag relates to IN00100763.</p> <p>3.1-5(a)</p>				

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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to ensure a resident's plan of care was updated or followed in that when a resident had pressure areas and specific orders related to antibiotic medication, the nursing staff failed update the plan of care to reflect the resident's condition, and treatment which included administer the medication as ordered. This deficient practice affected 1 of 6 sampled resident's. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed</p>	F0279	F-279This plan of correction is the centers credible allegation of complaince. 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. This plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law. What corrective action will accomplished for those residents found to have been affected by the deficient practice.No corrective action for this resident as she no longer resides in this	01/12/2012

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	<p>on 12-15-11 at 1:20 p.m. Diagnoses included but were not limited to severe Parkinson, a history of urinary tract infections, contractures, respiratory failure, dementia and aspiration. These diagnoses remained current at the time of the record review.</p> <p>The record also indicated the resident had a tracheostomy and received the services of a local wound care physician.</p> <p>The resident's current plan of care, originally dated 06-07-11 indicated "skin integrity impaired: actual pressure wounds to an unstageable left heel, sacrum and left ischium." Interventions included "administer medications as ordered, refer to wound MD [Medical Doctor] as needed. Tx. [treatment] as ordered."</p> <p>The "Wound Progress Note/Reassessment," by the Wound Care Specialist, dated 11-17-11 indicated the following: "Left hip [ischium] - 5.5 cm [centimeters] by 3.0 cm by 1.4 cm, Sacrum 2.6 cm by 8.6 cm by 0.1 cm both with drainage but no odor. A new area was identified on the resident's spine as a stage 3 and measured 1.6 cm by 0.9 cm by 0.1 cm. with drainage but no odor." A handwritten notation indicated, "Stage 3, sacrum unstageable pressure ulcer hip - debrided to [Stage] 4. Stage 3 - spine."</p>		<p>facility. The resident was treated for wounds while in the facility. The resident admitted with multiple wounds, including all that were present on DC to hospital. The resident was extremely compromised with health and nutrition. The wound MD completed wound debridement which resulted in increased drainage. The treatment was also changed to a caluim alginate which promotes increased drainage. Looking at the entire clinical picture with chronic leukocytosis, antibiotic therapy and treatment in process the change of condition with the wound occurred on the night the resident presented with a fever. The wound specialist determined the inability to heal as unavoidable due to disease process. Records reviewed with pharmacy and Emergency drug kits reflect 10 doses of antibiotic were sent. How other residents have the potential to be affected by the same practice will be identified and what corrective action will be taken. Every patient in the facility with a wound and antibiotic therapy could have been affected. If the physician circled the statement "Call me immediately for evidence of infection", they could have been affected. The facility Medical Director, follows in the facility 5 days per week. It has always been the standard to have the Medical Director's office follow</p>		

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	<p>Instructions included:</p> <p>"1. Call me immediately for evidence of infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>During interview on 12-16-11 at 11:45 a.m. the Director of Nursing services indicated the Wound Care Specialist physician came to the facility weekly, but the resident was not seen by the Wound Care Specialist the week of the Thanksgiving holiday [11-20-11].</p> <p>However, the record indicated the nursing staff on 11-22-11 [Tuesday], notified Nurse Practitioner #12, from a different physician service of the following, "Nursing states increased drainage [related to the pressure ulcers]."</p> <p>The Nurse Practitioner documented "leukocytosis - could be secondary to wound. Wound care is following [related to the Wound Care Specialist physician]. Will start clindamycin [an antibiotic] 300 mg [milligrams] per gastrostomy feeding tube two times a day for five days."</p> <p>A subsequent nurse practitioner [#11 also from the same physician service as nurse practitioner #12] progress note dated 11-28-11, indicated the resident's white</p>		<p>between visits for wound care, as with Resident 'A'. The facility was under the impression that doing the right thing by having the physician that was in the facility follow up, was the best plan of care for the resident. The wound MD's practice has been advised the facility requests the wording on the form be changed to 'Follow up with MD for evidence of infection, etc.' The facility will be instructed (educated) to follow with the wound MD for every wound. All wound drainage smells. It is a waste product of the body. Adding a product to the regimen to increase wound drainage, will cause increased odor due to increased amount. Medication administration inservice scheduled. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The wound MD is available for visits to the facility off his regular weekly visit and has accommodated the facility numerous times. The Licensed staff will contact as needed. When wound rounds are conducted, the plan of care will be update and reviewed to reflect current plan of care. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur. Education will be provided to the nurses to</p>		

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	<p>blood cell count increased and further noted the resident had been treated with clindamycin "thru 11-27-11 secondary to wound drainage - continue with Wound Team."</p> <p>Review of the Resident Progress Notes, dated 11-22-11 at 10:10 p.m., the nurse documented the resident was "started on ATB [antibiotic] tonight." The 11-23-11 10:00 a.m. notation as well as 11-24-11 at 9:00 p.m. and 11-27-11 at 12:00 p.m. and 8:00 p.m. indicated the resident's sacral and ischial wounds with foul smelling drainage."</p> <p>Review of the Medication Administration Record for 11-2011 indicated the resident received the prescribed antibiotic medication on 11-22-11 at 8:00 p.m., 11-23-11 at 8:00 a.m., 11-24-11 at 8:00 a.m. and 8:00 p.m., 11-25-11 at 8:00 a.m. and 8:00 p.m., and 11-26-11 at 8:00 a.m. and 8:00 p.m., for a total of 8 doses. The reverse side of the Medication Administration Record lacked information/clarification related to the missed doses of the antibiotics.</p> <p>Further review of the resident's current plan of care, originally dated 06-07-11 lacked the resident's current condition related to the staging of the pressure ulcers, drainage, odor, and the recent</p>		<p>call the wound MDwith changes in condition. This was an expected change in condition. The unexpected change in condidtion was when the resident vomited and has a trach. The primary MD was immediately contacted and the resident was sent to the hospital. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. How the corrective action will be monitored to ensure the deficient practice will not recur.The facility Performance Improvement Committee, or designee, will review reidents with wounds 3 days per week and PRN to ensure no change in condition related to the wound. The Unit Manager or designee will document accordingly. Justification for increased drainage will be explained in the medical by the treatments being used. NAR (nutrition at risk) will follow the residents with wound. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The Performance Improvement committee will follow this process for a period of three months if substantial</p>		

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F0282 SS=D	<p>physician orders which included antibiotic therapy.</p> <p>During interview on 12-19-11 at 10:30 a.m., the Director of Nursing Services verified the record indicated the resident received 8 of the 10 doses of the antibiotics and the nursing staff failed to document the reasoning of the two missed doses.</p> <p>This Federal tag relates to IN00100763.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to ensure a physician order was followed in regard to the administration of an antibiotic medication for 1 of 6 sampled residents. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 12-15-11 at 1:20 p.m. Diagnoses</p>	F0282	<p>compliance is maintained. Re-education will be provided if compliance is not maintained for a period of three months. Monitoring will stop after the deficiency has been corrected for a sustained period of three months.</p> <p>F-282This plan of correction is the centers credible allegation of complaine. 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. This plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law. What corrective action will</p>	01/12/2012	

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	<p>included but were not limited to severe Parkinson, a history of urinary tract infections, contractures, respiratory failure, dementia and aspiration. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had a tracheostomy and received the services of a local wound care physician.</p> <p>Review of a "Wound Progress Note/Reassessment," dated 10-27-11 indicated the resident had a sacral wound which measured 2.7 cm by 7.5 cm by 0.1 cm - drainage but no odor, the wound on the left ischium which measured 4.7 cm by 2.3 cm by 0.4 cm "improving" with drainage and no odor, and the left heel which measured 2.0 cm by 1.0 cm by 0.1 cm.</p> <p>The "Wound Progress Note/Reassessment," dated 11-10-11 indicated the resident's left ischium measured 5.3 cm by 3.5 cm by 0.5 cm drainage but no odor, and the sacrum 5.4 cm by 8.0 cm by 0.1 cm drainage but no odor. The progress note lacked documentation related to the left heel.</p> <p>A subsequent notation by the Wound Care Specialist, dated 11-17-11 indicated the following: "Left hip [ischium] - 5.5 cm [centimeters]</p>		<p>accomplished for those residents found to have been affected by the deficient practice.No corrective action for this resident as she no longer resides in this facility. The resident was treated for wounds while in the facility. The resident admitted with multiple wounds, including all that were present on DC to hospital. The resident was extremely compromised with health and nutrition. The wound MD completed wound debridement which resulted in increased drainage. The treatment was also changed to a calcuim alginate which promotes increased drainage. Looking at the entire clinical picture with chronic leukocytosis, antibiotic therapy and treatment in process the change of condition with the wound occurred on the night the resident presented with a fever. The wound specialist determined the inability to heal as unavoidable due to disease process. Records reviewed with pharmacy and Emergency drug kits reflect 10 doses of antibiotic were sent. How other residents have the potential to be affected by the same practice will be identified and what corrective action will be taken. Every patient in the facility with a wound and antiobiotic therapy could have been affected. If the physician circled the statement "Call me immediately for evidence of infection", they could have been</p>		

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	<p>by 3.0 cm by 1.4 cm, Sacrum 2.6 cm by 8.6 cm by 0.1 cm both with drainage but no odor. A new area was identified on the resident's spine as a stage 3 and measured 1.6 cm by 0.9 cm by 0.1 cm. with drainage but no odor."</p> <p>A handwritten notation indicated, "Stage 3, sacrum unstageable pressure ulcer hip - debrided to [Stage] 4. Stage 3 - spine."</p> <p>Instructions included: "1. Call me immediately for evidence of infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>During interview on 12-16-11 at 11:45 a.m. the Director of Nursing services indicated the Wound Care Specialist physician came to the facility weekly, but the resident was not seen by the Wound Care Specialist the week of the Thanksgiving holiday [11-20-11].</p> <p>However, the record indicated the nursing staff on 11-22-11 [Tuesday], notified Nurse Practitioner #12, from a different physician service of the following, "Nursing states increased drainage [related to the pressure ulcers]." The Nurse Practitioner documented "leukocytosis - could be secondary to wound. Wound care is following [related</p>		<p>affected. The facility Medical Director, follows in the facility 5 days per week. It has always been the standard to have the Medical Director's office follow between visits for wound care, as with Resident 'A'. The facility was under the impression that doing the right thing by having the physician that was in the facility follow up, was the best plan of care for the resident. The wound MD's practice has been advised the facility requests the wording on the form be changed to 'Follow up with MD for evidence of infection, etc.' The facility will be instructed (educated) to follow with the wound MD for every wound. All wound drainage smells. It is a waste product of the body. Adding a product to the regimen to increase wound drainage, will cause increased odor due to increased amount. Medication administration inservice scheduled. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The wound MD is available for visits to the facility off his regular weekly visit and has accommodated the facility numerous times. The Licensed staff will contact as needed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur.Education</p>		

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	<p>to the Wound Care Specialist physician]. Will start clindamycin [an antibiotic] 300 mg [milligrams] per gastrostomy feeding tube two times a day for five days."</p> <p>A subsequent nurse practitioner [#11 also from the same physician service as nurse practitioner #12] progress note dated 11-28-11, indicated the resident's white blood cell count increased and further noted the resident had been treated with clindamycin "thru 11-27-11 secondary to wound drainage - continue with Wound Team."</p> <p>During an interview on 12-19-11 at 10:15 a.m., the Nurse Practitioner #11, with documentation as noted on 11-28-11, indicated she was "probably approached by the nursing staff of the resident's laboratory results. I didn't observe the resident's wounds. Sometimes the staff do get us involved, but they should confer with the Wound Care Specialist."</p> <p>Review of the Resident Progress Notes, dated 11-22-11 at 10:10 p.m., the nurse documented the resident was "started on ATB [antibiotic] tonight." The 11-23-11 10:00 a.m. notation as well as 11-24-11 at 9:00 p.m. and 11-27-11 at 12:00 p.m. and 8:00 p.m. indicated the resident's sacral and ischial wounds with foul smelling drainage."</p>		<p>will be provided to the nurses to call the wound MD with changes in condition. This was an expected change in condition. The unexpected change in condition was when the resident vomited and has a trach. The primary MD was immediately contacted and the resident was sent to the hospital. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. How the corrective action will be monitored to ensure the deficient practice will not recur. The facility Performance Improvement Committee, or designee, will review reidents with wounds 3 days per week and PRN to ensure no change in condition related to the wound. The Unit Manager or designee will document accordingly. Justification for increased drainage will be explained in the medical by the treatments being used. NAR (nutrition at risk) will follow the residents with wound. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The Performance Improvement committee will follow this process for a period of</p>		

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	<p>Review of the Medication Administration Record for 11-2011 indicated the resident received the prescribed antibiotic medication on 11-22-11 at 8:00 p.m., 11-23-11 at 8:00 a.m., 11-24-11 at 8:00 a.m. and 8:00 p.m., 11-25-11 at 8:00 a.m. and 8:00 p.m., and 11-26-11 at 8:00 a.m. and 8:00 p.m., for a total of 8 doses. The reverse side of the Medication Administration Record lacked information/clarification related to the missed doses of the antibiotics.</p> <p>During interview on 12-19-11 at 10:30 a.m., the Director of Nursing Services verified the record indicated the resident received 8 of the 10 doses of the antibiotics and the nursing staff failed to document the reasoning of the two missed doses.</p> <p>This Federal tag relates to IN00100763.</p> <p>3.1-35(g)(2)</p>		<p>three months if substantial compliance is maintained. If compliance is not maintained, the PI committee will continue with re-education and monitoring until three consecutive months are compliant.</p>		

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F0314 SS=D	<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 record review and interview the facility failed to ensure treatment and services related to wound care, in that when the facility nursing staff involved a nurse practitioner in the care of a resident with multiple ulcers, the nursing staff failed to complete the scheduled number of antibiotic dosages for 1 of 3 resident's reviewed for pressure ulcers in a sample of 6. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 12-15-11 at 1:20 p.m. Diagnoses included but were not limited to Severe Parkinson's disease, a history of urinary tract infections, contractures, respiratory failure, dementia and aspiration. These diagnoses remained current at the time of the record review.</p> <p>In addition the record indicated the resident had a tracheostomy and received the services of a local Wound Care physician.</p>	F0314	F-314This plan of correction is the centers credible allegation of complaince. 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. This plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law. What corrective action will accomplished for those residents found to have been affected by the deficient practice.No corrective action for this resident as she no longer resides in this facility. The resident was treated for wounds while in the facility. The resident admitted with multiple wounds, including all that were present on DC to hospital. The resident was extremely compromised with health and nutrition. The wound MD completed wound debridement which resulted in increased drainage. The treatment was also changed to a calcuim alginate which promotes	01/12/2012	

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	<p>The "Wound Care Note/Reassessment," dated 10-20-11 indicated the resident's left ischium wound measured 5.0 by 2.7 by 0.3 centimeters, "unstageable" was "stable" with "drainage no odor" was debrided. Other areas identified by the local Wound Care physician included the Sacrum which measured 3.0 cm [centimeters] by 8.0 cm by 0.1 cm, and the left heel which measured 2.0 cm by 1.0 cm by 0.1 cm., both with drainage but no odor.</p> <p>Further documentation in regard to the left ischium indicated the ulcer was classified as "traumatic" - Stage 3 now aggravated by pressure, so must be reclassified. Debrided to Stage 3. Must off load. Wound details post [debridement] length 5.4 cm width 3.0 by 0.6 cm."</p> <p>Instructions from the Wound Care physician included: "1. Call me immediately for evidence of infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>Review of a "Wound Progress Note/Reassessment," dated 10-27-11 indicated the resident had a sacral wound</p>		<p>increased drainage. Looking at the entire clinical picture with chronic leukocytosis, antibiotic therapy and treatment in process the change of condition with the wound occurred on the night the resident presented with a fever. The wound specialist determined the inability to heal as unavoidable due to disease process. Records reviewed with pharmacy and Emergency drug kits reflect 10 doses of antibiotic were sent. How other residents have the potential to be affected by the same practice will be identified and what corrective action will be taken. Every patient in the facility with a wound and antiobiotic therapy could have been affected. If the physician circled the statement "Call me immediately for evidence of infection", they could have been affected. The facility Medical Director, follows in the facility 5 days per week. It has always been the standard to have the Medical Director's office follow between visits for wound care, as with Resident 'A'. The facility was under the impression that doing the right thing by having the physician that was in the facility follow up, was the best plan of care for the resident. The wound MD's practice has been advised the facility requests the wording on the form be changed to 'Follow up with MD for evidence of infection, etc.' The facility will be instructed (educated) to follow</p>		

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	<p>which measured 2.7 cm by 7.5 cm by 0.1 cm - "drainage" but "no odor," a wound on the left ischium which measured 4.7 cm by 2.3 cm by 0.4 cm "improving" with "drainage" and "no odor," and the left heel which measured 2.0 cm by 1.0 cm by 0.1 cm.</p> <p>The "Wound Progress Note/Reassessment," dated 11-10-11 indicated the resident's left ischium measured 5.3 cm by 3.5 cm by 0.5 cm "drainage" but "no odor," and the sacrum 5.4 cm by 8.0 cm by 0.1 cm with "drainage" but "no odor." The progress note lacked documentation related to the left heel.</p> <p>A subsequent notation by the Wound Care Specialist, dated 11-17-11 indicated the following: "Left hip [ischium] - 5.5 cm [centimeters] by 3.0 cm by 1.4 cm, sacrum 2.6 cm by 8.6 cm by 0.1 cm both with "drainage" but "no odor." A new area was identified on the resident's spine as a stage 3 and measured 1.6 cm by 0.9 cm by 0.1 cm. with "drainage but no odor." A handwritten notation indicated, "Stage 3, sacrum unstageable pressure ulcer hip - debrided to [Stage] 4. Stage 3 - spine."</p> <p>Instructions included: "1. Call me immediately for evidence of</p>		<p>with the wound MD for every wound. All wound drainage smells. It is a waste product of the body. Adding a product to the regimen to increase wound drainage, will cause increased odor due to increased amount. Medication administration inservice scheduled. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The wound MD is available for visits to the facility off his regular weekly visit and has accommodated the facility numerous times. The Licensed staff will contact as needed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur.Education will be provided to the nurses to call the wound MD with changes in condition. This was an expected change in condition. The unexpected change in condidtion was when the resident vomited and has a trach. The primary MD was immediately contacted and the resident was sent to the hospital. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. How the corrective action will be monitored to ensure the</p>		

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	<p>infection, i.e. increased erythema, warmth, tenderness, odor, drainage at the wound site, fevers, or chills. 2. Offload wound as much as possible... ."</p> <p>During interview on 12-16-11 at 11:45 a.m. the Director of Nursing services indicated the Wound Care Specialist physician came to the facility weekly, but the resident was not seen by the Wound Care Specialist the week of the Thanksgiving holiday [11-20-11].</p> <p>However, the record indicated the nursing staff on 11-22-11 [Tuesday], notified Nurse Practitioner #12, from a different physician service of the following, "Nursing states increased drainage [related to the pressure ulcers]." The Nurse Practitioner documented "leukocytosis - could be secondary to wound. Wound care is following [related to the Wound Care Specialist physician]. Will start clindamycin [an antibiotic] 300 mg [milligrams] per gastrostomy feeding tube two times a day for five days." The Nurse practitioner progress note was "blank" in the area provided for an assessment/documentation of the resident's skin/ulcers.</p> <p>A subsequent nurse practitioner [#11 also from the same physician service as nurse practitioner #12] progress note dated</p>		<p>deficient practice will not recur. The facility Performance Improvement Committee, or designee, will review residents with wounds 3 days per week and PRN to ensure no change in condition related to the wound. The Unit Manager or designee will document accordingly. Justification for increased drainage will be explained in the medical by the treatments being used. NAR (nutrition at risk) will follow the residents with wound. Education will be provided on medication administration. Medicine records will reviewed 3 days per week by the unit manager or desidnee to ensure proper documentation of medication administration and refusal. The Performance Improvement committee will follow this process for a period of three months if substantial compliance is maintained. Re-education and continued monitoring will occur if compliance is not maintained for three consecutive months.</p>		

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	<p>11-28-11, indicated the resident's white blood cell count increased and further noted the resident had been treated with clindamycin "thru 11-27-11 secondary to wound drainage - continue with Wound Team."</p> <p>During an interview on 12-19-11 at 10:15 a.m., the Nurse Practitioner #11, with documentation as noted on 11-28-11, indicated she was "probably approached by the nursing staff of the resident's laboratory results. I didn't observe the resident's wounds. Sometimes the staff do get us involved, but they should confer with the Wound Care Specialist."</p> <p>Review of the Resident Progress Notes, dated 11-22-11 at 10:10 p.m., the nurse documented the resident was "started on ATB [antibiotic] tonight." The 11-23-11 10:00 a.m. notation as well as 11-24-11 at 9:00 p.m. and 11-27-11 at 12:00 p.m. and 8:00 p.m. indicated the resident's sacral and ischial wounds with foul smelling drainage."</p> <p>The record lacked documentation the nursing staff notified the Wound Care physician, as directed in the "Instructions," for possible intervention of the resident's wounds.</p> <p>In addition a review of the Medication</p>				

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F0463 SS=E	<p>Administration Record for 11-2011 indicated the resident received the prescribed antibiotic medication on 11-22-11 at 8:00 p.m., 11-23-11 at 8:00 a.m., 11-24-11 at 8:00 a.m. and 8:00 p.m., 11-25-11 at 8:00 a.m. and 8:00 p.m., and 11-26-11 at 8:00 a.m. and 8:00 p.m., for a total of 8 doses.</p> <p>The reverse side of the Medication Administration Record lacked information/clarification related to the missed doses of the antibiotics.</p> <p>During interview on 12-19-11 at 10:30 a.m., the Director of Nursing Services verified the record indicated the resident received 8 of the 10 doses of the antibiotics and the nursing staff failed to document the reasoning of the two missed doses as prescribed.</p> <p>This Federal tag relates to IN00100763.</p> <p>3.1-40(a)(2)</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, record review and interview, the facility failed to ensure the efficiency of the resident call system for 1</p>	F0463	F-463This plan of correction is the centers credible allegation of complaine. Preparation and/or execution of this plan of	01/12/2012	

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	<p>of 4 units. This deficient practice affected 6 of 33 residents who resided on this unit in the rooms listed, and 1 of 2 common shower rooms. [rooms 216 201, 227, 230, 209, 329] [mens shower room]</p> <p>Findings include:</p> <p>Interview on 12-16-11 at 4:30 a.m., Licensed nurse employee #6 indicated there was a problem with the call light system. "We can hear it, and then have to look for the light above the resident's door, but the panel at the nurses station isn't working. It doesn't show what room for the call light."</p> <p>Interview on 12-16-11 at 4:40 a.m., Certified Nurses aide employee #7 indicated "When we came in last night [in reference to the beginning of the night shift] there was a problem with the call lights. It would show over the door but not on the board at the nurses station."</p> <p>Review of a "work order," dated 12-16-11 prepared by the licensed nurse indicated, "Rooms 201, 216, 219 and 227 call light not showing at nurse desk."</p> <p>Review of an additional "work order" dated 12-15-11 indicated "Location Room 228 - when room call light is on bathroom call light won't work."</p>		<p>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.</p> <p>This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. All resident room call lights were checked and found to be operational. The Maintenance Supervisor, Administrator, and State Surveyor observed every resident room light and found them to be operational. One shower room light was replaced. An outside technician (SAFECARE) was called in and found the lights to be operational. The call light system is inspected daily weekly and monthly. Call cords, bulbs, and needed parts are repaired or replaced immediately. How other residents having the potential to be affected by the same practice will be identified and what corrective action will be taken. All resident room call lights were checked and found to be operational. The Maintenance Supervisor, Administrator, and State Surveyor observed every resident room light and found them to be operational. One shower room light was replaced. An outside technician (SAFECARE) was called in and</p>		

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	<p>The Director of Nursing Services, the Administrator and the Maintenance Supervisor arrived at the facility at approximately 5:00 a.m., and the concern of the call system was discussed.</p> <p>Interview on 12-16-11 at 5:30 a.m., the Administrator indicated there had been a problem with the call light in Room 230, as identified by a resident's spouse, but when the maintenance supervisor went to the room the call light was functioning. The Administrator indicated they attempted various options which included a different call button for the resident, but eventually moved the resident to another room.</p> <p>During observation on 12-16-11 at 6:00 a.m., the Director of Nursing Services attempted to activate the call light in room 214. The Director of Nursing Services verified the call system for this room, was not working. The Director of Nursing Services then attempted to activate the call light in room 216, which was previously identified as "not working," now activated.</p> <p>Further observation on 12-16-11 the call light for the "Mens Shower room" did not illuminate over the door or at the nurses station when the call light was activated.</p>		<p>found the lights to be operational. The call light system is inspected daily weekly and monthly. Call cords, bulbs, and needed parts are reaired or replaced immedately. What measures will be put into place to ensure the practice does not recur Preventative maintenance How will the corrective action be monitored. The PI committee will continue to monitor concerns and repairs regarding call lights. Preventative maitntenance will continue.</p>		

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	<p>Interview on 12-16-11 at 6:00 a.m., the Administrator indicated the shower room was not used for showers but rather for storage.</p> <p>The technician for the Call system arrived at the facility at 6:30 a.m., and identified "broken wires" at the panel, located at the nurses station, for rooms 201, 227, 230 and 216.</p> <p>A review of the facility "work orders" from 11-01-11 thru 12-16-11 indicated the following related the facility call system.</p> <p>"11-04-11 - Room 230 call light won't turn off."</p> <p>"11-07-11 Room 230 call light only works sometimes. When pushed call light won't come on sometimes."</p> <p>"11-08-11 - Room 209 bathroom call light won't work."</p> <p>"11-28-11 Room 329 call light broke."</p> <p>"12-02-11 Room 302 call light won't work."</p> <p>"12-05-11 Room 230 call light not working properly - we put an easy touch [a different call button] in room."</p>				

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	<p>"12-06-11 Room 230 call light not working sporadically."</p> <p>Interview on 12-16-11 at 9:15 a.m., the service technician indicated the call light in Room 228 was not functioning.</p> <p>Observation on 12-16-11 at 9:25 a.m., a staff member was transporting a resident from the Mens Shower Room. When interviewed if the staff use this shower room, the staff member indicated, "Yes for the male resident's."</p> <p>On 12-16-11 at 10:00 a.m., the Administrator was notified the nursing staff was using the Mens Shower Room for bathing of the male resident's.</p> <p>During an interview on 12-15-11 at 10:20 a.m. a concerned family member indicated, "I complained to [name of Administrator] and he said he would come in on night shift to see what was going on with the call light in my [spouse's] room. They couldn't seem to get it fixed, my [spouse] called me during the night because no one would answer the light. That happened two times. They moved [name of spouse] to another room. After that everything was fine and they were very attentive."</p> <p>Interview on 12-16-11 at 11:00 a.m., the</p>				

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	<p>Administrator indicated they had experienced problems with the call system, and the facility had to replace two transformers. A review of the local area repair company indicated on 08-03-11 "Replaced two transformer <sic> in nurse call system and left extra batteries for customer. Two 12 V [volt] battery, 1 open frame transformer."</p> <p>Review of the "Service Call Report," dated 12-16-11 indicated "room on nurse call annunciating but not lighting. Found broken point wires on three of four rooms out. Rewired fourth room to annunciate and replaced room light bulb at annunciation. Rewired a fifth room that was lighting both dome light bulbs when both station <sic> was pulled."</p> <p>This Federal tag relates to IN00100958.</p> <p>3.1-19(u)(1) 3.1-19(u)(2)</p>				