STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155763	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE VILLAGE NURSING & REHAB CENTER	600 TRAIL RIDGE RD ALBION, IN 46701

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F0000	This visit was for the Investigation of Complaint IN00102747 Complaint IN00102747 - Substantiated. Federal/state findings related to the allegations are cited at F 309. Survey dates: 1/26-27 and 1/30/12 Facility number: 011296 Provider number: 155763 AIM number: 200827620 Survey team: Ellen Ruppel, RN Census bed type: SNF/NF: 59 Residential: 13 Total: 72 Census payor type: Medicare: 7 Medicaid: 38 Other: 27 Total: 72 Sample: 5 This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. Quality review 2/01/12 by Suzanne	F0000	**This plan of correction is to serve as North Ridge Village Nursing & Rehab Center's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing & Rehab Center or it's management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Williams, RN			

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F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, interviews and record review, the facility failed to comprehensively assess, develop and implement interventions to prevent skin breakdown for a resident wearing an immobilizer to the leg following a fracture. This resulted in worsening ulceration, infection and ultimately in the amputation of the leg. This deficient practice affected 1 of 2 residents in a sample of 5 whose records were reviewed for skin breakdown. Resident B Findings include: The closed clinical record of Resident B was reviewed, on 1/26/12 at 11:20 a.m., and indicated the resident had lived in the facility since March of 2007. Her diagnoses included, but were not limited to: history of intracranial hemorrhage, Alzheimer's dementia, hypothyroidism, osteoarthritis, degenerative joint disease and polio disease with right lower extremity weakness. A venous doppler study of the right lower leg, dated 5/4/11, indicated, "The	F0309	F309 483.25 Quality of Care It is the practice of North Ridge Village Nursing & Rehab Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. I. Resident B no longer resides at this facility. II. Residents currently using braces, splints or immobilizers, received skin assessments by a licensed nurse. No problems were identified. The devices in use were scrutinized for sharp edges and potential malfunctions. No problems were identified. Manufacturer's guidelines for all the devices in use were obtained and placed on the chart. Physician orders are present for the usage of all devices. Nursing and therapy personnel were reinserviced on the devices and appropriate positioning of the devices. III. The Medical Director, Therapy Director and Director of Nursing developed a new policy for the screening and evaluation of all immobilizers, splints and braces. A physicians order will be obtained prior to services. The policy addresses	02/08/2012

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	common femoral, superficial femoral and the popliteal veins of the right lower extremity reveal dampened flow." The report did not indicate deep vein thrombosis. The Minimum Data Set Assessment (MDS), of 10/20/11, indicated she was in need of extensive assistance of two persons for transfer and was transferred by mechanical lift. The assessment indicated she had cognitive impairments and problems with decision making. Review of an incident/accident report, dated 11/29/11 at 4:10 p.m., indicated Resident B had sustained a fall from the bed, causing injury to the right leg. The report indicated two staff members had been in the room, but did not see the resident fall. An x-ray, dated 11/30/11, indicated, a right non displaced supracondylar distal femur fracture. It also indicated the resident had osteopenia. Nurses notes, dated 12/1/11 at 9:00 p.m., indicated the resident had returned to the facility with an immobilizer on the right leg. Physician's orders, from 12/1/11, written by the orthopedic physician, indicated the		skin care, frequency of assessment, ongoing observation of the device, and physician notification. Licensed nurses and therapists have been educated on the new policy.The Assistant Director of Nursing received education regarding the use of immobilizing devices and to notify the physician with changes in the device. IV. The Director of Nursing or her designee is conducting quality improvement audits on 100% of residents receiving orders for immobilizers, splints or braces. The audit will evaluate the safety of the device, the presence of manufacturer's guidelines, the training of staff and routine skin assessments per policy. The audit will be completed weekly for 30 days; then monthly for 6 months. Ongoing audits will be completed based upon the level of compliance with the compliance goal of 100% Results of all audits are being reported to the QA Committee monthly to assist with additional recommendations if necessary.Completion date: 2-8-12	

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	resident was to be turned every two hours and the right leg supported at the knee and ankle during position changes. It also indicated the leg was to be checked daily for areas of pressure or skin breakdown. The orders included washing gently and drying the leg and allowing exposure to air 30 to 60 minutes daily. The orders instructed staff to position the knee immobilizer 2-3 inches above the ankle and add extra foam padding over pressure areas or slightly loosen the straps on the immobilizer. An Interdisciplinary Team (IDT) note, on 12/2/11, indicated she had been sent to the local hospital for orthopedic evaluation, due to pain and rotation of the right foot with the immobilizer on. The note indicated the orthopedic physician supported a non-surgical approach to the fracture. Nurses notes, dated 12/5/11 at 5:45 p.m., indicated the nurse had observed a skin tear on the right outer ankle. The physician was notified and an order for daily dressings until the area healed was obtained. A Weekly Wound Evaluation Flow Sheet, dated 12/5/11, indicated the area was non-pressure and measured 2 cm by 2.2 cm with a depth of less than 0.1 cm. The			

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	evaluation indicated it had a small amount of sanguineous drainage and granulation tissue was present. It also indicated the presence of edema. Daily dressings were indicated as the treatment. An IDT (Interdisciplinary Team) note, dated 12/6/11, indicated, "When the nurse discovered the skin tear he had to reposition the immobilizer and his thoutouts (sic) were that the immobilizer was to (sic) low and caught her skin. Per family request we have marked her leg as to where the immobilizer is to be positioned and memo out to staff for reminder and instructions are on the TAR (Treatment Administration Record)." There was no documentation to indicate extra foam padding had been added or the straps had been loosened slightly as the 12/1/11 orthopedic orders instructed. There was no documentation to indicate the therapy department had assessed the immobilizer or provided instructions for the placement of the stabilizing bars attached by Velcro to the immobilizer. The care plan related to the skin tear area on the right lower leg, dated 12/6/11, indicated: "A. TX (treatment) per order B. Observe for s/s (signs and symptoms) of infection daily C. Knee immobilizer is to be in proper			

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	position on leg D. Notify MD of presence of infection E. Wound nurse as needed (12/20/11) F. Encourage resident to consume meals (12/20/11) G. Medication per dr orders (12/28/11)" The care plan related to the fracture, dated 12/7/11, indicated, "B. Immobilizer on at all times except for bathing (reapply after skin is completely dry) C. Observe that leg is in proper alignment as resident moves around in chair frequently D. Adjust straps of immobilizer as needed (skinny straps first, then larger straps) E. PT (physical therapy) as needed/indicated F. Report any s/sx (signs or symptoms) increased pain to family and physician G. Hoyer lift for transfers" The Weekly Wound Evaluation Flow Sheet, dated 12/14/11, indicated the area on the right lower leg was the same size, depth and had the same granulation, with small amounts of serous drainage. It indicated edema was still present in surrounding skin and the treatment was a daily dressing. Daily nurses' notes from 12/14 to			

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	12/20/11 indicated the nurses were checking placement of the immobilizer. The notes indicated the changing of the dressing with no description of the drainage, redness of the area or changes from day to day. The note, dated 12/16/11 at 1:20 p.m., indicated the leg was tender to touch. The Weekly Wound Evaluation Flow Sheet, of 12/20/11, indicated the size of the area on the right lower leg had increased in size to 5 cm by 3 cm with less than 0.1 depth. The tissue description was eschar with a small amount of serosanguineous exudate present. The entry indicated edema in surrounding skin. The treatment was changed to Polymem dressing to be changed daily. Nurses notes, of 12/20/11 at 10:40 a.m., indicated the physician wrote an order for the wound nurse to see the area on the resident's lower right leg. A nurses note, at 1:45 p.m., on 12/20/11, indicated Medpass dietary supplement 90 ml, twice daily had been ordered, following an assessment by the dietician on 12/20/11. The dietary note, dated 12/20/11 (no time specified) indicated Resident B's albumin level was low at 2.6 and she had			

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	experienced a significant weight loss, due to low meal intakes. During an interview with the Director of Nursing, on 1/26/12 at 11:00 a.m., and review of a time line of events related Resident B's skin areas, she indicated a new immobilizer was provided on 12/20/11. No order for the new immobilizer or therapy evaluation of the immobilizer was available for review. Resident B was seen by the wound nurse, on 12/22/11, and the wound nurse indicated in her progress note she had measured the area on the right lower leg and found it to be 3.5 cm by 3 cm. No depth was recorded. She recommended Santyl daily after cleaning with wound cleaner. The TAR for 12/11 indicated the treatment was started on 12/23/11. Nurses notes, dated 12/27/11 at 1:30 a.m., indicated the immobilizer was off and a moderate amount of serous sanguineous drainage was present on the old dressing. The entry indicated 2 to 3 plus edema present in the right foot. The resident was seen by the orthopedic physician in the afternoon of 12/27/11, and diagnosed the area as a grade III to grade IV pressure area with mild cellulitis. He indicated the area was 2 cm			

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	by 8 cm and mostly covered by eschar. The antibiotic cefalxin was ordered for the infection. The 12/28/11 Weekly Wound Flowsheet Record indicated the size of the wound had increased to 7 cm by 2 cm with less than 0.1 depth and had serosanguineous drainage. The tissue description was eschar with edema of the surrounding skin. The facility physician saw the resident on 12/29/11, and indicated the area was not a pressure sore. The note indicated, "Patient, apparently at the beginning of December, had a fall resulting in distal femur fracture of the supracondylar region. At the time she was placed in a knee immobilizer. During that time, she had developed a skin flap which was documented by the nurses, or a skin tear just to the R (right) distal leg right at the edge of where the immobilizer ended on the lateral portion of the leg. They tried to treat the skin tear as best as they could with Bacitracin and wraps and apparently she developed a further wound in that area which appears to have been secondary from where the metal bar from the knee immobilizer had worked itself out and gone down and created a wound into the skin." The note also indicated "...It seems to match the measurements			

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	where the metal bar would have come out. She now has a new immobilizer. There is no surrounding erythema or warmth. She is still very tender to that area." Nurses notes, of 1/4/12 (no time specified), indicated the immobilizer was in place and the lower right extremity was red with 1 plus non pitting edema. The wound nurse's notes, dated 1/5/12 at 9:15 a.m., indicated the area was 8 cm by 3 cm with the tendon exposed. There was no documentation to indicate the physician was notified of the increased severity of the wound. The orthopedic physician saw her again on 1/10/12, and wrote, "Large ulcer on lat (lateral) R (right) leg now exhibits long stretch of exposed tendon (with) surrounding erythema- a new eschar has developed proximal to the original ulcer. L (left) heel has dry eschar ~3 cm diameter x-ray ->progressive healing of supracondylar fx (fracture) of R femur. Plan: 1. D/C (discontinue) knee immobilizer 2. saline wet - to- dry dsgs (dressings) R leg- plastic surgery consult re (regarding) wound coverage 3. pillow under L (left) calf to keep pressure off heel."			

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	The NP's note, of 1/12/12, indicated Resident B was no longer wearing the immobilizer and the wound was being treated with Kaltostat. The note also indicated the resident would likely continue to lose weight as her conditions deteriorate. Remeron had been added on 1/9/12, for appetite stimulation Nurses notes, of 1/13/12 at 9:00 p.m., indicated the wound on the right lower leg had purulent drainage and the results from a culture obtained while she was at the orthopedic physician's office on 1/10/12, indicated the presence of MRSA (methicillin resistant staphylococcus aureus). The antibiotic Cleocin was ordered (75 mg/5 ml 600 ml bottle take 10 ml orally four times daily until gone) It was begun on 1/13/12 at 4:00 p.m. The Weekly Wound Evaluation Flow Record, dated 1/18/12, indicated the size of the wound was 15 cm by 3.5 cm with a depth of 0.4 cm. The tissue description indicated the tendon was exposed and moderate serosanguineous drainage was present. Nurses notes, dated 1/19/12 at 12 noon, indicated the wound had yellow and brown drainage which had a foul odor. Resident B was transferred to the hospital,			

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	on 1/20/12, and underwent an amputation of the right lower leg, on 1/21/12. Hospital records, dated 1/20/12 at 7:50 a.m., indicated, "She does have some edema to her right lower extremity and some redness to her right lower extremity. Again, no hair growth. I am unable to really palpate a dorsalis pedis pulse. She has a large wound on the lateral posterior side of her right leg that measures approximately 17 x 4 x 0.5. There is dried tendon exposed and black eschar to the proximal aspect of the wound. There is positive drainage and mild odor." The immobilizer, identified by the DON, on 1/27/12 at 1:30 p.m., as the one originally applied on Resident B's right leg was observed for areas of roughness. The lower, outer aspect of the immobilizer had a rough area where the vertical stabilizing bar was attached. The bar was inside a Velcro sleeve, which was rough on the distal end. The area was not protected by the foam padding of the immobilizer and could have been in direct contact with skin on the lower aspect of the leg. When queried about the addition of extra foam over the area or moving the stabilizing bar up enough to keep it away from the edge of the immobilizer, the DON indicated no additional padding had been used and the staff had marked the			

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	resident's leg to show where the immobilizer was to be placed on the leg after the skin tear had occurred. She indicated therapy had not assessed the immobilizer and no instructions had come with the resident regarding the immobilizer when she returned from the hospital with it in place on the right leg. The nurse (LPN #3) who had written the entry on 12/5/11 and completed the skin occurrence form, was interviewed on 1/30/12 at 9:30 a.m. He indicated the daughter of the resident had notified him of an area on Resident B's lower right leg and when he observed it, the immobilizer had slid on her leg. He indicated Resident B was in the wheel chair at the time and the area looked like a skin tear with a skin flap. He indicated the immobilizer did not touch the area when it was positioned properly, but slid down frequently, due to the resident's moving around. He indicated a metal bar had come out of the immobilizer and slipped down to the area where the skin tear occurred. Observation of the immobilizer, on 1/30/12 at 9:55 a.m., did not reveal any open areas where the metal rods could come out. The Assistant Director of Nursing indicated she had sewed the ends of the pockets containing the metal bars shut and thought she had done this on			

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	12/19/11. No order for a second immobilizer could be found on 1/30/12 at 10:30 a.m., and when queried about a therapy evaluation of the original immobilizer or the second one obtained, none could be found. Two therapy screens, dated 12/5/11 and 12/27/11 noted an immobilizer in place. The screens were to determine if Resident B would benefit from therapy. Neither evaluated the effectiveness of the immobilizer or made recommendations regarding it. This federal tag relates to Complaint IN00102747. 3.1-37(a)			