

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155237	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER BETHANY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S SHELBY ST INDIANAPOLIS, IN 46227
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 26, 27, 28, and 29, and June 1, 2, and 3, 2015</p> <p>Facility number: 000142 Provider number: 155237 AIM number: 100266940</p> <p>Census bed type: SNF/NF: 95 Total: 95</p> <p>Census payor type: Medicare: 12 Medicaid: 67 Other: 16 Total: 95</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>The creation and submission of the Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies, or of any violation or regulation. Thisprovider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDEREDTHE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW IN LIEU OF POSTSURVEY REVIEW on or after June 22, 2015. Facility is also requesting a face to face IDR for F0314</p>	
F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to</p>			

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

TITLE

(X6) DATE

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

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	<p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview, and record review, the facility failed to revise a care plan for a resident with weight loss (Resident #6) and 2 residents with pressure ulcers (Resident #108 and Resident #40).</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #6, completed on 5/28/15 at 3:33 p.m., indicated the resident had diagnoses including, but not limited to hypertension (high blood pressure) and heart disease.</p> <p>The resident's admission weight on 2/3/15, was recorded on the Admission Nursing Assessment as 94 pounds. The resident's height was 64 inches.</p>	F 0280	<p><u>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP--</u></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws on the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #06 has an updated care plan for weight loss ·Resident #40, and #108 have an updated care plan for pressure ulcers <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who are a weight loss or have pressure ulcers have 	06/22/2015

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	<p>A physician's order dated 2/3/15, indicated the resident was prescribed Boost, a high protein nutritional supplement, 1 carton 3 times a day.</p> <p>A physician's order dated 2/7/15, indicated the resident was prescribed Megace ES (a medication used to increase the appetite) 625 mg (milligrams) every day.</p> <p>A care plan dated 2/12/15, indicated the resident required a therapeutic diet related to hypertension and heart disease. The care plan did not address the decreased weight and did not contain the prescribed interventions of Megace and Boost.</p> <p>During an interview with the Minimum Data Set (MDS) assessment Coordinator on 5/28/15 at 5:35 p.m., the MDS coordinator indicated dietary staff would be responsible for the updating of the care plan regarding weights and nutritional supplements.</p> <p>During an interview with the Dietary Services Manager (DSM) and the Director of Nursing Services (DNS) on 5/28/15 at 6:00 p.m., the DSM indicated the registered dietician developed and revised the care plans in regard to weight loss or gain and indicated the nursing</p>		<p>the potential to be affected by the alleged deficient practice</p> <ul style="list-style-type: none"> ·The DNS/designee will review all clinical records to identify residents who have pressure ulcers and update their care plans ·The Dietary Manager/designee will review all clinical records to identify resident who are a weight loss and update their care plans ·Licensed nurse and Certified Nurse's Aides will be in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such turning and repositioning and pressure relief ·The Interdisciplinary Team will review all physicians orders related to dietary interventions and wounds in clinical meeting to ensure that orders are verified and care plans are updated <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·DNS/Designee will review care plans during clinical meeting to ensure care plans are revised as needed to address pressure ulcers and weight loss for all residents ·Licensed nurse and Certified Nurse's Aides will be in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such turning and 	

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	<p>staff addressed anything involving medications. The DNS indicated the care plan should have been updated shortly after the physician's order was received to administer the medication used to increase the appetite.</p> <p>2. The clinical record review of Resident #108, completed 5/29/15 at 1:08 p.m., indicated the resident had diagnoses including, but not limited to diabetes.</p> <p>A written care plan dated 9/26/14, with a goal date of 6/26/15, indicated the resident was at risk for skin breakdown due to impaired/decreased mobility, diabetes, heart disease, and medication side effects. Interventions dated 9/26/14, included but were not limited to, assess and document skin condition weekly and as needed, pressure reducing/redistribution cushion in chair/wheelchair and mattress on the bed, and turn and reposition at least every 2 hours.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 2/19/15, assessed the resident as requiring extensive assistance of 2 or more staff members for bed mobility and transfers. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating no cognitive impairment,</p>		<p>repositioning and pressure relief</p> <p>·The Interdisciplinary Team will review all physicians orders related to dietary interventions and wounds in clinical meeting to ensure that orders are verified and care plans are updated</p> <p>Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</p> <p>·Care Plan Updating CQI tool will be utilized weeklyx 4, monthly x 5. Data will be submitted to the CQI committeefor follow up. If 95% threshold is notachieved, an action plan will be developed.</p>	

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	<p>as having a risk for the development of pressure ulcers, and having an unstageable pressure ulcer. Section M, Skin Conditions, of the MDS assessment did not indicate the resident was receiving a turning and repositioning program and did not indicated pressure ulcer care was being provided.</p> <p>A New Skin Event, started on 1/22/15 at 8:50 a.m., indicated the resident had a new open area on the right heel measuring 0.4 x 2.0 x < (less than) 0.1. The form indicated the measurements were L (length) x W (width) x D (depth) and were recorded in centimeters. The wound was described as white in color with a dusky wound bed and had a clear odorless drainage.</p> <p>The next documented evaluation or observation of the open area was on 1/26/15, 4 days after the open area was first noted, by the IDT (Interdisciplinary Team). The IDT progress note indicated the open area was on the left heel, had a moderate amount of serosanguineous (yellow with small amounts of blood) drainage, and the surrounding skin was moist and white. The progress note indicated the resident had increased swelling in both legs and was repositioned with legs elevated and pillows for pressure relief. The progress</p>			

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	<p>note indicated the physician would be contacted for further orders.</p> <p>A written plan of care dated 2/2/15, 11 days after the pressure ulcer was first noted, indicated the resident had a pressure ulcer described as a deep tissue injury to the right heel. The care plan lacked interventions for repositioning with legs elevated and pillows for pressure relief, an intervention noted in the IDT (Interdisciplinary Team) progress notes.</p> <p>The IDT note dated 2/17/15 at 1:48 p.m., indicated the root cause of the wound to the right heel was related to the resident being up in the wheelchair with heels against the foot rest. The resident refused to lay down between meals and was educated in the need to relieve pressure. The resident agreed to elevate the right leg when up in the wheelchair and have the heel float off the end of the wheelchair instead of resting on the leg rests. The written care plan for pressure ulcer was not revised to include the interventions as noted in the IDT progress notes.</p> <p>The care plan was updated on 2/26/15, to include foot cushion to be worn while up in wheelchair and at bedtime. The care plan did not indicate which foot or feet</p>			

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	<p>for the cushion.</p> <p>During an interview with the Director of Nursing Services (DNS), the Executive Director (ED), and the Corporate Clinical Consultant on 6/3/15 at 10:30 a.m., the DNS indicated the resident's care plan regarding the pressure ulcer should have been revised to include the interventions utilized for pressure reduction for the heels and wound healing.</p> <p>3. The clinical record of Resident #40 was reviewed on 6/1/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and polio.</p> <p>An annual Minimum Data Set assessment dated 5/5/15, and a quarterly (MDS) dated 2/13/15, indicated Resident #40 was independent in her ability to make decisions, needed extensive assistance of 2 staff for bed mobility, transferring and toileting, and was frequently incontinent.</p> <p>A New Skin Event, dated 5/7/15, indicated Resident #40 had developed a Stage 1 non-blanchable pressure ulcer on her right hip. A stage 1 pressure ulcer is a defined area of discolored, usually pink or red, intact skin on a surface which endures pressure. Non-blanchable means when pressure is applied, the area does</p>			

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	<p>not lose its color, as normal skin does. The Skin Event indicated this new stage 1 pressure ulcer measured 10.0 centimeters (cm) x 9.0 cm by < (less than) 0.1 cm.</p> <p>An Event dated 5/11/15, indicated the right hip stage 1 pressure ulcer measured 13.0 cm. x 9.0 cm. x <0.1 cm.</p> <p>An Event dated 5/18/15, indicated the right hip stage 1 pressure ulcer measured 10 cm. x 8 cm. x <0.1 cm.</p> <p>An event dated 5/26/15, indicated the right hip stage 1 pressure ulcer measured 13 cm. x 9.0 cm x <0.1 cm.</p> <p>An event dated 6/1/15, indicated the right hip stage 1 pressure ulcer measured 12 cm. x 9 cm. x <0.1 cm.</p> <p>An observation on 6/2/15 at 10:45 a.m., indicated a large, pinkish, red, and darker red area around the right buttock fold, upper thigh, hip area.</p> <p>A discontinued care plan, dated 6/22/14, indicated Resident #40 was at risk for skin breakdown. Interventions in place at the time the stage 1 pressure area was noted on 5/7/15, included turning and repositioning the resident at every 2 hours.</p>			

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	<p>A current care plan, created 5/13/15, indicated the resident being at risk for skin breakdown. Interventions including turning and repositioning at least every 2 hours.</p> <p>A current care plan, created 2/24/15, indicated Resident #40 had impaired skin integrity...stage I to right hip as of 5/6/15. Interventions included turning and repositioning every 2 hours.</p> <p>An observation on 6/2/15 between 11:10 a.m. and 1:40 p.m. (2 1/2 hours), indicated Resident #40 was sitting in her wheelchair. It appeared she was sitting directly on the stage I pressure area on her right buttock, upper thigh, hip area. There were no observations of attempts to reposition the resident during the 2 1/2 hour period.</p> <p>On 6/2/15 at 1:40 p.m., Certified Nursing Assistant (CNA) #1 indicated Resident #40 stays up in the wheelchair after lunch and likes to stay in the wheelchair all afternoon. The CNA indicated the resident will call if she is incontinent of stool, and sometimes the resident's urinary catheter bag gets emptied, but otherwise the staff doesn't do anything with the resident.</p>			

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	<p>On 6/2/15 at 3:30 p.m., the Clinical Education Coordinator (CEC)/wound nurse indicated Resident #40 refused to go back to bed during the day and didn't want to be repositioned. No documentation was found in the resident's record which indicated staff was repositioning the resident while up in the wheelchair. The CEC indicated at that time the resident's refusal to return to bed or be repositioned in the wheelchair was not care planned with alternative interventions for pressure relief.</p> <p>On 6/1/15 the Director of Nursing Services provided a policy titled, "Skin Management Program," dated 2/2015, and indicated it was the policy currently used by the facility. The policy indicated, "...The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation event on the next business day, Direct care givers will be notified of skin alterations and specific care needs, A plan of care will be initiated to include resident specific risk factors with appropriate interventions...A care plan will be developed specific to the resident's needs including prevention interventions Direct care givers will be notified of the resident's specific prevention interventions..."</p>			

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F 0282 SS=D Bldg. 00	<p>3.1-35(d)(2)(B)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to provide services in accordance with each resident's written plan of care for a resident with a pressure ulcer (Resident #40).</p> <p>Findings include: The clinical record of Resident #40 was reviewed on 6/1/15 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, pressure ulcer and polio.</p> <p>An annual Minimum Data Set assessment, dated 5/5/15, and a quarterly (MDS) dated 2/13/15, indicated Resident #40 was independent in her ability to make decisions, needed extensive assistance of 2 staff for bed mobility, transferring and toileting, and was frequently incontinent.</p> <p>A New Skin Event, dated 5/7/15, indicated Resident #40 had developed a</p>	F 0282	<p><u>F 282 SERVICES BYQUALIFIED PERSONS/PER CARE PLAN</u> The services provided or arranged by the facility must be provided by qualified person in accordance with each resident's writtenplan of care. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice? ·Resident #40 will be offered to beturned and repositioned at least every 2 hours per resident's plan of care Howwill you identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken? ·All residents who are care planned to be turned and repositioned every 2 hours have the potential to be affected by the alleged deficient practice ·All residents with wounds will have their care plan reviewed by DNS/Designee to ensure care</p>	06/22/2015

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	<p>Stage 1 non-blanchable pressure ulcer on her right hip. A stage 1 pressure ulcer is a defined area of discolored, usually pink or red, intact skin on a surface which endures pressure. Non-blanchable means when pressure is applied, the area does not lose its color, as normal skin does. The Skin Event indicated this new stage 1 pressure ulcer measured 10.0 centimeters (cm) x 9.0 cm by < (less than) 0.1 cm.</p> <p>An Event, dated 5/11/15, indicated the right hip stage 1 pressure ulcer measured 13.0 cm. x 9.0 cm. x <0.1 cm.</p> <p>An Event dated 5/18/15, indicated the right hip stage 1 pressure ulcer measured 10 cm. x 8 cm. x <0.1 cm.</p> <p>An event dated 5/26/15, indicated the right hip stage 1 pressure ulcer measured 13 cm. x 9.0 cm x <0.1 cm.</p> <p>An event dated 6/1/15, indicated the right hip stage 1 pressure ulcer measured 12 cm. x 9 cm. x <0.1 cm.</p> <p>An observation on 6/2/15 at 10:45 a.m., indicated a large, pinkish, red, and darker red area around the right buttock fold, upper thigh, hip area.</p> <p>A discontinued care plan, dated 6/22/14,</p>		<p>plans address residents' needs to help prevent pressure ulcers</p> <ul style="list-style-type: none"> ·Licensed nurse and Certified Nurse's Aides have been in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such turning and repositioning and pressure relief and following care plans Whatmeasures will be put into place or what systemic changes you will make toensure that the deficient practice does not recur? ·All residents with wounds will have their care plan reviewed and updated as needed ·Licensed nurse and Certified Nurse's Aides have been in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such turning and repositioning and pressure relief ·Licensed nurses will round every shift to ensure residents are turned and repositioned every 2 hours per plan of care using the Nurse Rounds Audit Tool ·DNS/Designee will review the Nurse Rounds Audit Tool Daily to ensure residents are being turned and repositioned per physician's orders and care plans for all residents Howthe corrective action(s) will be monitored to ensure the 	

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	<p>indicated Resident #40 was at risk for skin breakdown. Interventions in place at the time the stage 1 pressure area was noted on 5/7/15, included turning and repositioning the resident at every 2 hours.</p> <p>A current care plan, created 5/13/15, indicated the resident being at risk for skin breakdown. Interventions including turning and repositioning at least every 2 hours.</p> <p>A current care plan, created 2/24/15, indicated Resident #40 had impaired skin integrity...stage I to right hip as of 5/6/15. Interventions included turning and repositioning every 2 hours.</p> <p>An observation on 6/2/15 between 11:10 a.m. and 1:40 p.m. (2 1/2 hours), indicated Resident #40 was sitting in her wheelchair. It appeared she was sitting directly on the stage I pressure area on her right buttock, upper thigh, hip area. There were no observations of attempts to reposition the resident during the 2 1/2 hour period.</p> <p>On 6/2/15 at 1:40 p.m., Certified Nursing Assistant (CNA) #1 indicated Resident #40 stays up in the wheelchair after lunch and likes to stay in the wheelchair all afternoon. The CNA indicated the</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·Pressure Wound CQI tool will be utilized weekly x 4, monthly x 5. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed.</p>	

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F 0314 SS=G Bldg. 00	<p>resident will call if she is incontinent of stool, and sometimes the resident's urinary catheter bag gets emptied, but otherwise the staff doesn't do anything with the resident.</p> <p>3.1-35(g)(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. Based on observation, interview, and record review, the facility failed to ensure 2 residents who entered the facility without a pressure ulcer did not develop a pressure ulcer, in that a resident did not receive pressure relief to the heels and developed unstageable deep tissue injuries (Resident #108) and a resident was not turned and repositioned and developed a pressure ulcer on the right hip (Resident #40) for 2 of 2 residents reviewed for pressure ulcers.</p>	F 0314	<p><u>Facility request face to face IDR for F314 due to wound development was unavoidable due to risk factors F314 TREATMENT/SVCS TOPREVENT/HEAL PRESSURE SORES</u></p>	06/22/2015	

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	<p>Findings include:</p> <p>1. The clinical record review of Resident #108, completed 5/29/15 at 1:08 p.m., indicated the resident had diagnoses including, but not limited to diabetes.</p> <p>The resident was admitted to the facility on 9/20/14, following repair of a fractured left hip. An Admission Nursing Assessment completed 9/20/14, assessed the resident as having lower leg weakness and no pressure ulcers.</p> <p>A written care plan dated 9/26/14, with a goal date of 6/26/15, indicated the resident was at risk for skin breakdown due to impaired/decreased mobility, diabetes, heart disease, and medication side effects. Interventions dated 9/26/14, included but were not limited to, assess and document skin condition weekly and as needed, pressure reducing/redistribution cushion in chair/wheelchair and mattress on the bed, and turn and reposition at least every 2 hours.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 2/19/15, assessed the resident as requiring extensive assistance of 2 or more staff members for bed mobility and transfers. The resident</p>		<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who entersthe facility without pressure sores does not develop pressure sores unless theindividual's clinical condition demonstrates that they were unavoidable;</p>	

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	<p>was assessed as having a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating no cognitive impairment, having a risk for the development of pressure ulcers, and having an unstageable pressure ulcer. Section M, Skin Conditions, of the MDS assessment did not indicate the resident was receiving a turning and repositioning program and did not indicated pressure ulcer care was being provided.</p> <p>A physician's order dated 1/17/15, indicated the resident was to receive a high potency multivitamin daily. The special instructions in the physician's order indicated the resident had a history of pressure ulcers.</p> <p>A New Skin Event, started on 1/22/15 at 8:50 a.m., indicated the resident had a new open area on the right heel measuring 0.4 x 2.0 x < (less than) 0.1. The form indicated the measurements were L (length) x W (width) x D (depth) and were recorded in centimeters. The wound was described as white in color with a dusky wound bed and had a clear odorless drainage.</p> <p>A physician's order dated 1/23/15, indicated, "Apply skin prep to right heel followed with non-adherent dressing bid [twice a day]. Re-eval [re-evaluate] in 1</p>		<p>and aresident having pressure sores receives necessary treatment and services topromote healing, prevent infection and prevent new sores from developing.</p> <p>Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #108is receiving pressure relief to the heels and care plan is being followed forwound care ·Resident #40 is being turned andrepositioned per care plan <p>Howwill you identify other residents having the potential</p>	

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	<p>week." The web site smith-nephew.com, accessed on 6/4/15 at 10:50 a.m., indicated skin prep was a liquid film-forming dressing which provides a protective interface and may reduce friction during the removal of tape, may reduce irritation from contact with body wastes, and should only be used on intact skin.</p> <p>The next documented evaluation or observation of the open area was on 1/26/15, 4 days after the open area was first noted, by the IDT (Interdisciplinary Team). The IDT progress note indicated the open area was on the left heel, had a moderate amount of serosanguineous (yellow with small amounts of blood) drainage, and the surrounding skin was moist and white. The progress note indicated the resident had increased swelling in both legs and was repositioned with legs elevated and pillows for pressure relief. The progress note indicated the physician would be contacted for further orders.</p> <p>The Pressure Wound Skin Evaluation Report dated 1/26/15 at 2:41 p.m., indicated the wound measured 0.3 x 2.0 x 0.1. The area was staged as a Stage II, described as partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater. The</p>		<p>to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who enter the facility have the potential to be affected by the alleged deficient practice ·DNS and Nurse Managers conducted a facility skin sweep using the Bedside Wound Minutes Form to ensure all wound interventions and preventative measures are in place ·Licensed nurse and Certified Nurse's Aides have been in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such turning and repositioning and pressure relief and following care plans <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nurse and Certified Nurse's Aides have been in-serviced by Director of Nursing Services or designee by 6/19/15 on wound documentation and wound prevention such as turning and repositioning and pressure relief and following care plans ·DNS and Nurse Managers will conduct a facility skin sweep using the Bedside Wound Minutes Form to ensure all wound 	

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	<p>most severe tissue type was described as slough (yellow or white tissue adhering to the ulcer bed), had a minimum amount of serosanguineous drainage, and no odor.</p> <p>A physician's order dated 1/26/15, indicated, "Cleanse Lt [left] heel w/NS [with normal saline], Gently pat dry, apply skin prep to wound edges and heel. Apply silver alginate [an agent used to debride, remove, dead or dying tissue] to open area, protect w/Allevyn Heel Foam [a foam dressing used to absorb drainage from wounds], secure with kerlix [rolled gauze] daily and PRN [as needed] soilage/dislodgement."</p> <p>A nursing progress note dated 1/31/15 at 9:49 a.m., indicated the resident was up in the main dining room eating a meal. "...Dressing to LT [left] heel OA [open area] CDI [clean dry intact...."</p> <p>The progress notes lacked documentation of the implementation of pressure relieving measures.</p> <p>A Pressure Wound Skin Evaluation Report dated 2/2/15 at 7:55 a.m., indicated the wound, present since 1/22/15, to the right heel, was now considered unstageable as a deep tissue injury was suspected. The National</p>		<p>interventions and preventative measures are in place</p> <ul style="list-style-type: none"> ·IDT will review all new admissions using the IDT Admission Review Tool to ensure preventative measure are put into place upon admission for residents who are at risk ·DNS/Designee will conduct rounds each shift to ensure preventative measures are implemented per plan of care <p>Howthe corrective action (s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Pressure Wound CQI tool will be utilized weekly x 4, monthly x 5. Data will be submitted to the CQI committeefor follow up. If 95% threshold is notachieved, an action plan will be developed _ _ 	

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	<p>Pressure Ulcer Advisory Panel (NPUAP) described a deep tissue injury as, "a pressure related injury to subcutaneous tissues under intact skin." The measurements of the wound were 3.2 x 0.8 x 0.5, with tunneling (tissue destruction underlying intact skin along wound margins using a clock method to describe direction) of 0.5 cm located at 6 o'clock. The measurements indicated an increase in length and depth from the measurements on 1/26/15. The wound was described as purple/maroon intact skin on Achilles, having purulent drainage, foul odor, and the area around the wound was described as soft and mushy and warm to touch.</p> <p>The IDT progress note for 2/2/15, indicated the physician was notified of the wound on the right heel having signs and symptoms of infection. The notes indicated the resident complained of pain during the treatment to the heel and received pain medication as needed. The swelling of the lower legs was noted to be decreased, and the resident was repositioned with legs elevated and pillows for pressure relief.</p> <p>A written plan of care dated 2/2/15, 11 days after the pressure ulcer was first noted, indicated the resident had a pressure ulcer described as a deep tissue</p>			

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	<p>injury to the right heel. Interventions included assess for pain and treat as needed, notify physician of unrelieved/worsening of pain, assess wound weekly documenting measurements and description, notify physician of worsening or no change in wound or for signs of infection, encourage resident to eat 75% (percent) of meals, pressure reducing/redistribution cushion in chair, wound healing vitamins as ordered, and observe for signs of infection including redness, pain, malodorous drainage, fever, or increase in size/depth of wound. The care plan lacked repositioning with legs elevated and pillows for pressure relief.</p> <p>A physician's order dated 2/2/15, indicated, "Cleanse open area to the lateral left Achilles with normal saline, pat dry with gauze, apply skin prep to peri-wound, santyl [a topical ointment used to remove necrotic or dead tissue] to wound bed then cover with piece of silver alginate followed by foam. apply [sic] foam heel support wrap with kerlix and secure with tape. Change daily and PRN [as needed] for soilage and dislodgement."</p> <p>The resident was seen on 2/5/15, in the facility by the physician and an order was received to soak the wound (not</p>			

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	<p>designated as the left or right heel) in warm soapy water for 15-20 minutes, cleanse with N/S, apply Santyl, apply a non-adherent telfa pad, and wrap with kerlix daily and as needed. The physician's progress note indicated the wound started as a pressure blister on 1/22/15 and had developed into a deep tissue injury with cellulitis (an potentially serious bacterial skin infection).</p> <p>A physician's order dated 2/5/15, indicated the resident was prescribed Bactrim DS (an antibiotic) 800-160 mg every 12 hours for 7 days for treatment of the wound infection in the right heel.</p> <p>A Pressure Wound Skin Evaluation Report dated 2/9/15 at 4:21 p.m., indicated the wound, present since 1/22/15, to the right heel, was now considered unstageable and had necrotic (dead) tissue in the wound bed. The measurements were 4.1 x 7.4 and depth was indeterminate. The wound bed was described as purple/black and had minimal serosanguineous drainage with a slight odor. The area around the wound was described as intact and a dusky white color.</p> <p>A Pressure Wound Skin Evaluation Report dated 2/16/15 at 1:44 p.m., indicated the wound to the right heel</p>			

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	<p>measured 7 x 6 and the depth was indeterminate. The wound was described as black in color, had a moderate amount of serosanguineous drainage with a moderate odor, and the area around the wound was moist, mushy, and a dull pink color. No change in treatment was recommended.</p> <p>The IDT note dated 2/17/15 at 1:48 p.m., indicated the resident had pain during the treatment of the wound. The note indicated the root cause of the wound to the right heel was related to the resident being up in the wheelchair with heels against the foot rest. The note indicated the resident refused to lay down between meals and was educated in the need to relieve pressure. The note indicated the resident agreed to elevate the right leg when up in the wheelchair and have the heel float off the end of the wheel chair instead of resting on the leg rests.</p> <p>A Pressure Wound Skin Evaluation Report completed 2/23/15 at 4:52 p.m., indicated the wound measured 6.2 x 5.9 and the depth was indeterminate. The wound bed was described as necrotic tissue, having minimal serosanguineous drainage with a slight odor, and the tissue surrounding the wound was mushy, pale/white in color.</p>			

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	<p>The IDT note on 2/24/15, indicated the wound continued to self debride, was less mushy and boggy, and the wound bed was necrotic tissue. The note indicated the resident required cueing to float heel when up in wheel chair for pressure relief. No changes were recommended to the treatment.</p> <p>The care plan was updated on 2/26/15, to include foot cushion to be worn while up in wheelchair and at bedtime. The care plan did not indicate which foot or feet for the cushion.</p> <p>The Pressure Wound Skin Evaluation Report dated 3/2/15 at 2:31 p.m., indicated the wound to the right heel measured 5.7 x 5.3 and the depth was indeterminate. The color of the wound was described as necrotic purple/black with a moderate amount of serous foul smelling drainage. The area around the wound was described as macerated, moist, and mushy.</p> <p>The resident was seen on 3/2/15, in the facility by the nurse practitioner. The progress notes of the nurse practitioner indicated the resident had bilateral (both) unstageable heel wounds. The right heel wound was described as macerated with eschar (dark brown or black tissue) and odorous yellow drainage. The left heel</p>			

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	<p>ulcer was described as dry eschar. The nurse practitioner orders included stopping the warm soaks to the right heel, continuing the use of the Santyl to the right heel, starting Betadine (povidone-iodine) to the left heel 2 times a day, starting an antibiotic for the drainage, keeping pressure off of the wounds, and consulting with a wound clinic. The nursing progress notes lacked documentation regarding the wounds on the right and left heel.</p> <p>A Pressure Wound Evaluation Report dated 3/3/15 at 10:01 a.m., indicated the resident had a deep tissue injury on the left heel measuring 1.2 x 1.3 with the depth being indeterminate. The report indicated the wound was first observed on 3/2/15. The wound was described as purple in color with no drainage and the recommended treatment was povidone-iodine and a foot cushion.</p> <p>The IDT progress note for 3/3/15 at 1:44 p.m., indicated the resident had deep tissue injuries to both heels. A new mattress was ordered for the resident's bed, an antibiotic was going to be started for a wound infection in the right heel, and the the resident was to be in bed between meals for 30 minutes. The root cause of the pressure ulcers was noted to be related to the resident resting feet on</p>			

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	<p>the foot rests of the wheelchair when up in the chair. The note indicated the resident would continue to be positioned with legs elevated and pillows underneath the legs for pressure relief and would have foot cushions to both feet at all times when up in the chair.</p> <p>The care plan for pressure ulcers was updated 3/3/15, to include foot cushions to both feet when up in wheelchair and in bed and resident to be in bed between meals for at least 30 minutes.</p> <p>On 3/5/15, the resident went to the wound clinic for evaluation. The resident was sent from the wound clinic to the hospital for treatment of the wound infection in the right heel and cellulitis (an infection the tissue) of the right foot. The resident was admitted to the hospital and returned to the facility on 3/11/15, with 3 intravenous (IV) antibiotics and a negative pressure dressing to the wound on the right heel.</p> <p>The wound to the right heel was observed during a dressing change on 5/28/15 at 1:00 p.m. The resident had been up in the wheelchair for breakfast and lunch. After lunch, the resident was taken to the room for treatment of the heel ulcer. Registered Nurse (RN) #3 pushed the resident into the room and removed the</p>			

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	<p>leg rests from the wheel chair. The resident was observed to not have either foot elevated prior to the transfer and did not have cushions on either foot. The resident transferred with the assistance of 2 staff into the bed. Once in bed the resident's feet were placed on pillows on the bed.</p> <p>The old dressing had a moderate amount of serosanguineous drainage on it. The wound covered approximately 3/4 of the resident's heel and was approximately 1/4 of the side of the foot. The bottom edge of the resident's heel was missing. Part of the wound bed was beefy red with slough covering approximately 25% of the wound. An area of necrotic tissue covered the top half of the wound. The area surrounding the wound was red in color. No odor was noted. The resident denied complaints during the dressing change. Once the dressing change was completed, the resident transferred back into the wheelchair with the assistance of the staff.</p> <p>On 5/29/15 at 2:30 p.m., the resident was observed propelling in the hallway in a wheelchair. Neither of the foot rests were elevated on the wheelchair and foot cushions were not in place. The resident stated, "I can't stay in bed. I want to be up in my chair."</p>			

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	<p>During an interview with the Director of Nursing Services (DNS) and the Clinical Education Coordinator (CEC) on 6/2/15 at 1:30 p.m., the DNS indicated the treatment orders on 1/26/15, for an ulcer on the left foot and the IDT note on 1/26/15, were documentation errors and should have indicated the open area was on the right heel. The DNS indicated the staff knew which heel needed the treatment and the treatment had been completed to the right heel from 1/26/15, through 2/2/15, when the order was changed. The DNS indicated the staff had attempted to treat the heel ulcer in house and referred the resident to the wound clinic when the area continued to show a lack of improvement with changing of the treatments. The CEC provided an invoice dated 3/3/15, indicating the specialty mattress had been applied to the resident's bed on 3/3/15, for additional pressure relieving while in bed.</p> <p>During a review of the Treatment Administration Record (TAR) for January 2015 on 6/3/15 at 12:45 p.m., the TAR contained staff initials for the dates 1/26, 1/27, 1/28, 1/29, 1/30, 1/31, and 2/1/15, indicating the treatment, "Cleanse Lt [left] heel w/NS [with normal saline], Gently pat dry, apply skin prep to wound</p>			

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	<p>edges and heel. Apply silver alginate [an agent used to debride, remove, dead or dying tissue] to open area, protect w/Allevyn Heel Foam [a foam dressing used to absorb drainage from wounds], secure with kerlix [rolled gauze] daily and PRN [as needed] soilage/dislodgement," had been completed as ordered. The TAR and the nursing progress notes lacked documentation to indicate the wheelchair legs had been elevated and lacked documentation to indicate the heels had been elevated while in bed.</p> <p>During an interview with the DNS, the Executive Director (ED), and the Corporate Clinical Consultant on 6/3/15 at 10:30 a.m., the DNS indicated the resident's wheelchair did not have adaptive equipment to the leg rests for pressure relief, but did have elevating leg rests. The DNS indicated the resident was encouraged to elevate the legs of the chair, but was not always compliant with elevating them. The DNS indicated the facility did not document turning and repositioning every 2 hours and did not have documentation indicating when the resident had pillows under the legs for pressure relief.</p> <p>2. The clinical record of Resident #40 was reviewed on 6/1/15 at 11:00 a.m. Diagnoses for the resident included, but</p>			

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	<p>were not limited to, pressure ulcer and polio.</p> <p>An annual Minimum Data Set assessment, dated 5/5/15, and a quarterly (MDS) dated 2/13/15, indicated Resident #40 was independent in her ability to make decisions, needed extensive assistance of 2 staff for bed mobility, transferring and toileting, and was frequently incontinent.</p> <p>A New Skin Event, dated 5/7/15, indicated Resident #40 had developed a Stage 1 non-blanchable pressure ulcer on her right hip. A stage 1 pressure ulcer is a defined area of discolored, usually pink or red, intact skin on a surface which endures pressure. Non-blanchable means when pressure is applied, the area does not lose its color, as normal skin does. The Skin Event indicated this new stage 1 pressure ulcer measured 10.0 centimeters (cm) x 9.0 cm by < (less than) 0.1 cm.</p> <p>An Event, dated 5/11/15, indicated the right hip stage 1 pressure ulcer measured 13.0 cm. x 9.0 cm. x <0.1 cm.</p> <p>An Event dated 5/18/15, indicated the right hip stage 1 pressure ulcer measured 10 cm. x 8 cm. x <0.1 cm.</p>			

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	<p>An event dated 5/26/15 indicated the right hip stage 1 pressure ulcer measured 13 cm. x 9.0 cm x <0.1 cm.</p> <p>An event dated 6/1/15, indicated the right hip stage 1 pressure ulcer measured 12 cm. x 9 cm. x <0.1 cm.</p> <p>An observation on 6/2/15 at 10:45 a.m., indicated a large, pinkish, red, and darker red area around the right buttock fold, upper thigh, hip area.</p> <p>A discontinued care plan, dated 6/22/14, indicated Resident #40 was at risk for skin breakdown. Interventions in place at the time the stage 1 pressure area was noted on 5/7/15, included turning and repositioning the resident at every 2 hours.</p> <p>A current care plan, created 5/13/15, indicated the resident being at risk for skin breakdown. Interventions including turning and repositioning at least every 2 hours.</p> <p>A current care plan, created 2/24/15, indicated Resident #40 had impaired skin integrity...stage I to right hip as of 5/6/15. Interventions included turning and repositioning every 2 hours.</p> <p>An observation on 6/2/15 between 11:10</p>			

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	<p>a.m. and 1:40 p.m. (2 1/2 hours), indicated Resident #40 was sitting in her wheelchair. It appeared she was sitting directly on the stage I pressure area on her right buttock, upper thigh, hip area. There were no observations of attempts to reposition the resident during the 2 1/2 hour period.</p> <p>On 6/2/15 at 1:40 p.m., Certified Nursing Assistant (CNA) #1 indicated Resident #40 stays up in the wheelchair after lunch and likes to stay in the wheelchair all afternoon. The CNA indicated the resident will call if she is incontinent of stool, and sometimes the resident's urinary catheter bag gets emptied, but otherwise the staff doesn't do anything with the resident.</p> <p>On 6/2/15 at 3:30 p.m., the Clinical Education Coordinator (CEC)/wound nurse indicated Resident #40 refused to go back to bed during the day and didn't want to be repositioned. No documentation was found in the resident's record which indicated staff was repositioning the resident while up in the wheelchair. The CEC indicated at that time the resident's refusal to return to bed or be repositioned in the wheelchair was not care planned with alternative interventions for pressure relief.</p>			

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F 0514 SS=D Bldg. 00	<p>On 6/1/15 the Director of Nursing Services provided a policy titled, "Skin Management Program," dated 2/2015, and indicated it was the policy currently used by the facility. The policy indicated, "...The facility assigned wound nurse will complete further evaluation of the wounds identified and complete the appropriate skin evaluation event on the next business day, Direct care givers will be notified of skin alterations and specific care needs, A plan of care will be initiated to include resident specific risk factors with appropriate interventions...A care plan will be developed specific to the resident's needs including prevention interventions Direct care givers will be notified of the resident's specific prevention interventions..."</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient</p>						

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	<p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to accurately document the location and treatment of a pressure ulcer on the right heel for Resident #108.</p> <p>Findings include:</p> <p>The clinical record review of Resident #108, completed 5/29/15 at 1:08 p.m., indicated the resident had diagnoses including, but not limited to, diabetes.</p> <p>A New Skin Event, started on 1/22/15 at 8:50 a.m., indicated the resident had a new open area on the right heel measuring 0.4 x 2.0 x < (less than) 0.1. The form indicated the measurements were L (length) x W (width) x D (depth) and were recorded in centimeters. The wound was described as white in color with a dusky wound bed, and had a clear odorless drainage.</p> <p>The next documented evaluation or observation of the open area was on 1/26/15, 4 days after the open area was first noted, by the IDT (Interdisciplinary Team). The IDT progress note indicated the open area was on the left heel, had a moderate amount of serosanguineous</p>	F 0514	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that complete; accurately documented; readily accessible; and systematically organized. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident #108 has accurate documentation on location and treatment of a pressure ulcer on the right heel <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents with pressure ulcers have the potential to be affected by the same deficient practice · Licensed Nurses have been in-serviced on accurately documenting on wound location and treatment and verification of physician orders regarding wounds by the Director of Nursing Services/designee by 6/19/15 · Medical records of residents with wounds were reviewed by DNS/Designee to ensure 	06/22/2015

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	<p>(yellow with small amounts of blood) drainage, and the surrounding skin was moist and white.</p> <p>A physician's order dated 1/26/15, indicated, "Cleanse Lt [left] heel w/NS [with normal saline], Gently pat dry, apply skin prep to wound edges and heel. Apply silver alginate [an agent used to debride, remove, dead or dying tissue] to open area, protect w/Allevyn Heel Foam [a foam dressing used to absorb drainage from wounds], secure with kerlix [rolled gauze] daily and PRN [as needed] soilage/dislodgement."</p> <p>A nursing progress note dated 1/31/15 at 9:49 a.m., indicated the resident was up in the main dining room eating a meal. "...Dressing to LT [left] heel OA [open area] CDI [clean dry intact...."</p> <p>A written plan of care dated 2/2/15, 11 days after the pressure ulcer was first noted, indicated the resident had a pressure ulcer described as a deep tissue injury to the right heel. Interventions included assess for pain and treat as needed, notify physician of unrelieved/worsening of pain, assess wound weekly documenting measurements and description, notify physician of worsening or no change in wound or for signs of infection,</p>		<p>documentation of wound location and treatment was accurate per physician's order</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Licensed Nurses have been in-serviced on accurately documenting on wound location and treatment and verification of physician orders regarding wounds by the Director of Nursing Services/designee by 6/19/15 Director of Nursing/Designee will review Facility Activity Report Daily to ensure accurate documentation of wounds per plan of care <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> Facility Activity Report (FAR) tool will be utilized weekly x 4, monthly x 5. Data will be submitted to the CQI committee for follow up. If 95% threshold is not achieved, an action plan will be developed. 	

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	<p>encourage resident to eat 75% (percent) of meals, pressure reducing/redistribution cushion in chair, wound healing vitamins as ordered, and observe for signs of infection including redness, pain, malodorous drainage, fever, or increase in size/depth of wound. The care plan lacked repositioning with legs elevated and pillows for pressure relief.</p> <p>A physician's order dated 2/3/15, indicated, "Cleanse open area to the lateral left Achilles with normal saline, pat dry with gauze, apply skin prep to peri-wound, santyl [a topical ointment used to remove necrotic or dead tissue] to wound bed then cover with piece of silver alginate followed by foam. apply [sic] foam heel support wrap with kerlix and secure with tape. Change daily and PRN for soilage and dislodgement."</p> <p>A physician's order dated 2/5/15, indicated to soak the wound (not designated as the left or right heel) in warm soapy water for 15-20 minutes, cleanse with N/S, apply Santyl, apply a non-adherent telfa pad, and wrap with kerlix daily and as needed.</p> <p>During an interview with the Director of Nursing Services (DNS) and the Clinical Education Coordinator (CEC) on 6/2/15 at 1:30 p.m., the DNS indicated the</p>			

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	treatment orders on 1/26/15, for an ulcer on the left foot and the IDT note on 1/26/15, were documentation errors and should have indicated the open area was on the right heel. The DNS indicated the staff had inaccurately documented the treatment and the pressure ulcer as being on the left heel. 3.1- 50(a)2				