

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2012
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F0000	<p>This visit was for the Investigation of Complaint # IN00116303</p> <p>Complaint #IN00116303 Substantiated, Federal/ State deficiencies related to the allegations are cited at F309, F312, F314, and F514.</p> <p>Survey dates: September 19-21, 2012</p> <p>Facility #: 000173 Provider #: 155273 AIM #: 100290920</p> <p>Survey Team: Vickie Ellis, RN TC Diane Hancock, RN Barb Fowler, RN</p> <p>Census Bed Type: SNF: 13 SNF/NF: 71 Total: 84</p> <p>Censor Payor Type: SNF: 6 NF: 57 Other: 21 Total: 84</p> <p>Sample Size: 4</p>	F0000	<p>F 000</p> <p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>Cypress Grove Rehab desires this Plan of Correction to be considered the facility's Allegation of Compliance effective October 11, 2012.</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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 9/25/12 Cathy Emswiller RN</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.</p> <p>Based on record review and interview, the facility failed to ensure a resident did not receive foods, fluids, medications by mouth as ordered by the physician in 1 of a sample of 4 residents reviewed for orders. (Resident Z)</p> <p>Findings include:</p> <p>Resident Z's record was reviewed on 9/19/12 at 11:21 a.m. The diagnosis of Resident Z included, but were not limited to, Down's syndrome, venous insufficiency, osteoarthritis, seizures, and anemia.</p> <p>During initial tour, on 9/19/12 at 9:00 a.m., ADoN [Assistant Director of Nursing] #1 indicated Resident Z was receiving IV [intravenous] antibiotics [medications used in the treatment of infections] related to pneumonia. ADoN #1 indicated the resident had difficulty with swallowing and had probably aspirated. ADoN #1 indicated the resident had been receiving a puree diet</p>	F0309	<p>F309</p> <p>A respiratory assessment was completed on resident Z with no additional findings.. The primary physicians office was notified and orders were received.</p> <p>A 100% review of physician orders and Medication Administration Records (MAR) was completed on current in house residents to ensure orders for NPO status on residents were in place and transcribed appropriately on the MAR. Residents with NPO status were found to have orders transcribed appropriately.</p> <p>Re-education on policy and procedure for transcribing physicians orders was completed for Licensed Nurses. DON/designee will call each stations Licensed Charge Nurse 30 minutes prior to the end of each shift to review the orders obtained on the shift. Review will include the Charge Nurses observation of the Medication Administration Record (MAR) and</p>	10/11/2012	

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	<p>with honey-thickened liquids.</p> <p>During initial tour, on 9/19/12 at 9:00 a.m., Resident Z was observed lying in bed with oxygen on by nasal canula.</p> <p>On 9/19/12 at 3:35 p.m., an order was received for Resident Z to be NPO [nothing by mouth] for 48 hours due to signs and symptoms of aspiration with p.o. [oral] foods and liquids assessment per cervical auscultation.</p> <p>On 9/20/12 at 11:30 a.m., Resident Z's MAR [Medication Administration Record] was reviewed. Resident Z's MAR indicated the resident had received his oral medications at 9:00 a.m.</p> <p>On interviewed with LPN #2 on 9/20/12 at 11:30 a.m., she indicated she had given Resident Z his morning oral medications. LPN #2 indicated she had worked at the facility since May, 2012, she knew the resident very well, and she knew how to give him his medication. LPN #2 indicated she given Resident Z his oral medications slowly and in small bites along with his Miralax [a powdered laxative ordered on 4/27/12, that was to be dissolved in 8 ounces of water or juice] She indicated she had given him thickened liquids to help him swallow the medications and Resident Z had not had</p>		<p>Treatment Administration Record (TAR) to ensure orders received on that shift have been transcribed appropriately. Nursing Administration will conduct a follow-up review to ensure orders received on the previous day were transcribed appropriately.</p> <p>Review of orders and transcription between Nursing Administration and Licensed Charge Nurses will continue every shift x 14 days, 1 x daily random to cover all shifts x 14 days, 1 time weekly random to cover all shifts x 14 days then 1 x monthly ongoing random to cover all shifts.</p> <p>Identified non-compliance will result in 1:1 re-education up to and including termination. Results of audits will be forwarded to the Quality Assurance Committee for further review and recommendation monthly as deemed appropriate.</p>		

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	<p>any difficulty swallowing.</p> <p>Interview with ADoN #1 on 9/20/12 at 11:40 a.m., indicated Resident Z should not have received any morning oral medication. ADoN #1 indicated LPN #2 was aware of Resident Z's NPO status as LPN #2 was present when the NPO order was obtained on 9/19/12.</p> <p>The guidelines for NPO status, obtained on 9/21/12 at 11:25 a.m. from the DoN [Director of Nursing] indicated the person is not allowed to have any fluids at all. The NPO status included no water or ice chips, no food, no candy, and no gum.</p> <p>This federal tag relates to complaint # IN00116303.</p> <p>3.1-37(a)</p>				

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F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to provide services to maintain personal hygiene and oral care in that a resident did not receive oral care and proper bathing for 1 out of 4 residents sampled for personal hygiene and oral care. (Resident Z)</p> <p>Findings include:</p> <p>Record review of Resident Z on 9/19/12 at 11:21 a.m., The diagnosis of Resident Z included, but were not limited to, Down's syndrome, pneumonia, venous insufficiency, seizures, hearing loss, and anemia.</p> <p>During initial tour on 9/19/12 at 10:00 a.m., Resident Z was observed to be lying in bed with his lower extremities elevated and bolsters on each side of the upper part of the bed.</p> <p>Interview with the ADoN [Assistant Director of Nursing] on 9/19/12 at 10:00 a.m., indicated the resident was total care for his ADLs [Activities of Daily Living],</p>	F0312	<p>F312 Resident Z received a bath, oral and peri care.. A 100% visual observation of current in-house residents has been completed on residents identified as requiring assistance with bathing, oral and peri care. Identification of residents was completed utilizing the Care Tracker Resident Acuity report. Certified Nursing Assistant (CNA) Assignment Sheets have been updated to reflect identified residents current bathing, oral & peri care needs. Re-education on policy & procedure for bathing, peri care and oral care has been completed with CNA's. Return demonstrations of bathing, oral and peri care have been initiated by the Education Training Director (ETD). Utilizing the CNA Assignment Sheet Licensed Nurse are responsible to conduct rounds every shift to validate that bathing, oral and peri care has been provided to identified residents.</p>	10/11/2012			

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	<p>was incontinent, and the resident was receiving IV [intravenous] antibiotics [medications used in the treatment of infections] for pneumonia</p> <p>Interview with the ADoN on 9/20/12 at 8:40 a.m., indicated the resident to be NPO [nothing by mouth] for 48 hours which started on 9/19/12 at 3:35 p.m. related to signs and symptoms of aspiration.</p> <p>Observation of Resident Z on 9/20/12 at 8:20 a.m., indicated the resident to be lying on his back in bed with his mouth dry in appearance and dry skin on his lips.</p> <p>On observation of Resident Z during his bath on 9/20/12 at 9:40 a.m., the resident's mattress was observed to be wet and had a urine odor. The CNA's had 2 basins on the overbed table, one containing water with soap and one basin containing water for rinsing. CNA #1 was observed to wash the resident with soapy water but the resident was never rinsed before being dried with a towel. The resident was not given pericare during his bath and no oral care was observed. The resident had heel protectors on, but the protectors were never removed during his bath nor were his toes washed. [the heel protectors were on the resident to provide protection for his heels which had dressings on them]</p>		<p>Utilizing the CNA Assignment Sheet the DON/designee will conduct observational rounds on 25% of identified residents to validate that bathing, oral and peri care has been provided. Rounds will be conducted on a random basis across all shifts at least daily x 14 days and 5 x weekly thereafter.</p> <p>Identified non-compliance will result in 1:1 re-education up to & including termination. Results of above audits will be forwarded to the Quality Assurance Committee for further review & recommendations monthly as deemed appropriate.</p>	

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	<p>The bed linen under the resident was changed and a clean, dry sheet was placed on the wet mattress next to the resident. After turning the resident to his left side, a pillow was placed under the resident's back. The bed bolsters were picked up off of the resident's floor. CNA #1 wiped the left bolster with a dry washcloth but CNA #2 did not clean the right bolster. CNA #1 pulled the Velcro strap which was between the mattress and the bottom sheet on the bed and proceeded to secure the bolster onto the left side of the bed. CNA #2 pulled the Velcro and secured it to the bed.</p> <p>Interview with CNA #1 on 9/20/12 at 10:05 a.m., indicated the resident received oral care every shift.</p> <p>Interview with ADoN #1 on 9/20/12 at 10:20 a.m., indicated he noticed CNA #1 did not rinse the resident while giving his bath and he also noticed the wet area on the resident's bed. ADoN #1 indicated he did not know the Velcro straps were used to hold the bed bolsters in place.</p> <p>The policy obtained on 9/21/12 at 11:25 a.m. from the DoN [Director of Nursing] indicated for people who are not allowed to take foods and fluids by mouth will need oral care as often as every 1 to 2 hours to keep their mouths fresh and</p>				

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	<p>moist.</p> <p>The guidelines for bathing obtained on 9/21/12 at 11:25 a.m. from the DoN, indicated the skin is to be rinsed thoroughly to remove all soap. The guidelines also indicated the perineal area is to be washed during a full or partial bath.</p> <p>This federal tag relates to complaint # IN00116303.</p> <p>3.1-38(a)(2)(A)</p>				

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F0314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <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 observation, interview and record review, the facility failed to ensure treatment and services to prevent pressure sores were provided and on-going treatment for current pressure sores was done, for 3 of 4 sampled residents reviewed for pressure sores, in the total sample of 4. The lack of preventive treatment resulted in the development of a stage III heel pressure area. (Residents X, Resident Z, Resident V)</p> <p>Findings include:</p> <p>1. Resident X's clinical record was reviewed on 9/19/12 at 11:10 a.m. The diagnosis of Resident Z included, but not limited to, altered level of consciousness, history of fall, hypertension, history of transient ischemic attack, and osteoarthritis.</p> <p>Resident X had a "Resident Lifting,</p>	F0314	<p>F314</p> <p>Resident V no longer resides in the facility. A heelz-up is in place for resident X with heels floated. The dressing on resident Z has been changed per physician order.</p> <p>A 100% skin audit was completed on all current in-house residents on 9/20/12 to ensure there were no unidentified pressure areas. None were identified. A 100% review of current in-house residents physician orders for the past 30 days was completed to identify those resident with physician orders for dressing changes. The dressings of identified residents were observed by Nursing Administration to ensure dressings were changed per physician orders. A 100% review of Braden Scales on current in-house residents was</p>	10/11/2012			

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	<p>Transferring and Repositioning Data Collection" document, dated 7/7/12, which indicated the resident required "extensive assist of 1-2 with transfers" and "extensive assist 1-2 with bed mobility R/T [related to] generalized weakness.</p> <p>The resident had a care plan, dated 6/26/12, for skin integrity, prevention and treatment. The care plan indicated the resident had a Braden score [scale used to predict risk for pressure areas] of 16, indicating minimal risk. The care plan included, but was not limited to, the following:</p> <p>The care plan was a pre-written care plan with the facility placing check marks beside assessments, goals and interventions they were using. Assessment options for a resident with a score of 16 on the Braden assessment included frequent turning, maximal remobilization, protect heels, manage moisture, nutrition, friction and shear, and pressure-reduction support surface if bed or chair-bound. The only items checked for this resident were maximal remobilization, manage moisture, nutrition, friction and shear, and pressure-reduction support surface. Goals identified were remaining free of open areas and being cooperative with position changes.</p>		<p>completed to ensure residents identified as at risk for pressure areas had preventive measures in place.</p> <p>Re-education on policy & procedure for wound prevention. Re-education included but was not limited to pressure reduction interventions and timely treatment administration per physicians orders. Change of shift rounds have been initiated and will be completed by the licensed nurses. Rounds will consist of the on-coming & off-going licensed nurse observing those residents with orders for wound dressings to ensure dressings are appropriate per physicians order, in place & applied timely. Through the RAI process and utilizing the Braden Scale, residents assessed as being at high risk for skin breakdown will have individualized interventions initiated with visual validation by Nursing Administration.</p> <p>DON/designee will conduct random observation audits on residents with physician orders for wound dressings to ensure appropriate and timely dressings 5 times weekly x 14 days, 3 x weekly x 4 weeks and weekly thereafter. DON/designee will conduct random observation rounds across all shifts on 25% of residents assessed as being at</p>				

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	<p>Interventions checked were the following: Complete Braden Scale upon admission and weekly times 4 wks, quarterly, and with change of condition. Use commercial moisture barrier Use absorbent pads or diapers that wick and hold moisture Consult dietitian prn [as needed] Monitor nutrition and hydration status Monitor weight as applicable Monitor nutrition/hydration status with each meal Bathe with mild soap, rinse, and dry thoroughly Moisturize skin Keep skin clean, dry and free of body wastes, perspiration, and wound drainage Encourage ambulation Implement an individualized turning schedule Keep linen dry and wrinkle free Provide a pressure reduction or pressure relief surface for bed and/or wheelchair... Involve Therapy when indicated Instruct and encourage to reposition self at 15-20 minute intervals as able Monitor wound weekly and PRN See Skin Grid Provide treatment per MD order Update MD within 2 weeks if no evidence of healing</p> <p>Intervention options on the care plan that were not selected for this resident</p>		<p>high risk for skin breakdown to ensure appropriate pressure reduction interventions are in place 5 times weekly x 14 days, 3 x weekly x 4 weeks and weekly thereafter. Identified non-compliance will result in 1:1 re-education up to & including termination. Results of above audits will be forwarded to the Quality Assurance Committee for further review & recommendations monthly as deemed appropriate.</p>		

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	<p>included, but were not limited to, skin protection interventions, "Protect elbows and heels as needed."</p> <p>The record indicated the resident was hospitalized from 7/31/12 to 8/4/12.</p> <p>The Admission Skin Assessment, completed on 8/4/12, indicated the resident had a bruise on the left arm and was slightly red on the buttocks.</p> <p>Nurses' notes included, but were not limited to, the following: 8/4/12 at 1400 [2:00 p.m.] indicated the following: "resident returned from hosp. Family accompanied and [one] van attendant. Transferred per 2 assist, diff [difficult] to transfer alert to self et attempted to help transfer...skin free of o/a [open areas]..." 8/5/12 1000 [10:00 a.m.] "...non-wt [weight] bearing cont...[continues]" 8/6/12 1435 [2:35 p.m.] "New orders for PT [physical therapy]/OT [occupational therapy] to treat..." 8/7/12 0650 [6:50 a.m.] "Res. has rested quietly. T [and] R [turn and reposition] q [every] 2 [hours]. Abd [abdomen] soft, BS X 4 [bowel sounds in all four quadrants]. Resp [respirations] even et non labored. ii [two] assist for transfers et toileting..." 8/7/12 [no time] "New area noted to outer</p>			

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	<p>Rt. [right] heel MD [Medical Doctor] notified..."</p> <p>8/12/12 1415 [2:15 p.m.] "Paged [physician's name] and spoke with on call doctor [name]. He was informed that resident had an open area resulting from a blister that now had a dark spot in the center of wound..." "Resident had a blister that has popped and now has a black spot measuring approximately 1.2/1.3 cm [centimeters] in the middle..."</p> <p>8/12/12 2305 [11:05 p.m.] "...Pt. has a nickel size necrotic area [with] surrounding erythema and epidermal peeling, dressing applied per previous nurse. "[Family member] educated on all pressure areas...Heel elevated and education done [with] pt. and family on [no] pressure on her (L) [left] heel..."</p> <p>8/14/12 1430 [2:30 p.m.] "...(L) heel elevated will continue to monitor..."</p> <p>8/14/12 1730 [5:30 p.m.] "PT [physical therapy] eval completed for wound (L) medial heel..."</p> <p>The physical therapy evaluation, dated 8/14/12, indicated the following: "Patient has a necrotic pressure ulcer on L medial heel measuring: 4 cm [centimeters] X 6.4 cm with black eschar in the middle measuring: 2.2 cm X 1.8 cm X 0.1 cm. Has moderate serosanguineous exudate with moderate edema on L foot going up to mid leg.</p>			

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	<p>Peri wound is very red." The physical therapist identified the area as a stage III [Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss..."</p> <p>Facility documentation on their Skin Grid, indicated the following: 8/7/12, wound found on the left heel, not present on admission. Identified as a Suspected Deep Tissue Injury "[Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear]." 3 cm long by 2 cm wide by less than 0.1 cm deep. No drainage or odor. 8/14/12, stage unable to determine, 2.3 cm by 1.8 cm, no depth, red and black in color "Area assessed has now progressed to unstageable pressure area. Peri wound is clean with granulation present. Eschar is soft..." 8/21/12, 3.4 cm by 4.8 cm by 0.1 cm, serosanguineous drainage, red and black in color, "Black eschar in middle." 8/28/12, 3.3 cm by 4.8 cm by 0.1 cm, serosanguineous drainage, red and black in color. 9/4/12, 3.3 cm by 4.8 cm by 0.1 cm, serosanguineous drainage, red and black in color</p>			

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	<p>9/11/12, 1.8 cm by 3.0 cm by 0.1 cm, serosanguineous drainage, red and black in color</p> <p>9/18/12, stage III 1.7 cm by 3.0 cm by 0.1 cm, serosanguineous drainage, no color</p> <p>The treatment to Resident X was observed being done by RN #3 and the Physical Therapist on 9/20/12 at 8:35 a.m. RN #3 removed the dressing. The resident indicated she was having pain with the wound. The area was on the medial aspect of the left heel. It was approximately 3 centimeters in diameter. The wound bed had 25% coverage of yellow slough. The edges of the wound were white in color. The surrounding skin was pink. The Physical Therapist indicated the wound had improved. She indicated the first time she saw the wound, it was like a blister had ruptured and had black necrosis in the center of the wound. The Physical Therapist completed the treatment and dressing change using Santyl [a debriding agent] on the slough, skin prep around the edge of the wound, and calcium alginate [a wound dressing] over the wound, covered the area with a gauze pad and wrapped it with a gauze dressing.</p> <p>Assistant Director of Nursing #2 [ADoN #2] was interviewed on 9/20/12 at 10:30 a.m. She indicated she had just taken</p>			

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	<p>over supervision of the unit where Resident X resided. When queried about preventive measures to protect the heels when the resident returned from the hospital in a weakened condition, she indicated they were turning and repositioning the resident and the resident was on a pressure reducing mattress. The first indication the facility was relieving pressure from the heels was 8/7/12 when the pressure area was discovered.</p> <p>The policy and procedure for Wound Prevention and Treatment, dated November 1998 and revised April 2009, was provided by the Director of Nurses on 9/21/12 at 11:25 a.m. The procedure included, but was not limited to, the following: "[Name of company] strives to ensure that a resident entering the center without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates unavoidable skin breakdown." "[Name of company] will consider all residents as at risk for skin impairment and will implement the following interventions to prevent the development of pressure ulcers: -Reduce occurrence of pressure over bony prominence to minimize injury. -Protect against the adverse effects of external mechanical forces (pressure,</p>			

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	<p>friction, shear).</p> <p>-Increase the awareness of pressure ulcer prevention through educational programs.</p> <p>-Braden Risk Assessment."</p> <p>"[Name of company] also recognizes even the most vigilant nursing care may not prevent the development and/or worsening of pressure ulcers in some residents. In those cases, intensive efforts will be directed at the following:</p> <p>-Managing risk factors</p> <p>-Providing preventive interventions</p> <p>-Providing treatment"</p> <p>"...A resident with pressure ulcers will receive continued preventive interventions and necessary treatment and services to promote healing and prevent infection."</p> <p>2. Record review of Resident Z on 9/19/12 at 11:21 a.m., The diagnosis of Resident Z included, but were not limited to, Down's syndrome, pneumonia, venous insufficiency, seizures, hearing loss, and anemia.</p> <p>During initial tour on 9/19/12 at 10:00 a.m., Resident Z was observed to be lying in bed with his lower extremities elevated and bolsters on each side of the upper part of the bed.</p> <p>Interview with the ADoN [Assistant Director of Nursing] on 9/19/12 at 10:00 a.m., indicated the resident was total care</p>						

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	<p>for his ADLs [Activities of Daily Living], was incontinent, and the resident was receiving IV [intravenous] antibiotics [medications used in the treatment of infections] for pneumonia.</p> <p>On observation of Resident Z during his bath on 9/20/12 at 9:40 a.m., the resident's mattress was observed to be wet and had a urine odor. The CNA's had 2 basins on the overbed table, one containing water with soap and one basin containing water for rinsing. CNA #1 was observed to wash the resident with soapy water but the resident was never rinsed before being dried with a towel. The resident was not given pericare during his bath and no oral care was observed. The resident had heel protectors on, but the protectors were never removed during his bath nor were his toes washed. [the heel protectors were on the resident to provide protection for his heels which had dressings on them] The bed linen under the resident was changed and a clean, dry sheet was placed on the wet mattress next to the resident. After turning the resident to his left side, a pillow was placed under the resident's back. The bed bolsters were picked up off of the resident's floor. CNA #1 wiped the left bolster with a dry washcloth but CNA #2 did not clean the right bolster. CNA #1 pulled the Velcro strap which was between the mattress and the bottom</p>			

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	<p>sheet on the bed and proceeded to secure the bolster onto the left side of the bed. CNA #2 pulled the Velcro and secured it to the bed.</p> <p>Interview with ADoN #1 on 9/20/12 at 10:20 a.m., indicated he noticed CNA #1 did not rinse the resident while giving his bath and he also noticed the wet area on the resident's bed. ADoN #1 indicated he did not know the Velcro straps were used to hold the bed bolsters in place.</p> <p>The guidelines for bathing obtained on 9/21/12 at 11:25 a.m. from the DoN, indicated the skin is to be rinsed thoroughly to remove all soap. The guidelines also indicated the perineal area is to be washed during a full or partial bath.</p> <p>During record review, the areas of documentation for pressure areas listed Resident Z's bilateral heels.</p> <p>Resident Z had an order dated 4/27/12 for a weekly skin assessment.</p> <p>Resident Z had an order, dated 7/30/12, indicating his bilateral heels were to be cleansed with Normal Saline, Calcium Alginate [a dressing used to promote wound healing] was to be applied, the wounds were to be covered with Allevyn</p>			

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	<p>[a type of foam wound dressing], Kerlix [a type of gauze dressing] was to be wrapped around his bilateral heels and secured with Coban [a type of stick on wrap] every other day.</p> <p>During initial tour on 9/19/12 at 10:00 a.m., Resident Z was observed lying in bed with his bilateral lower extremities elevated. ADoN [Assistant Director of Nursing] #1 indicated Resident Z had 2 stage 2 pressure areas [partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. It may present as an intact or open/ruptured serum filled blister.] on his bilateral heels related to his peripheral vascular disease.</p> <p>Observation during Resident Z's bath on 9/20/12 at 9:40 a.m., indicated the resident had an stage 2 area on his right buttock which was open and bleeding. The left side of his buttock had an area which was dark brown in color but was not open. ADoN #1 indicated he was not aware of the open area on Resident Z's buttock.</p> <p>Interview with the DoN [Director of Nursing] on 9/20/12 at 11:30 a.m., indicated the resident had excoriation on his buttocks in the past and was receiving Xenaderm [an ointment used for treating</p>			

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	<p>skin wounds]. The DoN indicated she was unaware of any open areas on the resident's buttocks.</p> <p>During observation of the dressing change on Resident Z's bilateral heels on 9/20/12 at 1:45 p.m., the dressings on the resident's bilateral heels were marked the dressing was last changed on 9/14/12 and initialed.</p> <p>Interview of ADoN #2 on 9/20/12 at 2:00 p.m. indicated the dressing on Resident Z's bilateral heels indicated the dressings had not been changed since 9/14/12.</p> <p>3. A closed clinical record review on 9/19/12 at 11:30 a.m. of Resident V, indicated the resident had been admitted to the facility on 5/16/12 and expired at the facility on 8/22/12.</p> <p>An admission skin assessment dated 5/16/12 indicated the resident had no areas if skin impairment on admission.</p> <p>Included in resident V's clinical record was a document titled nursing-therapy communication and dated 7/9/12 indicating Resident V had a skin condition to the coccyx. No description was present on the form.</p> <p>There were no nursing notes available for the time frame from 7/3/12 to 7/11/12.</p>				

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	<p>The resident had a care plan dated 6/19/12 and updated 8/16/12 indicating interventions of but not limited to monitor wound weekly and PRN, See skin grid and provide treatment per MD.</p> <p>The treatment record for the month of July indicated weekly skin assessments were done on July 3, 17, 24 and 31 with no skin issues documented. There was no documented skin assessment for the week of July 10, 2012.</p> <p>A document titled nursing-therapy communication and dated 8/1/12 indicated the resident had a skin condition to the coccyx 1 inch in diameter which was open.</p> <p>A nursing note dated 8/2/12 at 12:45 p.m. indicated the nurse had completed a skin assessment and a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough may also present as an intact or open/ruptured serum filled blister) pressure ulcer had been found to the right buttock which measure 2 cm in length and 2 cm in width.</p> <p>On 8/2/12 a document titled skin grid-pressure/venous insufficiency ulcer/other indicated a stage 2 pressure area on the</p>			

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	<p>resident's right buttock. The area was 2 cm [centimeter a unit of measurement] in length by 2 cm in width.</p> <p>A doctors order dated 8/2/12 indicated the resident was to have a treatment and dressing change every 3 days and as needed.</p> <p>The treatment record for August indicated Resident V had a dressing change on August 2, 2012, but not another dressing change for 5 days. The date was August 7, 2012. Dressing changes were then documented as done on August 9, 11, and 14, 2012.</p> <p>The treatment record for the month of August indicated the resident did not have a skin assessment until August 14, 2012 even though the resident was care planned for weekly and as needed wound monitoring.</p> <p>The skin grid-pressure assessment dated 8/14/12 indicated the area on the coccyx had progressed to unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and or eschar in the ulcer bed) 10 cm in length by 9 cm in width.</p> <p>On 8/14/12 a doctor's order indicated that physical therapy was to evaluate and</p>			

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	<p>provide treatment to Resident V's right buttock pressure area.</p> <p>In an interview with the Director of Nursing [DoN] on 9/20/12 at 11:25 a.m. she indicated she did not know why there was documentation of a skin condition on the nurse therapy communication document dated 7/9/12 and "could not ask the nurse who signed the document, because she know longer works here."</p> <p>The DoN also indicated she did not know why the weekly skin assessment had not been documented on July 9, or in August until August 14, 2012.</p> <p>This federal tag relates to complaint # IN00116303.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 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 observation, record review, and interview, the facility failed to maintain accurate clinical records in 1 of 4 sampled residents whose clinical records were reviewed. (Resident Z)</p> <p>Findings include:</p> <p>Resident Z's record was reviewed on 9/19/12 at 11:21 a.m.</p> <p>The diagnosis of Resident Z included, but not limited to, Down's syndrome, venous insufficiency, osteoarthritis, seizures, and anemia.</p> <p>Resident Z had an order, dated 7/30/12, which indicated his bilateral heels were to be cleansed with Normal Saline, Calcium Alginate [a dressing used to promote</p>	F0514	<p>F514 The dressing on resident Z was changed per physician order on 9/20/12.</p> <p>All residents have the potential to be affected by this alleged deficit practice.</p> <p>Re-education has been provided to Licensed Nurses on documentation policy & procedure to include documentation of treatments that have not been provided. Dressing observation rounds have been implemented with the on-coming and off-going Licensed Nurses. Rounds will include but not be limited to ensuring dressing has been applied per physicians order.</p>	10/11/2012			

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	<p>wound healing] was to be applied, the wounds were to be covered with Allevyn [a type of foam wound dressing], Kerlix [a type of gauze dressing] was to be wrapped around his bilateral heels and secured with Coban [a type of stick on wrap] every other day.</p> <p>During observation of Resident Z's bilateral heel dressing changes on 9/20/12 at 1:45 p.m., the old dressings were dated 9/14/12 and initialed by RN # 5. RN #2 removed the old dressings, discarded them , and applied the new dressings as per the resident's order.</p> <p>Review of the MAR [Medication Administration Record] on 9/20/12 at 2:30 p.m., indicated a RN #4 had done the dressing change on 9/14/12. Documentation on the MAR indicated the dressing had been changed on 9/16/12 by LPN #3 and on 9/18/12 by RN #3.</p> <p>Interview of ADON #2 indicated the previous dressings were last changed on 9/14/12 by RN #4 and the dressings were not changed on 9/16/12 or 9/18/12.</p> <p>This federal tag relates to complaint # IN00116303.</p> <p>3.1-50(a)(2)</p>		<p>DON/designee will conduct a audit of the TAR to ensure complete and accurate documentation on those residents with physician orders for wound dressings. DON/designee will conduct random observation rounds to ensure application per physician order. The above audits will be conducted on 25% of identified residents 5 times weekly x 14 days, 3 x weekly x 4 weeks and weekly thereafter.</p> <p>Identified non-compliance will result in 1:1 re-education up to & including termination. Results of above audits will be forwarded to the Quality Assurance Committee for further review & recommendations monthly as deemed appropriate.</p>		

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