

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2013
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the Investigation of Complaint IN00140013.</p> <p>Complaint: IN00140013 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F314.</p> <p>Survey dates: December 2 & 4, 2013</p> <p>Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Type: Medicare: 7 Medicaid: 60 Other: 10 Total: 77</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>This plan of correction is the centers credible allegation of compliance. Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is provided by the provisions of the state and federal law. We respectfully request desk review in lieu of return visit.</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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	Quality Review was completed by Tammy Alley RN on December 9, 2013.			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to ensure a concerned family member and physician was notified, in that when a resident had a change in a pressure</p>	F000157	It is the practice of Pyramid Point to ensure responsible party and physicians are notified when a resident has a change in pressure ulcer and food consumption as well as notifying responsible party	01/03/2014			

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	<p>ulcer and food consumption, the nursing staff failed to immediately notify the resident's physician for possible intervention which resulted in a delay of treatment to a necrotic pressure ulcer.</p> <p>In addition the facility failed to inform a resident's family member of physician orders which included laboratory testing and the eventual addition of an antibiotic for a urinary tract infection.</p> <p>This deficient practice effected 2 of 5 sampled resident's. (Resident's "A" and "C").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-02-13 at 9:30 a.m. Diagnoses included, but were not limited to, hemiplegia, anemia, dementia, chronic pain, depressive disorder, diabetes mellitus and a history of pressure ulcer - Stage 3 (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. May include undermining or tunneling.) - buttocks. These diagnoses remained current at the</p>		<p>of physician order which include laboratory testing and addition of antibiotic. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident A no longer resides at facility Resident C Responsible Party notified on 12/3/12 How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A full house skin assessment was completed for each resident by 12/18/13. Physician & responsible parties were notified if necessary of change in pressure ulcer. A full house food consumption audit was completed to assure physician and responsible party were notified of changes if any. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Licensed nurses (LN) have been re-educated on expectation for notification of physician and responsible party regarding change in pressure ulcers, food consumptions, laboratory testing and addition of antibiotics. LN re-education on Change of Condition policy. Orders will be reviewed the next business day following the order by Health Information Manager (HIM) to assure documentation of</p>	

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	<p>time of the record review.</p> <p>A review of the resident's current plan of care originally dated 01-18-13 indicated the resident had the "potential for impaired skin integrity R/T [related to] requires assist with turning and repositioning - two assist, impaired mobility, incontinence and history of pressure ulcer." Interventions to the plan of care included "Observe skin integrity during am/pm care, and notify MD [Medical Doctor] promptly of skin breakdown."</p> <p>A review of the resident's Minimum Data Set assessment, dated 11-06-13 indicated the resident required extensive assistance with transfer, bed mobility, toileting, hygiene and was incontinent of bowel and bladder.</p> <p>The resident had consulting services provided by a local wound care company for treatment of pressure ulcers and a review of the consultant notes, dated 09-11-13, indicated an area to the "left buttock" was "resolved."</p> <p>The next wound care notation was dated 10-09-13 and indicated the resident was observed with "pressure ulceration." The areas included the</p>		<p>notification has been completed in chart regarding change in pressure ulcers, food consumptions, Laboratory testing and addition of antibiotics. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur? The DON/designee will monitor HIM audit of orders 3x/week x 6 weeks 2x/month for 2 months and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure notification of physician and responsible party regarding change in pressure ulcers, food consumptions, Laboratory testing and addition of antibiotics. Re-educate LNs will be conducted as necessary to assure proper notification has been completed. Results of these audits will be presented to the facility QA&A committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p>				

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	<p>"reopening" (10-09-2013) of an area on the left buttocks and a new ulcer identified on the "left gluteal fold at a Stage 3." The area measured "1.5 cm (centimeters) in length by 1.7 cm in width by 0.3 cm in depth" with a "scant amount of sero-sanguineous drainage noted."</p> <p>A wound care note, dated 10-16-13 indicated the continued treatment to the "left gluteal fold (10-09-2013)," but now the resident presented with "NEW" pressure ulcers to the "left ischiam and coccyx (10-16-13) - Quality: Stage 3."</p> <p>The left ischial - Stage 3 measured at "2.0 cm in length by 2.3 cm in width and 0.1 cm in depth." The area had sero-sanguineous drainage. In addition the resident had an pressure area noted at the coccyx (new) at a Stage 3 with measurements of 4.0 cm in length by 0.9 cm in width by 0.2 cm in depth and sero-sanguineous drainage." The area of the left gluteal fold remained present with measurement at 0.7 in length by 0.9 cm in width by 0.1 cm in depth - improving."</p> <p>All areas received the same treatment of "Cleanse wound bed with NS [normal saline]. Pat dry. Apply skin</p>			

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	<p>prep or barrier cream to periwound. Apply hydrogel moistened, fluffed gauze to wound bed followed by dry gauze and secure daily and PRN [as needed], soiled."</p> <p>The 10-23-13 wound care notes indicated the resident "presents with pressure ulceration" and indicated the area to the left ischial which measured 1.2 cm in length by 1.7 cm in width by 0.1 cm in depth - was improving.</p> <p>The coccyx remained at a Stage 3 with measurements at 3.2 cm in length by 0.4 cm in width by 0.1 cm in depth - improving and left gluteal fold Stage 3 and measured 0.3 cm in length by 0.4 cm in width by 0.1 cm in depth - improving."</p> <p>The nursing staff were instructed to continue with the same treatment as indicated on 10-16-13.</p> <p>A review of the nurses notes, dated 10-29-13 at 12:00 p.m., indicated "Wound nurse [Licensed Practical Nurse #5] notified of change in would <sic> appearance. Wound nurse states to continue same tx. [treatment] for today and will follow up later with wound N.P. [Nurse Practitioner]. Will continue to</p>			

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	<p>monitor. Resident remained in bed today and compliant with turning side to side. Will continue to monitor."</p> <p>The treatment continued as follows: "Cleanse wound bed with NS [normal saline]. Pat dry. Apply skin prep or barrier cream to periwound. Apply hydrogel moistened, fluffed gauze to wound bed followed by dry gauze and secure daily and PRN [as needed], soiled."</p> <p>During an interview on 12-04-13 at 8:30 a.m., the wound nurse indicated "I told her [the nurse] to continue with the current treatment because I knew the wound care nurse would be here the next day."</p> <p>The nurses note lacked description of the "change" in the wound however on 10-30-13 the resident was assessed by the local wound care company and indicated the "left ischial is a necrotic tissue (unstageable) pressure ulcer." The measurements documented indicated the area measured 2.5 cm in length by 3 cm in width and 0.1 cm in depth - the wound is deteriorating."</p> <p>"Coccyx is a Stage 3 pressure ulcer with measurements to include 2.7 cm by 1.0 cm in width by 0.1 cm in</p>			

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	<p>length," and the "left gluteal fold" pressure ulcer was assessed as "resolved."</p> <p>The treatment for the left ischial ulcer was changed to Santyl (a chemical debridement) after cleaning with normal saline, apply skin prep or barrier cream to wound edges and Santyl to open area. Cover with fluffed, saline moistened gauze and secure. Change daily and prn [as needed]. The treatment for the coccyx continued as noted on 10-16-13.</p> <p>During a family interview on 12-02-13 a concerned family member indicated she was aware about the coccyx but didn't know about the "new one". The wound nurse came to me and said she was concerned about it. I didn't even know [resident] had a new ulcer, they never called me."</p> <p>During an interview on 12-02-13 at 12:20 p.m. the Director of Nurses indicated "I can't find anywhere that family notification was done for (name of resident)."</p> <p>The resident's weight record for 10-03-13 indicated the resident weighed 159.2 lbs, and on 11-02-13 weighed 144.4 lbs.</p>			

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	<p>In addition an 11-06-13 Dietary review indicated the resident continued on a Regular puree diet with Honey thickened liquids, and instituted super cereal and fortified pudding at lunch and dinner. The dietary note indicated the resident had a significant weight loss in the last 30 days and had a pressure ulcer present.</p> <p>The 11-08-13 Nutritional Progress Note indicated the resident's weight declined 9% in 30 days and "triggers as a significant weight loss. Addendum: 2 areas Stage 3 and unstageable to left ischial/coccyx."</p> <p>A review of the food consumption report for November 2013, indicated the resident's consumption varied until November 9, 2013 when the resident's consumption declined and only ate "bites" for supper. The record for November 2013 was as follows: "11-10-13 ate bites for breakfast, 25 % for lunch and refused dinner." "11-11-13 ate 50 % for breakfast and lunch and refused dinner." "11-12-13 ate 25 % for breakfast, lunch and dinner." "11-13-13 ate bites for breakfast, lunch and dinner."</p>						

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	<p>The resident had a changed of condition which included non responsiveness to verbal and physical stimuli, altered mental status, increase in temperature, pulse, blood sugar with "breathing heavy congestion" and "diaphoresis noted." 911 was activated and the resident was transported to the local area hospital on 11-14-13. The hospital determined the resident "presented" to the hospital Emergency room in "septic shock and respiratory failure."</p> <p>The Director of Nurses indicated on 12-02-13 at 12:30 p.m., she could not find documentation the physician had been notified of the change in the resident's food consumption but "we put [resident] on Restorative Nursing."</p> <p>2. The record for Resident "C" was reviewed on 12-02-13 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimers dementia, depressive disorder, anemia, hypertension, diabetes mellitus, and dysphasia. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 11-25-13 for a urinalysis with a culture and sensitivity testing. The</p>				

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	<p>result of the urinalysis indicated the resident had a urinary tract infection and the resident was started on Sulfamethoxazole 800 mg (milligrams) / Trimethoprim 160 mg one by mouth two times a day for seven days.</p> <p>During an interview on 12-04-13 at 8:15 a.m., the Director of Nurses indicated the family had not been notified of the testing or the addition of the medication for the resident.</p> <p>3. Review of the facility policy titled "Change of Condition" when to report to the MD/NP/PA (medical doctor, nurse practitioner, physician assistant), on 12-02-13 at 12:30 p.m., and undated indicated the nursing staff should notify the physician either "immediately (Notify the attending or on-call MD, NP or PA on call as soon as possible, non-immediate (notify the attending or on-call MD, NP or PA no later than the next work day, routine (notify the attending or on-call MD, NP or PA no later than the next regular visit or phone or fax [facsimile] communication)."</p> <p>"Symptoms or Sign Pressure Sore - Non Immediate New Grade 2 of higher pressure sore OR progression of pressure sore despite</p>						

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	<p>interventions."</p> <p>"Symptoms or Sign Appetite, diminished - Non Immediate Significant decline in food and fluid intake of someone with marginal hydration and nutritional status."</p> <p>4. During a subsequent interview on 12-04-13 at 8:30 a.m., the Director of Nurses indicated the facility policy indicated the nursing staff should have notified the physician and responsible party of a resident's status, orders and interventions.</p> <p>This Federal tag relates to Complaint IN00140013.</p> <p>3.1-5(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure physician orders and resident plans of care were followed for 3 of 5 sampled resident's. (Resident's "A", "E" and "D").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-02-13 at 9:30 a.m. Diagnoses included, but were not limited to, hemiplegia, anemia, dementia, chronic pain, depressive disorder, diabetes mellitus and a history of pressure ulcer - Stage 3 (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. May include undermining or tunneling.) - buttocks. These diagnoses remained current at the time of the record review.</p> <p>The 10-23-13 wound care notes indicated the resident continued with an area to the left ischial which</p>	F000282	<p>It is the practice of Pyramid Point to ensure physician orders and resident plans of care are followed regarding pressure ulcers, floating heels and proper foot wear. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident A No longer resides at facility Resident D Care plan updated with correct interventions Resident E Dressing put in place per physician order How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A full house skin assessment was completed for each resident by 12/18/13. Care plans were reviewed/updated to ensure current treatment, off-loading and floating of heels were accurate. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur? Re-education of LNs regarding weekly skin assessments and pressure wound treatments and following physician orders and plans of</p>	01/03/2014			

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	<p>measured 1.2 cm in length by 1.7 cm in width by 0.1 cm in depth - improving. The coccyx was assessed at a Stage 3 with measurements at 3.2 cm in length by 0.4 cm in width by 0.1 cm in depth - improving and left gluteal fold Stage 3 and measured 0.3 cm in length by 0.4 cm in width by 0.1 cm in depth - improving."</p> <p>The treatment to the areas included "cleanse wound bed with NS [normal saline]. Pat dry. Apply skin prep or barrier cream to periwound. Apply hydrogel moistened, fluffed gauze to wound bed followed by dry gauze and secure daily and PRN [as needed], soiled."</p> <p>A review of the nurses notes, dated 10-29-13 at 12:00 p.m., indicated "Wound nurse [Licensed Practical Nurse #5 notified of change in wound <sic> appearance. Wound nurse states to continue same tx. [treatment] for today and will follow up later with wound N.P. [Nurse Practitioner]. Will continue to monitor. Resident remained in bed today and compliant with turning side to side. Will continue to monitor."</p> <p>The nurses note lacked description of the "change" in the wound however on 10-30-13 the resident was</p>		<p>care regarding pressure ulcers, floating heels and proper foot wear. Certified Nurse Assistance (CNAs) were re-educated regarding off-loading, floating heels, repositioning and proper footwear. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur?The DON/designee will monitor weekly skin sheets 3x/week x 6 weeks then 2x/month for 2 months and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure current treatment, off-loading and floating of heels were accurate.The DON/designee will monitor 5 residents/week x 6 weeks with potential for skin breakdown then 5 residents every other week for 2 months and then 5 residents/month x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure current treatment, off-loading and floating of heels were accurate.Re-educate LNs will be conducted as necessary to assure proper notification has been completed. Results of these audits will be presented to the facility QA&A committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p>	

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	<p>assessed by the local wound care company and the "left ischial is a necrotic tissue (unstageable) pressure ulcer." The measurements indicated the area was 2.5 cm in length by 3 cm in width and 0.1 cm in depth - the wound is deteriorating." "Coccyx is a Stage 3 pressure ulcer with measurements to include 2.7 cm by 1.0 cm in width by 0.1 cm in length," and the "left gluteal fold" pressure ulcer was assessed as "resolved." The treatment was changed to Santyl (a chemical debridement) for the coccyx and the treatment continued as noted on 10-16-13 for the left ischial.</p> <p>A review of the resident's current plan of care, originally dated 01-18-13, indicated the resident had the potential for impaired skin integrity R/T [related to] requires assist with turning and repositioning - two assist, impaired mobility, incontinence and history of pressure ulcer. Interventions to the plan of care included "Observe skin integrity during am/pm care, and notify MD [Medical Doctor] promptly of skin breakdown."</p> <p>2. The record for Resident "E" was reviewed on 12-04-13 on 9:30 a.m. Diagnoses included, but were not</p>			

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	<p>limited to, urosepsis, anemia, hematuria and an acquired pressure ulcer. These diagnoses remained current at the time of the record review.</p> <p>The resident's plan of care, originally dated 03-20-13 indicated the resident had a "recurrent" pressure ulcer to the coccyx." Interventions included "check dressing placement q [every] shift, monitor for s/s [signs and symptoms] of infection daily - increased warmth of surrounding tissue, redness, swelling,pain, purulent drainage, foul odor. Notify MD if identified."</p> <p>The resident received the services of a local wound care company and was last seen on 11-20-13. The Wound Progress Note/Reassessment, dated 11-20-13 indicated the area to the coccyx measured 4.7 cm by 3.2 cm by 2.0 cm and identified as DTI (deep tissue injury), with was "deteriorating." The "diagnosis/plan" indicated the following: "Stage 4 pressure ulcer on coccyx/sacrum, now DTI within wound bed along with nonviable tissue. Change to silver alginate daily, with foam and calmoseptine to the periwound."</p> <p>A review of the Nurses Progress</p>				

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	<p>notes, dated 11-27-13 at 1:00 p.m., indicated "Wound to coccyx 4.5 [cm] by 3.2 [cm] by 2.0 [cm] with undermining 1.6 cm from 6 - 12 o'clock. Wound improving."</p> <p>During an observation on 12-04-13 at 10:15 a.m., the resident was seated in a wheelchair in the dining area. The resident remained in the wheelchair until 1:40 p.m., when the resident was transferred to bed in order to perform an assessment on the coccyx/sacral area.</p> <p>After the resident was transferred to bed and slacks and incontinent brief removed, and with the Wound Nurse and Registered Nurse # 6 in attendance, the resident was turned to the right side. The Wound Nurse indicated the current treatment for the pressure ulcer included to "clean the area with normal saline, and pack with silver alginate and cover. We use calmoseptine to the periwound."</p> <p>As the resident lay to the right side a saturated gauze covered the sacral area. As the Wound Nurse removed the gauze an odor permeated the air. The gauze was saturated with a small amount of yellow drainage in addition to a brownish/gray drainage, and there was no packing in the resident's</p>						

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	<p>wound. The dressing was undated.</p> <p>The Wound Nurse questioned Registered Nurse # 6 if she was aware the dressing had come off or needed to be changed. The Registered Nurse indicated "I haven't changed the dressing today and no one came to me about the dressing."</p> <p>The Wound Nurse indicated "it's suppose to have packing and I don't know if it came off earlier or during the night, but it's suppose to have the packing."</p> <p>The Wound Nurse then measured the area and indicated the area now measured "5.9 cm in length by 3.1 cm in width by 2.0 cm in depth. The area had undermining at 1.6 cm around the entire wound.</p> <p>3. The record for Resident "D" was reviewed on 12-02-13 at 1:20 p.m. Diagnoses included, but were not limited to, Alzheimers disease, pain, depressive disorder, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>A plan of care, originally dated 08-26-13 indicated the resident had an "actual pressure ulcer to right</p>				

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	<p>heel." Interventions to this plan of care included provide off loading of ulcer site, monitor for pain indicators, monitor for s/s of infection, and pressure reducing mattress to bed."</p> <p>In addition the resident had a physician order, dated 08-28-13 "No shoe to right foot - heels to be floated of <sic> bed at all times."</p> <p>During an observation on 12-04-13 at 10:15 a.m., the resident was observed laying in bed. With Licensed Practical Nurse #7 in attendance the resident's socks were removed. A light pink area to the right heel was observed, with dry skin surrounding the area. The resident's heels were not floated while she was in bed.</p> <p>During a subsequent observation on 12-04-13 at 12:40 p.m., the resident had been dressed/groomed and transported to the dining area for lunch. The resident had a shoe to the right foot.</p> <p>This Federal tag relates to Complaint IN00140013.</p> <p>3.1-35(g)(2)</p>				

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F000314 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, record review and interview the facility failed to ensure a resident received treatment and services for pressure ulcers, in that when Resident "A" was assessed with 2 new pressure ulcers, which were not identified until they were a Stage 3 ulcers, the nursing staff failed to ensure the physician was immediately notified of a change in the condition of the resident's skin for possible physician intervention.</p> <p>In addition, two other residents who were assessed for a pressure ulcers the nursing staff failed to ensure treatment for Resident "E" and prevention interventions were implemented for Resident "D".</p> <p>This deficient practice effected 3 of 5 residents sampled for pressure ulcers in a sample of 5. (Residents "A", "E"</p>	F000314	<p>It is the practice of Pyramid Point to ensure a resident received treatment and services for pressure ulcers, physician is notified of a change in condition of the resident's skin. What corrective actions will be taken for those residents who have been found to have been affected by this alleged deficient practice? Resident A no longer resides in facility Resident D Care plan updated with correct interventions Resident E Dressing put in place per physician order How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken? A full house skin assessment was completed for each resident by 12/18/13. Physician & responsible parties were notified if necessary of change in pressure ulcer. Licensed nurses (LN) have been re-educated on expectation for resident received treatment</p>	01/03/2014			

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	<p>and "D")</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 12-02-13 at 9:30 a.m. Diagnoses included, but were not limited to, hemiplegia, anemia, dementia, chronic pain, depressive disorder, diabetes mellitus and a history of pressure ulcer - Stage 3 (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. May include undermining or tunneling.) - buttocks. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's current plan of care originally dated 01-18-13 indicated the resident had the "potential for impaired skin integrity R/T [related to] requires assist with turning and repositioning - two assist, impaired mobility, incontinence and history of pressure ulcer. Interventions to the plan of care included "Observe skin integrity during am/pm care, and notify MD [Medical Doctor] promptly of skin breakdown."</p>		<p>and services for pressure ulcers, physician is notified of a change in condition of the resident's skin. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not reoccur?Orders will be reviewed the next business day following the order by Health Information Manager (HIM) to ensure a resident received treatment and services for pressure ulcers, physician is notified of a change in condition of the resident's skin. How the corrective action will be monitored to ensure the alleged deficient practice does not reoccur?The DON/designee will monitor HIM audit of orders 3x/week x 6 weeks 2x/month for 2 months and then monthly x 2 months and then quarterly until a pattern of substantial compliance is maintained to ensure resident received treatment and services for pressure ulcers, physician is notified of a change in condition of the resident's skin. Re-educate LNs will be conducted as necessary to ensure residents received treatment and services for pressure ulcers, physician is notified. Results of these audits will be presented to the facility QA&A committee monthly X 3 months and then quarterly until a pattern of substantial compliance is maintained with a subsequent plan developed and implemented as necessary.</p>				

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	<p>A review of the resident's Minimum Data Set assessment, dated 11-06-13 indicated the resident required extensive assistance with transfer, bed mobility, toileting, hygiene and was incontinent of bowel and bladder.</p> <p>The resident had consulting services provided by a local wound care company for treatment of pressure ulcers and a review of the consultant notes, dated 09-11-13, indicated an area to the "left buttock" was "resolved."</p> <p>The next wound care notation was dated 10-09-13 and indicated the resident was observed with "pressure ulceration." The areas included the "reopening of an area on the left buttocks ulcer and a new ulcer identified on the "left gluteal fold at a Stage 3." The area measured "1.5 cm (centimeters) in length by 1.7 cm in width by 0.3 cm in depth" with a "scant amount of sero-sanguineous drainage noted."</p> <p>A wound care note, dated 10-16-13 indicated the continued treatment to the "left gluteal fold (10-09-2013)," but now the resident presented with "NEW" pressure ulcers to the "left ischiam and coccyx (10-16-13) - Quality: Stage 3."</p>			

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	<p>The left ischial - Stage 3 measured at "2.0 cm in length by 2.3 cm in width and 0.1 cm in depth." The area had sero-sanguineous drainage. In addition the resident had an pressure area noted at the coccyx (new) at a Stage 3 with measurements of 4.0 cm in length by 0.9 cm in width by 0.2 cm in depth and sero-sanguineous drainage." The area of the left gluteal fold remained present with measurement at 0.7 in length by 0.9 cm in width by 0.1 cm in depth - improving."</p> <p>All areas received the same treatment of "Cleanse wound bed with NS [normal saline]. Pat dry. Apply skin prep or barrier cream to periwound. Apply hydrogel moistened, fluffed gauze to wound bed followed by dry gauze and secure daily and PRN [as needed], soiled."</p> <p>The 10-23-13 wound care notes indicated the resident "presents with pressure ulceration" and indicated the area to the left ischial which measured 1.2 cm in length by 1.7 cm in width by 0.1 cm in depth - was improving.</p> <p>The coccyx remained at a Stage 3 with measurements at 3.2 cm in</p>			

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	<p>length by 0.4 cm in width by 0.1 cm in depth - improving and left gluteal fold Stage 3 and measured 0.3 cm in length by 0.4 cm in width by 0.1 cm in depth - improving."</p> <p>The nursing staff were instructed to continued with the same treatment as indicated on 10-16-13.</p> <p>A review of the nurses notes, dated 10-29-13 at 12:00 p.m., indicated "Wound nurse [Licensed Practical Nurse #5] notified of change in would <sic> appearance. Wound nurse states to continue same tx. [treatment] for today and will follow up later with wound N.P. [Nurse Practitioner]. Will continue to monitor. Resident remained in bed today and compliant with turning side to side. Will continue to monitor."</p> <p>During an interview on 12-04-13 at 8:30 a.m., the wound nurse indicated "I told her [the nurse] to continue with the current treatment because I knew the wound care nurse would be here the next day."</p> <p>The nurses note lacked description of the "change" in the wound however on 10-30-13 the resident was assessed by the local wound care company and indicated the "left</p>				

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	<p>ischial is a necrotic tissue (unstageable) pressure ulcer." The measurements documented indicated the area measured 2.5 cm in length by 3 cm in width and 0.1 cm in depth - the wound is deteriorating."</p> <p>"Coccyx is a Stage 3 pressure ulcer with measurements to include 2.7 cm by 1.0 cm in width by 0.1 cm in length," and the "left gluteal fold" pressure ulcer was assessed as "resolved." The treatment for the left ischial ulcer was changed to Santyl (a chemical debridement) after cleaning with normal saline, apply skin prep or barrier cream to wound edges and Santyl to open area. Cover with fluffed, saline moistened gauze and secure. Change daily and prn [as needed]. The treatment for the coccyx continued as noted on 10-16-13.</p> <p>The resident's weight record for 10-03-13 indicated the resident weighed 159.2 lbs, and on 11-02-13 weighed 144.4 lbs.</p> <p>An 11-06-13 Dietary review indicated the resident continued on a Regular puree diet with Honey thickened liquids, and instituted super cereal and fortified pudding at lunch and dinner. The dietary note indicated the</p>			

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	<p>resident had a significant weight loss in the last 30 days and had a pressure ulcer present.</p> <p>The 11-08-13 Nutritional Progress Note indicated the resident's weight declined 9% in 30 days and "triggers as a significant weight loss. Addendum: 2 areas Stage 3 and unstageable to left ischial/coccyx."</p> <p>A review of the food consumption report for November 2013, indicated the resident's consumption varied until November 9, 2013 when the resident's consumption declined and only ate "bites" for supper. The record for November 2013 was as follows: "11-10-13 ate bites for breakfast, 25 % for lunch and refused dinner." "11-11-13 ate 50 % for breakfast and lunch and refused dinner." "11-12-13 ate 25 % for breakfast, lunch and dinner." "11-13-13 ate bites for breakfast, lunch and dinner."</p> <p>A review of the nurses notes dated 11-14-13 at 7:50 a.m. indicated the following: "Summons to resident's room by CNA [certified nurses aide]. Upon entering noted resident to be non-responsive to verbal et [and] physical stimuli,</p>			

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	<p>eyes open, breathing heavy congestion et diaphoresis noted. O2 [oxygen] started right away d/t [due to] sats [oxygen saturation level] at 50%, BS [blood sugar] 344, T [temperature] 99.5, P [pulse] 104, R [respirations] 22 and B/P [blood pressure] 152/72. 911 called for transport to ER [emergency room]."</p> <p>A review of the hospital record on 11-27-13 at 8:30 a.m., indicated the resident "presented from the facility in septic shock and respiratory failure. The patient was admitted to the Intensive Care Unit. The patient has been bedridden for sometime and was found to have a large smelling and grossly necrotic sacral decubitus ulcer."</p> <p>A Hospital "Procedure Note," dated 11-14-13 indicated "Patient is a [age documented] who was admitted from [name of facility] with shortness of breath, change of mental status and deep draining decubitus ulcers of the buttocks. On further exam, the patient has a deep stage 3 left ischial ulcer and a stage 2 sacral ulcer. The patient has extensive gangrenous skin and necrosis down to ischial tuberosity on the left ischial ulcer."</p> <p>The hospital History and Physical,</p>			

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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	<p>dated 11-14-13 indicated the resident "has significant decubitus ulcers with drainage. She has significant Stage 3 decubitus ulcers at the sacral area with significant drainage. Impression:</p> <p>1. Acute respiratory failure likely due to hypoventilation and sepsis, 2. Altered mental status with encephalopathy, likely metabolic, 3 Decubitus ulcer that appears to be infected - the patient is critically ill."</p> <p>2. The record for Resident "E" was reviewed on 12-04-13 on 9:30 a.m. Diagnoses included, but were not limited to, urosepsis, anemia, hematuria and an acquired pressure ulcer. These diagnoses remained current at the time of the record review. The record indicated the resident had an indwelling foley catheter.</p> <p>During an interview on 12-04-13 at 8:30 a.m., the facility Wound Nurse identified Resident "E" with an acquired pressure ulcer.</p> <p>A review of the Residents Minimum Data Set assessment, dated 09-07-13 indicated the resident was totally dependent for care in the areas of transfer and bed mobility and extensive assistance with hygiene and toileting, incontinent of stool and</p>			

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	<p>had a pressure ulcer Stage 4 (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling), which measured 5.6 cm in length by 2.7 cm in width and 1.3 cm in depth."</p> <p>The resident's plan of care, originally dated 03-20-13 indicated the resident had a "recurrent" pressure ulcer to the coccyx. Interventions included "check dressing placement q [every] shift, monitor for s/s [signs and symptoms] of infection daily - increased warmth of surrounding tissue, redness, swelling,pain, purulent drainage, foul odor. Notify MD if identified."</p> <p>The resident received the services of a local wound care company and was last seen on 11-20-13. The Wound Progress Note/Reassessment, dated 11-20-13 indicated the area to the coccyx measured 4.7 cm by 3.2 cm by 2.0 cm and identified as DTI (deep tissue injury), which was "deteriorating." The "diagnosis/plan" indicated the following: "Stage 4 pressure ulcer on coccyx/sacrum, now DTI within wound bed along with nonviable tissue. Change to silver alginate daily, with foam and</p>			

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	<p>calmoseptine to the periwound."</p> <p>A review of the Nurses Progress notes, dated 11-27-13 at 1:00 p.m., indicated "Wound to coccyx 4.5 [cm] by 3.2 [cm] by 2.0 [cm] with undermining 1.6 cm from 6 - 12 o'clock. Wound improving."</p> <p>When interviewed on 12-04-13 at 8:30 a.m., the facility Wound Care Nurse indicated the consultant wound care company did not come to the facility with week of 11-25-13. "They had a short week and they changed their schedule around."</p> <p>During an observation on 12-04-13 at 10:15 a.m., the resident was seated in a wheelchair in the dining area. The resident remained in the wheelchair until 1:40 p.m., when the resident was transferred to bed in order to perform an assessment on the coccyx/sacral area.</p> <p>After the resident was transferred to bed and slacks and incontinent brief removed, and with the Wound Nurse and Registered Nurse # 6 in attendance, the resident was turned to the right side. The Wound Nurse indicated the current treatment for the pressure ulcer included to "clean the area with normal saline, and pack</p>			

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	<p>with silver alginate and cover. We use calmoseptine to the periwound."</p> <p>As the resident lay to the right side a saturated gauze covered the sacral area. As the Wound Nurse removed the gauze an odor permeated the air. The gauze was saturated with a small amount of yellow drainage in addition to a brownish/gray drainage, and there was no packing in the resident's wound. The dressing was undated.</p> <p>The Wound Nurse questioned Registered Nurse # 6 if she was aware the dressing had come off or needed to be changed. The Registered Nurse indicated "I haven't changed the dressing today and no one came to me about the dressing."</p> <p>The Wound Nurse indicated "it's suppose to have packing and I don't know if it came off earlier or during the night, but it's suppose to have the packing."</p> <p>The Wound Nurse then measured the area and indicated the area now measured "5.9 cm in length by 3.1 cm in width by 2.0 cm in depth. The area had undermining at 1.6 cm around the entire wound.</p> <p>3. The record for Resident "D" was</p>			

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	<p>reviewed on 12-02-13 at 1:20 p.m. Diagnoses included, but were not limited to, Alzheimers disease, pain, depressive disorder, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>A plan of care, originally dated 08-26-13 indicated the resident had an "actual pressure ulcer to right heel." Interventions to this plan of care included provide off loading of ulcer site, monitor for pain indicators, monitor for s/s of infection, and pressure reducing mattress to bed."</p> <p>In addition the resident had a physician order, dated 08-28-13 "No shoe to right foot - heels to be floated of <sic> bed at all times."</p> <p>During an observation on 12-04-13 at 10:15 a.m., the resident was observed laying in bed. With licensed practical nurse #7 in attendance the resident's socks were removed. A light pink area to the right heel was observed, with dry skin surrounding the area. The resident's heels were not floated while she was in bed.</p> <p>During a subsequent observation on 12-04-13 at 12:40 p.m., the resident had been dressed/groomed and</p>			

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	<p>transported to the dining area for lunch. The resident had a shoe to the right foot.</p> <p>This Federal tag relates to Complaint IN00140013.</p> <p>3.1-40(a)(2) 3.1-40(a)(3)</p>						