

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE HAVEN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00149013.</p> <p>Complaint IN00149013 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F314, and F514.</p> <p>Survey dates: May 21, 22, and 23, 2014</p> <p>Facility number: 000311 Provider number: 15E064 AIM number: 100285520</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: NF: 38 Total: 38</p> <p>Census payor type: Medicaid: 38 Other: 0 Total: 38</p> <p>Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	F-0000This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal Regulations, and not because Brookside Haven agrees with the allegations and citations listed on the statements of deficiencies. This Plan of Correction shall operate as Brookside Haven's written credible allegation of compliance. Brookside Haven respectfully request a return visit on the Plan of Correction.	

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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F000279 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive health care plan was developed in regards to pressure ulcer treatment and healing for 1 of 4 residents (Resident #C) reviewed for health care planning related to a pressure sore in a sample of 4.</p> <p>Findings include:</p>	F000279	<p>F- 0279</p> <p>1.) DON immediately in-serviced all licensed nursing staff on wounds, measuring, staging, identifying and documentation, including re-admissions and new admissions and obtaining treatment orders, notifying physician and family. Implemented skin assessment flow sheet, reviewed policy, procedure on skin monitoring, and the completion of the skin assessment</p>	06/09/2014

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	<p>1. During observation of a wound assessment for Resident #C, completed by the DoN and LPN #1 on 5/21/14 at 4 p.m., the following was observed:</p> <p>The wound was below the coccyx, but above the anus, in the buttock fold area. The wound measured 4.2 cm in length along the buttock fold by 0.4 cm in width with a depth of 1 cm. The width of the area could be made much wider if the buttocks were pulled wide apart and not kept in normal body alignment. The 0.4 cm width was the measurement taken in normal body alignment. An assessment and/or visualization of this wound required two staff members due to the resident's large size. The wound could not be assessed without one person holding the buttocks apart and the second person measuring the wound.</p> <p>The clinical record for Resident #C was reviewed on 5/21/14 at 10:20 a.m. Diagnoses for the resident included, but were not limited to, post motor vehicle accident with brain injury, right sided weakness, encephalopathy, and diabetes mellitus, type 2.</p> <p>A nursing note entry, dated 3/6/14 at 8 a.m., indicated "Resident has a small area on coccyx between buttocks. Measures</p>		<p>flow sheet (staging and description). See Exhibit "A" .</p> <p>DON immediately completed head to toe skin assessment on resident's #B, #C, and #D, and all other residents with skin issues to ensure proper treatment orders were in place. All treatment orders must have specific frequency; type of treatment, how often to be done, how to be cleansed, if appropriate and site of application. Resident "C" scheduled immediately to wound clinic and placed on pressure reducing air mattress. Resident "C" continues weekly visit to wound clinic.</p> <p>HFA immediately in-serviced LPN-MDS Coordinator on reviewing all new orders and updating care plan's daily to ensure an individualized comprehensive health care plan is developed in regards to pressure ulcer treatment and healing, including measurable objectives, to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) A weekly skin assessment including staging, measuring, identifying and documenting will be completed by DON or designee on all residents to ensure all skin issues are identified and acceptable treatment obtained from MD.</p>	

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	<p>1.5 cm [centimeters] by 0.25 cm. Notified MD [Medical Doctor] - new order received and family notified of new order."</p> <p>A physician's order, dated 3/6/14, indicated the staff were to wash the area on the coccyx with soap and water, then pat it dry and apply Elasto-gel dressing (a healing/protective wound covering) and secure with Tegaderm (a dressing that covers and helps secure the Elasto-gel dressing in place). The order indicated the treatment was to be changed every three days and as needed for soilage.</p> <p>A skin assessment sheet for Resident #C, dated 4/12/14, indicated the wound below the coccyx and between the buttocks [in the buttock groove] now measured 5 cm by 3 cm and was 1 cm in depth. No wound staging was documented. The assessment indicated the resident experienced pain when the treatment was done.</p> <p>A physician's order, dated 4/12/14, indicated a new order had been received for Resident #C's pressure area. The order indicated the staff were to cleanse the area between the buttocks (below coccyx), dry the area, and apply Duoderm 4 by 4 control gel dressing to be changed every 3 days and as needed for soilage.</p>		<p>Orders will be obtained and followed to promote wound healing, including treatments, vitamins, and nutritional supplements. MD will be notified of any non-healing skin issues to assess need for change of treatment. Wound Center will be utilized for all non-healing wounds as ordered by MD. Orders will be obtained timely to DC treatments only when skin issues are resolved as verified by skin assessment. DON went to Wound Clinic with resident "C" and had extensive training with wound center physician and nurse on staging and measuring of wounds. DON will continue to accompany resident "C" to Wound Clinic appointments.</p> <p>4.) DON or Designee will monitor shower sheets/skin assessments daily for 60 days, then weekly X 2 months, then monthly X 2 months to ensure compliance. The DON will report to the QA Committee each quarter regarding the citation and the facility will follow any recommendations made by the QA Committee.</p> <p>5.) Date Completed: 06/09/2014</p>				

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	<p>The April TAR (Treatment administration record) indicated this treatment was initiated on 4/12/14 and completed as ordered during the month of April.</p> <p>The wound continued to be measured weekly in May 2014. The wound was not consistently measured or staged.</p> <p>The resident had a health care plan problem, dated 4/25/14, related to the potential for impaired skin due to dementia, use of psychoactive medications, and incontinence.</p> <p>The clinical record lacked any comprehensive health care plan having been developed in regards to the open area on the resident's coccyx and subsequent assessments and treatment changes.</p> <p>The DoN was interviewed on 5/21/14 at 4:15 p.m. Additional information was requested related to lack of a comprehensive health care plan having been developed in regards to the open area on the resident's coccyx found on 3/6/14 and continuing thru the present.</p> <p>The facility failed to provide any additional health care plan information as of exit on 5/23/14.</p>						

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F000314 SS=G	<p>Review of the current, but undated, facility policy, titled "Interdisciplinary Care Plan Review", provided by the Administrator on 5/22/14 at 2:40 p.m., included, but was not limited to, the following:</p> <p>"Policy All residents will receive a review of the Plan of Care by the Interdisciplinary Team a minimum of quarterly.</p> <p>...Procedure: ...5. Update and revise Problems, Goals and approaches/interventions as determined appropriate for the resident...."</p> <p>This federal tag relates to Complaint IN00149013.</p> <p>3.1-35(a)</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</p>			

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	<p>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 3 of 4 residents (Resident #s B, C, and D) identified at risk for pressure sore development received care and services in a manner to promote healing and/or prevent new pressure sores from developing resulting in an increase in size and pain in the area for 1 of the residents (Resident #C) reviewed for treatment of pressure sores.</p> <p>Findings include:</p> <p>1. During observation of a wound assessment for Resident #C, completed by the DoN and LPN #1 on 5/21/14 at 4 p.m., the following was observed:</p> <p>The wound was below the coccyx, but above the anus, in the buttock fold area. The wound measured 4.2 cm in length along the buttock fold by 0.4 cm in width with a depth of 1 cm. The width of the area could be made much wider if the buttocks were pulled wide apart and not kept in normal body alignment. The 0.4 cm width was the measurement taken in normal body alignment. An assessment and/or visualization of this wound would required two staff members due to the</p>	F000314	<p>F-0314</p> <p>1.) DON immediately in-serviced all licensed nursing staff on wounds, measuring, staging, identifying and documentation, including re-admissions and new admissions and obtaining treatment orders, notifying physician and family. Implemented skin assessment flow sheet, reviewed policy, procedure on skin monitoring, and the completion of the skin assessment flow sheet (staging and description). See Exhibit "A" .</p> <p>DON immediately completed head to toe skin assessment on resident's #B, #C, and #D, and all other residents with skin issues to ensure proper treatment orders were in place. All treatment orders must have specific frequency; type of treatment, how often to be done, how to be cleansed, if appropriate and site of application. Resident "C" scheduled immediately to wound clinic and placed on pressure reducing air mattress. Resident "C" continues weekly visit to wound clinic.</p> <p>HFA immediately in-serviced LPN-MDS Coordinator on reviewing all new orders and updating care plan's daily to ensure an individualized comprehensive health care plan is developed in regards to pressure ulcer treatment and healing, including measurable</p>	06/09/2014

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	<p>resident's large size. The wound could not be assessed without one person holding the buttocks apart and the second person measuring the wound.</p> <p>The clinical record for Resident #C was reviewed on 5/21/14 at 10:20 a.m. Diagnoses for the resident included, but were not limited to, post motor vehicle accident with brain injury, right sided weakness, encephalopathy, and diabetes mellitus, type 2.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 4/13/14, indicated Resident #C was severely cognitively impaired and required the extensive assistance from the staff for all activities of daily living.</p> <p>A nursing note entry, dated 3/6/14 at 8 a.m., indicated "Resident has a small area on coccyx between buttocks. Measures 1.5 cm [centimeters] by 0.25 cm. Notified MD [Medical Doctor] - new order received and family notified of new order."</p> <p>A physician's order, dated 3/6/14, indicated the staff were to wash the area on the coccyx with soap and water, then pat it dry and apply Elasto-gel dressing (a healing/protective wound covering) and secure with Tegaderm (a dressing that</p>		<p>objectives, to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) A weekly skin assessment including staging, measuring, identifying and documenting will be completed by DON or designee on all residents to ensure all skin issues are identified and acceptable treatment obtained from MD. Orders will be obtained and followed to promote wound healing, including treatments, vitamins, and nutritional supplements. MD will be notified of any non-healing skin issues to assess need for change of treatment. Wound Center will be utilized for all non-healing wounds as ordered by MD. Orders will be obtained timely to DC treatments only when skin issues are resolved as verified by skin assessment. DON went to Wound Clinic with resident "C" and had extensive training with wound center physician and nurse on staging and measuring of wounds. DON will continue to accompany resident "C" to Wound Clinic appointments.</p> <p>4.) DON or Designee will monitor shower sheets/skin assessments daily for 60 days, then weekly X 2 months, then monthly X 2 months to</p>	

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	<p>covers and helps secure the Elasto-gel dressing in place). The order indicated the treatment was to be changed every three days and as needed for soilage.</p> <p>The Treatment Administration Records (TAR) for March 2014 indicated the treatment was completed as ordered.</p> <p>The April 2014 TAR indicated the treatment was completed on 4/1/14. The order was then marked as discontinued on 4/5/14. A handwritten entry on the April 2014 TAR initiated on 4/5/14 indicated the staff were to "monitor area just below coccyx for changes every shift." The area for documentation of the "monitoring" was initialed by nursing staff from 4/5/14 thru 4/12/14. The TAR lacked any treatment for the area having been completed from the 4/5/14 thru 4/12/14 time period.</p> <p>The clinical record lacked any physician's order for the discontinuation of the treatment to the coccyx on 4/5/14 or any explanation of why a treatment had not been completed on 4/4/14. The clinical record lacked any order for the "monitoring" of the wound initiated after the treatment was discontinued on 4/5/14.</p> <p>Skin assessment sheets, included, but were not limited to, wound information</p>		<p>ensure compliance. See Exhibit "B". The DON will report to the QA Committee each quarter regarding the citation and the facility will follow any recommendations made by the QA Committee.</p> <p>5.) Date Completed: 06/09/2014</p>		

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	<p>on the following dates:</p> <p>3/27/14 - the area below the coccyx measured "1.3 cm by 0.2 cm". No staging or other information provided.</p> <p>4/3/14 - "open area to coccyx, treatment continues" (no measurements, staging, or other information provided)</p> <p>4/12/14 (the next skin assessment sheet for Resident #C) indicated the wound below the coccyx and between the buttocks [in the buttock groove] now measured 5 cm by 3 cm and was 1 cm in depth. No wound staging was documented. The assessment indicated the resident experience pain when the treatment was done.</p> <p>A physician's order, dated 4/12/14, indicated a new order had been received for Resident #C's pressure area. The order indicated the staff were to cleanse the area between the buttocks (below coccyx), dry the area, and apply Duoderm 4 by 4 control gel dressing to be changed every 3 days and as needed for soilage. The April TAR indicated this treatment was initiated on 4/12/14 and completed as ordered during the month of April.</p> <p>The clinical record lacked any order to discontinue this Duoderm treatment</p>			

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	<p>noted above. The May 2014 TAR had not been updated to include the Duoderm order. The May 2014 TAR indicated the staff were doing an Elasto-gel treatment to the area.</p> <p>The wound continued to be measured weekly in May 2014. The wound was not consistently measured or staged.</p> <p>The skin assessment sheet, dated 5/14/14, indicated the area measured 1.4 cm by 0.4 cm by 0.3 cm No staging was documented. The wound sheet indicated the Elasto-gel treatment was being given (as documented on the May TAR) and not the Duoderm treatment.</p> <p>The DoN was interviewed on 5/21/14 at 4:15 p.m. Additional information was requested related to lack of consistent wound measurements and staging and wound treatment changed without an order.</p> <p>The DoN and Administrator were interviewed on 5/22/14 at 9:15 a.m. The DoN indicated the above noted pressure area, measured on 5/21/14, would be considered a Stage 3. She indicated she had no information to provide related to why the treatment was "discontinued and the area monitored" on 4/5/14 without an order. She indicated she had no</p>			

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	<p>information to provide related to the May 2014 TAR not being updated and an old treatment having been documented as being done. She indicated she had held a "pressure ulcer" inservice and had educated the staff on wound measurement, staging, and obtaining orders for treatments. She indicated the facility would now try to have the same nurse measuring and monitoring wounds. She indicated the resident's physician had been contacted and the Duoderm treatment reinstated. Vitamin C and Zinc had also been ordered to assist with wound healing. She indicated the resident was also going to be seen by the wound center for an evaluation and treatment as necessary to help with wound healing.</p> <p>2. During observation of a wound assessment for Resident #B, completed by the DoN and LPN #1 on 5/21/14 at 2:40 p.m., the following was observed:</p> <p>The resident had three pressure areas:</p> <p>The area on the lower coccyx was a circular area which measured 0.8 cms in diameter. The area had lost only the very top layer of skin surface and was very superficial. No depth could be measured and it was referred to as a stage 2 denuded area by the DoN. A whitish cream,</p>						

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	<p>identified by the DoN as "periguard" was observed on the area. The DoN indicated this was the "house barrier cream" used for incontinent residents. The clinical record lacked any order for a "periguard" treatment.</p> <p>The area on the left inner heel was a 3.4 by and 3.3 oval dark blister. The skin was intact and the blister appeared to be drying up. The blister did not appear to be deep. The DoN indicated this heel was being treated with "skin prep" to help toughen the skin.</p> <p>The area on the right outer heel was a 3.2 by 3 cm dark pink area. The area was identified as a Stage 1. The DoN indicated this heel was being treated with "skin prep" to help toughen the skin.</p> <p>The clinical record for Resident #B was reviewed on 5/21/14 at 11:45 p.m. Diagnoses for the resident included, but were not limited to, Bipolar disorder, severe psychosis, and hypertension.</p> <p>A quarterly MDS, dated 4/1/14, indicated the resident was moderately cognitively impaired and required the assistance of the staff for bed mobility, transfers, and toileting. The MDS indicated the resident was at risk for pressure ulcer development, but had no current open</p>			

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	<p>areas.</p> <p>A health care plan problem, dated 4/11/14, indicated the resident had a potential for impaired skin integrity due to hemiplegia and incontinence. One of the approaches for this problem was "report first sign of breakdown to physician".</p> <p>The clinical record indicated the resident had a decline in her mental status and physical condition on 5/7/14. She was seen by the Nurse Practitioner (NP) on that date and sent out to the hospital for evaluation and treatment.</p> <p>The clinical record indicated a skin assessment was done prior to the resident leaving for the hospital and a blister to the left heel had been noted at that time. The assessment indicated the area was a "new area" which had just been noted that day. The area was described as a fluid filled blister measuring 8 cm by 5 cm. No other areas were noted.</p> <p>The clinical record indicated the resident returned to the facility following treatment for a urinary tract infection on 5/9/14. A skin assessment completed upon readmission, dated 5/9/14, indicated the resident had the following pressure areas.</p>			

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	<p>Red area to coccyx 1.5 cm by 1 cm - stage 2 Left heel - 2 cm by 2 cm blister</p> <p>The skin assessment, dated 5/9/14, indicated "MD aware. No treatment orders."</p> <p>A physician's order, dated 5/12/14, indicated an new order had been received for the areas on the resident's heels. The staff were to "apply skin prep to bilateral heels every shift" and "float heels when in bed".</p> <p>The nursing notes lacked any information related to the physician having been called related to this order or why no order was obtained for the pressure area on the resident's coccyx. The May TAR indicated the treatment to the resident's heels was done as ordered. No treatment was documented for the coccyx wound prior to a new order obtained on 5/22/14.</p> <p>A skin assessment sheet, dated 5/15/14, indicated the resident continued to have areas on her coccyx and heels. The areas were not measured or staged in order to determine healing status. The area on the coccyx was identified only as a "red area".</p>			

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	<p>During an interview with the Administrator and DoN on 5/21/14 at 3:05 p.m., additional information was requested related to the lack of wound measurements and staging for the resident's wounds noted above. Additional information was also requested related to the lack of a treatment for the wound on the resident's coccyx and the use of "periguard".</p> <p>The facility failed to provide any additional information related to the above requests as of exit on 5/23/14.</p> <p>3. The clinical record for Resident #D was reviewed on 5/21/14 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, right hemiplegia, and traumatic brain injury with agitation.</p> <p>A significant change MDS, dated 4/1/14, indicated the resident was moderately cognitively impaired. The MDS indicated the resident was at risk for pressure ulcer development and required the assistance of the staff for bed mobility, transfers, and toileting.</p> <p>The clinical record indicated the resident had had a decline in overall condition and had been placed on hospice services on 3/27/14.</p>			

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	<p>A skin assessment sheet, dated 4/15/14, indicated a new pressure area had been found on the resident's coccyx. The area was identified as a stage 2 and measured 6 cm by 4 cm. The assessment indicated the current treatment was "periguard prn [as needed]"</p> <p>A physician's order, dated 4/15/14, indicated "Periguard prn for soilage to keep open area clean". This order was transcribed to the April 2014 TAR as "Periguard prn to keep open area clean". The location of the open area was not documented. The April TAR lacked any initials and/or information related to this order having ever been completed. It was blank in all areas.</p> <p>A skin assessment sheet, dated 4/18/14, indicated the pressure area on the resident's coccyx was a stage 2 and measured 6.2 cm by 4 cm. The assessment indicated "current treatment orders".</p> <p>A physician's order, dated 4/21/14 at 1:30 p.m., indicated a new order had been received for the staff to apply Duoderm to the resident's coccyx and change every 3 days and prn for soilage and/or displacement.</p>			

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	<p>The clinical record indicated the coccyx wound for Resident #D continued to be monitored weekly and a treatment done as ordered. The coccyx wound measured 5.2 cm by 3.5 cm on the 5/16/14 skin assessment record. No stage of the wound was documented.</p> <p>The Administrator and DoN were interviewed on 5/22/14 at 1 p.m. Additional information was requested related to the lack of documentation of the prn periguard treatment having been done to the resident's open area from 4/15/15 through 4/21/14. The DoN indicated a prn treatment should not have been taken for an stage 2 open area and she would review further.</p> <p>The facility failed to provide any additional information as of exit on 5/23/14.</p> <p>4. Review of current, but undated, facility policy titled "Skin Condition Monitoring", provided by the Administrator on 5/22/14 at 9:10 a.m., included, but was not limited to, the following:</p> <p>"Policy: Residents with skin lesions/wounds will be monitored and documented.</p>			

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	<p>...Procedure:</p> <p>1) When the Charge Nurse is aware of skin lesions, wounds, venous ulcers, or other skin abnormalities, the area is to be assessed and documented...</p> <p>...3) Initiate treatment per Physician's Order which is to include:</p> <p>a) type of treatment b) how often to be done c) how to be cleansed, if appropriate d) site of application</p> <p>PRN alone is not an acceptable treatment order. All treatments must have a specific frequency ...</p> <p>4) documentation of skin conditions must occur upon identification and at least once a week. Assessment must include:</p> <p>a) characteristics (i.e. [for example] size, shape, depth, color, presence of granulation tissue, necrotic tissue) b) treatment and response to treatment c) prevention techniques..."</p> <p>This federal tag relates to Complaint IN00149013.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F000514 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 record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 3 of 4 residents (Resident #'s B, C, and D) reviewed for clinical record documentation of physician contact, wound care orders and treatments, and wound assessments in a sample of 4.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #C was reviewed on 5/21/14 at 10:20 a.m. Diagnoses for the resident included, but were not limited to, Post motor vehicle accident with brain injury, right sided weakness, encephalopathy, and diabetes</p>	F000514	<p>F-514 1.) DON immediately in-serviced all licensed nursing staff on wounds, measuring, staging, identifying and documentation, including re-admissions and new admissions and obtaining treatment orders, notifying physician and family. Implemented skin assessment flow sheet, reviewed policy, procedure on skin monitoring, and the completion of the skin assessment flow sheet (staging and description). See Exhibit "A" . DON immediately completed head to toe skin assessment on resident's #B, #C, and #D, and all other residents with skin issues to ensure proper treatment orders were in place. All treatment orders must have specific frequency; type of</p>	06/09/2014
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	<p>mellitus, type 2.</p> <p>A nursing note entry, dated 3/6/14 at 8 a.m., indicated "Resident has a small area on coccyx between buttocks. Measures 1.5 cm [centimeters] by 0.25 cm. Notified MD [Medical Doctor] - new order received and family notified of new order."</p> <p>A physician's order, dated 3/6/14, indicated the staff were to wash the area on the coccyx with soap and water, then pat it dry and apply Elasto-gel dressing (a healing/protective wound covering) and secure with Tegaderm (a dressing that covers and helps secure the Elasto-gel dressing in place). The order indicated the treatment was to be changed every three days and as needed for soilage.</p> <p>The Treatment Administration Records (TAR) for March 2014 indicated the treatment was completed as ordered.</p> <p>The April 2014 TAR indicated the treatment was completed on 4/1/14. The order was then marked as discontinued on 4/5/14. A handwritten entry on the April 2014 TAR, initiated on 4/5/14, indicated the staff were to "monitor area just below coccyx for changes every shift." The area for documentation of the "monitoring" was initialed by nursing</p>		<p>treatment, how often to be done, how to be cleansed, if appropriate and site of application. Resident "C" scheduled immediately to wound clinic and placed on pressure reducing air mattress. Resident "C" continues weekly visit to wound clinic.</p> <p>HFA immediately in-serviced LPN-MDS Coordinator on reviewing all new orders and updating care plan's daily to ensure an individualized comprehensive health care plan is developed in regards to pressure ulcer treatment and healing, including measurable objectives, to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>2.) Any resident has the potential to be affected.</p> <p>3.) A weekly skin assessment including staging, measuring, identifying and documenting will be completed by DON or designee on all residents to ensure all skin issues are identified and acceptable treatment obtained from MD. Orders will be obtained and followed to promote wound healing including treatments, vitamins, and nutritional supplements. MD will be notified of any non-healing skin issues to assess need for change of treatment. Wound Center will be</p>	

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	<p>staff from 4/5/14 thru 4/12/14. The TAR lacked any treatment for the area having been completed from during the 4/5/14 thru 4/12/14 time period.</p> <p>The clinical record lacked any physician's order for the discontinuation of the treatment to the coccyx on 4/5/14 or any explanation of why a treatment had not been completed on 4/4/14. The clinical record lacked any order for the "monitoring" of the wound initiated after the treatment was discontinued on 4/5/14.</p> <p>Skin assessment sheets documented wound information on the following dates:</p> <p>3/27/14 - the area below the coccyx measured "1.3 cm by 0.2 cm". No staging or other information provided.</p> <p>4/3/14 - "open area to coccyx, treatment continues" (no measurements, staging, or other information provided)</p> <p>A physician's order, dated 4/12/14, indicated a new order had been received for Resident #C's pressure area. The order indicated the staff were to cleanse the area between the buttocks (below coccyx), dry the area, and apply Duoderm 4 by 4 control gel dressing to be changed every 3 days and as needed for soilage.</p>		<p>utilized for all non-healing wounds as ordered by MD. Orders will be obtained timely to DC treatments only when skin issues are resolved as verified by skin assessment. DON went to Wound Clinic with resident "C" and had extensive training with wound center physician and nurse on staging and measuring of wounds. DON will continue to accompany resident "C" to Wound Clinic appointments.</p> <p>4.) DON or Designee will monitor shower sheets/skin assessments daily for 60 days, then weekly X 2 months, then monthly X 2 months to ensure compliance. The DON will report to the QA Committee each quarter regarding the citation and the facility will follow any recommendations made by the QA Committee.</p> <p>5.) Date Completed: 06/09/2014</p>				

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	<p>The clinical record lacked any order to discontinue this Duoderm treatment. The May 2014 TAR had not been updated to include the Duoderm order. The May 2014 TAR indicated the staff were doing an Elastagel treatment to the area.</p> <p>The wound continued to be monitored weekly in May 2014. The clinical record lacked consistent measurements during the monitoring process.</p> <p>The DoN was interviewed on 5/21/14 at 4:15 p.m. Additional information was requested related to lack of clinical record documentation as noted above.</p> <p>The facility failed to provide any additional information as of exit on 5/23/14.</p> <p>2. The clinical record for Resident #B was reviewed on 5/21/14 at 11:45 p.m. Diagnoses for the resident included, but were not limited to, Bipolar disorder, severe psychosis, and hypertension.</p> <p>The clinical record indicated the resident returned to the facility from the hospital following treatment for a urinary tract infection on 5/9/14. A skin assessment completed upon readmission, dated 5/9/14, indicated the resident had the</p>			

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	<p>following pressure areas.</p> <p>Red area to coccyx 1.5 cm by 1 cm - stage 2 Left heel - 2 cm by 2 cm blister</p> <p>The skin assessment, dated 5/9/14, indicated "MD aware. No treatment orders."</p> <p>A physician's order, dated 5/12/14, indicated a new order had been received for the areas on the resident's heels. The staff were to "apply skin prep to bilateral heels every shift" and "float heels when in bed".</p> <p>The nursing notes lacked any information related to the physician having been called related to this order or why no order was obtained for the pressure area on the resident's coccyx. The May TAR indicated the treatment to the resident's heels was done as ordered. No treatment was documented for the coccyx wound prior to a new order obtained on 5/22/14.</p> <p>A skin assessment sheet, dated 5/15/14, indicated the resident continued to have areas on her coccyx and heels. The areas were not measured or staged in order to determine healing status. The area on the coccyx was identified only as a "red area".</p>			

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	<p>During an interview with the Administrator and DoN on 5/21/14 at 3:05 p.m., additional information was requested related to the lack of wound measurements and staging for the resident's wounds. Information was also requested related to the lack of nursing note documentation of the physician contact on 5/12/14 and whether any request had been made for a treatment to the resident's coccyx.</p> <p>The facility failed to provide any additional information related to the above requests as of exit on 5/23/14.</p> <p>3. The clinical record for Resident #D was reviewed on 5/21/14 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, right hemiplegia, and traumatic brain injury with agitation.</p> <p>A skin assessment sheet, dated 4/15/14, indicated a new pressure area had been found on the resident's coccyx. The area was identified as a stage 2 and measured 6 cm by 4 cm. The assessment indicated the current treatment was "periguard prn [as needed]".</p> <p>A physician's order, dated 4/15/14, indicated "Periguard prn for soilage to</p>						

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	<p>keep open area clean". This order was transcribed to the April 2014 TAR (Treatment administration record) as "Periguard prn to keep open area clean". The location of the open area was not documented. The April TAR lacked any initials and/or information related to this order having ever been completed. It was blank in all areas.</p> <p>The Administrator and DoN were interviewed on 5/22/14 at 1 p.m. Additional information was requested related to the lack of documentation of the prn perigaurd treatment having been done to the resident's open area from 4/15/15 through 4/21/14. The DoN indicated a prn treatment should not have been taken for an stage 2 open area and she would review further.</p> <p>The facility failed to provide any additional information as of exit on 5/23/14.</p> <p>4. Review of current, but undated, facility policy titled "Skin Condition Monitoring", provided by the Administrator on 5/22/14 at 9:10 a.m., included, but was not limited to, the following:</p> <p>"Policy: Residents with skin lesions/wounds will</p>			

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	<p>be monitored and documented.</p> <p>...Procedure:</p> <p>1) When the Charge Nurse is aware of skin lesions, wounds, venous ulcers, or other skin abnormalities, the area is to be assessed and documented...</p> <p>...3) Initiate treatment per Physician's Order which is to include:</p> <p>a) type of treatment b) how often to be done c) how to be cleansed, if appropriate d) site of application</p> <p>PRN alone is not an acceptable treatment order. All treatments must have a specific frequency ...</p> <p>4) documentation of skin conditions must occur upon identification and at least once a week. Assessment must include:</p> <p>a) characteristics (i.e. [for example] size, shape, depth, color, presence of granulation tissue, necrotic tissue) b) treatment and response to treatment c) prevention techniques..."</p> <p>This federal tag relates to Complaint IN00149013.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/23/2014
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	3.1-50(a)(1) 3.1-50(a)(2)				