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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155245 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/03/2014 |
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| F000000            | <p>This visit was for the Investigation of Complaints IN00141429, IN00141689, IN00141749.</p> <p>Complaints:<br/>IN00141429 Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00141689 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F328.</p> <p>IN00141749 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282 and F328.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates:<br/>December 30, 2013 and Janauray 2 &amp; 3, 2014</p> <p>Facility Number: 000149<br/>Provider Number: 155245<br/>AIM Number: 100266840</p> <p>Survey Team:<br/>Mary Jane G. Fischer RN</p> <p>Census Bed Type:</p> | F000000       | Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center. |                      |

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>SNF: 6<br/>SNF/NF: 40<br/>Total: 46</p> <p>Census Payor Type:<br/>Medicare: 3<br/>Medicaid: 38<br/>Other: 5<br/>Total: 46</p> <p>Sample: 6</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on January 8, 2014.</p> |               |   |                      |

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| F000157<br>SS=D  | <p>483.10(b)(11)<br/>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br/>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 record review and interview the facility failed to ensure the resident's physician was notified, in that when a resident had a change in consistency of bowel</p> | F000157   | I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident no longer resides in facility. | 02/02/2014  |  |   |  |

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|  | <p>movements which resulted in the excoriation of the skin adjacent to an ileostomy, the nursing staff failed to immediately notify the resident's physician for possible intervention for 1 of 2 resident's reviewed for ostomy care/physician notification in a sample of 6. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 12-30-13 at 11:00 a.m. Diagnoses included, but were not limited to, quadriplegia, renal failure, dysphasia, short bowel syndrome, muscle weakness and the resident had an ileostomy. These diagnoses remained current at the time of the record review.</p> <p>A review of the hospital Discharge Summary Notes, dated 11-27-13 indicated the resident had "short gut syndrome with chronic protein malnutrition" and physician orders for Lomotil 3 tabs four times a day as needed for diarrhea."</p> <p>A review of the "Admission Nursing Assessment," dated 11-27-13 indicated the resident site/skin surrounding the stoma of the ileostomy was without excoriation.</p> |   | <p>II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident experiencing a change in condition has the potential to be affected by the alleged finding. A 100% chart audit was completed to ensure MD had been notified of any condition changes in the past 30 days. MD was notified of any</p> |   |  |   |  |

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|  | <p>The resident's plan of care, dated 12-09-13 instructed the nursing staff to "monitor for s/s [signs and symptoms] complications and report to nurse: abdomen for s/s distention, resident complaints of pain, changes in output: color, consistency, amount. Report signs or symptoms of complications to physician."</p> <p>A review of the nurses notes indicated that on the day of admission, 11-27-13 the "Ileostomy drained 150 ml [milliliters] of stool."</p> <p>"11-29-13 Ileostomy intact output 700 - no s/s of infection at Ileostomy site."</p> <p>"12-01-13 Ileostomy draining with no difficulties."</p> <p>On 12-02-13 the resident was transported to the local area hospital and returned to the facility on 12-09-13. The Re-admission nursing assessment, dated 12-09-13, indicated the resident did not have excoriation adjacent to the ileostomy site.</p> <p>"12-11-13 at 3:40 p.m. Ileostomy patent draining loose stool. Bag changed."</p> |   | <p>unreported changes.</p> <p>III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur? Licensed nurses will be in-serviced on 1/28/14, on physician notification. DON/designee will conduct unit meetings with charge nurses daily (M-F) for six months to ensure any condition changes are reported to the physician.</p> |   |  |   |  |

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|  | <p>"12-12-13 Ileostomy non intact, ileostomy drainage bag replaced. Ileostomy drainage bag CDI (clean,dry, intact)."</p> <p>"12-14-13 at 2:00 p.m. Ileostomy patient/draining freely. Area around stoma redness noted. Barrier cream put on as a nurses measure."</p> <p>The record lacked documentation the physician had been notified of the redness around the stoma site.</p> <p>"12-15-13 2:00 p.m. Ileostomy intact patent. Draining loose stool large amount."<br/>This notation lacked documentation of the excoriation.</p> <p>On 12-15-13 at 9:00 p.m., the resident requested to be sent to the loca area hospital. The physician order indicated "resident request - indicated skin excoriation" to be transported to the local area hospital.</p> <p>"12-15-13 at 3:00 a.m. Arrived to the facility. Excoriation noted around ileostomy site. Hospital applied urostomy drainage bag at ileostomy site for better functioning. Ileostomy drainage is yellow and liquid. Excoriation noted in perineal area...</p> |   | <p>IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of daily (M-F) audits will be presented by the DON/designee to the QA Committee during Monthly QA Meetings to ensure compliance.</p> |   |  |   |  |

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|  | <p>"</p> <p>A subsequent entry also dated 12-15-13 and noted as a "late entry" at 1:00 a.m., indicated "Pt. [patient] was evaluated by hospital because of complications with ileostomy. Ileostomy changed at the hospital and a urostomy drainage bag was attach [sic] because of loose consistency of stool, excoriation around ileostomy site, excoriation noted around perineal areas excoriation noted on coccyx."</p> <p>On 12-16-13 at 4:25 p.m. The resident again requested to be transported to the local area hospital. The physician order indicated, "Send to ER for excoriation to ostomy site et c/o pain per resident's request."</p> <p>"12-16-13 4:40 p.m. [sic] Resident transported to hospital per resident's request et [and] orders received. Resident with excoriation et redness at ostomy site. When changing ostomy bag resident c/o [complained of] pain et burning. Area very reddened et moist."</p> <p>"12-16-13 at 11:45 p.m. Resident arrived back at facility. Ostomy changed and orders for nystatin</p> |   |   |   |  |   |  |

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|  | <p>powder two times daily. Resident was given pain medication at ER [emergency room] 2 Norco [a narcotic analgesic] and 1 - 6 mg [milligrams] morphine [a narcotic pain medication] injection."</p> <p>"12-20-13 at 3:20 a.m. Changed ileostomy times 2 due to leakage."</p> <p>The record indicated the resident requested to be transported to the local area hospital on 12-20-13 at 10:00 a.m. for an unrelated complaint.</p> <p>Review of the Physician Progress notes, dated 11-30-13, 12-11-13, 12-12-13, 12-17-13 and 12-19-13 lacked documentation the physician had been notified of the excoriation of the resident's skin.</p> <p>The hospital record review on 01-02-14 at 8:00 a.m., dated 11-25-13, prior to admission, indicated the resident's, ileostomy assessment "assisted with complete pouch change - thin high pouch. Placed in high output pouch to foley bag - will need to change to standard opening pouch if output thickens."</p> <p>Six days after the resident was</p> |   |   |                      |   |

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|  | <p>admitted to the facility she was transported to the local area hospital on 12-02-13. The discharge summary, dated 12-09-13 included a diagnosis of "history of chronic diarrhea on prn Lomotil [a medication to control diarrhea]. This is likely due to short-gut syndrome."</p> <p>Upon return to the facility, the resident had a physician order for Lomotil 3 tablets four times a day as needed." The record lacked documentation, the facility obtained the prescription from the facility physician and sent to the local pharmacy.</p> <p>The record lacked documentation the resident received the medication to treat the diarrhea stool or that the physician had been notified of the need for a prescription to obtain the medication.</p> <p>The resident was transported to the local area hospital once again on 12-16-13. The hospital notation titled "Physical Exam," indicated, "ostomy to RLQ [right lower quadrant] of abd. [abdomen] not attached, with surrounding erythema and warmth." In addition the ER (Emergency Room) nurses notes indicated, the resident was "from</p> |   |   |   |  |   |  |

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|                    | <p>Castleton Care, pt. [patient] with foley cath. [catheter] in place, states has been in place for a few wks. [weeks]. Stoma to right side draining yellowish colored stool. Area around stoma and on leg excoriated and red. New ostomy barrier device placed with bag. Ostomy is filling up quickly and busting, skin is red and irritated around stoma."</p> <p>The record indicated the patient was sent to the Emergency Department from ECF (extended care facility) due to ostomy leaking. "She has a large amount of skin irritation at the area that the ostomy is leaking. This most likely represents irritation rather than cellulitis given the fact that the ostomy has been leaking onto this area. We repaired the ostomy in the Emergency Department. Plan will be for her to go home with barrier cream as well as some Nystatin as it could represent early yeast infection with inflammation at this area."</p> <p>The hospital diagnoses included "altered bowel elimination due to intestinal ostomy and disorder of skin or subcutaneous tissue." The resident returned to the facility with physician orders to apply "emollient</p> |               |   |                      |

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|                    | <p>combination no. 69 [Eucerin Skin Calming] cream two times daily and Nystatin [Mycostatin powder] two times daily."</p> <p>During a subsequent admission to the local area hospital on 12-20-13, the Hospital "Physical Exam," indicated the "ostomy site without a bag and significant skin breakdown with irritation and drainage, tenderness surround the area as well - large area of erythema surrounding ostomy with powder - erythema in perineal and sacral area."</p> <p>The hospital nurses notes indicated "...large areas of excoriation below ostomy and into peri area and sacrum."</p> <p>A review of the "Treatment Record" for December 2013 indicated the resident had a physician order, dated 12-13-13 for "mastisol glue - apply to outer edge of ostomy bag to increase adhesiveness. Apply, blot dry with gauze." The treatment record indicated the nurses initials with a circle around each initial on 12-14-13, 12-15-13, 12-16-13 and 12-18-13.</p> <p>During an interview on 01-03-14 at</p> |               |   |                      |

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|                    | <p>1:00 p.m., the Director of Nurses indicated the facility was unable to purchase the "glue." The record lacked documentation the of the full extent of the excoriation of the resident's skin from fecal matter or the physician had been notified for intervention.</p> <p>During an interview on 01-02-14 at 12:30 p.m., licensed nurse # 7 indicated "When we would put the paste on [the resident] would just cry - it hurt so bad. Yes it was excoriated. We sent [resident] out a few times for that problem. One time [resident] came back with a urostomy bag on it. It seemed to get better but we didn't have very many of those bags so we went back to using the ileostomy bag. Sometimes if we couldn't get the ileostomy bag on we just put the Chux under her and it [in regard to feces] would just flow out."</p> <p>The record lacked documentation the physician had been notified of the nurses inability to secure the drainage bag to the resident or the pain the resident experienced when the nursing staff attempted to apply the device or the consistency of the fecal matter.</p> |               |   |                      |

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|  | <p>During an interview on 01-02-14 at 2:10 p.m., licensed nurse #8 indicated, "I think the nurse practitioner looked at it - I know she looked at an abdominal wound [in reference to a surgical wound] the resident had. The one time I saw it, it was an irritation. I think that was around the first part of December."</p> <p>A review of the facility policy on 01-03-14 at 10:00 a.m., titled "Change in a Resident's Condition [bold type]," and dated 10-24-2011, indicated the following:</p> <p>"Policy [bold type] The facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, residents rights, etc.)."</p> <p>"Protocol for Notification - Notification of Attending Physician [bold type] - The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a significant change in the resident's physical/emotional/mental condition; a need to alter the</p> |   |   |                      |   |

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| F000166<br>SS=D    | <p>resident's medical treatment significantly ...."</p> <p>This Federal tag relates to Complaints IN00141689 and IN00141749.</p> <p>3.1-5(a)</p> <p>483.10(f)(2)<br/>RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br/>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br/>Based on observation, record review and interview, the facility failed to ensure the resolution to grievances were made on a continuance basis, in that when family members voice concern over ongoing concerns with the lack to ensuring prompt</p> | F000166       | I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? | 02/02/2014           |

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|  | <p>incontinent care, the facility nursing staff failed to provide the needed services to aid in the resident's incontinent needs for 1 of 3 residents reviewed for incontinence in a sample of 6. [Resident "F"].</p> <p>Findings include:</p> <p>The record for Resident "F" was reviewed on 12-30-13 at 7:20 a.m. Diagnoses included, but were not limited to, multiple sclerosis, seizure disorder, overactive bladder and hypertension. The record also indicated the resident had a history of pressure ulcers. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 11-15-13, indicated the resident was total care for transfer, bed mobility, ambulation, dressing, hygiene and toileting. The resident was assessed as frequently incontinent of bowel and bladder.</p> <p>The resident's current plan of care, dated 11-21-13, indicated the resident "cannot tolerate placement on bedpan or commode related to multiple sclerosis and decreased perception to void."</p> |   | <p>Resident was immediately provided incontinence care by staff.</p> <p>II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</p> |                      |   |

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|  | <p>Approaches to this plan of care included "Report any changes in bladder status to nurse: urgency, frequency, bladder distention, low urine output, foul smelling urine or bladder distention, Check resident Q [every] 2 - 3 hours and PRN [as needed] for incontinent episodes, provide incontinent/pericare after each incontinent episode."</p> <p>The resident's clinical record contained documentation related to "care plan conferences." The following was noted.</p> <p>"02-28-13 - Care plans reviewed and updated as needed. Will continue to invite resident and family to care plan conferences."</p> <p>"05-23-13 - Family expressed concern about staff changing resident. DON [Director of Nurses] and ADON [Assistant Director of Nurses] are planning to come up with an individualized plan regarding checking and changing resident frequently accommodating her activities want and needs."</p> <p>"08-29-13 Residents' spouse commented on satisfaction with activities and meals. Spouse</p> |   | <p>Any resident filing a grievance has the potential to be affected by the alleged finding. The Social Service Director has talked with any resident filing a grievance in the past 30 days to ensure issue has been resolved. No other resident was found to be affected by the alleged finding.</p> <p>III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?The facility Administrator will in-service all Department Managers on Grievance Procedure by 1/28/14.The Social Service</p> |                      |   |

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|  | <p>expressed concerns regarding resident consistently being found wet/soiled. SSD [Social Service Director] agreeable to complete concern form and notify Administrator and DON regarding concerns. SSD to address spouse concerns with DON/Administrator and reply to spouse."</p> <p>"11-21-13 Care plans reviewed and updated."</p> <p>"11-27-13 Resident family voiced being very pleased with care."</p> <p>A review of a "concern form" dated 12-17-13 indicated "Writer and DON [Director of Nurses] met with family due to family concern with care. Family voiced concern how does staff know need of resident due to incont. [incontinent] care. DON informed family CNA [Certified Nurses Aides have "care guides" on residents daily. Family voiced understanding. Family voiced concerns are always taken care of and believes DON is doing everything possible. DON informed family will inform all staff departments heads to inform staff before resident taken off hallways after meals to check with nurse/staff to ensure incont. care completed.</p> |   | <p>Director/designee will follow-up with any resident filing a grievance 2 weeks after the grievance was filed for six months to ensure resolution put into place has resolved the issue. Any issued found to be unresolved will be reviewed by the appropriate Department Manager for further resolution.</p> <p>IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not</p> |                      |   |

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|  | <p>Family pleased and voiced understanding."</p> <p>During an interview on 01-03-14 at 9:42 a.m., the Administrator indicated he was unaware of the concern noted on the 08-29-13 Care Plan Conference Note.</p> <p>During an observation on 01-03-14 at 8:00 a.m., the resident was observed in bed. Licensed Nurse #9 was at the resident's bedside administering the resident's medication. Upon completion of the medication administration a request was made to check the resident for incontinence.</p> <p>During this observation, the resident was turned to the left side and the nurse removed the resident's incontinent brief. The resident's incontinent brief was saturated and heavy with urine from the front and up through the entire back of the brief. The resident indicated "someone changed me during the night but that was the last time."</p> <p>During an interview on 01-03-14 at 9:15 a.m., a concerned family member indicated ongoing concern/communication with the nursing staff as well as</p> |   | <p>recur, i.e., what quality assurance program will be put into place?</p> <p>Results of the Social Service Director/designee audits will be presented by the Social Service Director/designee to the QA Committee during Monthly QA Meetings to ensure compliance.</p> |                      |   |

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|  | <p>Administrative staff in regard to the resident's continuance of being observed incontinent by the concerned family member.</p> <p>"I've talked with the Director of Nurse, Administrator and the Social Worker. It's a recurrent problem and I'm at my wits end. It gets better for a little while and then it gets bad again. I can't get past it. I usually come in during the day but on New Years Day I came about 7:00 p.m. [Resident's name] was in the wheelchair and I asked the aides to take her back to her room and let her go to bed. They have to use a Hoyer lift to do it. When they got it all hooked up and started to move her from the wheelchair to the bed, the urine just flowed from the lift pad onto the floor. The Director of Nurses said they would put a plan in place and she said she wrote up the plan for the nurses and aides to follow. I don't see the aides are following it." When interviewed what the plan included the family member indicated, "They're suppose to change her when she wakes up. They should probably check before lunch, but they told me another time would be between 12:30 and 2:00 p.m. - sometime after lunch and before the day shift goes home.</p> |   |   |   |  |   |  |

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|  | <p>There is suppose to be another change between 4:00 p.m. and 5:00 p.m. - the one before dinner and then when they put her to bed. Of course they would have to check during the night because she can't tell anyone she is wet. She had a history of pressure ulcers since she's been here and I don't want that to happen again."</p> <p>During an observation on 01-03-14 at 11:45 a.m., the resident was moved from the Activity room to the Main Dining Room. Interview with CNA #11 indicated "it isn't time to change her because we usually change her every two hours and of course as needed."</p> <p>After the interview, the CNA transported the resident to her room. The CNA looked down the front of the resident's slack and indicated "she's wet, I'll have to change her before lunch." With the assistance of another CNA, the resident was transferred from the wheelchair to bed. The CNA indicated she put the "time" on the resident's brief to indicated the last time the resident was checked/changed for incontinent care. The brief had the "time" 9:50 a.m., documented on the brief. After the resident's brief was</p> |  |  |  |
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|  | <p>removed it was observed saturated with urine.</p> <p>A review of the facility policy on 01-03-14 at 10:00 a.m., and titled "Grievance Procedures [bold type], and dated 12-01-2003 indicated the following:</p> <p>"Any person who believes that he/she or any class of individuals has been subjected to discrimination prohibited by Section 504 of the Rehabilitation Act of 1973, Title VI of the Civil Right Act of 1964, the Age Discrimination Act of 1975, or any other prohibited basis may file a complaint on his/her own behalf or on behalf of another person or on behalf of persons as a class. The procedure below has been developed for this purpose."</p> <p>"All persons are free to and encouraged to use these procedures for handling problems and filing complaints. The filing of a complaint will not result in any form of adverse personnel action, retaliation or otherwise negative treatment."</p> <p>"Step 1 Any person who has a complaint concerning any matter which affects him/her, directly or indirectly, should contact the</p> |   |   |                      |   |

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|  | <p>Department Head of the facility."</p> <p>"Step 2 If the complaint is not resolved satisfactorily, the concern may be presented to the Social Worker, who serves as the center's in-house "Ombudsman." The Social Worker will try to work on behalf of the customer to resolve any problems and is always available to assist those patients who need help presenting a grievance."</p> <p>"Step 3 If the grievance is not resolved, the customer may notify the Director of Nursing, or the Administrator."</p> <p>"Step 4 If after normal business hours there is a concern that must be addressed immediately, the customer may contact the posted staff member in charge. This may be the Charge Nurse during evenings and weekends."</p> <p>In the event that concerns are not resolved satisfactorily, the customer may at any time contact the following outside agencies."</p> <p>The Agencies listed included the "Nursing Home Ombudsman - Division of Aging and Rehabilitative Services," and the "Indiana State</p> |   |   |                      |   |

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| F000282<br>SS=D  | <p>Department of Health."</p> <p>During an interview on 01-03-14 at 9:15 a.m., the concerned family member indicated he followed all the steps and talked to everyone he was suppose to inform of his concerns and now he was talking with the "State Board of Health."</p> <p>3.1-7(a)(2)</p> <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br/>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, record review and interview, the facility failed to ensure physician orders and resident's plans of care were followed in regard to ileostomy care and urinary incontinence for 2 of 6 sampled resident's. (Resident "B" and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 12-30-13 at 11:00 a.m. Diagnoses included, but were not limited to, quadriplegia, renal failure,</p> | F000282   | <p>I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident B no longer resides in facility. Resident F immediately received incontinence care.</p> | 02/02/2014           |   |

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|                    | <p>dysphasia, short bowel syndrome and muscle weakness. The record indicated the resident had an ileostomy. These diagnoses remained current at the time of the record review.</p> <p>A review of the hospital Discharge Summary Notes, dated 11-27-13 indicated the resident had "short gut syndrome with chronic protein malnutrition" and physician orders for Lomotil 3 tabs four times a day as needed for diarrhea."</p> <p>A review of the "Admission Nursing Assessment," dated 11-27-13 indicated the resident site/skin surrounding the stoma of the ileostomy was without excoriation.</p> <p>The resident's plan of care, dated 12-09-13 instructed the nursing staff to "monitor for s/s [signs and symptoms] complications and report to nurse: abdomen for s/s distention, resident complaints of pain, changes in output: color, consistency, amount. Report signs or symptoms of complications to physician."</p> <p>The record indicated the resident was transported to the local area hospital on 12-02-13 and returned to the facility on 12-09-13. The</p> |               | <p>II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All resident have the potential to be affected by the alleged finding. 100% Care Plan Audit was completed to ensure care plans reflected care provide. No other resident was found to be affected by the alleged finding.</p> |                      |

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|  | <p>Re-admission nursing assessment, dated 12-09-13, indicated the resident did not have excoriation adjacent to the ileostomy site.</p> <p>The nurses notes indicated the following observations:<br/>"12-14-13 at 2:00 p.m. Ileostomy patient/draining freely. Area around stoma redness noted. Barrier cream put on as a nurses measure."</p> <p>The record lacked documentation the physician had been notified of the redness around the stoma site. The record indicated that on 12-14-13 at 9:00 p.m., the "resident request - indicated skin excoriation," to be transported to the local area hospital."</p> <p>"12-15-13 at 3:00 a.m. Arrived to the facility. Excoriation noted around ileostomy site. Hospital applied urostomy drainage bag at ileostomy site for better functioning. Ileostomy drainage is yellow and liquid. Excoriation noted in perineal area..."</p> <p>A subsequent entry also dated 12-15-13 and noted as a "late entry" at 1:00 a.m., indicated "Pt. [patient] was evaluated by hospital because of complications with ileostomy.</p> |   | <p>III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?Nursing Staff will be in-serviced on following Care Plans on 1/28/14. DON/designee will audit 3 Care Plans and residents per week for six months to ensure care plans reflect care provided.</p> |                      |   |

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|                    | <p>Ileostomy changed at the hospital and a urostomy drainage bag was attach [sic] because of loose consistency of stool, excoriation around ileostomy site, excoriation noted around perineal areas excoriation noted on coccyx."</p> <p>"12-15-13 2:00 p.m. Ileostomy intact patent. Draining loose stool large amount."</p> <p>On 12-16-13 at 4:25 p.m. The resident again requested to be transported to the local area hospital. The physician order indicated, "Send to ER for excoriation to ostomy site et [and] c/o pain per resident's request."</p> <p>"12-16-13 4:40 p.m. [sic] Resident transported to hospital per resident's request et orders received. Resident was excoriation et redness at ostomy site. When changing ostomy bag resident c/o [complained of] pain et burning. Area very reddened et moist."</p> <p>"12-16-13 at 11:45 p.m. Resident arrived back at facility. Ostomy changed and orders for Nystatin powder two times daily. Resident was given pain medication at ER [emergency room] 2 Norco [a</p> |               | <p>IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of audits will be presented by DON/designee to QA Committee during monthly QA Committee Meeting to ensure compliance.</p> |                      |

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|  | <p>narcotic analgesic] and 1 - 6 mg [milligrams] morphine [a narcotic pain medication] injection."</p> <p>"12-20-13 at 3:20 a.m. Changed ileostomy times 2 due to leakage."</p> <p>Six days after the resident was admitted to the facility she was transported to the local area hospital on 12-02-13. The discharge summary, dated 12-09-13 included a diagnosis of "history of chronic diarrhea on prn Lomotil [a medication to control diarrhea]. This is likely due to short-gut syndrome."</p> <p>The discharge record contained a physician order for Lomotil 3 tablets four times a day as needed." The record lacked documentation, the facility obtained the prescribed medication. The record lacked documentation the resident received the medication to treat the diarrhea stool or that the physician had been notified of the need for a written prescription to obtain the medication.</p> <p>The resident was transported to the local area hospital on 12-16-13. The hospital notation "Physical Exam," indicated "ostomy to RLQ [right lower quadrant] of abd. [abdomen]</p> |   |   |                      |   |

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|  | <p>not attached, with surrounding erythema and warmth," and further indicated "ostomy site without a bag and significant skin breakdown with irritation and drainage, tenderness surround the area as well - large area of erythema surrounding ostomy with powder - erythema in perineal and sacral area."</p> <p>The ER (Emergency Room) nurses notes indicated, the resident was "from Castleton Care, pt. [patient] with foley cath. [catheter] in place, states has been in place for a few wks. [weeks]. Stoma to right side draining yellowish colored stool. Area around stoma and on leg excoriated and red. New ostomy barrier device placed with bag. Ostomy is filling up quickly and busting, skin is red and irritated around stoma."</p> <p>"The patient sent to the Emergency Department from ECF [extended care facility] due to ostomy leaking. She has a large amount of skin irritation at the area that the ostomy is leaking. This most likely represents irritation rather than cellulitis given the fact that the ostomy has been leaking onto this area. We repaired the ostomy in the Emergency Department. Plan will</p> |   |   |                      |   |

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|  | <p>be for her to go home with barrier cream as well as some Nystatin as it could represent early yeast infection with inflammation at this area."</p> <p>The resident returned to the facility with diagnoses which included "altered bowel elimination due to intestinal ostomy and disorder of skin or subcutaneous tissue." Physician orders included "apply emollient combination no. 69 [Eucerin Skin Calming] cream two times daily and Nystatin [Mycostatin powder] two times daily."</p> <p>The hospital nurses notes indicated "...large areas of excoriation below ostomy and into peri area and sacrum."</p> <p>A review of the "Treatment Record" for December 2013 indicated the resident had a physician order, dated 12-13-13 for "mastisol glue - apply to outer edge of ostomy bag to increase adhesiveness. Apply, blot dry with gauze." The treatment record indicated the nurses initials with a circle around each initial on 12-14-13, 12-15-13, 12-16-13 and 12-18-13.</p> <p>During an interview on 01-03-14 at 1:00 p.m., the Director of Nurses</p> |   |   |   |  |   |  |

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|                    | <p>indicated the facility was unable to purchase the "glue." The record lacked documentation of the full extent of the excoriation of the resident's skin from fecal matter or the physician had been notified the "glue" was unavailable.</p> <p>During an interview on 01-02-14 at 12:30 p.m., licensed nurse # 7 indicated "When we would put the paste on [the resident] would just cry - it hurt so bad. Yes it was excoriated. We sent [resident] out a few times for that problem. One time [resident] came back with a urostomy bag on it. It seemed to get better but we didn't have very many of those bags so we went back to using the ileostomy bag. Sometimes if we couldn't get the ileostomy bag on we just put the Chux under her and it [in regard to feces] would just flow out."</p> <p>During an interview on 01-02-14 at 2:10 p.m., licensed nurse #8 indicated, "I think the nurse practitioner looked at it - I know she looked at an abdominal wound [in reference to a surgical wound] the resident had. The one time I saw it, it was an irritation. I think that was around the first part of December."</p> |               |   |                      |

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|  | <p>The record lacked documentation the physician had been notified of the nurses inability to secure the drainage bag, the pain the resident experienced when the nursing staff attempted to apply the device, the medication Lomotil had not been supplied to the facility, nor the lack of availability of the adhesive.</p> <p>2. The record for Resident "F" was reviewed on 12-30-13 at 7:20 a.m. Diagnoses included, but were not limited to, multiple sclerosis, seizure disorder, overactive bladder and hypertension. The record also indicated the resident had a history of pressure ulcers. These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 11-15-13, indicated the resident was total care for transfer, bed mobility, ambulation, dressing, hygiene and toileting. The resident was assessed as frequently incontinent of bowel and bladder.</p> <p>The resident's current plan of care, dated 11-21-13, indicated the resident "cannot tolerate placement on bedpan or commode related to multiple sclerosis and decreased</p> |   |   |                      |   |

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|  | <p>perception to void."</p> <p>Approaches to this plan of care included "Report any changes in bladder status to nurse: urgency, frequency, bladder distention, low urine output, foul smelling urine or bladder distention, Check resident Q [every] 2 - 3 hours and PRN [as needed] for incontinent episodes, provide incontinent/pericare after each incontinent episode."</p> <p>The resident's clinical record contained documentation related to "care plan conferences." The following was noted.</p> <p>"02-28-13 - Care plans reviewed and updated as needed. Will continue to invite resident and family to care plan conferences."</p> <p>"05-23-13 - Family expressed concern about staff changing resident. DON [Director of Nurses] and ADON [Assistant Director of Nurses] are planning to come up with an individualized plan regarding checking and changing resident frequently accommodating her activities want and needs."</p> <p>"08-29-13 Residents' spouse commented on satisfaction with</p> |   |   |   |  |   |  |

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|  | <p>activities and meals. Spouse expressed concerns regarding resident consistently being found wet/soiled. SSD [Social Service Director] agreeable to complete concern form and notify Administrator and DON regarding concerns. SSD to address spouse concerns with DON/Administrator and reply to spouse."</p> <p>"11-21-13 Care plans reviewed and updated."</p> <p>"11-27-13 Resident family voiced being very pleased with care."</p> <p>A review of a "concern form" dated 12-17-13 indicated "Writer and DON [Director of Nurses] met with family due to family concern with care. Family voiced concern how does staff know need of resident due to incont. [incontinent] care. DON informed family CNA [Certified Nurses Aides] have "care guides" on residents daily. Family voiced understanding. Family voiced concerns are always taken care of and believes DON is doing everything possible. DON informed family will inform all staff departments heads to inform staff before resident taken off hallways after meals to check with nurse/staff</p> |   |   |                      |   |

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|                    | <p>to ensure incont. care completed Family please and voiced understanding."</p> <p>During an interview on 01-03-14 at 9:42 a.m., the Administrator indicated he was unaware of the concern noted on the 08-29-13 Care Plan Conference Note.</p> <p>During an observation on 01-03-14 at 8:00 a.m., the resident was observed in bed. Licensed Nurse #9 was at the resident's bedside administering the resident's medication. Upon completion of the medication administration a request was made to check the resident for incontinence.</p> <p>During this observation, the resident was turned to the left side and the nurse removed the resident's incontinent brief. The resident's incontinent brief was saturated and heavy with urine from the front and up through the entire back of the brief. The resident indicated "someone changed me during the night but that was the last time."</p> <p>During an interview on 01-03-14 at 9:15 a.m., a concerned family member indicated ongoing concern/communication with the</p> |               |   |                      |

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|  | <p>nursing staff as well as Administrative staff in regard to the resident's continuance of being observed incontinent by the concerned family member.</p> <p>"I've talked with the Director of Nurse, Administrator and the Social Worker. It's a recurrent problem and I'm at my wits end. It gets better for a little while and then it gets bad again. I can't get past it. I usually come in during the day but on New Years Day I came about 7:00 p.m. [Resident's name] was in the wheelchair and I asked the aides to take her back to her room and let her go to bed. They have to use a Hoyer lift to do it. When they got it all hooked up and started to move her from the wheelchair to the bed, the urine just flowed from the lift pad onto the floor. The Director of Nurses said they would put a plan in place and she said she wrote up the plan for the nurses and aides to follow. I don't see the aides are following it." When interviewed what the plan included the family member indicated, "They're suppose to change her when she wakes up. They should probably check before lunch, but they told me another time would be between 12:30 and 2:00 p.m. - sometime after lunch and</p> |  |  |  |
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|                    | <p>before the day shift goes home. There is suppose to be another change between 4:00 p.m. and 5:00 p.m. - the one before dinner and then when they put her to bed. Of course they would have to check during the night because she can't tell anyone she is wet. She had a history of pressure ulcers since she's been here and I don't want that to happen again."</p> <p>During an observation on 01-03-14 at 11:45 a.m., the resident was moved from the Activity room to the Main Dining Room. Interview with CNA #11 indicated the "it isn't time to change her because we usually change her every two hours and of course as needed."</p> <p>After the interview, the CNA transported the resident to her room. The CNA looked down the front of the resident's slack and indicated "she's wet, I'll have to change her before lunch." With the assistance of another CNA, the resident was transferred from the wheelchair to bed. The CNA indicated she put the "time" on the resident's brief to indicated the last time the resident was checked/changed for incontinent care. The brief had the "time" 9:50 a.m., documented on the</p> |               |   |                      |

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| F000328<br>SS=G  | <p>brief. After the resident's brief was removed it was observed saturated with urine.</p> <p>This Federal tag relates to Complaints IN00141689 and IN00141749.</p> <p>3.1-35(g)(2)<br/>483.25(k)<br/>TREATMENT/CARE FOR SPECIAL NEEDS<br/>The facility must ensure that residents receive proper treatment and care for the following special services:<br/>Injections;<br/>Parenteral and enteral fluids;<br/>Colostomy, ureterostomy, or ileostomy care;<br/>Tracheostomy care;<br/>Tracheal suctioning;<br/>Respiratory care;<br/>Foot care; and<br/>Prostheses.</p> <p>Based on observation, record review and interview the facility failed to ensure integrity of resident's skin, in that when resident's had ileostomy's, the nursing staff failed to ensure the resident's skin was not exposed to fecal matter which resulted in extensive excoriation to one resident's abdomen and leg. This deficient practice effected 2 of 2 resident's reviewed with ileostomy's in a sample of 6. [Resident "B" and "E"]</p> <p>Findings include:</p> | F000328   | I. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident B no longer resides in facility. Resident E immediately received ileostomy care. | 02/02/2014  |  |   |  |

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|                    | <p>1. The record for Resident "B" was reviewed on 12-30-13 at 11:00 a.m. Diagnoses included, but were not limited to, quadriplegia, renal failure, dysphasia, short bowel syndrome muscle weakness. The resident also had an abdominal surgical wound and the resident had an ileostomy. These diagnoses remained current at the time of the record review.</p> <p>A review of the hospital Discharge Summary Notes, dated 11-27-13 indicated the resident had "short gut syndrome with chronic protein malnutrition" and physician orders for Lomotil e tabs four times a day as needed for diarrhea."</p> <p>A review of the "Admission Nursing Assessment," dated 11-27-13 indicated the resident site/skin surrounding the stoma of the ileostomy was without excoriation. The notation indicated the ileostomy was "functioning." The "interim" plan of care, dated 11-27-13, indicated the resident had an ileostomy. The "goal" indicated the resident "will receive assistance to be kept clean, dry and comfortable on an ongoing basis." The "approach" to the plan of care</p> |               | <p>II. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident with an ileostomy has the potential be affected by the alleged finding. Resident E is the only resident in the facility with an ileostomy.</p> |                      |

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|                    | <p>included "check resident every 2 - 3 hours and PRN [as needed] for incontinent episodes, ileostomy care per order."</p> <p>A subsequent plan of care, dated 12-09-13 instructed the nursing staff to "monitor for s/s [signs and symptoms] complications and report to nurse: abdomen for s/s distention, resident complaints of pain, changes in output: color, consistency, amount. Report signs or symptoms of complications to physician."</p> <p>A review of the nurses notes indicated that on the day of admission, 11-27-13 the "Ileostomy drained 150 ml [milliliters] of stool."</p> <p>"11-29-13 Ileostomy intact output 700 - no s/s of infection at ileostomy site."</p> <p>"12-01-13 Ileostomy draining with no difficulties."</p> <p>The resident was transported to the local area hospital on 12-02-13 and returned to the facility on 12-09-13. The Re-admission nursing assessment, dated 12-09-13, indicated the resident did not have excoriation adjacent to the ileostomy site.</p> |               | <p>III. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur?Nursing staff will be in-serviced on ileostomy care on 1/28/14. DON/designee will observe ileostomy care 2 times weekly for six months for complete and appropriate care.</p> |                      |

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|                    | <p>"12-11-13 at 3:40 p.m. Ileostomy patent draining loose stool. Bag changed."</p> <p>"12-12-13 Ileostomy non intact, ileostomy drainage bag replaced. Ileostomy drainage bag CDI (clean,dry, intact)."</p> <p>"12-14-13 at 2:00 p.m. Ileostomy patient/draining freely. Area around stoma redness noted. Barrier cream put on as a nurses measure."</p> <p>The resident was transported to the local area hospital on 12-14-13 at 9:00 p.m., per resident "request - indication skin excoriation."</p> <p>"12-15-13 at 3:00 a.m. Arrived to the facility. Excoriation noted around ileostomy site. Hospital applied urostomy drainage bag at ileostomy site for better functioning. Ileostomy drainage is yellow and liquid. Excoriation noted in perineal area... "</p> <p>"12-15-13 2:00 p.m. Ileostomy intact patent. Draining loose stool large amount."</p> <p>A subsequent entry also dated 12-15-13 and noted as a "late entry"</p> |               | <p>IV. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of the audits will be presented by the DON/designee to the QA Committee during Monthly QA Committee Meetings to ensure compliance.</p> |                      |

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|                    | <p>at 1:00 a.m., indicated "Pt. [patient] was evaluated by hospital because of complications with ileostomy. Ileostomy changed at the hospital and a urostomy drainage bag was attach because of loose consistency of stool, excoriation around ileostomy site, excoriation noted around perineal areas excoriation noted on coccyx."</p> <p>The resident had a physician order dated 12-16-13 to "Send to ER for excoriation to ostomy site et c/o pain per resident's request."</p> <p>"12-16-13 4:40 p.m. Resident transported to hospital per resident's request et [and] orders received. Resident with excoriation et redness at ostomy site. When changing ostomy bag resident c/o [complained of] pain et burning. Area very reddened et moist."</p> <p>"12-16-13 at 11:45 p.m. Resident arrived back at facility. Ostomy changed and orders for Nystatin powder two times daily. Resident was given pain medication at ER [emergency room] 2 Norco [a narcotic analgesic] and 1 - 6 mg [milligrams] morphine [a narcotic pain medication] injection."</p> |               |   |                      |

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|                    | <p>"12-20-13 at 3:20 a.m. Changed ileostomy times 2 due to leakage."</p> <p>The record indicated the resident requested to be transported to the local area hospital on 12-20-13 at 10:00 a.m.</p> <p>A review of the Physician Progress notes, dated 11-30-13, 12-11-13, 12-12-13, 12-17-13 and 12-19-13 lacked documentation the physician had been notified of the excoriation of the resident's skin.</p> <p>The hospital record review on 01-02-14 at 8:00 a.m., dated 11-25-13, indicated the resident's, ileostomy assessment "assisted with complete pouch change - thin high pouch. Placed in high output pouch to Foley bag - will need to change to standard opening pouch if output thickens."</p> <p>The resident was again transported to the local area hospital on 12-02-13. The discharge summary, dated 12-09-13 included a diagnosis of "history of chronic diarrhea on prn Lomotil [a medication to control diarrhea]. This is likely due to short-gut syndrome."</p> <p>Upon return to the facility, the</p> |               |   |                      |

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|                    | <p>resident had a physician order for Lomotil 3 tablets four times a day as needed." The record lacked documentation, the facility obtained the prescription from the facility physician for the medication. In addition the record lacked documentation the resident received the medication to treat the diarrhea stool.</p> <p>The resident was transported to the local area hospital once again on 12-16-13. The hospital notation titled "Physical Exam," indicated, "ostomy to RLQ [right lower quadrant] of abd. [abdomen] not attached, with surrounding erythema and warmth." In addition the ER (Emergency Room) nurses notes indicated, the resident was "from Castleton Care, pt. [patient] with foley cath. [catheter] in place, states has been in place for a few wks. [weeks]. Stoma to right side draining yellowish colored stool. Area around stoma and on leg excoriated and red. New ostomy barrier device placed with bag. Ostomy is filling up quickly and busting, skin is red and irritated around stoma."</p> <p>The record indicated the patient was sent to the Emergency Department</p> |               |   |                      |

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|                    | <p>from ECF (extended care facility) due to ostomy leaking. She has a large amount of skin irritation at the area that the ostomy is leaking. This most likely represents irritation rather than cellulitis given the fact that the ostomy has been leaking onto this area. We repaired the ostomy in the Emergency Department. Plan will be for her to go home with barrier cream as well as some Nystatin as it could represent early yeast infection with inflammation at this area."</p> <p>The hospital diagnoses included "altered bowel elimination due to intestinal ostomy and disorder of skin or subcutaneous tissue." The resident returned to the facility with physician orders to apply "emollient combination no. 69 [Eucerin Skin Calming] cream two times daily and Nystatin [Mycostatin powder] two times daily."</p> <p>During a subsequent admission to the local area hospital on 12-20-13, the Hospital "Physical Exam," indicated the "ostomy site without a bag and significant skin breakdown with irritation and drainage, tenderness surround the area as well - large area of erythema surrounding ostomy with powder -</p> |               |   |                      |

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|  | <p>erythema in perineal and sacral area."</p> <p>The hospital nurses notes indicated "...large areas of excoriation below ostomy and into peri area and sacrum."</p> <p>A review of the "Treatment Record" for December 2013 indicated the resident also had a physician order, dated 12-13-13 for "mastisol glue - apply to outer edge of ostomy bag to increase adhesiveness. Apply, blot dry with gauze." The treatment record indicated the nurses initials with a circle around each initial on 12-14-13, 12-15-13, 12-16-13 and 12-18-13. The 12-19-13 nurse practitioner progress note indicated the resident had a "history of very loose stools with dark green color" but lacked an assessment or knowledge the resident had extensive excoriation from the leaking of the ostomy of fecal matter onto her skin.</p> <p>During an interview on 01-03-14 at 1:00 p.m., the Director of Nurses indicated the facility was unable to purchase the "glue." The record lacked documentation the of the full extent of the excoriation of the resident's skin from fecal matter or</p> |   |   |   |  |   |  |

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|  | <p>the physician had been notified for intervention.</p> <p>During an interview on 01-02-14 at 12:30 p.m., licensed nurse # 7 indicated "When we would put the paste on [the resident] would just cry - it hurt so bad. Yes it was excoriated. We sent [resident] out a few times for that problem. One time [resident] came back with a urostomy bag on it. It seemed to get better but we didn't have very many of those bags so we went back to using the ileostomy bag. Sometimes if we couldn't get the ileostomy bag on we just put the Chux under her and it [in regard to feces] would just flow out."</p> <p>During an interview on 01-02-14 at 2:10 p.m., licensed nurse #8 indicated, "I think the nurse practitioner looked at it - I know she looked at an abdominal wound the resident had. The one time I saw it, it was an irritation. I think that was around the first part of December."</p> <p>2. The record for Resident "E" was reviewed on 01-02-14 at 12:20 p.m. Diagnoses included, but were not limited to, history of paraplegia due to a motor vehicle accident, sepsis, congestive heart failure, chronic</p> |   |   |                      |   |

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|                    | <p>obstructive pulmonary disease, septic shock and an ileostomy. These diagnoses remained current at the time of the record review.</p> <p>A review of the nurses notes indicated episodes of the ileostomy bag leaking/busted which exposed the resident's skin to fecal matter:</p> <p>"12-07-13 at 5:40 p.m. colostomy bag was leaking so I replaced it."</p> <p>"12-08-13 at 8:00 p.m. colostomy was leaking again and had to be changed."</p> <p>"12-09-13 at 6:00 a.m. ileostomy bag busted again and changed at 11:00 p.m."</p> <p>"12-09-13 at 12:30 p.m. ileostomy was changed 3 times on noc (night) shift is intact."</p> <p>"12-17-13 at 2:55 a.m. Resident resting until ostomy bag started leaking. Changed ostomy bag and resident requested PRN [as needed] pain medication."</p> <p>"12-18-13 at 5:50 a.m. Ileostomy changed since it had busted open. Seems to be draining OK now."</p> |               |   |                      |

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|  | <p>"12-29-13 at 11:00 a.m. Colostomy bag changed d/t (due to) leakage. Patent draining loose stool."</p> <p>During an observation on 01-03-14 at 10:40 a.m., the resident was positioned in bed slightly leaning to the left side. The Director of Nurses indicated the resident was going to be transported to the local area hospital for the evaluation of a wound on his leg.</p> <p>With permission of the resident, the ileostomy site was observed. The ostomy stoma was without redness or excoriation to the surrounding skin, however the ostomy bag was full of brown stool. The area adjacent to the stoma/fecal bag dried fecal matter was observed. The dried matted extended approximately 2 inches down the mid sternal area. During this observation, the resident indicated, "It's [in reference to the dried fecal matter], from being turned and it [in regard to the drainage bag] needs to be emptied."</p> <p>3. A review of the facility policy on 01-02-14 at 1:15 p.m., titled "Colostomy Care," and dated 08-14-2008, indicated the following:</p> |   |   |                      |   |

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|  | <p>"Purpose [bold type] The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal mater. When evaluating the condition of the residents skin, note the following - breaks in the skin, excoriation, signs of infection (heat, swelling, pain, redness, purulent exudate, etc.)."</p> <p>4. A review of the facility policy on 01-03-14 at 10:00 a.m., titled "Change in a Resident's Condition [bold type]," and dated 10-24-2011, indicated the following:</p> <p>"Policy [bold type] The facility shall promptly notify the resident, his or her attending physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, residents rights, etc.)."</p> <p>"Protocol for Notification - Notification of Attending Physician [bold type] - The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a significant change in the resident's physical/emotional/mental</p> |   |   |   |  |   |  |

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|  | <p>condition; a need to alter the resident's medical treatment significantly ...."</p> <p>This Federal tag relates to Complaint IN00141689 and IN00141749.</p> <p>3.1-47(a)(3)</p> |   |   |   |  |   |  |