

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/02/2014
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NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F000000	<p>This visit was for the Investigation of Complaints IN00144648 and IN00146506.</p> <p>Complaint IN00144648-Substantiated. Federal/state deficiency related to the allegation is cited at F312.</p> <p>Complaint IN00146506-Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F312, and F314.</p> <p>Survey dates: April 1 &amp; 2, 2014</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF: 7 SNF/NF: 117 Total: 124</p> <p>Census payor type: Medicare: 11 Medicaid: 108 Other: 5</p>	F000000		
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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><b>Total: 124</b></p> <p><b>Sample: 9</b></p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 7, 2014, by Janelyn Kulik, RN.</p>			
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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review, and Interviews, the facility failed to ensure care was provided for excoriated skin areas related to ongoing assessment and treatment of excoriated areas for 1 of 3 resident's reviewed for alteration in skin integrity in the sample of 9. (Resident #F)</p> <p>Findings include:</p> <p>On 4/1/14 at 9:20 a.m., Resident #F was observed in bed. LPN #1 and LPN #2 entered the resident's room to perform a skin check. The LPN's repositioned the resident and removed her incontinence brief. The resident was incontinent of loose light brown/yellowish liquid stool. The resident had an open pressure ulcer along the crease of the coccyx. There were scattered areas of open skin to the resident's bilateral inner buttock area. Bleeding was noted to the areas. There were small open areas to the right and left upper</p>	F000309	<p><b>F309</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Treatment and incontinence care was provided to Resident #F.</b></p> <p><b>2) How the facility identified other residents:</b></p>	04/15/2014			

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	<p>posterior thigh areas. The areas were red in color with scant amount of sanguineous drainage noted. There were no dressings covering the areas.</p> <p>On 4/1/14 at 9:45 a.m., Wound Nurses #1 and #2 entered the resident's room to assess the resident. The Wound Nurses observed the above skin conditions. When interviewed at this time, Wound Nurse #2 indicated the open excoriated areas were new.</p> <p>On 4/2/14 at 7:30 a.m., LPN #3 and CNA #2 were observed in the resident's room to provide incontinence care. The resident was repositioned and her incontinence brief was removed by the CNA. There was a urine odor noted when her brief was removed. The CNA opened the brief after it was removed and the brief was wet with urine from side to side. Loose liquid stool was observed from the rectum at this time. There were scattered areas of open skin to the resident's bilateral inner buttock area. Bleeding was noted to the areas. There were small open areas to the right and left upper posterior thigh areas. The areas were red in color with scant amount of sanguineous drainage noted.</p>		<p><b>Incontinence rounds were completed and care provided as indicated to incontinent residents.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed staff and CNA's will be in-serviced regarding timely identification, reporting and treatment of skin concerns.</p> <p>Random observation rounds will be completed on at least 5 incontinent residents with skin breakdown per week at varied times/shifts to observe for incontinence care completed, dressings in place/treatments rendered as ordered, and any new skin issues observed during care.</p> <p>The Director of Nursing or designee is responsible for oversight of these rounds.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>		

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	<p>There were no dressings covering the areas.</p> <p>The record for Resident #F was reviewed on 4/1/14 at 10:24 a.m. The resident's diagnoses, included, but were not limited to, cerebral artery occlusion, congestive heart failure, high blood pressure, asthma, and acute kidney failure. The resident was hospitalized on 3/11/14 and was readmitted to the facility on 3/20/14.</p> <p>The 3/27/14 Minimum Data Set (MDS) Significant Change Assessment indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required total dependence of two staff members for bed mobility and transfers. The assessment indicated the resident was dependent on staff for personal hygiene and bathing. The assessment also indicated the resident had impairment in range of motion of both of her upper and lower extremities. The assessment also indicated the resident was frequently incontinent of urine and always incontinent of bowel.</p> <p>A Re-admission data Collection form was completed on 3/20/14. There was no documentation of any</p>				

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	<p>excoriation present on the resident's perineal, buttock or gluteal fold areas.</p> <p>Review of the Nursing Progress Notes from 3/20/14 through 3/31/14 indicated there was no documentation of the resident having any excoriation to the buttock, upper thigh, or gluteal fold areas.</p> <p>Review of the 3/29/14 Weekly Skin Observation Report indicated the resident had no open area, skin tears , rashes, burns or any other alterations in skin integrity.</p> <p>The 4/2014 Treatment Administration Record was reviewed. A Physician's order was written on 3/22/14 to cleanse the sacrum wound with wound cleanser, pat the area dry, apply Aquacel AG bandage and cover with a dry dressing every five days and prn (as needed).</p> <p>An Initial Non-Pressure Skin Report was completed by a Wound Nurse on 4/1/14 at 10:05 a.m. The report indicated the resident had scattered excoriated areas to the right and left gluteal fold areas. The areas were 100% red/pink with a scant amount of sanguineous drainage. The report also indicated scattered excoriation was noted to the right and left</p>			
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	<p>posterior upper thigh areas. A scant amount of sanguineous drainage was noted to the areas. There were no measurements recorded for the any of the above areas.</p> <p>When interviewed on 4/2/14 at 7:50 a.m., LPN #3 indicated she worked the midnight shifts the past two nights and was assigned to care for Resident #F. The LPN indicated on the midnight shift from 3/31/14 at 11:00 p.m. through 4/1/14 at 7:00 a.m., the resident had "some excoriation" to the above areas. The LPN indicated the areas were "pink" then and did not look like they did today. LPN #3 indicated the areas were not bleeding then. The LPN indicated on last nights shift (4/1/14 -4/2/14) the CNA reported the resident had loose stools and she put some Calmoseptine cream into a small medicine cup and gave it to the CNA to apply. The LPN indicted she did not provide treatment to the areas.</p> <p>When interviewed on 4/2/14 at 10:15 a.m. Wound Nurse #2 indicated she was first made aware of the resident's excoriated areas when she observed them yesterday morning. The Wound Nurse indicated she had completed treatments to the</p>			
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	<p>resident's coccyx pressure ulcer in the last couple days and she did not observe any excoriation to the areas. The Wound Nurse indicated the staff Nurse should have reported the excoriated to one of the Wound Nurses when it was first observed on 3/31/14. Wound Nurse #2 indicated an Initial Skin Report with an assessment of the areas should have been completed at the time the excoriated area was first observed. The Wound Nurse indicated no Skin Reports were completed related to the resident's excoriations prior to the 4/1/14 report.</p> <p>This Federal tag relates to Complaint IN00146506.</p> <p>3.1-37(a)</p>				

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure resident's who were incontinent and dependent on staff for ADL (Activities of Daily Living) care were repositioned in bed and provided incontinence care in a timely manner for 2 of 3 residents who were reviewed for ADL (Activities of Daily Living) assistance in the sample of 9. (Residents #B &amp; #F)</p> <p>Findings include:</p> <p>1. On 4/2/14 at 4:22 a.m., LPN #3 and CNA #2 entered Resident #B's room. The staff members repositioned resident on her left side. The resident's incontinence brief was not removed or changed at this time.</p> <p>Continuous observations of the resident indicated no staff members were observed repositioning the resident or providing incontinence care for the resident between 4:22 a.m. and 7:15 a.m.</p>	F000312	<p><b>F312</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Incontinence care and repositioning was provided for Resident #B and Resident #F.</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>Incontinence rounds were</b></p>	04/15/2014			

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	<p>On 4/2/14 at 6:55 a.m., LPN #3 entered the resident's room. The resident was in bed and was positioned on her left side. The resident had gastrostomy (tube inserted into the stomach to provide feeding) tube in place. The LPN changed the dressing over the gastrostomy tube site and then flushed the gastrostomy tube with water. The resident was not repositioned at this time.</p> <p>On 4/2/14 at 7:15 a.m. the Day Supervisor and another staff member entered the resident's room. The staff members repositioned the resident from her left side to her back. No incontinence care was provided at this time.</p> <p>The record for Resident #B was reviewed on 4/1/14 at 12:15 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, failure to thrive. protein calorie malnutrition, and altered mental status.</p> <p>The 1/13/14 MDS (Minimum Data Set) Quarterly Assessment indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance of staff for bed</p>		<p><b>completed and care provided as indicated to incontinent residents.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed staff and CNA's will be in-serviced regarding timely identification, reporting and treatment of skin concerns.</p> <p>Random observation rounds will be completed on at least 5 incontinent residents with skin breakdown per week at varied times/shifts to observe for incontinence care completed, dressings in place/treatments rendered as ordered, and any new skin issues observed during care.</p> <p>The Director of Nursing or designee is responsible for oversight of these rounds.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>				

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	<p>mobility and transfers. The assessment indicated the resident was totally dependent on staff for bathing and personal hygiene. The assessment indicated the resident was frequently incontinent of bowel and always incontinent of urine.</p> <p>A 3/24/14 Pressure Ulcer Report indicated a Stage III pressure ulcer to the resident's coccyx had healed.</p> <p>A Braden Scale for predicting pressure ulcer risk was completed on 1/11/14. The resident's score was (14). This score indicated the resident was at moderate risk for the development of pressure ulcers.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 1/7/14 indicate the resident was incontinent of bowel and bladder. Care plan interventions included to provide incontinence care after each incontinence episode and to complete weekly skin assessment. Another care plan initiated on 1/7/14 indicated the resident had the potential for pressure ulcer development.</p> <p>When interviewed on 4/2/14 at 7:05 a.m., CNA #2 indicated she was assigned to care for the resident on</p>			

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	<p>the night shift. The CNA indicated she had last checked Resident #B for incontinence just prior to repositioning the resident with the Nurse this AM on her 4:00 a.m. rounds. The CNA indicated she did not remove the resident's brief at this time. The CNA indicated she felt the outside of the brief and it seemed dry and had no checked or provide any other care for the resident since the 4:00 a.m. rounds.</p> <p>2. On 4/2/14 at 4:05 a.m., Resident #F was observed in bed. The resident was asleep. The resident was positioned on her left side facing the door. There were no staff members in the resident's room at this time. On 4/2/14 at 4:13 a.m., LPN #3 and CNA #2 entered the resident's room and repositioned the resident's roommate. At 4:15 a.m., the LPN and the CNA repositioned Resident #F in bed. The staff turned the resident on her back and pulled her up in bed. The above staff did not remove or pull the resident's incontinence brief down at this time. LPN #3 and CNA #2 then left the resident's room and walked across the hall to another resident's room to provide care. At 4:20 a.m., the two staff members left this resident's room.</p>						

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	<p>Continuous observation between 4:20 a.m. and 6:55 a.m., no staff members were observed providing incontinence care or repositioning Resident #F. On 4/2/14 at 7:30 a.m., LPN #3 and CNA #4 were observed in the resident's room to provide incontinence care. The resident was repositioned and her incontinence brief was removed by the CNA. There was a urine odor noted when the brief was removed. The CNA opened the brief after it was removed and the brief was wet with urine from side to side. Loose liquid stool was observed from the rectum at this time. An open pressure ulcer was observed to the resident's coccyx area. There were red open bleeding areas noted to the resident's bilateral buttock area. The areas were approximately 3 cm in diameter on each buttock.</p> <p>The record for Resident #F was reviewed on 4/1/14 at 10:24 a.m. The resident's diagnoses, included, but were not limited to, cerebral artery occlusion, congestive heart failure, high blood pressure, asthma, and acute kidney failure. The resident was hospitalized on 3/11/14 and was readmitted to the facility on 3/20/14.</p>			
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	<p>The 3/27/14 Minimum Data Set (MDS) Significant Change Assessment indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required total dependence of two staff members for bed mobility and transfers. The assessment indicated the resident was dependent on staff for personal hygiene and bathing. The assessment also indicated the resident had impairment in range of motion of both of her upper and lower extremities. The assessment also indicated the resident was frequently incontinent of urine and always incontinent of bowel. The assessment also indicated the resident had two Stage II pressure ulcers.</p> <p>A Braden Scale for predicting pressure ulcer risk was completed on 3/27/14. The resident's score was (12). A score of (12) indicated the resident was at high risk for pressure ulcer development.</p> <p>When interviewed on 4/2/14 at 7:05 a.m., CNA #2 indicated she was assigned to care the resident on the night shift. The CNA indicated she "checked" the resident just before she was repositioned with the LPN</p>			
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NAME OF PROVIDER OR SUPPLIER  TIMBERVIEW HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404			
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	<p>this morning. The CNA indicated at this time she felt the outside of the resident's brief with her hand and did not remove the brief at this time. The CNA indicated prior to this time the resident was last changed and repositioned around midnight when she was incontinent of stool. The CNA indicated she had not repositioned the resident since was turned during her 4:00 a.m. rounds.</p> <p>The facility policy titled "Policy for Prevention of Pressure Ulcers" was reviewed on 4/2/14 at 1:00 p.m. There was no date on the policy. The Nurse Consultant provided the policy and identified the policy as current. The policy indicated Nursing care was to include "Turning and positing at a minimum of every 2 hours with inspection of bony prominence's" and "Incontinence care every 2 hours and as needed."</p> <p>This Federal tag relates to Complaints IN00144648 and IN00146506.</p> <p>3.1-38(a)(2)(B) 3.1-38(a)(2)(C)</p>						

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F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to provide the necessary treatment and services to promote healing of pressure ulcers related to wound dressing not in place for 1 of 3 residents reviewed for pressure ulcers in the sample of 9. (Resident #F)</p> <p>Findings include:</p> <p>On 4/1/14 at 9:20 a.m., Resident #F was observed in bed. LPN #1 and LPN #2 entered the resident's room to perform a skin check. The LPN's repositioned the resident and removed her incontinence brief. The resident was incontinent of loose light brown/yellowish liquid stool. The resident had an open pressure ulcer along the crease of the coccyx. The area was approximately 5 cm</p>	F000314	<p><b>F314</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Treatment was completed and incontinence care was provided to Resident #F.</b></p>	04/15/2014			

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	<p>(centimeters) x 1.5 cm. x .1 cm. The surrounding tissue was pink. The center of the wound was pink with some sanguineous(bloody) drainage. There was no dressing in place to the pressure ulcer. There was no dressing in the resident's brief or in her bed.</p> <p>On 4/1/14 at 9:45 a.m., Wound Nurses #1 and #2 entered the resident's room. Wound Nurse #1 measured the coccyx area at this time and stated the wound measured 8.6 cm x 1.0 cm x .1 cm. Wound Nurse #2 indicated the wound was Stage II (partial thickness tissue loss with no bone, muscle, or tendon exposed) pressure ulcer and was present when the resident was readmitted to the facility.</p> <p>On 4/2/14 at 7:30 a.m., LPN #3 and CNA #4 were observed in the resident's room to provide incontinence care. The resident was repositioned and her incontinence brief was removed by the CNA. There was a urine odor noted when he brief was removed. The CNA opened the brief after it was removed and the brief was wet with urine from side to side. Loose liquid stool was observed from the rectum at this time. There was a loose dressing</p>		<p><b>2) How the facility identified other residents:</b></p> <p>Rounds were completed on residents with pressure ulcer dressings to ensure dressings were intact.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Licensed staff and CNA's will be in-serviced regarding timely identification, reporting and treatment of skin concerns, including notifying nurse immediately if wound dressing becomes dislodged or heavily soiled.</p> <p>Random observation rounds will be completed on at least 5 incontinent residents with skin breakdown per week at varied times/shifts to observe for incontinence care completed, dressings in place/treatments rendered as ordered, and any new skin issues observed during care.</p> <p>The Director of Nursing or designee is responsible for oversight of these rounds.</p> <p><b>4) How the corrective actions will be monitored:</b></p>				

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	<p>near the resident's wound. The dressing was discolored a light tan color. The dressing was not covering the entire pressure ulcer.</p> <p>The record for Resident #F was reviewed on 4/1/14 at 10:24 a.m. The resident's diagnoses, included, but were not limited to, cerebral artery occlusion, congestive heart failure, high blood pressure, asthma, and acute kidney failure. The resident was hospitalized on 3/11/14 and was readmitted to the facility on 3/20/14.</p> <p>The 3/27/14 Minimum Data Set (MDS) Significant Change Assessment indicated the resident's cognitive skills were severely impaired. The assessment also indicated the resident required total dependence of two staff members for bed mobility and transfers. The assessment indicated the resident was dependent on staff for personal hygiene and bathing. The assessment also indicated the resident had impairment in range of motion of both of her upper and lower extremities. The assessment also indicated the resident was frequently incontinent of urine and always incontinent of bowel. The assessment also indicated the resident had two Stage II pressure</p>		<p><b>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</b></p>		

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	<p>ulcers.</p> <p>A Braden Scale for predicting pressure ulcer risk was completed on 3/27/14. The resident's score was (12). A score of (12) indicated the resident was at high risk for pressure ulcer development.</p> <p>Review of the 3/20/14 re-admission data Collection form indicated the resident had pressure ulcers to the coccyx and the left heel. The coccyx ulcer measured 1.5 cm (centimeters) x 1.5 cm. The left heel ulcer measured 2 x 3.0 cm. There was no stage listed for either of the pressure ulcers. There was no documentation of any excoriation present on the resident's perineal, buttock or gluteal fold areas.</p> <p>The 4/2014 Treatment Administration Record was reviewed. A Physician's order was written on 3/22/14 to cleanse the sacrum wound with wound cleanser, pat the area dry, apply Aquacel AG bandage and cover with a dry dressing every five days and prn (as needed.)</p> <p>An Initial Pressure Ulcer Report dated 3/21/14 indicated the resident Stage II pressure ulcers to the sacrum and the left heel. The</p>						

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	<p>sacrum wound measured 1.5 cm x 05. cm x 0.1 cm. The left heel pressure ulcer measured 2.0 cm x 3.0 cm, x 0.1 cm. The report indicated the wound bed of the sacrum ulcer was 100 % red and the surrounding tissue was intact.</p> <p>The 3/27/14 Pressure Ulcer Progress Report indicated the wound to the sacrum measured 7.5 cm x 0.4 cm x 0.1 cm. The report also indicated the wound bed was 100% red and the surrounding tissue was intact.</p> <p>The resident's care plans were reviewed. A care plan with a target goal date of 3/28/14 was reviewed. The care plan indicated the resident had pressure ulcers to the left heel and the sacrum areas. Care plan interventions included for staff to provide wound care treatments as ordered and to assess the effectiveness of the treatment. A plan with a target goal date of 3/28/14 indicated the resident was incontinent of bowel and bladder. Care plan interventions included for staff to provide incontinence care after each incontinence episode and to complete weekly skin assessments. Another care plan with a target goal date of 3/28/14 was reviewed. This care plan indicated the resident had</p>			

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	<p>the potential for the development of pressure ulcers related to immobility. Care plan interventions included to provide treatments as ordered and notify the Nurse of any new areas of skin breakdown observed during bathing or daily care.</p> <p>The resident's Laboratory test results were reviewed on 4/2/14 at 8:00 a.m. The results of a stool specimen for C-Difficile (an infection in the stool) collected on 3/31/14 were reported as Positive (indicating infection was present). The report indicated the results were called to a Nurse at the facility on 4/1/14 at 5:13 p.m.</p> <p>When interviewed on 4/1/14 at 10:00 a.m., LPN #1 indicated she had not provided care for or assessed the ulcer until she repositioned the resident at 9:20 a.m.</p> <p>When interviewed on 4/1/14 at 9:30 a.m., CNA #1 indicated she was assigned to care for the resident on the day shift. CNA #1 indicated she had not provided incontinence care for the resident yet this morning.</p> <p>When interviewed on 4/2/14 at 9:07 a.m. , the Director of Nursing indicated the resident should have had a dressing in place to the</p>			
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	<p>pressure ulcer as ordered by the Physician.</p> <p>This Federal tag relates to Complaint IN00146506.</p> <p>3.1-40(a)(2)</p>			
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