

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2016
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NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00208664.</p> <p>Complaint IN00208664 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309, and F314.</p> <p>Survey date: September 2, 2016</p> <p>Facility number: 001198 Provider number: 155367 AIM number: 100471000</p> <p>Census bed type: SNF: 18 SNF/NF: 109 Residential: 45 Total: 172</p> <p>Census payor type: Medicare: 13 Medicaid: 73 Other: 41 Total: 127</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F 0000		

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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F 0157 SS=G Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed by 32883 on 9/6/16.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as</p>				

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	<p>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 notify a resident's Physician in a timely manner, related to a change in status of a skin abrasion, for which a resident was admitted to a hospital due to infection of the area to be treated with intravenous antibiotics, for 1 of 3 residents reviewed for Physician notification in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 09/02/16 at 10 a.m. The resident's diagnoses included, but were not limited to stroke and dementia.</p> <p>A Nurses' Progress Note, dated 08/18/16 at 7:41 a.m. indicated an abrasion to the left elbow was found, cleaned and a Duoderm (hydrocolloid dressing for wounds) dressing was applied.</p> <p>A Skin Condition form, dated 08/18/16, indicated an area on the left elbow, which measured 4 centimeters (cm) by 4 cm was found by nursing and the resident's Physician was notified.</p>	F 0157	<p>1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>1. Resident #B transferred to hospital on 8/23/16, no longer resides in this facility.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>Any resident who has a change of condition could be affected.</p> <p>1.All Residents had skin checks performed to assure that no other issues are found related to a change in skin condition that had not been reported to the physician and/or the family. No other residents were found to have a skin condition that had changed where the physician/family were not notified.</p> <p>2.Nurse Managers are monitoring changes of condition in the Resident's records to determine if physician/family have been notified as necessary in a timely manner.</p> <p>3.If discrepancies are found, corrective actions are taken and the nurse(s) who did not make</p>	09/30/2016

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	<p>A Physician's Order, dated 08/18/16, indicated to apply a Duoderm dressing to the left elbow every 3 days.</p> <p>A Nurses' Progress Note, dated 08/22/16 at 3:59 p.m., a late entry for 08/21/16 (no time documented) indicated, the left elbow had a border gauze (absorbs drainage) in place and a dressing change to the left outside elbow had been completed with a duoderm dressing being placed over the left elbow area. The note indicated a normal saline flush was used to loosen the border gauze dressing and the area was open on the edges of the wound with a dark red area in the center of the wound. The note indicated, "...Area measured 9 cm x (by) 5 cm with darker red area 6 cm x 2 1/2 cm @ widest part..."</p> <p>A Wound Care Specialist Note, dated 08/23/16, indicated the resident had an unstageable necrotic pressure area on the left outer elbow, which measured 6.3 cm by 2.5 cm, with redness and induration (hardening) with the surrounding area of the wound purple/maroon colored. The left elbow had heavy serous (clear) drainage and the wound was 60% covered with necrotic tissue. Additional information on the note, indicated, "Wound debrided...considerable swelling</p>		<p>proper notification will be counseled, re-educated, and disciplined as appropriate.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Nursing staff was in serviced regarding notification of physician and families according to change of condition policy. The in-service included a test to measure staff understanding of the intent of the policy.</p> <p>b. Staff also received documentation training to assure that all nursing staff input data, accurately related to change of condition.</p> <p>c. Individual counseling and re-education of the specific nurses who failed to notify the physician and family of the change in Resident #B's skin condition.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.</p> <p>1. The DON/nurse managers/RCN will review daily report from PCC to assure compliance with notification of family and physician related to changes in skin conditions and</p>	

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	<p>and watery discharge, large amount necrotic tissue debrided but concerned with extent of induration and infection. Feel wisest to admit to hospital..."</p> <p>An Emergency Room History and Physical, dated 08/23/16, indicated the resident had an odorous and draining wound to the left elbow, with purulent (contains pus) drainage, surrounded by redness and swelling to the left elbow and forearm. The differential diagnoses were pressure ulceration of left elbow, cellulitis of the left elbow, and sepsis, and the resident was ordered intravenous (IV) antibiotics.</p> <p>A Hospital Admission History and Physical, dated 08/25/16, indicated, "...A local doctor tried to do debridement but could not...examined by the ER (Emergency Room) physician, and he agreed that she has a pretty badly infected wound on the left elbow that needs debridement and IV antibiotics...Final Impression: 1. Decubitus ulcer, quite large, stage 3 (full thickness skin loss involving damage or necrosis of subcutaneous tissue), infected, left elbow. Needs debridement and intravenous antibiotics..."</p> <p>During an interview on 09/02/16 at 2:10 p.m., the Unit Manager indicated when</p>		<p>other significant conditions according to policy.</p> <p>2.Audits to be conducted daily for one month, then weekly for 1 month, every other week for one month and then monthly for 3 months for a total of six months.</p> <p>3.Reports of the audits will be reported to the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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	<p>she observed the area on 08/22/16 (Monday), there were two areas on the left elbow which were red and swollen with drainage and she immediately notified the Physician.</p> <p>The Unit Manager continued to indicate an investigation was started on 08/22/16 because of the change in condition of the left elbow. She indicated the area on the left elbow was found on 08/18/16 (Thursday) and was classified as an abrasion, the Nurse Practitioner was notified and an order for a Duoderm dressing was received. The Unit Manager indicated on 08/19/16 (Friday), LPN #1 removed the Duoderm dressing and applied a border gauze dressing and indicated the left elbow was open and draining. The Unit Manager indicated LPN #1 had not notified the Physician in the change of condition of the area. The Unit Manager indicated on 08/21/16 (Sunday), RN #2 replaced the border gauze with a Duoderm dressing.</p> <p>The investigation, dated 08/29/16, indicated on 08/21/16 at 2:55 p.m., RN #2 completed a dressing change to the left elbow and used normal saline to remove the border gauze dressing. The area was draining, red and swollen, and one area measured 9 cm by 5 cm and the second area measured 6.5 cm by 2 cm.</p>			

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	<p>RN #2 left the wound open to air until it dried then re-applied a Duoderm dressing. The Unit Manager indicated the Physician had not been notified of the change in condition.</p> <p>A statement, dated 09/01/16, indicated a review of the events from 08/18/16 and 08/19/16 with LPN #1 had occurred. LPN #1's statement indicated on 08/18/16 she observed an unopened abrasion on the left elbow, notified the Physician and a Duoderm dressing was ordered. LPN #1 indicated on 08/19/16 the Duoderm had come off the left elbow and the area was "crusty, red and had started to bleed" LPN #1 indicated she cleaned the area and applied bacitracin and border gauze. LPN #1 indicated she did not remember if she called the Physician.</p> <p>During an interview on 09/02/16 at 3:20 p.m., LPN #1 indicated she did not remember if the Physician had been notified of the change in condition of the left elbow on 08/19/16. LPN #1 indicated the facility policy was to notify the Physician with a change in condition.</p> <p>A facility policy, dated 12/07/11, titled, "Change of Condition", received from the Director of Nursing as current, indicated, "...The physician/responsible party will be notified when: a. The change is</p>			

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	<p>sudden in onset, OR b. Represents a marked changed (sic) in relation to usual signs and symptoms...Symptoms of an infectious process...need to significantly alter the resident's treatment...The nurse will document in the clinical record. Documentation and assessment will be ongoing until condition has stabilized..."</p> <p>This Federal tag relates to Complaint IN00208664.</p> <p>3.1-5(a)(2)</p>			

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F 0309 SS=D Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide necessary care and services to a resident related to applying a treatment to a skin condition without a Physician's Order, for 1 of 3 residents reviewed for skin conditions in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 09/02/16 at 10 a.m. The resident's diagnoses included, but were not limited to stroke and dementia.</p> <p>A Nurses' Progress Note, dated 08/18/16 at 7:41 a.m. indicated an abrasion to the left elbow was found, cleaned and a Duoderm (hydrocolloid dressing for wounds) dressing was applied.</p> <p>A Physician's Order, dated 08/18/16, indicated to apply a Duoderm dressing to</p>	F 0309	<p>1.What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #B nursing staffs were re-educated to ensure that the proper procedure for assuring change of condition policy is followed.</p> <p>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>All residents skin checked to assure that documentation of skin conditions is accurate. Any changes had physician notification and new orders followed according to policy as well as accurate documentation. Skin check completed 8/29-8/30/16.</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure</p>	09/30/2016

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	<p>the left elbow every 3 days.</p> <p>A Nurses' Progress Note, dated 08/22/16 at 3:59 p.m., a late entry for 08/21/16 (no time documented) indicated, the left elbow had a border gauze (absorbs drainage) in place and a dressing change to the left outside elbow had been completed and a Duoderm was placed over the left elbow area.</p> <p>During an interview on 09/02/16 at 2:10 p.m., the Unit Manager indicated an investigation was started on 08/22/16 because of the change in condition of the left elbow. She indicated the area on he left elbow was found on 08/18/16 (Thursday) and was classified as an abrasion, the Nurse Practitioner was notified and an order for a Duoderm dressing was received. The Unit Manager indicated on 08/19/16 (Friday), LPN #1 removed the Duoderm dressing and applied a border gauze dressing. The Unit Manager indicated LPN #1 had not notified the Physician in the change of condition of the area. The Unit Manager indicated there was not a Physician's Order for the bacitracin and border gauze treatment.</p> <p>A statement, dated 09/01/16, indicated a review of the events from 08/18/16 and 08/19/16 with LPN #1 had occurred.</p>		<p>that the deficient practice does not recur.</p> <p>Nursing staff re-education began 8/22/16. Change of condition policy reviewed related to physician and family notification immediately for any new or changes in skin condition as well as proper, accurate documentation of the skin condition.</p> <p>DON/ designee will complete mandatory in servicing for all nurses related to following change of condition policy.</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>The DON/nurse manager/RCN will audit 2 residents with skin conditions per day per unit 5 times weekly for 4 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, and 1 time weekly for an additional 8 weeks to determine that the physician orders are followed and documented appropriately, including proper notification. Audits will be reported to the Quality Assurance meeting monthly. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until</p>	

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	<p>LPN #1's statement indicated on 08/18/16 she observed an unopened abrasion on the left elbow, notified the Physician and a Duoderm dressing was ordered. LPN #1 indicated on 08/19/16 the Duoderm had come off the left elbow and the area was "crusty, red and had started to bleed" LPN #1 indicated she cleaned the area and applied bacitracin and border gauze. LPN #1 indicated she did not remember if she called the Physician.</p> <p>During an interview on 09/02/16 at 3:20 p.m., LPN #1 indicated she did not remember if the Physician had been notified for a new order to treat the left elbow with bacitracin and border gauze on 08/19/16.</p> <p>This Federal tag relates to Complaint IN00208664.</p> <p>3.1-37(a)</p>		corrections are effective.				

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F 0314 SS=G Bldg. 00	<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 record review and interview, the facility failed to ensure a resident received necessary treatment and services to promote healing of pressure sores and prevention of infections, related to a treatment without a Physician's order of a pressure area, a Physician not notified in a timely manner of a change in condition, and continued assessment of the change in condition of the pressure sore, for which the resident was admitted to the hospital with an infection requiring intravenous (IV) antibiotics and debridement of the pressure area, for 1 of</p>	F 0314	<p>1.What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1.Resident #B was hospitalized at the time of this complaint survey.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p>	09/30/2016

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	<p>3 residents reviewed for pressure areas in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 09/02/16 at 10 a.m. The resident's diagnoses included, but were not limited to stroke and dementia.</p> <p>A Nurses' Progress Note, dated 08/18/16 at 7:41 a.m. indicated an abrasion to the left elbow was found, cleaned and a Duoderm (hydrocolloid dressing for wounds) dressing was applied.</p> <p>A Skin Condition form, dated 08/18/16, indicated an area on the left elbow, which measured 4 centimeters (cm) by 4 cm was found by nursing and the resident's Physician was notified.</p> <p>A Physician's Order, dated 08/18/16, indicated to apply a Duoderm dressing to the left elbow every 3 days.</p> <p>There were no assessments of the left elbow area in the Nurses' Progress Notes on 08/19/16.</p> <p>The Daily Skilled Note, dated 08/19/16 at 10:11 p.m., indicated the resident had no skin conditions.</p>		<p>2. All residents who are at risk for any skin condition have the potential to be affected by the same practice.</p> <p>.Facility wide skin assessment and braden scale update completed of all current residents 1.8/29-8/30/16</p> <p>3.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>1.In-service Nursing Staff on the following: Perform thorough head to toe assessment on notification of any change of condition related to skin issues; obtain appropriate order to treat any skin conditions identified during assessment; document accurately the presence of any skin condition, physician and family notification of skin condition and/or changes in skin condition; complete treatments as ordered. If no improvement in skin condition within 2-3 weeks, notify physician and consider alternative treatment option.</p> <p>Nurse managers/designee will audit 24 hour report and discuss at Morning meeting Monday through Friday. On weekends this audit will be performed by Weekend Manger.</p> <p>The nurses will observe every dressing related to skin condition to ensure that it is clean, dry and</p>	

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	<p>There were no assessments of the left elbow area in the Nurses' Progress Notes on 08/20/16.</p> <p>The Daily Skilled Note, dated 08/20/16 at 10:02 a.m., indicated the resident had a left elbow dressing, the note was signed and dated 08/23/16. There was no assessment of the area.</p> <p>The Daily Skilled Note, dated and signed 08/21/16 at 3:46 p.m., indicated the resident had a left elbow dressing. There was no assessment of the area.</p> <p>A Nurses' Progress Note, dated 08/22/16 at 3:59 p.m., a late entry for 08/21/16 (no time documented) indicated, the left elbow had a border gauze (absorbs drainage) in place and a dressing change to the left outside elbow had been completed with a Duoderm dressing being placed over the left elbow area. The note indicated a normal saline flush was used to loosen the border gauze dressing and the area was open on the edges of the wound with a dark red area in the center of the wound. The note indicated, "...Area measured 9 cm x (by) 5 cm with darker red area 6 cm x 2 1/2 cm @ widest part..."</p> <p>A Wound Care Specialist Note, dated 08/23/16, indicated the resident had an</p>		<p>intact and document in the TAR, every shift.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1. The DON/designee will audit 2 residents with skin conditions per day per unit 5 times weekly for 4 weeks, 4 times weekly for 4 weeks, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks, and 1 time weekly for an additional 8 weeks to determine that the physician orders are followed and documented appropriately, including proper notification. Audits will be reported to the Quality Assurance meeting monthly. If deficiencies are noted the Quality Assurance Committee will develop plans of action to correct and recommend continued monitoring until corrections are effective.</p>	

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	<p>unstageable necrotic pressure area on the left outer elbow, which measured, 6.3 cm by 2.5 cm, with redness and induration (hardening) with the surrounding area of the wound purple/maroon colored. The left elbow had heavy serous (clear) drainage and the wound was 60% covered with necrotic tissue. Additional information on the note indicated, "Wound debrided...considerable swelling and watery discharge, large amount necrotic tissue debrided but concerned with extent of induration and infection. Feel wisest to admit to hospital..."</p> <p>A Nurses' Progress Note, dated 08/23/16 at 5:17 p.m., indicated an order was received to transfer the resident to the Hospital Emergency Room for evaluation and treatment of the left elbow area.</p> <p>An Emergency Room History and Physical, dated 08/23/16, indicated the resident had an odorous and draining wound to the left elbow, with purulent (contains pus) drainage, surrounded by redness and swelling to the left elbow and forearm. The differential diagnoses were pressure ulceration of left elbow, cellulitis of the left elbow, and sepsis and the resident was ordered intravenous (IV) antibiotics.</p> <p>A Hospital Admission History and</p>			

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	<p>Physical, dated 08/25/16, indicated, "...A local doctor tried to do debridement but could not...examined by the ER (Emergency Room) physician, and he agreed that she has a pretty badly infected wound on the left elbow that needs debridement and IV antibiotics...Final Impression: 1. Decubitus ulcer, quite large, stage 3 (full thickness skin loss involving damage or necrosis of subcutaneous tissue), infected, left elbow. Needs debridement and intravenous antibiotics..."</p> <p>During an interview on 09/02/16 at 2:10 p.m., the Unit Manager indicated when she observed the area on 08/22/16 (Monday), there were two areas on the left elbow which were red and swollen, and had drainage and she immediately notified the Physician.</p> <p>The Unit Manager continued to indicate an investigation of the change of condition of the left elbow was started on 08/22/16. She indicated the area was found on 08/18/16 (Thursday) and was classified as an abrasion, the Nurse Practitioner was notified and an order for a Duoderm dressing was received.</p> <p>The Unit Manager indicated on 08/19/16 (Friday), LPN #1 removed the Duoderm dressing and applied a border gauze</p>			

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	<p>dressings and indicated the left elbow was open and draining. The Unit Manager indicated LPN #1 had not notified the Physician in the change of condition of the area and there had not been a Physician's Order for the border gauze and bacitracin. The Unit Manager indicated on 08/21/16 (Sunday), RN #2 replaced the border gauze with a Duoderm dressing.</p> <p>The investigation, dated 08/29/16, indicated on 08/21/16 at 2:55 p.m., RN #2 completed a dressing change to the left elbow and used normal saline to remove the border gauze dressing. The area was draining, red and swollen and one area measured 9 cm by 5 cm and the second area measured 6.5 cm by 2 cm. RN #2 left the wound open to air until it dried then re-applied a Duoderm dressing.</p> <p>A statement, dated 09/01/16, indicated a review of the events from 08/18/16 and 08/19/16 with LPN #1 had occurred. LPN #1's statement indicated on 08/18/16 she observed an unopened abrasion on the left elbow, notified the Physician and a Duoderm dressing was ordered. LPN #1 indicated on 08/19/16 the Duoderm had come off the left elbow and the left elbow area was "crusty, red and had started to bleed" LPN #1 indicated she</p>			

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	<p>cleaned the area and applied bacitracin and border gauze. LPN #1 indicated she did not remember if she called the Physician to obtain an order for the border gauze and bacitracin.</p> <p>During an interview on 09/02/16 at 3:20 p.m., LPN #1 indicated she did not remember if the Physician had been notified of the change in condition of the left elbow on 08/19/16. LPN #1 indicated she could not remember if she had a Physician's Order to treat the left elbow area with border gauze and bacitracin.</p> <p>A facility policy, dated 01/14/14, titled, "Wound Management", received as current from the Clinical Documentation Specialist, indicated, "...Daily Skin Observation - to be done by RN/LPN or CNA daily during routine care...An assessment will be used to provide a consistent means of wound evaluation...The wound will be treated according to physician's orders..."</p> <p>This Federal tag relates to Complaint IN00208664.</p> <p>3.1-40(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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