

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155653	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2013
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NAME OF PROVIDER OR SUPPLIER LAKE COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5025 MCCOOK AVE EAST CHICAGO, IN 46312
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F0000	<p>This visit was for the Investigation of Complaints IN00118432 and IN00121032.</p> <p>Complaint IN00118432-Substantiated. Federal/state deficiencies related to the allegations are cited at F157 and F309.</p> <p>Complaint IN00121032-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309, and F328.</p> <p>Survey dates: January 2 & 3, 2013</p> <p>Facility number: 000108 Provider number: 155653 AIM number: 100267410</p> <p>Survey team: Janet Adams, RN</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 4 Medicaid: 77 Other: 1</p>	F0000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review on or after February 2 nd , 2013.</p>	
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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>Total: 82</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 9, 2013, by Janelyn Kulik, RN.</p>			

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F0157 SS=E	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review, and interview, the facility failed to notify the Physician of alterations in skin integrity, redness and removal of a peripheral intravenous catheter for</p>	F0157	F157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC) §483.10(b)(11) -- Notification of changes. (i) A facility must immediately inform the resident; consult with the	02/02/2013

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	<p>3 of 7 residents reviewed for Physician notification of change in condition in the sample of 8. (Residents #B #D, and #G)</p> <p>The facility also failed to notify the resident's family or responsible party of changes in the residents condition or treatments for 3 of 7 reviewed for family notification of changes in the sample of 8. (Residents #C, #E, and #F)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 1/2/13 at 9:25 a.m., Resident #B was observed in bed. The resident was awake. There was a white dressing in place on the top of the resident's right hand. There was no date on the dressing. On 1/2/13 at 9:55 a.m., the Director of Nursing removed the dressing from the top of the resident's hand. There was a moderate amount of tan dried drainage on the dressing. The scabbed area measured approximately 1.5 cm (centimeters) x 1.5 cm. The skin around the scab was open at the top and side edges. The open skin appeared dark red in color and was moist. There were no open areas or scabs on the resident's left hand. The Director of Nursing indicated she recalled a scab being</p>		<p>resident's physician; and if known, notify the resident's legal representative or an interested family member when there is-- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) 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); (C) 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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a). (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is-- (A) A change in room or roommate assignment as specified in §483.15(e)(2); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility must record and periodically update the</p>				

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	<p>present on the resident's hand a few weeks ago and the scab was intact. The resident's current Treatment Administration Record (TAR) was reviewed at this time. There were no Physician orders for any treatments for the right hand area.</p> <p>The record for Resident #B was reviewed on 1/2/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, cellulitis, chronic kidney disease, anxiety, congestive heart failure, and renal dialysis. Review of the current Physician orders indicated there were no orders for any treatments or dressings to the right hand area.</p> <p>The 12/2012 and 1/2013 Progress Notes were reviewed. An Occupational Therapy staff member completed an entry on 12/27/12 at 1:54 p.m. This entry indicated there was a bandage over the dorsum (top) of the resident's hand, there was drainage seeping from the bandage, and nursing was notified. There were no Nursing Progress notes completed on 12/27/12. Review of Nursing Progress noted from 12/20/12 through 1/2/13 indicated there was no documentation of any scab, open area, or injury to the top of the right hand. There was</p>		<p>address and phone number of the resident's legal representative or interested family member. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #B: The physician of resident B was notified. A treatment order was received and the responsible party was notified. · Resident #D reported that the dressing had been changed as per policy. Charge Nurse changed dressing and dated it on 1/3/2013. The physician was notified that the peripheral line had been removed and it was documented in the residents' record. · Resident G was immediately re-assessed and the dressing was changed and dated. The physician was notified. Treatment orders were obtained and the treatment administration record was updated. · Resident E no longer resides at the facility. · Resident F's responsible party was notified of physicians order. · Resident C no longer resides at the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who currently reside at the facility with IV's and skin concerns are at risk to be affected by the same alleged</p>		

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	<p>no documentation of the Physician being notified of the right hand area.</p> <p>When interviewed on 1/3/13 at 10:10 a.m., LPN #1 indicated she was assigned to care for Resident #B today. The LPN indicated she recalled a few days ago another staff Nurse asked her to look at the resident's right arm and she then looked at the area with the other Nurse. LPN #1 then indicated there had been dark brown drainage on the dressing around the area and she advised the other Nurse to cleanse the area and apply a dry dressing.</p> <p>When interviewed on 1/3/13 at 1:15 a.m., the Director of Nursing indicated the Physician should have been called related to the area on hand.</p> <p>2. During Orientation Tour on 1/2/13 at 9:35 a.m., Resident #D was observed in bed. The resident had an external IV (intravenous) catheter to his right upper chest area. The resident was not receiving any intravenous fluids or medications through the IV catheter at this time. There was a dressing over the IV catheter insertion site. There was no date on the dressing. The dressing was dry and intact. When interviewed</p>		<p>deficient practice. Residents who currently reside at the facility who have IV's in place were reviewed during the survey to ensure the proper protocol was followed. The residents' records were updated as indicated by the Director of Nursing and/or designee. Residents who currently reside at the facility with skin conditions were reviewed on 1/7/2013 to ensure that a proper treatment order was in place and that the proper notification was given to the physician and the residents' responsible party. Any areas requiring update was immediately addressed and documented in the clinical record. All treatment orders from 1/1/2013 through 1/15/2013 were reviewed by the Director of Nursing and/or designee to ensure proper notification was given and that the proper documentation was in place. Any issues were immediately addressed. Nurses were reeducated on 1/9/2013 by the Director of Nursing and/or designee on the Acute Condition Change Clinical Protocol, Policy and Procedures on proper dressing changes, Physician and Family notification and documentation. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Nurses were reeducated on 1/9/2013 by the Director of Nursing and/or designee on the</p>		

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	<p>at this time, the Director of Nursing indicated IV antibiotics were being administered through the IV line.</p> <p>On 1/2/13 at 4:15 p.m., the resident was observed in bed. The Director or Nursing assessed the residents hands and arms and no peripheral IV lines were observed. The resident indicated there had been an IV in his arm and it had been taken out.</p> <p>The record for Resident #D was reviewed on 1/2/13 at 3:50 p.m. The resident's diagnoses included, but were not limited to, peripheral arterial disease, chronic pain syndrome, and osteomyelitis (bone infection). The resident was admitted to the facility on 12/19/12. The current Physician orders were reviewed. There was an order for the resident to receive Cefazolin (an antibiotic) 1 gram every eight hours for 28 days. There were no physician orders for care or treatments to the right arm IV or the right chest IV site. There was no Physician order to discontinue the right forearm peripheral IV catheter.</p> <p>The 12/2012 and 1/2013 Nursing Progress Notes were reviewed. An entry made on 12/19/12 at 8:00 p.m. indicated the resident had a heparin lock (peripheral IV catheter) in place</p>		<p>Acute Condition Change Clinical Protocol, Policy and Procedures on proper dressing changes, Physician and Family Notification and documentation. The Director of Nursing and/or designee will continue to review the 24 hour report, nursing documentation and physician orders to ensure the alleged deficient practice does not reoccur. · Charge nurses will continue to complete body assessments on new, readmit and condition changes as indicated. · Wound nurses will do follow up body assessments on residents who are new, readmitted and with condition changes as indicated. Any areas identified as requiring further assessments and/or physician and family notification will be completed and documented in the resident's record. 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 placeThe Director of Nursing and/ or designee will use the Notification and Order audit tool to audit 50% of the resident records to ensure compliance monthly x 2 then quarterly thereafter. Any issues found were immediately corrected during review. · The audit will be submitted to the QA Committee for review as indicated. An action plan may be developed for identified issues. §</p>				

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	<p>to the right forearm and and a right Subclavian central line IV in place also. An entry made on 12/21/12 at 5:08 a.m. indicated the resident had a heparin lock in place to the right forearm. An entry made on 12/23/12 at 4:06 a.m. indicated the resident had a right Subclavian central line in place and a right forearm PICC (Peripherally Inserted Central Catheter) IV in place. An entry made on 12/30/12 at 4:24 p.m. indicated the resident had an IV in place to the right forearm. There were no further entries related to the right forearm IV line. There was no documentation of the Physician being notified related to the removal of the right forearm IV line.</p> <p>When interviewed on 1/2/13 at 4:25 p.m., RN #1 indicated Resident #D was admitted with a Subclavian IV line to the chest and a Heparin lock IV to the arm. The RN indicated the IV to the forearm was not being used and he removed the IV line.</p> <p>When interviewed on 1/2/13 at 4:30 p.m., the Director of Nursing indicated there was no Physician notification of the IV being removed.</p> <p>3. On 1/3/13 at 7:50 a.m., Resident #G was observed in bed. The</p>		Noncompliance with facility procedures will result in education and/or disciplinary action.		

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	<p>resident had a blue sock on his left foot. The Director of Nursing removed the sock at this time. There was a clear transparent dressing on the ball of the resident's left foot. There was no date on the dressing The dressing was covering a flat intact dark red area measuring approximately 2 cm (centimeters) x 2 cm. There was no drainage around the area. When interviewed at this time, Resident #G indicated he had recently been in the hospital and the dressing had probably come from the hospital.</p> <p>The record for Resident #G was reviewed on 1/2/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, heel ulcer, spinal stenosis, diabetes mellitus, congestive heart failure, chronic kidney disease, and peripheral vascular disease. The resident was originally admitted to the facility on 11/16/12 and was last readmitted on 12/28/12.</p> <p>An Admission-Clinical Body Observation note was completed on 12/30/12 at 12:50 a.m. as a late entry. The note indicated the resident had pressure ulcers to the right heel. There was no documentation of any skin impairment areas to the left foot.</p>			

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	<p>A Skin Integrity Condition note was completed on 1/2/2013 and the observation date was recorded as 12/28/12 at 2:06 p.m. This note indicated the resident had a full thickness wound to the right plantar foot.</p> <p>When interviewed on 1/3/13 at 8:50 a.m., the Wound Nurse indicated the resident was recently readmitted and had an ulcer to the right foot. The Wound Nurse indicated she was not aware of the any areas to the left foot.</p> <p>Review of the 12/2012 and 1/2013 Physician orders indicated there were no orders for any treatment to the area on the bottom of the resident's left foot. Review of the 12/2012 and 1/2013 Treatment Records indicated there were no treatment orders for the left foot area.</p> <p>When interviewed on 1/3/13 at 8:50 a.m., the Director of Nursing indicated there were no Physician orders for the dressing to the left foot. The Director of Nursing indicated the Physician should have been notified of the area to obtain treatment orders.</p> <p>4. The closed record for Resident #E was reviewed on 1/2/13 at 10:55 a.m.</p>			

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	<p>The resident was admitted to the facility on 10/16/12. The resident was sent to the hospital on 10/24/12 and did not return to the facility. The resident's diagnoses included, but were not limited to, chronic pain, dysphagia(difficulty swallowing), high blood pressure, diabetes mellitus, and kidney disease.</p> <p>The 10/16/12 Admission Full Clinical/Body Observation note indicated the resident was admitted with pressure ulcers and a rash. The 10/2012 Physician orders were reviewed. An order was written on 10/17/12 to cleanse the left buttock with normal saline or wound cleanser, pat peri wound area dry, and apply a Hydrocolloid dressing(a dressing applied for wound healing) every three days and as needed.</p> <p>Review of the 10/2012 Nursing Progress Notes indicated there was no documentation the resident's family was notified of the order for the Hydrocolloid dressing.</p> <p>When interviewed on 1/3/13 at 1:15 p.m., the Director of Nursing indicated the resident's family should have been notified of the treatment order. The Director of Nursing indicated notification of family and Physician</p>			

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	<p>would be documented in the Nursing Progress Notes.</p> <p>5. The closed record for Resident #F was reviewed on 1/3/13 at 11:30 a.m. The resident was admitted to the facility on 10/15/12. The resident was sent to the hospital on 12/29/12 and did not return to the facility. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and dysphagia (difficulty swallowing).</p> <p>Review of the 12/2012 Bath and Skin Report Sheet indicated entries were made on 12/3/12, 12/6/12, 12/10/12, 12/13/12, 12/17/12, 12/20/12, 12/24/12, and 12/27/12. There were body diagram printed on the sheet. There were "X" marking made on or near the residents buttock/groin areas on each of the above dates. The sections with the body diagrams were completed by a CNA. The top section of the sheet was to be completed by a Nurse. This section indicated "redness and rash" was checked for each of the above entries with the Nurses initials.</p> <p>The 12/2012 Nursing Progress Notes were reviewed. An entry made on 12/4/12 at 2:00 p.m. indicated the wound Physician was in to see the</p>						

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	<p>resident and orders were obtained to apply Clotrimazole 1% cream to the resident's groin area for 4 weeks. An entry made on 12/4/12 at 8:00 p.m. indicated a new Physician order noted to apply Clotrimazole cream(an ointment to treat skin conditions) to the groin area twice a day. The entry did not indicate the resident's family was notified of the new order. Entries made 12/4/12 through 12/6/12 did not indicate the family was notified of the 12/4/12 Physician order.</p> <p>When interviewed on 1/3/13 at 1:15 p.m., the Director of Nursing indicated the family should have been notified of the new orders and this should have been recorded in the Nursing Notes.</p> <p>6. The closed record for Resident #C was reviewed on 1/2/13 at 2:00 p.m. The resident was admitted to the facility on 3/9/12 and was discharged on 7/11/12. The resident's diagnoses included, but were not limited to, high blood pressure, psychosis, anemia, dementia, and osteoporosis.</p> <p>Review of the 7/2012 Physician orders indicated there was an order written on 7/5/12 to cleanse two medium sized blisters to the resident's right thumb with normal</p>			

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	<p>saline and then apply a transparent dressing every five days.</p> <p>The 7/2012 Nursing Progress Notes were reviewed. An entry made on 7/5/12 at 6:57 p.m. indicated two medium sized blisters were noted to the resident's right thumb and the Physician was notified and new orders were received. The entry did not indicate the resident's family was notified of the treatment order for the new blisters. Entries made 7/5/12 through 7/8/12 did not indicate the resident's family was notified of the 7/5/12 treatment orders.</p> <p>When interviewed on 1/3/13 at 1:15 p.m., the Director of Nursing indicated the family should have been notified of the new orders and this should have been recorded in the Nursing Notes.</p> <p>The facility policy titled "Acute Condition Change-Clinical Protocol" was reviewed on 1/2/13 at 11:15 a.m. The policy had a revised date of August 2008. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the Nurse was to notify the resident and/or the responsible part of changes and document.</p>			

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	<p>This federal tag relates to Complaints IN00118432 and IN00121032.</p> <p>3.1-5(a)(3)</p>			

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F0309 SS=E	<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 interview the facility failed to provide necessary treatment and services related to completing skin assessments, treatment of hand wound, and follow up of skin conditions for 4 residents in the sample of 8. (Residents #B, #C, #F, and #G) The facility also failed to provide necessary treatments and services related to assessing PICC (Peripherally Inserted Central Catheter) IV catheters and Subclavian(area of a vein in the chest area) IV catheters for 2 of 3 resident's reviewed with Intravenous catheters. (Residents #D and #G)</p> <p>Findings include:</p> <p>1. During Orientation Tour on 1/2/13 at 9:25 a.m., Resident #B was observed in bed. The resident was awake. There was a white dressing in place on the top of the resident's right hand. There was no date on the</p>	F0309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELLBEING 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident B was assessed and the treatment order was obtained.</p> <p>Resident C no longer resides in the facility. While at the facility she was being followed by a dermatologist.</p> <p>Resident F was sent out to see the dermatologist on 12/17/12. An order was received for the rash to his groin and it has since improved. Residents F rash was also assessed by the wound physician at the facility on 1/16/2013. A new order was</p>	02/02/2013			

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	<p>dressings. On 1/2/13 at 9:55 a.m., the Director of Nursing removed the dressing from the top of the resident's hand. There was a moderate amount of tan dried drainage on the dressing. The scabbed area measured approximately 1.5 cm (centimeters) x 1.5 cm. The skin around the scab was open at the top and side edges. The open skin appeared dark red in color and was moist. There were no open areas or scabs on the resident's left hand. The Director of Nursing indicated she recalled a scab being present on the resident's hand a few weeks ago and the scab was intact. The resident's current Treatment Administration Record (TAR) was reviewed at this time. There were no Physician orders for any treatments for the right hand area.</p> <p>The record for Resident #B was reviewed on 1/2/13 at 11:00 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, cellulitis, chronic kidney disease, anxiety, congestive heart failure, and renal dialysis. Review of the current Physician orders indicated there were no orders for any treatments or dressings to the right hand area.</p> <p>The 12/2012 and 1/2013 Progress Notes were reviewed. An</p>		<p>received. The residents' record was updated and the family was notified of the new order.</p> <p>Resident G immediately had a full skin assessment and treatment orders were obtained by the physician. PIC line orders were clarified and updated on 1/2/2013. The PIC line dressing was changed and dated. The residents' record was updated.</p> <p>Resident D's IV dressing was immediately changed and dated during the survey. He reported that the dressing had been changed as per policy. Charge nurse has since documented removal of the peripheral IV. IV orders were updated.</p> <p>Nurses were reeducated on 1/9/2013 by the Director of Nursing and/or designee on the Acute Condition Change Clinical Protocol, policy and procedures on proper dressing changes, physician and family notification and documentation.</p> <p>The Director of Nursing Services re-educated the shower aides and the treatment nurses on skin checks of residents refusing showers on 1/9/2013.</p> <p>How will you identify other residents having the potential to be affected by the same</p>		

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	<p>Occupational Therapy staff member completed an entry on 12/27/12 at 1:54 p.m. This entry indicated there was a bandage over the dorsum (top) of the resident's hand, there was drainage seeping from the bandage, and nursing was notified. There were no Nursing Progress notes completed on 12/27/12. Review of Nursing Progress noted from 12/20/12 through 1/2/13 indicated there was no documentation of any scab, open area, or injury to the top of the right hand. There was no documentation of the Physician being notified of the right hand area.</p> <p>When interviewed on 1/3/13 at 10:10 a.m., LPN #1 indicated she was assigned to care for Resident #B today. The LPN indicated she recalled a few days ago another staff Nurse asked her to look at the resident's right arm and she looked at the area with the other Nurse. LPN #1 indicated there had been dark brown drainage on the dressing around the area and she instructed the Nurse to clean the area and apply a dressing.</p> <p>When interviewed on 1/3/13 at 8:50 a.m., the Director of Nursing indicated there had been a change in the scab to resident's right hand and there was</p>		<p>deficient practice and what corrective action will be taken</p> <p>Residents who currently reside at the facility with IV's and skin concerns are at risk to be affected by the same alleged deficient practice. Residents who currently reside at the facility who have IV's in place were reviewed during the survey to ensure the proper protocol was followed. The residents' records were updated as indicated by the Director of Nursing and/or designee.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>The Director of Nursing Services re-educated the shower aides and the treatment nurses on skin checks of residents refusing showers on 1/9/2013</p> <p>The Director of Nursing and/or designee will review 75% of the weekly treatment notes x 2months then 50% ongoing to ensure continued compliance as indicated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>				

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	<p>no treatment ordered until 1/2/13. The Director of Nursing also indicated the area had changed since the last time she observed it.</p> <p>2. The closed record for Resident #C was reviewed on 1/2/13 at 2:00 p.m. The resident was admitted to the facility on 3/9/12 and was discharged on 7/11/12. The resident's diagnoses included, but were not limited to, high blood pressure, psychosis, anemia, dementia, and osteoporosis.</p> <p>Review of the 7/2102 Physician orders indicated there was an order written on 7/5/12 to cleanse cleanse the two medium sized blisters to the resident's right thumb with normal saline and then apply a transparent dressing every five days.</p> <p>The 7/2012 Bath and Skin Report Sheet was reviewed. The sheet indicated the bottom section was to be completed by the CNA. A body diagram was included on the bottom section. The top section indicated Nurses to check if the skin was intact, or bruises, blisters, rashes, and open areas were present.</p> <p>The first entry on the 7/2012 sheet was completed on 7/3/12. An "X" was marked on both hands of the body diagram on 7/3/12 by the CNA and</p>		<p>program will be put into place</p> <p>The Director of Nursing and/or designee will complete the Skin Condition audit tool for 75 % of the residents who currently reside at the facility with skin conditions monthly x 2 then 50 % ongoing to ensure compliance is met as indicated. . Any deficiencies found will be immediately corrected during review.</p> <p>The audit tools will be submitted to the QA Committee for review and follow up as indicated. Actions plans will be developed for thresholds that are not met.</p> <p>Noncompliance with facility procedures will result in education and/or disciplinary action.</p>		

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	<p>the Nursing section indicated "skin intact " was checked.</p> <p>The 7/6/12 entry also indicated an "X" was marked on both hands of the body diagram by the CNA and the Nursing section indicated "blister" was checked.</p> <p>The 7/9/12 entry indicated an "X" was marked on the right hand on the body diagram by the CNA and Nursing section indicated "blister" was checked.</p> <p>The 7/2012 Nursing Progress Notes were reviewed. The first entry was made on 7/2/12 at 2:01 p.m. There was no documentation of any upper extremity blisters in this entry. The next entry was made on 7/3/12 at 2:00 p.m. There was no documentation of any upper extremity blisters in this entry. The next entry was made on 7/5/12 at 2:11 p.m. There was no documentation of any upper extremity blisters in this entry. The next entry was made on 7/5/12 at 6:57 p.m. This entry indicated two medium sized blisters were noted to the resident's right thumb and the Physician was notified and new orders were received. There was no documentation of any blisters to the left upper extremity 7/2/12 through 7/9/12. An entry made on 7/9/12 at 4:11 p.m. indicated transparent</p>			

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	<p>dressings were in place to blisters on the the resident's right and left thumbs. The entry also indicated the resident was sent to the hospital emergency room for evaluation due to multiple blisters. An entry made on 7/9/12 at 8:21 p.m., indicated the resident returned to the facility with new orders for Silvadene 1% cream to be applied topically as needed. There was no documentation any assessments of the sizes or descriptions of the blisters in the 7/2012 Nursing Progress Notes other than above 7/5/12 entry indicating the two blisters on the right thumb were "medium sized".</p> <p>When interviewed on 1/3/13 at 1:15 p.m., the Director of Nursing indicated there were no ongoing assessments of the blisters.</p> <p>3. The closed record for Resident #F was reviewed on 1/3/13 at 11:30 a.m. The resident was admitted to the facility on 10/15/12. The resident was sent to the hospital on 12/29/12 and did not return to the facility. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and dysphagia (difficulty swallowing).</p> <p>The 12/2012 Physician orders were</p>			

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	<p>reviewed. An order was obtained on 12/17/12 for Mupirocin 2% ointment to be applied to the thighs twice day.</p> <p>Review of the 12/2012 Bath and Skin Report Sheet indicated entries were made on 12/3/12, 12/6/12, 12/10/12, 12/13/12, 12/17/12, 12/20/12, 12/24/12, and 12/27/12.</p> <p>There were body diagram printed on the sheet. There were "X" marking made on or near the residents buttock/groin areas on each of the above dates. The section with the body diagrams were completed by a CNA. The top section of the sheet was to be completed by a Nurse. This section indicated "redness and rash" was checked for each of the above entries with the Nurses initials.</p> <p>The 12/2012 Nursing Progress Notes were reviewed. An entry made on 12/4/12 at 8:00 p.m. indicated a new Physician order noted to apply Clotrimazole cream(an ointment to treat skin conditions) to the groin area twice a day. A Physician order was obtained on 12/17/12 to apply Mupirocin 2% ointment to the thighs twice a day.</p> <p>The 12/2102 Nursing Progress Notes were reviewed. The first entry regarding the the resident's groin rash</p>			

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	<p>was made on 12/4/12 at 2:00 p.m. This entry indicated the Physician was in to see the resident and orders were obtained to apply Clotrimazole 1% cream to the groin area for four weeks. There was no assessment of the groin rash in this entry. There next documentation of the groin rash was made on 12/12/12 at 9:30 p.m. This entry indicated treatment continued to the rash. An entry made on 12/17/12 at 8:20 a.m., indicated the resident was sent out to a Dermatology appointment.</p> <p>4. On 1/2/13 at 12:00 p.m., Resident #G was observed in his room. The resident had a clear transparent dressing in place to the right upper arm. There was a piece of gauze under the transparent dressing. The dressing was covering the PICC (peripherally inserted central catheter) IV (intravenous) insertion site. The Assistant Director of Nursing was present at this time. The Assistant Director of Nursing assessed the dressing and indicated the dressing came from the hospital.</p> <p>On 1/3/13 at 7:50 a.m., Resident #G was observed in bed. The resident had a blue sock on his left foot. The Director of Nursing removed the sock</p>				

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	<p>at this time. There was a clear transparent dressing on the ball of the resident's left foot. There was no date on the dressing The dressing was covering a flat intact dark red area measuring approximately 2 cm (centimeters) x 2 cm. There was no drainage around the area. When interviewed at this time, Resident #G indicated he had recently been in the hospital and the dressing had probably come from the hospital.</p> <p>The record for Resident #G was reviewed on 1/2/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, heel ulcer, spinal stenosis, diabetes mellitus, congestive heart failure, chronic kidney disease, and peripheral vascular disease. The resident was originally admitted to the facility on 11/16/12 and was last readmitted on 12/28/12.</p> <p>Review of the Nursing Progress Notes from 12/28/12 through 1/2/13 indicated there were no assessment of the area to the resident's left foot. There were no wound observation notes for the red area on the bottom of the resident's left foot.</p> <p>The 1/2013 Treatment Records were reviewed. There was an order written</p>			

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	<p>on 12/31/12 to change the transparent dressing and caps to the right double lumen PICC line once a day on Mondays. The order also indicated the total length of the catheter exposed and the circumference of the arm were to be measured in cm. (centimeters). This treatment had not been signed out as completed 1/1/13 through 1/2/13.</p> <p>The 12/2012 Treatment Records were reviewed. There were no orders for any PICC line dressing changes, catheter or arm circumference measurements on the Treatment Record.</p> <p>Review of the 12/2012 and 1/2013 Physician orders indicated there were no orders for any treatment to the area on the bottom of the resident's left foot. Review of the 12/2012 and 1/2013 Treatment Records indicated there were no treatment orders for the left foot area.</p> <p>When interviewed on 1/3/13 at 8:30 a.m., the Wound Nurse indicated the resident was recently readmitted and had an ulcer to the right foot. The Wound Nurse indicated she was not aware of any areas to the left foot.</p>			

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	<p>When interviewed on 1/3/13 at 8:50 a.m., the Director of Nursing indicated dressing changes should be completed as order and as per the facility policy. The Director of Nursing also indicated the external catheter length should have measured upon admission as per the policy.</p> <p>5. During Orientation Tour on 1/2/13 at 9:35 a.m., Resident #D was observed in bed. The resident had an external IV (intravenous) catheter to his right upper chest area. The resident was not receiving any intravenous fluids or medications through the IV catheter at this time. There was a dressing over the IV catheter insertion site. There was no date on the dressing. The dressing was dry and intact. When interviewed at this time, the Director of Nursing indicated IV antibiotics were being administered through the IV line.</p> <p>On 1/2/13 at 4:15 p.m., the resident was observed in bed. The Director or Nursing assessed the residents hands and arms and no peripheral IV lines were observed. The resident indicated there had been an IV in his arm and it had been taken out.</p> <p>The record for Resident #D was reviewed on 1/2/13 at 3:50 p.m. The</p>			

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	<p>resident's diagnoses included, but were not limited to, peripheral arterial disease, chronic pain syndrome, and osteomyelitis (bone infection). The resident was admitted to the facility on 12/19/12. The current Physician orders were reviewed. There was an order for there resident to receive Cefazolin (an antibiotic) 1 gram every eight hours for 28 days. There were no physician orders for care or treatments to the right arm IV or the right chest IV site. There was no Physician order to discontinue the right forearm peripheral IV catheter.</p> <p>There were no Physician orders related to right to IV site care for any IV's to the right chest of the right arm. There were no Physician orders to remove the right forearm IV catheter.</p> <p>The 12/2012 and 1/2013 Nursing Progress Notes were reviewed. An entry made on 12/19/12 at 8:00 p.m. indicated the resident had a heparin lock (peripheral IV catheter) in place to the right forearm and and a right Subclavian central line IV in place also. An entry made on 12/21/12 at 5:08 a.m., indicated the resident had a heparin lock in place to the right forearm. An entry made on 12/23/12 at 4:06 a.m. indicated the resident had a right Subclavian central line in</p>				

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	<p>place and a right forearm PICC (Peripherally Inserted Central Catheter) IV in place. An entry made on 12/30/12 at 4:24 p.m. indicated the resident had an IV in place to the right forearm. There were no further entries related to the right forearm IV line. There was no documentation of the Physician being notified related to the removal of the right forearm IV line. There was no documentation indicating the right chest Subclavian IV dressing had been changed. There was no documentation the right arm peripheral IV catheter had been changed between 12/19/12 and 12/24/12.</p> <p>Review of the 12/2012 and 1/2013 Treatment Records indicated there were no treatment orders to change the transparent dressing over the Subclavian IV insertion site.</p> <p>The facility policy titled "Central Venous Catheter (CVC) Dressing Change" was reviewed on 1/2/13 at 3:30 p.m. The policy had a revision date of July 1, 2012. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated Central Venous catheters included PICC and non tunneled Subclavian, jugular, or femoral catheters. The policy</p>			

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	<p>indicated the length of the external catheter was to be obtained upon admission. The policy also indicated a sterile dressing change was to be completed at least weekly and the dressing was to be labeled with the date, time, and Nurses' initials. The policy also indicated an assessment of the site was to be completed with the dressing change. The policy also indicated staff were to document the site assessments in the medical record.</p> <p>The policy titled "Peripheral Catheter Removal" was reviewed on 1/3/13 at 9:30 a.m. The policy was received from the Director of Nursing and identified as current. The policy had revision date of July 1, 2012. The policy indicated staff were to document the reason for the removal, length and condition of the catheter, and site assessment. The policy also indicated peripheral catheters were to be changed every 96 hours.</p> <p>When interviewed on 1/2/13 at 4:25 p.m., RN #1 indicated Resident #D was admitted with a Subclavian IV line to the chest and a Heparin lock IV to the arm. The RN indicated the IV to the forearm was not being used and he removed the IV line on 12/24/12 or 12/25/12.</p>			

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	<p>When interviewed on 1/3/13 at 8:50 a.m., the Director of Nursing indicated the facility policies related to IV care should be followed.</p> <p>This federal tag relates to Complaints IN00118432 and IN00121032.</p> <p>3.1-37(a)</p>			

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F0328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper technique was followed related to masks not worn during a PICC (peripherally inserted central catheter) line IV site dressing change for 1 of 1 residents observed during a PICC line dressing change procedure in the sample of 8. (Resident #G) (LPN #2)</p> <p>Findings include:</p> <p>On 1/2/13 at 2:10 p.m., Resident #G was observed in bed. LPN #2 entered the resident's room to complete a dressing change to the PICC (peripherally inserted central catheter) IV line in place in the resident's right upper arm. The LPN washed her hands and put on a pair of disposable gloves. The LPN then removed the transparent dressing</p>	F0328	<p>F 328 TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections Parenteral and eternal fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>Resident G suffered no ill effects from the dressing change. Resident showed no signs or symptoms of infection from his IV site throughout the duration of his stay.</p> <p>LPN # 2 received one on one</p>	02/02/2013
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	<p>which was covering the insertion site. The LPN then removed a folded piece of gauze from the insertion site. LPN #4 was not wearing a mask when she removed the dressing. The LPN did not place a mask on the resident prior to removing the dressings. The LPN then removed her gloves, cleansed her hands with hand sanitizing gel, put on a mask, and sterile gloves and began to cleanse the insertion site. The LPN did not place a mask on the resident.</p> <p>The record for Resident #G was reviewed on 1/21/13 at 1:00 p.m. The resident's diagnoses included, but were not limited to, heel ulcer, spinal stenosis, diabetes mellitus, congestive heart failure, chronic kidney disease, and peripheral vascular disease. The resident was originally admitted to the facility on 11/16/12 and was last readmitted on 12/28/12. The resident was readmitted with a PICC line to the right upper arm.</p> <p>The facility policy titled "Central Venous Catheter (CVC) Dressing Change was reviewed on 1/2/13 at 3:35 p.m.. The policy was dated with a revision date of July 1, 2012. The Director of Nursing provided the policy and indicated the policy was</p>		<p>education on our policy and procedure for PIC line dressing changes on 1/2/2013.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <p>Residents who reside at the facility with a PIC/IV line have the potential to be affected by this same alleged deficient practice.</p> <p>Residents who currently reside at the facility who have PIC/IV's in place were reviewed during the survey to ensure the proper protocol was followed. There were no other residents identified as being affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>LPN # 2 received one on one education on our policy and procedure for Central Venous Catheter Dressing Changes on 1/2/2013</p> <p>Nurses we reeducated on 1/9/2013 by the Director of Nursing and/or designee on the</p>				

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	<p>current.</p> <p>The policy indicated Central venous catheters included Peripherally Inserted Central Catheters (PICC). The policy indicated two masks were to be provided, one each for the resident and the Nurse. The policy indicated staff were to assemble the equipment and supplies, position the resident for comfort and ease of access to the catheter, put on a mask and clean gloves, and then remove the old dressing or securement device.</p> <p>When interviewed on 1/2/13 at 4: 45 p.m., the Director of Nursing indicated the policy should have been followed when staff completed the dressing change.</p> <p>This federal tag relates to Complaint IN00121032.</p> <p>3.1-47(a)(2)</p>		<p>Central Venous Catheter Dressing Changes.</p> <p>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 Director of Nursing and/or designee will complete competency testing with the treatment nurses once per week x 4 weeks then 1 x per month ongoing as indicated.</p> <p>The Director of Nursing and/or designee will complete the PIC/IV audit tool to audit 100 % of the residents with PIC/IV's that reside in the facility to ensure compliance is met ongoing. Any deficiencies found will be immediately corrected during review.</p> <p>The audit tools will be submitted to the QA Committee for review and follow up as indicated. Actions plans will be developed for thresholds that are not met. Noncompliance with facility procedures will result in education and/or disciplinary action.</p>		