

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2012
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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
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F0000	<p>This visit was for Investigation of Complaint IN00111656.</p> <p>Complaint IN00111656 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: July 16 & 17, 2012</p> <p>Facility number: 000103 Provider number: 155196 AIM number: 100290000</p> <p>Survey team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF/NF: 71 Residential: 61 Total: 132</p> <p>Census payor type: Medicare: 21 Medicaid: 30 Other: 81 Total: 132</p> <p>Sample: 3</p> <p>These deficiencies also reflect state</p>	F0000		

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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	findings cited in accordance with 410 IAC 16.2. Quality review 7/19/12 by Suzanne Williams, RN			

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F0157 SS=D	<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 and record review, the facility failed to ensure the notification of a resident's physician, in that when a resident developed a pressure ulcer and skin abrasions, the nursing staff</p>	F0157	<p>F157 483.10(b)(11)NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC) 1. Resident "A" no longer resides at this community.</p>	08/16/2012			

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	<p>failed to notify the physician for possible intervention for 1 of 1 resident reviewed with a pressure ulcer and skin abrasions in a sample of 3. [Resident "A"]</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The hospital discharge instructions, dated 06-29-12 included "balsam Peru/castor oil/trypsin topical (Vasolax topical ointment) 1 App [application] two times a day as needed for not specified to the skin <sic>."</p> <p>The admission nursing assessment, dated 06-29-12 indicated the resident was admitted to the facility without a pressure ulcer.</p> <p>Review of the notation titled "Observation details," dated 07-02-12 indicated the resident was "noted to have small pressure wound to sacral area. Resident denies pain or discomfort. Vasolex cream applied as ordered." The document indicated the area was</p>		<p>2. All current residents will be reviewed to determine if there is a new pressure ulcer or skin abrasions or a need for change in treatment, and the physician will be notified for possible interventions. This review will include a facility wide skin sweep conducted by nursing administration.</p> <p>3. A systemic change will include:</p> <ul style="list-style-type: none"> · All new admissions will have a second skin assessment within 24 hours of admission from a nursing administration team member to review for any skin conditions as well as physician notification. · Treatment orders for skin conditions will be reviewed at the next clinical meeting (5 days a week) for physician notification as well as a need for treatment change. · Weekly skin checks will be completed by licensed nurses and reviewed by the Unit Manager or designee at the daily (Monday through Friday) clinical meeting and the physician will be notified for any changes in condition in skin conditions. · All current skin conditions are measured weekly and will be reviewed at the weekly at risk meeting by the interdisciplinary team. This will include a review of change in condition and notification of the physician for possible interventions with an increase in size or new area. 	

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	<p>classified as a "Stage 2" [partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough] - and measured .3 cm [centimeters] by .5 cm. depth < 0.1 cm."</p> <p>During observation on 07-16-12 at 11:45 a.m., the resident was seated in a recliner with family members in attendance. The resident pulled off the socks to both feet, and during this observation, the toes on the left foot appeared bruised and scabbed.</p> <p>The current nursing "skin assessment" dated 07-16-12, indicated the area to the resident's sacral area was noted as a "Stage 2" pressure ulcer which now measured "2.6 cm by 2.0 cm and no depth."</p> <p>During observation on 07-17-12 at 9:25 a.m., with Licensed Nurse employee #8 in attendance, a body assessment was conducted. The Licensed Nurse removed the resident's pajama's, and incontinent brief. The incontinent brief was stained with bright red blood. The opened pressure ulcer on the resident's sacral area was red in color.</p> <p>The resident's left foot had areas which appeared as scabs noted on the great toe, 1st, 2nd, 3rd and 4th toe. The area</p>		<p>Education will be provided to licensed nurses regarding notifying the physician for possible interventions with any changes in condition to current skin areas or new skin conditions.</p> <p>4. The Director of Nursing or designee will review all new admission initial and second skin assessments for appropriate treatment and physician notification daily (Monday through Friday) for one month, and then weekly thereafter. In addition, the Director of Nursing or designee will review all weekly skin checks and weekly skin measurements for physician notification and/or need for a treatment change due to a change in condition related to skin issues weekly. Any concerns will be addressed and the physician will be notified.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.</p> <p>Completion Date: August 16, 2012</p>	

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	<p>adjacent to the resident's left knee was also scraped. The Licensed Nurse employee #8, felt the areas on the resident's toes and indicated "It's smooth. I didn't know about these."</p> <p>A request was made for the Licensed Nurse to measure the areas including the sacral are. The Licensed Nurse measured the areas, with the exception of the sacral area, and provided the following measurements:</p> <p>"Left ft. [foot] toes: #1 - 1.5 cm [centimeters] by 1.0 cm, #2 - .6 cm by 0.6 cm, #3 - 0.3 cm by 0.3 cm and top of toe 0.3 cm. by 0.2 cm., #4 - 0.3 cm by 0.3 cm and top of toe 1.0 cm by 0.2 cm."</p> <p>"Lt. [left] side knee #1 - 1.0 cm by 0.5 cm, #2 - .5 cm by 0.2 cm, #3 - 0.3 cm by 0.1 (scratches)."</p> <p>"Knee outter <sic> aspect 0.4 cm by 0.2 cm and 0.2 in diameter."</p> <p>The resident's record lacked documentation the resident's physician was notified of the increase in size of the pressure ulcer, or if an alternate treatment/intervention was preferred.</p> <p>The Licensed Nurse employee #8 received a physician order on 07-17-12 at</p>			

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	<p>11:50 a.m. for treatment to the abrasions, more than 24 hours after the areas to the resident's toes were first observed.</p> <p>Review of the facility policy on 07-17-12 at 2:00 p.m., titled "Change in a Resident's Condition or Status," and dated as "revised August 2006, indicated the following:</p> <p>"Policy statement [bold type] - Our facility shall promptly notify the residents, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)."</p> <p>"Policy Interpretation and Implementation [bold type] 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: e. A need to alter the resident's medical treatment significantly; h. Instructions to notify the physician of changes in the resident's condition."</p> <p>3.1-5(a)</p>			

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F0272 SS=D	<p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure the accuracy of a resident's assessment, in that when a resident was assessed with a pressure ulcer, the resident's Minimum Data Set assessment lacked documentation and accuracy of the resident's current status</p>	F0272	<p>F272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <ol style="list-style-type: none"> Resident "A" no longer resides at the community. All current residents with pressure ulcers have been identified and an audit will be conducted of the most recent Minimum Data Set 	08/16/2012

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	<p>for 1 of 1 resident reviewed for pressure ulcers in the sample of 3. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The admission nursing assessment, dated 06-29-12 indicated the resident was admitted to the facility without a pressure ulcer.</p> <p>Review of the notation titled "Observation details," dated 07-02-12 indicated the resident was "noted to have small pressure wound to sacral area. Resident denies pain or discomfort. Vasolex cream applied as ordered." The document indicated the area was classified as a "Stage 2" [partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough] - and measured .3 cm [centimeters] by .5 cm. depth < 0.1 cm."</p> <p>The Initial Minimum Data Set Assessment, dated 07-06-12 indicated the resident was admitted to the facility</p>		<p>assessment for documentation and accuracy of the resident's current status related to pressure ulcers. This will include a review of the most recent CAA (care area assessment) for inclusion of a pressure ulcer. Any identified concerns will be corrected via a new MDS and CAA to include the pressure ulcer.</p> <p>3. The systemic change includes that a member of the MDS team will attend the portion of the daily stand up meeting that includes new orders and/or communication of any new pressure ulcer that will trigger an MDS for inclusion in the minimum data set. Education will be provided to the MDS nurses regarding the systemic change and the need to include any pressure in the MDS and CAA.</p> <p>4. The MDS coordinator or designee will review all new MDSs and CAAs for inclusion of any pressure areas. This review will be conducted three times a week for 30 days, then weekly for 60 days, then every other week for a duration of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.</p> <p>Completion Date: August 16, 2012</p>	

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	<p>without a pressure ulcer but was at risk for developing pressure ulcers.</p> <p>Review of the CAA [care area assessment] detail report, dated 07-06-12 indicated the resident was "at risk" for the development of pressure ulcers, but no pressure areas were present upon admission.</p> <p>The current "skin assessment" dated 07-16-12 indicated the area was noted as a "Stage 2" pressure ulcer which now measured "2.6 cm by 2.0 cm and no depth."</p> <p>During the exit conference the corporate clinical specialist indicated "I talked with the MDS [minimum data set] staff, and this was just a mistake, an oversight."</p> <p>3.1-31(i)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview and record review, the facility failed to develop a plan of care, in that when a resident was admitted to the facility without a pressure ulcer and then acquired a pressure ulcer, the nursing staff failed to develop a plan of care which addressed possible interventions or approaches for the healing of the ulcer for 1 of 1 resident reviewed for a pressure ulcer in a sample of 3. [Resident "A"].</p> <p>Findings include:</p>	F0279	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <ol style="list-style-type: none"> Resident "A" no longer resides at the community. All current residents with pressure ulcers have been identified and the plan of care will be reviewed for inclusion of possible interventions or approaches for the healing of the ulcer. Any concerns will be addressed in the plan of care. The systemic change includes: <ul style="list-style-type: none"> Weekly skin assessments will be conducted by a licensed nurse and reviewed by the Unit Manager 	08/16/2012	

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	<p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The hospital discharge instructions, dated 06-29-12 included "balsam Peru/castor oil/trypsin topical (Vasolax topical ointment) 1 App [application] two times a day as needed for not specified to the skin <sic>."</p> <p>The admission nursing assessment, dated 06-29-12 indicated the resident was admitted to the facility without a pressure ulcer.</p> <p>Review of the notation titled "Observation details," dated 07-02-12 indicated the resident was "noted to have small pressure wound to sacral area. Resident denies pain or discomfort. Vasolex cream applied as ordered." The document indicated the area was classified as a "Stage 2" [partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough] - and measured .3 cm [centimeters] by .5 cm. depth < 0.1 cm."</p> <p>The Initial Minimum Data Set</p>		<p>for inclusion of any newly identified pressure ulcer.</p> <p>All residents with an identified pressure ulcer are reviewed at the facility's weekly interdisciplinary at risk meeting. This meeting includes a review of the current plan of care regarding pressure areas for inclusion of and appropriate interventions for healing the ulcer. Education will be provided to licensed nurses regarding conducting the weekly skin assessments as well as development of a plan of care for healing of a pressure ulcer. In addition, nursing administrative team member will be provided education regarding the systemic change of reviewing the current plan of care regarding pressure areas for inclusion of and appropriate interventions for healing the ulcer.</p> <p>4. The Unit Manager or designee will review all weekly skin checks that identify a new pressure ulcer for inclusion of a plan of care addressing appropriate interventions for healing the ulcer. This review will be conducted 5 days a week for 30 days, then weekly thereafter. In addition, the Director of Nursing or designee will review all weekly interdisciplinary at risk meeting notes for inclusion of a plan of care regarding pressure areas for appropriate interventions for healing a pressure area. This review</p>				

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	<p>Assessment, dated 07-06-12 indicated the resident was admitted to the facility without a pressure ulcer but was at risk for developing pressure ulcers.</p> <p>The resident's "initial" plan of care, dated 06-29-12, indicated the resident was at risk for skin breakdown related to incontinence, CA [cancer], and decreased mobility. Interventions included "report signs and symptoms of breakdown (sore, red, tender, or broken down area)."</p> <p>Review of the 07-04-12 "weekly skin sheet" instructed the nursing staff as follows: "Directions: Nursing Assistants will monitor skin daily and report problems to the licensed nurse. The licensed nurse will validate all reported skin integrity problems and initiate an action plan." The flow sheet completed by a CNA [certified nurses aide], lacked identification of the ulcer on the resident's sacral area.</p> <p>This "Skin Integrity Flow Sheet," was signed by Licensed Nurse employee #6</p> <p>The current "skin assessment" dated 07-16-12 indicated the area was noted as a "Stage 2" pressure ulcer which now measured "2.6 cm by 2.0 cm and no depth."</p> <p>During observation on 07-17-12 at 9:25</p>		<p>will be conducted weekly.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter.</p> <p>Frequency and duration of reviews will be increased as needed.</p> <p>Completion Date: August 16, 2012</p>	

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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN 46237
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	<p>a.m., with Licensed Nurse employee #8 in attendance, a body assessment was conducted. The Licensed Nurse removed the resident's pajamas, and incontinent brief. The incontinent brief was stained with bright red blood. The opened pressure ulcer on the resident's sacral area was red in color.</p> <p>The nursing staff failed to develop a plan of care for the existence of a pressure ulcer.</p> <p>During the exit conference on 07-17-12 at 2:00 p.m., the Registered Nurse Clinical Specialist confirmed the plan of care did not address the resident's existing pressure ulcer.</p> <p>3.1-35(a)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident's plan of care was followed, in that when a resident was admitted to the facility with known cognitive impairment and at risk for falls, the nursing staff failed to implement the various interventions noted on the plan of care for 1 of 3 residents reviewed for falls in a sample of 3. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The hospital discharge instructions, dated 06-29-12, included the resident "requires the assistance of two to transfer to a bedside commode, wheel chair, or toilet. [Resident] is confused at times and when [resident] is confused will try to get up on own. [Resident] is not safe when gets up</p>	F0282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <ol style="list-style-type: none"> Resident "A" no longer resides at the community. All residents at risk for falls have been identified and will have an audit conducted for the nursing staff implementing the various interventions noted on the plan of care. Any concerns will be addressed. The systemic change includes: <ul style="list-style-type: none"> Licensed nurses will conduct rounds every shift to observe for implementation of interventions noted on the plan of care to prevent falls. The Unit Manager or designee will conduct rounds five days a week to observe for implementation of interventions noted on the plan of care to prevent falls. All interventions for falls are noted on the C.N.A. assignment sheet and this sheet will be utilized for rounds as mentioned above. The C.N.A. will sign the assignment sheet and return it to her nurse every shift to signify that they have reviewed and monitored that all fall interventions have been 	08/16/2012

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	<p>on own."</p> <p>The resident's plan of care, dated 06-29-12, indicated the resident was "at risk for falling R/T [related to] effects of dementia, delirium." Interventions to this plan of care included "ensure resident has non skid footwear on, OT [occupational therapy] to evaluate resident for w/c [wheelchair] positioning, [family member] suggests to leave resident's <sic> in w/c during the day when here visiting to keep [resident] awake more during the day, obtain a scoop mattress for resident, bed, w/c alarm, assure the floor is free of glare, liquids, foreign objects, keep bed in lowest position with brakes locked."</p> <p>The resident "event reports" indicated the resident had falls. A fall occurred on 07-08-12 at 6:47 a.m. The report indicated the resident had been sitting in recliner, had intermittent confusion, balance problems when standing and walking and was found "barefoot" at the time of the fall.</p> <p>An additional fall occurred on 07-10-12 at 12:19 a.m. while the resident was "sitting in recliner in the dining room." The event report indicated the resident was "barefoot." The document indicated a "new intervention" included "non skid</p>		<p>implemented.</p> <ul style="list-style-type: none"> Nurses will check alarms every shift for appropriate functioning and this is noted on the treatment record. <p>Education will be provided to nursing staff regarding the systemic change above.</p> <p>4. The Unit Manager or designee will monitor that rounds are conducted every shift by the licensed nurse to observe for implementation of fall interventions as well as the every shift alarm check on the TAR by nurses. In addition, the Unit Manager or designee will review the C.N.A. assignment sheets for signature of the C.N.A. to signifies the C.N.A. is aware of and implanted the fall intervention. These audits will be conducted daily for 30 days, then weekly for 60 days, then every other week for a total of 12 months of review. Any concerns will be addressed.</p> <p>The Director of Nursing or designee will review the Unit Manager's rounds for implementation of fall interventions three times a week for 30 days, then weekly thereafter. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.</p>	

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	<p>footwear."</p> <p>During an observation on 07-17-12 at 9:05 a.m., the resident was seated in a wheelchair in the dining room. A Certified Nurses Aide was in attendance and attempted to feed the resident. The resident refused numerous attempts by the certified nurses aide. The certified nurses aide left the resident unattended and went to various tables to assist other residents with their breakfast. The alarm to alert the nursing staff of unassisted ambulation had not been attached to the wheelchair.</p> <p>During interview on 07-17-12 at 9:25 a.m. Licensed Nurse employee #8 verified the alarm was not attached to the resident's wheelchair.</p> <p>3.1-35(g)(2)</p>		Completion Date: August 16, 2012	

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F0309 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, interview and record review, the facility failed to provide treatment to abrasions, in that when a resident was noted with abrasions, the nursing staff failed to ensure a resident's received appropriate treatment to the affected areas for 1 of 1 resident reviewed with abraised skin areas in a sample of 3. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The hospital discharge instructions, dated 06-29-12, included "balsam Peru/castor oil/trypsin topical (Vasolax topical ointment) 1 App [application] two times a day as needed for not specified to the skin <sic>."</p>	F0309	<p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEES WELL BEING</p> <ol style="list-style-type: none"> 1. Resident "A" no longer resides at the community. 2. All residents with abrasions have been identified and are receiving appropriate treatment to the affected areas. 3. The systemic change includes all weekly skin assessments are conducted by the licensed nurse and reviewed by the Unit Manager for appropriate treatment to an affected area. Weekly skin assessments are reviewed and discussed at the daily (Monday through Friday) clinical meeting, including a discussion of appropriate treatment for any new skin abrasions. Any concerns are addressed at the daily clinical meeting. <p>Education will be provided to licensed nurses regarding obtaining appropriate treatment for any newly identified skin abrasion. In addition, education will be provided to nursing administration regarding the</p>	08/16/2012			

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	<p>The admission nursing assessment, dated 06-29-12, indicated the resident was admitted to the facility without concerns of skin breakdown or abrasions.</p> <p>The Initial Minimum Data Set Assessment, dated 07-06-12, indicated the resident was assessed as "extensive assistance" with dressing.</p> <p>Review of the 07-04-12 "weekly skin sheet" instructed the nursing staff as follows: "Directions: Nursing Assistants will monitor skin daily and report problems to the licensed nurse. The licensed nurse will validate all reported skin integrity problems and initiate an action plan." The flow sheet completed by a CNA [certified nurses aide], identified a scar to the resident's left lower leg "scar" and an additional area noted to the resident's left foot. This "Skin Integrity Flow Sheet," was signed by Licensed Nurse employee #6. A notation at the bottom of the flow sheet instructed the nurse as follows, "Nurse must do skin assessment. No exceptions."</p> <p>During observation on 07-16-12 at 11:45 a.m., the resident was seated in a recliner with family members in attendance. The resident pulled off the socks to both feet, and during this observation, the toes on</p>		<p>above systemic change.</p> <p>4. The Unit Manager or designee will review all weekly skin assessments for identification of and appropriate treatment of skin abrasions 5 days a week. Any concerns will be addressed.</p> <p>The Director of Nursing or designee will review that weekly skin assessments are discussed at the daily clinical meeting (Monday through Friday) including a discussion of appropriate treatment for any new skin abrasions. This review will be conducted 3 times a week for 30 days, then weekly for 60 days, then every other week thereafter for a total of 12 months of auditing. Any concerns will be addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.</p> <p>Completion Date: August 16, 2012</p>		

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	<p>the left foot appeared bruised and scabbed.</p> <p>During observation on 07-17-12 at 9:25 a.m., with Licensed Nurse employee #8 in attendance, a body assessment was conducted. The Licensed Nurse removed the resident's shoes and socks.</p> <p>The resident's left foot had areas which appeared as scabs noted on the great toe, 1st, 2nd, 3rd and 4th toes. The area adjacent to the resident's left knee was also scraped. The Licensed Nurse employee #8, felt the areas on the resident's toes and indicated "It's smooth. I didn't know about these."</p> <p>The Licensed Nurse measured the areas and provided the following measurements:</p> <p>"Left ft. [foot] toes: #1 - 1.5 cm [centimeters] by 1.0 cm, #2 - .6 cm by 0.6 cm, #3 - 0.3 cm by 0.3 cm and top of toe 0.3 cm. by 0.2 cm., #4 - 0.3 cm by 0.3 cm and top of toe 1.0 cm by 0.2 cm."</p> <p>"Lt. [left] side knee #1 - 1.0 cm by 0.5 cm, #2 - .5 cm by 0.2 cm, #3 - 0.3 cm by 0.1 (scratches)."</p> <p>"Knee outter <sic> aspect 0.4 cm by 0.2 cm and 0.2 in diameter."</p>			

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	<p>A notation dated 07-17-12 at 11:50 a.m. indicated "N.O. Sting Skin Prep q [every] shift" over 24 hours after the initial observation of the resident.</p> <p>3.1-37(a)</p>			

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F0314 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, interview and record review, the facility failed to ensure appropriate treatment for a resident with a pressure ulcer, in that when a resident was identified with a pressure ulcer and the ulcer increased in size, the facility failed to provide the necessary treatment and services to promote healing and prevent infection for 1 of 1 resident reviewed for pressure ulcers in a sample of 3. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 07-16-12 at 9:45 a.m. Diagnoses included but were not limited to malignant neoplasm of the pancreas, delirium, and dementia. These diagnoses remained current at the time of the record review.</p> <p>The hospital discharge instructions, dated</p>	F0314	<p>F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <ol style="list-style-type: none"> Resident "A" no longer resides at the community. All residents with a pressure ulcer have been identified and reviewed for an increase in size as well as provision of necessary treatment and services to promote healing and prevent infection. The systemic change includes: <ul style="list-style-type: none"> Weekly skin checks will be completed by licensed nurses for all residents and reviewed by the Unit Manager or designee at the daily (Monday through Friday) clinical meeting. This includes a review for an increase in size as well as provision of necessary treatment and services to promote healing and prevent infection. A pressure ulcer evaluation is conducted by the Unit Manager or designee weekly on all residents with an existing pressure ulcer. This evaluation is reviewed by the 	08/16/2012			

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	<p>06-29-12 included "balsam Peru/castor oil/trypsin topical (Vasolax topical ointment) 1 App [application] two times a day as needed for not specified to the skin <sic>."</p> <p>The admission nursing assessment, dated 06-29-12, indicated the resident was admitted to the facility without a pressure ulcer.</p> <p>Review of the notation titled "Observation details," dated 07-02-12, indicated the resident was "noted to have small pressure wound to sacral area. Resident denies pain or discomfort. Vasolex cream applied as ordered." The document indicated the area was classified as a "Stage 2" [partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough] - and measured .3 cm [centimeters] by .5 cm. depth < 0.1 cm."</p> <p>The Initial Minimum Data Set Assessment, dated 07-06-12, indicated the resident was admitted to the facility without a pressure ulcer but was at risk for developing pressure ulcers. The resident's "initial" plan of care, dated 06-29-12, the resident was at risk for skin breakdown related to incontinence, CA [cancer], and decreased mobility. Interventions included "report signs and</p>		<p>interdisciplinary team weekly at the facility's At Risk Meeting for an increase in size as well as provision of necessary treatment and services to promote healing and prevent infection. Any increase in size is communicated to the physician for changes in treatment as deemed appropriate by the physician.</p> <p>A licensed nurse will make rounds with physicians and discuss any current pressure ulcers during rounds, including any increase in size of a pressure ulcer and appropriate treatment for the same. Education will be provided to licensed nurses regarding the above mentioned systemic changes.</p> <p>4. The Unit Manager or designee will review all weekly skin assessments daily for changes in skin conditions. In addition, the Unit Manager or designee will review the physician documentation during facility rounds in regards to documentation regarding current skin condition weekly for 12 months of monitoring. Any concerns will be addressed.</p> <p>The Director of Nursing or designee will review the weekly pressure ulcer evaluation weekly at the At Risk Meeting for an increase in size as well as provision of necessary treatment and services to promote healing and prevent infection and physician notification. This review will continue for a duration of 12 months and any concerns will be</p>		

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	<p>symptoms of breakdown (sore, red, tender, or broken down area)."</p> <p>The resident's "initial" plan of care, dated 06-29-12, indicated the resident was at risk for skin breakdown related to incontinence, CA [cancer], and decreased mobility. Interventions included "report signs and symptoms of breakdown (sore, red, tender, or broken down area)."</p> <p>Review of the 07-04-12 "weekly skin sheet" instructed the nursing staff as follows: "Directions: Nursing Assistants will monitor skin daily and report problems to the licensed nurse. The licensed nurse will validate all reported skin integrity problems and initiate an action plan." The flow sheet completed by a CNA [certified nurses aide], lacked identification of the ulcer on the resident's sacral area.</p> <p>This "Skin Integrity Flow Sheet," was signed by Licensed Nurse employee #6</p> <p>The current "skin assessment" dated 07-16-12 indicated the area was noted as a "Stage 2" pressure ulcer which now measured "2.6 cm by 2.0 cm and no depth."</p> <p>During observation on 07-17-12 at 9:25 a.m., with Licensed Nurse employee #8 in attendance, a body assessment was</p>		<p>addressed.</p> <p>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter. Frequency and duration of reviews will be increased as needed.</p> <p>Completion Date: August 16, 2012</p>	

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	<p>conducted. The Licensed Nurse removed the resident's pajamas, and incontinent brief. The incontinent brief was stained with bright red blood. The opened pressure ulcer on the resident's sacral area was red in color.</p> <p>During interview on 07-17-12 at 12:30 p.m., Licensed Nurse employee #8 indicated the nursing staff used the Vasolex ointment as a treatment to the pressure ulcer, as originally noted on the hospital discharge instructions and a subsequent physician order dated 07-02-12.</p> <p>The resident's record lacked documentation or notification of the resident's physician for additional treatment/intervention to prevent the possibility of continued deterioration or potential of infection as the pressure ulcer increased in size from 07-02-12 until 07-16-12.</p> <p>In addition, the physician progress notes dated 07-01-12, 07-03-12 and 07-11-12 indicated the resident's skin was "warm, dry and intact," without open areas.</p> <p>The facility policy titled "Pressure Ulcer Treatment," reviewed on 07-17-12 at 2:00 p.m., indicated the following:</p>			

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	<p>"Progress Toward Healing [bold type]: If a pressure ulcer fails to show some evidence towards healing within 2 - 4 weeks, the pressure ulcer and the resident's overall clinical condition should be reassessed. Reevaluation of the treatment plan including determining whether to continue or modify the current interventions is also indicated. If, following assessment, the current treatment regimen is retained, documentation of rationale is placed in the clinical record."</p> <p>3.1-40(a)(2)</p>			