

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/07/2013
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R000000	<p>This visit was for the investigation of Complaint IN00138487.</p> <p>Complaint IN00138487 - Substantiated. State deficiency related to allegation is cited at R0036.</p> <p>Survey dates: November 4 & 7, 2013</p> <p>Facility number: 010416 Provider number: NA AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: Residential: 62 Total: 62</p> <p>Census payor type: Other: 62 Total: 62</p> <p>Sample: 5</p> <p>This state finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on November 8, 2013.</p>	R000000	<p>The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the complaint survey completed on 11/7/13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.</p>	

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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R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview the facility failed to ensure the physician was notified of a resident's change in condition, in that when a resident's condition changed in regard to mental status changes, an increase in temperature and progressive integumentary changes, the nursing staff failed to immediately notify the resident's physician for intervention for 1 of 3 resident's reviewed for change in condition in a sample of 5. (Resident "A").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 11-04-13 at 11:25 a.m. Diagnoses included, but were not limited to, Frontal Temporal Dementia, dementia with behaviors, hemiplegia, depressive disorder, history of fall, abnormality of gait, debility, impaired decision making,</p>	R000036	The following is the Plan of Correction for Clare Bridge of Carmel in regards to the Statement of Deficiencies for the complaint survey completed on 11/7/13. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective. What corrective action(s) will be accomplished for those residents found to have	12/06/2013			

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	<p>coronary artery disease and incontinence. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 12-28-12.</p> <p>A review of the physician progress notes, dated 01-28-13 indicated the resident "has had a new rash on buttocks for a week. Patient is unable to provide history due to dementia. Skin B [bilateral] patchy, circular pink lesion on V buttocks and in midline crease, discrete and raised borders. Assessment and Plan - Tinea Corporis [ring worm] - Ketoconazole 2% daily until resolved."</p> <p>The record indicated the resident received the prescribed treatment as ordered.</p> <p>The record indicated the resident again presented with this fungal infection and received physician orders, dated 03-24-13, for Miconazole Cream 2% with instruction to the nursing staff to "apply sparingly with cotton tip applicator two times a day for one week then re-evaluate - start when [medication] arrives." A review of the Treatment Administration Record indicated the prescribed medication arrived at the facility on 03-26-13 and</p>		<p>been affected by the alleged deficient practice?~Resident A no longer resides at the community. The community continued to communicate openly with the resident's wife regarding all observations, as well as to attempt to help her cope with the resident's progressive illness. She was a frequent visitor of the community, and staff made every attempt to help and guide her through the disease progression associated with frontal-temporal lobe dementia. If "concerned family member", as quoted in the survey, was unaware, it is possible only because this family member did not visit or because the wife chose not to share such information with them. Due to privacy issues involved in this resident's care, the community is only allowed to share information as dictated by the responsible party's preferences. In addition, the ER note: "Wound/Ostomy report dated 6-18-13" indicates a "boil present for a month". We would like to respectfully disagree with this statement/observation as it conflicts with all documentation provided by the Home Health Agency nurse, as well as the community nurse observations. As is common practice for our assisted living, in the event the resident does not have a physician willing to come to the community to see their patient, the family must make appointments to see their</p>				

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	<p>the resident received the treatment through 04-01-13.</p> <p>The record indicated a physician order dated 04-01-13, for treatment to the area of the resident's left upper thigh for Miconazole lotion 2% apply sparingly with cotton tip applicator two times a week then re-evaluate." A notation at the bottom of the physician order indicated "noc [night] nurse to notify family in a.m."</p> <p>The nurses notes, dated 04-10-13 indicated the facility received an additional order to continue the medication but the family requested to "hold" on the administration of the medication and the family member would "advise 04-17-13."</p> <p>A physician progress notes dated 05-20-13 indicated the residents "chief complaint" was weakness. The physical exam indicated the resident again had "B patchy, circular pink lesion on V buttocks and in midline crease, discrete and raised borders. Assessment and Plan: 1. Tinea Corporis - Ketoconazole 2 % daily until resolved."</p> <p>The record lacked a physician order for the prescribed treatment.</p>		<p>physician of choice. The physician visit occurred on 6-18-13, at which time the physician sent the resident to the ER for further evaluation and treatment. the primary physician and hospital then assumed all care for the resident. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?~A 100% audit all residents has been completed by licensed nurses to determine the status of all residents' skin. These skin observations contain a Braden scale to determine frequency of further skin observation. No significant findings were noted. Routine skin observations will continue on a monthly basis for residents with a Braden score greater than 16, but will continue on a weekly basis for residents with Braden of 16 or below or with any existing open area.Nursing staff have been re-educated on the exisitng Skin Integrity Program, as well as given instruction related to "Notification Requirements for changes in condition". Please Note: the "policy" noted in the survey document by the surveyor "When to notify the Physician" and dated 3-11-03 is NOT a current policy, rather it was a docuement written by a previous medical director no longer employed by the community. It applied to a time</p>				

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	<p>During an interview on 11-07-13 at 11:00 a.m., the physician who examined the resident on 05-20-13 indicated, "Yes I saw him and the area. I wanted him to have the Ketoconazole. I was not the primary physician for him and the nursing staff should have contacted his primary physician to get the order. The nurses will ask me to look at resident's from time to time, for reasons like a runny nose, that sort of thing. But a lot of the resident's there have their own doctors."</p> <p>The record lacked documentation the primary physician had been notified of the resident's condition as noted on 05-20-13 and the resident did not receive treatment as recommended.</p> <p>The record also indicated the resident received Home Health Care Services.</p> <p>The Home Health Care "Visit Note," dated 05-30-13, indicated the resident was assessed with bruising, poor turgor [skin] rash, itching." The "notation" section of the report indicated "AL [assisted living] HHA [home health aide] notified this writer Pt [patient] has skin irritation. Writer observed skin rash like area in groin area that runs down BLE [bilateral lower extremities] thighs. Old</p>		<p>when the community was certified as a skilled nursing provider (SNF), and was not given to her by the Health and Wellness Director or Executive Director of this community. Re-training on the current policy was provided by the Executive Director/Health and Wellness Director/ (LPN)/designee. An Alert-Charting log will be utilized to communicate changes in resident condition. Documentation for residents on the Alert Charting log will include vital signs q shift x a minimum of 72 hours. A nurse will be designated to review the log for compliance with physician/family notification on a daily basis and report any non-compliance to the Health and Wellness Director or Nurse Designee. Community Health and Wellness Director/Nurse Designee will meet weekly with Home Health Third-Party providers x 4 weeks to review resident skin concerns. Thereafter, meetings will occur every two weeks, on-going to review residents with at-risk findings/changes in condition. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ~Alert-charting logs will be utilized as an in-house communication tool to ensure proper notifications and documentation for the clinical</p>	

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	<p>reddened and purple rash on buttocks. AL nurse states Pt has had similar rash in the past. Dr. [name] notified."</p> <p>The facility Nurses Notes, dated 05-30-13, indicated "Resident seen by ISC [Innovative Senior Care], noted rash on groin and thighs. ISC nurse called Dr. [name] to get orders for tx. [treatment]."</p> <p>The record lacked further physician orders or follow up by the nursing staff in regard to the treatment.</p> <p>During an interview on 11-07-13 at 11:50 a.m., Licensed Nurse # 5 indicated "[Resident "A"] had these rashes in the past. It had to do with skin breakdown that he had in the past. I gave the aides education about keeping [Resident "A"] clean and dry. It wasn't weeping - I thought it was mostly like a healed area - like skin breakdown especially for [Resident "A"] being incontinent. When I do my assessments I usually don't take their clothes completely off. If the aide tells me there is a concern I would look at that. The rash area or that area on [Resident "A"] looked like skin breakdown to me."</p> <p>Further review of the Nurses notes</p>		<p>record.~Skin observation forms will be completed for all residents once monthly.~For residents with a Braden score of 16 or less, and/or any resident with an existing open area, Skin Observation Forms will be completed on a weekly basis.~Any residents with a stage II or above wound will be referred to a third-party provider Home Health Organization for further support and treatment recommendations.~In the event a stage II or above wound is noted, the physician and responsible party will be notified within 24 hours of finding. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place?~Collaborative Care meetings will occur 2 x monthly to review residents with changes of condition and other at-risk situations.~Physician and responsible party notification will occur per existing policy.~Outside Home Health agencies will be required to provide all pertinent documentation to the community within a 7 day timeframe, and any new orders obtained by an outside agency are to be communicated to the community nurse within 8 hours. ~The Regional Nurse will meet with the Home Health Agency representatives, as well as the community Health and Wellness Director to implement further</p>				

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	<p>from 05-30-13 through 06-14-13 lacked further assessment, family or physician notification of the resident's status.</p> <p>The nurses notes, dated 06-15-13 at 9:00 a.m. indicated "Res. [resident] has a temp. [temperature] 103.0, have given [resident "A"] Tylenol to see if that will help. Family has been notified and will continue to monitor."</p> <p>"06-15-13 9:30 a.m. - Resident's fever has gone done [sic] some after the PRN [as needed] Tylenol. Currently temp. is 101.0 and will continue to monitor"</p> <p>"06-15-13 2:00 p.m. - Resident's temp has since stabilized at 98.6. Will continue to monitor."</p> <p>"06-15-13 6:30 p.m. - Temp this shift 99.0 No s/s [signs or symptoms] of pain or discomfort."</p> <p>"06-16-13 2:20 - Resident resting in recliner at this time. Temp 100.6 PRN Tylenol given. Cool compress placed on resident forehead and neck. Fluids encouraged. Area to right buttocks open. Dressing placed. Will continued to monitor."</p> <p>"06-18-13 7:25 - Resting in bed at</p>		recommendations, based on outcomes.				

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	<p>this time. Temp 99.1. Resident has red rash covering bilateral legs, trunk and bilat. [bilateral] arms. Resident somewhat lethargic. Area on buttocks cleansed, dry dressing applied. Cool cloths placed on resident forehead. Left message with POA [Power of Attorney], MD's [Medical Doctor] office unable to leave VM [voice mail] Will continue to mtr. [monitor]."</p> <p>"06-18-13 8:25 POA returned call to facility. POA advised resident needs to be examined by MD. POA will call and make MD appt. [appointment] today."</p> <p>"06-18-13 11:20 Resident left facility with POA for MD appt. [appointment]."</p> <p>2. A review of the hospital Emergency Room record on 11-07-13 at 8:30 a.m. indicated the following:</p> <p>"C/O [complaints of] fever about 6 days. Boil on buttock started small - large and draining. Fever 103 degrees - not continent of bowel and bladder. History of fungal rash on groin - responded to treatment. Decreased responsiveness for about 2 days. Referred by Dr. [name of family physician]."</p>			

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	<p>"Pt. [patient] came thru ED [emergency department] with sepsis/large gluteal ulcer. Surgical intervention noted as needed for gluteal ulcer."</p> <p>"Fever about 6 days and diffuse body rash. 103 [temperature] on 06-15-[2013], Tylenol - chronic rash fungal genital, abdomen, buttocks spreading to legs, itching - wound buttocks since at least 1 month."</p> <p>"Impression Assessment: 1. Right buttock wound progressing over one month. Likely secondary to pressure per wound care with secondary infection possible given fever 103. 2. Sepsis, tachycardia, febrile with likely since buttocks wound."</p> <p>The Wound/Ostomy report, dated 06-18-13 indicated "Pt. chart states pt had a boil to right buttocks for 1 month. Area has increased in size since then. Wound sits over right ischium and may be partially pressure related. Wound with surrounding erythema and induration. Pt with temp. from 100.5 to 103.</p> <p>The hospital notation dated 06-19-13 indicated the resident had "Rt. [right] ischial pressure ulcer - 1. sepsis</p>			

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	<p>likely secondary to infected pressure ulcer, 2. ischial ulcer - local debridement of necrotic tissue. CT [cat scan] with evidence of gas - no abscess. Likely needs debridement and wound care."</p> <p>"The large right gluteal ulcer is not open at the surface, to explain the air in the muscle - must assume deep infection and probably needs to be opened surgically."</p> <p>The hospital record further indicated debridement of the right buttocks decubites ulcer with drainage on 06-19-13. The report indicated the area was "warm with surrounding erythema yellow and black slough at the base and odor present. The area measured 10 by 3.5 by 0.2 centimeters with suspected "deep tissue infection."</p> <p>In addition the hospital performed cultures in which "the cultures were found with MRSA [Methicillin Resistant Staphylococcus Aureus]."</p> <p>The Hospital record indicated the resident expired on 06-27-13. The "cause of death included, "A. sepsis, B. Pressure Ulcer, C. Frontotemporal Dementia."</p>			

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	<p>During an interview on 11-08-13 at 7:30 a.m., a concerned family member indicated, "I went to visit [resident] on Father's Day. I couldn't believe the difference. He was so tired, so I asked the nurse if [resident] had been given anything. She told me there was nothing new, but that he did have a fever that they were treating with Tylenol. That was on a Sunday. On Tuesday, [family member] received a call that we needed to take him to the doctor. We did, and when the doctor saw him he told us to take him to the Emergency Room at [nameof hospital]. We couldn't believe it when they told us that he had a large pressure ulcer. We had no idea. They had to do surgery on it, and [resident] just continued to get worse. They told us it was the infection due to the pressure ulcer. [Resident] died the following week. Because of his dementia he couldn't talk or tell us if he was in pain."</p> <p>When further interviewed if the family had been told the resident had earlier been diagnosed with ringworm, the concerned family member indicated "no."</p> <p>The nursing staff failed to ensure the resident's family and physician were</p>			

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	<p>notified regarding the resident continued decline. The nursing staff failed to provide ongoing assessments regarding the resident's skin and cognitive status to the physician for possible intervention.</p> <p>3. Review of the facility policy on 11-04-13 at 10:10 a.m., titled "Physician Notification Summary - When to call the Doctor," dated 03-11-03, indicated the following:</p> <p>"Condition - Acute Change in Mental Status. Immediate (Call) sudden onset of change in mental status. Non-Immediate (Write in M.D. [Medical Doctor],/ N.P. [Nurse Practitioner Book) Gradual change in responsiveness."</p> <p>"Condition - Pressure Ulcer. Immediate Stage 2, 3 or 4 receiving no treatment and treatment protocol not available to cover condition. Wound infection, purulent discharge, erythema, fever. Non-Immediate New Stage 1 or 2 pressure sore. any state, when current treatment is not effective, progression of Stage 2 pressure sore to a Stage 3 or 4."</p> <p>"Condition - Skin rash. Immediate Significant urticaria with swelling about the face and neck. Rash in</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>someone taking a new medication. Rash or blister formation associated with pain or fever. Non-Immediate Generalized utricaria without symptoms, localized, no other symptoms, recurrent."</p> <p>This State findings relates to Complaint IN00138487.</p>						