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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 06/03/2014 |
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| NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF VALPARAISO | STREET ADDRESS, CITY, STATE, ZIP CODE 3405 N CAMPBELL RD VALPARAISO, IN 46385 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00149769.</p> <p>Complaint IN00149769- Substantiated. Federal/State deficiency related to the allegations were cited at F314.</p> <p>Survey dates: June 2 and 3, 2014</p> <p>Facility number: 000224 Provider number: 155331 Aim number: 100267700</p> <p>Survey team: Regina Sanders, RN, TC Heather Hite, RN (June 3, 2014)</p> <p>Census bed type: SNF: 19 SNF/NF: 81 Total: 100</p> <p>Census payor type: Medicare: 31 Medicaid: 56 Other: 13 Total: 100</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> | F000000 | <p>I respectfully request consideration for paper compliance. I have forwarded additional supportive documentation via fax today (6-13-14) to 1-317-233-7322. Please reference the attached 2567 as "Credible Allegation of Compliance" for a complaint survey conducted on June 2-3, 2014. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws. Please feel free to contact us should you have any questions. Thank you. Amber Janeczko, Executive Director</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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| F000314 SS=D | <p>Quality review completed on June 6, 2014, by Janelyn Kulik, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review, and interview, the facility failed to follow a Physician's order for a treatment of a pressure sore, failed to assess a pressure sore, and failed to notify a resident's Physician of the pressure sore, for 1 of 3 residents reviewed for pressure sores in a total sample of 5. (Resident #D)</p> | F000314 | F314SS=D1. The area identified on Resident #D was assessed by licensed nursing staff, measurements recorded and the physician and responsible party were informed by 6/3/14. An appropriate treatment was in place as of 6/2/14 and confirmed as appropriate by the Wound Care physician on 6/4/14. | 06/25/2014 |

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| | <p>Findings include:</p> <p>During an initial tour of the facility on 06/02/14 at 9:10 a.m., LPN #1 indicated Resident #D had a pressure area.</p> <p>Resident #D's record was reviewed on 06/03/14 at 9:35 a.m. The resident's diagnoses included, but were not limited to, multiple sclerosis and dementia.</p> <p>A resolved care plan, dated 11/12/13, indicated the resident had a Stage IV pressure sore (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) on her right hip. The care plan indicated the area was healed on 12/25/13, then on 01/05/14 the resident was readmitted with an unstagable area with a scab over the center of the area, which was resolved on 02/12/14 per the Wound Physician.</p> <p>The care plan interventions, included complete weekly skin check (discontinued 02/12/14), notify the Nurse immediately of any new areas (discontinued on 02/12/14), and wound care as ordered (see current Wound Treatment and Progress Record) (discontinued on 02/12/14)</p> | | <p>Resident #D's care plan was updated to reflect the wound by 6/3/14. 2. In order to identify any other residents with pressure areas that were not monitored per facility policy, all facility residents had head to toe skin assessments performed by licensed nurses by 6/7/14. A listing of residents with wound care treatments was obtained from Medical Records staff at Care Pharmacy by 6/6/14 and used by Nursing Administrative staff to ensure that all open areas had an appropriate treatment in place and that all areas with treatments were being assessed by licensed staff. These audits were completed by 6/9/14. 3. Education was developed by the Staff Development Coordinator and DON by 6/10/14 to address the management of pressure areas and presented to licensed nursing staff by 6/15/14. This education included the policy and procedure for identification of pressure areas, weekly wound care assessments and weekly skin assessments. Additional training was also provided regarding the responsibility of licensed nurses to communicate any changes in the status of a wound to the Charge Nurse and/or Nursing Administration. As of 6/13/14, a listing of all wound care treatments will be provided weekly by Care Pharmacy Medical Records staff for Nursing Administrative staff to use to</p> | | |

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| | <p>A care plan, dated 06/16/14, goal date of 07/10/14, indicated the resident was a risk for further development of pressure ulcers. The interventions included, complete weekly skin assessment, notify the Nurse immediately of any new areas of the skin, and report changes in skin status to Physician.</p> <p>The Physician's Recapitulation Orders, Dated 06/14, indicated an order, dated 01/23/14 to cleanse the resident's right hip with normal saline, apply small amount of hydrogel (wound ointment, which promotes granulation and debridement) to wound bed, cover with foam and change every two days.</p> <p>A) A Wound Care Specialist Evaluation, dated 02/12/14, indicated the unstagable (necrosis) area on the right hip was resolved on 02/12/14 and to continue the treatment of the hydrogel as ordered for protection of the area until the scab on the area fell off.</p> <p>There was a lack of documentation to indicate the right hip area had continued to be assessed for the condition of the scab.</p> <p>The Treatment Administration Record (TAR), dated 03/14, indicated the hydrogel treatment continued every two</p> | | <p>correlate treatment plans with areas of skin breakdown identified per Weekly Wound Care Measurements on each unit. 4. The DON and/or designee have developed an audit tool to monitor for compliance with the policy for identification and management of skin breakdown and ensure all areas of skin breakdown are assessed with an appropriate treatment plan. Audits by DON and/or Designee will continue weekly for a minimum of 6 months to ensure compliance. The DON/Designee presents a report of her findings at the monthly QAQI meeting. Any negative trends will be addressed with an action plan. The criteria for determining that monitoring is no longer necessary will be 100% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional 6 months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules. DATE CERTAIN: 6-25-14</p> | | | | |

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| | <p>days from 03/01/14 through 03/31/14, except on 03/19/14 and 03/21/14 (no initials on TAR).</p> <p>The TAR, dated 04/14, indicated the hydrogel treatment continued every two days from 04/01/14 through 04/20/14, except on 04/12/14 (no initials on TAR).</p> <p>The TAR, dated 05/14, indicated the hydrogel treatment continued every two days from 05/01/14 through 05/31/14.</p> <p>The Nutrition Intervention Program progress note, dated 03/06/14, indicated the right hip had been closed for four weeks.</p> <p>During an interview on 06/04/14 at 1:50 p.m., the Wound Nurse/Assistant Director of Nursing (ADoN) indicated there was no documentation when the scab on the right hip had fallen off. Further interview at 2 p.m., the Wound Nurse/ADoN indicated the floor Nurse should have noted the area healed and discontinued the order for the hydrogel when the scab had fallen off. She indicated the facility follows the healed area for two weeks to ensure the area does not open back up. She indicated the area had healed on 03/05/14 by review of the Nutrition Intervention Program, which did not mention a scab and the</p> | | | | | | |

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| | <p>treatment should have been discontinued on 03/05/14. She indicated the treatment continued after it should have been discontinued.</p> <p>B) During an observation on 06/02/14 at 10:47 a.m., with LPN #1 present, Resident #D had a dressing, dated 06/01/14, on her right hip.</p> <p>The Weekly Skin Integrity Data Collection forms, dated 04/02/14, 04/10/14, 04/16/14, 04/23/14, 04/30/14, 05/07/14, 05/14/14, 05/21/14, and 05/28/14 indicated the hip treatment had been completed. There was a lack of documentation to indicate the right hip appearance had been assessed or the resident's Physician had been notified of the appearance of the right hip.</p> <p>During an interview on 06/03/14 at 2 p.m., the Wound Nurse/ADoN indicated the first she was aware of a concern on the right hip was 05/09/14 when the Midnight Nurse had documented the right hip had an abrasion area. She indicated the resident actually had an abrasion area on the inner right thigh and the documentation stating it was on the right hip was an error in charting. She indicated she had asked the Charge Nurse to verify the area. She indicated there was no documentation of the appearance</p> | | | |

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| | <p>of the right hip. She indicated she was unsure of the exact date the right hip had re-opened and the staff had not informed her the area was open. She indicated she had not assessed the right hip. She indicated no one had reported the right hip pressure area and it should had been reported to her.</p> <p>A Pressure Ulcer Status Record, indicated the area on the right hip was first observed on 06/03/14, was located on the right hip over a previous Stage IV area, was staged at a Stage IV (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling) with measurements of 0.3 cm (centimeter) x 0.4 cm with a depth of 0.1 cm (Stage II-partial thickness loss of dermis, shallow open ulcer with red or pink wound bed, without slough).</p> <p>During an interview on 06/03/14 at 2:50 p.m., the Wound Nurse/ADoN indicated she had been taught with wound care training when a Stage III or IV area reopens, the area was staged at this stage because the area was now considered scar tissue and the tissue was no longer considered healthy tissue. She indicated it was common practice to stage the area what it had been prior to healing. She indicated LPN #1 denied knowledge of</p> | | | |

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| | <p>the right hip open area. She indicated if the treatment was still being done on the right hip, the Nurse should have seen the open area on the right hip.</p> <p>Resident #D's right hip area was observed with the Wound Nurse/ADoN and the RN Nurse Consultant present on 06/03/14 at 3 p.m., The Wound Nurse/ADoN indicated the right hip had pink scar tissue with an opening of 0.4 cm x 0.5 cm with 0.1 cm depth. Both the Wound Nurse/ADoN and the RN Nurse Consultant indicated the area on the right hip was a pressure area and the resident's Physician and the Wound Care Specialist would be notified.</p> <p>A facility policy, dated 10/07/10, titled, "Pressure Ulcer Program Manual", received from the Administrator as current, indicated, "...Treatment orders...After observation/evaluation of the affected skin area, the physician is notified...The physician order is followed...Pressure ulcers as assessed and monitored once a week...with each dressing change, the pressure ulcer is observed for developments that may indicate the need for change in treatment..."</p> <p>This Federal Tag relates to complaint IN00149769.</p> | | | |

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| | 3.1-40(a)(1) 3.1-40(a)(2) | | | |