

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155376	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/03/2013
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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069
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F0000	<p>This visit was for the Investigation of Complaint IN00121500.</p> <p>Complaint: IN00121500 Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F309 & F323.</p> <p>Survey dates: January 2 & 3, 2012</p> <p>Facility Number: 000336 Provider Number: 155376 AIM Number: 100290170</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 65 Total: 65</p> <p>Census Payor Type: Medicare: 9 Medicaid: 47 Other: 9 Total: 65</p> <p>Sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the plan of correction is prepared and submitted solely because of the requirements under State and Federal law.	

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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	Quality Review completed on 1/11/13, by Brenda Meredith, R.N.				

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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 record review and interview, the facility failed to immediately notify a physician for possible intervention or keep interested family members informed,</p>	F0157	1. Resident A discharged from facility on 12/14/2012.2. A review of all current residents charts from 11/19/12 to current was completed by 01/23/2013, to insure the physician	02/02/2013			

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	<p>in that when a resident received an injury during a transfer, the nursing staff failed to promptly notify the physician of radiology recommendations, the need for additional treatment with possible involvement of a wound care specialist and inform interested family members of a decline in status related to an injury for 1 of 3 resident's reviewed for injury/occurrences in a sample of 7. [Resident "A"]</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 01-02-14 at 10:30 a.m. Diagnoses included but were not limited to, senile delusions, convulsions, difficulty in walking, lack of coordination, cerebral atherosclerosis, diabetes mellitus and chronic obstructive pulmonary disease. These diagnoses remained current at the time of the record review.</p> <p>Review of the nurses progress notes indicated the following:</p> <p>"12-01-12 at 0045 [12:45 a.m.] Resident was sitting in recliner chair. When CNA [certified nurse aide] went to give incontinent care, she lowered</p>		<p>and resident's legal guardian or interested family member was informed of all incidents involving injuries, radiology reports with recommendations, significant alterations in treatment or a significant decline in status.3. The DON or designee will review all inc/acc reports, physician orders and the 24 hr reports to determine all residents with an inc/acc with injury, radiology reports with recommendations, significant alteration in treatment and significant decline in status. The DON or designee will review the chart to insure the physicaian and family were notified and that documentation is present. Any failure to do so will be listed on the daily Homework Sheet for completion and follow up. The DON or designee will initial each incident report, physicians order and 24 hour report when reviewed. An Inservice was held on 1/18/13 and 1/21/13 on notification of changes for all licensed nurses.4. The DON or designee will record any resident with an incident/ accident investigation with injury, radiology report with recommendations, significant alteration in treatment or sign of decline in status on the QAPI monitoring tool. The DON or designee will attest all changes have been reported to the physician and family.Licensed staff responsible, DON or designee to monitor. QAPI to review monthlyfor compliance of</p>		

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	<p>pt. [patient] to the floor d/t [due to] unable to follow directions [resident] placed left forearm to the floor. Obtained injury swelling and bruising noted. Ordered x-ray ordered [sic]. M.D. [Medical Doctor] aware and notified. Nurse on call aware and family aware and notified."</p> <p>"12-01-12 11:00 a.m. Results of x-ray left forearm marked as soft tissue swelling notes. Left hip x-ray shows mild osteoarthritis to left hip. MD on call notified of results and awaiting on call back due to a diffieur [sic] from 11-16-12."</p> <p>"12-02-12 at 0430 [4:30 a.m.] forearm swelling persist. Left hip swelling and bruising noted."</p> <p>"12-02-12 Left arm edematous, firm and reddened."</p> <p>"12-03-12 at 0100 [1:00 a.m.] Resting in bed. Yells out with T & R [turning and repositioning] et [and] ADL [activities of daily living] care. 3+ edema to left elbow, moves arm without grimaces or yelling out. Left hip discoloration cont. [continues]."</p> <p>"12-03-12 at 1400 [2:00 p.m.] note left arm still edematous, reddened and firm area opened - lg. [large]</p>		100%DOC: 2/02/13Addendum: Homework sheets are initialed when completed and returned to DON or designee whom will ensure it was completed. Any task not completed on next scheduled sift will be addressed by Supervisor to include additional training, coaching and or disciplinary action.				

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	<p>amount of bleeding. Area cleansed and dressed. Note lg. [large] bruise cont. left hip. swelling cont. but has not moved past previously marked and measured area. Phys. [physician] response to monitor bruising."</p> <p>"12-03-12 at 2100 [9:00 p.m.] Bruise left hip continues, Res. grimaces in pain when staff moves left leg. Area on left arm bleeding times 1 this shift, dressing changed."</p> <p>"12-04-12 at 1000 [10:00 a.m.] [Name of physician] here. Discussed aspirating blood pool from left arm. Phys. thinks it would not benefit. Order noted to re-X-ray left hip d/t cont. pain - refusal to bear weight. Note bruising and swelling cont. left hip and left arm."</p> <p>"12-04-12 at 1900 [7:00 p.m.] Note area left arm bleeding lg. [large] amts. [amounts] c/o [complains of] little disc. [discomfort] with arm but yells and grimaces with movement of left leg."</p> <p>"12-06-12 at 1400 [4:00 p.m.] Note discomfort esp. [especially] when leg moved. Note copious amts. of blood from left arm - swelling decreased."</p> <p>"12-06-12 at 2100 [9:00 p.m.]</p>			

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	<p>Dressing left arm CDI [clean, dry and intact] Bruise remains and is bigger left upper leg. Res. not standing as good as [resident] once did."</p> <p>"12-07-12 at 0500 [5:00 a.m.] Res. has hole in left forearm 1/2 " by 1/2 " around and 5 " deep. Large amount of yellow green discharge. left forearm was cleansed, wet to dry packing with NS [normal saline] 0.9 % placed into wound. MD notified that res. needs ATB [antibiotic] and dressing changed to BID [two times a day] wet to dry packing until healed."</p> <p>"12-08-12 at 0730 [7:30 a.m.] Res. left forearm dressing dry. Large amount of discharge with odrt [sic] brown in color. Res. to start ATB as ordered."</p> <p>"12-08-12 at 2100 [11:00 p.m.] Note copious amount of milky red drainage coming from left forearm wound when doing dressing change. Left arm warm to the touch. Tunneling at least four inches back toward elbow. Sent fax [facsimile] to MD asking for wound consult."</p> <p>Continued review of nurses notes indicated: "12-09-12 at 2100 [8:00 p.m.] Bruise on left upper leg remains. Wet to dry</p>			

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	<p>dressings change done [in regard to the left forearm] and note moderate amount of milky red drainage. Left hand +1 edema and left arm continues to feel warm to the touch. Res. continues to grimace and say 'ouch' when having to transfer or roll from side to side. Awaiting reply from MD regarding wound consult."</p> <p>"12-12-12 at 1420 [2:20 p.m.] Left forearm cleanse with woud [sic] cleanser, apply silvadene 1 % cr. [cream] cover with non-adhesive drsg., wrap with Kerlix the wrap with coband." The nurses note indicated the area measured 3.3 cm [centimeters] by 1.4 cm by .5 cm." In addition the nursing staff received a subsequent physician order to schedule the resident for an additional x-ray of the left hip.</p> <p>The resident's record indicated that on 12-14-12 at 1510 [3:00 p.m.], the resident was found non-responsive while seated in the lounge area of the South Station, and was subsequently transported to a local area hospital for evaluation and treatment.</p> <p>On 01-03-13 at 1:00 p.m., review of the original report sent to the physician's office on 12-08-12 at 2130 [9:30 p.m.] from licensed nurse</p>			

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	<p>employee #7 indicated, "Note moderate amount of milky red drainage coming from wound on left forearm. Hole is approx. [approximately] 1 inch by 1/2 in and is easily 1/2 inch deep and tunnels back toward elbow approx. 4 inches. Left arm is very warm to the touch. Res. is in pain and only has PRN [as needed] pain meds at this time. I realize you are already aware of resident's wound but I feel res. could really stand to have a wound ostomy consult ASAP [as soon as possible]."</p> <p>Review of the mobile vendor x-ray service company report on 01-03-13 at 10:00 a.m., indicated a completed the x-ray of the left hip on 12-12-12 and faxed the result to the facility. Further review of the radiology report, received at the facility on 12-14-12 at 10:27 a.m., indicated "No acute abnormality. The findings are unchanged from 12-04-12. Follow up advised given history. If there is high suspicion for fracture, recommend CT [cat scan] or MRI [magnetic resource imaging]."</p> <p>During the Exit conference on 01-03-13 at 2:00 p.m., the facility administrative staff were unable to provide documentation the physician was notified of the radiology</p>				

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	<p>recommendation.</p> <p>Review of the hospital emergency room department notes on 12-31-12 at 8:45 a.m., and dated 12-14-12 at 1603 [4:03 p.m.], indicated the following:</p> <p>"10 cm by 10 cm red [illegible word] area to left lateral hip, warmth, bruising to left flack region. After sterile prep [preparation]/drape used #11 blade and made 3 cm incision with blood/clot expressed. No bleeding after collapse. Packed with iodoform and Zosym [an antibiotic] started."</p> <p>Review of the Emergency Room nurses narrative notes on 12-31-12 at 9:00 a.m., dated 12-14-12 at 2030 [8:30 p.m.], indicated Left FA [forearm] wound measures at or about 2 inches by 4 inches and appears to be Stage 4 [terminology used to describe pressure areas - full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling]. Left hip wound draining large amounts serosanguinous fluid."</p> <p>Review of the hospital "History and</p>						

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	<p>Physical," on 12-31-12 at 9:00 a.m., dated 12-15-12 at 0900 [9:00 a.m.], indicated "Final Dx. [diagnosis]: Sepsis."</p> <p>On 01-02-13 at 1:21 p.m., interview with a concerned family member indicated "they told us when [resident] originally hurt [resident] arm. They told us it was a skin tear. When I was at the hospital the nurse started to remove the dressing, and the non stick pad was stuck, as she pulled it off pus oozed out and the smell was terrible, just like you would think an infection would smell like. [Family member] was at the nursing home on 12-05-12 and everything seemed OK they didn't tell us anything any different. The sore on [resident] arm was more than a skin tear - it was all the way to the bone and I would guess it measured 5 inches by 4 inches."</p> <p>On 01-03-12 at 1:30 p.m., interview with the Assistant Director of Nurses indicated the nurse should not have faxed information to the physicians office about a wound consult, because it was a weekend [Saturday] and the physician's office was closed at that time. The Assistant Director of Nurses also indicated the nurse "refaxed" the information to the</p>			

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	<p>physician's office the following day [Sunday]. The Assistant Director of Nurse indicated when she interviewed the nurse he stated he knew the wound care clinic was not opened on the weekend anyway.</p> <p>Interview on 01-03-13 at 12:15 p.m., Staff Nurse employee #3 indicated, "The area on [resident] forearm was awful and it was large. The hip was the thing - I couldn't count how many times we x-rayed it. I was the one who actually marked the edges of the bruise and what was funny was that there was swelling/edema lower to that [in regard to the bruise]."</p> <p>Review of facility policy, on 01-03-13 at 8:40 a.m., titled "Change in Resident Condition," and dated 03-12, indicated the following:</p> <p>"POLICY [bold type] The clinical Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as possible."</p> <p>"PROCEDURE [bold type] 3. The Physician/Family/Responsible Party will be notified as soon as possible include [sic] but not limited to significant change, accident/incident,</p>			

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	<p>change in treatment, transfer/D/C [discharge]. 4. Notification of the physician and agent/surrogate/contact person of a significant change in status shall routinely occur during the shift in which it occurs."</p> <p>On 01-03-13 at 8:40 a.m., review of a subsequent facility policy, titled "FAMILY NOTIFICATION [bold type]," dated 09-01-2011, indicated the following:</p> <p>"POLICY [bold type]: It is the policy of The Company to: 1. keep families informed."</p> <p>"PROCEDURE [bold type] 1. The family will be notified of any resident changes, i.e. [for example]: b. health problems"</p> <p>This Federal tag relates to Complaint IN00121500.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received the necessary care and services to maintain the highest quality of life in regard to an injury received during transfer for 1 of 3 resident's reviewed for injury in a sample of 7. [Resident "A"]</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 01-02-14 at 10:30 a.m. Diagnoses included but were not limited to, senile delusions, convulsions, difficulty in walking, lack of coordination, cerebral atherosclerosis diabetes mellitus and chronic obstructive pulmonary disease. These diagnoses remained current at the time of the record review.</p> <p>Review of the nurses progress notes indicated the following:</p> <p>"12-01-12 at 0045 [12:45 a.m.]</p>	F0309	<p>1. Resident A discharged from facility 12/14/12.2. Any resident with inc/acc could be affected. All charts of current residents having an inc/acc with injury since 11/14/12 were reviewed to ensure inc/acc with injury, radiology reports with recommendations, any significant decline in status or a need to alter treatment significantly were reported to the physician, family and followed up, so that the resident received necessary care and services, to maintain/attain the highest level of well being.3. The DON or designee will review all inc/acc reports, physciains orders and 24 hour reports to ensure all residents with an inc/acc with injury or report with recommendationsor signs of decline in status or needs to alter significantly were reported to the physician and followed up promptly. Any failure to do so will be listed on the homework sheet for completion and follow up. The DON or designee will initial all inc/acc reports, physicians orders and 24 hour report when</p>	02/02/2013	

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	<p>Resident was sitting in recliner chair. When CNA [certified nurse aide] went to give incontinent care, she lowered pt. [patient] to the floor d/t [due to] unable to follow directions [resident] placed left forearm to the floor. Obtained injury swelling and bruising noted. Ordered x-ray ordered [sic]. M.D. [Medical Doctor] aware and notified. Nurse on call aware and family aware and notified."</p> <p>"12-01-12 11:00 a.m. Results of x-ray left forearm marked as soft tissue swelling notes. Left hip x-ray shows mild osteoarthritis to left hip. MD on call notified of results and awaiting on call back due to a diffeur [sic] from 11-16-12."</p> <p>"12-02-12 at 0430 (4:30 a.m.) Left forearm swelling persist. Left hip swelling and bruising noted."</p> <p>"12-02-12 Left arm edematous, firm and reddened."</p> <p>"12-03-12 at 0100 [1:00 a.m.] Resting in bed. Yells out with T & R [turning and repositioning] et [and] ADL [activities of daily living] care. 3+ edema to left elbow, moves arm without grimaces or yelling out. Left hip discoloration cont. [continues]."</p>		<p>reviewed. An inservice for licensed nurses will be held on 1/24 and 1/27/2013 on providing care r/t/ia with injury, reporting of radiology reports significant changes in condition and follow up care. 4. The DON or designee will record any resident with an incident/accident investigation with injury, radiology report with recommendations, significant alteration in treatment or sign of decline in status on the QAPI monitoring tool. The DON or designee will attest all changes have been reported to the physician and family. Licensed staff responsible, DON or designee to monitor. QAPI to review monthly for compliance of 100%. Addendum: Homework sheets are initialed when complete and returned to DON or designee whom will ensure it was completed. Any task not completed on next scheduled sift will be addressed by Supervisor to include additional training, coaching and or disciplinary action.</p>				

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	<p>"12-03-12 at 1400 [2:00 p.m.] note left arm still edematous, reddened and firm area opened - lg. [large] amount of bleeding. Area cleansed and dressed. Note lg. [large] bruise cont. left hip. swelling cont. but has not moved past previously marked and measured area. Phys. [physician] response to monitor bruising."</p> <p>"12-03-12 at 2100 [9:00 p.m.] Bruise left hip continues, Res. grimaces in pain when staff moves left leg. Area on left arm bleeding times 1 [one] this shift, dressing changed."</p> <p>"12-04-12 at 1000 [10:00 a.m.] [Name of physician] here. Discussed aspirating blood pool from left arm. Phys. thinks it would not benefit. Order noted to re-X-ray left hip d/t cont. pain - refusal to bear weight. Note bruising and swelling cont. left hip and left arm."</p> <p>"12-04-12 at 1900 [7:00 p.m.] Note area left arm bleeding lg. [large] amts. [amounts] c/o [complains of] little disc. [discomfort] with arm but yells and grimaces with movement of left leg."</p> <p>"12-06-12 at 1400 [4:00 p.m.] Note discomfort esp. [especially] when leg moved. Note copious amts. of blood</p>				

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	<p>from left arm - swelling decreased."</p> <p>"12-06-12 at 2100 [9:00 p.m.] Dressing left arm CDI [clean, dry and intact] Bruise remains and is bigger left upper leg. Res. not standing as good as [resident] once did."</p> <p>"12-07-12 at 0500 [5:00 a.m.] Res. has hole in left forearm 1/2 " by 1/2 " around and 5 " deep. Large amount of yellow green discharge. left forearm was cleansed, wet to dry packing with NS [normal saline] 0.9 % placed into wound. MD notified that res. needs ATB [antibiotic] and dressing changed to BID [two times a day] wet to dry packing until healed."</p> <p>"12-08-12 at 0730 [7:30 a.m.] Res. left forearm dressing dry. Large amount of discharge with odrt [sic] brown in color. Res. to start ATB as ordered."</p> <p>"12-08-12 at 2100 [11:00 p.m.] Note copious amount of milky red drainage coming from left forearm wound when doing dressing change. Left arm warm to the touch. Tunneling at least four inches back toward elbow. Sent fax [facsimile] to MD asking for wound consult."</p> <p>Continued review of nurses notes</p>				

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	<p>indicate:</p> <p>"12-09-12 at 2100 [8:00 p.m.] Bruise on left upper leg remains. Wet to dry dressing change done [in regard to the left forearm] and note moderate amount of milky red drainage. Left hand +1 edema and left arm continues to feel warm to the touch. Res. continues to grimace and say 'ouch' when having to transfer or roll from side to side. Awaiting reply from MD regarding wound consult."</p> <p>"12-12-12 at 1420 [2:20 p.m.] Left forearm cleanse with woud [sic] cleanser, apply silvadene 1 % cr. [cream] cover with non-adhesive drsg., wrap with Kerlix the wrap with coband." The nurses note indicated the area measured 3.3 cm [centimeters] by 1.4 cm by .5 cm." In addition the nursing staff received a subsequent physician order to schedule the resident for an additional x-ray of the left hip.</p> <p>The resident's record indicated that on 12-14-12 at 1510 [3:00 p.m.] the resident was found non-responsive while seated in the lounge area of the South Station, and was subsequently transported to a local area hospital for evaluation and treatment.</p> <p>On 01-03-13 at 1:00 p.m., review of</p>				

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	<p>the original report sent to the physician's office on 12-08-12 at 2130 [9:30 p.m.] from licensed nurse employee #7 indicated, "Note moderate amount of milky red drainage coming from wound on left forearm. Hole is approx. [approximately] 1 inch by 1/2 in and is easily 1/2 inch deep and tunnels back toward elbow approx. 4 inches. Left arm is very warm to the touch. Res. is in pain and only has PRN [as needed] pain meds at this time. I realize you are already aware of resident's wound but I feel res. could really stand to have a wound ostomy consult ASAP [as soon as possible]."</p> <p>Review of the mobile vendor x-ray service company report on 01-03-13 at 10:00 a.m., indicated a completed the x-ray of the left hip on 12-12-12 and faxed the result to the facility. Further review of the radiology report, received at the facility on 12-14-12 at 10:27 a.m., indicated "No acute abnormality. The findings are unchanged from 12-04-12. Follow up advised given history. If there is high suspicion for fracture, recommend CT [cat scan] or MRI [magnetic resource imaging]."</p> <p>Review of the hospital emergency room department notes on 12-31-12</p>				

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	<p>at 8:45 a.m., and dated 12-14-12 at 1603 [4:03 p.m.], indicated the following,</p> <p>"10 cm by 10 cm red [illegible word] area to left lateral hip, warmth, bruising to left flack region. After sterile prep [preparation]/drape used #11 blade and made 3 cm incision with blood/clot expressed. No bleeding after collapse. Packed with iodoform and Zosym [an antibiotic] started."</p> <p>Review of the Emergency Room nurses narrative notes on 12-31-12 at 9:00 a.m., dated 12-14-12 at 2030 [8:30 p.m.], indicated Left FA [forearm] wound measures at or about 2 inches by 4 inches and appears to be Stage 4 [terminology used to describe pressure areas - full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling]. Left hip wound draining large amounts serosanguinous fluid."</p> <p>Review of the hospital "History and Physical," on 12-31-12 at 9:00 a.m., dated 12-15-12 at 0900 [9:00 a.m.], indicated "Final Dx. [diagnosis]: Sepsis."</p>				

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	<p>On 01-02-13 at 1:21 p.m., interview with a concerned family member indicated "they told us when [resident] originally hurt [resident] arm. They told us it was a skin tear. When I was at the hospital the nurse started to remove the dressing, and the non stick pad was stuck, as she pulled it off pus oozed out and the smell was terrible, just like you would think an infection would smell like. [Family member] was at the nursing home on 12-05-12 and everything seemed OK they didn't tell us anything any different. The sore on [resident] arm was more than a skin tear - it was all the way to the bone and I would guess it measured 5 inches by 4 inches."</p> <p>On 01-03-12 at 1:30 p.m., interview with the Assistant Director of Nurses indicated the nurse should not have faxed information to the physicians office about a wound consult, because it was a weekend [Saturday] and the physician's office was closed at that time. The Assistant Director of Nurses also indicated the nurse "refaxed" the information to the physician's office the following day [Sunday]. The Assistant Director of Nurse indicated when she interviewed the nurse he stated he knew the</p>						

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	<p>wound care clinic was not opened on the weekend anyway.</p> <p>Interview on 01-03-13 at 12:15 p.m., Staff Nurse employee #3 indicated, "The area on [resident] forearm was awful and it was large. The hip was the thing - I couldn't count how many times we x-rayed it. I was the one who actually marked the edges of the bruise and what was funny was that there was swelling/edema lower to that [in regard to the bruise]."</p> <p>During the Exit conference on 01-03-13 at 2:00 p.m., the facility administrative staff were unable to provide documentation the physician was notified of the radiology recommendation.</p> <p>This Federal tag relates to Complaint IN00121500.</p> <p>3.1-37(a)</p>						

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F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure safe transfer and transport of residents, in that when residents were dependent upon staff for transfer/transport, the nursing staff failed to ensure residents did not receive injury for 3 of 3 resident's reviewed for injury in a sample of 7. [Resident's "A", "D" and "E"]</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 01-02-14 at 10:30 a.m. Diagnoses included but were not limited to, senile delusions, convulsions, difficulty in walking, lack of coordination, cerebral atherosclerosis, diabetes mellitus and chronic obstructive pulmonary disease. These diagnoses remained current at the time of the record review.</p> <p>Review of the nurses progress notes indicated the following:</p>	F0323	<p>1. The inc/acc investigation for residents AC&E was reviewed by the ADON and any new interventions were initiated. Resident A discharged on 12/14/12. Resident C discharged on 1/7/2013. 2. All inc/acc with injury since 11/29/12 were reviewed to determine if occurrence was during transfer or transport of resident and any new interventions implemented. 3. All inc/acc with injury will be reviewed by the DON or designee and discussed in the Performance Improvement/Falls committee meeting during Morning Meeting. A thorough investigation of all inc/acc with injury will be completed by the DON or designee to ensure adequate supervision and assistive devices were provided. The ED or designee will review and sign all inc/acc investigations. 4. All residents with inc/acc will be listed on the QAPI monthly follow up tool to insure that adequate supervision and assistive devices were present to prevent accidents. Licensed staff responsible, DON ED to monitor and QAPI to validate. Addendum: the QAPI tool is reviewed daily in</p>	02/02/2013			

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	<p>"12-01-12 at 0045 [12:45 a.m.] Resident was sitting in recliner chair. When CNA [certified nurse aide] went to give incontinent care, she lowered pt. [patient] to the floor d/t [due to] unable to follow directions [resident] placed left forearm to the floor. Obtained injury swelling and bruising noted. Ordered x-ray ordered [sic]. M.D. [Medical Doctor] aware and notified. Nurse on call aware and family aware and notified."</p> <p>"12-01-12 11:00 a.m. Results of x-ray left forearm marked as soft tissue swelling notes. Left hip x-ray shows mild osteoarthritis to left hip. MD on call notified of results and awaiting on call back due to a diffieur [sic] from 11-16-12."</p> <p>"12-02-12 at 0430 (4:30 a.m.) Left forearm swelling persist. Left hip swelling and bruising noted."</p> <p>"12-02-12 Left arm edematous, firm and reddened."</p> <p>"12-03-12 at 0100 [1:00 a.m.] Resting in bed. Yells out with T & R [turning and repositioning] et [and] ADL [activities of daily living] care. 3+ edema to left elbow, moves arm without grimaces or yelling out. Left hip discoloration cont. [continues]."</p>		<p>morning meeting, the weeklycare meeting and the monthly QAPI meeting by thee IDT. The DON or designee will address any supervision and/or adaptive equipment issues as deemed appropriate.</p>				

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	<p>"12-03-12 at 1400 [2:00 p.m.] note left arm still edematous, reddened and firm area opened - lg. [large] amount of bleeding. Area cleansed and dressed. Note lg. [large] bruise cont. left hip. swelling cont. but has not moved past previously marked and measured area. Phys. [physician] response to monitor bruising."</p> <p>"12-03-12 at 2100 [9:00 p.m.] Bruise left hip continues, Res. grimaces in pain when staff moves left leg. Area on left arm bleeding times 1 this shift, dressing changed."</p> <p>"12-04-12 at 1000 [10:00 a.m.] [Name of physician] here. Discussed aspirating blood pool from left arm. Phys. thinks it would not benefit. Order noted to re-X-ray left hip d/t cont. pain - refusal to bear weight. Note bruising and swelling cont. left hip and left arm."</p> <p>"12-04-12 at 1900 [7:00 p.m.] Note area left arm bleeding lg. [large] amts. [amounts] c/o [complains of] little disc. [discomfort] with arm but yells and grimaces with movement of left leg."</p> <p>"12-06-12 at 1400 [4:00 p.m.] Note discomfort esp. [especially] when leg</p>						

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	<p>moved. Note copious amts. of blood from left arm - swelling decreased."</p> <p>"12-06-12 at 2100 [9:00 p.m.] Dressing left arm CDI [clean, dry and intact] Bruise remains and is bigger left upper leg. Res. not standing as good as [resident] once did."</p> <p>"12-07-12 at 0500 [5:00 a.m.] Res. has hole in left forearm 1/2 " by 1/2 " around and 5 " deep. Large amount of yellow green discharge. left forearm was cleansed, wet to dry packing with NS [normal saline] 0.9 % placed into wound. MD notified that res. needs ATB [antibiotic] and dressing changed to BID [two times a day] wet to dry packing until healed."</p> <p>"12-08-12 at 0730 [7:30 a.m.] Res. left forearm dressing dry. Large amount of discharge with odrt [sic] brown in color. Res. to start ATB as ordered."</p> <p>"12-08-12 at 2100 [11:00 p.m.] Note copious amount of milky red drainage coming from left forearm wound when doing dressing change. Left arm warm to the touch. Tunneling at least four inches back toward elbow. Sent fax [facsimile] to MD asking for wound consult."</p>			

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	<p>Continued review of nurses notes indicated:</p> <p>"12-09-12 at 2100 [8:00 p.m.] Bruise on left upper leg remains. Wet to dry dressing change done [in regard to the left forearm] and note moderate amount of milky red drainage. Left hand +1 edema and left arm continues to feel warm to the touch. Res. continues to grimace and say 'ouch' when having to transfer or roll from side to side. Awaiting reply from MD regarding wound consult."</p> <p>"12-12-12 at 1420 [2:20 p.m.] Left forearm cleanse with woud [sic] cleanser, apply silvadene 1 % cr. [cream] cover with non-adhesive drsg., wrap with Kerlix the wrap with coband." The nurses note indicated the area measured 3.3 cm [centimeters] by 1.4 cm by .5 cm." In addition the nursing staff received a subsequent physician order to schedule the resident for an additional x-ray of the left hip.</p> <p>The resident's record indicated that on 12-14-12 at 1510 [3:00 p.m.], the resident was found non-responsive while seated in the lounge area of the South Station, and was subsequently transported to a local area hospital for evaluation and treatment.</p>			

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NAME OF PROVIDER OR SUPPLIER SHERIDAN REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 803 S HAMILTON ST SHERIDAN, IN 46069			
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	<p>On 01-03-13 at 1:00 p.m., review of the original report sent to the physician's office on 12-08-12 at 2130 [9:30 p.m.] from licensed nurse employee #7 indicated, "Note moderate amount of milky red drainage coming from wound on left forearm. Hole is approx. [approximately] 1 inch by 1/2 in and is easily 1/2 inch deep and tunnels back toward elbow approx. 4 inches. Left arm is very warm to the touch. Res. is in pain and only has PRN [as needed] pain meds at this time. I realize you are already aware of resident's wound but I feel res. could really stand to have a wound ostomy consult ASAP [as soon as possible]."</p> <p>Review of the mobile vendor x-ray service company report on 01-03-13 at 10:00 a.m., indicated a completed the x-ray of the left hip on 12-12-12 and faxed the result to the facility. Further review of the radiology report, received at the facility on 12-14-12 at 10:27 a.m., indicated "No acute abnormality. The findings are unchanged from 12-04-12. Follow up advised given history. If there is high suspicion for fracture, recommend CT [cat scan] or MRI [magnetic resource imaging]."</p> <p>During the Exit conference on</p>						

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	<p>01-03-13 at 2:00 p.m., the facility administrative staff were unable to provide documentation the physician was notified of the radiology recommendation.</p> <p>Review of the hospital emergency room department notes on 12-31-12 at 8:45 a.m., and dated 12-14-12 at 1603 [4:03 p.m.], indicated the following,</p> <p>"10 cm by 10 cm red [illegible word] area to left lateral hip, warmth, bruising to left flack region. After sterile prep [preparation]/drape used #11 blade and made 3 cm incision with blood/clot expressed. No bleeding after collapse. Packed with iodoform and Zosym [an antibiotic] started."</p> <p>Review of the Emergency Room nurses narrative notes on 12-31-12 at 9:00 a.m., dated 12-14-12 at 2030 [8:30 p.m.], indicated Left FA [forearm] wound measures at or about 2 inches by 4 inches and appears to be Stage 4 [terminology used to describe pressure areas - full thickness loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the ulcer bed. Often includes undermining and tunneling]. Left hip</p>				

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	<p>wound draining large amounts serosanguinous fluid."</p> <p>Review of the hospital "History and Physical," on 12-31-12 at 9:00 a.m., dated 12-15-12 at 0900 [9:00 a.m.], indicated "Final Dx. [diagnosis]: Sepsis."</p> <p>On 01-02-13 at 1:21 p.m., interview with a concerned family member indicated "they told us when [resident] originally hurt [resident] arm. They told us it was a skin tear. When I was at the hospital the nurse started to remove the dressing, and the non stick pad was stuck, as she pulled it off pus oozed out and the smell was terrible, just like you would think an infection would smell like. [Family member] was at the nursing home on 12-05-12 and everything seemed OK they didn't tell us anything any different. The sore on [resident] arm was more than a skin tear - it was all the way to the bone and I would guess it measured 5 inches by 4 inches."</p> <p>2. The record for Resident "D" was reviewed on 01-02-13 at 12:35 p.m. Diagnoses included but were not limited to, altered mental status, difficulty in walking, dysphasia, acute kidney failure and hypertension.</p>				

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	<p>These diagnoses remained current at the time of the record review.</p> <p>The resident's Minimum Data Set Assessment, dated 10-25-12, indicated the resident required extensive assistance and two + staff persons, to safely transfer the resident.</p> <p>Review of the facility "Incident/Accident Listing," on 01-02-13 at 9:50 a.m., indicated the resident received a "skin injury" on 12-29-12 at 12:00 p.m.</p> <p>The physician was notified of the "skin injury" to the left lower leg, and the nursing staff received an order to "apply steri-strips to the skin tear on the left lower extremity."</p> <p>The "skin grid," dated 12-29-12, indicated the area measured 1.8 cm [centimeters] by 1.8 cm and had a small amount of serous drainage which was red in color.</p> <p>Review of the facility investigation of the resident's injury indicated the CNA attempted to transfer the resident independently from bed to the wheelchair rather than with the assistance of another staff member when the resident received the skin</p>			

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	<p>tear.</p> <p>During an observation on 01-03-13 at 1:10 p.m., the resident was seated in a wheelchair with a family member in attendance. The licensed nurse, employee #1, received approval by the resident to assess the left lower leg. The licensed nurse raised the resident's pant leg. The skin tear/area was without steri-strips, appeared red in color with skin intact.</p> <p>3.. The record for Resident "E" was reviewed on 01-02-13 at 1:45 p.m. Diagnoses included but were not limited to, dementia with behaviors, abnormality of gait, lack of coordination, vascular dementia and anemia. These diagnoses remained current at the time of the record review.</p> <p>Review of the skilled nursing notes," dated 12-17-12 at 1900 [7:00 p.m.], indicated CNA [certified nurse aide] accidentally hit residents hand into wall while pushing in wheelchair. 3 by 3 1/2 skin tear to left hand. Cleansed applied steri-strips, bacitracin and gauze."</p> <p>Review of the "skin grid" indicated this skin tear occurred on 12-17-12 with a notation in regard to drainage: small</p>				

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	<p>moderate, serous with no odor, color pink/red. In addition to this skin tear, the resident also had a skin tear noted on 12-24-12, which measured 2.8 centimeters by 3.0 centimeters and 12-31-12 which measured 2.7 cm by 3.0 cm, with a notation in regard to each area as "drainage: small moderate, serous with no odor, color pink/red."</p> <p>During an observation on 01-03-13 at 11:50 a.m., the resident was seated in a wheelchair. The licensed nurse, employee #1, requested and received approval by the resident to assess the left hand. As the licensed nurse removed the dressing, brown drainage was observed on the dressing. The resident's left hand had an obvious wound, in the process of healing, without redness.</p> <p>This Federal tag relates to Complaint IN00121500.</p> <p>3.1-45(a)(2)</p>						