

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction of the Investigation of Complaint IN00189160.</p> <p>Survey dates: December 16, 17, 21, 22, & 23, 2015</p> <p>Facility number: 011049 Provider number: 155670 AIM number: 200258250</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census Payor type: Medicaid: 59 Medicare: 12 Other: 17 Total: 88</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completd by #02748 on December 29, 2015.</p>	F 0000		

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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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview, observation, and record review, the facility failed to ensure a care plan was revised for 1 of 1 residents reviewed in a total sample of 3 residents who received dialysis. A resident with a dialysis catheter had a care plan for a hemodialysis shunt. (Resident #48)</p> <p>Findings include:</p> <p>During an interview on 12/17/15 at 8:32</p>	F 0280	Resident's #48's Care plan was revised on 12/22/15 by the RN Unit Manager to indicate the resident's use of a dialysis catheter in her right leg and the proper care and monitoring for that catheter. The care plans for all other residents on dialysis services were reviewed on 1/7/16 by the Unit Managers. No other dialysis residents care plans were found to be inaccurate. Licensed nurses were educated by the Staff Development Coordinator on the proper care planning procedure for dialysis patients	01/18/2016

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	<p>a.m., Resident #48 indicated she received dialysis on Tuesday, Thursday, and Saturday of every week. Resident #48 indicated she had a catheter in her right leg for dialysis. Upon query, Resident #48 indicated the facility staff did not usually check the catheter.</p> <p>During an observation on 12/17/15 at 8:45 a.m., Resident #48 was observed to have a dialysis catheter in her right leg.</p> <p>The clinical record for Resident #48 was reviewed on 12/21/15 at 3:18 p.m. Resident #48 had a admission BIMS (Brief Interview for Mental Status) assessment score of 6, dated 11/17/15, which indicated severe cognitive impairment. Resident #48 had diagnoses including, but not limited to, ESRD (end stage renal disease), seizure disorder, history of cerebral vascular disease, and failed right arteriovenous fistula.</p> <p>A care plan for hemodialysis, dated 11/23/15, included, but was not limited to, the following: observe and report any signs or symptoms of renal failure, protect shunt site from injury - left femoral, avoid constriction on the affected leg, observe the shunt site by palpating for thrill and auscultation of bruit every shift - notify physician of absence of either, and check shunt site for</p>		<p>and the facility policy on revision of care plans to reflect resident status. This education will be completed by 1/17/16. Care plans for all residents who receive dialysis will be reviewed weekly times three months and monthly thereafter by the Director of Nursing or the Assistant Director of Nursing to ensure they properly reflect the resident's condition and plan of treatment. Findings of these reviews will be reported to the facility Quality Assurance and Performance Improvement committee monthly for at least six months to ensure continued compliance and for review and recommendation.</p>		

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F 0309 SS=D Bldg. 00	<p>signs or symptoms of infection.</p> <p>During an interview on 12/23/15 at 9:05 a.m., RN #1 indicated she would be the person to revise the care plans. RN #1 indicated the care plan for Resident #48 was incorrect and she would be revising it immediately.</p> <p>A policy titled, "Dialysis Monitoring" and undated, indicated residents who had ESRD would be provided appropriate clinical interventions... The policy further indicated the dressing to the catheter is to be kept clean and dry and if a problem occurred, with the dressing or catheter, the physician would be called.</p> <p>3.1-35(d)(2)(B)</p> <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 interview, observation, and record review, the facility failed to ensure</p>	F 0309	Resident #48's dialysis access site was assessed on 12/22/15 by an RN and found to be intact with	01/18/2016

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	<p>1 of 1 resident sampled, in a total sample of 3 residents receiving dialysis, had their access sites assessed. Resident #48 had a dialysis access site that was not routinely assessed by staff. (Resident #48)</p> <p>Findings include:</p> <p>During an interview on 12/17/15 at 8:32 a.m., Resident #48 indicated she received dialysis on Tuesday, Thursday, and Saturday of every week. Resident #48 indicated she had a catheter in her right leg for dialysis. Upon query, Resident #48 indicated the facility staff did not usually check the catheter.</p> <p>During an observation on 12/17/15 at 8:45 a.m., a dialysis catheter was observed to be in Resident #48's right leg.</p> <p>The clinical record for Resident #48 was reviewed on 12/21/15 at 3:18 p.m. Resident #48 had an admission Minimum Data Set (MDS) assessment dated 11/17/15, the BIMS (Brief Interview for Mental Status) assessment score of 6, which indicated severe cognitive impairment. Special treatments identified the resident received dialysis. Resident #48 had diagnosis including, but not limited to, ESRD (end stage renal disease), seizure disorder, history of cerebral vascular disease, and failed right</p>		<p>no signs or symptoms of infection. The access sites for all other residents receiving dialysis services were assessed on 1/7/16 by an RN and all other access sites were found to be intact with no signs or symptoms of infection. All Licensed nurses were educated by the Staff Development Coordinator on the facility policy for monitoring and assessing dialysis access sites. This education will be completed by 1/17/16. The Unit managers will check the assessment records for all residents receiving dialysis services five times weekly for one month then once weekly for 3 months. Additionally the Unit managers will visualize the access sites one time weekly for one month to ensure proper assessment and care is being completed. The Unit Managers will report their findings to the facility Quality Assurance and Performance Improvement committee monthly for at least six months to ensure continued compliance and for review and recommendation.</p>				

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	<p>arteriovenous fistula.</p> <p>A care plan for hemodialysis, dated 11/23/15, indicated the access site was to be checked for signs and symptoms of infection and avoid constriction on the affected leg. The care plan also indicated the shunt site should be protected from injury - left femoral site and to observe the shunt site for thrill and bruit every shift.</p> <p>The clinical record, dated 11/15/15, indicated Resident #48 had been transferred to the hospital emergency room as she was bleeding from the dialysis catheter site. The clinical record further indicated the catheter site required a suture to stop the bleeding.</p> <p>The clinical record indicated Resident #48's dialysis catheter had been checked on the day shift on 11/24/15, 11/26/15, 11/28/15, 12/2/15, 12/12/15, 12/14/15, and 12/17/15.</p> <p>A "Dialysis Communication Record" indicated the catheter was not checked on 11/14/15, 12/21/15, 12/18/15, 11/11/15, 12/8/15, 11/21/15</p> <p>During an interview on 12/22/15 at 9:34 a.m., RN #1 indicated Resident #48's dialysis site should be checked daily. RN</p>			

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F 0371 SS=E Bldg. 00	<p>#1 further indicated a "Dialysis Communication Record" had a form indicating the ports were capped and clamped, which the facility staff should have documented on when the resident returned from dialysis.</p> <p>A policy titled, "Dialysis Monitoring" and undated, indicated residents who had ESRD would be provided appropriate clinical interventions... The policy further indicated the dressing to the catheter is to be kept clean and dry and if a problem occurred, with the dressing or catheter, the physician would be called.</p> <p>3.1-37(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interview, the facility failed to distribute and serve foods under sanitary conditions in 3 of 3 dining rooms observed. Hand hygiene was lacking and straws were handled with bare hands during a lunch</p>	F 0371	The facility was unable to determine who the identified residents are as they are not listed on the resident roster. In a review of the facility infection control tracking, no trends were identified as to residents who eat in the dining room, a particular	01/18/2016

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	<p>observation. (Main Dining Room, Sunshine Dining Room, Rainbow Dining Room)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an observation on 12/16/15 at 12:10 p.m., CNA #3 was observed to wash her hands for 10 seconds before assisting with delivering trays to residents in the "Sunshine" dining room. 2. During an observation on 12/16/15 at 12:13 p.m., CNA #2 was observed to wipe her nose with her right hand, obtained tea and lemonade for Resident #24. No hand hygiene was observed. 3. During an observation on 12/16/15 at 12:20 p.m., CNA #4 was observed to handle a straw with her bare hands prior to placing the straw into Resident #90's chocolate milk. 4. During an observation on 12/16/15 at 12:25 p.m., CNA #2 was observed to obtain Resident #23's tray. CNA #2 placed it in front of the resident. CNA #2 was observed to pick up a chair from another table and place it aside of the resident and fed the resident. No hand hygiene was observed. 5. During 1 of 2 observations of the 		<p>location in the building, or a particular infection/bacteria. All residents who eat in the dining rooms have the potential to be impacted by the cited deficiency . Tracking and trending of infections revealed no findings that could be related to the cited deficiency. All staff was educated on the policy and procedure for proper hand hygiene. All staff who assist residents with meal service were educated on proper handling of food and resident items during meal service. All dining services staff were educated on proper hand hygiene during food preparation. This education is being completed by RN nurse managers and will be completed by 1/17/16. A licensed nurse will monitor meal service in the dining rooms daily for one and three times weekly for 3 months to ensure proper hand hygiene is observed. The Dietary Services manager or designee will monitor staff on the tray line 5 times weekly for one month then weekly thereafter to ensure proper hand hygiene is observed by kitchen staff. Any staff member found in violation of the facility hand hygiene protocol will receive additional training and discipline up to and including discharge will be implemented for continued non-compliance. The results of the observations reports will be reported to the facility Quality Assurance and Performance Improvement committee monthly</p>	

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	<p>kitchen on 12/21/15 at 12:07 p.m., Cook #1 was observed to be dishing food into bowls and onto plates for the noon meal. Cook #1 was observed to wipe her hands onto the back of her slacks. Cook #1 proceeded to obtain a small bowl by the inside of the bowl, and place vegetables into the bowl. No hand hygiene was observed.</p> <p>During an interview on 12/22/15 at 10:28 a.m., the DON (Director of Nursing) indicated hands should be washed for 20 seconds.</p> <p>6. On 12/16/15 at 12:19 p.m., CNA #1 was observed to assist residents in preparing for the noon meal. CNA #1 adjusted Resident #103's shirt and placed a clothing protector on. CNA #1 proceeded to apply a clothing protector on Resident #39, Resident #59, Resident #8, Resident #66, and Resident #14. CNA #1 moved Resident #66 to another location and then proceeded to apply clothing protectors to Resident #19, Resident #22. CNA #1 adjusted Resident #22's chair and proceeded to apply clothing protectors to Resident #67 and Resident #72. During the time CNA #1 was observed to move residents and apply clothing protectors, no hand hygiene was observed.</p> <p>7. On 12/16/15 at 12:27 p.m., CNA #2</p>		for at least six months to ensure continued compliance and for review and recommendation.	

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F 0431 SS=D Bldg. 00	<p>was observed to handle Resident #51's straw with bare hands.</p> <p>On 12/22/15 at 10:22 a.m., the Administrator provided the Handwashing policy, undated. The policy included, but was not limited to, work up a lather cleansing in front and back of hands, between fingers, around cuticles, under nails and up wrist, continue for at least 20 seconds.</p> <p>3.1-21(1)(3) 3.1-18(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>			

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	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure outdated medications were discarded for 2 of 4 medication carts reviewed. (100 North Medication Cart, 200 South Medication Cart)</p> <p>Findings include:</p> <p>On 12/22/15 at 10:45 a.m., the 100 North Medication cart was observed. An Advair Diskus (a medication to treat wheezing and shortness of breath) was observed with an open date of 10/20/15. RN #1 indicated an Advair Diskus expired 30 days after the open date.</p> <p>On 12/22/15 at 10:56 a.m., the 200 North Medication Cart was observed. An Advair Diskus was observed with an</p>	F 0431	Both the expired Advair Diskus medication was discarded on 12/22/15 and a new supply obtained. The medication carts were audited on 12/23/15 by the Unit Managers with no other medications found to be expired. Licensed nurses were educated by the Staff Development Coordinator on the policy and procedure for storage of medications with special expiration date requirements, including Advair Diskus. The Unit Managers will review medication carts 5 days weekly for one month and weekly thereafter to ensure medications are stored properly and have not expired. Findings from these cart reviews will be reported monthly by the Director of Nursing or designee to the facility Quality Assurance and Performance Improvement committee monthly for at least six	01/18/2016

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F 0441 SS=D Bldg. 00	<p>open date of 11/14/15. RN #2 indicated she was unsure how long Advair Diskus were good for.</p> <p>On 12/22/15 at 11:05 a.m., RN #2 indicated an open Advair Diskus was good as long as the expiration date on the box had not passed.</p> <p>On 12/22/15 at 4:11 p.m., the DON (Director of Nursing) provided the Medications with Special Expiration Date Requirements Policy, dated 12/2012. The policy included, but was not limited to, Advair Diskus: Expiration date: 30 days after removal from foil pack.</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>		months to ensure continued compliance and for review and recommendation.	

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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure handwashing was completed for 3 of 5 residents observed for care. (CNA #1, Activity Staff #1, Central Supply Director)</p> <p>Findings include:</p> <p>1. During an observation on 12/16/15 at 12:01 p.m., Activity Staff # 1 (Act Staff) and Central Supply Director (CS Director) were observed to assist</p>	F 0441	Residents #11, 90 and 93 were not listed on the sample resident list. All residents have the potential to be impacted by the cited deficiency. Tracking and trending of infections revealed no findings that could be related to the cited deficiency. All staff were educated by RN nurse managers on the facility policy and procedure for handwashing and hand hygiene including frequency and standards of professional practice for when hand hygiene is required. This education will be completed by	01/18/2016

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF NEWBURGH				STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630			
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	<p>Resident #11 into a wheelchair. Act Staff #1 and CS Director washed their hands for 10 seconds prior to applying their gloves and after assisting the resident into the wheelchair.</p> <p>2. During an observation on 12/23/15 at 8:53 a.m., the Central Supply Director (CS Director) was observed to assist Resident #90 to the bathroom. The CS Director was observed to wash her hands for 10 (ten) seconds, applied gloves, applied a gait belt to the resident and assisted the resident onto the commode. The CS Director was observed to remove her gloves and wash her hands for 7 (seven) seconds. The CS Director was observed to apply clean gloves, obtain a wipe and perform pericare. The CS Director applied a clean brief, assisted the resident with her slacks, and assisted the resident into her wheelchair.</p> <p>During an interview on 12/22/15 at 10:28 a.m., the DON (Director of Nursing) indicated hands should be washed for 20 seconds.</p> <p>During an interview on 12/22/15 at 8:57 a.m., the CS Director indicated hands should be washed for 30 seconds before and after giving care to the resident.</p> <p>3. On 12/22/15 at 9:58 a.m., CNA #1 and</p>		<p>1/17/16. Nurse managers will observe five staff members providing direct resident care 7 days a week for 1 week, then five days a week for one month then three times per week thereafter to ensure proper hand hygiene is observed. Any staff member found in violation of the facility hand hygiene protocol will receive additional training and discipline up to and including discharge will be implemented for continued non-compliance. Results of these observations reviews will be reported monthly by the Director of Nursing or designee to the facility Quality Assurance and Performance Improvement committee monthly for at least six months to ensure continued compliance and for review and recommendation.</p>				

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	<p>RN #3 were observed to provide care for Resident #93. CNA #1 and RN #3 assisted Resident #93 to the commode. CNA #1 was observed to hand wash under running water. CNA #1 applied gloves and provided a washcloth for Resident #93 to wash their face. CNA #1 washed, rinsed and dried, Resident #93's arms, chest, and abdomen. CNA #1 assisted Resident #93 to don a shirt and pants. CNA #1 removed her gloves completed a hand wash under running water. CNA #1 donned gloves and cleansed Resident #93's buttocks. CNA #1 was observed to remove gloves and assist Resident #93 with pulling up a brief. CNA #1 was observed to perform hand hygiene for 11 seconds under running water.</p> <p>On 12/22/15 at 10:22 a.m., the Administrator provided the Handwashing policy, undated. The policy included, but was not limited to, work up a lather cleansing in front and back of hands, between fingers, around cuticles, under nails and up wrist, continue for at least 20 seconds.</p> <p>On 12/22/15 at 10:22 a.m., the Administrator provided the Standard Precautions policy, dated 8/2007. The policy included, but was not limited to: Hands shall be washed with soap and</p>			

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F 9999 Bldg. 00	<p>water whenever visibly soiled, in the absense of visible soiling of hands, alcohol-based hand rubs are preferred, and wash hands after removing gloves.</p> <p>3.1-18(l)</p> <p>3.1-13 Administration and Management (g) The administrator is responsible for the overall management of the facility but shall not function as a department, for example, director of nursing or food service supervisor, during the same hours, The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone</p>	F 9999	No further incidents of accident with injury have occurred.All events for the last 60 days will be reviewed by the Clinical Nurse Consultant on 1/13/16 to ensure that no other events were documented that were not reported according to the guidelines. The department leaders were all retrained 12/22/15 on the Incident Reporting Policy by the clinical consultant. All licensed staff will receive education to be completed by 1/17/16 by the Staff Development Coordinator related to the reporting guidelines. The Clinical consultant will review all events for 3 months to ensure proper reporting has occurred. Results of these observations reviews will be reported monthly by the Director of Nursing or designee to the facility Quality Assurance and Performance Improvement committee monthly for at least six months to ensure	01/18/2016

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	<p>number (317) 383-6144) of the division.</p> <p>This State rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to report a major accident for 1 of 4 residents reviewed for falls. A resident had a fall that resulted in an injury which required sutures. (Resident C)</p> <p>Findings include:</p> <p>On 12/21/15 at 3:16 p.m., Resident C's clinical record was reviewed.</p> <p>The [Name of Facility] Nursing Assessment for [Name of Resident], indicated the resident had a fall on 12/11/15 at 2:00 p.m. The Assessment indicated the resident had self reported a fall and the left elbow was bleeding. The Assessment further indicated the elbow had been cleansed to be assessed, a deep laceration was revealed, which had bled quite a bit and pressure was applied. The Assessment indicated the wound had been covered with a non-stick dressing and a pressure dressing had been applied until the emergency room could place sutures to stabilize the wound.</p> <p>The Physician's Telephone Orders, dated</p>		continued compliance and for review and recommendation.	

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	<p>12/11/15 at 2:10 p.m., indicated to send the resident to the Emergency Room for sutures to a deep cut to the left elbow for a fall.</p> <p>The Hospital Emergency Room Visit Note indicated the resident had been seen on 12/11/5 for a fall with a laceration.</p> <p>On 12/21/15 at 4:11 p.m., the DON indicated Resident C had a fall on 12/11/15 that resulted in a skin tear to the left elbow that required sutures.</p> <p>On 12/21/15 at 4:30 p.m., the DON indicated the fall with injury had not been reported.</p> <p>3.1-13(g)(1)(D)</p>			