STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00217457 and IN00215760. Complaint IN00217457 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314. Complaint IN00215760 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314. Survey dates: December 27 and 28, 2016 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF/NF: 125 SNF: 11 Total: 136 Census payor type: Medicare: 18 Medicaid: 103 Other: 15 Total: 136 Sample: 5	F 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by 21662 on January 3, 2017.			
F 0314 SS=G Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure a pressure ulcer was assessed accurately, prevention interventions were implemented to prevent the worsening of the pressure	F 0314	**F314** **I. The corrective actions to be accomplished for those**	01/16/2017

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	ulcer and physician orders were followed for 1 of 5 residents reviewed for pressure ulcers (Resident C). Resident C's pressure ulcer to the sacral region was discovered after admission as an unstageable wound, then deteriorated to necrotic bone being exposed. Finding includes: Resident C's record was reviewed on 12/27/16 at 12:00 p.m. Diagnoses included, but were not limited to, sepsis, unstageable pressure ulcer of the sacral region, muscle weakness, dementia, Clostridium Difficile colitis (C-Diff), and urinary tract infection. A Hospital "patient transfer report" dated 7/15/16, indicated "...Pressure Ulcer present on admission to hospital... location: left foot 2nd metatarsal... appearance: reddened intact...." Resident C's care plan dated 7/17/16, which addressed the problem she was at risk for skin breakdown related to incontinence, current open areas, dementia, decreased mobility, and weakness. Interventions included, but were not limited to, "7/17/16--Offload heels when in bed check every shift, Pressure reducing surfaces: mattress/chair cushion, Provide resident education on		**residents found to have been affected by the deficient practice.** Resident C no longer resides at the facility. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Any residents with a pressure ulcer is at risk of the pressure ulcer worsening. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Corporate directed education was provided to the nurse management team including wound prevention techniques, wound identification, physician order transcription and auditing techniques specific to wound orders.	

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	staff assist, Skin prep to heels before bed, Head of bed elevated no more than 30 degrees when in bed unless clinically contraindicated check every shift, Skin protectant/barrier cream, Turn and reposition every shift...." A change in condition form dated 7/20/16 at 2:53 p.m., indicated "...description: open area to coccyx... 3 cm [centimeter] x 2.5 cm x 0 cm... Interventions: Dermaseptine [a skin protectant moisture barrier cream]... to be monitored via wound team...." No description of the wound or staging of the wound was located. The facility's MDS (Minimum Data Set) admission assessment for Resident C dated 7/24/16, indicated she was at risk of developing a pressure ulcer and did not have a Stage I or higher pressure ulcer upon admission to the facility. A skin condition assessment dated 7/26/16 at 5:13 p.m., indicated Resident C had an acquired (facility grown) pressure sore to her coccyx which measured 4 cm by 2.7 cm by 0.2 cm. The date of origin was 7/20/16. It was "...unstageable with 75% slough (yellow, green, gray, nonviable tissue) and 25% epithelial (deep pink to pearly pink) with no odor...."		Licensed Nurses were re-educated on appropriate implementation of pressure reducing interventions, documentation and assessments of wounds upon admission and ongoing and adherence to physician orders with regards to pressure ulcers. Certified Nursing Assistants were re-educated on wound prevention including risk factors, reporting areas to licensed staff, preventative measures and utilization of resident care sheets. All residents that have pressure ulcers were reviewed for appropriate interventions and initiation of physician orders including resident care plans and care sheets. **IV The facility will monitor the corrective action by implementing the following measures.** DON or designee will audit residents with current pressure ulcers and newly admitted residents with pressure ulcers for	

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	Resident C's care plan dated 7/28/16, which addressed the problem she presents with an unstageable pressure area to her coccyx related to immobility, weakness, infection, and cognition. Interventions included, but were not limited to, "...7/28/16--Record location and size of wound, Wound care center to evaluate and treat, Monitor and report any signs of localized infection (swelling, redness, pain or tenderness)... 8/4/16--Low air loss mattress with a setting of 5-check function every shift, Administer medications as ordered...." Physician orders dated 7/28/16, indicated wound center to evaluate and treat. Wound Center note dated 8/2/16, indicated "...I was asked to see this resident for a pressure ulcer found on her sacrum/coccyx by the nursing staff on 7/20/16... Now with a new pressure on her right buttocks found today... Coccyx is unstageable... measurements are 3.3 cm x 4.5 cm x 0.4 cm... Wound bed is 76-100% slough, 1-25% granulation...Right buttocks is a Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough at be present but does not obscure the depth of tissue loss. May include undermining		preventative interventions, documentation, assessment and adherence to physician orders daily for 8 weeks, then monthly for 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the audits and rounds will be addressed immediately. Staff not adhering to the education provided will be re-educated up to and including termination. Results of the audits will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of audits will be adjusted as needed. **V. Plan of Correction completion date.** January 16, 2017 . The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	and tunneling) pressure injury... measurements are 3.8 cm x 2.8 cm x 0.1 cm...Coccyx- cleanse wound bed with normal saline. Pat dry. Apply skin prep or barrier cream to periwound. Santyl to wound bed followed by hydrogel moistened, fluffed gauze, then cover with dry gauze and secure daily... Right buttocks- Cleanse wound area with mild soap and water. Rinse thoroughly. Dry. Apply Calmoseptine, or equivalent, to the wound bed area once a shift... Upgrade mattress to Low air loss mattress. Upgrade wheelchair cushion to ROHO or equivalent. Turn every 2 hours...." A Physician order dated 7/17/16, indicated to turn and reposition every shift. No documentation for turning and repositioning every two hours, an order for Calmoseptine to the right buttocks or a ROHO cushion were located in Resident C's record. Wound Center note dated 8/9/16, indicated "...Coccyx measurements are 3.5 cm x 5 cm x 0.4 cm... Wound bed is 76-100% slough, 1-25% pink granulation. The wound is deteriorating...Patient currently has appropriate offloading wheelchair cushion: No...." Wound Center note dated 8/16/16,			

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	indicated "...Coccyx measurements are 3.5 cm x 3.7 cm x 0.4 cm... Wound bed is 76-100% slough, 1-25% pink granulation... Patient currently has appropriate offloading wheelchair cushion: No..." A skin condition assessment dated 8/23/16 at 1:37 p.m., indicated Resident C had a pressure sore to her coccyx which measured 3.8 cm by 3.0 cm by 1.2. The date of origin was 7/20/16 and was developed in house. It was "...unstageable with 50% slough (yellow, green, gray, nonviable tissue) and 50% epithelial (deep pink to pearly pink) with strong odor and the wound edge was macerated/soft...." A skin condition assessment dated 8/30/16 at 4:26 p.m., indicated Resident C had a pressure sore to her coccyx which measured 3.8 cm by 2.7 cm by 1.2 with undermining (Destruction of the tissue or ulceration, which extended under the skin edges, so the pressure ulcer was larger at the base of the wound than at the skin surface) . The date of origin was 7/20/16 and was developed in house. It was "...unstageable with 50% slough (yellow, green, gray, nonviable tissue) and 50% epithelial (deep pink to pearly pink) with strong odor and the wound edge was macerated/soft...."			

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Wound Center note dated 9/6/16, indicated "...Coccyx measurements are 4 cm x 2.8 cm x 1.2 cm... Undermining has been noted at 8:00 and ends at 2:00 with a maximum distance of 1.9 cm...Wound bed is 26-50% slough, 51-75% pink granulation. The wound is deteriorating... Patient currently has appropriate offloading wheelchair cushion: No..."

No Wound Center notes or skin assessment with the wound measurements were located for the week of September 13th.

A skin condition assessment dated 9/20/16 at 12:15 p.m., indicated Resident C had a pressure sore to her coccyx which measured 3.2 cm by 2.0 cm by 1.0 cm. The date of origin was 7/20/16 and was developed in house. It was "...unstageable with 25% slough (yellow, green, gray, nonviable tissue) and 75% epithelial (deep pink to pearly pink)...."

Wound Center note dated 9/27/16, indicated "...Coccyx is a Stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle) measurements are 3.5 cm x 1.8 cm x 1.2 cm... Bone is exposed... Undermining has been noted at 10:00 and ends at 2:00 with a maximum distance of 1.8 cm...Wound bed is 1-25%

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	slough, 76-100% pink granulation... Patient currently has appropriate offloading wheelchair cushion: No..." Wound Center note dated 10/4/16, indicated "...Coccyx is a Stage 4 measurements are 3.5 cm x 2 cm x 1.2 cm... Necrotic bone is exposed... Undermining has been noted at 9:00 and ends at 2:00 with a maximum distance of 3 cm. There is a moderate amount of yellow drainage noted which has no odor. The patient reports a wound pain of 4/10. The wound margin is thickened and rolled under. Wound bed is 1-25% slough, 76-100% pink granulation. The wound is deteriorating... Patient currently has appropriate offloading wheelchair cushion: No... Make sure has ROHO cushion if up in wheelchair...." During an interview on 12/28/16 at 8:39 a.m., a family member of Resident C indicated when she arrived for a visit, the resident's door was always closed and Resident C was in isolation for C-Diff. She indicated during her visits, she did not observe staff turning and repositioning her family member. During an interview on 12/28/16 at 2:30 p.m., the Director of Nursing (DON) indicated she could not find documentation or a physician order for			

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	the ROHO cushion. She indicated wounds were to be measured weekly in house by the wound center doctor or by the facility staff. During an interview on 12/28/16 at 4:09 p.m., the DON indicated the Calmoseptine order for Resident C's right buttocks was not transcribed correctly and an order was not found. She indicated the staff nurses were not allowed to stage the wounds when they were discovered. A member of the Interdisciplinary Team (IDT) or the wound doctor were the ones who staged the wounds. A current policy titled "Wound Management" dated 3/2015, provided by the Director of Nursing on 12/28/16 at 3:45 p.m., indicated "Purpose: To provide clinical guidance and best practices for the management of skin conditions...Skin condition worsened...Review of the care plan/ MD order(s)/ nurse aide sheet...Can any new interventions be added to further reduce pressure to the affected site...." This Federal tag relates to Complaint IN00217457 and IN00215760. 3.1-40(a)(1) 3.1-40(a)(2)			

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