STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155682	B. WING		03/14/2013
NAME OF I	PROVIDER OR SUPPLIE	R	STREE	TT ADDRESS, CITY, STATE, ZIP CODE	
				ROCKPORT RD	
WOODM	IONT HEALTH CA	MPUS	BOO	NVILLE, IN 47601	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE COMPLETION PRIATE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
	This visit was f	on the Investigation of	F000000	E 214 Decident A has surre	
		or the Investigation of	F00000	F 314 Resident A has curre ulcer assessment and treat	-
	Complaint IN00	J125482.		orders in place with carepla	
				updated as indicated to refl	
	-	0125482 Substantiated -		current needs with staff that	
		eficiencies related to the		for her inserviced on	
	allegations are o	cited at F314.		these Completion Date 4-1	
				Resident B has current ulc	
	Survey dates:			assessments and treatmen orders in place with carepla	
	March 13 and 1	4, 2013		updated as indicated to refl	
		,		current needs with staff tha	
	Facility number	002724		for him inserviced on	
	Provider number			these.Completion Date 4-1	
	AIM number: 2			Resident C no longer resid	
	Allvi liuliloci. 2	00507550		the facility. Completion Da	
	a i			4-13-13 All residents have potential to be affected by t	
	Survey team:			alleged deficient practice	
	Anne Marie Cra	ays RN		therefore have had skin	
				assessed to ensure all	
	Census bed type	e:		impairments are appropriat	-
	SNF: 11			categorized and interventio	
	SNF/NF: 39			careplans are in place Com	-
	Residential: 29			Date 4-13-13 Directed wou inservice will be provided to	
	Total: 79			ADON and DON as well MI	
				medical records nurse and	
	Census payor ty	/ne:		managers.Completion Dat	
	Medicare: 13	, P ~.		3-29-13 Licensed nurses w	
	Medicaid: 26			have wound training includi	ng
				staging, assessment and	
	Other: 39			documentation requirements.CNA's inservi	ced
	Total: 79			on pressure relieving	
				interventions and skin care	
	Sample: 5			including communication to	nurse
				when treatments dislodge of	
	This deficiency	reflects state findings in		refused. Completion Date	
		-	1	4-13-13 Systemic change i	s that

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04/04/2013

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.

155682 A.		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/14/2013	
	PROVIDER OR SUPPL		1325 F	ADDRESS, CITY, STATE, ZIP CODE ROCKPORT RD VILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICI REGULATORY accordance wi	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) th 410 IAC 16.2. Y completed on March 20, Meyer, RN	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY) skin impairment grids will be in Treatment record so that nurses will know when a res has a skin impairment. Completion Date 4-13-13 Through inservices and aud will ensure that identification areas and interventions/assessments carried out timely, pressure relieving devices are in plac accurate staging and documentation of wounds occurs. Completion Date 4-13-13 DHS/Designee will conduct daily rounds to ensu that pressure reduction interventions are being carri out, grids and skilled documentation is accurate a complete, treatments are in and proper staging for resid and B and random sample residents/day x4 weeks, the residents/day x4weeks, and 3/week thereafter. Skin sw will be performed monthly DHS/designee to determine there are any unaccounted skin impairments. Results audit as well as full skin re	e kept all sident dits n of are e, e, ure ed and place ent A of 5 n 3 eep by e if l for of	(X5) COMPLETIO DATE
				will be forwarded to the QA committee monthly x12 mo and suggestions/recommendat carried out as deemed necessary by committee.	A onths	

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	B NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155082	B. WING		- 03/14/2013	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				ROCKPORT RD		
WOODM	ONT HEALTH CA	MPUS	BOON	VILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
-000314 SS=E	PRESSURE SO Based on the co a resident, the fa resident who en pressure sores of sores unless the condition demor unavoidable; an sores receives n services to prom	VCS TO PREVENT/HEAL RES mprehensive assessment of acility must ensure that a ters the facility without does not develop pressure individual's clinical astrates that they were d a resident having pressure eccessary treatment and note healing, prevent event new sores from				
	record review, t accurate assess that the staging not accurate, do wounds was no relief was not o 3 of 3 residents areas, in a samp and C Findings includ 1. On 3/13/13 a initial tour, the Nursing [ADO] had a pressure a	t 1:30 P.M., during the Assistant Director of N] indicated Resident A area on her coccyx. The	F000314	F 314 Resident A has curren ulcer assessment and treatm orders in place with careplan updated as indicated to reflec current needs with staff that of for her inserviced on these. Completion Date 4-13 Resident B has current ulcer assessments and treatment orders in place with careplan updated as indicated to reflec current needs with staff that of for him inserviced on these. Completion Date 4-13 Resident C no longer reside the facility. Completion Date 4-13-13 All residents have th potential to be affected by the alleged deficient practice therefore have had skin assessed to ensure all impairments are appropriatel categorized and interventions careplans are in place Compl Date 4-13-13 Directed woun	ent ct care -13 	04/13/2013
	required a dress	d the pressure area ing on it. Resident A was on her right side. A skin		inservice will be provided to ADON and DON as well MDS medical records nurse and u	S,	

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Event ID: CDUJ11

Facility ID: 002724

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2013 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC				OMB NO. 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION		A. BUILDING	00		
		155682	B. WING		03/14/2013	
NAME OF F	PROVIDER OR SUPPLIE	B	STREET	ADDRESS, CITY, STATE, ZIP CODE		
	NO VIDER OR DOI VEIE		1325 F	ROCKPORT RD		
WOODM	IONT HEALTH CAN	MPUS	BOON	VILLE, IN 47601		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	BROWIDER'S DI ANI OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	assessment was	requested at that time. A		managers.Completion Date	•	
	pressure area wa	as observed on the		3-29-13 Licensed nurses w		
	-	x. The pressure area had a		have wound training including	ng	
		wound bed. No dressing		staging, assessment and		
		e ADON indicated the		documentation requirements.CNA's inservio	and	
	-			on pressure relieving		
	-	have come off when they		interventions and skin care		
		he ADON indicated the		including communication to	nurse	
	wound was a "S	tage II."		when treatments dislodge o	r are	
				refused.Completion Date		
	The clinical reco	ord of Resident A was		4-13-13 Systemic change is		
	reviewed on 3/1	3/13 at 2:15 P.M.		skin impairment grids will be	•	
	Diagnoses inclu	ded, but were not limited		in Treatment record so that all nurses will know when a resident		
	to, vascular dem			has a skin impairment.	suent	
				Completion Date 4-13-13		
	A Minimum Do	ta Set [MDS] assessment,		Through inservices and au	dits	
				will ensure that identification		
		indicated the resident was		areas and		
	-	ete an interview for		interventions/assessments	are	
		red extensive assistance of		carried out timely, pressure		
	two + staff for b	bed mobility and transfer,		relieving devices are in plac accurate staging and	e,	
	and had no pres	sure ulcers.		documentation of wounds		
				occurs. Completion Date		
	A Pressure Ulce	er Assessment indicated:		4-13-13 DHS/Designee will		
	"Date 1/20/13. I	Present on admission? N		conduct daily rounds to ens		
		mid coccyx, Pressure,		that pressure reduction		
		s: II, Length 2, width 1,		interventions are being carri	ied	
	•	idate [none]Tx		out, grids and skilled documentation is accurate a	and	
	-			complete, treatments are in	-	
	[treatment]: Optifoam, Cleanse [with] wound cleanser, use skin prep, [change] Q [every] 3 days [and] PRN [as needed]"			and proper staging for resid		
			and B and random sample			
			residents/day x4 weeks, the	en 3		
			residents/day x4weeks, and			
			3/week thereafter. Skin sw			
	The Pressure UI	cer Assessment indicated		will be performed monthly	-	
	the pressure are:	a was measured on $1/28$,		DHS/designee to determine		
	-	B. An assessment dated		there are any unaccounted		
	2^{-1} , und $2^{-1}J/12$			skin impairments. Results	от	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: CDUJ11

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP, CODE		сом - 03/1	(X3) DATE SURVEY COMPLETED 03/14/2013	
	PROVIDER OR SUPPLIEF			1325 R	address, city, state, zip co CCKPORT RD VILLE, IN 47601	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH(CROSS-REFERENCED TO THE AF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
3.2, W Exudate Consist treatment - Optifo	3.2, W [width] 1 Exudate, Color: Consistency: ser treatment: Clear	d: "Type: II, L [length] .5, D[depth] 0.1, Serous, Amount: Scant, osanguinousCurrent ise, skin prep, maxorb AG nge] QD [every day]"			audit as well as full ski will be forwarded to th committee monthly x1 and suggestions/recomme carried out as deemed necessary by committe	e QA 2 months ndations	
	from, dated 2/23 indicated, " Sk [with] tx [treatm	ssment Acute Change /13 at 2:00 P.M., inpressure wounds ent] implemented, on, R for [evaluation and					
	7:00 P.M., indic	sheet, dated 2/23/13 at ated, "Coccyx, Wound essure] stage 3"					
	2/26/13, indicate	ge III pressure ulcer					
indica Ulcers [stage [sic] c Stag I form o	indicated, "Ski Ulcers, Locatior [stage] III, Treat [sic] q [every] 3 Stag I pressure u	fer form, dated 2/26/13, in/Wound Care: Redness, a: Ulcer on sacrum, Stag ment: [Change] drssg DD [days]float heels ilcers" The transfer icate a right foot area					
	Resident A was on 2/26/13. A N	readmitted to the facility ursing Admission					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 155682 03/14/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1325 ROCKPORT RD WOODMONT HEALTH CAMPUS BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Assessment, dated 2/26/13 at 5:00 P.M., indicated an anatomical drawing which had an "X" on the coccyx area, and the notation, "Open area 4 x 3 cm 0.1 cm." An additional notation indicated, "Rt [right] [illegible] ball of foot 1.3 x 1.3 eschar..." Physician orders, dated 2/26/13, included: "Ulcer on sacrum Stg [stage] III, clean [with] wound cleanser, apply medisorb... [change] drsg [every 3 days]." A "Weekly Follow Up," dated 2/28/13, included: "...Res [resident] has been out to hospital...Tx [treatment] to coccyx...hospital measured 2/25/13 4 x 3 x 0.1...Stage III...." A Pressure Ulcer Assessment, dated 3/5/13, indicated: "Pressure/Stage: II...Color: Serous...Wound Bed, Color/tissue/percent/location: red/yellow " A MDS assessment, dated 3/5/13, indicated the resident had a short-term and long-term memory problem, and required total dependence of two + staff for bed mobility and transfer. The MDS assessment indicated the resident had "1" Stage 1, "1" Stage 2, and "1" Unstageable pressure areas. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CDUJ11 Facility ID: 002724 If continuation sheet Page 6 of 15

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 COMPLETED . BUILDING 155682 03/14/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1325 ROCKPORT RD WOODMONT HEALTH CAMPUS BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG A "Skilled Nursing Assessment and Data Collection, dated 3/6/13 at 12:00 P.M., indicated, "...Skin...History of resolved ulcer(s): N [no]...Currently has skin impairment: N [no]...Other skin issues: N [no]...." A Pressure Ulcer Assessment, dated 3/12/13, indicated: "Pressure/Stage: [left blank]...Exudate, Color: Serous...Wound Bed...red/yellow " On 3/13/13 at 3:45 P.M., a right foot wound assessment was requested. On the right ball of the foot was a small, hard black pressure area. On 3/13/13 at 9:20 A.M., a skin assessment was again requested. The resident had been sitting up, and was being transferred to bed. A dressing was removed from her coccyx area. The dressing had a moderate amount of tannish drainage. The pressure area had 2 distinct yellow areas, and yellow material was scattered throughout the pink wound bed. QMA # 1 indicated the area "usually had drainage." The ADON indicated at that time that "we talked about putting Santyl [a debriding agent] on it." On 3/14/13 at 10:40 A.M., during interview with the MDS Coordinator, she indicated she obtains the pressure area FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CDUJ11 Facility ID: 002724 If continuation sheet Page 7 of 15

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	r í	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155682	A. BUILDING 00 B. WING				ipleted 14/2013
NAME OF	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP COD	DE	
	IONT HEALTH CA				OCKPORT RD /ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	COMPLETIC DATE
1/10	-	m the ADON and the skin		1110			DATE
		OS Coordinator indicated					
		locumentation that the					
		admitted on $2/26/13$ with a					
		re ulcer, and so she asked					
	the ADON, who informed her it was a Stage II.						
	Stage II.						
	The clinical rec	ord of Resident A was					
		on 3/14/13 at 2:10 P.M. A					
	-	er, dated $3/14/13$,					
		[discontinue] current tx					
		occyx wound. Start -					
		Santyl to wound bed"					
	Cicanse, appry	Santyi to would bed					
	2. On 3/13/13 a	tt 1:30 P.M., during the					
	initial tour, the	ADON indicated Resident					
		nall" Stage II pressure area					
	-	tock. The ADON indicated					
	-	ea "may even be a Stage I;					
		ed." The ADON indicated					
	the resident did	not require a dressing to					
	the area. Reside	ent B was observed sitting					
	up in a wheelch	nair at that time, asleep.					
	On 3/14/13 at 9	2:15 A.M., the DON was					
	requested to let	the nursing staff know					
	that a wound as	ssessment was requested					
	whenever feasi	ble. At 9:20 A.M., QMA #					
	1 indicated they	would be lying Resident					
	B down in bed	soon.					
	On 3/14/13 at 9:55 A.M., the clinical	0.55 A M the clinical					
		ent B was reviewed.					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE S COMPLE	TED
		155682	B. WING		03/14/2	013
NAME OF			STREET	ADDRESS, CITY, STATE, ZIP COL	DE	
NAME OF	PROVIDER OR SUPPLIE	ĸ	1325 R	OCKPORT RD		
WOODN	IONT HEALTH CA	MPUS	BOON	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	Diagnoses inclu	ided, but were not limited				
	to, dementia.					
		ata Set [MDS] assessment,				
	dated 2/18/13, i	indicated the resident				
	scored an 11 ou	t of 15 for cognition, with				
	15 indicating no	o memory impairment.				
	The resident real	quired extensive assistance				
	of two + staff fe	or bed mobility and				
	transfer. The M	DS assessment indicated				
		I "1" Stage II pressure area.				
	The most recen	t Pressure Ulcer				
	Assessment, da	ted 3/12/13, indicated:				
	"Location: Lt	[left] buttock,				
	PressureType	: I visualized, L 0.3, W				
	0.1, DWoun	d BedColor/tissue				
	type/percent Re	ed/pinkSurrounding				
	tissue: red/pink	"				
	On 3/14/13 at 1	0:00 A.M., QMA # 1				
	indicated Resid	ent B's wife was visiting,				
	and requested to	o leave the resident up in				
	the chair.					
	On 3/14/13 at 1	0:30 A.M., the door to				
		om was observed to be				
		nocking and entering,				
		observed to be lying in				
		ADON, QMA # 1, RN #				
		were all at the bedside.				
		vife was also in the room.				
		ated they were measuring				
		ounds. The resident's				
	une resident s W	ounds. The resident's		1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155682 03/14/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1325 ROCKPORT RD WOODMONT HEALTH CAMPUS BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG bilateral buttocks were observed to be very reddened and excoriated. The right lower buttock had a pressure area, red and drying. The right inner buttock had a small open and red area. The left upper buttock had a large open area, and appeared dark red. The DON indicated the resident's bottom "didn't look like this a couple of days ago." The DON indicated staff would call the physician and obtain different treatment orders. On 3/14/13 at 11:55 A.M., QMA # 1 obtained Pressure Ulcer Assessment sheets for Resident B. The sheets included: "Date: 3/14/13, Present on admission? N [no], Location, [Left] upper buttock, Pressure, Stage/Thickness: II, Length 8, Width 5.8, Depth 0.1...Color R [red]...Surrounding tissue: R [red]..." "3/14/13, Present on admission? N, Location: [Right] inner buttock, Pressure, Stage/Thickness: II, Length 0.7, Width 0.6, Depth <0.1...Color R..." "3/14/13, Present on admission? N, Location : [Right] buttock, Pressure, Stage/Thickness: I, Length 7, Width 6.6, Depth -...Color: R...." 3. On 3/13/13 at 1:30 P.M., during the initial tour, the ADON indicated Resident C was admitted with a pressure area on Facility ID: 002724

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Event ID: CDUJ11

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2013	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 ROCKPORT RD BOONVILLE, IN 47601			CODE		
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC	
TAG	his toe, and also on his left heel.	had a reddened Stage I Resident C was observed heelchair, eating lunch.		TAG	Jaren er		DATE	
	reviewed on 3/1	ord of Resident C was 3/13 at 4:05 P.M.						
	to, renal failure	ded, but were not limited and peripheral vascular dent was admitted to the 3.						
	· ·	Fer form, dated 3/6/13, Wound Care: Fragile"						
	3/6/13 at 3:45 P. problems presen diabetic foot ulc foot? Y [yes] Le Plan of CareEl	e pressure relieving device						
	3/6/13, indicated	r Assessment, dated l: "Location: Lt [left] c, Stage/Thickness: E "						
	3/7/13 at 7:15 A	ng Assessment, dated .M., indicated, skin impairment: N						
	A Skilled Nursin	ng Assessment, dated						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CC	INSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155682		UILDING	00		COMPLETED 03/14/2013
		100002	B. W	/ING			00/11/2010
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE	E, ZIP CODE	
WOODN	IONT HEALTH CA	MPUS			OCKPORT RD /ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S DI AD	N OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	CTION SHOULD BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIE		DATE
	3/7/13, indicate	ed: " Time: 10-6Currently					
	has skin impair	ment: N [no]"					
	A Skilled Nurs	ing Assessment, dated					
		A.M., indicated,					
		s skin impairment: N					
	[no]"	is skin impairment. N					
	[110]						
	A Pressure Ulc	er Assessment indicated,					
	"Date: 3-11-13	, Present on admission? N					
	[no], Location:	[Left] heel, Pressure,					
	Stage/Thicknes	ss: I, Length 2.5, Width 1.8,					
	Depth 0Color						
	A Physician's o	order, dated 3/11/13,					
		patient] to wear Z flo boot					
		hile in bed, utilize bed					
		of bed. Float heels, apply					
	Ŭ	ft] heel q [every] shift."					
	skill prep to fie	itj neel q [evely] sinit.					
		1:30 A.M., Resident C					
	was observed s	itting in a wheelchair. He					
	-	ipper socks, and both of his					
	feet were press	ing on the floor. A skin					
	assessment was	s requested at that time.					
	Both feet appea	ared slightly swollen. The					
		reat toe had a small intact					
	-	h of the resident's heels					
		soft. Resident C indicated,					
		been putting that stuff on it					
	-	ident's pressure relieving					
		ved on a chair. Resident C					
		dn't like wearing it, and he					
		ear it in bed." Resident C					
	only nau to we	ai n ili beu. Kesiuelli C					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155682	(X2) MULTIPLE CO A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 03/14/2013			
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	DDE			
WOODN	IONT HEALTH CA	MPUS	1325 ROCKPORT RD BOONVILLE, IN 47601					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETIC		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	 morning, and had a should get the rest should get the rest should get the rest the wheelchair. 4. On 3/14/13 a of Nursing prove policy on "Wou Identification E undated. The popressure ulcers other wounds should be rest and the rest should be rest should be rest should be rest should be rest	d been to therapy that ad been sitting up. QMA # nat time that maybe they resident some leg rests for at 2:10 P.M., the Director vided the current facility and Staging and Education Information," olicy included, "Only should be 'staged.' All hould be described as nickness woundsStage I,						
	which does not of relief of caus thickness woun epidermis and p not extend into tissueWound painful. A Stag have or ever ha (necrotic tissue thickness woun epidermis and c subcutaneous ti	hout skin breakdown, resolve within 30 minutes se2. Stage II, a. Partial d, involving loss of partial loss of dermis. Does subcutaneous bed is moist, pink and e II pressure ulcer cannot ve had slough or eschar)3. Stage III, a. Full d, involving loss of lermis and extending into ssueWill present as a nd may include slough or						
	eschar, exudate Remove all nor and maintain a environment ¹ ulcer, a. Unable	s (drainage)Goal - nviable tissue, protect site,						

	R MEDICARE & MEDIC NT OF DEFICIENCIES	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION		OMB NO. 0938-03 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 155682	A. BUI		00	CON	MPLETED 14/2013
		155082	B. WIN				14/2013
NAME OF	PROVIDER OR SUPPLIEF	ι			DDRESS, CITY, STATE, ZIP CO	DDE	
WOODN	IONT HEALTH CAN	IPUS			OCKPORT RD /ILLE, IN 47601		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of thick slough of	or eschar"					
		Director of Nursing also					
	provided the cur	rent facility policy on					
	"General Wound	l and Skin Care					
	Guidelines," und	lated. The policy					
	included: "Eva	luate the need for a					
	pressure reduction	on surface for bed/chair					
	and the need for	the elbow protectors					
	and/or heel float	sPerform the wound					
	treatmentReev	aluate the wound's					
	response to the p	prescribed					
	treatmentInfor	m MD of wound					
	statusDocume	nt type of wound,					
		f applicable), length,					
		id treatment of the wound					
	weekly"						
	This federal tag	relates to Complaint					
	IN00125482.						
	3.1-40(a)(2)						
	2-99) Previous Versions Ob	osolete Event ID: C		Facility I	D: 002724 If conti	nuation sheet	Page 14 of 15

STATEMEN	MEDICARE & MEDI T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATI	MB NO. 0938-03 E SURVEY PLETED
		155682	B. WING				
NAME OF PI	ROVIDER OR SUPPLI	ER			DDRESS, CITY, STATE, ZIP COI DCKPORT RD	DE	
WOODMO	ONT HEALTH CA	MPUS			ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APF DEFICIENCY)		COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE