STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155664	A. BUILDING 00 B. WING	03/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE CREEK HEALTHCARE CENTER	4102 SHORE DR INDIANAPOLIS, IN 46254

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00290041, IN00290471, and IN00290523. Complaint IN00290041 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00290471 - Substantiated. Federal/state deficiencies related to the allegations are cited at F585 and F684. Complaint IN00290523 - Unsubstantiated due to lack of evidence. Survey dates: March 21, 22, 25, and 26, 2019 Facility number: 010666 Provider number: 155664 AIM number: 200229930 Census Bed Type: SNF/NF: 78 Total: 78 Census Payor Type: Medicare: 7 Medicaid: 36 Other: 35 Total: 78 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on April 3, 2019.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint Survey on March 26, 2019. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other			

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

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	agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances			

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	may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the			

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	grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on observation, interview, and record review, the facility failed to implement their grievance policy to help prevent chronic reoccurrence of resident and family voiced complaints for 1 of 2 residents reviewed for grievances (Resident L). Findings include: During a telephone conversation, on 3/22/19 at 11:17 a.m., Resident L's daughter indicated, she and her sister had visited the previous day, and had spoken with the Director of Nursing Services (DNS) regarding concerns with open wounds on her mother's bottom, and finding her mother with the gastrointestinal tube not connected causing her mother and the bed to be soaked with formula. While the daughter helped staff clean up the resident, the resident's brief was observed to be saturated with urine and looked as if it had not been changed all day. There were also multiple new deep pink sore areas on her bottom, in addition to old healing wounds, due to the brief being too small and too tight. The daughter	F 0585	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident L hand splint and foot bar are in place per therapy recommendation. Correct sized briefs in resident room and available to staff. Resident's bed linens changed and will be changed on-going per routine schedule and as needed. Resident's bathing preferences obtained, plan of care / kardex updated and resident will be bathed per preference. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: All residents are at risk for the alleged deficient practice. ED/designee will conduct the	04/22/2019

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	observed 4 new packages of briefs the aides had delivered to the room, all marked as extra-large. When the daughter questioned the aides about not having bariatric size for proper fit, she had been told there were no bariatric briefs available. On 3/22/19 at 1:35 p.m., Resident L was observed sitting at bedside in her wheel chair facing the television, with her daughter at the bedside. The daughter indicated, the following reoccurring concerns had been discussed with the Executive Director (ED) and DNS on numerous occasions with no resolution: a. A right hand splint had been ordered by the therapy department in January to be put on the resident 4-6 hours daily by the restorative aide, but she had not seen it worn since the resident moved to the current room. A hand splint was observed in the top drawer of the bedside stand. b. A foot bar had been ordered by the therapy department in January to prevent the resident's right foot from sliding off of the wheel chair pedal. The daughter was originally told the foot bar had been ordered and it would be applied when it arrived to the facility. On 3/15/19 the daughter spoke to Therapist 13, and the bar was still not available. c. The bed sheets were not routinely changed when soiled. The DNS had been notified, the sheets on the bed before hospitalization on 2/25/19 were soiled, and still on the bed when the resident returned on 2/27/19. The daughter had marked the sheets, and the sheets were not changed until the DNS was notified. d. The daughter did not believe the resident had been showered at all since in the facility. The most recent conversation with the DNS regarding lack of showers had been on 3/5/19, and the DNS had assured her a new schedule for showers on		follow: 1.Audit of grievances for the past 30 days to ensure follow up and resolution **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The ED/designee will educate on the following: 1.All staff on policy for grievances, follow up and resolution. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the ED or designee: 1. Review of 5 resident or family grievances 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance: ensure follow up and resolution is complete. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	Monday and Wednesday one week, and Tuesday, Thursday the next week would be implemented. The daughter did not believe the resident had received any showers as of 3/18/19. This was the first day she had been assisted out of bed since returning from the hospital. Record review for Resident L was completed on 3/22/19 at 2:20 p.m. The record indicated, the resident was admitted on 10/3/18 and moved to her current room on 2/6/19. Diagnoses included, but were not limited to: cerebral infarct, aphasia (impairment of language production and comprehension of speech), need for assistance with personal care, and mild cognitive impairment. Review of an Admission 5 day Minimum Data Set (MDS) assessment, dated 7/5/18, indicated, it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. There was no documentation to indicate resident preferences in the resident record. On 3/25/19 at 10:35 a.m., the ED provided documents, titled, "Complaints/Grievances", dated 1/1/19 - 3/22/19. The reports indicated, there was no documentation to indicate complaints/grievances had been logged or followed up for Resident L. On 3/25/19 at 2:10 p.m., the DNS provided a reports, titled, "Documentation Survey Report", dated February 2019 and March 2019, and indicated, the reports were documentation of the Resident L being bathed or showered. The reports indicated, there was no documentation of the resident receiving a shower. On 3/22/19 at 11:17 a.m., Resident L's daughter indicated, she had spoken to the ED and DNS on			

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	multiple occasions in the past regarding her mother being placed in briefs that were too small and not having her brief changed often enough, both contributing to the resident having recurrent open areas. The daughter indicated, she was tired of having these conversations and had been calling up the corporate chain of leadership to get results. On 3/22/19 at 1:50 p.m., Certified Nursing Assistant (CNA) 6 indicated, Resident L was assisted out of bed around 11:40 a.m. The resident usually was assisted out of bed close to noon, and put back to bed after 5:00 p.m.. CNA 6 usually just changed the resident twice on her shift, in the morning and before she was assisted up into her wheelchair, she did not check or change the resident during the remainder of the shift. The resident needed bariatric briefs and the correct size briefs were not always available, so the resident would get an extra-large brief instead that was too small and tight. The nurses and DNS were notified when the correct sized briefs were not available. On 3/22/19 at 2:15 p.m., the daughter indicated, the situation with Resident L had been going on for months. She had talked to the DNS and ED over and over again with the same concerns, and she was tired. Tired of her mom having briefs being too small, tired of asking if her mom was being changed every 2 hours, tired of going to the management and nothing being done, and just tired of talking to get her mother just basic care. She needed her concerns to stop falling on deaf ears. When she's asked, the ED, DNS and nurses had assured her the bariatric briefs were being ordered, and the resident's brief was being checked while she was up in the chair during the day, but she did not belief this to be true and she			

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	continuously had open sores. The DNS who was present during the interview did not respond. On 3/26/19 at 10:57 a.m., the ED indicated, the facility policy for grievances was to follow up any concern within 72 hours. Any staff employee could take a complaint/grievance from residents or their family members. The person receiving the grievance was to fill out a grievance form, and the grievance form would be taken to the Social Service Director to document the concern on a monthly Complaint/Grievance Log. The concern would then be passed along to the responsible department. Grievances were reviewed each day for follow up and resolution. On 3/26/19 at 12:45 p.m., the ED provided a policy, titled, "Resident Grievance Indiana", dated 6/19/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotion needs and concerns of the residents. This facility will provide a venue for residents and others involved in patient care, to voice concerns, complaints, or grievances to facility leadership and external parties ...1. Prevent Ongoing Violations. a. Upon receipt of an oral, written or anonymous grievance submitted by a resident, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, if indicated ...The Grievance Officer shall complete an investigation of the resident's grievance ...The grievance review will be conducted in a reasonable time frame consistent with the type of grievance but not to exceed 30 days ...Upon completion of the review, the Grievance Officer will complete a written grievance decision ...The Grievance Officer will meet with the resident and inform the resident of the results of			

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	the investigation and how the resident's grievance was resolved or will be resolved, if applicable. A copy of the written grievance decision will be provided to the resident upon request ...The facility will keep evidence of the resolution of all grievances for a period of three[3] years from the date the grievance decision is issued...." This Federal tag relates to Complaint IN00290471. 3.1-7(a)(1) 3.1-7(b)(2) 3.1-7(b)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to provide nursing services, assessment, and treatment for a non-pressure wound, resulting in an abrasion becoming an open wound, for 1 of 3 residents reviewed for wound care (Resident L). Findings include: On 3/22/19 at 11:14 a.m., Resident L was observed sitting at bedside in her wheel chair, she was alert and facing the television.	F 0684	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident L to be provided correct size briefs. Weekly skin assessments to be completed. Abrasion area is healed. Resident L's non-verbal pain indicators to be reviewed and added to plan of care. Turning and repositioning schedule to be added to plan of	04/22/2019

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	During a telephone conversation, on 3/22/19 at 11:17 a.m., Resident L's daughter indicated, she and her sister had visited the previous day, and had spoken with the Director of Nursing Services (DNS) regarding concerns with her mother's open wounds on her bottom. When the daughter helped staff clean up the resident, her brief was observed to be soaked with urine and looked as if it had not been changed all day. There were also multiple new deep pink sore areas on her bottom, in addition to old healing wounds, due to the brief being too small and tight. The daughter observed 4 new packs of brief the aides had delivered to the room, all marked as extra-large. When the daughter questioned the aides about not having bariatric size for proper fit, she had been told there were no bariatric briefs available. There were A & D ointment (skin protectant) packets in the resident's bedside drawer that were used by staff on the resident's bottom when her brief was changed. In her opinion, her mother did not have pressure ulcers, she just had sores from continually not being changed as needed, having the wrong sized briefs, and she was upset that her mother had to endure having constant open wounds. On 3/22/19 at 1:32 p.m., the DNS provided a list, titled, "Skin", undated, and indicated it was a list of current residents with skin concerns. The list indicated, Resident L had an abrasion to the buttocks. On 3/22/19 at 2:07 p.m., Resident L's inner thighs, buttocks, and upper outer left thigh, were observed with the daughter, DNS, Licensed Practical Nurse (LPN) 7, and Certified Nursing Assistants (CNA's) 5 and 6. The following was observed: a. On the upper left thigh outside the brief were 2		care. **Identification of other residents having the potential to be affected by the same alleged deficient practice and Corrective actions taken**: The Director of Nursing or designee will complete the following: 1.Observe all residents who wear briefs to ensure they are the correct fitting and fit comfortable for the resident 2.Develop a log to list what size brief each resident wears 3.Audit supply of briefs to ensure we have all the correct sizes and enough of those sizes in house 4.Observe all residents skin to identify any current or new impairment 1.Ensure MD and family notification 2.Assessment complete and documented 3.Treatment ordered and implemented 4.Weekly skin monitoring scheduled and implemented **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Director of Nursing or designee will in-service the Licensed Nurses on the following policies: 1.Physician notification	

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	areas the DNS indicated were healing wounds that appeared to be from the brief being too small. LPN 7 indicated, the areas were from the resident scratching. b. On both upper inner thighs there with long lines of lighter colored skin, that the daughter, DNS, and LPN 7 all agreed were healed wounds from the brief being too small. The DNS and LPN 6 indicated, they had no knowledge of the old wounds on the inner thighs. The CNA's acknowledged they knew the areas were there. c. On the right inner lower buttock there were multiple horizontal and vertical lines, most of the lines were pink in color. There were multiple open areas with a scant amount of bloody drainage from the longest line that measured approximately 4 inches in length and 0.5 inches in width. The DNS and daughter agreed yesterday the lines were solid deep pink and white colored, as if the top layer of skin was gone. Both agree the lines and open areas were from the brief being too small, and the resident being saturated from urine and not being changed timely. d. When Resident L was placed into bed for observation of her skin, her brief was saturated with urine and her skin moist. e. When Resident L was turned side to side to observe her bottom, she yelled out and moaned several times. The daughter indicated she was yelling out and moaning due to the sores on her bottom hurting. Record review for Resident L was completed on 3/22/19 at 2:20 p.m. The record indicated, the resident was admitted on 10/3/18 and moved to her current room on 2/6/19. Diagnoses included, but were not limited to: cerebral infarct, aphasia (impairment of language production and comprehension of speech), need for assistance with personal care, and mild cognitive impairment.		2.Monitoring a wound 3.Pain management and assessment The Director of Nursing or designee will in-service the non-licensed and licensed nurses on the following policies: 1.Nurse Aide Rounds 2.Brief Sizes Directed inservice on nursing services, assessments and treatments for all direct care staff. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing or designee: 1.Observe 5 residents who wear briefs to ensure they fit comfortably and correctly - 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance 2.Review log list of brief sizes for residents to ensure it is kept up to date - 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance 3.Review the supply of briefs to ensure we have the correct sizes and enough in house - 5 times per week for 2 weeks, then 1	

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	Review of Resident L's Physician's orders, indicated: a. On 11/1/18 "cleanse area to right gluteal fold with normal saline, pat dry and apply calmoseptine [moisture barrier] and cover with dry dressing two times a day for wound" b. On 6/28/18 "pain monitoring using verbal/non-verbal 0-10 scale, every shift for monitoring level of comfort" c. On 10/26/18 weekly skin assessments. "Document any changes in the nurse's notes. Every evening shift every Thursday for weekly skin assessment. Use form in PCC [Point Click Care electronic documentation system]" d. On 6/28/18 "Acetaminophen Tablet 325 milligrams [mg], give 2 tablet by mouth every 4 hours as needed for mild pain; moderate pain" Review of Resident L's Medication Administration Record (MAR), dated 3/1/19 - 3/22/19 indicated, there was no documentation to indicate Tylenol 325 mg had been administered for pain. Review of assessments for Resident L, titled, "Weekly Skin Sheets", dated 2/1/19 - 3/22/19, indicated: a. On 2/14/19 at 10:48 p.m., Registered Nurse (RN) 14 documented, there were no skin conditions or changes, ulcers, or injuries. b. On 2/28/19 at 10:18 p.m., LPN 15 documented, there were no skin conditions or changes, ulcers, or injuries. c. On 3/15/19 at 2:16 a.m., LPN 15 documented, there were no skin conditions or changes, ulcers, or injuries. d. There were no documented Weekly Skin Sheets found for the weeks of 2/7/19, 3/8/19, or 3/21/19. Review of Resident L's Progress Notes, dated		times per week for 4 weeks, then monthly for 4 months to ensure compliance 4.Review of residents with skin impairment to ensure MD/family have been notified, assessment is complete and documented, treatment is ordered and implemented, weekly skin monitoring is scheduled and implemented - 5 times per week for 2 weeks, then 1 times per week for 4 weeks, then monthly for 4 months to ensure compliance The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation	

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	155664	A. BUILDING 00 B. WING	03/26/2019

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	3/1/19 - 3/22/19, indicated: a. On 3/11/19 at 10:15 p.m., LPN 7 documented, sharing noted to left thigh after resident scratching protective dressing applied, daughter aware. Review of a quarterly Minimum Data Set (MDS) assessment, dated 3/11/19, indicated, Resident L was able to make herself understood and to understand others sometimes, and she had short and long term memory problems. The resident required extensive assistance of 2+ persons for bed mobility, and dressing, and was totally dependent for transfers, toilet use, and personal hygiene. The resident was occasionally incontinent of bladder, and frequently incontinent of the bowel. She was on a routine pain regimen, was unable to indicate pain intensity, and had no pain indicators to include non-verbal sounds, vocal complaints of pain, or facial expressions during the assessment period. Resident L was at risk for developing pressure ulcers/injuries, but had no other ulcers, wounds and skin problems. There was no turning/repositioning program, or nutrition/hydration intervention to manage skin problems. Review of Care Plans for Resident L, indicated, "1. 11/5/18 Focus: Actual alteration in skin integrity (non-pressure) related to [resident] has shearing to her right thigh due to incontinence. Goal: Wound will be free of infection. Interventions: Assess for pain/comfort level every shift/prn/prior to dressing change and medicate per physician order. Follow physician orders for skin care and treatment ...Protective skin care with incontinence care. Skin care treatment as ordered by MD [physician]. Weekly documented skin check. 2. 6/29/18 Focus: [Resident] has potential for alteration in comfort related to general complaints			

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	of pain. Goal: [Resident] will not have an interruption in normal activity due to pain through the review date. Interventions: Administer medications as ordered ...Assess and document characteristics of [resident's] pain [location, duration, quality, aggravating/alleviating factors, radiation, intensity, etc.], Complete pain assessment on admission, quarterly and with significant change in pain ...Monitor [resident] for signs of mood changes and distress ...3. 6/29/18 Focus: Potential for skin/tissue integrity-skin breakdown due to decreased mobility, incontinence and dependence on staff for weight bearing assist with bed mobility. Goal: Will decrease the risk of skin breakdown on a daily basis and [resident] will have skin intact. Interventions: Assess [resident's] skin weekly by nurse, daily with care and prn. Use pressure relieving mattress. When [resident] is out of bed, encourage and or assist to change position by toileting, uploading, shift weight, ambulating or return to bed to rest...." On 3/25/19 at 10:25 a.m., the ED provided a report, titled, "[Company Name]", dated 3/25/19, and indicated it was a report from the wound doctor seeing Resident L that morning. The report indicated, "Wound #1 status is open. The wound is current classified as a full thickness without exposed support structures wound with etiology of abrasion and is located on the right, posterior upper leg. The wound measures 2 cm [centimeters] length x [by] 4 cm width x 0.1 cm depth ...There is a small amount of serosanguinous [bloody] drainage noted. The wound margin is flat and intact. There is medium [34 - 66%] red granulation within the wound bed ...Cleanse wound bed with normal saline [NS] or wound cleaner. Pat dry. Apply skin prep, or equivalent, to periwound, then apply hydrocolloid			

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	[transparent dressing] to wound bed. Change every 3 days and prn [as needed], soilage. Area due to brief as it is linear, transverse, and at point of contact with lower brief edge. Avoid brief use in bed; begin hydrocolloid as a physical barrier to further friction as well as to incontinence related moisture." On 3/22/19 at 11:17 a.m., Resident L's daughter indicated, she had spoken to the Executive Director (ED) and DNS on multiple occasions in the past regarding her mother being placed in briefs that were too small and not having her brief changed often enough, both contributing to the resident having recurrent open areas. The daughter indicated, she was tired of having these conversations and had been calling up the corporate chain of leadership to get results. On 3/22/19 at 1:49 p.m., CNA 5 indicated, she was not routinely Resident L's primary aide, but to her knowledge the resident was assisted out of bed after breakfast. On 3/22/19 at 1:50 p.m., CNA 6 indicated, Resident L was assisted out of bed on that date around 11:40 a.m. The resident usually was assisted out of bed close to noon, and put back to bed after 5:00 p.m. CNA 6 usually changed the resident twice on her shift, in the morning and before she was assisted up into her wheelchair, she did not check or change the resident during the remainder of the shift. The resident needed bariatric briefs and the correct size briefs were not always available, so the resident would get an extra-large brief instead that was too small and tight. The nurses and DNS were notified when the correct sized briefs were not available. On 3/22/19 at 1:57 p.m., the DNS indicated, she			

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	had assessed Resident L's bottom on 3/21/19, but she did not document her findings in the resident's medical record. The resident had no pressure wounds, just lines from the brief. The wound doctor rounded on Mondays, and any findings were not documented until after the wound doctor had seen the resident. Nurses were to document wound assessments on the Weekly Skin Assessment form. On 3/22/19 at 2:15 p.m., the daughter indicated, the situation with Resident L had been going on for months. She had talked to the DNS and ED over and over again with the same concerns, and she was tired. Tired of her mom having briefs being too small, tired of asking if her mom was being changed every 2 hours, and tired of going to the management and nothing being done. When she's asked, the ED, DNS and nurses had assured her the bariatric briefs were being ordered, and the resident's brief was being checked while she was up in the chair during the day, but she did not belief this to be true and she continuously had open sores. The DNS who was present during the interview did not respond. On 3/22/19 at 2:20 p.m., the DNS indicated, she assessed Resident L's bottom the day before, and had observed new areas on the resident's bottom that appeared to be from the brief being too tight. She did not document her findings, and the MD was not notified. The area on the bottom had deteriorated and opened since yesterday, although the resident did have a calmoseptine order and the aides were applying the ointment to the resident. On 3/25/19 at 10:25 a.m., the ED indicated, Resident L was seen by the wound doctor for the first time that morning.			

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	On 3/26/19 at 11:00 a.m., the DNS indicated, weekly wound sheets should have been filled out with weekly skin assessment by the nurses, or by the DNS as needed. If a new skin issue or wound was found, the MD should have been notified during the same shift to obtain orders. Residents were to be toileted when they requested as they needed to go. If a resident was unable to verbalize the need to toilet, staff should go in at least every 2 hours or as needed to take or change them. On 3/26/19 at 12:47 p.m., the ED provided a policy, titled, "Physician Notification for Change in Condition Reporting", revised date 8/1/16. The policy indicated, "It is the policy of this facility to promote resident centered care by using evidence based practice for notification of providers for changes in condition and when to report signs and symptoms to the MD/NP[Nurse Practitioner]/PA[Physician's Assistant] ...Unless there are documented extenuating circumstances, the nurse will report CID's based on the following criteria for reporting to the physician/provider ...Abrasions report immediately if accompanied by significant pain or bleeding, report next office day if bleeding continues or if associated with evidence of local infection...." On 3/26/19 at 12:47 p.m., the ED provided a policy, titled, "Monitoring A Wound", dated 7/1/16. The policy indicated, "Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to hospital and upon return from the hospital ...Conduct daily rounds to verify the following is present with resident/patient care: appropriate wound			

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	treatments are completed and documented...frequent redistribution off area of pressure ...toileting schedules are followed...." On 3/26/19 at 12:47 p.m., the ED provided a policy, titled, "Nurse Aid Rounds", revised date 3/29/16. The policy indicated, "It is the policy of this facility that CNA's/STNA[State Tested Nurse Aide] provide patient centered care by monitoring patient care needs and safety on a routine basis throughout the day per the facility and individual needs ...CNA's will routinely monitor residents/patients for routine care needs and safety-this may be referred to as rounding or making rounds. Rounding will be completed by CNA/STNA to safely transfer care between on-coming and off-going shifts and periodically during each shift as directed by nurse and plan of care ...Monitor and attend to toileting needs including incontinence needs ...report concerns or changes in condition to nurse, turn and reposition residents in bed, repositioning needs-including weight shifting and turning ...Nurses will monitor the rounding schedule is adequate and completed for meeting resident needs...." On 3/26/19 at 12:47 p.m., the ED provided a policy, titled, "Pain Management and Assessment", dated 7/25/18. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents ...The purpose of this policy is to provide guidance to the clinical staff ...the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of			

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	pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain-relief measures ...To the extent possible and in consideration of cognitive abilities, the nurse will provide a thorough assessment by observation of activities and treatment/relief for detection of pain and to attempt to identify location and any limitations imposed by the pain ...facial grimaces during care ...unexplained behaviors when the resident is unable to verbalize ...may require on occasion, adjuvant therapies including pharmacological and non-pharmacological interventions for enhancing pain relief...." This Federal tag relates to Complaint IN00290471. 3.1-37(a)			