

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2018
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP COD 118 MEDICAL DR CARMEL, IN 46032
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00250568 and IN00251490. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy.</p> <p>Complaint IN00250568 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695.</p> <p>Complaint IN00251490 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F677, and F867 .</p> <p>Unrelated deficiencies are cited at F689 .</p> <p>Survey dates: January 19, 22, 23 and 24, 2018</p> <p>Facility number: 000095 Provider number: 155181 AIM number: 100290490</p> <p>Census Bed Type: SNF/NF: 12 SNF: 135 Total: 147</p> <p>Census Payor Type: Medicare: 11 Medicaid: 109 Other: 27 Total: 147</p> <p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed on January 29, 2018.</p>	F 0000	<p>This plan of correction is to serve as Carmel Health and Living's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Carmel Health and Living or its management company that the allegations contained in the survey report are 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.</p>	
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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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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 0677 SS=E Bldg. 00	<p>483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;</p> <p>Based on observation, interview and record review, the facility failed to provide nail care and bathing and grooming for residents according to their shower schedules and the facility policy and procedure for 5 of 7 residents being observed and reviewed for ADL's (Activities of Daily Living) (Residents C, D, K, N and O).</p> <p>Findings include:</p> <p>1. On 1/19/18 at 11:22 a.m., during the facility tour with LPN 1 in attendance, Resident C was observed sitting in his broda chair. His bilateral thumb nails were long and the right fingernails were long. . The resident had long toe nails on his bilateral feet. LPN 1 indicated at that time, his fingernails needed cut.</p> <p>During an interview on 1/22/18 at 10:04 a.m., a family member voiced concerns the staff were not bathing this resident or clipping his finger or toe nails on a regular basis. The family member was told by staff the CNA's were not allowed to clip fingernails and she indicated the nurses were to busy to cut his fingernails. There was no staff from the facility who could cut his toenails.</p> <p>A document titled "Shower List 2" was provided by the SDC (Staffing Development Coordinator) on 1/22/18 at 3:15 p.m. This list indicated Resident C was to have a shower on Wednesdays and Fridays on</p>	F 0677	<p>F677 ADL Care Provided for Dependent Residents</p> <p>I. Residents C,D,K,N and O have received showers/ baths per their individual preference. Residents C,D,K,N, and O are receiving nail care.</p> <p>Resident O has been shaved per his preference.</p> <p>II. All residents that need assistance for ADL care have the potential to be affected by the alleged deficient practice. All requiring assistance for ADL care have been reviewed.</p> <p>They are receiving showers, nail care and shaving per their preference.</p> <p>III. Education has been provided to all staff regarding</p>	02/07/2018	

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	<p>the evening shift.</p> <p>The record review for Resident C was completed on 1/22/18 at 3:37 p.m. Diagnoses included, but were not limited to pressure ulcer sacral region Stage IV, contracted bilateral knees, dysphagia, chronic pain, and hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage.</p> <p>The resident's quarterly MDS (Minimum Data Set) assessment data 11/17/17, indicated he was severely cognitively impaired. His ADL function indicated he was totally dependent with one assist for bathing.</p> <p>The resident had a Care Plan dated 5/19/17 and edited on 11/8/17, which addressed the problem he was unable to complete his ADL's independently due to weakness related to a cerebrovascular accident and hemiplegia, which he required extensive assistance for bed mobility, transfers, toileting and eating. The approaches for the residents care plan did not address the ADL bathing or personal hygiene.</p> <p>The resident's "Point of Care ADL Category Report" dated 11/16/17 through 1/21/18 was reviewed and indicated the the resident did not a shower as scheduled on 1/17/18.</p> <p>2. On 1/19/18 at 11:01 a.m., during the facility tour with LPN 1 in attendance, Resident D was observed laying in bed with long bilateral finger nails. LPN 1 indicated at that time she clipped this resident's fingernails two weeks ago, but they did need to be clipped at that time. She indicated fingernails were to be clipped when the CNA's bathed the residents and as needed.</p> <p>During interview and observation, on 1/22/18 at</p>		<p>providing ADL care including grooming of facial hair and nail care. The systemic change includes Charge Nurses will be responsible to ensure care needs</p> <p>are met to include nail care, shaving, and showering/bathing. Each resident will have an associate assigned to them. The assigned representatives will assist in monitoring the resident to ensure compliance with ADL care.</p> <p>IV.</p> <p>The DON/designee will audit through direct observation 5 random residents for ADL care to include showers are received and shaving and nail care are provided. This auditing will occur daily (including Saturday and Sunday) for 4 weeks; then, monthly thereafter totaling 12 months of monitoring.</p> <p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p>		

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	<p>12:05 p.m., the resident was observed with long fingernails. He indicated at that time he did not want his fingernails a long length. He cannot cut his own fingernails and the staff cannot cut them soon enough for him.</p> <p>A document titled "Shower List 1" was provided by the SDC (Staffing Development Coordinator) on 1/22/18 at 3:15 p.m. This list indicated Resident D was to have a shower on Tuesdays and Thursdays on the day shift.</p> <p>The record review for Resident D was completed on 1/22/18 at 4:00 p.m. Diagnoses included, but were not limited to, pneumonitis, pseudobulbar abnormal posture, pulmonary embolism, malignant neoplasm, anxiety disorder, and chronic pain.</p> <p>The resident's quarterly MDS assessment dated 12/17/17, indicated he was severely cognitively impaired. His functional status indicated he required extensive assistance of one person with personal hygiene and bathing required total dependence with assistance of one person.</p> <p>The resident had a Care Plan dated 2/19/17 with an edited date of 12/21/17, which addressed the problem he required dependent care for ADL's related to functional deficit. Approaches included, but were not limited to, "...2/19/17- -Provide full staff performance for hygiene, grooming and dressing, Provide full staff performance for nail care with bathing...2/19/17- -Provide full staff performance with full body bathing per resident preference.</p> <p>The resident's "Point of Care ADL Category Report," dated 11/16/17 through 1/21/18, was reviewed and indicated the resident did have a</p>		<p>Facility Administrator will be responsible for ensuring compliance.</p>	

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	<p>shower as scheduled on 11/16/17 and 11/28/17.</p> <p>3. On 1/19/18 at 12:45 p.m., during the facility tour with LPN 1 in attendance, Resident K was observed laying in bed and had bilateral hand contractures with a right palm protector and the left hand had a wash cloth in it. The resident had long fingernails and toenails. LPN 1 indicated at that time, his fingernails and toenails needed to be cut. She indicated at that time, the podiatrist needed to clip his toenails and a nurse needed to clip his fingernails due to the contractures of his hands.</p> <p>On 1/22/18 at 11:58 a.m., CNA 10 was observed in Resident K's room completing his bed bath. The resident had long fingernails and toenails. CNA 10 indicated the resident was on therapy case load for his bilateral hand contractures and they applied his palm splints. She indicated his right hand had a palm splint and his left hand had a rolled up wash cloth. She indicated a resident with a contracture had their nails cut by a nurse or therapy. CNA's were allowed to cut residents nails who were not diabetic or had contractures. The podiatrist came and clipped the residents toenails and the CNA's clipped the residents' fingernails without any contractures.</p> <p>A document titled "Master Shower Schedule" was provided by the SDC (Staffing Development Coordinator) on 1/22/18 at 3:15 p.m. This list indicated Resident K was to have a bed bath daily in the evening. The schedule indicated "All residents are to be shaved daily, and nails must be trimmed/cleaned on shower days."</p> <p>A record review was completed for Resident K on 1/22/18 at 3:55 p.m. Diagnoses included contractures of bilateral wrist and right elbow,</p>			

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	<p>diffuse traumatic brain injury with loss of consciousness, dysphagia, quadriplegia and tracheostomy.</p> <p>The resident's quarterly MDS assessment dated 12/05/17, indicated the resident was severely cognitively impaired. His functional status indicated he required total dependence with assistance of two people for bathing.</p> <p>The resident had a Care Plan dated 9/25/17 and edited on 12/6/17, which addressed the problem he was unable to independently perform late loss ADL's related to decreased mobility and weakness indicated he was dependent assist for bed mobility, transfers, toileting and eating. The approaches did not address bathing or personal hygiene.</p> <p>The resident's "Master Shower Schedule" dated 11/16/17 through 1/21/18 was reviewed indicating "All residents are to be shaved daily, and nails must be trimmed/cleaned on shower days," "Evening Shift Showers/Bed Baths daily: Rooms 307 A...."indicated the resident did not receive his bedbath on 11/16/17 through 11/24/17, 11/27/17 through 11/28/17, 11/30/17, 12/2/17 through 12/8/17, 12/11/17 through 12/12/17, 12/14/17 through 12/31/17, 1/1/18 through 1/3/18, 1/5/18 through 1/6/18, 1/8/18 through 1/21/19 and 1/22/18.</p> <p>4. On 1/19/18 at 11:01 a.m., during the facility tour with LPN 1 in attendance, Resident N was observed laying in bed and had bilateral hand contractures with palm protectors in each hand, with long nails, which had black debris under all the nails. LPN 1 indicated at that time, Resident N was a diabetic, so the nurses had to cut her nails, but the CNA's could clean under them. She</p>			

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	<p>indicated her nails needed cleaned and cut.</p> <p>On 1/22/18 at 11:41 a.m., the resident was observed with long fingernails with black debris under them. She had palm protectors in her hands with bilateral hand contractures. At that time, CNA 9 was in attendance in her room and indicated she did have long fingernails and they were dirty under them. She indicated night shift gave her a bed bath daily and someone should have cleaned under her nails while doing her bed bath, then a nurse had to cut them because she was diabetic.</p> <p>A document titled "Master Shower Schedule" was provided by the SDC (Staffing Development Coordinator) on 1/22/18 at 3:15 p.m. This list indicated Resident N was to have a bed bath on Wednesdays and Saturdays on the day shift.</p> <p>The record review for Resident N was completed on 1/22/18 at 4:20 p.m. Diagnoses included, but were not limited to, hemiplegia, hemiparesis, viral pneumonia, contractures of bilateral hands and left elbow, spastic hemiplegia, Xerosis, spastic hemiplegia, seizures and acute kidney failure.</p> <p>The resident's quarterly MDS assessment dated 10/24/17, indicated the resident was severely cognitively impaired. Her functional status indicated she required extensive assistance of two people for personal hygiene and required total dependence with assistance of two people for bathing.</p> <p>The resident had a Care Plan dated 6/18/13, with an edited date of 10/26/17, which addressed the problem she required dependent care for ADL's related to cognitive loss and hemiplegia. Approaches included, but were not limited to,</p>			

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	<p>"...1/20/15----Complete bed bath at least twice weekly with partial baths as needed...1/20/15--Provide (assistance/full staff performance) for washing/drying face, hands, perineum...1/20/15--Resident prefers a B/B [bed bath] due to current status, not refusing."</p> <p>The resident's "Point of Care ADL Category Report" dated 11/16/17 through 1/21/18, was reviewed and indicated the resident did have a shower as scheduled on Wednesdays and Saturdays on day shift on 11/18/17, 11/22/17, 12/2/17, 12/9/17, 12/16/17, 12/20/17, 12/27/17, 1/3/18 and 1/6/18.</p> <p>5. On 1/19/18 at 4:33 p.m., during the facility tour with LPN 1 in attendance Resident O was observed sitting in his electric wheelchair. He had a thick beard and a mustache with flakes of dry white skin inside his beard and mustache and along the side of his face from his earlobe down his jawline. His bilateral ears had dry skin around the outside of the ear at the top and along the earlobe in the front and inside the ear. The right ear was worse than the left. The right ear canal opening was completely full of white dry flaked skin and the opening to his right ear could barely be seen. He had white flakes of skin or dandruff in his hair. The white dry flakes of skin fell onto his red sweatshirt and onto a cell phone, which was sitting on his over the bed rolling table sitting next to him. His hair was greasy. At this time during interview, he indicated he did not like to have a beard and mustache. His fingernails were long. He indicated he quit asking about getting shaved and his showers because it was like a broken record. He indicated he had not had a shower in four weeks.</p> <p>On 1/22/18 at 11:30 a.m., the resident was</p>			

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	<p>observed sitting in his electric wheelchair in his room. He had dry skin around the inside of the top of his ear and inside the opening of his ear canal. He had dry skin around the nap of his neck and around his mouth along his chin up towards his ears. He had the dry flaky white skin in his hair. He indicated he was shaved, but he still did not get a shower. His hair remained greasy.</p> <p>A document titled "500 Shower List" was provided by the SDC (Staffing Development Coordinator) on 1/22/18 at 3:15 p.m. This list indicated Resident O was to have a shower on Tuesdays and Fridays on the day shift.</p> <p>The record review for Resident O was completed on 1/22/18 at 4:37 p.m. Diagnoses included, but were not limited to, Multiple Sclerosis, Xerosis, quadriplegia and neuromuscular dysfunction.</p> <p>The resident's quarterly MDS assessment dated 11/7/17, indicated the resident required total assistance of two people for personal hygiene and bathing.</p> <p>The resident had a Care Plan dated 10/26/17, with an edited date of 11/03/17, which addressed the problem he was unable to independently perform late loss ADL's related to decreased mobility and weakness secondary to multiple sclerosis and required extensive to dependent assist for bed mobility, transfers toileting and eating. Approaches included, but were not limited to, "...10/26/17--Instruct in use of assistive devices as needed...."</p> <p>The resident's "Point of Care ADL Category Report" dated 11/16/17 through 1/21/18 was reviewed indicating the following dates the resident did have a shower as scheduled on</p>			

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	<p>Tuesdays and on day shift: 12/16/17 (was not his normal shower day)--no other shower days were documented.</p> <p>During an interview, on 1/22/18 at 12:07 p.m., RN 8 indicated the nurses cut the residents' nails with Diabetes Mellitus and the CNA'S can cut the residents' nails, who do not have medical conditions. The residents' nails should be cut and cleaned on the residents shower days and as needed.</p> <p>A current policy titled "Care of Fingernails/Toenails" dated October 2010, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Preparation: 1. Review the resident's care plan to assess for any special needs of the resident... General Guidelines: 1. Nail care includes daily cleaning and regular trimming...3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual (s) who administered the nail care. 3. The condition of the resident's nails and nail bed, including: a. Redness or irritation of skin of hands and feet; b. Breaks or cracks in skin, specially between toes; c. Pale, bluish or gray discoloration of feet, d. Bluish or dark color of nail beds; e. Corns or calluses; f. Ingrown nails; g Bleeding; and/or h. Pain. 4. Any difficulties in cutting the resident's nails. 5. Any problems or complaints made by the resident with his/her hands or feet or any complaints related related to the procedure. 6. If the resident refused the treatment, the reason</p>			

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F 0686 SS=J Bldg. 00	<p>(s) why and the intervention taken...."</p> <p>A current policy titled "Shower/Tub Bath" dated October 2010, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "Purpose: The purpose of this procedure are to promote cleanliness provide comfort to the resident and to observe the condition of the resident's skin. General Guidelines:...5. Observe the resident's skin for any redness, rashes, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown. 6. Do not trim the resident's toenails or fingernails unless otherwise instructed by your supervisor...Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual (s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores etc., on the resident's skin obtained during the shower/tub bath...5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath...."</p> <p>This Federal tag relates to Complaint IN00251490.</p> <p>3.1-38(3)(A) 3.1-38(3)(B) 3.1-38(3)(D) 3.1-38(3)(E)</p> <p>483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity</p>				

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	<p>§483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>Based on observation, interview and record review, the facility failed to prevent, identify, assess and treat pressure ulcers and DTI (Deep Tissue Injury) wounds for 4 of 5 residents observed and reviewed for pressure ulcers (Residents K, C, R and M).</p> <p>The Immediate Jeopardy began January 16, 2018, when the facility failed to implement prevention interventions to prevent the formation of new pressure ulcers and DTI's, failed to identify and assess the formation of pressure ulcers and DTI's, until the wounds were a Stage 3 up to Unstageable pressure ulcers while failing to obtain treatment orders from the Physician for these Pressure Ulcers and DTI's after they were identified. The Administrator, Director of Nursing (DON), Clinical Specialist, Director of Clinical Services and the Regional Director of Operations were notified of the Immediate Jeopardy on 1/23/18 at 1:20 p.m. The Immediate Jeopardy was removed on 1/24/18, but noncompliance remained at the lower scope and severity of pattern, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy</p>	F 0686	<p>F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>We respectfully disagree with the findings of the surveyor. As such, we are requesting an IDR.</p> <p>I. Resident K has current measurements and assessments on his bilateral lower extremity wounds. He is being seen weekly by the Wound Doctor.</p> <p>Resident C is receiving treatment to his coccyx wound as ordered. The wound to the left index finger received a status of resolved by the wound doctor on 1-31-18. He is seen weekly by the wound doctor for the coccyx wound.</p>	02/07/2018	

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	<p>Findings include:</p> <p>1. On 1/19/18 at 12:45 p.m., during the facility tour with LPN 1 in attendance Resident K was observed sitting in his bed with his heels floated on pillows, no Prevalon boots were in place. His left foot was crossed over, laying on top of his right foot. When LPN 1 removed the left foot off the top of the right foot, there was a dime size indent in the blackened/purple area of the medial left heel. The top of the right foot, where the left heel was sitting, had a area at the bone protrusion. from the middle of his foot with a blackened scabbed area. The right medial heel had a bluish/purple area, which was closed. The left 5th metatarsal had a blister on it. The top middle area of his left foot had a dime sized black scabbed area to the area of the bone protrusion from his foot. No drainage was observed from any wound. LPN 1 indicated the resident's left foot should not have been crossed over onto the top of his right foot and the resident was unable to cross his own feet, so a staff member had to have crossed his feet.</p> <p>A record review was completed for Resident K on 1/22/18 at 3:55 p.m. Diagnoses included contractures of bilateral wrist and right elbow, diffuse traumatic brain injury with loss of consciousness, dysphagia, quadriplegia and tracheostomy.</p> <p>A "Physician Order Report" dated January 2018, included, but were not limited to: 10/19/16--Skin prep (topical medication when applied forms a protective film or barrier to heels daily before bedtime The following orders were received after the wound were identified on initial tour on 1/19/18. 1/20/18--Elevate heels on pillows every shift.</p>		<p>Resident R has current measurements and assessments on his left heel wound. He is receiving treatment to the wound as ordered by the MD. He is being seen weekly by the Wound Doctor.</p> <p>Resident M has Prevalon Boots on per MD order. She is receiving treatment to her wounds per MD order. She is being seen weekly by the Wound Doctor.</p> <p>II. All residents at risk for skin breakdown have the potential to be affected by the alleged deficient practice.</p> <p>The community completed a skin assessment on 100% of the residents on 1-23-18. All areas of concern were assessed by a licensed nurse. MD notification was completed with orders received for concerns. Families and care plans were updated with any new identified concerns. Preventative skin treatments were put into place to prevent further skin conditions from developing.</p> <p>III. Education has been</p>		

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	<p>1/21/18--Betadine Solution (potent topical antiseptic used to prevent or treat infections in minor wounds) (10%) topical solution moderate amount topical apply to unspecified lower leg every shift. (Order was unclear as to which area to apply the Betadine)</p> <p>The resident had a Care Plan dated 10/19/16, which addressed the problem he was at risk for skin breakdown related to quadriplegia, incontinence, history of open areas, contractures with splint and palm protector use, HOB (head of bed) elevated at all times, decreased mobility and weakness. Goal: "Reduce risk and prevent new wound/open area" Target date 3/6/18. Approaches included, but were not limited to, "...10/19/16--Offload heels when in bed, Pressure reducing surfaces: mattress, chair cushion... 10/19/16--Provide resident education on staff assist, Skin prep to heels...."</p> <p>The following change in condition reports were initiated after identification of the wounds on the initial tour on 1/19/18.</p> <p>A "Change in Condition" report dated 1/21/18 at 11:59 p.m., indicated a left heel blister was found on the resident. The wound measured 6.5 x 5.0 x 0.1 cm (Centimeters). The wound was classified as a blister. The Physician was notified on 1/19/18 at 3:00 p.m. and gave a new order for Betadine every shift. The resident's (Family member) was notified of the new wound on 1/22/18 at 1:00 p.m. There was no further assessment of this wound in the resident's record or on this report.</p> <p>A "Change in Condition" report dated 1/21/18 at 11:59 p.m., indicated a right heel blister was found on the resident. The resident "acquired a skin tear (1 cm x .1 cm) to right heel which was a formed</p>		<p>provided to all licensed nursing staff regarding the skin risk assessment and wound management policy. Education has been provided to all C.N.A.s regarding preventative wound care interventions and their role in early identification of skin conditions. All newly hired staff will be educated prior to working with residents related to skin prevention, skin condition identification process, how to assess (licensed nurses) and treat skin conditions.</p> <p>The systemic change includes All new admissions will be assessed for risk for skin breakdown on admission and weekly for 4 weeks. Monthly thereafter and with a significant change. Any at risk areas for skin breakdown will have preventative measures put into place immediately.</p> <p>All residents currently at Carmel Health and Living have a new skin risk assessment and risk factors and interventions are in place to prevent new areas from developing.</p> <p>Residents residing at Carmel Health and Living are assessed and all skin conditions are identified effective 1/23/2018.</p>	

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	<p>blood blister, while being repositioned, moderate amt [amount] bleeding. Previous order skin prep to heels and off load while resting in bed."</p> <p>The wound started on 1/21/18 at 11:25 p.m. The wound was classified as a skin tear. It measured 1.0 x 0.1 x 0.1 cm. There was a moderate amount of bleeding from the wound. The family was notified of the new wound on 1/21/18 at 11:38 a.m. and the Physician was notified regarding the new wound on 1/21/18 at 11:58 a.m. The interventions were previous order skin prep to heels and off load while resting in the bed. There was no further assessment of this wound in the resident's record or on this report.</p> <p>A "Change in Condition" report dated 1/22/18 at 4:09 p.m., indicated the resident had open areas to his left foot on the 2nd, 3rd and 5th toes. There was no further assessment of this wound documented in the residents record or on this report.</p> <p>A "Change of Condition" report dated 1/22/18 at 4:09 p.m., indicated the resident had an open area to his left lateral foot. This wound started on 1/19/18 at 3:00 p.m. The wound was classified as an open area to the left lateral area. The wound measured 6.5 x 3.0 x 0.1 cm. The Physician was notified on 1/19/18 at 3:00 p.m. and the responsible family member was notified on 1/22/18 at 3:00 p.m. There was no further assessment of this wound documented in the resident's record.</p> <p>A "Change of Condition" report dated 1/22/18 at 4:10 p.m., indicated the resident had a blister to the top of his right foot. There was no further assessment of this wound documented in the resident's record.</p>		<p>Current residents residing at Carmel Health and Living will have skin inspections daily by nursing staff during ADL care. All skin conditions identified will be reported to the licensed nurse immediately.</p> <p>Newly identified skin conditions are assessed with wound measurements, a physician ordered treatment in place and the plan of care updated. Preventative skin treatments are in place to prevent further skin conditions from developing.</p> <p>IV. The director of nurses or designee will audit through direct observation five random residents per day 7 days a week to determine preventative measures are in place for residents that are determined to be at risk for skin breakdown. This audit will be conducted weekly for 12 weeks and, if appropriate measures are in place, then audits will be monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education</p>	

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	<p>The bilateral feet wounds, which were assessed were lacking in assessments of wound beds, stages of wounds and measurements of wounds.</p> <p>On 1/23/18 at 12:17 p.m., with the DON, RN 2, LPN 3 and the Nursing Consultant present in Resident K's room, the pressure ulcers were observed. The resident's planter portion of his bilateral feet were flat up against the foot of the bed even though his heels were up on pillows, therefore his bilateral heels were touching the mattress, so there was no offloading of the bilateral heels. The following observations were made when his bilateral foot dressings were removed:</p> <p>1. Left foot:</p> <p>a. The left lateral foot was a black/purplish color going down the foot towards the heel, with an open area and with white slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist and light in color; may be stringy) around the open area. Bright red blood was oozing down the side of his foot under the wound onto the towel under the resident's foot. The DON indicated this wound was a DTI (Deep Tissue Injury) (Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissues).</p> <p>b. The inner left heel was a dark black/purplish color with a small flap of skin pulled up away from the bottom of his heel with bright red bleeding dripping from the open area with the flap of skin. The DON indicated this wound would be a Stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not</p>		<p>or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit through direct skin assessments all residents weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit the results of the weekly skin assessments on all residents to determine assessment, treatments and preventative measures are in place. This audit will be conducted weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The</p>	

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	<p>exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) when it opens, but was a DTI at that time. The dressing was stuck to the resident's heel and LPN 3 moistened it with Normal Saline prior to removing it, but as she removed the dressing bright red blood began to drip from the open area where the flap of skin was located.</p> <p>c. The middle of the left 4th and 5th digits (middle phalanges) had open areas. The DON indicated these wounds were Stage 3's.</p> <p>d. The top of the 5th digit (distal phalange) had a blackened hard eschar (thick, leathery necrotic (dead tissue) or devitalized tissue, frequently black or brown in color). The DON indicated this wound was an unstageable wound (Destruction of tissue or ulceration that extended under the skin edges, so that the pressure ulcer was larger at its base than at the skin surface).</p> <p>e. The top of the left foot had an area at bone protrusion, with a hardened black eschar covering the wound bed. The DON indicated this wound was unstageable.</p> <p>2. Right foot:</p> <p>a. The medial side of the right heel was a bluish/purple color. The DON indicated the wound was a blood blister, which was a DTI.</p> <p>b. The lateral side of the right heel was a dark blackish/purple color. The DON indicated the wound was a blood blister, which was a DTI.</p> <p>At that time, RN 2 indicated she had measured both of these wounds as one wound when she assessed Resident K's right heel. There was a</p>		<p>nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit through direct observation five random residents per day 7 days per week to determine their ordered treatments are in place. This audit will be conducted weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit all new admissions daily to ensure any skin conditions are identified, assessed and treated and preventative skin measures are in place and effective. This audit will be ongoing. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p>		

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	<p>strip of brown colored skin observed between the medial and the lateral heel wounds, which divided these wounds into two wounds.</p> <p>c. The top of the right foot had an area where the bone protruding, with a hardened black eschar covering the wound bed. The DON indicated this wound was an unstageable.</p> <p>d. The middle of the right 3rd, 4th and 5th digits (middle phalanges) had scabbed wounds. The DON indicated these were open wounds, which were almost healed.</p> <p>e. The right great toe had a scabbed wound. The DON indicated this was an open wound, which was almost healed.</p> <p>f. The proximal area from the right great toe (around the 1st metatarsal) had an open area. The DON indicated this wound was a "denuded" blister at a Stage 3.</p> <p>The Wound Physician visited Resident K to assess his wounds to his bilateral feet on 1/24/18 at 8:00 a.m., and the following were observed:</p> <p>A "Visit Note," dated 1/24/18 at 8:00 a.m., indicated the resident presented with multiple lower extremity ulcers. He had a pressure ulcer to the left heel, which had a start date of 1/19/18. The wound occurred from pressure and was aggravated by debility from a traumatic brain injury and contractures in the lower extremities, which are worsening. The wound had minimal (Usually no more than 25% saturation to the wound dressing and the dressing was considered damp) sanguineous (Drainage primarily composed of blood. It is bright in color and thick in consistency. If the wound continues to drain</p>		<p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>		

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	<p>after a few hours, it can indicate trauma to the wound) drainage. His feet were susceptible to injury and had ulcers to his toes from trauma when he first admitted to the facility. Several new ulcers to his bilateral feet and toes were noted on 1/19/18. The cause of the pressure wounds were having pressure into the footboard of the bed due to plantar contractures of his feet. The pressure to his medial bilateral heels was likely due coming in contact with each other due to external rotation of his hips. The pressure ulcers to his bilateral heels and feet were new problems and offloading was the most important part of the wound healing. He had a pillow between his legs and knees now to prevent contact. Resident K had a history of pressure wounds and of being a quadriplegia.</p> <p>Left foot: Wound #1 was currently classified as an unstageable (Destruction of tissue or ulceration that extended under the skin edges, so that the pressure ulcer was larger at its base than at the skin surface) wound on the left medial (inside portion) calcaneus (Heel) caused by pressure. It measured 5.5 x 6.0 x 0.1 cm. There was a medium amount (25-75% saturation of dressing, which means the dressing was soaked) of sanguineous drainage noted. There was a small amount of (1-33%) red granulation (Pink-red moist tissue that fills an open wound when it begins to heal) in the wound bed and a large amount (67-100%) amount of necrotic tissue in the wound bed including eschar (thick, leathery necrotic (dead tissue) or devitalized tissue, frequently black or brown in color).</p> <p>Wound #2 was currently classified as an unstageable wound on the left lateral (outside portion) foot caused by pressure. The wound</p>			

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	<p>measured 11.0 x 3.0 x 0.1 cm. There was a small amount of serosanguineous (drainage composed primarily of blood and plasma, which was bright in color and thick in consistency and the runoff appeared pink. This drainage indicated damage to blood vessels and capillaries) drainage from the wound. There was a small amount (1-33%) of red granulation within the wound bed and a large (67-100 %) amount of necrotic tissue within the wound bed, which included eschar and adherent slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist and light in color; may be stringy).</p> <p>Wound #3 was currently classified as an unstageable wound on the left proximal (situated closer to the foot), distal (situated away from the foot) and dorsal (top surface of the foot) foot caused by pressure. The wound measured 0.8 x 0.6 x 0.1 cm. There was a large amount (67-100 %) of necrotic tissue within the wound bed, which included eschar. The surrounding skin color had erythema (redness and inflammation).</p> <p>Wound #4 was currently classified as an unstageable wound on the left dorsal, fourth toe caused by pressure. The wound measured 1.5 x 0.7 x 0.1 cm. There was a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar.</p> <p>Wound #5 was currently classified as an unstageable wound on the left dorsal third toe caused by pressure. The wound measured 1.0 x 0.9 x 0 cm. The surrounding wound skin color had erythema.</p> <p>Wound #6 was currently classified as an unstageable wound on the left distal dorsal foot caused by pressure. The wound measured 1.0 x</p>			

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	<p>0.9 x 0 cm. The surrounding wound skin color had erythema. "General Note: DTI [Deep Tissue Injury] [Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissues]."</p> <p>Right Foot: Wound #7 was currently classified as an unstageable wound on the right lateral calcaneus caused by pressure. The wound measured 5.0 x 2.7 x 0 cm. "General Note: blood filled blister."</p> <p>Wound #8 was currently classified as an unstageable wound on the right medial calcaneus caused by pressure. The wound measured 4.0 x 3.5 x 0 cm. "General Notes: DTI."</p> <p>Wound #9 was currently classified as an unstageable wound located on the right proximal dorsal foot caused by pressure. The wound measured 1.3 x 2.0 x 0.1 cm. The wound margin was fibrotic; thickened scar.</p> <p>Wound #10 was currently classified as an unstageable wound located on the right distal lateral foot caused by pressure. The wound measured 0.8 x 5.0 x 0 cm. "General Notes: Possible DTI."</p> <p>Wound #11 was currently classified as an unstageable wound located on the right dorsal third toe caused by pressure. The wound measured 0.1 x 0.1 x 0.1 cm. There was a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar.</p> <p>Wound #12 was currently classified as an</p>			

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	<p>unstageable wound located on the right dorsal fourth toe caused by pressure. The wound measured 0.1 x 0.3 x 0.1 cm. The wound had a small amount of serosanguineous drainage. There was a large amount (67-100%) red granulation within the wound bed. There was no necrotic tissue within the wound bed. "General Notes: Now essentially a stage 2."</p> <p>Wound #13 was currently classified as an unstageable wound located on the right lateral fifth toe caused by pressure. The wound measured 2.5 x 1.2 x 0.1 cm. There is a small amount of serosanguineous drainage. There is a small amount (1-33%) red granulation within the wound bed and a small amount (1-33%) of necrotic tissue within the wound bed, which included eschar.</p> <p>During an interview, on 1/24/18 at 2:49 p.m., the DON indicated Resident K developed the pressure ulcers to the top of his bilateral tops of his toes and his lateral side of his left foot due to the footboard at the end of his bed.</p> <p>2. On 1/19/18 at 11:22 a.m., during the facility tour with LPN 1 in attendance, Resident C was observed sitting in his Broda chair. LPN 1 indicated he had a pressure wound to his coccyx and a wound to his finger on his left hand. Unable to visualize the dressing to his finger due to the resident's contracture and he was having pain at that time. His bilateral thumb nails were long and the right fingernails were long. LPN 1 indicated at that time, his fingernails needed cut.</p> <p>On 1/19/18 at 11:27 a.m., CNA 6 and CNA 7 were observed transferring Resident C to bed with the Hoyer lift and giving pericare. The pressure ulcer dressing on his coccyx did not have a date on it.</p>			

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	<p>The bottom of the dressing had bowel movement on it and the dressing was open at the bottom due to no tape was applied to close it. During the pericare, CNA 6 removed the resident's coccyx dressing indicating she would notify the nurse she had removed the dressing and it needed to be reapplied.</p> <p>On 1/19/18 at 12:13 p.m., after the CNA's were finished with the resident, RN 8 was asked when she would be reapplying the dressing to his coccyx. She indicated she would have to wait until his pain medication arrived from the pharmacy.</p> <p>At this time during interview, LPN 1 indicated she heard the CNA inform RN 8 the resident needed his dressing replaced.</p> <p>During an interview on 1/19/18 at 1:30 p.m., RN 8 indicated when asked if she was going to place a dressing over the resident's coccyx to cover it until his pain medication arrived, she indicated she did not know his dressing was off his coccyx. RN 8 indicated the the CNA did not tell her the coccyx dressing had came off during the earlier personal care.</p> <p>On 1/19/18 at 1:42 p.m., RN 8 and LPN 1 completed the treatment to Resident C's coccyx. RN 8 indicated at that time, when she was packing the dressing into the coccyx wound, the resident had tunneling of the wound.</p> <p>During an interview on 1/22/18 at 10:04 a.m., a family member indicated she was visiting and bathing Resident C on 1/17/18, and she smelled something "sour" or "yeasty." She indicated she realized the smell was coming from his left hand, so she notified his primary nurse. She indicated</p>			

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	<p>when the nurse removed the splint in his left hand two "gnats" flew out from his hand and there was a "rotten smell" when the nurse opened his hand. There was a wound on his index finger from his nail "digging" into his finger. She indicated she had "begged" someone to cut his nails for three months. She indicated she was told the CNA's did not cut his nails.</p> <p>During an interview on 1/22/18 at 12:08 p.m., RN 8 clarified Resident C had a wound to his left index finger.</p> <p>The record review for Resident C was completed on 1/22/18 at 3:37 p.m. Diagnoses included, but were not limited to pressure ulcer sacral region Stage IV, contracted bilateral knees, dysphagia, chronic pain, and hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage.</p> <p>The resident had a Care Plan dated 12/14/17, which addressed the problem he was admitted with a stage IV pressure ulcer to the coccyx. He was a poor surgical candidate and bone resection was contraindicated due to risk of bacteremia. Approaches included, but were not limited to, "...5/10/17--Administer treatment as ordered...."</p> <p>The resident had a Care Plan dated 1/18/18, which addressed the problem he had a pressure ulcer to his left forefinger. Approaches included, "...1/18/18--Administer treatment as ordered...1/18/18--Splint removed until wound healed."</p> <p>An EMAR (Electronic Medication Administration Record dated January 2018, included, but were not limited to, the following orders: 7/25/17--Monitor open area to left index finger weekly (the month of January the EMAR has been</p>			

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	<p>signed off as this order was completed)</p> <p>1/17/18--Cleanse 2nd digit on left hand with soap and water. Apply Silver foam cover with dry dressing daily. (Discontinued 1/18/18)</p> <p>1/18/18--Cleanse wound to left forefinger with NS, pat dry, apply skin prep to periwound, apply silver foam to wound bed and secure with dry dressing. Change daily. 7:00 a.m.-3:00 p.m.</p> <p>1/18/18--Cleanse wound to left forefinger with NS, pat dry, apply skin prep to periwound, apply silver foam to wound bed and secure with dry dressing. Change as needed for soilage/displacement.</p> <p>1/19/18--Wound C & S (Culture and Sensitivity) 3rd digit left hand one time.</p> <p>1/20/18--Left fingers and left hand. X-ray 2nd digit to left hand to rule out osteomyelitis stat</p> <p>A Progress note, dated 1/17/18 at 8:59 p.m., indicated "Resident has wound to left hand, 2nd digit. Washed hand, flushed wound with NS, dried and wrapped with sterile guaze. nystatin powder applied to palm and between fingers. Trimmed nails on left hand...."</p> <p>A "Skin Condition Assessment Tool," dated 1/18/18 at 10:40 a.m., indicated the resident had an open area to the left 2nd finger. The wound measured 3.0 x 2.0 cm. Date of origin was 1/17/20. The wound was an acquired wound. There was a strong odor. There was no stage, wound bed description or depth measurement marked on the assessment document.</p> <p>During an interview, on 1/22/18 at 5:00 p.m., the Clinical Specialist indicated the wound on Resident C's left 2nd finger was a pressure ulcer from his fingernail.</p> <p>On 1/23/18 at 11:42 a.m., Resident C's left index finger was observed to have an open wound in</p>			

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	<p>the middle portion of his finger. The wound bed had white slough in it. His finger was swollen and was a darker color than his other digits on that particular hand.</p> <p>A "Visit Note" from the Wound Physician, dated 1/24/18 at 7:00 a.m., indicated the resident presented with an open area to his coccyx/sacrum area and a new area of pressure to his left index finger.</p> <p>Wound #1 was located to the resident's coccyx. The original cause of the wound was a pressure injury. The resident was admitted from the hospital in 2017 with this wound. The wound was currently classified as a Stage IV wound with the cause being pressure ulcer. The wound measured 4.0 x 2.5 x 0.3 cm. There was bone and fascia exposed with a medium amount of serosanguineous drainage on the dressing. The wound margin was well defined, but not attached to the wound base. There was a large amount (67-100%) red granulation within the wound bed and a small amount (1-33%) of necrotic tissue within the wound bed, which includes adherent slough. The wound was unchanged from the last assessment.</p> <p>Wound #2 was located to his left hand index finger. The current classification was a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) caused by pressure ulcer. The wound measured 0.1 x 0.1 x 0.1 cm with small amount of serosanguineous drainage on the dressing. There is a large (67-100%) pink, pale granulation within the wound bed. There was no necrotic tissue within the wound bed. "General</p>			

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	<p>Notes: Based on history this will be a healing Stage 3 although looks more like a Stage 2 on my exam today."</p> <p>During an interview, on 1/24/18 at 5:25 p.m., the DON indicated Resident C's pressure ulcer was on his left index finger. The nurse who had documented "Skin Assessment Tool" and the progress note was counting his thumb as his first digit, then his index finger being his second digit. She indicated the nurses required education on wound assessments.</p> <p>3. On 1/19/18 at 12:22 p.m., during the facility tour with LPN 1 indicated Resident R had a pressure ulcer to his coccyx and he was at lunch at that time.</p> <p>The record review for Resident R was completed on 1/23/18 at 10:00 a.m. Diagnoses included, but were not limited to, dysphagia, Alzheimer's disease, pain and depressive disorder.</p> <p>A "Change in Condition" report, dated 1/16/18 at 5:16 p.m., indicated the resident had eschar on his left heel. The start date was 1/16/18 at 2:00 p.m. The wound classification was not documented on this report. The wound measured 2.0 x 2.0 x <0.1 cm (centimeters). The color of the wound was black. Interventions were to monitor the left heel.</p> <p>A progress note, dated 1/16/18 at 5:20 p.m., indicated, "res [resident] noted to have open area on left heel wound bed is black in color, new orders for skin prep q [every] shift, wound team to eval [evaluate] and tx [treat]...."</p> <p>A "Physician Order Report," dated January 2018, included, but were not limited to, the following orders:</p>			

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	<p>1/16/18--Prevalon boots while in bed 1/19/18--skin prep every shift to left heel</p> <p>There was no treatment ordered for Resident R's left heel wound from the date it was discovered on 1/16/18 until 1/19/18.</p> <p>On 1/23/18 at 10:04 a.m., Resident R's left heel wound was observed with the DON in attendance. His left heel wound had an approximate dime sized brown/black eschar area. At that time, the DON indicated the wound was a pressure ulcer and the resident wore tennis shoes when he was up, but he did not wear them now.</p> <p>A "Visit Note" report, from the Wound Physician dated 1/24/18 at 9:00 a.m., indicated the resident had a pressure ulcer to his left heel, which was discovered on 1/16/18 and the cause was pressure.</p> <p>Wound #1 was currently classified as an unstageable wound caused by a pressure ulcer located on the left posterior (back) Calcaneous (heel). The wound measured 1.2 x 1.4 x 0.1 cm. There was a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar. The most important part of the wound healing was offloading his heels.</p> <p>4. On 1/19/18 at 2:12 p.m., during the facility tour with LPN 1 in attendance, Resident M's pressure ulcer to her left inner heel was observed to have black eschar. The resident had her bilateral heels on the mattress and there were no Prevalon boots on her bilateral feet or in her room. LPN 1 indicated at that time, the resident was to have her Prevalon boots on both feet and she looked around her room for them, indicating there were</p>			

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	<p>none in her room. LPN 1 went to get LPN 11, who was her primary nurse, who also looked for the boots and indicated they were not in the room. LPN 11 indicated she did not know where she could get another pair for the resident. LPN 1 indicated to her where she could obtain the boots.</p> <p>The record review for Resident M was completed on 1/22/18 at 5:30 p.m. Diagnoses included, but were not limited to, open wound left foot, osteoarthritis, cerebrovascular disease, Diabetes Mellitus, and contracture left knee.</p> <p>A "Change of Condition" dated 7/3/17 at 6:52 a.m., indicated the resident had a black area on her left heel. The wound started on 7/3/17 at 7:00 a.m. The wound classification was other skin--black area. The wound measured 4.0 x 5.0 cm and it was black colored. The treatment was betadine and the interventions put into place was Prevalon boots and a composure mattress.</p> <p>An EMAR dated January 2018, included, but were not limited to, the following orders: 2/2/17--Offload heels when in bed 2/2/17--Skin prep to heels 7/5/17--Prevalon boots on at all times</p> <p>The resident had a Care Plan dated 7/5/17, which address"addressed the problem she had a pressure ulcer to plantar aspect of left foot due to fractured left knee resulting in decreased mobility, resident slept in bed with knees flexed and feet flat on bed surface. Approaches included, but were not limited to, "...7/19/17--Prevalon boots at all times no shoes to be worn...."</p> <p>A "Visit Note" from the Wound Physician dated 1/24/18 at 7:00 a.m., indicated the resident had a pressure ulcer to her foot. Her pressure ulcer</p>			

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	<p>started on the planter surface of her foot on 7/2/18. The wound was stabilized with the treatment of Betadine, but now it was lifting at the edges slightly. She was offloading with Prevalon boots.</p> <p>Wound #2 was currently classified as an unstageable wound located to the left planter (bottom) calcaneous caused by pressure injury. The wound measured 3.5 x 3.0 x 0.1 cm. There is a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar. The wound was unchanged from the last assessment. "Plan...Continue diligent offloading. May need to debride eschar if it lifts anymore or starts to drain from underneath...."</p> <p>A current policy titled "Wound management" dated 2/15/17, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "Purpose: To provide clinical guidance and best practices for the management of skin conditions within the [Name of Company] communities...Verification: Trust but verify: Each community will have a system in place to verify that skin conditions are being reported timely. It is the policy of [Name of company] that quarterly skin sweeps will be conducted on all residents in order to verify that all skin conditions are accounted for. The frequency of skin sweeps maybe increased to monthly by the nurse consultant when applicable. The wound team...Each wound will be visualized by the wound team to provide oversight of the care plan interventions and ensure that each resident's condition is accurately assessed in a timely manner. This list is not all inclusive but should serve as an example of skin conditions the wound team should evaluate: New wounds or open areas, Existing pressure and non-pressure open areas...</p>			

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F 0689 SS=D Bldg. 00	<p>IDT: The interdisciplinary team (IDT) will document the wound assessment in the medical record. The 'skin condition assessment tool' will be utilized and completed every seven (7) das on abnormal skin conditions by a member of the IDT wound team or designee...."</p> <p>The Immediate Jeopardy that began on 1/16/18 was removed on 1/24/18 when the facility completed facility wide skin assessments of all resident to ensure pressure ulcers were identified for intervention and treatment, completed inserving of staff on pressure ulcer prevention, assessment and treatment, and began the monitoring process to ensure on-going assessment of skin to prevent the development of pressure ulcers and to ensure implementation of current pressure ulcer prevention, intervention, assessment and treatments. The noncompliance remained a a lower scope and severity of pattern, no actual harm, with potential for more than minimal harm that was not Immediate Jeopardy.</p> <p>This Federal tag relates to Complaint IN00251490.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure the safety of residents when medications were left unattended by staff at a residents' bedside for 2 of 14 residents reviewed for safe medication administration (Residents G and L).</p> <p>Findings include:</p> <p>1. During the facility tour on 1/19/18 at 11:04 a.m., with LPN 1 in attendance, the following medications were observed at Resident G's bedside. At that time, LPN 1 indicated these medications should not be at the resident's bedside without an order.</p> <p>Flonase (a nasal spray medication, which decreases inflammation in the nasal passages) Spiriva Inhaler (inhaler medication used to dilate the bronchiole tubes in the lungs) Symbicort Inhaler (inhaler medication used to decrease inflammation in the lungs) Deep Sea Nasal Spray (Normal Saline nasal spray used to moisten the nasal passages) Capsaicin Cream 0.025% (a topical medication used to block pain messages to the nerves in that particular area where the cream was applied)</p> <p>The record review for Resident G was completed on 1/22/18 at 4:07 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the colon, generalized muscle weakness, acute respiratory failure, centrilobular emphysema and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The resident's "Physician Order Report" dated January 2018, included, but were not limited to, the following orders: 12/20/17--Fluticasone spray (Flonase) suspension 50 mcg (micrograms)/actuation instill one spray</p>	F 0689	<p>F 689 Free of Accident Hazards/Supervision/Devices</p> <p>I. LPN #3 has received 1:1 education related to correct procedure with medication administration. Residents G and L are observed by a licensed nurse when taking medications.</p> <p>II. All residents receiving medications from a licensed nurse have the potential to be affected by the alleged deficient practice. On 1-19-18 a full house inspection was conducted to ensure no medications were left at bedside.</p> <p>III. Education will be provided to all licensed nurses related to correct procedures of medication administration. The systemic change includes all licensed nurses will receive education related to the correct procedure for medication administration upon hire and annually thereafter.</p>	02/07/2018			

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	<p>per nostril nasally daily. 1/4/18--Symbicort aerosol inhaler 160-4.5 mcg/actuation Inhale two puffs twice daily. Rinse mouth after each use.</p> <p>There was no order for the medications to be a bedside at the time of the observation.</p> <p>2. During the facility tour on 1/19/18 at 1:30 p.m., with LPN 1 in attendance a vial of Ipratropium Bromide (a medication, which dilates the bronchial tubes in the lungs to open them) 0.5 mg (milligrams) and Albuterol Sulfate (a medication, which relaxes the bronchial tubes in the lungs) 3.0 mg in 2.5 ml Inhalation Solution was observed laying unopened next to Resident L's nebulizer machine. The resident indicated at that time, the nurse put that medication in the cup on her mask and she placed the mask on and took her treatment. At that time, LPN 1 indicated the vial of medication should not have been in her room without a physicians order.</p> <p>On 1/22/18 at 11:46 a.m., the resident was observed in her room sitting her wheelchair with a nebulizer mask on her face and the nebulizer machine was running. There was no nurse in the room with her while the nebulizer treatment was running.</p> <p>On 1/22/18 at 11:50 a.m., the resident took the mask off and shut her nebulizer machine off at this time. There was some vapor still coming out of the nebulizer mask when the resident removed the mask and shut the machine off. She placed the mask in her top drawer. Resident L indicated at that time, the nurses start the medication in the machine, then she takes the mask off when the medication was finished.</p>		<p>IV. The DON/Designee will audit by observation medication administration on all shifts 7 times weekly for 4 weeks, weekly for 4 weeks then monthly for 4 months. Any identified concerns from these audits will be addressed immediately. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>		

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	<p>On 1/22/18 at 11:52 a.m., LPN 3 came into the resident's room indicating she had to leave the resident with her nebulizer running because she had a resident having a seizure. She indicated to the resident she needed to assess her respiratory status and she would be right back. The resident left her room heading to the dining room.</p> <p>The record review for Resident L was completed on 1/22/18 at 4:45 p.m. Diagnoses included, but were not limited to, cervicgia, macular degeneration, Type 2 Diabetes Mellitus, shortness of breath, and acute renal failure.</p> <p>The resident's "Physician Order Report" dated January 2018, included, but was not limited to, the following order: 1/17/18--Ipratropium-Albuterol Solution for Nebulization 0.5 mg-3 mg (2.5 mg base)/3 ml amount inhalation for shortness of breath four times a day.</p> <p>Resident L's record lacked an order indicating she was able to take her nebulizer treatment by herself and she was able to keep the Ipratropium-Albuterol Solution at her bedside.</p> <p>A current skills validation for nebulizer treatments undated, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "Nebulizer Treatment Validation:..22. Remained with the resident for the treatment monitored for rapid pulse, restlessness and nervousness throughout the treatment. 23. Stopped the treatment and notified MD if the pulse increased to 20% above baseline or if resident complained of nausea/vomiting. 24. Tapped the nebulizer cup occasionally to ensure release of droplets from the</p>						

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F 0695 SS=E Bldg. 00	<p>sides of the cup. 25. Encouraged resident to cough and expectorate as needed. 26. Administered therapy until medication was gone... 28. Turned off nebulizer and disconnected pieces. 29. Obtained post treatment: a. Pulse after b. O2 sats after c. Respirator rate after d. Lung sounds after e. Minutes...."</p> <p>3.1-45(a)(1)</p> <p>483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>Based on observation, interview and record review, the facility failed to administer a nebulizer breathing treatment following facility protocol (Resident L). The facility also failed to timely change oxygen tubing, nebulizer equipment, and tracheal masks for 7 of 8 residents observed and reviewed for respiratory equipment being changed in a timely manner (Residents G, H, J, K, P and Q).</p> <p>Findings include:</p> <p>1. On 1/22/18 at 11:46 a.m., Resident L was observed in her room sitting in her wheelchair with a nebulizer mask on her face and the nebulizer machine was running. There was no nurse in the room with her while the nebulizer</p>	F 0695	<p>F 695</p> <p>Respiratory/Tracheostomy Care and Suctioning</p> <p>I. LPN #3 has received 1:1 education related to correct procedure with medication administration. Resident L is observed by a licensed nurse when taking a breathing treatment.</p> <p>Residents G, H, J and P have had all of their Oxygen</p>	02/07/2018	

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	<p>treatment was running.</p> <p>On 1/22/18 at 11:50 a.m., the resident took the mask off and shut her nebulizer machine off at this time. There was some vapor still coming out of the nebulizer mask when the resident removed the mask and shut the machine off. She placed the mask in her top drawer. Resident L indicated at that time, the nurses start the medication in the machine, then she takes the mask off when the medication was finished.</p> <p>On 1/22/18 at 11:52 a.m., LPN 3 came into the resident's room indicating she had to leave the resident with her nebulizer running because she had a resident having a seizure. She indicated to the resident she needed to assess her respiratory status and she would be right back. The resident left her room heading to the dining room.</p> <p>The record review for Resident L was completed on 1/22/18 at 4:45 p.m. Diagnoses included, but were not limited to, cervicgia, macular degeneration, Type 2 Diabetes Mellitus, shortness of breath, and acute renal failure.</p> <p>The resident's "Physician Order Report" dated January 2018, included, but was not limited to, the following order: 1/17/18--Ipratropium-Albuterol Solution for Nebulization 0.5 mg-3 mg (2.5 mg base)/3 ml amount inhalation for shortness of breath four times a day.</p> <p>Resident L's record lacked an order indicating she was able to take her nebulizer treatment by herself.</p> <p>2. During the facility tour on 1/19/18 at 11:04 a.m., with LPN 1 in attendance, Resident G's oxygen</p>		<p>supplies changed. They are dated and oxygen storage bags are in place. Residents K and Q have had their trach collars changed. They are dated with the change.</p> <p>II. All residents receiving breathing treatments, oxygen or tracheostomies have the potential to be affected by the alleged deficient practice.</p> <p>All residents receiving breathing treatments have been reviewed and are receiving breathing treatments and are supervised by a licensed nurse.</p> <p>All residents receiving oxygen have had their supplies changed and are dated with a current date.</p> <p>All residents that have tracheostomies have been reviewed and their equipment is dated with a current date.</p> <p>III. Education will be provided to all licensed nurses related to correct procedures of medication administration and dating and bagging oxygen and tracheostomy supplies.</p>	

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	<p>tubing was observed attached to the concentrator was not dated when it was opened for use or placed in a bag and the nebulizer equipment was observed not dated or placed into a bag.</p> <p>On 1/22/18 at 12:10 p.m., Resident G's nebulizer or oxygen equipment was not marked with the date they were opened for use and neither one was placed in a bag for storage.</p> <p>The record review for Resident G was completed on 1/22/18 at 4:07 p.m. Diagnoses included, but were not limited to, malignant neoplasm of the colon, generalized muscle weakness, acute respiratory failure, centrilobular emphysema and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>The resident's "Physician Order Report" dated January 2018, included, but were not limited to, the following orders: 12/20/17--Albuterol Sulfate solution for Nebulization 2.5 mg/3 ml (0.083%) Inhale one vial every four hours 01/15/18--Oxygen 4 liters/min continuous per nasal cannula every shift</p> <p>3. During the facility tour on 1/19/18 at 11:48 a.m., with LPN 1 in attendance, Resident H's oxygen humidifier bottle on the oxygen concentrator, oxygen tubing or the plastic bag the oxygen equipment was kept in was not dated. At that time, LPN 1 indicated the humidifier bottle, oxygen equipment and the plastic bag should have had the date they were changed.</p> <p>The record review for Resident H was completed on 1/22/18 at 4:15 p.m. Diagnoses included, but were not limited to, thrombocytopenia, cervicalgia, dysphagia, neuromuscular dysfunction of his bladder and respiratory disorder.</p>		<p>The systemic change includes all licensed nurses will receive education related to the correct procedure for medication administration and dating and bagging oxygen supplies upon hire and annually thereafter.</p> <p>IV. The DON/Designee will audit by observation medication administration and Oxygen storage and dating on all shifts 7 times weekly for 4 weeks, weekly for 4 weeks then monthly for 4 months. Any identified concerns from these audits will be addressed immediately.</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of the reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>		

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	<p>The resident had a Care Plan dated 11/20/17 with an edited date 1/21/17, which addressed the problem he was at risk for ineffective breathing pattern related to a diagnosis respiratory disorder, cough, history of pneumonia and pleural effusion. Approaches included, but were not limited to, "...11/20/17--Administer oxygen at 4 via NC [nasal cannula]. Observe oxygen precautions...."</p> <p>4. During the facility tour on 1/19/18 at 11:41 a.m., with LPN 1 in attendance, Resident J's portable oxygen tubing did not have a bag to store it in or a date when it was replaced. LPN 1 indicated the oxygen tubing should have been replaced and a date put on it to indicate when it was opened and put into a marked bag.</p> <p>The record review for Resident J was completed on 1/22/18 at 4:22 p.m. Diagnoses included, but were not limited to, pneumonia, palliative care, acute kidney failure, and chronic pain.</p> <p>A "Physician Order Report" dated January 2018, included, but were not limited to, the following order: 12/14/17--May titrate oxygen (2-10 liter/minute) to maintain sats greater than 90% every shift.</p> <p>5. During a facility tour on 1/19/18 at 12:45 p.m., with LPN 1 in attendance, Resident K's tracheostomy collar mask did not have a date to indicate when it was initiated for use. LPN 1 indicated at that time, the trach collar needed to be replaced.</p> <p>A record review was completed for Resident K on 1/22/18 at 3:55 p.m. Diagnoses included contractures of bilateral wrist and right elbow, diffuse traumatic brain injury with loss of</p>			

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	<p>consciousness, dysphagia, quadriplegia and tracheostomy.</p> <p>A "Physician Order Report" dated January 2018, included, but were not limited to, 9/22/17--Change Trach collar weekly on Mondays</p> <p>6. During a facility tour on 1/19/18 at 4:22 p.m., with LPN 1 in attendance, Resident P's nebulizer equipment was not dated or stored in a bag. LPN 1 indicated at that time, the nebulizer equipment was to be stored in a plastic bag and dated when changed.</p> <p>On 1/22/18 at 11:32 a.m., Resident P's nebulizer equipment was observed and there was no date on the nebulizer mask and the mask was laying on the night stand desk without being stored in a bag.</p> <p>A record review was completed for Resident P on 1/22/18 at 3:50 p.m. Diagnoses included, but were not limited to, upper respiratory infection, fibromyalgia, anxiety disorder, arthritis.</p> <p>A "Physician Order Report" dated January 2018, included, but were not limited to, to the following order: 1/4/18--Ipratropium-Albuterol Solution for Nebulization 0.5 mg-3 mg (2.5 mg base)/3 ml 1 vial inhalation four times a day PRN</p> <p>7. During a facility tour on 1/19/18 at 5:31 p.m., with LPN 1 in attendance, Resident Q's trach mask did not have a date on it and was not in a bag while it was not being used by the resident. LPN 1 indicated the trach mask should have had a date on the mask and have been stored in a bag.</p> <p>A record review was completed for Resident Q on</p>			

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	<p>1/22/18 at 4:25 p.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 Diabetes Mellitus. encephalopathy, and acute respiratory failure with hypoxia.</p> <p>A "Physician Order Report" dated January 2018, included, but were not limited to, the following order: 12/29/17--Change Trach collar weekly and PRN on Mondays 1/17/18--Airvo37c/30 lmp/32% Fio2 at 6 liters of oxygen every shift.</p> <p>A current skills validation for nebulizer treatments undated, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "Nebulizer Treatment Validation:..22. Remained with the resident for the treatment monitored for rapid pulse, restlessness and nervousness throughout the treatment. 23. Stopped the treatment and notified MD if the pulse increased to 20% above baseline or if resident complained of nausea/vomiting. 24. Tapped the nebulizer cup occasionally to ensure release of droplets from the sides of the cup. 25. Encouraged resident to cough and expectorate as needed. 26. Administered therapy until medication was gone... 28. Turned off nebulizer and disconnected pieces. 29. Obtained post treatment: a. Pulse after b. O2 sats after c. Respirator rate after d. Lung sounds after e. Minutes...."</p> <p>A current policy titled "Heated High Flow Oxygen Device (AIRVO) Trach Mask/High Flow Nasal Cannula/Direct Connect to Trach" dated 1/11/16, provided by the Clinical Specialist on 1/22/18 at 1:15 p.m., contained the following, "...Assessment of Outcomes/Documentation Resources: All supplies of the Airvo system will be changed weekly, every 30 days , and PRN. This includes</p>			

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F 0867 SS=F Bldg. 00	<p>but limited to: A. Inlet filter (Change in between residents) B. Heated wire circuit (Change Q [every] 30 days and PRN) C. Resident interface (cannula, trach mask, etc.)-(Check weekly and PRN) D. Oxygen supply tubing from concentrator/liquid tank to the Airvo Device (Change Weekly and PRN). E. Water Chamber (Change Q 30 days and PRN) F. Water supply bag, refillable. (Change Q 30 days and PRN). G. All related supplies should be dated and initialed when changed. H. All related supplies should be placed in storage bag when not in use with the resident's name."</p> <p>This Federal tag relates to Complaint IN00250568.</p> <p>3.1-47(a)(4) 3.1-47(a)(6)</p> <p>483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p> <p>Based on observations, interview and record review, the facility failed to develop and implement appropriate plans of action to address pressure ulcers being assessed appropriately for 4 of 5 residents, failed to implement pressure ulcer prevention interventions and ensure treatments were ordered in a timely manner for 4 of 5 residents as identified during the Complaint survey (Residents C, K, M and R).</p>	F 0867	<p>F 867</p> <p>QAPI/QAA Improvement Activities</p> <p>I. Resident K has current measurements and assessments on his bilateral lower extremity wounds. He is</p>	02/07/2018

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	<p>Findings include:</p> <p>On 1/24/18 at 6:41 p.m., the Executive Director and Director of Health Service were in attendance for an interview. The following concerns were discussed:</p> <p>1. During the initial tour, on 1/19/18, Resident K was observed with multiple pressure ulcers. Resident had 13 pressure ulcers ranging from stage 2- unstageable on his bilateral feet that were not identified until survey process for pressure ulcer intervention.</p> <p>Wound physician assessment on 1/24/18 indicated: Left foot: Wound #1 was currently classified as an unstageable (Destruction of tissue or ulceration that extended under the skin edges, so that the pressure ulcer was larger at its base than at the skin surface) wound on the left medial (inside portion) calcaneus (Heel) caused by pressure. It measured 5.5 x 6.0 x 0.1 cm. There was a medium amount (25-75% saturation of dressing, which means the dressing was soaked) of sanguineous drainage noted. There was a small amount of (1-33%) red granulation (Pink-red moist tissue that fills an open wound when it begins to heal) in the wound bed and a large amount (67-100%) amount of necrotic tissue in the wound bed including eschar (thick, leathery necrotic (dead tissue) or devitalized tissue, frequently black or brown in color).</p> <p>Wound #2 was currently classified as an unstageable wound on the left lateral (outside portion) foot caused by pressure. The wound measured 11.0 x 3.0 x 0.1 cm. There was a small</p>		<p>being seen weekly by the Wound Doctor.</p> <p>Resident C is receiving treatment to his coccyx wound as ordered. The wound to the left index finger received a status of resolved by the wound doctor on 1-31-18. He is seen weekly by the wound doctor for the coccyx wound.</p> <p>Resident R has current measurements and assessments on his left heel wound. He is receiving treatment to the wound as ordered by the MD. He is being seen weekly by the Wound Doctor.</p> <p>Resident M has Prevalon Boots on per MD order. She is receiving treatment to her wounds per MD order. She is being seen weekly by the Wound Doctor.</p> <p>II. All residents at risk for skin breakdown have the potential to be affected by the alleged deficient practice.</p> <p>The community completed a skin assessment on 100% of the residents on 1-23-18. All areas of concern were assessed by a licensed nurse. MD notification</p>	

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	<p>amount of serosanguineous (drainage composed primarily of blood and plasma, which was bright in color and thick in consistency and the runoff appeared pink. This drainage indicated damage to blood vessels and capillaries) drainage from the wound. There was a small amount (1-33%) of red granulation within the wound bed and a large (67-100 %) amount of necrotic tissue within the wound bed, which included eschar and adherent slough (Necrotic or avascular in the process of separating from viable tissue. Usually soft, moist and light in color; may be stringy).</p> <p>Wound #3 was currently classified as an unstageable wound on the left proximal (situated closer to the foot), distal (situated away from the foot) and dorsal (top surface of the foot) foot caused by pressure. The wound measured 0.8 x 0.6 x 0.1 cm. There was a large amount (67-100 %) of necrotic tissue within the wound bed, which included eschar. The surrounding skin color had erythema (redness and inflammation).</p> <p>Wound #4 was currently classified as an unstageable wound on the left dorsal, fourth toe caused by pressure. The wound measured 1.5 x 0.7 x 0.1 cm. There was a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar.</p> <p>Wound #5 was currently classified as an unstageable wound on the left dorsal third toe caused by pressure. The wound measured 1.0 x 0.9 x 0 cm. The surrounding wound skin color had erythema.</p> <p>Wound #6 was currently classified as an unstageable wound on the left distal dorsal foot caused by pressure. The wound measured 1.0 x 0.9 x 0 cm. The surrounding wound skin color had</p>		<p>was completed with orders received for concerns. Families and care plans were updated with any new identified concerns. Preventative skin treatments were put into place to prevent further skin conditions from developing.</p> <p>III. Education has been provided to all licensed nursing staff regarding the skin risk assessment and wound management policy. Education has been provided to all C.N.A.s regarding preventative wound care interventions and their role in early identification of skin conditions. All newly hired staff will be educated prior to working with residents related to skin prevention, skin condition identification process, how to assess (licensed nurses) and treat skin conditions.</p> <p>The systemic change includes All new admissions will be assessed for risk for skin breakdown on admission and weekly for 4 weeks. Monthly thereafter and with a significant change. Any at risk areas for skin breakdown will have preventative measures put into place immediately.</p>	

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	<p>erythema. "General Note: DTI [Deep Tissue Injury] [Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissues]."</p> <p>Right Foot: Wound #7 was currently classified as an unstageable wound on the right lateral calcaneus caused by pressure. The wound measured 5.0 x 2.7 x 0 cm. "General Note: blood filled blister."</p> <p>Wound #8 was currently classified as an unstageable wound on the right medial calcaneus caused by pressure. The wound measured 4.0 x 3.5 x 0 cm. "General Notes: DTI."</p> <p>Wound #9 was currently classified as an unstageable wound located on the right proximal dorsal foot caused by pressure. The wound measured 1.3 x 2.0 x 0.1 cm. The wound margin was fibrotic; thickened scar.</p> <p>Wound #10 was currently classified as an unstageable wound located on the right distal lateral foot caused by pressure. The wound measured 0.8 x 5.0 x 0 cm. "General Notes: Possible DTI."</p> <p>Wound #11 was currently classified as an unstageable wound located on the right dorsal third toe caused by pressure. The wound measured 0.1 x 0.1 x 0.1 cm. There was a large amount (67-100%) of necrotic tissue within the wound bed, which included eschar.</p> <p>Wound #12 was currently classified as an unstageable wound located on the right dorsal</p>		<p>All residents currently at Carmel Health and Living have a new skin risk assessment and risk factors and interventions are in place to prevent new areas from developing.</p> <p>Residents residing at Carmel Health and Living are assessed and all skin conditions are identified effective 1/23/2018.</p> <p>Current residents residing at Carmel Health and Living will have skin inspections daily by nursing staff during ADL care. All skin conditions identified will be reported to the licensed nurse immediately.</p> <p>Newly identified skin conditions are assessed with wound measurements, a physician ordered treatment in place and the plan of care updated. Preventative skin treatments are in place to prevent further skin conditions from developing.</p> <p>IV. The director of nurses or designee will audit through direct observation five random residents per day 7 days a week to determine preventative measures are in place for residents that are determined to be at risk for</p>		

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	<p>fourth toe caused by pressure. The wound measured 0.1 x 0.3 x 0.1 cm. The wound had a small amount of serosanguineous drainage. There was a large amount (67-100%) red granulation within the wound bed. There was no necrotic tissue within the wound bed. "General Notes: Now essentially a stage 2."</p> <p>Wound #13 was currently classified as an unstageable wound located on the right lateral fifth toe caused by pressure. The wound measured 2.5 x 1.2 x 0.1 cm. There is a small amount of serosanguineous drainage. There is a small amount (1-33%) red granulation within the wound bed and a small amount (1-33%) of necrotic tissue within the wound bed, which included eschar.</p> <p>2. Resident C had the following wounds: a. Wound #1 was located to the resident's coccyx. The original cause of the wound was a pressure injury. The resident was admitted from the hospital in 2017 with this wound. The wound was currently classified as a Stage IV wound with the cause being pressure ulcer. The wound measured 4.0 x 2.5 x 0.3 cm. There was bone and fascia exposed with a medium amount of serosanguineous drainage on the dressing. The wound margin was well defined, but not attached to the wound base. There was a large amount (67-100%) red granulation within the wound bed and a small amount (1-33%) of necrotic tissue within the wound bed, which includes adherent slough. The wound was unchanged from the last assessment.</p> <p>During the initial tour on 1/19/18, the coccyx wound dressing was removed during pericare by the CNA and was not replaced for over 2 hours.</p>		<p>skin breakdown. This audit will be conducted weekly for 12 weeks and, if appropriate measures are in place, then audits will be monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit through direct skin assessments all residents weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit the results of the weekly skin assessments on all residents to determine assessment, treatments and preventative measures are in</p>		

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	<p>Wound #2 was located to his left hand index finger. The current classification was a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) caused by pressure ulcer. The wound measured 0.1 x 0.1 x 0.1 cm with small amount of serosanguineous drainage on the dressing. There is a large (67-100%) pink, pale granulation within the wound bed. There was no necrotic tissue within the wound bed. "General Notes: Based on history this will be a healing Stage 3 although looks more like a Stage 2 on my exam today."</p> <p>This wound was not identified until it was a Stage 3 pressure ulcer.</p> <p>3. Resident R had an unstageable pressure ulcer to his left heel that was not identified until it was an unstageable ulcer with eschar.</p> <p>A "Change in Condition" report, dated 1/16/18 at 5:16 p.m., indicated the resident had eschar on his left heel. The start date was 1/16/18 at 2:00 p.m. The wound classification was not documented on this report. The wound measured 2.0 x 2.0 x <0.1 cm (centimeters). The color of the wound was black. Interventions were to monitor the left heel.</p> <p>4. Resident M had an unstageable pressure ulcer on her left plantar aspect of her left foot that was not identified until it was an unstageable pressure ulcer with eschar.</p> <p>A "Change of Condition" dated 7/3/17 at 6:52 a.m., indicated the resident had a black area on her left heel. The wound started on 7/3/17 at 7:00 a.m. The wound classification was other skin--black</p>		<p>place. This audit will be conducted weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit through direct observation five random residents per day 7 days per week to determine their ordered treatments are in place. This audit will be conducted weekly for 12 weeks then monthly for 12 weeks then quarterly for 6 months to total 12 months of auditing, unless issues are identified during the audits in which case, auditing frequency and duration will continue. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>The director of nursing or designee will audit all new admissions daily to ensure any skin conditions are identified,</p>	

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	<p>area. The wound measured 4.0 x 5.0 cm and it was black colored. The treatment was betadine and the interventions put into place was Prevalon boots and a composure mattress.</p> <p>During an interview, on 1/24/18 at 4:47 p.m., the Director of Nursing indicated there was a system failure regarding the pressure ulcers. A manager knew about the new wounds on Resident K and the nurse knew the manager was aware of the wounds and thought the manager was taking care of the wounds. There was poor follow through with the process.</p> <p>During an interview, on 1/24/18 at 6:41 p.m., with the Administrator and the Regional Director of Operations in attendance, the Administrator indicated the management team was aware there was a problem with the pressure ulcers being assessed appropriately, interventions being implemented and treatments being started in a timely manner.</p> <p>The Administrator indicated they had a system failure oversight. The Regional Director of Operations indicated the system failed because of a communication problems and staff needed to be held accountable for the breakdown in the process.</p> <p>This Federal tag relates to Complaint IN00251490.</p> <p>3.1-52(b)(2)</p>		<p>assessed and treated and preventative skin measures are in place and effective. This audit will be ongoing. If issues are identified education or other corrective actions will be provided and documented. The nurse consultant will audit this process weekly.</p> <p>Results of these audits will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible for ensuring compliance.</p>		