Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0027	A. BUILDING _____ B. WING _____	09/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARROLL MANOR NURSING & REHAB	725 BUCHANAN ST., NE WASHINGTON, DC 20017

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L 000	Initial Comments The Licensure Survey was conducted on September 25, 2012. The deficiencies are based on observation, record review and resident and staff interview for 33 sampled residents.	L 000	Carroll Manor Rehabilitation Center makes its best effort to operate in substantial compliance with both Federal and state laws. Submission of the Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as the truth of the facts alleged or the validity of the conditions set forth on the statement of deficiencies. This plan of correction (POC) is prepared and/or executed because it is required by the state and federal laws.	
L 027	3207.2 Nursing Facilities The Medical Director shall: (a)Coordinate medical care in the facility; (b)Implement resident care policies; (c)Develop written medical bylaws and medical policies; (d)Serve as liaison with attending physician physicians to ensure the prompt issuance and implementation of order; (e)Review incidents and accidents that occur on the premises to identify hazards to health and safety; (f)Ensure that medical components of resident care policies are followed; (g)Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing procedures for emergency medical care; and (h)Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substance registration on file in the facility,	L 027		

Health Regulation & Licensing Administration

Tina Sanchez — TITLE: Administrator — (X6) DATE: 11/16/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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L 027	Continued From page 1 along with initial and annual certification of their freedom from communicable diseases. This Statute is not met as evidenced by: Based on a review of records, it was determined that the facility failed to ensure that attending medical professionals who treat residents in the facility had annual certification of their freedom from communicable disease in nine (9) of 11 records reviewed. The findings include: A review of the facility ' s medical staff (credentialing) documents on September 24, 2012 at 4:00 PM revealed that nine (9) of 11 medical professionals failed to provide documented evidence of an annual certification of freedom from communicable disease. The dates of the most recent certification of freedom from communicable disease were as follows: Employee #50, August 10, 2011 Employee #52, no record on file Employee #53, September 9, 2011 Employee #54 ,November 2010 Employee #55, April 14, 2011 Employee #56, July 20, 2011 Employee #57, November 26, 2010 Employee #58, March 4, 2011	L 027	L 027 3207.2 NURSING FACILITIES 1. Copies of the current certification of freedom from communicable disease for the eight medical professionals were provided to the surveyor on 9/2/12. The remaining one was faxed to DOH on 9/29/12. 2. An audit of all medical professional's files was conducted. All files were in compliance. 3. The Medical Records Manager will contact attending physicians and medical affairs within 60 days prior to upcoming expirations. 4. The Medical Records Manager will conduct a monthly audit of medical credentials. The results will be report to medical affairs and Carroll Manor administration. The report of findings will be reported at the quarterly QA/QI meeting.	9/28/12 9/28/12 11/9/12 Ongoing

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L 027	Continued From page 2 Employee #59, August 16, 2010 Employee #60, August 2, 2011 Employee #61, September 7, 2011 The findings were acknowledged by Employee #24 during the time of the review.	L 027		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record review and staff	L 051	L051 3210.4 NURSING FACILITIES 1 1. Resident #16 was discharged from the facility at the time of this observation and the plan of care was unable to be retroactively corrected. 2. All residents with alteration in skin integrity have been identified and care plans have been developed. 3. All licensed staff have been in-serviced on developing care plans to address alteration in skin integrity.	5/29/12 11/9/12 11/9/12

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L 051	Continued From page 3 interview for four (4) of 33 sampled residents, it was determined that the charge nurse failed to develop care plans for: two (2) residents with altered skin integrity; one (1) resident receiving Hospice services and one (1) resident who exhibited mental/psychosocial concerns and non-compliance with care. Residents #16, #103, #289 and #376. The findings include: 1. The charge nurse failed to develop a care plan for Resident #16 ' s alteration in skin integrity. A review of the " Progress Notes By Resident " dated May 5, 2012 11:23 AM revealed that Resident #16 was admitted to the facility with an alteration in the integrity of the skin of his/her coccyx area. Review of the care plans last updated May 29, 2012 lacked evidence of a care plan with appropriate goals and approaches to address altered skin integrity. A face-to-face interview was conducted with Employee #3 on September 21, 2012 at approximately 1:00 PM. After review of the above, the employee acknowledged the findings. The record was reviewed on September 21, 2012. 2. The charge nurse failed to develop an integrated care plan for hospice services for Resident #103.	L 051	4. Monthly audits will conducted by the Nurse Manager or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting. 2 1. Resident #103's care plan was undated to include an integrated care plan for hospice. 2. All residents receiving hospice care have been identified and integrated care plans for hospice services are in place. 3. Licensed staff have been in-serviced on integrating care plans for hospice services. 4. Monthly audits will be conducted by the Nurse Manger or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI meeting.	Ongoing 9/21/12 11/9/12 11/9/12 Ongoing

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L 051	Continued From page 4 According to a physician ' s interim order dated June 30, 2011 directed, " Please admit to [name of agency] hospice. " According to an " Admission & Annual Physical Exam Form " dated June 4, 2012 revealed, " Advance Directives: DNR [Do Not Resuscitate]/ DNI [Do Not Intubate], No Artificial Feeding, No dialysis, Hospice. " A review of the active clinical record revealed the last updated hospice care plan was October, 2011. A review of the facility ' s care plans; last updated April 11, 2012 lacked evidence that the care plan was integrated with goals and approaches to specify the various aspects of hospice care for Resident #103. A face-to-face interview was conducted with Employee #7 on September 21, 2012 at approximately 10:30 AM. After reviewing the clinical record; he/she acknowledged that the care plan did not incorporate the hospice services for Resident #103. A face-to-face interview was conducted with Employee #25 on September 21, 2012 at approximately 4:30 PM. He/she stated that the hospice nursing notes were used instead of a care plan and that process began in October	L 051		

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L 051	Continued From page 5 2011. The clinical record was reviewed on September 21, 2012. 3. The charge nurse failed to develop a care plan for Resident #289 ' s altered skin of the malleolus. Review of the " Progress Notes by Resident " dated April 25, 2012 at 21:35 revealed that Resident #289 was admitted to the facility with an alteration in the integrity of the skin of the right ankle. A review of the resident ' s care plan last updated May 5, 2012 lacked evidence of a care plan with appropriate goals and approaches to address altered skin integrity of the right ankle. A face-to-face interview was conducted with Employee #3 on September 21, 2012 at approximately 1:00 PM. After review of the above, he/she acknowledged the findings. The record was reviewed on September 21, 2012. 4. The charge nurse failed to initiate a care plan with goals and approaches to address Resident #376 ' s alleged suicidal ideations and non-compliance with care. A review of progress notes in Resident # 376 ' s	L 051	3 1. Resident #289 was discharged from the facility at the time of this observation. 2. All residents with altered skin integrity have been identified and care plans are in place. 3. All licensed staff have been in–serviced on developing care plans to address altered skin integrity. 4. Monthly audits will be conducted by nurse manager or designee. Results will be submitted to the DON for presentation to the quarterly QA/QI meeting.	5/29/12 11/9/12 11/9/12 Ongoing

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L 051	Continued From page 6 active clinical record revealed: "July 10, 2012 at 08:01 ...old scratches noted on [his/her] body, Resident said [he/she] scratches [him/herself] ...[he/she] screamed on and off, she slept for sometimes, woke up again [started] screaming, resident said [he/she] wants to go to [his/her] house ..." "July 11, 2012 at 03:06 ...Slept on and off, scream and yelling occasionally loudly" "July 11, 2012 at 15:12 ...repetitive health complaints, [cried] and tearful most of the shift. Does not like being alone. Mood problems not easily changed." "July 12, 2012 at 14:30 ...persistent screaming..." "July 14, 2012 at 23:12 ...call by the front desk secretary to go and see resident in [his/her] room because of [his/her] pain. [He/she] stated that resident has been calling that if [he/she] did not get relief from [his/her] pain, [he/she] is going to hurt [him/herself]. Upon getting to [his/her] room I observed [multiple] open areas on the resident ' s hip/thigh area with bright red blood. Skin tears measured about 0.7cm x 0.8cm some of them unmeasurable. [Primary Attending] made aware and family also made aware. Calmoseptine [ointment] to be applied [every] shift. Resident remains alert, confused and stable." 'July 14, 2012 at 23:45-Resdient throughout the PM repeatedly called out to the hallway for help, and called on the telephone to the receptionist. Resident was seen with both legs dangling at the side of the bed ...Resident complained of pain, stated, " It ' s my hemorrhoids, they been hurting for 48 hours. Given Tylenol 650 mg and	L 051	4 1. Resident #376's care plan for alleged suicidal ideation and non-compliance with care was initiated. 2. All residents with suicidal ideation and non-compliance with care have been identified. It has been determined that care plans are in place. 3. All licensed staff have been in-serviced on initiating care plans for suicidal ideation and non-compliance with care. 4. Monthly audits will be conducted by Nurse Manager or designee. Results will submitted to the DON for presentation at the quarterly QA/QI meeting.	9/21/12 11/9/12 11/9/12 Ongoing

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L 051	Continued From page 7 re-assessed with minimal effect. Incontinent of large BM [bowel movements], no hemorrhoids seen. Assessed for behavior and also for skin area of which resident has scratched multiple times. [His/her] left gluteus. Left gluteus has multiple denuded scratches. [Primary physician] was made aware of behaviors and complaints of pain. Order for Ativian 0.5 mg every 8 hours PRN ordered for Anxiety. Calmoseptine for the skin areas. [responsible party] informed via phone of behaviors ...he/she informed, " I would not mind if you all gave him/her something for anxiety. And [he/she] scratched [him/herself] in the hospital too..." "July 16, 2012 at 23:34 ...refused to be turned and repositioned ..." "July 17, 2012 at 14:02 ...Resident is readmit back to Carroll Manor with ESRD (End Stage Renal Disease" and refuses Dialysis at this time. Remains a full code ..." "July 18, 2012 at 15:26 ...Resident had periods of yelling ...." "July 19, 2012 at 20:15 ...The writer tried to administer [medication] times two but resident continue to refuse. Attempted to give patient teaching, but resident was not ready to listen, [he/she] said, " I do not want to hear anything from anybody. " "July 19, 2012 at 22:59 ...complaining to feeling pain all over [his/her] body ...This writer approached the resident to assess the level and exact location of the pain but resident declined and said, " I do not want any medicine for pain. " I feel much better now, I do not have pain ... "	L 051		

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L 051	Continued From page 8 "July 21, 2012 at 20:28 ...Resident refused all of [his/her] [medications]" "July 22, 2012 at 22:49 ...Refused to be turned side to side ..." "July 24, 2012 at 17:21 ...[Social worker] visited with resident in a quiet corner in the living room and resident expressed unhappiness at being in LTC (long term care) setting. [Social worker] explored ADL [activities of daily living] needs with resident, and resident asserted, " [he/she] can do everything for [him/herself] and doesn ' t need any help. " Resident stated [he/she] feels like [he/she] is " in prison " and " just look at these people. " Per resident [his/her] sleep and appetite have improved. [He/she] would prefer to be at home " doing everything [he/she] use to do " . Resident showed little insight about [his/her] current health status ...[Social Worker] reminded resident of the circumstances surrounding his/her admission (multiple intubations) and resident agreed [he/she] almost died-and said [he/she] sometimes " wishes God would take [him/her]. " Resident denied [suicidal] and hallucinations or delusions. He/she quickly added that " suicide is a sin and God forgive me. " [Social worker] will share this with IDT [interdisciplinary team] and recommend psychiatric consult for depressive symptoms. " "July 26, 2012 at 23:34 ...Resident refused all [his/her] medication this shift." "July 27, 2012 at 14:15 ...Resident habitually will refuse [his/her] [medications], scream and cry for help often." "July 29, 2012 at 14:30 ...Resident had a behavioral problem with the certified Nurse Aide	L 051		

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L 051	Continued From page 9 ..." "July 30, 2012 at 14:59 ...Resident was resistant to take morning medicine, but eventually agreed to take them. Resident declined to get out of bed today. Resident was noted to be crying today ... " "July 30, 2012 at 16:49 ...pending psychiatry consult" "July 30, 2012 at 19:28 ...Refused all [medications] this evening ...Resident stated, " I am not gonna take those medicine until you take me to the hospital. " "July 31, 2012 at 11:09 ...[Social Worker] met with resident in his/her room after CNA (certified nurse aide) reported resident has been irritable. Resident said, " Get me outta here. " Social Worker discussed discharge planning resources and need for 24-hour care. Resident expressed firm belief that [he/she] was " walking and well " when [he/she] came into this place, " and now [he/she] keeps being told, " You ' re sick " and can ' t leave. [Social Worker] reviewed resident ' s rights and explored discharge options. Resident continues to believe that [facility named] and [hospital] staff wish to keep him/her here. [He/she] expressed anger, frustration and disbelief about [his/her] current health status. [He/she] said [he/she] wished [he/she] was dead but denied suicidality, stating " Suicide is a sin. " Resident did not respond to supportive counseling or redirection but did say [he/she] understood that someone would need to care for [him/her] at [his/her] home. [Social Worker] to share [his/her] thoughts of death with [nursing] and pastoral care."	L 051		

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L 051	Continued From page 10 "August 2, 2012 at 22:33 ... Resident refused [his/her] [medications] ..." "August 6, 2012 at 23:20...Resident refused [his/her] [medications] ..." "August 10, 2012 at 05:00 ...Resident did not sleep during the night. [He/she] stated that [he/she] is nervous and is afraid to die. Saying. " I just want someone to hold my hand until I fall asleep. " CNA stayed in the room with [him/her] and [talked], and encouraged [him/her] ..." "August 11, 2012 at 20:30 ...Arguing and getting angry over simple things ..." "August 14, 2012 at 23:18 ...Resident have been refusing Remeron x 2 [times two] days now ..." "August 16, 2012 at 08:47 ...Resident was seen by Psych [Psychiatric] for suicidal thoughts and asking [his/her] therapist to assist [him/her] in executing his/her thoughts. According to rehab [staff name] the resident told [him/her] that [he/she] wanted to kill [him/herself] by jumping through [his/her] window. [He/she] said the resident also asked [him/her] to please help him/her do so. Resident was seen last week by Psych; [he/she] did express suicidal thoughts and [his/her] high level of anxiety ... " A review of the care plan revealed that there was no care plan initiated to address the resident ' s refusal of care, refusal to take his/her medications as prescribed and thoughts of harming his/herself/suicidal thoughts. A face-to-face interview was conducted on September 21, 2012 at approximately 10:30 AM	L 051		

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L 051	Continued From page 11 with the Employee #13. He/she acknowledged that care plans were not initiated to address the resident ' s refusal of care, refusal to take his/her medications as prescribed and thoughts of harming his/herself suicidal thoughts. The record was reviewed on September 21, 2012.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c)Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;	L 052		

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L 052	Continued From page 12 (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interview for three (3) of 33 sampled residents, it was determined that sufficient nursing time was not given to ensure that Resident #3, who had an alteration in skin integrity, classified by the facility as a " denuded " area to the coccyx received necessary treatment and services in a timely manner to promote healing; subsequently the wound progressed to a Stage 4 pressure ulcer. Additionally, sufficient nursing time was not given to ensure to consistently assess the characteristics and monitor the progression of pressure sores for two other residents. Residents #3, 16 and 289. The findings include: 1. Sufficient nursing time was not given to ensure that to ensure that Resident #3, who had	L 052		

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	HFD02-0027	A. BUILDING _____ B. WING _____	09/25/2012

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L 052	Continued From page 13 an alteration in skin integrity, classified by the facility as a " denuded " area to the coccyx. The area progressed over approximately 3 months to Stage 4 pressure ulcer. There was no evidence that facility staff consistently provided necessary treatment and services to promote wound healing. Subsequently, the wound progressed to a Stage 4 pressure ulcer. According to the facility ' s policy entitled; " Pressure Ulcer Management; Policy No: 1215; Revised Date: 08/10/12 " stipulated the following: " II. Procedure: 2. Weekly rounds are made on residents with new or difficult to manage pressure areas. On these rounds, the present treatment modality is evaluated for effectiveness. Changes in treatment may be suggested at this time. 5. Wound care Nurse or designee will observe application of dressings to ensure proper technique. 6. The CNA [Certified Nursing Assistant] will report any changes in the skin and turn in the report to their Team Leader that shift. The Team Leader will observe the skin, document wound status, treatment and measurement on the Skin and Wound update section of the EMR [Electronic Medical Record], and notify the Nurse Manager/Designee or Supervisor for that shift of the changes. 7. The Team Leader will follow up the physician for orders as needed and notify the responsible party; and 9. The Nurse Manager/Designee will make weekly skin assessment rounds and the RN [Registered Nurse] will ensure that the wound status, treatment and measurements on the " Skin and Wound " section on the EMR is correct. " According to Stedman ' s Medical dictionary,	L 052	L052 3211.1 NURSING FACILITIES 1 1. Resident #3's wound was assessed, and it was determined that the facility staff consistently provided necessary treatment and services to promote wound healing. 2. All residents with alteration with skin integrity have been identified. Necessary treatment and services to promote wound healing are in place. 3. All licensed staff have been in-serviced on facility's wound care protocol. 4. Monthly audits will be completed by wound nurse or designee. Results will be submitted to DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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L 052	Continued From page 14 Denude is to perform denudation. Denudation is defined as " Depriving of a covering or protecting layer; as in the removal of epithelium from an underlying surface. 1995, (p. 458, 26th Edition) According to the quarterly MDS dated October 9, 2011 revealed that Resident #3 was coded for requiring extensive assistance in Bed Mobility, Transferring, Dressing, Toileting, Personal Hygiene under Section G (Functional Status); Section H (Bladder and Bowel) the resident was coded, Urinary and Bowel as always incontinent; and Section M (Skin Conditions) was coded as at risk of developing pressure ulcers and Section M was coded as none of the above for the presence of Skin impairment of any type. Section I the resident ' s diagnoses included: Hypertension, Hyperlipidemia, Alzheimer ' s disease, Cerebral Vascular Accident, Hemiplegia, Depression, Psychotic Disorder. The annual MDS dated January 1, 2012 revealed that Resident #3 was coded for requiring extensive assistance in Bed Mobility, Dressing, Personal Hygiene and total dependence in transferring, and toileting under Section G (Functional Status); Section H (Bladder and Bowel) the resident was coded, Urinary as always incontinent and frequently incontinent of Bowel; and Section M (Skin Conditions)-M0150 was coded as at risk of developing pressure ulcers and M1040 was coded as none of the above were present. However, the resident had alteration in skin integrity to his/her coccyx. The care plan entitled, " Problem #41, Hx	L 052	1. Resident #3's alteration in skin integrity was coded correctly in significant change MDS assessment dated 3/11/2012. All subsequent MDS's have been coded correctly. 2. All residents with altered skin integrity have been identified. All MDS's are coded correctly. 3. All MDS staff have been in-serviced on proper coding of section M. 4. Random audits will be conducted by MDS coordinator. Results will be submitted to DON for presentation at the quarterly QA/QI meeting.	9/24/12 11/9/12 11/9/12 Ongoing

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L 052	Continued From page 15 (history) of Interruption in Skin Integrity " initiated 01/24/11 revealed, and " Goal-wound will be free of infection and healing gradually within 90 days. Approach: ...1. Turn and position every 2 hours. 2. Measure and document size of wound. 3. Reassess wound every 7 days and PRN. 4. Notify Wound nurse of new wound. 5. Treat wound as ordered ... " On 11/11/11 the care plan was updated to included " Interruption in Skin Integrity related to Coccyx area " . On February 29, 2012 the care plan was updated to include, " wound nurse staged coccyx ulcer as Stage 3 " On March 1, 2012 the care plan was updated to include, " Coccyx ulcer unstageable " Braden Scale or Predicting Pressure Sore Risk dated October 17, 2011=14 mod (moderate) risk; 13-14= moderate risk. For scores below 18 institute Carroll Manor Pressure Ulcer Prevention Protocol Laboratory Results- A review of the laboratory results dated November 9, 2011 revealed that Resident #3 ' s albumin level was 3.0 Low, reference range 3.2-5.0g/dl. The laboratory results dated March [unable to read date] 2012 revealed that the Albumin level was 2.6 Low (range not indicated). Physician ' s Interim Orders " November 11, 2011 at 2035 ...Clean open pink on coccyx area with Bedside Care Foam and pat dry. Apply Calmoseptine Ointment twice daily x	L 052		

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L 052	Continued From page 16 (times) 14 days ... " " November 29, 2011 at 1030 ...Clean denuded area on the Coccyx with Bedside Care Foam, apply Saf-Gel, cover with 4x4 gauze and secure with Tegaderm. Change dsg (dressing) daily x 14 days. D.C. (discontinue) Calmoseptine Ointment to Coccyx open area ... " " December 7, 2011 at 1123 ...Cleanse denuded area on the Coccyx with Bedside Care Foam, apply Mepilex Sacral Boarder. Change every 3 days and PRN. D.C Saf-Gel dsg to Coccyx. " " December 28, 2011 at 1100 ... Cleanse denuded areas on the Sacro-Coccyx area with Bedside Care Foam, apply Stomadhesive powder and Calmoseptine and Baza Clear, apply BID (twice daily). D.C. Rx (medical prescription) with Mepilex Border ... " " December 30, 2011 at 1430 ...Vitamin C 500mg by mouth twice daily for wound healing x 14 days. Zinc Sulphate 220mg by mouth daily for wound healing x 14 days ... " " February 7, 2012 at 1100 ...Sacro-Coccyx Ulcer: Cleanse with normal saline, apply Santyl Ointment, cover with 4x4 gauze; Secure with Tegaderm. Change dsg daily x 14 days. Keep the heels floated while in bed with the help of pillows ... " " February 15, 2012 at 1710 ...Increase Ensure to TID [three times a day] (Provides 1050 Kcal, 39 g protein). Give Zinc Sulfate 220mg p.o. daily x 14 day(s) for wound. Give Vitamin C 500 mg p.o. daily for wound x 14 days ... "	L 052		

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L 052	Continued From page 17 " February 22, 2012 at 1040 ...D.C. previous Rx order dated 2/15/2012. Cleanse Sacro-Coccyx Ulcer with Normal Saline. Fill the wound bed with 2x2 gauze saturated with ¼th strength Dakin ' s Solution. Cover with 4x4 gauze, secure with tape. Change dsg Q (every) shift/PRN x 7 days. " " February 28 [2012] at 1300 ...D.C. previous Rx order for Sacro-Coccyx Ulcer dated 2/22/12. Cleanse Sacro-Coccyx Ulcer with Normal Saline; apply/sprinkle Polysporin pwd (powder). Fill the wound with gauze saturated with Santyl Ointment. Cover with 4x4 gauze, secure with Tegaderm. Change dsg daily x 21 days. " A review of the Treatment Administration Records (TAR) revealed: According to the TAR the resident received Calmoseptine Ointment as ordered from November 11 - 25, 2011. It was noted that treatment/dressing change on November 25, 2011 (the second dressing) and November 26, 27 and 28, 2011 were omitted. The resident received Bedside Care Foam with Mexiplex Sacral Border as ordered on December 10, 14, 17, 19, 21, 24, 26, and 28, 2011. It was noted that treatment/dressing change on December 8 and 9, 2011 were omitted. According to the documentation on the TAR, February 16 thru 22 and 29, 2012 the resident received a treatment to cleanse Sacro-Coccyx	L 052		

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L 052	Continued From page 18 ulcer with Normal Saline, sprinkle Polysporin powder; apply pack 2x2 gauze saturated with poly Santyl ointment, cover with 4x4 gauze; secure with Tegadem. However, there is no documented evidence of a physician ' s order to direct this treatment. In summary, there was no evidence that facility staff administered the wound treatment in accordance with the physician ' s orders. Additionally, from February 16 thru 22, 2012facility staff conducted a wound treatment to the resident ' s sacro-coccyx in the absence of a physician ' s order. Skin Condition Report -Unhealed Daily Wound Assessment revealed: " 11/11/2011 Present on the Coccyx is a denuded area. The following findings were documented, length in cm=0.8, width in cm=0.5, no odor is present, no drainage is apparent, recent changes were made to the treatment orders for this site, no itching or discomfort, General comments: At 2020 reported by CNA resident noted open pink area on coccyx measuring 0.8cm x 0.5cm, Dr Soufi notified and gave order to clean the area with bedside care foam and pat dry, apply Calmoseptine ointment twice daily x14 days. " " 11/15/2011 Present on the Coccyx is a denuded area: The following findings were documented, General comments: Resident denuded area on coccyx assessed this morning, area measures 0.5 x 0.5 appearance is pink, no drainage noted. Treatment continues to cleanse with bedside foam and apply Calmoseptine bid	L 052	1. Resident #3's wound treatment was administered according to physician order dated 2/15/12 for polysporin administration and tegaderm . 2. All residents with wound treatments have been identified. There are corresponding physician orders for the treatments. 3. All licensed staff have been in-serviced on administering wound treatments in accordance with physician orders. 4. Random audits will be conducted by wound nurse or designee. Results will be submitted to the DON for presentation at the quarterly QA/QI.	2/15/12 11/9/12 11/9/12 Ongoing

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L 052	Continued From page 19 x14 days. " " 11/23/2011 Present on the Coccyx is a denuded area: The following findings were documented, Length 0.2 x width 0.2, skin is not blanchable, no odor is apparent, no drainage is apparent, This wound was not present on admission, wound baseline visible, pink wound base = 100%, granulation tissue type = 100%, no itching, or discomfort, condition is flat, color is pink, wound has no pattern -scattered, no foreign bodies , surrounding tissues is normal, The affected area has an absence of hair, skin tissue temperature is warm to touch, margins are regular, resident has no pain. Skin turgor is fair, General comments: Denuded area on coccyx healing well, site dry and pink in color, site improvement noted. " " 11/24/11 Present on the coccyx is a denuded area. The following findings were documented, PA, NP, MD were notified of the present status of site. No changes in site condition, no recent changes were made to the treatment orders for this site, antibiotics are not currently in use. General Comments: Open area on coccyx assessed, cleanse with bedside foam as ordered and Calmoseptine applied to site, no bleeding or odor at site. " " 11/28/2011 Present on the coccyx is a denuded area. The following findings were documented Length in cm=0.5, width in cm=0.5, depth in cm= 0, no odor is apparent, no drainage is apparent recent changes were made to the treatment orders for this site, the wound was not present on admission, General comment: pale pink dry wound bed, also noted moist areas in the gluteal fold and in the periwound area, current applying Safgel ointment and covering	L 052		