

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/28/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
-----------------------------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  Amended  An Abbreviated Survey to Investigate KY#00017056 was conducted on 09/21/11 through 09/28/11. KY#00017056 was substantiated with deficiencies cited at 42 CFR 483.25 (F-309) at a Scope and Severity (S/S) of a "G".	F 000	Maysville Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.	
F 309 SB=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of the Emergency Room (ER) report and hospital record, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure ongoing assessment, failed to ensure the Physician was informed of all changes, and failed to implement timely treatment to Resident #1's right lower leg. On 08/28/11, Resident #1 was hospitalized, treated with Intravenous (IV) antibiotics, and required surgical intervention for an infection in the right lower leg.	F 309	Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers tis responses, credible allegations of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cornelia Burkhardt, RN, BSN</i>	TITLE <i>Administrator</i>	(X6) DATE 10/20/11
-------------------------------------------------------------------------------------------------------------	-------------------------------	-----------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/28/2011	
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41058		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the ER report, dated 08/28/11, revealed Resident #1 presented in the ER with significant soft tissue swelling, with a fluctuant area on his right lower leg where the blisters had resolved, but he/she had erythema (redness of the skin which can occur with infection and/or inflammation), cellulitis and possible abscess. The resident was started on intravenous (IV) antibiotics and a needle was used to aspirate large amounts of gross purulent fluid. Further review of the ER report revealed, after the purulent fluid was drained from both abscesses, the area was irrigated thoroughly until the fluid ran clear, and the fluctuant areas were completely resolved using suction. On 08/29/11, the resident was taken to the operating room and an incision was made to the lower right leg, and large amounts of purulent fluid was drained from both abscesses. The whole pretibial area was swollen and appeared to be one continuous fluctuant area with some cellulitis. There was dried skin that was consistent with prior blisters that had already popped and mild cracks in the skin where it had been dry and irritated.</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 05/26/11, with diagnoses which included Type Two Diabetes, Chronic Inflammatory Demyelinating Polyneuropathy (a neurological disorder causing progressive weakness in the arms and legs), and a Fracture, related to fall prior to admission, with a cast to right lower leg.</p> <p>Review of the Admission Minimum Data Set</p>	F 309	<p>compliance and plan of correction as part of its on-going effort to provide quality care to residents.</p> <p>Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents.</p> <p>It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents.</p> <p>Resident #1 was admitted to Maysville Nursing and Rehabilitation Facility on 06/03/2011 with a cast in place. The cast was removed by the orthopedic surgeon on 07/01/2011. On 07/03/2011 the doctor was notified of the blister, and a treatment was ordered by the attending physician. On 07/05/2011 the orthopedic surgeon applied a cast over the blistered areas. This cast remained in place until 08/22/2011. The blister areas were noted and reported to the attending physician.</p> <p>1. Resident #1 was discharged from the facility on 08/28/2011.</p>	

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/28/2011
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 309	<p>Continued From page 2</p> <p>(MDS) Assessment, dated 06/10/11, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of fourteen (14), indicating the resident was oriented with no cognitive impairment. Review of the Comprehensive Care Plan, developed on 06/14/11 revealed the facility had developed a Care Plan for Impaired skin integrity, with interventions that included report any red or open areas and weekly skin checks.</p> <p>Record review of the Orthopedic Physician's report, dated 08/22/11, revealed when the cast to the resident's lower right leg was removed, the leg looked good with minimal redness over the tibia. The skin was dry and peeling; however, there was no tenderness and no signs of infection. Interview with the Orthopedic Physician, on 09/22/11 at 3:20 PM, revealed when the cast was removed on 08/22/11, the skin was slightly red, with dry peeling areas of skin; however, there were no open areas, no blisters, no swelling, and no signs of infection.</p> <p>Interview with Resident #1's spouse, on 09/27/11 at 6:00 PM, revealed he/she was with Resident #1 when the cast was removed. The spouse stated the right lower leg was slightly red and had dry skin patches. He/she further stated the skin did not have any open areas or blisters until later in the evening. Per interview, Resident #1's bed was broken and the resident was placed in a chair until the bed was repaired, and it was at that point, with the leg hanging down, the blisters developed. He/she informed Licensed Practical Nurse (LPN) #5 about the blisters; however, LPN #5 told the resident's spouse this was normal and the doctor had ordered mineral oil for the blisters.</p>	F 309	<p>2. All residents with skin conditions have been reassess by the Assistant Director of Nursing and treatments were verified with the physicians on 10/18/2011. Any changes were reported to the attending physicians.</p> <p>3. Weekly, the Director of Nursing, Assistant Director of Nursing, MDS nurse and Administrator will review all skin conditions and treatments to ensure treatments are appropriate and physicians have been notified timely. Licensed nurses (RNs and LPNs) were inserviced on physician notification related to wound assessments and documentation by the Administrator on 09/30/2011.</p> <p>4. As part of the facility's ongoing quality assurance program, the Assistant Director of Nursing will assess all skin conditions weekly to ensure they are being assessed properly and the appropriate treatments are in place and physicians have been notified of any changes. This practice will be an ongoing process for the next six months.</p> <p>5. 10/19/2011.</p>	

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/28/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
-----------------------------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 3</p> <p>Review of the Weekly Nurses Notes, dated 08/22/11, revealed LPN #5 documented under Skin Condition, "the cast was removed from the right lower leg, red patchy areas, skin cracked". Further review of the Weekly Nurses Notes, on 08/22/11 at 6:50 PM, revealed LPN #5 documented the resident had fluid filled intact blister to shin and intact fluid filled blister to ankle inner aspect.</p> <p>Interview with LPN #5, on 08/23/11 at 10:00 AM, revealed the evening of 08/22/11, Resident #1 had developed clear fluid filled blisters on his/her lower right leg. She further stated the leg appeared slightly discolored, with dry peeling skin.</p> <p>Review of the Physician's Orders, on 08/22/11, revealed an order given by the Orthopedic Physician, to apply mineral oil to the right lower leg two times a day. However, interview with the Orthopedic Physician, on 09/22/11 at 3:20 PM, revealed he had never given an order to apply mineral oil to the resident's leg. He stated, "I would never give an order for the use of mineral oil on an open area". He further stated the facility had not contacted his office about Resident #1's right lower leg developing blisters and the last time his office had been contacted by the facility was 08/15/11.</p> <p>Interview with Resident #1's Physician, on 09/22/11 at 2:20 PM, revealed he received a fax on 08/23/11 stating the resident had developed clear fluid filled blisters and they had been using mineral oil for the dry skin. He further stated he had not given the order to use mineral oil on the</p>	F 309		

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/28/2011
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4 resident's leg.</p> <p>Interview with LPN #5, on 09/28/11 at 8:50 AM, revealed it had been a nurses order to apply the mineral oil to the areas of dry skin. She further stated she did not know why she wrote the Orthopedic Physician's name of the order.</p> <p>Interview with Resident #1's spouse, on 09/27/11 at 6:00 PM, revealed he/she reported to the nurses on Thursday, 08/25/11, the pain in the resident's leg had become worse and when he/she questioned the appearance of the leg, LPN #2 stated there was nothing wrong, and the appearance was the same as the day the cast had been removed. Further interview revealed, by Friday, 08/26/11, Resident #1 had become increasingly more confused. Per interview, the spouse reported to LPN #4 the resident had been seeing things that were not there, and again voiced concerns about the appearance of the resident's leg and the resident's increased pain in the right lower leg. The spouse was told the leg appeared normal and the resident had just received pain medication.</p> <p>Review of the Weekly Nurses Notes for the week of 08/21/11 to 08/26/11, revealed the only documentation related to the blisters on the resident's leg was made by LPN #5 on 08/22/11.</p> <p>Further interview with Resident #1's spouse, on 09/27/11 at 6:00 PM, revealed on Saturday, 08/27/11, the spouse again was told, by LPN #5 the leg appeared to be healing and the reddened areas were normal. The spouse stated he/she became very upset and insisted the Physician be notified. He/she further stated the leg had</p>	F 309			

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/28/2011
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>become a "very angry shade of red", very swollen, and the pain had become even more severe in the leg. Further interview revealed, he/she came to the facility, on the evening of 08/27/11, after Resident #1 called and reported he/she was seeing people in his/her room and the pain had become a lot worse. The spouse spent the night with the resident and was awake all night because Resident #1 was hurting and the nurse was unable to reposition his/her leg in a manner to relieve the pain.</p> <p>Record review of the Weekly Nurses Notes, dated 08/27/11 at 1:15 AM, revealed the resident was complaining of leg pain and requesting pain medication. The resident was unable to receive pain medication because he/she had received pain medication for leg pain at 12:00 AM. Further review of the Weekly Nurses Notes revealed the nurse tried to reposition the leg to help with the pain but was unable to change the position enough to make a difference.</p> <p>Review of the Weekly Nurses Notes, dated 08/27/11 at 9:00 AM, revealed new treatment to the right lower leg. Further review revealed at 2:30 PM, the Attending Physician was notified of right lower leg and treatment was changed secondary to fluid filled blister type areas and that the resident was seeing little people.</p> <p>Review of the Physician Order's, dated 08/27/11 at 9:00 AM, revealed an order to discontinue the mineral oil to leg and apply Aquacel and cover with ABD pad and dry dressing to right lower leg shin area and inner ankle, change daily and as needed for fourteen (14) days for burst blisters. Further review of the Care Plan revealed an</p>	F 309			

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/28/2011
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>Intervention added on 08/27/11, for Aquacel and cover with ABD pad and dry dressing to right lower leg every day and as needed for fourteen (14) days for blisters.</p> <p>However, interview with LPN #5, on 09/22/11 at 10:00 AM, revealed the order for Aquacel and cover with ABD pad and dry dressing was a nursing order, not a Physician's order.</p> <p>Interview with Resident #1's Physician, on 09/22/11 at 2:20 PM, revealed when LPN #5 called him on 08/27/11 at 2:00 PM, she notified him of the increased pain from the bladder spasms but did not inform him of increased pain in the leg, the change in the resident's mental status, or the change in the appearance of the right lower leg. Interview further revealed he had never given an order for a dressing change or ointment to be applied. He stated he had not given the order for a dry dressing change.</p> <p>Record review of the Weekly Nurses Notes, dated 08/28/11 at 1:00 AM, revealed Resident #1's temperature was 99.6 and pain medication was given; and, at 8:00 AM, Resident #1's temperature was still 99.6. Further review revealed LPN #5 documented the leg was red, with fluid filled blisters and warm to the touch.</p> <p>Continued interview with Resident #1's spouse, on 09/27/11 at 6:00 PM, revealed on 08/28/11, when the first shift nurse came into the room to assess the resident, he/she told the nurse the Physician needed to be called immediately and the resident's leg needed to be addressed because it was infected.</p>	F 309			

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/28/2011
NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 7</p> <p>Interview with LPN #7, on 09/25/11 at 5:30 PM, revealed she had taken care of Resident #1 on 08/27/11 and 08/28/11. She stated Resident #1 had not complained of pain to her nor had the wife reported any complaint of pain in the right leg. She further stated the right lower leg had a blister which had burst with clear drainage. She further stated the leg appeared slightly red with dry slough skin; however, she did not notify the Physician.</p> <p>Interview with LPN #5, on 09/23/11 at 10:00 AM, revealed she had taken care of Resident #1 on 08/27/11 and 08/28/11. She stated, on 08/27/11 she noticed the leg had started to look different. Further Interview revealed the blisters were flat and not fluid filled. She stated the skin was dry and sloughing off, the color was off, and the areas where the blisters had been were raw looking and had dry skin around the edges. She further stated the leg was not warm to the touch nor was it red or swollen. She stated, on 08/28/11, when she arrived at work, LPN #7 reported to her in report, Resident #1 had complained of pain in the right leg and the wife had spent the night. She stated she went to Resident #1's room first and she assessed the leg at that time and found a raised area which was not there the day before. She further stated she had only assessed one raised area, it was fluid filled with serious sanguineous (blood tinged) fluid, it had become slightly reddened, but it was not warm to the touch.</p> <p>Interview with Resident #1's Physician, on 09/22/11 at 2:20 PM, revealed he should have been notified sooner about the change in the leg. He stated, "An abscess can develop over night</p>	F 309			

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

PRINTED: 10/13/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/28/2011
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41058
-----------------------------------------------------------------------------------	---------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 309	<p>Continued From page 8</p> <p>but I cannot prudently say two abscesses, that size, could develop over night. It appeared the blisters had burst and the blister cover had obviously dried up, almost completely resolved, but the subcutaneous layer underneath the area had become infected at some point and the abscess developed". He stated the right lower leg appeared an angry deep red, with fluctuant, very swollen, pretibial (from the ankle to just below the knee), and there was significant soft tissue swelling. He stated the whole area underneath was one large abscess. He further stated there was an open area which appeared to be an old blister which had burst at some point, with granulation tissue. Interview further revealed there was a second abscess on the inner aspect of the ankle. This area was described as being the size of a baseball with fluctuant, dark red in color, warm to the touch, with sloughing skin. He further stated, LPN #5's skin assessment completed on 08/28/11, before Resident #1 was sent to the Emergency Room (ER), did not accurately describe the appearance of the resident's lower right leg.</p> <p>Record review revealed on 08/28/11, Resident #1 was hospitalized, treated with Intravenous (IV) antibiotics, and required surgical intervention for an infection in the right lower leg.</p>	F 309		