

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

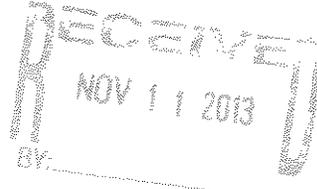
PRINTED: 09/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/16/2013
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NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00020654, KY#00020660, KY#00020686, KY#00020693, KY#00020694 and KY#00020696 were initiated on 09/12/13 and concluded on 09/18/13. KY#00020654, KY#00020660, KY#00020686, KY#00020693 and KY#00020694 were unsubstantiated with no related deficiencies cited. KY#00020696 was substantiated with related deficiency cited. The highest Scope and Severity (S/S) was cited at a "G" with the facility having no opportunity to correct.	F 000	Plan of Action Cambridge Place Abbreviated Survey 9/16/2013 Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 309 SS=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 facility's protocol, it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of nine (9) sampled residents, (Resident #7). On 03/02/13, Resident #7 sustained an injury to the left outer ankle resulting in a skin tear; however, there was no documented evidence of	F 309	Quality of Care 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.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 11/8/13
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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.

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F 309	<p>Continued From page 1</p> <p>seventy-two (72) hour monitoring as per the facility's protocol. Further, there was no documented evidence of facility intervention related to the injury until 03/09/13 when Resident #7's nurse requested the wound care nurse assess the area which was documented as a skin tear measuring 0.7 X 0.8 X 0.1 centimeters (cm) with a dark pink wound base, with scant serous drainage and surrounding skin dark brown with some scar tissue.</p> <p>Review of Resident #7's Hospital History and Physical Note, performed by the Primary Care Physician (PCP), on 09/03/13 at 8:32 PM, revealed Resident #7 was admitted to the hospital with admission diagnoses of Left Lower Extremity Cellulitis with possible osteomyelitis. Review of the Brief History portion of the History and Physical revealed "...the wound has opened up on hts/her left foot and that is not appropriately taken care of".</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 09/13/13 at 10:45 AM, revealed the process of reporting an injury would be if the State Registered Nursing Assltant (SRNA) discovered an injury, the SRNA should alert the nurse. The nurse would go and took at the injury, notify the Physictan, and get an order for treatment. If the Physictan did not give an order for treatment, nursing would then continue with a weekly skin assessment. The DON also stated a seventy-two (72) hour monitoring sheet would be put into place due to a change of condition. The DON stated a "skin tear" would be considered a change of condition.</p>	F 309	<p>Criteria 1: -Resident #7 is not currently in the facility. Weekly skin and wound assessments were completed/documentd on the resident prior to discharge. The resident was followed by the wound care center with visit documentation included in the chart.</p> <p>Criteria 2: -All residents with skin tears in the last 20 days have been reviewed and audited by the DON, QA Nurse, and Treatment Nurse to determine that indicated documentation has been completed, including but not limited to: assessment with measurements, MD treatment orders, Treatment Administration Record (TAR), 72 hour follow up documentation, and care plan updates. The audit was completed on 9/19/13. -All residents had weekly skin assessments conducted by the charge nurses from 9/17/13 to 9/24/13 to determine that there were no unidentified/unreated skin issues.</p> <p>Criteria 3: -Licensed nurses have received in-service education on skin tear documentation including but not limited to: assessment with measurements, MD treatment orders, Treatment Administration Record (TAR), 72 hour follow up documentation, and care plan updates. The Staff Development Nurse completed the in-services on 9/20/13.</p>		

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F 309	<p>Continued From page 2</p> <p>Review of the facility's policy, "Code 72 (Acute Episode/Post Admission Charting)", undated, revealed observational charting was to be continued until condition stabilized or resolved.</p> <p>Record review revealed the facility admitted Resident #7 on 11/30/07 with diagnoses which included Genetic Torsion Dystonia (painful muscle contractions resulting in uncontrollable distortions), Muscle Weakness, Peripheral Vascular Disease, Contracture of Joint - Multiple Sites, Spasm of Muscle, and Osteomyelitis.</p> <p>Review of the Comprehensive Care Plan for Resident #7, updated on 12/12/12, revealed focus area of potential for alteration in skin integrity due to diagnosis of Peripheral Vascular Disease (PVD) (the decreased circulation to the extremities), amputation of right 4th and 5th toes, history of Methicillin-resistant Staphylococcus aureus (MRSA), (bacterium responsible for several difficult-to-treat infections in humans), osteomyelitis, incontinence, decreased mobility, tetraparesis, and reoccurring open areas to bilateral lower extremities (BLE). Interventions included weekly skin assessments per licensed nurse, assess skin during perineal care, and reporting areas of concern to Medical Doctor (MD) and wound care nurse.</p> <p>Interview with SRNA #9, on 09/13/13 at 2:08 PM, revealed on 03/02/13, after lifting Resident #7 out of bed and into a chair utilizing a mechanical lift, SRNA #9 noticed blood on the resident's left outer ankle. SRNA #9 described the injury as "like a scrape". SRNA #9 stated Resident #7 had problems with his/her feet. SRNA #9 stated she informed Registered Nurse (RN) #1 of the</p>	F 309	<p>Criteria 4: -The CQI indicator for the monitoring of nursing documentation will be utilized monthly X 2 months and then quarterly thereafter, under the supervision of the DON. Results are reviewed with the QA committee, which includes the Administrator and Medical Director. An action plan is developed for failure of the indicator to meet the established threshold, and the indicator repeated again the following month for committee review to determine nursing compliance.</p> <p>Criteria 5:</p>	9/25/13

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F 309	<p>Continued From page 3</p> <p>Incident and stated she told RN #1 to get a Physician's order for treatment. SRNA #9 stated she saw Licensed Practical Nurse (LPN) #1 put a "patch" on it. SRNA #9 stated Resident #7 usually wore socks throughout the day due his/her feet were always cold. She also stated Resident #7 usually received his/her baths on the evening shift so she did not usually perform a skin assessment. SRNA #9 stated she thought someone had taken care of the resident's wound.</p> <p>Review of the facility's Incident/Accident report, dated 03/02/13, revealed Resident #7 received a skin tear to the left outer ankle with a possible causative factor of contact of left ankle with bed cradle. Further review of the Incident/Accident report revealed no documented evidence of measurements or a description of the wound. The Incident/Accident report was completed by RN #1. However, there was no documented evidence of the 72 hour monitoring sheet.</p> <p>Interview with the Administrator, on 09/16/13 at 11:50 AM, revealed the facility was unable to produce a seventy-two (72) hour monitoring form which should have been started on 03/02/13.</p> <p>Interview with RN #1, on 09/16/13 at 9:40 AM, who was assigned to Resident #7 on 03/02/13, revealed she remembered the incident and filling out the Incident/Accident Report. RN #1 stated she was busy with another resident and was unable to assess the wound, so LPN #1 put a Mediplex, (self-adherent absorbent dressing), on the wound, on 03/02/13. RN #1 also stated LPN #1 started the seventy-two (72) hour monitoring sheet.</p> <p>Interview with LPN #1, on 09/13/13 at 10:15 AM,</p>	F 309		
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F 309	<p>Continued From page 4</p> <p>revealed if a resident had an injury, the nurse should go assess the wound, including measurements. Then the nurse should contact the Physician to get a treatment order and contact the family to inform them of the situation. LPN #1 stated if the Physician did not order a treatment, the nurse should contact the House Supervisor, stating this was an open area and ask what should be done. LPN #1 also stated for a new skin tear, a seventy-two (72) hour monitoring sheet, regardless of the size of the injury, should be started by the nurse. If the injury was getting worse, you should call the Physician and get a treatment and/or antibiotics if necessary. Continued interview with LPN #1, on 09/13/13 at 2:25 PM, revealed she did not remember this incident with Resident #7 and didn't remember if she applied a bandage to Resident #7's wound or not and didn't remember starting a 72 hour monitoring sheet.</p> <p>Interview with LPN #2, on 09/13/13 at 10:25 AM, revealed if a skin tear was reported, the nurse should go and look at it and start the procedures of calling the Physician and the family. LPN #2 stated the wound should be measured and staff should start a seventy-two (72) hour monitoring sheet.</p> <p>Interview with the Unit Manager where Resident #7 resided, on 09/13/13 at 10:35 AM, revealed after a nurse learns of an injury, the nurse should go and assess the resident. The Unit Manager stated the nurse, depending on the severity of the wound, would need to provide care and treatment to the resident. The Unit Manager also stated after any injury, the resident should be monitored every fifteen (15) minute for the first twenty-four (24) hours. The Unit Manager also stated a</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>seventy-two (72) hour monitoring tool should be put in place.</p> <p>Interview with the Administrator and the DON, on 09/13/13 at 2:50 PM, revealed once an incident/accident report was filled out, it was discussed the next day during the morning meetings held daily. The report was then sent back to the Unit Manager to follow up on the incident/accident. When completed the form was turned into the DON to sign, then to the Administrator, and finally to the Medicaid Director.</p> <p>Review of the Nurses' Notes revealed no documented evidence of assessment, monitoring or treatment to the left ankle wound from 03/03/13 through 03/08/13.</p> <p>Review of the facility's Assignment Sheet, dated from 03/02/13 to 03/09/13, revealed SRNA #6 had been assigned to Resident #7 on 03/03/13 from 3:00 PM to 11:00 PM. Further review of the the facility's Assignment Sheet revealed SRNA #6 returned on 03/05/13, 03/06/13 and 03/07/13 and was assigned to Resident #7 from 3:00 PM to 11:00 PM on those dates.</p> <p>Interview with SRNA #6, on 09/16/13 at 1:00 PM, revealed she remembered Resident #7 having a dressing on the right ankle but did not remember a dressing on the left ankle. SRNA #6 further stated Resident #7 usually wore socks to help prevent the ankles from rubbing together.</p> <p>Review of the facility's Assignment Sheet, from 03/02/13 to 03/09/13, revealed SRNA #7 had been assigned to Resident #7 on 03/03/13 from 11:00 PM to 7:00 AM.</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>Interview with SRNA #7, on 09/16/13 at 1:29 PM, revealed she did not remember the exact events in regards to Resident #7's left ankle wound.</p> <p>Review of the facility's Assignment Sheet, dated from 03/02/13 to 03/09/13, revealed RN #2 had been assigned to Resident #7 on 03/04/13, 03/05/13, and 03/06/13 from 3:00 PM to 11:00 PM.</p> <p>Interview with RN #2, on 09/16/13 at 1:37 PM, revealed she didn't remember any incident in regards to Resident #7. RN #2 stated she just remembered doing daily dressing changes for Resident #7; however record review revealed no documented evidence of dressing changes to Resident #7's left ankle between 03/02/13 and 03/08/13.</p> <p>Continued interview with SRNA #9, on 03/09/13, revealed she was changing Resident #7's socks and saw a dressing she described as "looking old". SRNA #9 stated she then removed the dressing and called for the nurse when she saw the open wound.</p> <p>Interview with the Wound Care Nurse (WCN), on 09/13/13 at 11:00 AM, revealed she was in the facility working on 03/09/13 when a nurse asked her to look at Resident #7's wound. The WCN could not remember which nurse approached her. After assessing the wound, the WCN stated she called the Physician for orders to begin treating the wound. The WCN also stated she started a seventy-two (72) hour monitoring form at that time. The WCN revealed she was unaware of any injury Resident #7 received on 03/02/13.</p>	F 309		
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F 309	Continued From page 7 Review of Resident #7's Nursing Note, written on 03/09/13 with no time given, written by the WCN revealed the left ankle wound measured 0.7 x 0.8 x 0.1 centimeters (cm) and was noted to have scant serous drainage and treatment in place. Treatment consisted of cleanse wound with seadern (use to remove dead skin cells) and apply Iodosorb (used to treat exuding wounds) and cover with Mepilex twice a day. Review of Resident #7's Nursing Note, written on 03/12/13 with no time given, written by the WCN revealed the left ankle wound measured 0.7 x 0.8 x 0.1 cm, noted to have pink wound base with granulating tissue as well as scant serous drainage. The Note further revealed the Nurse was to continue with current treatment. Review of Resident #7's Nursing Note, written on 03/19/13 with no time given, written by the WCN revealed the left ankle wound measured 1.0 x 0.8 x 0.2 cm, noted to have dark pink wound base with scant areas of white tissue, light serous drainage was also noted. Review of the Physician's orders revealed a new order to cleanse with seadern and santyl (used to remove necrotic tissue from wounds) with normal saline, cover with Hydroflex dressing. Review of the Wound Care Specialist Evaluation, dated 03/26/13, revealed the wound size of the left ankle wound measured 1.4 x 0.9 x 0.2 cm with light sero-sanguinous drainage. There was a new order for treatment, written by the Advanced Registered Nurse Practitioner (ARNP) on 03/27/13, to cleanse with seadern, apply Iodosorb, and cover with mepilex and kerlex wrap.	F 309			

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F 309	<p>Continued From page 8</p> <p>Review of the Wound Care Specialist Evaluation, dated 04/02/13, revealed the wound size of 1.4 x 0.9 x 0.2 cm with light sero-sanguinous drainage. There was an order for a wound culture to be performed by the Physician. No treatment ordered for wound.</p> <p>Review of the laboratory results from the wound culture on 04/03/13 was reported to the facility on 04/06/13 with result of Staphylococcus aureus with a new medication order written by the ARNP, on 04/08/13, for medication addition of Augmentin (antibiotic) 875 milligrams (mg), one pill taken twice a day for ten (10) days and Acidephillis (omega-3 fish oil), one pill taken once a day for thirteen (13) days for infection.</p> <p>Review of the Wound Care Specialist Evaluation, dated 04/09/13, revealed the wound size of 2.0 x 1.3 x 0.2 cm and noted the deterioration was due to infection. A surgical procedure of excisional debridement of muscle was performed on the wound and a new order for silvaden (Topical Sulfonamide/Silver antibacterial) dry protective dressing, zinc oxide to surrounding skin and cover wound with thick foam with hole cut out in distribution of wound. Secure with soft, non-constricting kertext wrap.</p> <p>Review of the Wound Care Specialist Evaluation, dated 04/30/13, revealed wound size of 0.7 x 0.5 x 0.1 cm with findings that indicated improvement noted due to decreased necrotic tissue, decreased drainage, decreased surface area, and increased granulation. The new treatment ordered was dry protective dressing, Iodoform packing, skin prep with overlying zinc oxide to surrounding skin. Secure with soft, non-constricting kertext wrap.</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>Review of the Wound Care Specialist Evaluation, dated 05/14/13, revealed the wound size of 0.9 x 0.7 x 0.2 cm with wound progression noted not to be improved. Cauterization of hypergranulation tissue performed on left ankle to facilitate healing. New treatment ordered of dry protective dressing, silver alginate packing, zinc oxide to surrounding skin, secure with soft, non-constricting kerlex wrap.</p> <p>Review of the Wound Care Specialist Evaluation, dated 06/04/13, revealed the wound size of 0.7 x 0.4 x 0.2 cm with wound progress noted as not improved and a surgical procedure of excisional debridement of muscle was needed. There was a new treatment ordered of dry protective dressing, santyl, hydrofere blue (effective against numerous bacteria including MRSA), skin prep with overlying zinc oxide to surrounding skin. Secure with soft, non-constricting kerlex wrap.</p> <p>Review of the Wound Care Specialist Evaluation, dated 07/09/13, revealed the wound size of 0.4 x 0.3 x 0.2 cm with wound progress noted as stable. The note also noted the resident was to now be seen by an ankle and foot surgeon.</p> <p>Review of the Physician's Progress Note, written on 07/16/13 by the surgeon, revealed wound measured 0.4 x 0.3 x 0.3 cm. No new treatment ordered.</p> <p>Review of Resident #7's Nursing Note, written on 07/23/13 with no time given, written by the WCN revealed the left ankle wound measured 0.3 x 0.3 x 0.2. Resident has an appointment with the surgeon on 08/27/13.</p>	F 309		

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F 309	<p>Continued From page 10</p> <p>Review of Resident# 7's Nursing Note, written on 08/27/13 with no time given, written by the WCN revealed the left ankle wound measured 1.0 x 0.5 x 0.5 cm. A New order for Aquacel (Dressing to facilitate healing) was received and an appointment with the surgeon was made for 09/03/13.</p> <p>Review of Resident #7's Nursing Note, written on 09/03/13 with no time given, written by the WCN revealed Resident #7 left the facility for appontment with the surgeon and then was directly admitted to the hospital.</p> <p>Review of Resident #7's Hospital History and Physical Note, performed by the Primary Care Physician (PCP), on 09/03/13 at 8:32 PM, revealed Resident #7 was admitted to the hospital with admission diagnoses of Left Lower Extremity Cellulitis with possible osteomyellitis. Review of the Brief History portion of the History and Physical revealed "...the wound has opened up on his/her left foot and that is not appropriately taken care of".</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP), on 09/13/13 at 11:55 AM, revealed due to past experience and medical history of Resident #7, she stated a wound could change quickly and become worse. The ARNP stated she felt the standard practice was to monitor a wound and contact the medical staff if it worsened.</p> <p>Interview with Resident #7's Primary Care Physician (PCP), on 09/13/13 at 12:16 PM, revealed the facility had a protocol in regards to monitoring new wounds and he expected the facility to follow it. The PCP also stated he felt</p>	F 309			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185444	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/16/2013
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CAMBRIDGE DRIVE LEXINGTON, KY 40504		
(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	Continued From page 11 the facility should have been closely monitoring Resident #7 due to medical history of paralysis, soft muscle dystrophy, and PVD.	F 309			