

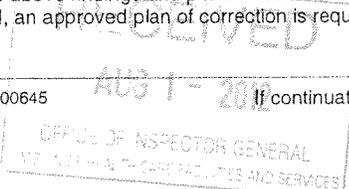
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                           |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185289 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>C<br>07/12/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HURSTBOURNE CARE CENTRE AT STONY BROOK |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2200 STONY BROOK DR<br>LOUISVILLE, KY 40220   |   |
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| F 000  | INITIAL COMMENTS   | F 000  | <p><b>This plan of correction constitutes a written allegation of compliance for deficiency cited on July 12, 2012. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by federal and state law.</b></p> <p><b>1):</b><br/>Resident #1 received a skin assessment from her attending physician on 7/23/12. No further orders were determined to be necessary at this time.</p> <p><b>2):</b><br/>Residents have had a head to toe skin assessment completed by a licensed nurse by 8/2/2012 to identify any further skin concerns. No further orders were determined to be necessary at this time.</p> |   |
| F 314<br>SS=D  | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>An abbreviated survey was initiated on 07/11/12 and concluded on 07/12/12 to investigate KY18618. The Division of Health Care substantiated the allegation with regulatory violations identified and deficiencies were cited.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview, record review and review of the facility's policy and procedures on pressure sores, it was determined the facility failed to provide preventive care to ensure one (1) of five (5) residents sampled did not develop a pressure sore. Resident #1.</p> <p>The findings include:<br/>Review of the facility's Pressure Sore policy and procedures, effective date of March 2012, under skin protections revealed residents at risk for skin breakdown should have a skin barrier applied after each episode of incontinence. Under the skin assessment portion, the nurse will complete a full body assessment prior to hospital transfer.</p> | F 314  |  |   |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 8/1/12

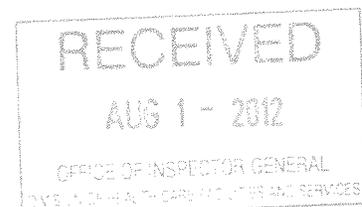
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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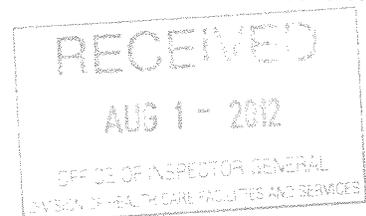
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| F 314   | <p>Continued From page 1</p> <p>The nursing staff will visually observe the resident's skin condition, the nurse will complete the skin assessment, and place a copy of the assessment in the clinical record. In addition, weekly skin integrity checks would be conducted on all residents.</p> <p>Review of the clinical record revealed the facility admitted Resident #1, on 03/22/12, with diagnoses of Dementia, Anxiety, Muscle Weakness, and Hypertension. The admission assessment, dated 03/28/12, revealed the resident had no pressure ulcers but was at risk for development related to incontinence. Periguard ointment was ordered by the physician to be applied to the buttocks three times a day and as needed. The facility assessed the resident to require assistance with transfers, ambulation, and toileting needs. The resident was assessed to have a cognition impairment with memory loss and decision-making deficit. Review of the dietary assessment conducted on 03/27/12 revealed the resident had experienced a significant weight loss of 12.6% in 30 days.</p> <p>Review of the pressure ulcer prevention care plan (dated 7/10/12) revealed the resident's skin was to be inspected daily during care and skin barrier cream applied after each episode of incontinence. The bladder incontinence care plan revealed the facility identified the resident to have functional incontinence and developed approaches to assist the resident with peri-care and remind the resident to go to the bathroom.</p> <p>Continued review of the clinical record revealed on 06/24/12 at 9:30 AM, the resident was transported by EMS to a local hospital for</p> | F 314   | <p><b>3):</b><br/>Licensed staff have be re-educated by 8/9/2012 by the Assistant Director of Nursing or Director of Nursing regarding the policy and procedure related to skin assessments.</p> <p>Licensed staff have been re-educated on the policy and procedure related to transferring a resident to the Hospital or related Facility by the Assistant Director of Nursing or the Director of Nursing by 8/9/2012.</p> <p>Weekly skin assessments will be signed off by the licensed staff and submitted to the unit Coordinators daily when the skin assessment is due to be completed.</p> <p><b>4):</b><br/>Skin assessment logs will be reviewed Monday through Friday by the Unit Coordinators or the Assistant Director of Nursing or the Director of Nursing. Licensed staff identified to have not completed the assessments correctly will be re-educated by the Unit Coordinator daily Monday through Friday.</p> |                      |   |



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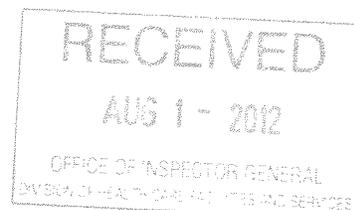
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| F 314  | <p>Continued From page 2</p> <p>respiratory problems. Review of the EMS transfer form revealed the resident was experiencing shortness of air. Review of the nurses notes, dated 06/24/12, revealed the resident received a breathing treatment prior to transfer but there was no documentation of a skin assessment. In addition, there was no documented evidence a skin assessment form (that the facility's policy stated would be completed prior to transfer) was completed.</p> <p>Review of the hospital's ED documentation revealed Resident #1 arrived at the ED and was triaged at 10:06 AM. A medical screen exam was conducted at 10:22 AM with findings of mild respiratory distress. At 11:30 AM, the resident was found to be incontinent of bowel. A partial bath and incontinent care was provided. The nurse documented the resident's skin was "Erythematous (very red), excoriated skin rash located in skin folds and on the genitalia (to buttock region and vagina)." Pictures of the excoriated area were taken. Review of the photos revealed a large area of excoriation on the resident's buttocks and peri-area.</p> <p>On 07/12/12 at 3:20 PM, interview with the ED nurse, who assessed the resident's skin at the hospital, revealed when she went to change the resident's incontinent brief she observed very red, excoriated skin that extended to both buttocks, per-area, and inner thighs. She stated she had to wipe the resident several times to get her clean and she did not see any barrier cream applied to the resident's skin. She reviewed the paperwork that the nursing facility had sent with the resident and did not see any skin treatment ordered. She stated she was concerned because the resident's</p> | F 314  | <p>A review of the discharge assessment will be completed by the Assistant Director of Nursing or the Director of Nursing. Licensed staff that did not complete the discharge skin assessment correctly will be re-educated by the Assistant Director of nursing or the Director of Nursing and/or the Unit Managers immediately upon identification of the incorrectly completed discharge skin assessment.</p> <p>Results of the skin assessment reviews will be discussed in the Quality Assurance meeting monthly.</p> | 8/10/2012            |   |



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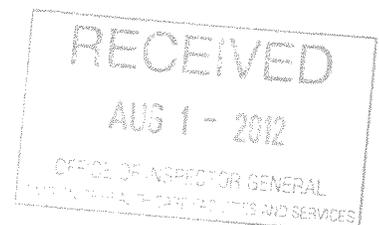
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| F 314  | <p>Continued From page 3</p> <p>skin was so excoriated and did not know how long the resident's skin had been in that condition. Review of the forms and paperwork the hospital received from the nursing facility revealed no evidence a skin assessment had been completed by the nursing facility staff prior to transferring the resident to the hospital.</p> <p>At the nursing facility, review of the June physician orders and treatment administration record (TAR) revealed Periguard cream was ordered to be applied to the resident's buttocks three times a day and as needed. Continued review of the June TAR revealed the staff initialed they had applied the cream each day including June 25-26, 2012. However, the resident was in the hospital those days.</p> <p>Interview with the 100 Unit Manager, on 07/11/12 at 2:35 PM, revealed it was the facility's practice to fill out the skin sheet with all transfer papers. She stated she had searched but could not find evidence of a skin assessment that was conducted prior to the resident's transfer according to the facility's policy. The Unit Manager stated the hospital reported to the nursing facility staff that the resident had on an incontinent brief.</p> <p>Interview, on 07/12/12 at 10:15 AM, with CNA #1, the nursing assistant that cared for Resident #1 the morning he/she was transferred to the hospital, revealed she had toileted the resident that morning before breakfast. She stated she was unaware when the resident left for the hospital and did not check for incontinence prior to transfer. However, review of the Bowel and Bladder detail report (computer print out)</p> | F 314  |   |                      |   |



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| F 314   | <p>Continued From page 4</p> <p>revealed the resident received incontinent care at 10:06 AM, thirty-six minutes after the resident was transferred to the hospital. The CNA stated she got busy and did not document the previous incontinent care (prior to breakfast) until after the resident was gone.</p> <p>Interview with LPN #2, on 07/12/12 at 10:35 AM, revealed she was the nurse who assessed Resident #1 and completed the transfer papers for the hospital. The nurse stated the resident was experiencing chest pain and weakness. The nurse called the physician and received orders to transfer to the Ed for evaluation. She stated she did a skin assessment but could not validate if she had completed the skin form. "I believe I did but can't validate." She stated she had removed the resident's brief and the resident's skin was not red. However, photos taken at the hospital revealed very excoriated red skin.</p> <p>Review of the weekly skin assessment for July 2012 revealed the scheduled skin assessment for July 3, 2012 was not initialed as completed. Review of the July TAR revealed the weekly skin assessment was scheduled for July 3rd; however, there were no initials to indicate the skin assessment had been completed as scheduled. In addition, there was no documentation in the nurses' notes to indicate the skin assessment was completed.</p> <p>Interview with the Director of Nursing, on 07/12/12 at 11:00 AM, revealed a search for the skin assessment form that was suppose to be completed prior to transfer was unsuccessful and she could not find documented evidence the weekly skin assessment scheduled for July 3,</p> | F 314   |   |   |



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| F 314   | Continued From page 5<br>2012 was completed. She stated LPN #2 was responsible for conducting the skin assessment. LPN #2 was re-interviewed and she stated she had conducted the weekly skin assessment but forgot to document in all three places.<br><br>Observation of a skin assessment for Resident #1, on 07/11/12 at 3:00 PM, revealed the excoriation to the resident's buttocks, peri-area, and inner thigh was healing and was only slightly red. Observation revealed the skin barrier cream had been applied to those areas. | F 314   |   |                      |   |

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