

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 282	<p>Continued From page 43 each resident's plan of care.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at</p>	F 282	<p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication</p>		

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F 282	<p>Continued From page 44</p> <p>11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Interviews on 12/12/12, at 3:15 PM with the MDS Coordinator, at 10:55 AM with the MDS Assistant On 10/23/12, the MDS staff (MDS Coordinator, MDS Assistant and LPN #12) reviewed all weekly nurses' summary including skin assessments to ensure the resident's plan of care were up to</p>	F 282	<p>Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>A form was created to use in monitoring of turning and repositioning of residents. This was developed by Mary Arms, DON on 12/7/12. See Attachment #36</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week to observe turning and repositioning to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/26/12. The results of the audits will be reported weekly in the QA meeting and quarterly through CQI by Emily Jones- Gray Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The facility will continue to use the original form that was used prior to</p>		

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F 282	Continued From page 45 date. The staff also reviews all residents' new orders daily (seven (7) days a week) and updates each resident's plan of care.	F 282	the survey to monitor safe transfer of residents. See Attachment #37.	
F 309 SS=J	Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings. 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 facility policy review, it was determined the facility failed to ensure residents received and facility staff provided the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care for two (2) of twenty-four (24) sampled residents (Residents #1 and #14). On 09/12/12, facility staff assessed Resident #1 and noted the resident had a scabbed wound to the left great toe. Facility staff notified the resident's physician of the wound and new orders were obtained that included to refer the resident to a Wound Care Clinic (WCC).	F 309	The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week for appropriate transfer. This will be completed for 6 months and then re-evaluated. This started on 11/28/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future. A form was created on 11/23/12 to use in evaluation of treatment procedures performed by licensed staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #33 Four (4) treatments per week will be observed by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA	

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F 309	<p>Continued From page 46</p> <p>Resident #1 was seen at the WCC on 09/13/12, 09/20/12, and staff was to schedule a follow-up appointment for Resident #1 to be seen in the WCC on 09/27/12; however, there was no documented evidence Licensed Practical Nurse (LPN) #1 arranged transportation for the resident's follow up appointment for the 09/27/12, appointment, and the resident was not assessed/treated at the WCC.</p> <p>Facility staff documented an assessment of the wound on Resident #1's left great toe on 09/28/12, (fifteen days after the last documented assessment of the wound on 09/13/12) and noted the wound was red with pink surrounding tissue measuring 1.4 centimeters (cm) x 0.2 cm x 0.1 cm.</p> <p>The Minimum Data Set (MDS) Assistant revealed in an interview that she had conducted an assessment of Resident #1 on 10/15/12, and the resident's toe was moist with black necrotic tissue, brown purulent drainage, a foul odor and redness to the first joint of the toe. According to the MDS assistant, she did not document the assessment but reported her concerns related to the resident's wound to LPN #1 to notify the physician. However, a review of documentation revealed LPN #1 failed to notify the physician of the change in Resident #1's wound on 10/15/12.</p> <p>Although facility staff documented treatments were administered to the wound on Resident #1's left foot from 09/28/12, to 10/16/12, facility staff failed to document an assessment of the wound until 10/17/12, nineteen (19) days after the previous assessment of the wound on 09/28/12. A review of the nurses notes dated 10/17/12,</p>	F 309	<p>Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of medication administration by licensed staff regarding following physician orders. This was developed by Mary Arns DON and Deborah Fitzpatrick Administrator. See Attachment #34</p> <p>Four (4) med pass observations will be completed weekly by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The results of all audits will be reported quarterly through CQ by Emily Jones-Gray Assistant Administrator or the person completing the audits. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of</p>		

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F 309	<p>Continued From page 47</p> <p>revealed the wound to the resident's left toe had an odor, was draining, and that facility staff notified the resident's physician and orders were received to culture the wound and refer the resident to the WCC. Facility staff also notified Resident #1's family member of the changes and new orders.</p> <p>On 10/18/12, Resident #1's family member insisted on observing the wound on the resident's left great toe. Documentation revealed the wound was assessed and LPN #1 documented the wound was red and inflamed, had a yellow sloughing and an odor, and was necrotic. Resident #1 was transported to an acute care facility on 10/18/12. Resident #1's toe was amputated on 10/20/12, due to a diagnosis of wet gangrene. (Refer to F157, F282 and F514.)</p> <p>In addition, facility staff failed to ensure physician's orders for wound treatments were followed for Resident #14, and failed to document an assessment of Resident #14's wound from 06/29/12 until 07/27/12 (a timeframe of twenty-eight days).</p> <p>The failure of the facility to ensure residents received and facility staff provided the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p>	F 309	<p>all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of completion 1/8/13</p> <p>F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>It is the policy of this facility that 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.</p> <p>1. The attending physician and the family of resident #1 was notified on 10/17/12 by LPN #3 of the change in condition related to the wound on the left great toe. See attachment #1</p> <p>The attending physician was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being sent transferred to KDMC to the physician that had previously performed surgery on resident #1 prior to her admission to this facility. See Attachment #2 Mary Arms, DON began reviewing the medical record of resident #1 on 10/18/12 and investigating the</p>		

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F 309	<p>Continued From page 48</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.25 Quality of Care, with a scope and severity of "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Skin Care" revised September 2001, revealed all wounds were to measured and recorded weekly.</p> <p>Review of the facility policy entitled "Wound Documentation" (undated) revealed pressure ulcers, diabetic ulcers and other wounds deemed necessary to measure should be measured weekly by licensed staff. The policy revealed documentation should include wound location, stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, and granulation, description of surrounding tissue, pain and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified.</p> <p>Review of the facility policy entitled "Transportation Policy" dated May 2008, revealed the facility would assist resident by making transportation arrangements for resident's scheduled appointments. The review revealed nursing staff was responsible to make</p>	F 309	<p>incident. She completed the review on 10/19/12 and continued to investigate.</p> <p>The attending physician of resident #1 was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3</p> <p>The medical record of resident #1 was reviewed on 10/20/12 by Mary Arms, DON to ensure that other appointments had not been missed.</p> <p>The MDS and care plan of resident #1 was reviewed on 10/19/12 by Roberta Thompson, RN MDS Coordinator.</p> <p>The son of resident #1 was notified on 10/20/12 by Mary Arms, DON of the missed appointment to the wound care clinic and that we had reported this to APS and OIG.</p> <p>Resident #1 has not returned to this facility.</p> <p>A medication error form was completed on 11/2/12 by Mary Arms, DON regarding failure to follow the physician order for resident #14. See Attachment #32</p>		

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F 309	<p>Continued From page 49</p> <p>transportation arrangements as soon as aware of the resident's appointment. The policy further stated staff would maintain a record of appointments, would obtain confirmation of transportation arrangements, and would check the appointment book daily to ensure appointments were kept.</p> <p>Interview on 11/01/12, at 3:45 PM with the Administrator revealed the facility did not have a policy related to facility staff following physician's orders. However, according to the Administrator, following physician orders was a "standard of practice" and nursing staff were to follow physician's orders in the provision of resident care.</p> <p>1. A review of Resident #1's closed medical record revealed the resident was admitted on 06/26/12, for rehabilitation due to a Right Below the Knee Amputation (BKA) with diagnoses of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Review of Resident #1's Significant Change MDS Comprehensive Assessment dated 09/07/12, revealed the resident was assessed to be at risk for development of pressure ulcers. Review of Resident #1's Comprehensive Care Plan dated 07/16/12, revealed the facility had addressed the resident's risk of alteration in skin integrity secondary to history of skin tears, assistance required for bed mobility, general weakness, right BKA, peripheral vascular disease, history of malnutrition diabetes, and VRE carrier. Some interventions on the care plan were for staff to check the resident's skin condition daily during care and report any changes to the nurse, and for staff to provided skin care as ordered by the</p>	F 309	<p>The MD was notified on 11/2/12 of the error by Mary Arms, DON.</p> <p>LPN #2 was in-serviced and verbally counseled on 11/2/12 by Mary Arms, DON at the time she signed the Medication/Treatment error.</p> <p>Licensed staff was in-serviced on reading the entire physician order prior to beginning treatment and on following the physician orders for resident #14 and all other residents receiving treatments by Mary Arms, DON. In-services started on 11/8/12 and were completed on 11/23/12.</p> <p>On 10/19/12 a full skin assessment was completed on Resident #14 by Jessica Arnett, RN and Heather Mowery, LPN to ensure that all wounds were identified and assessed.</p> <p>A copy of the skin assessment for resident #14 completed on 10/19/12 was given to the MDS department for review. The skin assessment was compared with the most recent MDS and care plan of resident #14. The MDS and care plan was revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p>		

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F 309	<p>Continued From page 50 physician.</p> <p>Continued review of Resident #1's medical record revealed nurse's noted dated 09/12/12, at 9:30 AM, by Licensed Practice Nurse (LPN) #1 that noted Resident #1 had a new scabbed area to the left great toe that measured less than 0.1 centimeter (cm) in diameter. LPN #1 notified the physician and obtained orders for treatment to the wound and a referral to the WCC.</p> <p>Review of Resident #1's Wound Care Clinic's (WCC) note dated 09/13/12, revealed the wound was assessed and determined to be a Diabetic Ulcer measuring 2.2 cm x 1.8 cm x 0.1 cm. The WCC sent orders back to the facility on 09/13/12, for multiple tests, antibiotics, treatment of Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound), 4 x 4 gauze and wrap with "Kiing" (a roll of gauze bandage) every forty-eight (48) hours, and a follow up appointment for 09/20/12. On 09/20/12, documentation by the WCC revealed the wound was a scabbed wound with a pale pink base, measuring 0.7 cm x 0.6 cm x 0.1 cm with no eschar, no yellow sloughing, no drainage and no odor. The WCC sent orders back to the facility on 09/20/12, for oral antibiotic and for a follow up appointment in one (1) week, on 09/27/12. However, there was no documented evidence LPN #1 made transportation arrangements for the resident's follow up appointment on 09/27/12, and the resident was not seen again at the WCC.</p> <p>Continued review of Resident #1's care plan revealed the care plan was revised on 09/20/12, with additional interventions to include the</p>	F 309	<p>On 10/20/12 the wound monitoring record for resident #14 was reviewed and compared to the skin assessment completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the skin assessment of resident #14 completed on 10/19/12 were compared to the treatment MAR to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>The physician of resident #14 was notified via fax of the wound, type and location by Christy Moore, RN on 10/22/12.</p> <p>The care plan and MDS of resident #14 was reviewed for accuracy by Crystal Cantrell, LPN MDS Staff. 11/23/12</p> <p>2. The charts of all residents having weekly outside appointments for medical treatment outside the facility were reviewed to ensure they had not missed appointments due to transportation not being scheduled. This was completed by Mary Arms, DON and Christy Moore, RN on</p>		

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F 309	<p>Continued From page 51</p> <p>following: 1) for staff to cleanse area to the left great toe with normal saline, dry and apply Aquacel AG then a 4 x 4 gauze and wrap with "Kling" every forty-eight (48) hours, and 2) for staff to observe for signs and symptoms of infection such as an increase in drainage, an elevated temperature, an rapid pulse, or a decreased blood pressure and to notify the physician of any of the signs.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #1's wound measurements on 09/13/12, as "2.2 cm x 1.8 cm x 0.1 cm," and on 09/28/12, as "1.4 cm x 0.2 x 0.1 cm"; however, there were no other measurements documented on the flow sheet. Review of the Wound Evaluation Flow Sheet revealed the sheet contained instructions on the top of the sheet stating the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. According to the instructions, the staff failed to conduct a wound assessment for weeks of 09/21/12, 10/05/12 and 10/12/12.</p> <p>A review of a Treatment Administration Record (TAR) for September and October 2012, revealed every forty-eight hours, staff was to cleanse Resident #1's left great toe with normal saline, cover with Aquacel AG and a 4 x 4 gauze, and then wrapped with Kling, the treatment was to be performed every forty-eight (48) hours. The TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12, 10/14/12 and on 10/18/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12 and on 10/16/12.</p>	F 309	<p>10/20/12. There were no other appointments missed for failure to make transportation arrangements.</p> <p>All current residents with scheduled appointments were reviewed to ensure that transportation arrangements had been made. This was completed by Ora Little, LPN and Jessica Wireman, RN on 10/21/12.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of all residents identified as having a pressure area for accuracy.</p> <p>On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified</p>	

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F 309	Continued From page 52 Further review of nurse's notes revealed on 10/17/12, at 2:50 PM LPN #3 documented the wound to Resident #1's left great toe had an odor and drainage. Documentation revealed Resident #1's physician was notified of the assessment and the physician requested facility staff to obtain a culture of the wound and to refer the resident to the WCC. The documentation further revealed the resident's family member was also notified of the change and the new orders. Review of Resident #1's nurse's notes dated 10/18/12, at 10:30 AM, Resident #1's family member insisted on observing the resident's wound. Documentation revealed LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing for the resident's left great toe and the wound was observed to be red and inflamed with a necrotic, yellow sloughing and an odor. Further review revealed the resident was transported to an acute care facility on 10/18/12, at 3:15 PM for further assessment and treatment. A review of a "History and Physical" report dated 10/18/12 revealed a physician at the acute care facility noted Resident #1 had Cellulitis of the toe associated with a Diabetic Ulcer that appeared to have central gangrene, and the physician recommended a consultation with a Vascular Surgical. Review of a Vascular Surgical Consultation Report dated 10/19/12, revealed Resident #1 had a quarter sized ulceration to the left great toe with purulent drainage. The report revealed a foul odor was noted when the dressing was removed and the entire great toe up to the base of the foot	F 309	were care planned appropriately. This was completed on 10/24/12. On 10/20/12 the wound monitoring records for each individual resident were reviewed and compared to the individual resident skin assessments completed on 10/19/12 to ensure that all wounds(both pressure and non-pressure) have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN. All areas identified on the individual resident skin assessments completed on 10/19/12 were compared to the individual resident treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12. Any new areas or areas in question (both pressure and non-pressure areas identified on the skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12. All physicians were notified via fax on 10/22/12 of their respective residents with the type of wound. This was completed by Christy Moore, RN. See attachment #4	

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F 309	<p>Continued From page 53</p> <p>was erythematous. Based on documentation in the report, the Vascular Surgeon recommended amputation of Resident #1's great toe.</p> <p>A review of a Surgical Report dated 10/20/12, revealed Resident #1's the left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview with the Minimum Data Set (MDS) Assistant on 10/25/12, at 1:00 PM revealed she had conducted a Discharge Assessment of Resident #1 on 10/15/12. According to the MDS Assistant, at that time, Resident #1's toe was assessed to be moist, with black necrotic tissue, brown purulent drainage, a foul odor and up to the first joint of the toe was red. According to the MDS assistant, the Discharge Assessment only addressed pressure ulcer and because the</p>	F 309	<p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on both pressure and non-pressure wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell, ADON, Chantry Purcell</p>	
	<p>resident's wound was not a pressure ulcer, she did not document the assessment; however, the MDS assistant stated she reported her concerns to LPN #1 and thought LPN #1 would notify Resident #1's physician of the assessment. However, a review of documentation revealed Resident #1's physician was not notified of the resident's wound on 10/15/12, and the care plan was not revised to reflect the change in the resident's wound.</p> <p>An interview on 10/24/12, at 4:30 PM with LPN #1 revealed wounds were assessed/measured every Friday and documented on the wound flow sheet. LPN #1 revealed Resident #1's left great toe had "a small black spot" when she last assessed the wound but could not remember the date. The LPN stated she did not know why there was no documentation of an assessment of the wound</p>			

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F 309	<p>Continued From page 54 .</p> <p>during the first two (2) weeks of October 2012. LPN #1 acknowledged on 10/18/12, Resident #1's family member insisted on observing the resident's wound and, at that time, the resident's entire toe was red with black necrotic tissue, with sloughing to the side. LPN #1 stated staff was to assess a resident's wound with each treatment and the physician was to be notified of any changes in the wound; (however, there was no documented evidence from 09/12/12 until 10/18/12). LPN #1 stated she did not recall being informed that the wound on the Resident #1's great toe had changed or had an odor. The LPN also could not recall why she did not make transportation arrangements for the follow up appointment to the WCC for 09/27/12.</p> <p>An interview on 10/24/12, at 12:50 PM with LPN #3 revealed wounds were to be assessed/measured every Friday during wound care and documented on the wound flow sheet. LPN #3 revealed the wound on Resident #1's great toe appeared as a dry callused wound when she performed wound care to the wound on 10/12/12. However, according to LPN #3 when she assessed the wound on 10/17/12, the wound had an odor and drainage, so the LPN notified the physician and orders were obtained. LPN #3 did not know why there were no wound assessments/measurements on the wound flow sheet for Resident #1 during first two (2) weeks in October 2012.</p> <p>An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician confirmed she had not been informed of the decline in the status of Resident #1's wound unit 10/17/12. According to the physician, she expected the nurses to</p>	F 309	<p>LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified.</p> <p>3. LPN #1 was terminated on 10/18/12 by Mary Arms, DON.</p> <p>LPN #3 was given a disciplinary warning and placed on probation on 10/20/12 by Mary Arms, DON.</p> <p>LPN #2 was in-serviced and verbally counseled on 11/2/12 by Mary Arms, DON at the time she signed the Medication/Treatment error.</p> <p>The facility process for making transportation arrangements for outside appointments was reviewed by Deborah Fitzpatrick, Administrator and Mary Arms, DON on 10/19/12.</p> <p>The facility transportation policy was reviewed and revised on 10/19/12 by Deborah Fitzpatrick Administrator and Mary Arms, DON on 10/19/12. The Medical Director is in agreement with the revision. See attachment #7</p>	

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F 309	<p>Continued From page 55</p> <p>follow physician's orders, to assess the resident's wounds while performing wound care, and to be notified of any changes in the wound. The interview revealed the physician was unaware Resident #1 missed the follow up appointment at the WCC until after the resident was transported to the hospital on 10/18/12.</p> <p>Interviews on 10/23/12, at 6:15 PM and on 11/01/12, at 2:35 PM with the Director of Nursing (DON) revealed when a wound was identified on a resident the nurse was required to notify the resident's physician, obtain orders for treatment, assess the wound to include measurements and document the assessment on the Wound Evaluation Flow Sheet. The DON stated all wound should be assessed/measured and documented at least once a week, by the nurse assigned to the resident while providing wound care every Friday unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed nurses received in-service training twice a year on assessments, measurements and documentation of wounds. The interview revealed the facility did not conduct any audits to ensure physicians were notified of a resident's change in condition; however, licensed nurses were to notify a resident's physician of any changes in the resident's condition. The DON stated she was unaware Resident #1 had missed the follow up appointment at the WCC, until investigating the resident's wound deterioration. According to the DON, staff was responsible to provide care in accordance with each resident's plan of care. The interview revealed the Quality</p>	F 309	<p>A transportation log was developed to track appointment and transportation arrangements. This was completed by Deborah Fitzpatrick, Administrator, Mary Arms, DON and Christy Moore, RN on 10/20/12. See attachment #8</p> <p>An instruction sheet was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>A list of transportation services, phone numbers, required forms and special requirements was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>The system used to keep the appointment information and transportation arrangements was reviewed and revised on 10/19/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. Two books had been used to make appointments. The books were combined into one book. Each nursing unit has an appointment/transportation book with the following items:</p> <ul style="list-style-type: none"> • Transportation Policy • Instructions for making appointments. 	

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F 309	<p>Continued From page 56</p> <p>Assurance (QA) nurses (the Assistant Director of Nursing (ADON) and RN #2) were responsible for conducting the QA of wounds on first and second floor. (Refer to F520.)</p> <p>Interviews on 10/23/12, at 6:15 PM and on 11/01/12, at 3:45 PM with the Administrator revealed when a wound was identified on a resident the nurse was required to notify the resident's physician, obtain orders for treatment, assess the wound to include measurements and document the assessment on the Wound Evaluation Flow Sheet. The Administrator revealed the facility monitored a sample of charts monthly to ensure notification was conducted for all change of condition; however, the monitoring had been discontinued due to meeting the goal. According to the Administrator, staff was responsible to provide care in accordance to the president's plan of care.</p> <p>2. Review of the medical record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included Previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension and Nonpsychotic Disorder.</p> <p>A review of Resident #14's care plan revealed facility staff revised the care plan on 05/04/12, with additional interventions to include the following: 1) to cleanse the area to the resident's left lateral ankle with normal saline, apply Santyl ointment (an active enzymatic therapy that removes necrotic tissue from wounds), a 4 x 4 gauze and wrap the wound with "Kling" (a roll of</p>	F 309	<ul style="list-style-type: none"> • Phone numbers for the transportation services and notification requirements of each service. • Transportation Log • Appointment Calendar • Transportation Forms <p>Licensed staff was in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick</p>	

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F 309	<p>Continued From page 57</p> <p>gauze bandage) every day; and 2) for staff to cleanse the resident's bilateral breast folds with soap and water, dry, and apply Nystatin (a prescription anti-fungal medication used to treat fungal infections) powder twice a day. The care plan also revealed nursing staff were to complete a skin assessment every week and report any alterations to the physician.</p> <p>A review of the monthly Physicians orders for October 2012, revealed staff were to cleanse the folds underneath Resident #14's breast with soap and water, pat dry, and apply Nystatin powder (an antifungal agent) to the breast folds every shift.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #14's wound measurements of the resident's left, lateral ankle on 05/18/12, as "1.5 cm x 1.5 cm x 0.0 cm," and on 06/01/12 (fourteen days after the last assessment) as "1.0 cm x 1.2 x 0.0 cm", then weekly for the next three weeks until 06/29/12. However, there were no other measurements documented on the flow sheet until 07/27/12 (twenty-eight days later). Review of the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. However, a review of the sheet revealed staff failed to conduct a wound assessment for weeks of 05/21/12, 07/02/12, 07/09/12 and 07/16/12.</p> <p>Observation on 10/29/12, at 7:35 PM revealed Licensed Practical Nurse (LPN) #2 applied Nystatin powder to Resident #14's breast folds; however, LPN #2 failed to cleanse the breast folds with soap and water and dry the area prior to applying the Nystatin powder.</p>	F 309	<p>Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p> <p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>The current wound documentation flow sheet was reviewed on 10/24/12 and revised so that the areas for documentation are larger, more organized with descriptive terms used to describe wounds. This was completed by Mary Arms, DON and Deborah Fitzpatrick, Administrator. See Attachment #13</p> <p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah</p>		

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F 309	Continued From page 58 Interview on 10/29/12, at 7:45 PM with LPN #2 revealed she failed to read the entire physician's order prior to the treatment for Resident #14. LPN #2 stated she was "nervous" during the observation, had rushed to complete the treatment, and failed to ensure the treatment was performed in accordance with the physician's orders. Interview on 11/01/12, at 2:30 PM with the Director of Nursing (DON) revealed staff should review physician's orders prior to treatments to ensure treatments were performed in accordance with physician's orders. The DON stated the facility did not monitor to ensure physician's orders were followed. Interview on 11/01/12, at 3:45 PM with the	F 309	Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1) The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2) All documentation guidelines, policies related to wound prevention, assessment and identification, MD and family notification and treatment procedure and wound monitoring should be used for both pressure and non-pressure wounds.	
	Administrator revealed nurses were to follow physician's orders and this was a nursing "standard of practice." The Administrator stated the facility monitored to ensure physician's orders were entered into the computer system correctly; however, there was no monitoring conducted to ensure physician's orders were followed. **An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An extended survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged. --A review of the AOC revealed the following: On 10/18/12, Licensed Practical Nurse (LPN) #1		Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk	

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F 309	<p>Continued From page 59</p> <p>was terminated by the Director of Nursing (DON) due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>On 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported to the acute care facility the resident had previously been treated prior to admission to this facility.</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, the Minimum Data Set (MDS) Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all residents for accuracy.</p> <p>On 10/19/12, Registered Nurses (RN) #4, #6 and LPNs #2, #4, and #13 conducted skin/wound assessments on all residents.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>On 10/19/12, the Administrator and the DON</p>	F 309	<p>medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p>		

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F 309	<p>Continued From page 60</p> <p>reviewed and revised the facility's transportation policy and procedure. The Medical Director was in agreement with the revision of the policy. The revisions included combining the appointment book and transportation book into one (1) book. The book is kept at each nurses' station and contains the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, and 6) Transportation Forms.</p> <p>On 10/20/12, the Administrator, the DON and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff reference.</p> <p>On 10/20/12, the DON reviewed Resident #1's chart to identify if any other appointments had been missed. The DON and RN #2 reviewed all residents' charts with weekly outside medical appointments to ensure arrangements had been made for transportation to each appointment with no problems identified.</p> <p>On 10/20/12, LPN #3 was reprimanded and placed on probation by the DON due to the failure to assess/document Resident #1's wound.</p> <p>On 10/20/12, RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment</p>	F 309	<p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQL.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment</p>		

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F 309	<p>Continued From page 61</p> <p>Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>On 10/21/12, the DON notified Resident #1's physician by fax regarding the missed appointment to the wound care clinic.</p> <p>On 10/21/12, RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. LPN #12 also compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>On 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets (utilized for in-service) were placed in the nursing policy/procedure manuals and in the wound care monitoring books kept at each nursing station for staff reference.</p> <p>On 10/21/12, the Administrator and the DON reviewed the facility's Pressure Ulcer policy and the Wound Documentation policy and no revisions required. The Medical Director was also in agreement.</p>	F 309	<p>of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. She will work full time.</p> <p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or</p>		

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F 309	<p>Continued From page 62</p> <p>On 10/21/12, LPNs #10 and #14, reviewed all residents' charts with outside medical appointments to ensure transportation arrangements had been made.</p> <p>On 10/22/12, RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p> <p>On 10/24/12, the Administrator and the DON reviewed and revised the Wound Documentation Flow Sheet which was larger, more organized, with descriptive terms used to describe wounds.</p> <p>On 10/24/12, the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>On 10/24/12, a new wound care nurse started employment and will be assessing and providing treatments to all wounds five (5) days a week. RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The wound care nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description and current treatment.</p> <p>As part of the facility's CQI for monitoring skin</p>	F 309	<p>other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment #19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then</p>		

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F 309	<p>Continued From page 63</p> <p>assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>As part of the facility's CQI for monitoring the transportation arrangement, the Assistant Administrator or the Activity Director will review the transportation logs on each unit to ensure all transportation arrangements have been made and any problems identified will be reported to the nursing administration immediately for correction.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>The Administrator formed a QA subcommittee which consists of each department head/manager that will meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p>	F 309	<p>perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per</p>	
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F 309	<p>Continued From page 64</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #1's Employee Disciplinary Report dated 10/18/12, revealed the LPN was terminated due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of Resident #1 concerning the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of a faxed letter revealed on 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported back to the acute care facility the resident had previously been treated, prior to admission to this facility.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p>	F 309	<p>week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective</p>	

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F 309	<p>Continued From page 65</p> <p>Interviews on 12/12/12 at 2:15 PM with LPN #4; on 12/13/12 at 11:00 AM with RN #4; at 11:10 AM with LPN #2; at 1:15 PM with RN #6; at 1:20 PM with LPN #13; and review of notes revealed on 10/19/12, the above licensed staff conducted skin/wound assessments on all residents.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of in-service records dated 10/19/12 through 10/21/12 revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12 at 11:00 AM with RN #2; at 2:15 PM with LPN #4; at 5:00 PM with LPN #12; on 12/13/12 at 2:00 PM with LPN #9; at 11:00 AM with RN #4; at 11:10 AM with LPN #2; at 1:15 PM with RN #6; and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's transportation</p>	F 309	<p>action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS</p>		

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F 309	<p>Continued From page 66</p> <p>policy/procedure revealed the policy was revised on 10/19/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director and review of the facility's transportation policy/procedure revealed the Medical Director was in agreement with the revision of the policy.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed an Appointment/Transportation book kept at each nursing station. The book contained the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, 6) Transportation Forms and 7) Instructional sheet.</p> <p>Interviews on 12/12/12 at 11:00 AM with RN #2; at 2:15 PM with LPN #4; at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2; at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 revealed the licensed staff were knowledgeable of the contents and use of the Appointment/Transportation book.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/12/12, at 11:00 AM with RN #2, on 12/13/12, at 2:55 PM with the Administrator, and review of the facility's transportation policy/procedure revealed on 10/20/12, the Administrator, the DON and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for</p>	F 309	<p>Coordinator. This will be ongoing. See attachment #23</p> <p>All results will be reported quarterly through CQI by the QA Coordinator, Emily Jones-Gray or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>It is the policy of this facility 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. This is evidenced by the following:</p> <ol style="list-style-type: none"> The MDS and care plan of residents #2, #3, #5, #6, #7, #8 and #9 was reviewed for accuracy by Roberta 		

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F 309	<p>Continued From page 67</p> <p>making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/12/12, at 11:00 AM with RN #2, and on review of notes dated 10/20/12, revealed the DON reviewed Resident #1's chart to identify if any other appointments had been missed. The interviews and record review further revealed the DON and RN #2 reviewed all residents' charts with weekly outside medical appointments to ensure arrangements had been made for transportation to each appointment with no problems identified.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #3's Employee Disciplinary Report dated 10/20/12, revealed LPN #3 was reprimanded and placed on probation due to the failure to assess/document Resident #1's wound.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, and review of notes dated 10/20/12, revealed RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON and review of a letter with a faxed confirmation dated 10/21/12, revealed the DON notified Resident #1's physician regarding the missed</p>	F 309	<p>Thompson, MDS Coordinator on 10/19/12.</p> <p>On 10/19/12 residents #2, #3, #5, #6, #7, #8 and #9 had skin assessments completed by staff nurses working on 10/19/12. Their names are Jeri Frazier, LPN, Jessica Arnett, RN, Heather Mowery, LPN, Donna McDowell, LPN, Yvette Short, RN and Christy Allen, LPN.</p> <p>On 10/20/12 the individual resident wound monitoring flow sheets for residents, #2, #3, #5, #6, #7, #8 and #9 were reviewed and compared to their respective skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>The physicians for resident #2, #3, #5, #6, #7, #8 and #9 were notified on 10/22/12 (via fax) of their respective resident's wounds. This was completed by Christy Moore, RN. See attachment #4</p> <p>Medication error sheet was completed on 10/25/12 for resident #6 regarding treatment not being completed per physician order by Christy Moore, RN.</p>	

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F 309	<p>Continued From page 68 appointment to the wound care clinic.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets where in page protectors in the front of each nursing policy/procedure manuals and in the wound care monitoring books for staff reference.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN</p>	F 309	<p>The MD of resident #6 was notified of the omitted treatment on 10/25/12 by Christy Moore, RN.</p> <p>Medication/Treatment error sheets for residents #3 and #7 were completed due to omitted treatments. This was completed on 11/23/12 by Mary Arms, DON.</p> <p>The MD was notified of the omitted treatments for their respective residents on 11/23/12 by Mary Arms, DON.</p> <p>On 10/28/12 and 10/29/12 the physicians for residents #2, #3, #5, #6, #7, #8 and #9 were notified of their respective residents wounds and the current treatments for the wounds using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>The DON attempted to interview resident #7 on 11/24/12 but was unable to due to resident confusion. Interviews with staff by the DON revealed that resident is unable to lie on left side due to complaints of smothering. The comprehensive care plan and the CNA care plan and assignment sheet for resident #7 was reviewed on 11/24/12 by Mary Arms, DON and updated to reflect this.</p>	

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F 309	<p>Continued From page 69</p> <p>#13 revealed the licensed staff were knowledgeable of the contents and use of the Wound Care book.</p> <p>Interview on 12/12/12, at 11:00 AM with RN #2 and review of the nursing policy/procedure manuals and wound care books kept at each nurses' station revealed on 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets were placed manuals and books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's policies revealed the Pressure Ulcer policy and the Wound Documentation policy were reviewed 10/21/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director was in agreement with not revising the policies.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 1:30 PM with the Medical Director and review of an e-mail revealed on 10/21/12, the DON notified the Medical Director of the issues identified related to the investigation of Resident #1's wound and missed appointment with the WCC. The Medical Director was also notified and in agreement with the facility's corrective measures taken.</p> <p>Interviews on 12/12/12, at 6:00 PM with LPN #10, LPN#14, and review of the LPNs notes dated 10/21/12, revealed the LPNs reviewed all residents' charts with outside medical appointments to ensure transportation arrangements had been made.</p>	F 309	<p>Resident #7 expired on 12/3/12.</p> <p>2. On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p> <p>On 10/20/12 the wound monitoring records were reviewed and compared to the skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the skin assessments completed on 10/19/12 were compared to the treatment MARs to ensure that treatments were ordered if necessary to all identified</p>	

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F 309	<p>Continued From page 70</p> <p>Interviews on 12/12/12 at 11:00 AM with RN #2, on 12/13/12 at 1:30 PM with the Medical Director and review notification letters dated 10/22/12, revealed RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the old and new Wound Documentation Flow Sheet revealed the sheet was larger, organized, with descriptive terms used to describe wounds.</p> <p>Interview on 12/13/12, at 3:10 PM with the Assistant Administrator and review of notes dated 10/24/12, revealed the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The interview also revealed the Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed an instructional sheet to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p>	F 309	<p>areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians were notified via fax on 10/22/12 of their respective residents with the type of wound. This was completed by Christy Moore, RN. See attachment #4.</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley</p>		

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F 309	<p>Continued From page 71</p> <p>Interview on 12/12/12, at 2:45 PM with the newly hired wound care nurse revealed she started employment on 10/24/12, and will be assessing and providing treatments to all wounds five (5) days a week. Interview on 12/12/12 at 11:00 AM with RN #2 revealed RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The interviews revealed the wound care nurse or RN #2 will fax each resident's physician a bi-weekly notification of the resident's wound type, location, description and current treatment. Review of the newly hired wound care nurses' employee file revealed she started employment at the facility on 10/24/12. Further review of physician notifications letters revealed faxes were being sent bi-weekly to the residents' physician notifying the physicians of the residents' wound type, location, description and current treatment.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 10/25/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>Interviews on 12/13/12, at 3:10 PM with the</p>	F 309	<p>Maggard, LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>A copy of the skin assessments completed on 11/16/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their individual MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned. This was completed on 11/24/12.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell, ADON, Chantry Purcell, LPN, Christy Moore RN and Brenda Humphries, RN.</p> <p>On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments</p>		

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F 309	<p>Continued From page 72</p> <p>Assistant Administrator, on 12/12/12, at 4:25 PM and on 12/13/12, at 1:40 PM with the Activity Director and review of audit book kept by the Activity Director notes revealed as part of the facility's CQI for monitoring the transportation arrangement, the Activity Director had been reviewing the transportation logs on each unit to ensure all transportation arrangements have been made and no problems have been identified; however, if a problem is identified, it will be reported to the nursing administration immediately for correction.</p> <p>Interview on 12/12/12 at 4:40 PM with the DON, at 11:00 AM with RN #2, and a review of personal hand written notes revealed the DON and RN #2 will review all weekly nurse summaries of each resident, including skin assessments, and assess each resident to ensure the skin assessments match and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>Interviews on 12/12/12 at 4:40 PM with the DON; on 12/13/12 at 2:55 PM with the Administrator; at 3:10 PM with the Assistant Administrator; at 1:40 PM with the Activity Director, and review of the QA subcommittee meeting minutes for the 10/23/12, meeting revealed the Administrator formed a QA subcommittee which consists of each department head/manager that meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p> <p>Interviews on 12/13/12 at 2:55 PM with the</p>	F 309	<p>provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified.</p> <p>On 12/7/12 an audit was completed facility wide to observe turning and repositioning of residents using the facility turn and reposition schedule. If residents were observed not to be in the scheduled position staff was questioned as to the reason why. This was completed by Kathy Meadows and Misty Pennington, Social Services, Marie Pennington, Activity Director, Brenda Humphries RN, QA nurse, Kitty Harmon, Housekeeping Supervisor, Crystal Cantrell LPN, MDS staff.</p> <p>3. Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>LPN #6 and LPN#7 were terminated on 11/7/12 for failure to follow MD orders and falsification of records by Mary Arms, DON.</p> <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the</p>	

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F 309	Continued From page 73 Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.	F 309	transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10	
F 314 SS=H	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of facility policies/procedures, it was determined there were fifteen (15) residents in the facility with pressure sores and nine (9) of the fifteen residents were selected for review. A review of the nine (9) residents with pressure sores revealed the facility failed to ensure necessary treatment/services to promote healing or prevent the development of new pressure sores was provided for seven (7) of the residents (Resident #2, #3, #5, #6, #7, #8 and #9). The facility failed to perform weekly wound assessments as per facility policy for Residents #2, #3, #5, #8 and #9. In addition, the facility failed to follow physician orders related to wound care for Resident #3, #6 and #7 and also failed to turn/reposition Resident #7 in accordance with the resident's care plan. (Refer to F282 and	F 314	Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service. The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10 The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11 The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12 A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the new wound monitoring form. See Attachment #13	

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F 314	<p>Continued From page 74 F514.)</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Skin Care" revised September 2001, revealed wounds were required to be measured and recorded weekly.</p> <p>Review of the facility policy entitled "Wound Documentation" (undated) revealed pressure ulcers, diabetic ulcers and other wounds deemed necessary to measure should be measured weekly by licensed staff. The policy revealed documentation should include wound location, stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, granulation, description of surrounding tissue, pain, and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12 with multiple Pressure Ulcers and diagnoses of Contractures of Tendons in Lower Extremities, Dementia, and Anorexia.</p> <p>Review of Resident #3's Wound Evaluation Flow Sheet revealed on 10/04/12, the resident had an area to a bunion on the left foot that measured 0.6 centimeters (cm) x 0.4 cm x unable to determine (UTD); an area to the left outer ankle with measurements of 0.4 cm x 0.4 cm x UTD; an area to the left heel that measured 1.7 cm x 2.3 cm x UTD; a Stage II to the coccyx with measurements of 3 cm x 3 cm x 0.2 cm; and an</p>	F 314	<p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. (See Attachment #14 (1))</p> <p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p>	

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F 314	<p>Continued From page 75 area to the right heel with no measurements.</p> <p>A review of the monthly Physician's orders for October 2012, revealed an order for staff to treat Resident #3's right heel, left heel, bunion to the left foot, and the left outer ankle with Granutex Spray, apply 4 x 4 gauze, then wrap with "Kling" (gauze bandage) every day. The orders revealed staff was to cleanse the coccyx with normal saline, apply Aquacel AG Extra Hydrofiber dressing cover with Transparent dressing every three (3) days.</p> <p>Review of Resident #3's admission Minimum Data Set (MDS) Assessment dated 10/10/12 revealed the resident was at risk for pressure ulcers and was admitted with several pressure ulcers at various stages.</p> <p>Review of Resident #3's plan of care dated 10/24/12, revealed the facility addressed the resident's risk for impaired skin integrity related to stage II pressure ulcer to the coccyx, unstageable ulcers to bilateral heels, and stage II pressure areas to the resident's lower ankle. A review of interventions revealed nursing staff was 1) to complete a skin assessment every week and report any alterations to the physician and 2) to provide treatments as ordered by the physician.</p> <p>Further review of Resident #3's Wound Evaluation Flow Sheet revealed no other assessments of the wounds had been conducted until 10/20/12 (a timeframe of sixteen days after the last assessment). The flow sheet revealed on 10/20/12, the bunion to the resident's left foot measured slightly larger at 0.6 cm x 0.5 cm x UTD; the area to the left outer ankle measured</p>	F 314	<p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQL.</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure</p>	

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F 314	<p>Continued From page 76</p> <p>slightly larger at 0.4 cm x 0.5 cm x UTD; the area to the left heel measured the same; the Stage II to the coccyx measured larger at 7 cm x 3.5 cm x UTD; and the area to the right heel measured 3.4 cm x 4.1 cm x UTD and the area to the resident's left third toe measuring 0.6 cm x 0.8 cm x UTD. There was no documented evidence the resident's physician was notified for the increase in size of the resident's wounds to the left foot, left outer ankle, and coccyx.</p> <p>Review of Resident #3's Treatment Administration Record (TAR) for October 2012, revealed Licensed Practical Nurse (LPN) #7 documented the treatment had been provided to the resident's feet on 10/27/12 and 10/28/12. In addition, documentation revealed LPN #6 provided the treatment on 10/29/12.</p> <p>Observation on 10/30/12, at 3:00 PM of Resident #3's wound care performed by LPN #3 revealed the area to the resident's coccyx had red tissue surrounding the open wound which, based on measurements obtained by the LPN, measured 8.3 cm x 6.2 cm, and the open wound measured 5.4 cm x 4.7 cm x 0.5 cm. The coccyx wound was pink with yellow/white sloughing noted. The observation revealed the "Kling" dressings to both heels had a date of 10/26/12, written in black marker on both dressings. LPN #3 acknowledged the initials on the dressings were hers and stated although she had not worked for the last three (3) days, the wound care to the resident's feet was ordered to be completed every day. The resident's right inner ankle was slightly red with no open wounds, the right heel was boggy and dark measuring 2.2 cm x 3.4 cm, and the left outer ankle was yellow, with a slight</p>	F 314	<p>required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/24/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p>		

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F 314	<p>Continued From page 77</p> <p>amount of yellow drainage noted on the old dressing, and measured 1.2 cm x 1 cm x 0.1 cm. The left heel had a dark area that measured 1.5 cm x 1.2 cm. The bunion to the outer side of the resident's left foot was dark and measured 0.4 cm x 0.4 cm and the third toe on the left foot had black edge on a dark area that measured 0.4 cm x 0.8 cm.</p> <p>Interview on 10/30/12, at 6:17 PM with LPN #7 revealed she had signed that the treatments to Resident #3's heels on 10/27/12 and 10/28/12 had been provided; however, the LPN acknowledged she had not completed the treatments. LPN #7 stated she ran out of time, but had reported the treatments had not been provided to the night nurse (LPN #8) who was supposed to provide the treatments.</p> <p>During an interview on 10/30/12, at 6:40 PM with LPN #8, the LPN stated she had not provided treatments to Resident #3's heels on 10/27/12 and 10/28/12. LPN #8 also stated she had not been notified that Resident #3's treatments needed to be provided.</p> <p>Interview on 10/30/12, at 5:20 PM with LPN #6 confirmed the LPN signed off the treatment to Resident #3's heels on 10/29/12, but did not complete the treatment. LPN #6 stated she provided wound care to the resident's coccyx, but was called out of the room before providing wound care to the resident's heels. The interview revealed the LPN "forgot" to go back and provide the wound care to the resident's heels.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on</p>	F 314	<p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>The Medical Director reviewed all the initial physician notification.</p>	

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F 314	<p>Continued From page 78</p> <p>10/31/11, with diagnoses of left buttock ulcer, sacral ulcer, Anemia, Peripheral Vascular Disease and Diabetes. Resident #2's medical record revealed the resident was readmitted from an acute care facility on 08/06/12 with a pressure ulcer to the left buttock and blisters to both heels. The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 (one day after re-admission) and the wound to the left buttock measured 3 cm x 3.5 cm x 4 cm; the left heel wound measured 5 cm x 5 cm; and the right heel wound measured 5 cm x 5 cm.</p> <p>Review of Resident #2's Significant Change MDS Assessment dated 08/10/12, revealed a decline in the resident's cognition, Activities of Daily Living (ADL) status, continence, and new development of pressure ulcers following a hospitalization.</p> <p>Review of Resident #2's plan of care dated 11/20/11, revealed the facility addressed the resident's risk for alteration in skin integrity and at risk for development of pressure ulcers was revised on 08/06/12, when the resident was readmitted with unstageable pressure ulcers to both heels and a Stage IV to the left buttocks, with interventions to provide treatments as ordered by the physician.</p> <p>Continuous review of Resident #2's Wound Evaluation Flow Sheet dated 08/19/12, revealed documentation that the left heel wound measured 6.1 cm x 8.6 cm x UTD; there were no documented measurements of the wound to the resident's right heel and the wound on the resident's left buttocks measured 3 cm x 3.4 cm x 5 cm. There was no documented evidence the</p>	F 314	<p>regarding wounds that was sent on 10/22/12. See attachment #4</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department.</p> <p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray,</p>	

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F 314	<p>Continued From page 79</p> <p>physician was notified of the increase in size of the left heel wound.</p> <p>The Wound Evaluation Flow Sheet revealed the next documented assessment of the Resident #2's wound to the left buttock was on 09/07/12 (4 weeks after the previous assessment on 08/07/12) and the wound measured 3 cm x 3 cm x UTD. There was no documentation of an assessment and/or measurement of the wounds on Resident #2's heels.</p> <p>Further review of the Wound Evaluation Flow Sheets revealed on 09/14/12 (5 weeks after the previous assessment on 08/19/12) the wound to the resident's left heel measured 2 cm x 2 cm and the right heel wound measured 2.5 cm x 1 cm. Review of the Wound Evaluation Flow Sheet revealed the next measurement of the resident's left heel was on 10/21/12 (four weeks after the previous assessment) and revealed the wound measured 3 cm x 1.8 cm.</p> <p>Observation on 10/23/12, at 3:40 PM, of Resident #2's wound care with LPN #2 revealed a dark, dry, scabbed area with redness of the wound on the left heel and a small amount of swelling around the wound. The wound measured 3 cm x 1.5 cm with no drainage or odor. The observation revealed the right heel had no wound and the resident's buttocks had a wound vacuum with an occlusive dressing.</p> <p>Interview on 10/23/12, at 7:30 PM, with Registered Nurse (RN) #2, revealed she was unsure why nurses had failed to document weekly wounds assessments for Resident #2.</p>	F 314	<p>Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment 19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for</p>	

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F 314	<p>Continued From page 80</p> <p>3. A review of Resident #5's medical record revealed the facility admitted the resident on 01/14/12, with diagnosis of Cerebral Vascular Accident, Congestive Heart Failure, Depression, and Failure to Thrive.</p> <p>Continued review of Resident #5's medical record revealed nurse's notes dated 08/27/12, that the resident's physician was notified the resident had a Stage II pressure ulcer to the coccyx. Treatment orders were obtained to cleanse the resident's coccyx area with normal saline, pat the area dry, apply Bactroban ointment (an antibacterial used to treat skin infections), and to cover the area with a "Telfa" pad (non-adherent absorbent cotton dressing) and Hypafix (self-adhesive, non-woven fabric for dressing retention) every day. However, there was no documentation of the appearance or size of the pressure wound.</p> <p>Review of Resident #5's plan of care revealed a revision date of 09/05/12, with additional interventions for staff to cleanse area to the coccyx with normal saline, pat dry and apply Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) and a 4 x 4 gauze and cover with Hypafix every seventy-two (72) hours.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff failed to document the status of Resident #5's pressure ulcer until 09/14/12, (eighteen days after first identified), and at that time, the ulcer measured 1.4 cm x 1.0 cm x 0.2 cm. Review of the Wound Evaluation Flow Sheet revealed the form was to be completed by a nurse upon identification of a wound and at</p>	F 314	<p>completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are</p>	

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F 314	<p>Continued From page 81</p> <p>least weekly from the date of identification. However, a review of the Wound Evaluation Flow Sheet revealed staff failed to conduct an assessment of Resident #5's wound during the weeks of 08/26/12, and 09/02/12.</p> <p>A review of instructions on a Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse Resident #5's coccyx pressure ulcer with normal saline, pat dry, cover with Aquacel AG and a 4 x 4 gauze, and then secure with Hypafix Kling. The treatment was to be performed every seventy-two (72) hours. The TAR revealed wound care was performed as ordered by the physician.</p> <p>4. A review of Resident #6's medical record revealed the facility admitted the resident on 08/17/12. A review of Resident #6's Wound Evaluation Flow Sheet revealed on 10/21/12, the facility identified a new Stage II pressure sore to the right buttock area on Resident #6. The facility assessed the wound to measure 1.0 cm x 1.5 cm x 0.1 cm. The facility further assessed the wound to be red with no drainage and a small amount of brown crust.</p> <p>A review of physician's orders dated 10/21/12, revealed an order to clean the Stage II on Resident #6's right buttock with normal saline, pat the area dry, apply "Bactroban" (a topical treatment for bacterial skin infections) and "Telfa" (a cotton, non-adherent dressing), and secure with "Hypafix" (a self-adhesive non-woven fabric for dressing retention) daily for fourteen (14) days.</p> <p>Observation of a skin assessment of Resident #6</p>	F 314	<p>accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arins, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported</p>	

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F 314	<p>Continued From page 82</p> <p>on 10/25/12, at 4:08 PM revealed a dressing in place on the right buttock. Observation revealed a Stage II wound was approximately three (3) inches from the dressing. Interview with LPN #5 during the skin assessment at 4:08 PM on 10/25/12, revealed Resident #6 had previously received wound care on 10/25/12, by Certified Medication Aide (CMA) #1, so the dressing was not removed for this observation. LPN #5 stated she was not aware Resident #6 had developed a second Stage II wound and stated the wound did not "look new."</p> <p>Interview on 10/25/12, at 4:40 PM with Certified Medication Assistant (CMA) #1 revealed the CMA had performed wound care on Resident #6 at approximately 10:00 AM on the morning of 10/25/12. The CMA stated during wound care to Resident #6 the resident only had one wound on the right buttock and that wound was treated as per physician order. The CMA further stated she had not identified another wound on Resident #6's buttocks during wound care.</p> <p>Review of facility's "Job Description" for "Certified Medication Technician" undated revealed CMTs can observe, monitor, and report symptoms of potential skin breakdown and/or decubitus ulcers to the Charge Nurse and provide treatment as directed.</p> <p>A review of a physician note dated 10/26/12, revealed Resident #6 had a Stage II pressure sore to the right buttock and a tape abrasion to the right buttock in the same vicinity. The note further revealed a nursing aide had inadequately covered the abrasion with the treatment that was ordered for the Stage II pressure sore, and as a</p>	F 314	<p>quarterly through CQI by Emily Gray Assistant Administrator or Marie Pennington, Activity Director. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week to observe turning and repositioning to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/26/12. The results of the audits will be reported weekly in the QA meeting and quarterly through CQI by Emily Jones- Gray Assistant Administrator, QA Coordinator or the QA nurse.</p>	

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F 314	<p>Continued From page 83</p> <p>result, facility staff failed to provide the treatment as ordered by the physician to the Stage II pressure sore on the resident's right buttock.</p> <p>5. Review of Resident #7's medical record revealed the facility admitted the resident on 08/23/12. A review of Resident #7's Minimum Data Set (MDS) Assessment completed after admission, dated 08/30/12, revealed the facility assessed Resident #7 to be cognitively intact. Further review revealed the facility assessed Resident #7 to require extensive assistance from two (2) staff with bed mobility.</p> <p>A review of Resident #7's comprehensive plan of care dated 09/12/12 revealed the resident was at risk for alteration in skin integrity due to the resident's dependency on two (2) staff to provide the resident "weight-bearing" assistance, position changes, and bed mobility every two (2) hours and as needed.</p> <p>A review of the October 2012, Certified Nursing Assistant (CNA) care plan revealed staff was required to reposition Resident #7 every two (2) hours.</p> <p>Observations were conducted of Resident #7 on 10/30/12, at 8:57 AM, 9:38 AM, 11:18 AM, 12:27 PM, 3:20 PM, 4:50 PM and 6:30 PM. During each observation Resident #7 was positioned in bed on his/her right side.</p> <p>Interview with Resident #7 on 10/25/12, at 11:55 AM revealed staff did not assist the resident with turning and repositioning every two (2) hours. Resident #7 stated, "They [staff] don't offer" to assist the resident with turns and reposition.</p>	F 314	<p>This audit may be delegated to other staff in the future.</p> <p>Room checks are completed 3 times a week by Kathy Meadows and Misty Pennington, Social Services, Marie Pennington, Activity Director, Brenda Humphries RN, QA nurse, Kitty Harmon, Housekeeping Supervisor, MDS staff and Chanity Purcell, Staff Development. As of 12/7/12 turning and repositioning is being audited as room checks are completed. This will be ongoing. The results will be reported quarterly through CQI by Kathy Meadows, Social Services or Emily Jones-Gray, QA Coordinator.</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week for appropriate transfer to ensure that the resident care plan and physician orders are being followed. This will be completed for 6 months and then r-evaluated. This started on 11/28/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of treatment procedures performed by licensed</p>	

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

PRINTED: 12/28/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1625 EUCLID AVENUE PAINTSVILLE, KY 41240	
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F 314	<p>Continued From page 84</p> <p>Resident #7 further stated staff encouraged the resident to stay off his/her right side, but stated, "Sometimes I forget." A second interview with Resident #7 on 10/30/12, at 7:50 PM revealed, it "would be nice if staff helped [her/him] turn."</p> <p>Interview with CNA #5 on 10/30/12, at 12:42 PM, and CNA #13 at 12:00 PM revealed they were not aware Resident #7 required assistance with turning and repositioning every two (2) hours. Both CNA #5 and CNA #13 stated Resident #7 turned her/himself in bed and were not aware Resident #7's care plan stated the resident required assistance with turning and repositioning every two (2) hours. However, the CNA care plan for Resident #7 revealed staff was required to reposition the resident every two (2) hours.</p> <p>Interview with Registered Nurse (RN) #2 on 10/30/12, at 3:15 PM revealed CNAs were required to review care plans daily for each resident and provide the care that the care plan required.</p> <p>In addition, a review of Resident #7's nurse's notes dated 10/28/12 revealed the resident had complained of pain to the right hip. Upon assessment by facility staff, an "abrasion" was observed on the resident's right hip.</p> <p>A review of physician orders, not dated, revealed an order to clean the abrasion to the right hip with normal saline, pat the area dry, apply "Bactroban," cover with "Telfa," and secure with "Hypafix" daily, for ten days.</p> <p>Observation during a wound care assessment, on 10/30/12, at 10:30 AM of Resident #7's right hip</p>	F 314	<p>staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #33</p> <p>Four (4) treatments per week will be observed by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of medication administration by licensed staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #34</p> <p>Four (4) med pass observations will be completed weekly by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits</p>	

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F 314	<p>Continued From page 85</p> <p>revealed a Stage II pressure sore that measured 1.6 cm x 1.8 cm, with no dressing in place. A review of Resident #7's October 2012 Treatment Administration Record (TAR) revealed the physician ordered treatment was documented on the TAR to be provided daily; however, no treatment was documented on 10/29/12.</p> <p>Interview with LPN #2 on 10/31/12, at 9:15 PM revealed she did not provide treatment to Resident #7's wound on 10/29/12. The LPN stated, "it was a crazy day" on 10/29/12, and she must have forgotten to perform the wound care.</p> <p>6. A review of Resident #8's medical record revealed the facility admitted the resident on 09/21/10, with diagnosis of Chronic Ischemic Heart Disease, Cerebral Vascular Accident, Kyphosis, and Anemia.</p> <p>Continued review of Resident #8's medical record revealed nurse's notes dated 08/31/12, which revealed staff notified the resident physician the resident had a Stage II pressure ulcer to the right buttock. Treatment orders were obtained to cleanse the resident's right buttock with normal saline, pat dry, apply Bactroban ointment (an antibacterial used to treat skin infections), cover with a "Telfa" (a non-adherent absorbent cotton dressing pad), and to secure the "Telfa" with a Hypafix (a self-adhesive, non-woven fabric for dressing retention). The treatment was to be performed every day. However, facility staff failed to document the appearance or size of the pressure wound until 09/16/12.</p> <p>Review of Resident #8's care plan revealed the care plan was revised on 09/04/12, and on</p>	F 314	<p>will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The results of all audits will be reported quarterly through CQ by Emily Jones-Gray Assistant Administrator or the person completing the audits. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is the policy of this facility that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>		