

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

PRINTED: 08/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/25/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating Complaint #KY 21901 was conducted on 07/08/14 through 07/11/14 to determine the facility's compliance with Federal requirements. Complaint #KY 21901 was substantiated with deficiencies cited at the highest Scope and Severity of a "D".

After supervisory review, Complaint #KY 21901 was reopened on 07/25/14 to obtain additional information, and concluded on 07/25/14. Complaint #KY 21901 was substantiated with deficiencies cited at the highest Scope and Severity of a "G".

On 03/27/14, the facility identified Resident #1 had a non-pressure wound to the left buttock; however, the physician was not notified of the wound until 04/02/14, six (6) days later. The facility failed to conduct the initial wound assessment until 04/02/14 and failed to conduct ongoing weekly wound assessments per the facility's policy. On 04/22/14 Resident #1 was sent to the Wound Care Center due to the wound having a foul odor. The wound care physician at the Wound Care Center identified the wound as a chronic full thickness abscess with signs and symptoms of infection noted

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=G (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's

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F-157

8/25/14

I. Resident Affected

Resident # 1 no longer resides in the center as of 6/19/14. As stated in the 2567 dated 7/25/14, resident's POA and MID were notified of the wound by Licensed Nurse on 4/2/14.

II. Residents With the Potential to be Affected

All residents have the potential to be affected. Residents identified with an actual wound were reviewed by Director of Nursing (DNS), Staff Development Coordinator (SDC), and Unit Managers (UMs) to assure that the resident's MD and family POA have been notified regarding current status of skin, and that an appropriate skin treatment was ordered by physician. This review began 8/18/14 and completed on 8/22/14.

III. Systemic Change

Licensed nurses were re-educated by the Regional Quality Specialist (RQS), District Director of Clinical Operations

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

TITLE

(X6) DATE

Executive Director

8/18/14

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

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physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to notify the physician and responsible party regarding a change in condition for one (1) of seven (7) sampled residents (Resident #1). On 03/27/14 Resident #1 was noted to have a non-pressure area to the left buttock, pink in color, with the appearance of shearing (Stage 2), measuring approximately six (6) centimeters (cm) in length and three (3) cm in width, with no depth noted. The physician and responsible party were not notified of the wound

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(DDCO) and DNS on 8/6- 8/7/14 regarding Condition Change of a Resident, Documenting change of condition in the Medical Record, Documenting Resident Health Status, and Documenting in the Medical Record. This education will also be provided for newly hired licensed nurses in Employee Orientation by the SDC (Staff Development Coordinator) and or DNS (Director of Nursing); this will be an on-going intervention.

Licensed nurses were also educated by the Regional Wound Nurse on August 5-6, 2014 on the steps to be taken after identification of pressure or non-Pressure wound on admission or skin check".

DNS, UM (Unit Manager), and or SDC will update the Pressure and Non-Pressure Weekly Ulcer Log on weekly basis. This Log will be utilized to track pressure and non-pressure wounds weekly. The licensed nurse who identifies any new skin area will be responsible for MD and family POA notification, and implementing appropriate skin/wound care and

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until 04/02/14, six (6) days later.

Findings include:

Review of the facility's policy and procedure titled "Notifications", dated 09/23/03 and revised on 04/28/13, revealed staff should inform the patient, consult with the attending physician, and notify the patient's surrogates when a significant change occurs in the patient's physical, mental or psychosocial status and when treatment needs to be altered significantly.

Record review revealed the facility admitted Resident #1 on 02/12/13 with diagnoses which included Diabetes Mellitus Type II, Pernicious Anemia, Depression, Hyperlipidemia, Hypertension, Anxiety, and Alzheimer's Disease.

Review of the Nursing Progress Note, dated 03/27/14 at 10:24 PM, revealed while providing incontinent care for Resident #1, staff identified an open area to the left buttock, with the appearance of shearing (Stage 2), pink in color, measuring approximately six (6) cm in length and three (3) cm in width, with no depth noted. Adaptic (non-adherent dressing) was applied and the wound nurse was notified. However, there was no documented evidence the Power of Attorney (POA) or physician was notified until 04/02/14 when a new order was received for the treatment of the left buttock wound.

Interview with Licensed Practical Nurse (LPN) #4, on 07/10/14 at 12:40 PM, revealed she identified the left buttock wound on Resident #1 on 03/27/14 and could not recall if she notified the physician at that time. The LPN stated she told the resident's daughter, who worked at the

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treatment. Validation of MD and family POA notification will occur in Clinical Rounds.

Residents identified as having significant change(s) in condition will continue to be reviewed in daily Clinical Rounds. Clinical Rounds was implemented by DNS on 5/13/14 to validate physicians and families have been notified as needed with changes in resident condition.

On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee.

IV. Monitoring

The Pressure and Non-Pressure Weekly Ulcer Log will be reviewed by Unit Managers prior to weekly PI (Performance Improvement) meeting to assure MD and family notification.

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 facility, about the wound in passing (who was not the POA). Additionally, she revealed there was no reason for her not to notify the physician or the other daughter, who was the POA.

Interview with the Wound Nurse, on 07/10/14 at 9:43 AM, revealed the nurse who identified the left buttock wound on 03/27/14 should have notified the physician and the family about the change in condition.

Interview with Hall 1 Unit Manager (UM) #1, on 07/10/14 at 9:30 AM, revealed the charge nurses were responsible for obtaining new physician's orders and notifying the physician and family of any resident's change in condition.

Interview with the Director of Nursing (DON), on 07/10/14 at 10:53 AM, revealed he was unsure when the physician and family were notified regarding the left buttock wound, but the nurse should have notified the physician and family of any change in condition in the resident.

Interview with the Executive Director (ED), on 07/11/14 at 10:20 AM, revealed nursing should have notified the physician and the family when the wound was identified on 03/27/14.

Interview with Resident #1's Physician/Medical Director, on 07/09/14 at 4:25 PM, revealed the staff should have been better communicators in regard to the new wound to the left buttock, and he expected nursing staff to notify him of a resident's change in condition.

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Findings from the log will be tracked and trended weekly by the Director of Nursing, UM, and or SDC and forwarded to the Performance Improvement Committee weekly with further review. Subsequent education or actions taken will be determined by the Committee.

By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate interventions are appropriate.

The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.

The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of the facility's policy/procedure, and review of Hospital Discharge Instructions, it was determined the facility failed to ensure the comprehensive care plan was revised for one (1) of seven (7) sampled residents (Resident #1). On 03/27/14 Resident #1 was noted to have a non-pressure area to the left buttock, pink in color, with the appearance of shearing (Stage 2) Licensed Practical Nurse (LPN) #4, who identified the wound, notified the facility's Wound Nurse and received a recommended treatment of Adaptic (non-adherent dressing) and Blatoin (Silicone foam) dressing. However, LPN #4 did not revise

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F-280 8/25/14

I. Resident Affected

Resident # 1 care plan was reviewed on 5/12/14 by MDS (Minimum Data Set) Coordinator. Resident # 1 is no longer residing in the center as of 6/19/14.

II. Residents With the Potential to be Affected

All residents have the potential to be affected. Resident identified with actual alterations with skin integrity had their care plans reviewed from 8/5/14 to 8/24/14 by the MDS Coordinator, DNS, and SDC to assure that care plans accurately reflect resident's current level of care. Any identified care plan discrepancies were corrected by licensed nurses and or MDS Coordinator.

Residents on specialty beds/mattresses/products were assessed by Nursing Administrative Team Members (DNS, MDS Coordinator, SDC, Case Manager, and UM) from 8/12/14 through 8/18/14 to assure each

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F 280	<p>Continued From page 5</p> <p>the care plan for altered skin integrity.</p> <p>In addition, on 04/29/14, the physician ordered an Alternating Pressure Mattress for the resident; however the care plan was not revised for the use of this mattress. On 05/04/14, Resident #1 fell from the bed and sustained a laceration to the right side of his/her head and was sent to the Emergency Room (ER). The resident's forehead laceration required Dermabond (liquid adhesive bandage).</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled "Comprehensive Plan of Care, dated 08/31/12, revealed the care plan was re-evaluated and modified as necessary to reflect changes in care, service and treatment, and with a significant change of condition assessment. Staff would update the care plan during the course of care delivery to reflect improvement and declines, new problems, and modified interventions. New or changed care plans would be communicate to members of the interdisciplinary team and to caregivers. The facility would ensure any care cues were placed appropriately to remind caregivers of the patient's special needs.</p> <p>Record review revealed the facility admitted Resident #1 on 02/12/13 with diagnoses which included Diabetes Mellitus Type II, Pernicious Anemia, Depression, Hyperlipidemia, Anxiety, Hypertension, and Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 04/30/14, revealed the facility assessed Resident #1's cognition as severely impaired due to his/her inability to be interviewed.</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i></p> <p>resident has a current bed assessment and updated care plan detailing safety risks.</p> <p>III. Systemic Changes</p> <p>Licensed nurses were re-educated on August 6⁷ 2014 by the RQS, DDCO, and DNS, and SDC on procedure titled, "Comprehensive Plan of Care". This procedure details the Interdisciplinary team member's role in updating the care plan to reflect improvement, and declines, new problems, and modified interventions. This in service will be provided by the SOC and or DNS for newly hired licensed nurses in New Employee Orientation; this will be an on-going intervention.</p> <p>Licensed nurses will be responsible for updating the resident's plan of care as needed. Residents that are identified with wounds will (in addition) have their care plan reviewed weekly by the DNS, UM's, and or MDS Coordinator to assure necessary updates to the care plan reflect improvement, declines, new problems, and modified intervention, this will be an on-going measure.</p>	

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Review of the Nursing Progress Note, dated 03/27/14 at 10:24 PM, revealed while providing incontinent care for Resident #1, an open area to the left buttock was identified which appeared to be shearing, pink in color, measuring six (6) centimeters (cm) in length and three (3) cm in width, (Stage 2), with no depth noted

However, review of the Comprehensive Care Plan for altered skin integrity, initiated on 12/24/13 and last revised 05/12/14, revealed there was no revision to the care plan to address the wound on the left buttock.

Interview with LPN #4, on 07/10/14 at 12:40 PM, revealed she identified the left buttock wound on Resident #1 on 03/27/14 and she was responsible for revising the care plan with changes related to a resident's condition; however, she failed to revise the care plan when she identified the wound.

Interview with the facility's Wound Nurse, on 07/09/14 at 7:54 AM, revealed the first time she saw the wound on Resident #1's left buttock was on 04/02/14. She stated the wound appeared as a shear to the left buttock with necrosis measuring three (3) cm in length, one (1) cm in width, and one tenth (0.1) cm in depth. She revealed she received a new order for treatment to the left buttock wound, but did not revise the care plan.

Further record review for Resident #1 revealed a Physician's Order, dated 04/29/14, for a STAT 5000 Low Air Loss mattress to the bed to promote wound healing. Review of the resident's Comprehensive Care Plan, titled "I am at risk for

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The Clinical Rounds process which was implemented on 5/13/14 by the DNS serves as an Interdisciplinary process to validate new orders and care plans are initiated, reviewed, and modified when a resident is identified as having a significant change in condition; The Clinical Rounds process will remain ongoing and the Clinical Rounds Audit Tool will be utilized to include any updates made to the resident's plan of care. On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee.

IV. Monitoring

The Clinical Rounds Audit Tool will identify concerns with updating resident's plan of care. Findings from the audit tool will be tracked and trended by the Director of Nursing weekly and forwarded to the Performance Improvement Committee

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falling", initiated 03/01/14, revealed there were no revision made to the care plan to address the implementation of a STAT 5000 Air Mattress and any risks related to the use of the mattress.

On 05/04/14, Resident #1 fell from the bed and sustained a laceration to the right side of the head and was sent to the Emergency Room (ER). Review of the Hospital Discharge Instructions, dated 05/04/14, revealed Resident #1 was diagnosed with a forehead laceration from the fall, which required Dermabond (liquid adhesive bandage).

Interview with Certified Nurse Aide (CNA) #1, on 07/10/14 at 9:00 AM, revealed a wedge was placed behind the resident's back to prevent pressure on the resident's buttock. She stated the resident may have been too close to the edge of the bed and when the mattress fluctuated, it caused the resident to be pushed out of the bed.

Interview with LPN #1, on 07/11/14 at 2:25 PM, revealed if a resident had a change in condition which needed to be added to the care plan and new orders were received, she would be responsible for adding the problem to the existing care plan or for initiating a new one.

Interview with LPN #2, on 07/11/14 at 2:30 PM, revealed she and the other licensed nurses would be responsible for updating a care plan if a new order was received

Interview with the Director of Nursing (DON), on 07/10/14 at 10:53 AM, revealed documentation by the staff may not be what it should be at times, and the care plan should have been updated at the time the left buttock wound was identified, on

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with further education or actions taken as determined by the Committee.

By reviewing the findings, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate compliance to system.

The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity Director, and Therapy Services Director.

The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.

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03/27/14, as well as with interventions for the use of the alternating air mattress.

Interview with the Executive Director (ED), on 07/11/14 at 10:20 AM, revealed nursing staff should have ensured the care plans were revised regarding the resident's new left buttock wound and the use of the STAT 5000 alternating mattress. Additionally, she revealed the care plan should have identified any risk factors related to the use of the air mattress.

F 280

Interview with the MDS Coordinator, on 07/11/14 at 2:10 PM, revealed the person responsible for updating the care plan with new orders, treatments, etc., was the licensed nurse who received the new order. She revealed the new orders and care plans were reviewed in the morning meeting to ensure the care plan was appropriate to meet the resident's needs.

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=G HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by.
Based on interview, record review, and review of the facility's policies/procedures, it was determined the facility failed to ensure necessary

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 309	<p>Continued From page 9</p> <p>care and services were provided to attain/maintain the highest practicable physical, mental, and psychosocial well being in accordance with the comprehensive assessment and plan of care for one (1) of seven (7) sampled residents (Resident #1). The facility identified Resident #1 had a non-pressure wound to the left buttock on 03/27/14; however, the facility failed to conduct the initial wound assessment until 04/02/14 and failed to conduct ongoing weekly wound assessments per the facility's policy. On 04/22/14 Resident #1 was sent to the Wound Care Center due to the wound having a foul odor. The wound care physician at the Wound Care Center identified the wound as a chronic full thickness abscess with signs and symptoms of infection noted</p> <p>Findings include:</p> <p>Review of the facility's policy and procedure titled "Patient Assessment", dated 04/26/14, revealed the facility's assessment process included direct observation and communication with the patient [resident] as well as communication with direct care staff on all shifts. Discussions with the attending physician, family members, outside consultants, and review of the patient's [resident's] medical record may also be used in the process. Assessment Data was collected on data collection and/or assessment forms and/or in an electronic medical record to individualize and direct patient [resident] care.</p> <p>Review of the facility's policy and procedure titled "Prevention and Treatment of Pressure Ulcers and Non-Pressure Related Wounds", dated 08/31/12, revealed the identification of pressure and non-pressure related wound characteristics</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F-309 8/25/14.</p> <p>I. Resident Affected</p> <p>Resident # 1 had BWAT (Bates-Jensen Wound Assessment Tool) completed by Licensed Nurse 4/2/14.</p> <p>II. Residents With Potential to be Affected</p> <p>All residents have the potential to be affected. Residents identified as having pressure wounds were audited by DNS, SDC, UM to assure that a current BWAT had been completed. This audit was initiated on August 18, 2014 and completed on August 22, 2014.</p> <p>III. Systemic Change</p> <p>Licensed nurses were re-educated to policy titled, "Prevention and Treatment of Pressure Ulcers and Non-Pressure Related Wounds" on August 6 and August 7, 2014 by RQS, DDCO, and DNS.</p>

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F 309 Continued From page 10

initially, at regular intervals, and as needed with a change in wound status was to be documented using the Bates-Jensen Wound Assessment Tool (BWAT). Interview with the Director of Nursing (DON) and the facility's Wound Nurse revealed "regular intervals" meant weekly wound assessments were to be completed.

Record review revealed the facility admitted Resident #1 on 02/12/13 with diagnoses which included Diabetes Mellitus Type II, Pernicious Anemia, Depression, Hyperlipidemia, Hypertension, and Alzheimer's Dementia.

Review of the Nursing Progress Note, dated 03/27/14 at 10:24 PM, revealed while providing incontinent care for Resident #1, staff identified an open area to the left buttock, pink in color, with the appearance of shearing (Stage 2), measuring approximately six (6) cm in length and three (3) cm in width, with no depth noted. The wound nurse was notified of the new area and gave direction to apply Adaptic (non adhering dressing) and Biatain (Silicone foam) dressing. However, record review revealed there was no documented evidence the initial BWAT assessment was completed and the physician was notified to obtain treatment. Review of the Physician's Orders and Treatment Administration Record (TAR) revealed there was no documented evidence any treatments were provided to the resident's left buttock wound from 03/27/14 through 04/01/14

Review of the physician's orders revealed an order on 04/02/14 to clean the left buttock open area with wound cleanser and apply Hydrogel (90% water in a gel base dressing) and a foam dressing to be changed daily and as needed.

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This Plan of Correction is the center's credible allegation of compliance

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law

Regional Wound Nurse Consultant provided additional education to the Licensed Nurses on the following:
Weekly Pressure Ulcer BWAT Report,
Daily Monitoring/Pressure Ulcer Form,
MD Role in Wound/Skin Issues,
Pressure Ulcer Prevention for Nurses,
Skin Injury/Ulcer Definitions, Staging
Pressure Ulcers Algorithm, Best
Practice Guides for Lower Extremity
Ulcers, Wound Measurement and
Documentation Guide, Steps to be
Taken after Identification of Pressure or
Non-Pressure Wound on Admission or
Skin Check, and Best Practice
Guidelines for Pressure Ulcers and
Wounds, and Medications that Effects
Wound Healing. This education was
provided on August 12-13, 2014.

Nursing Assistants were also provided training on Skin Prevention to include:

off loading of pressure sites, and
reporting skin variances to the Licensed
Nurse by the Regional Wound Nurse
Consultant on August 12-13, 2014.

DNS, UM (Unit Manager), and or SDC
will update the Pressure and Non-

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F 308	Continued From page 11 Review of the Comprehensive Care Plan for altered skin integrity, initiated on 12/24/13 and last revised 05/12/14, revealed the resident's care plan was not revised to address the wound to the left buttock. Further record review revealed the first BWAT Assessment was completed on 04/02/14 and identified the wound measured 3.2 cm in length and 2.9 cm in width with no depth. The wound was unstagable with necrotic tissue identified as firmly adherent soft, black eschar covering 75-100 % of the wound with a small amount of serosanguineous (thin, watery, pale, red/pink) exudate (drainage), undermining less than two (2) cm in any area and edges were distinct and outline clearly visible and attached even with wound base. The skin surrounding the wound was bright red and blanches to touch with minimal swelling around the wound. The peripheral tissue induration was two (2) cm to four (4) cm extending greater than or equal to 50 % around the wound with no granulation tissue present. Further record review revealed weekly BWAT assessments were not conducted on the resident's left buttock wound on 04/09/14 and 04/16/14 per facility policy and interview. Review of a Plan of Care Note, dated 04/18/14 at 1:08 PM, revealed Resident #1 was scheduled a wound care appointment on 04/22/14 due to the wound appearing worse and had an odor. However, review of the Daily Monitoring/Pressure Ulcer form, dated April 2014, revealed there were no changes to the wound noted until 04/20/14 when the wound was noted to have deteriorated,	F 309	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> clinical rounds form/audit tool and the recommendations of the Performance Improvement Committee. IV. Monitoring The Pressure (to include resident's BWAT assessment score) and Non-Pressure Weekly Ulcer Log will be reviewed prior to weekly PI (Performance Improvement) meeting. Findings from the log will be tracked and trended weekly by the Director of Nursing, UM, and/or SDC and forwarded to the Performance Improvement Committee weekly with further review. Subsequent education or actions taken will be determined by the Committee. By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.

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F 309	<p>Continued From page 12</p> <p>the dressing was leaking drainage, and the surrounding skin was black or hyperpigmented.</p> <p>In addition, review of the April 2014 TAR revealed on 04/03/14 and 04/18/14, the dates were circled on the TAR indicating the treatment was not completed. Additionally, on 04/09/14 and 04/16/14, the dates were left blank indicating the treatment was not completed.</p> <p>Interview with Unit Manager (UM) #2, on 07/25/14 at 11:15 AM, revealed the possible causes for the omitted spaces on the TAR could have been due to the dressing to the area being clean and dry from the previous shift changing the dressing; therefore, not requiring a change. However, there was no documented evidence of this being the case.</p> <p>Review of the Wound Care Center Progress Note, dated 04/22/14, revealed the left buttock area was identified as an abscess in chronic condition with measurements of 3.2 cm in length, 3.6 cm in width, 2.7 cm depth, and 4.0 cm undermining. Additionally, the wound was noted to have a strong odor, purulent drainage with moderate exudate amounts and was edematous with one (1) to twenty-five (25)% adherent yellow slough, one (1) to twenty-five (25)% moist yellow slough, twenty-six (26) to fifty (50)% moist black eschar, one (1) to twenty-five (25)% pink granulation, twenty-six (26) to fifty (50)% non-granulation with muscle exposed prior to debridement. The area was debrided by the wound care physician based on the wound having slough and being necrotic. Review of the lab culture collected on 04/22/14 at 2:50 PM, revealed the culture of the wound to the left buttock to have Proteus Mirabilis (Rod shaped</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director,</p> <p>Activity director and Therapy Services Director.</p> <p>The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.</p>	

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bactenum), which required antibiotics for treatment

Interview with the Wound Care Physician, on 07/10/14 at 8:25 AM, revealed when Resident #1 presented to the Wound Care Center, he/she had a large abscess on the left buttocks with an odor that could be smelled down the hallway. He stated the wound did not present as a pressure ulcer, but as an abscess. He stated he did not know when the odor began, but it was undetected by the nursing home staff and he could not understand how the nursing home staff could not have noticed it. He stated he was unsure when the wound opened.

Interview with Licensed Practical Nurse (LPN) #4, on 07/10/14 at 12:40 PM, revealed she identified the left buttock wound on 03/27/14, which appeared as bright pink and as shearing with no drainage or odor noted. She stated she could not recall if she notified the physician or the Power of Attorney (POA) at the time the new wound was identified. She revealed she made the Wound Nurse aware of the area and implemented a treatment per the Wound Nurse's suggestion; however, review of the TAR revealed no treatment was documented from 03/27/14 to 04/01/14. Further review of the TAR revealed no documentation of treatment to the resident's wound until 04/02/14 after the BWAT was completed by the Wound Nurse, and the physician notified for a treatment order for the area.

Interview with the facility's Wound Nurse, on 07/09/14 at 7:54 AM and 07/10/14 at 9:43 AM, revealed 04/02/14 was the first time she observed the area on Resident #1's left buttocks because

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that was the day the wound rounds for every resident with a pressure ulcer were due. Additionally, she revealed she had given LPN #4 recommendations for an immediate treatment. She stated unless the charge nurse specifically asked her to look at a wound immediately, she would wait until the next wound rounds were due; however, further interview revealed the licensed nurse who identified the wound should have completed a BWAT. She stated the area appeared as a shear to the left buttock with necrosis measuring three (3) cm in length, one (1) cm in width, and one tenth (0.1) cm in depth. Further interview revealed she received a new order for treatment on 04/02/14 to the left buttock wound, but did not revise the care plan as it should have been. When asked why the BWATs were not completed weekly after the wound was assessed on 04/02/14 per the facility's protocol, she replied she had been in and out of the facility due to an illness in the family, and she did not know why the next BWAT was not completed until 04/24/14. She stated the Charge Nurse was responsible for completing the assessments when she was not available. Additionally, she revealed there was no documentation related to an odor to the wound prior to the resident going to the Wound Care Center on 04/22/14; and she did not know how the odor from the wound could have been missed prior to the resident going to the Wound Center. However, record review revealed a Plan of Care Note, dated 04/18/14 at 1:08 PM, that the wound appeared worse and had an odor.

Further interview with the facility's Wound Nurse, on 07/25/14 at 10:25 AM, revealed Resident #1's left buttock wound appeared superficial and had a small amount of slough and necrosis to it. She

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revealed LPN #4 documented the wound as open on 03/27/14 related to shearing and she was unsure if the wound had deteriorated from 03/27/14 to 04/02/14 when she first assessed the wound. Additionally, she stated the day shift licensed nurses were the ones who documented on the Daily Wound Monitoring Logs and should have documented on the areas of the assessment pertaining to a wound with a dressing as was the case with Resident #1's left buttock wound. Additionally, she revealed the nurse who identified the wound (LPN #4) should have placed the treatment for the wound on the TAR on 03/27/14 when the wound was identified.

Additional interviews with Certified Nurse Aide (CNA) #4 and #10, on 07/25/14 at 9:40 AM and 9:55 AM, revealed they had seen the left buttock wound and it was open and had an odor to it. Both CNAs revealed the wound became larger and the odor worsened approximately mid-April.

However, interview with CNA #11, on 07/25/14 at 11:40 AM, revealed she did not recall the left buttock wound having an odor and each time she provided incontinent care to Resident #1, the wound dressing was clean and intact.

Interview with Registered Nurse (RN) #1, on 07/25/14 at 9:00 AM, revealed she worked with Resident #1 on 04/14/14 and she saw the left buttock wound and did not recall the wound having drainage or an odor.

Interview with LPN #2, on 07/25/14 at 8:39 AM, revealed before Resident #1 was sent to the wound center for treatment, the area was worsening with an odor.

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F 309	<p>Continued From page 16</p> <p>Interview with UM #1, on 07/25/14 at 10:15 AM, revealed she could not recall the left buttock wound worsening until Resident #1 went to the Wound Care Center on 04/22/14. Additionally, she revealed a BWAT assessment should have been completed by the licensed nurse (LPN #4) when the wound was first identified on 03/27/14. She revealed the DON was responsible for ensuring the BWAT assessment was completed timely, then the Unit Managers.</p> <p>Interview with the Minimum Data Set (MDS) Nurse (former DON), on 07/25/14 at 12:55 PM, revealed she could not recall seeing the wound on Resident #1's left buttock. She acknowledged she completed the weekly skin assessment on Resident #1 on 04/01/14 and documented the left buttock wound to be present and to "See BWAT" for additional information; however a BWAT was not completed until 04/02/14. She revealed when she performed the skin assessment on 04/01/14, the dressing to the wound was intact; therefore, she did not remove it because she knew the wound nurse would be doing pressure ulcer rounds the following day. Additionally, she revealed the wound care process was when a wound was identified, it was to be assessed, measured, and documented, and the physician and POA should be notified. A treatment order should be obtained and all information regarding the wound should be documented on the TAR and a daily monitoring log should be implemented. Further interview revealed the charge nurses should have completed the BWAT assessments in the wound nurse's absence and the Unit Managers were responsible for ensuring the BWAT assessments were being completed weekly on all residents with pressure ulcers.</p>	F 309		

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F 309	Continued From page 17 Interview with the Executive Director (ED), on 07/11/14 at 10:20 AM, revealed she expected staff to assess the wound and ensure interventions were in place to care for the wound. Additionally, the licensed nurse who identified the wound should have documented on the TAR, initiate a Pressure Ulcer Monitoring Log, and complete a BWAT assessment.	F 309	<i>This Plan of Correction is the center's credible allegation of compliance</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</i>
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure 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. This REQUIREMENT is not met as evidenced by. Based on interview, record review, review of the facility's policies/procedures, and review of the "Key Guidelines for the STAT 5000 Mattress", it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (1) of seven (7) sampled residents (Resident #1). On 04/29/14, a Stat 5000 low air loss mattress was implemented for Resident #1. The facility failed to conduct a Bed Safety Evaluation per policy and failed to revise the care plan for any falls risks related to the use of the mattress. On 05/04/14 at approximately 11:30 PM, Resident #1 experienced a fall from the bed to the floor resulting in a laceration to the forehead requiring Dermabond (liquid adhesive bandage).	F 323	F-tag 323 8/25/14 I. Resident Affected Resident # 1 care plan was reviewed on, and updated on 5/05/14 to include bilateral 1/4 upper rails to stabilize mattress, ensure that resident is positioned in the middle of the bed, a landing strip to the floor on bilateral sides of bed, low bed for safety, and to lower the HOB no more than a 30 degree angle when he/she is not eating. Resident #1 was reviewed by Occupational Therapy on 5/7/14 for further positioning and safety interventions. Resident #1 discharged from facility 6/19/14. II. Residents With the Potential to be Affected Residents on specialty beds/mattresses/products were assessed by Nursing Administrative Team Members (DNS, MDS Coordinator, SDC, Case Manager, and UM) from 8/12/14 through 8/18/14 to assure each resident has a current bed assessment

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Findings include:

Review of the facility's policy and procedure titled "Fall Response and Management", dated 05/12/14, revealed residents were assessed after a fall to attempt to determine the cause of the fall and implement individualized interventions to reduce the risk of fall occurrence.

Review of the Key Guidelines for use of the STAT 5000 Mattress, (no date), revealed the head of the bed should be no higher than thirty (30) degrees or at the lowest degree of elevation consistent with the patient's medical condition to prevent sliding, shear, or injury.

Review of the facility's policy and procedure titled "Specialty Mattress/Beds and/or Products", last revised 10/31/09, revealed if a resident was determined to be appropriate for the use of a lateral rotation mattress, the facility was to complete the safety evaluation to determine what, if any, interventions needed to be implemented with use of the mattress (e.g., low bed, soft mat on floor, side rail pads, etc.).

Record review revealed the facility admitted Resident #1 on 02/12/13 with diagnoses which included Diabetes Mellitus Type II, Pernicious Anemia, Depression, Hyperlipidemia, Anxiety, Hypertension, and Alzheimer's Dementia. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, dated 04/30/14, revealed the resident's Brief Interview Mental Status (BIMS) score of ninety-nine (99) with severely impaired cognition. He/she required extensive assistance with one person for bed mobility, was non-ambulatory, and at risk for falls.

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and updated care plan detailing safety risks.

III. Systemic Changes

Regional Quality Specialist provided education on procedure titled "Specialty Mattress/Bed and/ or Products to Nursing Administrative Team Members (see above for positions) on 8/18/14.

On May 10th, 2014 the Director of Nursing revised the falls packet for the Licensed Nurses to use to investigate a fall at the time of an occurrence. This revision includes using a new Falls Scene Investigation Report form the Kentucky Quality Improvement Organization and guides a licensed nurse to determine root cause with any fall that occurs. This packet was reviewed again on 8/12/14 by the RQS to assure validity of each form in packet.

As of 7/15/14 the IDT Falls Review Form has been utilized and completed in daily Clinical Rounds to assure interventions and applicable measures have been implemented to reduce and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/26/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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Review of a Physician's Order, dated 04/29/14, revealed a new order for a STAT 5000 Low Air Loss mattress to the bed to promote wound healing. Further record review revealed there was no documented evidence the facility conducted a Bed Safety Evaluation per the facility's policy and procedure prior to implementing the mattress.

Review of the Comprehensive Care Plan, titled "I am at risk for falling", initiated 03/01/14, revealed there were no revision made to the care plan to address the implementation of a STAT 5000 Air Mattress and any risks related to the use of the mattress or interventions.

Review of a Nursing Progress Note, dated 05/04/14 at 11:29 PM, revealed Resident #1's roommate came out into the hall screaming that the resident had fallen to the floor. When the charge nurse entered the room, the resident was on the floor on the window side of the bed. The charge nurse applied first aid to the head wound and the ambulance was called to send the resident to the Emergency Room (ER) for treatment for possible head trauma and a laceration to the right side of the head measuring 3.2 centimeters (cm) in length and 0.4 cm in width.

Review of the facility's Post Fall Assessment, dated 05/04/14 at 11:30 PM, revealed the resident's activity at the time of the fall was determined to be the resident's positioning too close to the edge of the air mattress. Interventions initiated after the fall included a recommendation for bed rails and staff education on positioning.

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prevent future falls from occurring. The DNS and or UM/Supervisor is responsible for completing this form daily.

On 7/23-24/14 and 8/5-6/14 the RQS, DDCO, SDC, DNS re-educated the Licensed Nurses on the following policies and procedures: Accidents and Supervision to Prevent Accidents, Root Cause Analysis, and Fall Response and Management. This education will be ongoing as part of New Employee Orientation for Licensed Nurses and will be provided by the SDC and or DNS.

Daily, each post fall is reviewed in Clinical Rounds to assure that identified findings of the fall is reviewed and immediate corrective action by the IDT team (refer to members) has taken place. As of 5-17-14 the daily clinical rounds form is utilized as an audit tool (Daily Clinical Rounds Form/Audit Tool) by the Director of Nursing (DNS), RN Weekend Supervisor, RN Case Manager, and/or Unit Manager (UM) to assist in identifying findings from the clinical rounds that require additional

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Interview with Certified Nurse Aide (CNA) #1, on 07/10/14 at 9:00 AM, revealed she and the Charge Nurse were the first two (2) in the room after Resident #1 fell. She stated she was working a double shift on 05/04/14, and around 11:30 PM to 11:45 PM, the resident's roommate came out in the hallway and was crying and told her that Resident #1 had fallen out of the bed. She stated the Charge Nurse assessed the resident and there was a laceration to the resident's forehead and she held a towel to the resident's head and waited for the ambulance to arrive. Further interview revealed she and the Charge Nurse attempted to determine how the resident fell out of the bed. They determined there was a wedge behind the resident's back to prevent pressure on the resident's buttock and the only conclusion was the resident was too close to the edge of the bed and when the mattress fluctuated, it caused the resident to be pushed out of the bed. She revealed she was unsure how the resident was positioned in the bed, because when she got to the room, Resident #1 was on the floor.

Interview with CNA #2, on 07/10/14 at 5:00 PM, revealed she was working the midnight shift after Resident #1 fell from the bed. She stated she entered the room after the resident had fallen and did not know where the resident was positioned in the bed prior to the fall.

Interview with the Executive Director (ED), on 07/11/14 at 10:20 AM, revealed she realized after the fall, there were areas of improvement needed related to the investigation process after a fall. She stated after reviewing the results from the post fall assessment she felt comfortable in determining the root cause of the fall was

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follow up by the IDT.

On an ongoing basis, The Director of Nursing, Unit Manager, RN Weekend Supervisor and/or The Registered Nurse Staff Development Coordinator will conduct clinical education as needed based on findings/trends of the daily clinical rounds form/audit tool, IDT Falls Review Form and the Falls Scene Investigation Report and the recommendations of the Performance Improvement Committee.

IV. Monitoring

The clinical rounds daily audit tool and or the IDT Falls Review Form is completed by the Director of Nursing (or Unit Manager, Staff Development Coordinator, Case Manager, or Weekend Supervisor when the Director of Nursing is not available). These audit tools will identify any concerns with falls investigations and revision of interventions to prevent reoccurrence of falls. Findings from the audit tool and or IDT Falls Review Form will be tracked and trended by the Director of Nursing

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NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066
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improper positioning of the resident in the bed.

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weekly and forwarded to the Performance Improvement Committee with further education or actions taken as determined by the Committee.

By reviewing the findings of the tracking and trending, the Performance Improvement Committee will monitor the effectiveness and compliance with the plan weekly to validate solutions is sustained.

The Performance Improvement Committee consists of the Executive Director, Director of Nursing, Unit Managers, Staff Development Coordinator, Case Manager, MDS nurse, Social Services Director, Activity director, and Therapy Services Director.

The Performance Improvement Committee is meeting weekly at this time, but will resume monthly meetings once substantial compliance is achieved.