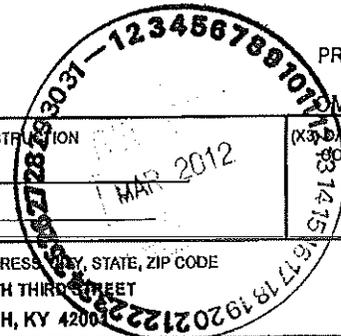


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2012
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NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated/partial extended survey (KY #17340, KY #17428, KY #17339 and KY #17220) was conducted 01/17/12 through 01/23/12. After supervisory review, the investigation was reopened on 02/06/12 and concluded on 02/08/12. KY #17340 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 10/07/11 at 483.13 Resident Behavior and Facility Practices, F223 and F228 at a scope and severity of a "J". Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices.</p> <p>On 10/07/11, it was reported Certified Nurse Aide (CNA) #3 grabbed Resident #4's hair causing his/her head to be pulled back. Resident #4 spat on CNA #3, then CNA #3 slapped Resident #4 across the left cheek with an open hand. CNA #1 and CNA #2 reported the incident to Licensed Practical Nurse (LPN) #1. However, LPN #1 did not remove CNA #3 from direct care immediately. CNA #3 remained on the hall the remainder of the shift, approximately two hours to two and a half hours after the incident was reported. After becoming aware of the incident the facility initiated an investigation on 10/08/11. The facility developed and implemented interventions to correct the deficiency. Immediate Jeopardy was determined to exist on 10/07/11 through 10/11/11. It was determined the facility had completed all corrective action prior to the State Agency initiating the abbreviated survey on 01/17/12, thus resulting in the determination of Past Jeopardy. The Jeopardy was determined to be corrected on 10/12/11.</p> <p>KY #17428 and KY #17339 were substantiated</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Care and Rehabilitation Center does not admit that the deficiency listed on this form exist nor does the Center admit to any statements, findings, facts, or conclusions that for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sorja Henderson-Maddox</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/2/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 with deficiencies cited at a scope and severity of a "G." KY #17220 was unsubstantiated with unrelated deficiencies cited.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (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 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.	F 157	1. Resident #8 was discharged from our facility on 11/24/11. LPN # 2 was re-educated on policy and procedure for change of condition with physician and family/responsible party notification by Assistant Director of Nursing on 02/21/2012. Director of Nursing was re-educated by Regional Director of Clinical Operations on policy and procedure with physician and family/responsible party notification on 01/27/2012. 2. Current Residents with change in condition were reviewed by Director of Nursing Services and Assistant Director Services on 02/02/2012 for physician and family/responsible party notification and RD recommendations. Notifications completed as indicated	

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F 157	Continued From page 2 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 consult/notify the resident's physician when there was a need to alter treatment significantly for one resident (#8), in the selected sample of ten residents. Resident #8 was re-admitted to the facility on 09/30/11, with excoriation to buttocks noted and treatment was ordered. On 10/11/11, a skin assessment identified a new pressure sore on the resident's coccyx area measuring 7.9 centimeters (cm) length by 4.1 cm width by 0.1 cm depth. There was no documented evidence the physician was notified of the new pressure sore or consulted to alter treatment. On 10/18/11, the facility assessed the coccyx wound had increased in size, measuring 8.9 cm length by 4.8 cm width by 0.1 cm depth. The facility faxed the physician notification, on 10/18/11, of the wound worsening; however, there was no evidence the physician received the fax and no change in treatment was received. Treatment to the resident's coccyx was not changed until 10/26/11, 8 days later. On 11/01/11, the wound was noted to exhibit an odor; however, there was no documented evidence the facility notified the physician. Additionally, a multivitamin (MVI) was recommended on 10/04/11 to promote wound healing. The facility failed to notify the physician of the dietician's recommendation. The findings include: A review of the facility's policy/procedure, "Change in Condition of a Resident," dated	F 157	3. Licensed Nursing staff was re-educated by Director of Nursing and Assistant Director of Nursing as of 2/24/12 on policy and procedure for change in condition with physician and family/responsible party notification including RD recommendations. 4. The Director of Nursing, and/or Assistant Director of Nursing, Unit Manger, Clinical Case Manager and MDS Coordinator will audit five charts per week for three weeks then four charts per month for one month to validate physician and family/responsible party notification was completed as indicated. Director of Nursing will report findings to Performance Improvement Committee monthly for further recommendations. 5. Completion Date	3/19/12

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F 157	<p>Continued From page 3</p> <p>01/08, revealed "It is the policy of the center to take appropriate action and provide timely communication to the resident's physician and responsible party relating to a change in condition of a resident."</p> <p>A closed record review revealed Resident #8 was admitted to the facility on 06/24/11 and re-admitted to the facility on 09/30/11 with diagnoses to include Failure To Thrive, Psychosis, Anemia and Protein-calorie Malnutrition.</p> <p>A review of Resident #8's "Potential for Skin Breakdown," care plan, dated 07/06/11, revealed to "observe skin every shift for signs/symptoms of potential skin breakdown (e.g. redness/dyscoloration or open areas)." Per the care plan, if breakdown was identified, the charge nurse should be alerted so the nurse could notify the physician if needed for treatment orders.</p> <p>A review of the nurse's notes, dated 09/30/11, revealed excoriation was noted to the buttocks and groin. There was no formal skin assessment completed upon re-admission. However, on 10/02/11, an order was received for border gauze to an open area on the coccyx and to change as needed.</p> <p>A review of a "Medical Nutrition Therapy Assessment," dated 10/04/11, revealed the resident's needs were increased to promote wound healing. A MVI was recommended for overall nutritional status and to aid in wound healing. There was no evidence the physician was ever notified of this dietary recommendation.</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>An interview with the Registered Dietician (RD), on 01/20/12 at 10:15 AM, revealed copies of the recommendations were given to the Director of Nursing (DON), Assistant Director of Nursing (ADON), Dietary Manager, and to the respective nursing station. If a resident was given a dietary recommendation, she expected the nurse to contact the physician for an order. She stated a MVI provided extra nutrients to aid in wound healing which the resident may not have received by po intake.</p> <p>A review of Resident #8's "Pressure Wound and Skin Documentation Form," completed on 10/11/11, revealed a new Stage II wound to the coccyx, measuring 7.9 centimeters (cm) length by 4.1 cm width by 0.1 cm depth. There was no evidence the physician was notified of the new wound, or consulted to alter treatment of the pressure ulcer. Further review revealed on 10/18/11 the pressure ulcer measurements were 8.9 cm length by 4.8 cm width by 0.1 cm depth. The physician was notified by fax on 10/18/11 by Licensed Practical Nurse (LPN) #2, but there was no evidence the physician received the fax and no change in treatment was received.</p> <p>An interview with LPN #2, on 01/20/12 at 2:39 PM, revealed if there was a change in wound status or presence of a wound odor, she was supposed to notify the physician. She was unable to recall the skin assessment on 10/11/11, and when she notified the physician of the worsening of the pressure ulcer on 10/18/11.</p> <p>A review of the physician's progress notes, dated 10/19/11, revealed the Nurse Practitioner (NP) ordered a wound care consultation due to the</p>	F 157			

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F 157	<p>Continued From page 5</p> <p>nurse's concern that the wound on the resident's sacral area was not healing. Per the NP's progress notes, the wound continued to grow in size and had developed a dark center. After receipt of the wound care consult order on 10/19/11, the facility scheduled the wound care consultation for 10/31/11. However, the NP did not give an order on 10/19/11 to alter treatment for the pressure sore, and the facility did not notify the physician for a change in treatment until seven days later (10/26/11). There was no documented evidence the nurse practitioner or Resident #8's physician was notified of the time lapse of the initial wound care consult ordered on 10/19/11, and the resident's scheduled appointment on 10/31/11.</p>	F 157		
	<p>Further record review revealed, on 11/01/11, a wound odor was identified by the DON during a skin assessment; however, review of Resident #8's physician orders and nurse's notes revealed no evidence of physician notification.</p> <p>An interview with the DON, on 01/19/12 at 3:46 PM, revealed if a nurse identified an area worsened or with an odor, she expected the staff to notify the physician by phone or fax. Additionally, she expected the staff to contact the physician with dietary recommendations.</p> <p>An interview with Resident #8's physician, on 01/20/12 at 4:00 PM, revealed he expected the staff to contact him regarding dietary recommendations. Additionally, he expected the staff to intensify treatment if the wound deteriorated. He expected the staff to re-evaluate, adjust treatment according to the facility's protocol, and notify him if there was a</p>			

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F 157 F 223 SS=J	Continued From page 6 change in wound status. 483.13(b), 483.13(b)(1)(I) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure, review of the facility's Investigative Report, and review of the timeclock record, it was determined the facility failed to ensure one resident (#4), in the selected sample of ten residents, was free from physical abuse. The facility failed to follow their Abuse policy/procedure to ensure protection of residents from abuse. On 10/07/11, it was reported that Certified Nurse Aide (CNA) #3 grabbed Resident #4's hair causing his/her head to be pulled backward. Resident #4 then spit on CNA #3. Afterward, CNA #3 slapped Resident #4 across the left cheek with an open hand. CNA #1 and CNA #2 witnessed and reported the incident to Licensed Practical Nurse (LPN) #1; however, LPN #1 did not remove CNA #3 from direct care immediately. CNA #3 remained on the hall after the alleged incident occurred at approximately 8:30 PM, through the remainder of the shift, which ended at 11:00 PM.	F 157 F 223		

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F 223	<p>Continued From page 7</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 10/07/11 through 10/11/11. The facility implemented corrective action which was completed on 10/12/11 prior to the State Agency's investigation, thus it was determined Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices. (Refer to F226)</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," revised 11/10, revealed "abuse was defined as the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Further review of the policy/procedure revealed "the Administrator/designee shall suspend all employees suspected of abuse pending the outcome of the investigation." The Director of Nursing (DON) revealed the facility's policy, on 10/07/11, included if there was an allegation of abuse, the staff member should be suspended immediately.</p> <p>An interview with the current Administrator, on 02/07/12 at 4:00 PM, revealed she expected the staff to protect the resident first, when there was an allegation of abuse. She stated staff should leave the room. The incident should be reported immediately to the supervisor. The supervisor should take control of the staff member, notify the DON and Administrator immediately, and the employee should be suspended. The charge</p>	F 223			

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F 223	<p>Continued From page 8</p> <p>nurse should do a complete head-to-toe assessment on the resident. The family and physician should be notified regarding the findings/incident. An investigation should be initiated, and all State agencies should be notified the same day or within 24 hours, depending on the time of the incident.</p> <p>A record review revealed Resident #4 was admitted to the facility on 10/01/08 with diagnoses to include Dementia, Depressive Disorder, Anxiety and Cerebral Vascular Disease.</p> <p>A review of the annual Minimum Data Set (MDS), dated 11/17/11, revealed Resident #4 had severely impaired decision-making skills. Further review of the MDS revealed Resident #4 had physical behavioral symptoms directed toward others daily.</p>	F 223			
	<p>A review of the facility's Final Investigative Report, dated 10/11/11, revealed, on 10/07/11 at approximately 8:30 PM, CNA #1 and CNA #2, along with CNA #3, were providing care for Resident #4. Resident #4 had a history of combative behaviors during provision of care. The Investigative Report detailed Resident #4 kicked CNA #3 during the provision of care. CNA #1 and CNA #2 both witnessed CNA #3 pull Resident #4's hair causing his/her head to be pulled back. Resident #4 then spit on CNA #3. CNA #1 and CNA #2 detailed CNA #3 slapped Resident #4 across the left cheek with an open hand. Additional review of the Final Investigative Report revealed, after completion of Resident #4's care, CNA #1 and CNA #2 reported the incident to their immediate nursing supervisor. Upon notification, the nursing supervisor</p>				

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F 223	<p>Continued From page 9</p> <p>completed a visual skin assessment of Resident #4. She noted no evidence of physical injury or skin concerns at approximately 9:00 PM, which was a half-hour after the alleged incident occurred. Further review of the Final Investigative Report revealed the DON, on 10/08/11, completed a head to toe assessment on Resident #4 which identified no issues. The report revealed Resident #4 was unable to recall any of the events that occurred and did not show any signs of pain or discomfort. CNA #3 was suspended on 10/08/11, and terminated on 10/11/11.</p> <p>A review of CNA #1's signed investigation interview, dated 10/08/11 at 11:15 AM, and a review of CNA #2's signed investigation interview, dated 10/08/11 at 11:00 AM, revealed they witnessed an incident during second shift, on 10/07/11, between CNA #3 and Resident #4.</p>	F 223		
	<p>An interview with CNA #1, on 01/18/12 at 3:10 PM, 02/07/12 at 1:10 PM, and on 02/08/12 at 3:35 PM, and an interview with CNA #2, on 01/18/12 at 3:50 PM, 02/07/12 at 3:10 PM, and on 02/08/12 at 3:15 PM, revealed, at approximately 8:30 PM, on 10/07/11, CNA #1, CNA #2 and CNA #3 were providing care for Resident #4, and the resident became combative. CNA #1 and CNA #2 each stated CNA #3 wrapped her hand in Resident #4's hair and pulled it hard, causing his/her head to be pulled backward. They stated Resident #4 then covered his/her face, started kicking and spit on CNA #3. CNA #3 "slapped" the face of Resident #4 leaving a red imprint. They stated Resident #4 cursed at CNA #3, and CNA #3 then grabbed his/her face. CNA #3 stated, "You all didn't see anything. What happens in this room stays in this room." CNA #1</p>			

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F 223	Continued From page 10 and CNA #2 asked CNA #3 to leave the room. CNA #3 stated, "no, I've got it." The CNAs finished providing care to Resident #4 and all three CNAs left the room at the same time. CNA #1 and CNA #2 further stated they went to the nurse's desk and reported the incident immediately to LPN #1. CNA #1 and CNA #2 stated they were not aware if LPN #1 talked to CNA #3; however, LPN #1 called the DON and left her a message. They further stated CNA #3 remained on the hall after the incident and clocked out at the end of the shift at 11:00 PM. CNA #2 stated "I cannot say I actually saw CNA #3 go into a resident's room after the incident." An interview with LPN #1, on 01/18/12 at 2:33 PM and 5:00 PM, and on 02/07/12 at 2:15 PM, and a review of LPN #1's investigation interview, dated 10/08/11, revealed she was the charge nurse on second shift on 10/07/11. She stated, at approximately 9:00 PM, CNA #1 and CNA #2 reported to her that CNA #3 slapped Resident #4. She stated she first completed a skin assessment on Resident #4, and no injuries or redness were noted. She stated the resident voiced no complaints of pain. She stated she attempted to notify the DON, but just left her a message. She stated she did not speak to CNA #3. She stated CNA #3 remained on the hall and completed her shift on 10/07/11. A review of the investigation interview revealed the LPN did not do anything to protect other residents. She stated, "I watched where she was going." She stated it was the facility's policy/procedure to suspend staff from direct care when there was an allegation of abuse. She revealed she did not follow the facility's policy/procedure, and stated, "I will be honest. I didn't know exactly what to do." A review	F 223			

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F 223	<p>Continued From page 11</p> <p>of CNA #3's "Time Clock Record," dated 10/07/11, revealed she clocked out at 11:07 PM, allowing the perpetrator access to all residents of the facility for more than two hours after the alleged physical abuse.</p> <p>A review of the nurses' note, dated 10/08/11, revealed LPN #1 documented "Late entry for 10/07/11, at 2130, resident's skin assessed. He/she was laying on right cheek. No marks on that side. The left cheek was pale in color. No blood or bruising noted on cheek or mouth."</p> <p>An interview with CNA #3 was attempted, on 01/18/12 at 2:10 PM. She stated, "I have not worked there in a long time. I think you have the wrong person."</p>	F 223		
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	<p>An interview with the DON, on 01/19/12 at 6:35 PM, on 02/07/12 at 3:30 PM, and on 02/08/12 at 12:50 PM, revealed LPN #1 left a message reporting the incident regarding Resident #4 and CNA #3, on 10/07/11, sometime after 9:30 PM. She stated she returned LPN #1's phone call, and was told while CNAs #1, #2, and #3 were completing rounds between 9:00 and 10:00 PM, CNA #1 and CNA #2 observed CNA #3 pull Resident #4's hair and slap him/her. She stated LPN #1 told her that CNA #3 worked the remainder of the shift. She revealed LPN #1 did not remove CNA #3 from direct care immediately. She stated, "The facility policy was not followed."</p> <p>An interview with the former Administrator, on 02/07/12 at 11:58 AM, revealed he was aware of the incident that occurred on 10/07/11, where CNA #1 and CNA #2 witnessed the resident spit on CNA #3, and CNA #3 pulled the resident's hair</p>			
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F 223	<p>Continued From page 12</p> <p>and then slapped him/her. He further stated the staff did not follow the facility's policy. "One CNA should have left the room and gone to tell the charge nurse. The charge nurse should have suspended CNA #3 immediately." He stated when he was made aware of the incident, on the next day, CNA #3 and LPN #1 were suspended immediately.</p> <p>**The facility implemented the following actions to correct the deficiency:</p> <p>*The DON interviewed CNA #3, on 10/08/11 at 3:07 PM, and advised her she was suspended pending the investigation and escorted her out of the building.</p> <p>*LPN #1 was suspended for 24 hours related to the failure to follow the facility policy/procedure.</p> <p>*An in-service was conducted for all staff from 10/08/11 through 10/10/11 to educate them on abuse/neglect.</p> <p>*The resident's physician was notified about the incident, on 10/08/11 at 10:00 AM. He assessed the resident on 10/08/11 at 5:00 PM. The facility's Medical Director was notified on 10/08/11. The resident's family was notified about the incident on 10/08/11 at 10:00 AM.</p> <p>*CNA #3 was terminated on 10/11/11.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>A review of the Personnel Record for CNA #3 revealed her last day worked was on 10/07/11.</p>	F 223		

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F 223	<p>Continued From page 13</p> <p>The facility notified CNA #3 on 10/11/11 and terminated her for gross misconduct.</p> <p>A review of "Record of Counseling," dated 10/08/11, revealed LPN #1 was suspended for "not following protocol related to abuse guidelines/policy and improper notification." The document was signed by LPN #1, the DON and the former Administrator.</p> <p>An interview with the DON, on 02/07/11 at 3:30 PM, revealed she interviewed CNA #3, on 10/08/11, regarding the incident between her and Resident #4 on 10/07/11. She stated she suspended CNA #3 following the interview and escorted her out of the facility. She further stated she suspended LPN #1 for 24 hours.</p>	F 223		
	<p>A review of inservices, dated 10/08/11 through 10/10/11, revealed all staff was educated on abuse/neglect, to report events immediately to the DON and the Administrator and staff must speak with them personally, and maintain resident dignity. Nurses were also educated to suspend a staff member pending an investigation, and must be made to leave the facility immediately. A list of all employees was compared against the inservice sign in sheets. All employees were inserviced on 10/07/11.</p> <p>An interview with RN #1, RN #2, RN #3, MDS Coordinator #1, MDS Coordinator #2, LPN #2, LPN #3, CMA #1, CNA #1, CNA #2, CNA #4, CNA #5, on 02/07/11 and 02/08/11 between 1:30 PM and 5:05 PM, revealed they were inserviced on abuse/neglect in October, 2011 related to resident abuse, immediate reporting of events to the DON and the Administrator and dignity. They</p>			

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F 223	<p>Continued From page 14</p> <p>were aware of all the types of abuse, who to report it to and that the staff member must leave the facility immediately. No concerns were identified.</p> <p>An interview with LPN #1, on 02/07/12 at 2:15 PM, revealed she was inserviced on abuse/neglect, on 10/08/11, related to abuse of staff, suspension of employees, reporting, notification of family and physician. She was aware of types of abuse, who to report it to and that staff member must leave the facility immediately. No concerns were identified.</p> <p>Interviews with eight interviewable residents (#7, #8, #9, #10, #11, #12, #13, and #14), were conducted on 02/07/12, who CNA #3 may have provided care to while she was on duty, on 10/07/11, from 3:00 PM to 11:00 PM. All eight residents stated the staff treated them fine and took good care of them. They further stated they have not been mistreated, yelled at or harmed by any staff, and they had not seen the staff mistreat any other residents. They were aware they should report any abuse to the staff.</p> <p>An interview with the Medical Director, on 02/08/12 at 3:00 PM, revealed the facility notified him of the incident on 10/08/11. He stated he contacted Resident #4's attending physician and requested that he see the resident.</p> <p>A review of the "Allegation of Abuse Investigation" revealed Resident #4's attending physician was made aware of events that occurred on 10/07/11, between CNA #3 and Resident #4, on 10/08/11 at 10:00 AM. A review of the progress note, dated 10/08/11 at 5:00 PM, revealed he assessed</p>	F 223			

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F 223	Continued From page 15 Resident #4. He documented "Resident is alert, talkative, no headache or change in vision, no complaints of neck or arm pain. Scalp shows no lesions, face symmetrical, tongue midline." An interview with Resident #4's son, on 02/08/12 at 2:58 PM, revealed the facility notified him of the incident on 10/07/11. He stated "I think it happened at night. The DON called me the next day." He further stated the facility later notified him regarding the outcome of the investigation, and the CNA was terminated.	F 223		
F 226 SS=J	483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's policy/procedure, review of the facility's Final Investigative Report, and review of the timeclock record, it was determined the facility failed to follow the Prohibition of Abuse policy that prohibits abuse of residents for one resident (#4), in the selected sample of ten residents. The facility failed to protect residents from further abuse by allowing the perpetrator access to residents of the facility after an allegation of abuse was made. On 10/07/11, Certified Nurse Aide (CNA) #1 and CNA #2 witnessed CNA #3 grab and pull Resident #4's hair and then slap his/her left cheek. CNA #1 and CNA #2 reported the incident to Licensed Practical Nurse (LPN) #1	F 226		

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F 226	Continued From page 16 at approximately 8:00 PM. LPN #1 did not remove CNA #3 from direct care immediately. CNA #3 remained on the hall after the alleged incident occurred at approximately 8:30 PM, through the remainder of the shift, which ended at 11:00 PM. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The immediate jeopardy was determined to exist on 10/07/11 through 10/11/11. The facility implemented corrective action which was completed on 10/12/11 prior to the State Agency's investigation, thus it was determined Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices. (Refer to F223)	F 228		
	The findings include: A review of the facility's policy/procedure, "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," revised 11/10, revealed "the Administrator or his/her designee investigates allegations of abuse, takes action to protect the resident during the investigation, and implements corrective actions depending on the results of the investigation. The Administrator/designee shall suspend all employees suspected of abuse pending the outcome of the investigation." The DON stated the facility's policy on 10/07/11, revealed if there was an allegation of abuse, the staff member should be suspended immediately. A review of the facility's Final Investigative Report, dated 10/11/11, revealed, on 10/07/11 at approximately 8:30 PM, CNA #1 and CNA #2,			

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F 228	Continued From page 17 along with CNA #3, were providing care for Resident #4. Resident #4 had a history of combative behaviors during provision of care. The Investigative Report detailed Resident #4 kicked CNA #3 during the provision of care. CNA #1 and CNA #2 both witnessed CNA #3 pull Resident #4's hair causing his/her head to be pulled back. Resident #4 then spit on CNA #3. CNA #1 and CNA #2 detailed CNA #3 slapped Resident #4 across the left cheek with an open hand. Additional review of the Final Investigative Report revealed, after completion of Resident #4's care, CNA #1 and CNA #2 reported the incident to their immediate nursing supervisor. Upon notification, the nursing supervisor completed a visual skin assessment of Resident #4. She noted no evidence of physical injury or skin concerns at approximately 9:00 PM, which was a half-hour after the alleged incident occurred. Further review of the Final Investigative Report revealed the Director of Nursing (DON), on 10/08/11, completed a head to toe assessment on Resident #4 which identified no issues. The report revealed Resident #4 was unable to recall any of the events that occurred and did not show any signs of pain or discomfort. CNA #3 was removed from direct care on 10/08/11 at 3:07 PM and terminated on 10/11/11. An interview with CNA #1, on 01/18/12 at 3:10 PM, 02/07/12 at 1:10 PM, and on 02/08/12 at 3:35 PM, and an interview with CNA #2, on 01/18/12 at 3:50 PM, 02/07/12 at 3:10 PM, and on 02/08/12 at 3:15 PM, revealed, at approximately 8:30 PM, on 10/07/11, CNA #1, CNA #2 and CNA #3 were providing care for Resident #4, and the resident became combative. CNA #1 and CNA #2 each stated CNA #3	F 226			

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F 228	Continued From page 18 wrapped her hand in Resident #4's hair and pulled it hard, causing his/her head to be pulled backward. They stated Resident #4 then covered his/her face, started kicking and spit on CNA #3. CNA #3 "slapped" the face of Resident #4 leaving a red imprint. They stated Resident #4 cursed at CNA #3, and CNA #3 then grabbed his/her face. CNA #3 stated, "You all didn't see anything. What happens in this room stays in this room." CNA #1 and CNA #2 asked CNA #3 to leave the room. CNA #3 stated, "no, I've got it." The CNAs finished providing care to Resident #4 and all three CNAs left the room at the same time. CNA #1 and CNA #2 further stated they went to the nurse's desk and reported the incident immediately to LPN #1. CNA #1 and CNA #2 stated they were not aware if LPN #1 talked to CNA #3; however, LPN #1 called the DON and left her a message. They further stated CNA #3 remained on the hall after the incident and clocked out at the end of the shift at 11:00 PM. CNA #2 stated "I cannot say I actually saw CNA #3 go into a resident's room after the incident." Interviews with CNA #1 and CNA #2 revealed they did not address the incident or try to remove the CNA, rather they allowed CNA #3 to continue to provide care to this resident and waited to report the incident to the nurse. Furthermore, CNA #1 and CNA #2 revealed CNA #3 continued to work through the end of her shift. A review of CNA #3's "Time Clock Record," dated 10/07/11, revealed she clocked out at 11:07 PM, allowing the perpetrator access to all residents of the facility for more than two hours after the alleged physical abuse. An interview with LPN #1, on 01/18/12 at 2:33 PM	F 228		

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F 226	Continued From page 19 and 5:00 PM, and on 02/07/12 at 2:15 PM, and a review of LPN #1's investigation interview, dated 10/08/11, revealed, on 10/07/11 at approximately 9:00 PM, CNA #1 and CNA #2 reported to her that CNA #3 slapped Resident #4. She stated she first assessed Resident #4, and no injuries or redness were noted. She stated she attempted to call the Director of Nursing (DON) and leave her a message. She stated she did not speak to CNA #3. She stated CNA #3 remained on the hall and completed her shift on 10/07/11. A review of the investigation interview revealed there was no documented evidence of action taken by the facility to remove the perpetrator after it was alleged that CNA #3 physically abused Resident #4. She stated it was the facility's policy to suspend staff from direct care when there was an allegation of abuse. She revealed she did not follow the facility's policy, and stated, "I will be honest. I didn't know exactly what to do." An interview with the DON, on 01/19/12 at 6:35 PM, on 02/07/12 at 3:30 PM, and on 02/08/12 at 12:50 PM, revealed LPN #1 attempted to notify her to report the incident about Resident #4 and CNA #3, on 10/07/11, sometime after 9:30 PM. She stated she spoke to LPN #1 at approximately 1:30 AM on 10/08/11 and LPN #1 revealed CNA #1 and CNA #2 witnessed CNA #3 pull Resident #4's hair and slap him/her. She stated LPN #1 did not remove CNA #3 from direct resident care and allowed the CNA to work the remainder of the shift. She stated, "The facility's policy was not followed." An interview with the former Administrator, on 02/07/12 at 11:58 AM, revealed he was aware of the incident that occurred on 10/07/11, which	F 226			

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F 228	<p>Continued From page 20</p> <p>Involved CNA #3 and Resident #4, where CNA #3 was witnessed pulling Resident #4's hair and slapping the resident. He further stated the staff did not follow the facility's policy. He stated, "one CNA should have left the room and gone to tell the charge nurse. The charge nurse should have suspended CNA #3 immediately." He stated when he was made aware of the incident, the next day, CNA #3 and LPN #1 were suspended.</p> <p>**The facility implemented the following actions to correct the deficiency:</p> <p>*The DON interviewed CNA #3, on 10/08/11 at 3:07 PM, and advised her she was suspended pending the investigation and escorted her out of the building.</p>	F 226		
	<p>*LPN #1 was suspended for 24 hours related to the failure to follow the facility policy/procedure.</p> <p>*An in-service was conducted for all staff from 10/08/11 through 10/10/11 to educate them on abuse/neglect.</p> <p>*The resident's physician was notified about the incident, on 10/08/11 at 10:00 AM. He assessed the resident on 10/08/11 at 5:00 PM. The facility's Medical Director was notified on 10/08/11. The resident's family was notified about the incident on 10/08/11 at 10:00 AM.</p> <p>*CNA #3 was terminated on 10/11/11.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>A review of the Personnel Record for CNA #3</p>			

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NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001	
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F 226	Continued From page 21. revealed her last day worked was on 10/07/11. The facility notified CNA #3 on 10/11/11 and terminated her for gross misconduct. A review of "Record of Counseling," dated 10/08/11, revealed LPN #1 was suspended for "not following protocol related to abuse guidelines/policy and improper notification." The document was signed by LPN #1, the DON and the former Administrator. An interview with the DON, on 02/07/11 at 3:30 PM, revealed she interviewed CNA #3, on 10/08/11, regarding the incident between her and Resident #4 on 10/07/11. She stated she suspended CNA #3 following the interview and escorted her out of the facility. She further stated she suspended LPN #1 for 24 hours.	F 226		
	A review of inservices, dated 10/08/11 through 10/10/11, revealed all staff was educated on abuse/neglect, to report events immediately to the DON and the Administrator and staff must speak with them personally, and maintain resident dignity. Nurses were also educated to suspend a staff member pending an investigation, and must be made to leave the facility immediately. A list of all employees was compared against the Inservice sign in sheets. All employees were inserviced on 10/07/11. An interview with RN #1, RN #2, RN #3, MDS Coordinator #1, MDS Coordinator #2, LPN #2, LPN #3, CMA #1, CNA #1, CNA #2, CNA #4, CNA #5, on 02/07/11 and 02/08/11 between 1:30 PM and 5:05 PM, revealed they were inserviced on abuse/neglect in October, 2011 related to resident abuse, immediate reporting of events to			

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F 226	<p>Continued From page 22</p> <p>the DON and the Administrator and dignity. They were aware of all the types of abuse, who to report it to and that the staff member must leave the facility immediately. No concerns were identified.</p> <p>An interview with LPN #1, on 02/07/12 at 2:15 PM, revealed she was inserviced on abuse/neglect, on 10/08/11, related to abuse of staff, suspension of employees, reporting, notification of family and physician. She was aware of types of abuse, who to report it to and that staff member must leave the facility immediately. No concerns were identified.</p> <p>Interviews with eight interviewable residents (#7, #8, #9, #10, #11, #12, #13, and #14), were conducted on 02/07/12, who CNA #3 may have provided care to while she was on duty, on 10/07/11, from 3:00 PM to 11:00 PM. All eight residents stated the staff treated them fine and took good care of them. They further stated they have not been mistreated, yelled at or harmed by any staff, and they had not seen the staff mistreat any other residents. They were aware they should report any abuse to the staff.</p> <p>An interview with the Medical Director, on 02/08/12 at 3:00 PM, revealed the facility notified him of the incident on 10/08/11. He stated he contacted Resident #4's attending physician and requested that he see the resident.</p> <p>A review of the "Allegation of Abuse Investigation" revealed Resident #4's attending physician was made aware of events that occurred on 10/07/11, between CNA #3 and Resident #4, on 10/08/11 at 10:00 AM. A review of the progress note, dated</p>	F 226			

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F 226	Continued From page 23 10/08/11 at 5:00 PM, revealed he assessed Resident #4. He documented "Resident is alert, talkative, no headache or change in vision, no complaints of neck or arm pain. Scalp shows no lesions, face symmetrical, tongue midline."	F 226		
F 280 SS=G	An interview with Resident #4's son, on 02/08/12 at 2:58 PM, revealed the facility notified him of the incident on 10/07/11. He stated "I think it happened at night. The DON called me the next day." He further stated the facility later notified him regarding the outcome of the investigation, and the CNA was terminated. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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.	F 280	1. Resident #8 was discharged from the facility on 11/24/11. RN # 4 last day worked at facility was 09/30/2011 and LPN # 2 was re-educated by Assistant Director of Nursing on updating care plans with change in condition/interventions timely on 02/21/2012. Director of Nursing was re-educated by Regional Director of Nursing on timely Care Plan updates with change of conditions/interventions on 01/27/2012. 2. Current Residents' Care Plans were reviewed on 02/23/2012 by Assistant Director of Nursing, Clinical Care Specialist and MDS Coordinator and updated as indicated, including skin integrity and dietary recommendations.	

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F 280	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on Interview, record review and review of the facility policy/procedures, it was determined the facility failed to review and revise a comprehensive care plan for one resident (#8), in the selected sample of ten residents related to the revision of Resident #8's individual care plan upon re-admission to the facility on 09/30/11, after new skin integrity issues were identified and treatment was altered. On 10/11/11 a pressure sore was identified on the resident's coccyx area, measuring 7.9 centimeters (cm) length by 4.1 cm width by 0.1 cm depth. On 10/18/11, the facility identified the coccyx wound had increased in size, measuring 8.9 cm length by 4.8 cm width by 0.1 cm depth. However, the resident's care plan was not revised until 10/20/11.	F 280	3. Licensed Nursing staff was re-educated as of 2/24/12 by Director of Nursing and Assistant Director of Nursing for implementing and revising the care plan with change of condition/interventions timely.	
	In addition, Resident #8's care plan was not revised after recommendations from the Registered Dietician (RD), on 10/04/11, for a multi-vitamin (MVI); on 10/09/11, to prevent altered skin integrity to the extremities when the resident's extremities were swollen and blisters were noted on the resident's perit-area and upper thighs; and, on 10/25/11 to reflect the new interventions to elevate/float the resident's bilateral heels and to check the resident every two hours after the identification of blisters to the resident's bilateral heels. The findings include: A review of the facility's policy/procedure, "Putting the Plan into Action," dated January 2008, revealed "Nursing assistants, licensed nurses, and the entire interdisciplinary team all play a role		4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Clinical Case Manager & MDS Coordinator will review three Care Plans per month for three Months to validate care plans are updated /revised with a change of condition timely. The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months for further recommendations. 5. Completion Date	3/19/12

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F 280	<p>Continued From page 25 in reviewing the care plan's effectiveness."</p> <p>A record review Resident #8 was admitted to the facility on 08/24/11 and re-admitted to the facility on 09/30/11 with diagnoses to include Failure To Thrive, Psychosis, Anemia and Protein-calorie Malnutrition.</p> <p>A review of Resident #8's Admission Minimum Data Set (MDS), dated 07/06/11, revealed the facility assessed the resident was cognitively independent, required total dependence for Activities for Daily Living (ADL's), and had no identified behaviors or identified skin issues.</p> <p>A review of Resident #8's "Potential for Skin Breakdown," care plan, dated 07/08/11, revealed to "Observe skin every shift for signs/symptoms of potential skin breakdown (e.g. redness/dyscoloration or open areas)." If breakdown was identified, the charge nurse should be alerted so the nurse could notify the physician if needed for treatment orders.</p> <p>A review of the nurse's notes, dated 09/30/11 at 12:46 PM, revealed Resident #8 was re-admitted to the facility from the hospital, with excoriation to the resident's groin and buttocks noted. There was no evidence that the resident's care plan was revised to address the identified excoriation.</p> <p>An interview with Registered Nurse (RN) #4, on 01/19/12 at 10:14 AM, revealed she could not provide specific information regarding Resident #8's skin assessment upon re-admission to the facility on 09/30/11. She stated she was not sure who would be responsible for initiation of skin interventions, such as wheelchair cushions or air</p>	F 280		

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F 280	<p>Continued From page 26 mattresses.</p> <p>A review of a "Medical Nutrition Therapy Assessment," dated 10/04/11, revealed the resident's needs were increased to promote wound healing. A MVI was recommended to improve overall nutritional status and to aid in wound healing. There was no evidence the care plan was revised to reflect this intervention.</p> <p>A review of the nurses' notes, dated 10/09/11 at 6:30 AM, revealed documentation by the Director of Nursing (DON) that the "Daughter.....voiced concern over edema and 'blisters' on per[one] area and upper thighs." There was no documented evidence that the skin integrity care plan was revised to include the "blistered" areas to the per[one] area and upper thighs.</p>	F 280		
	<p>A review of Resident #8's "Pressure Wound and Skin Documentation Form," revealed, on 10/11/11, a new Stage II wound was identified to the coccyx, measuring 7.9 centimeters (cm) length by 4.1 cm width by 0.1 cm depth, was identified by Licensed Practical Nurse (LPN) #2. There was no evidence the skin integrity was revised to address the new identified wound on 10/11/11.</p> <p>A review of Resident #8's significant change Minimum Data Set (MDS), dated 10/14/11, revealed the facility assessed Resident #8 as cognitively independent, and to require extensive assistance to total dependence for Activities of Daily Living (ADLs). Resident #8 was assessed to be incontinent of bowel and had a urinary catheter.</p>			

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F 280	Continued From page 27 A review of Resident #8's comprehensive care plan, dated 10/14/11, revealed a problem of swelling to all extremities, with interventions for medications as ordered, monitoring for new or worsened condition, and to notify the MD of any changes. No intervention was put into place to prevent altered skin integrity to the extremities. On 10/18/11, the facility identified the coccyx wound had increased in size, measuring 8.9 cm length by 4.8 cm width by 0.1 cm depth. However, Resident #8's care plan was not revised until two days later (10/20/11), to reflect the pressure ulcer. A review of the "Non-pressure Wound and Skin Condition Documentation Form," dated 10/26/11, revealed a new blister was identified on the left heel on 10/26/11, which measured 4 cm length X 5 cm width, and a new blister on the right heel, which measured 6 cm length X 5 cm width. A review of a physician's order, dated 10/28/11, revealed "elevate/float bilateral heels, check every two hours." However, neither Resident #8's comprehensive care plan nor nursing aide care plan was updated to reflect the new interventions. An interview with the DON, on 01/19/12 at 3:45 PM, revealed on admission, the admitting nurse performs a head-to-toe assessment along with a Norton Pressure Ulcer Scale. Resident #8's care plan should have been revised on 09/30/11 to address the excoriated areas. She stated, on 10/07/11, when the nurse documented that the skin was not intact, the care plan should have been revised to reflect the non-intact skin. On 10/14/11, when swelling was identified to the	F 280		

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F 280	Continued From page 28 resident's extremities, Resident #8's skin integrity care plan should had been revised to protect the skin integrity. She could not provide an explanation as to why an intervention such as heel boots were not implemented to prevent alteration in skin integrity. Additionally, she stated any licensed staff member could implement and revise the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide care in accordance with the resident's written plan of care for one (#7) out of ten sampled residents. The facility failed to ensure licensed staff provided foot care daily for Resident #7. The findings include: An interview with the Director of Nursing (DON), dated 01/18/12 at 11:20 AM, revealed there was no policy and procedure to specifically address the implementation of the care plan. A record review revealed Resident #7 was admitted to the facility on 05/10/11 with a diagnosis of Diabetes, Type II.	F 282	1. Resident # 7 Care Plan was reviewed and revised to reflect current needs of the Resident by Clinical Care Specialist on 01/19/2012. RN # 3, 5, and 6, and LPN # 3 was re-educated by Director of Nursing Services on 01/27/2012 on following the care plan. 2. Current Residents identified at high risk by diagnosis and extensive/dependent bed mobility for skin related foot issues were reviewed by Director of Nursing, Assistant Director of Nursing and Clinical Case Manager, MDS Coordinator for appropriate interventions and care plans were revised as indicated on 02/24/2012	

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F 282	Continued From page 29 A review of the quarterly Minimum Data Set (MDS) assessment, dated 11/12/11, revealed the facility assessed Resident #7 and determined Resident #7 had Diabetes, his/her decisions were poor and the resident required cues and supervision. A review of the Comprehensive Care Plan for Diabetes, dated 05/25/11, revealed a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) should provide daily foot care and observe skin for signs and symptoms of infection. A review of the December 2011 and January 2012 Treatment Administration Record (TAR) revealed no evidence the resident was receiving daily foot care.	F 282	3. Nursing staff was re-educated as of 2/24/12 on the need to follow the Care Plan and Certified Nursing Assistant Care Card with instructions to report any changes that would require revisions to the Plan of Care by Director of Nursing Services and Assistant Director of Nursing. 4. The Director of Nursing, Assistant Director of Nursing, Clinical Case Manager, MDS Coordinator will review three Care Plans per month for three Months to validate care is provided in accordance with the resident's plan of care. Director of Nursing will report findings to the Performance Improvement Committee monthly for three months for further recommendations 5. Completion Date	3/19/12	
	Observation of Resident #7's feet, on 01/18/12 at 9:30 AM, revealed the resident's feet were covered with thick, dry, flaky skin to include in between the resident's toes. The resident's heels were dry and appeared cracked, but the skin was intact. When the resident removed his/her socks, dried, flaky skin fell to the floor. Interview with LPN #3, on 01/18/12 at 2:30 PM, revealed Resident #7's feet were in horrible condition and she was embarrassed when she assisted the resident in removing his/her socks. Interviews with RN #3, RN #5, RN #6 and LPN #3, on 01/18/12 at 2:10 PM, 2:20 PM, 2:45 PM and 4:05 PM, revealed they were not aware they were suppose to provide daily foot care and assess the resident's feet daily.				

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F 282	Continued From page 30 Interview with the DON, on 01/19/12 at 6:15 PM, revealed "daily foot care" means the resident's feet should have been assessed daily, and if any skin issues were identified, the staff should have documented it in the nurse's notes and provided the appropriate care.	F 282		
F 309 SS=D	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.	F 309	1. Registered Nurse completed skin assessment on resident #7 on 2/3/12. 2. Current residents care plans reviewed on 02/23/2012 by Assistant Director of Nursing, Clinical Case Manager and MDS Coordinator to validate the plan of care is implemented per physician orders. Plan of Cares updated as indicated.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide 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 one resident (#7), in the selected sample of ten residents. The facility failed to implement the care plan related to licensed nurses providing daily foot care and to assess for signs and symptoms of infection and failed to provide the appropriate care for dry skin on the resident's feet. The findings include: An interview with the Director of Nursing (DON), on 01/18/12 at 11:20 AM, revealed there was no policy and procedure to address Diabetic		3. Licensed Nursing staff re-educated on foot care by Director of Nursing Services as of 2/24/12. The education included: assessment/inspection of feet, legs, bathing feet, applying lotions, podiatrist consult and follow up as needed,	

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F 309	Continued From page 31 residents related to foot care or dry skin. However, the DON revealed "daily foot care" means the resident's feet should be assessed daily, and if any skin issues are identified, the staff should document it in the nurse's notes and provide the appropriate care. A record review revealed Resident #7 was admitted to the facility on 05/10/11 with a diagnosis of Diabetes, Type II. A review of the quarterly Minimum Data Set (MDS) assessment, dated 11/12/11, revealed the facility assessed Resident #7 to have Diabetes, his/her decisions were poor and the resident required cues and supervision. A review of the physician's orders, January 2012, revealed there were no orders for any treatments related to dry skin. A review of the Comprehensive Care Plan for Diabetes, dated 05/25/11, revealed a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) should provide daily foot care and observe skin for signs and symptoms of infection. A review of the December 2011 and January 2012 Treatment Administration Record (TAR) revealed there was no evidence the resident was receiving daily foot care. Further review of the January 2012 TAR revealed the resident's last skin assessment was conducted on 01/13/12 and the resident's skin was intact. A review of the nurse's note for 01/13/12, revealed there was no documentation	F 309	4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Clinical Case Manager, MDS Coordinator will review treatment administration records to validate skin assessments are completed as scheduled and the plan of care is implemented by auditing and assessing three Residents weekly for three months. The Director of Nursing will report findings to the Performance Improvement Committee monthly for three months for further recommendations. 5. Completion Date	3/19/12

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NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 32 of any concerns related to Resident #7's skin. An interview with LPN #4, on 01/19/12 at 2:40 PM, revealed she had completed Resident #7's skin assessment on 01/13/12. She stated she identified the resident's feet were very dry, but she did not document it in the nurse's notes or provide care to address the resident's dry skin. Observation of Resident #7's feet, on 01/18/12 at 9:30 AM, revealed the resident's feet were covered with thick, dry, flaky skin to include in between the resident's toes. The resident's heels were dry and appeared cracked, but the skin was intact. When the resident removed his/her socks, dried, flaky skin fell to the floor. Interview with LPN #3, on 01/18/11 at 2:30 PM, revealed Resident #7's dried skin on his/her feet should have been documented in the nurse's notes. She stated Resident #7's feet were in horrible condition and she was embarrassed when she assisted the resident in removing his/her socks.	F 309			
F 314 SS=G	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	F 314	1. Resident #8 was discharged from the facility on 11/24/11. RN # 4 last day worked at facility was 09/30/2011.		

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F 314	Continued From page 33 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 interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one resident (#8), in the selected sample of ten residents.	F 314	2. Current residents had a skin assessment completed to determine necessary treatments were provided by a licensed nurse on 2/5/12. The physician/family notification was completed with care plan updated as indicated. 3. The licensed nursing staff have been re-educated by Director of Nursing, Assistant Director of Nursing, and Medline Wound Care Representative as of 2/24/12 to the Skin Management Program. The education included weekly skin assessment, implementation of pressure reduction measures for high risk residents, admission assessments, staging-of-pressure-ulcers, and treatment options for pressure ulcers. 4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Clinical Case Manager, and/or MDS Coordinator will review by auditing and assessing three residents weekly for three months; treatment records to assure skin assessments/weekly pressure ulcer assessments are completed as scheduled and physician/family notifications implemented and treatment adjustments as indicated. Director of Nursing will report findings to the Performance Improvement Committee monthly for three months for further recommendations.	
	Resident #8 was at high risk for impaired skin integrity related to his/her multiple clinical conditions. Resident #8 was re-admitted to the facility on 09/30/11, with excoriation to buttocks noted. The facility failed to complete an assessment which included a pressure risk assessment (Norton Plus Pressure Ulcer Scale) upon re-admission from the hospital on 09/30/11. On 10/04/11, a recommendation was made by the Registered Dietician (RD) for a Multivitamin (MVI) to promote wound healing; however, there was no documented evidence the physician was notified regarding this recommendation. Record review revealed, on 10/09/11, Resident #8 sat in his/her wheelchair for an undetermined amount of time prior to the oncoming shift's arrival on 10/08/11 (which started at 7:00 PM), through 10/09/11 at 11:00 AM. On 10/11/11 a new pressure sore was identified on the resident's coccyx area, measuring 7.9 centimeters (cm)			

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F 314	<p>Continued From page 34</p> <p>length by 4.1 cm width by 0.1 cm depth. There was no documented evidence the physician was notified of the new pressure sore or consulted to alter treatment. On 10/18/11, the facility identified the coccyx wound had increased in size, measuring 8.9 cm length by 4.8 cm width by 0.1 cm depth. The facility faxed the physician notification, on 10/18/11, of the wound worsening; however, there was no evidence the physician received the fax and no change in treatment was received. Treatment to the resident's coccyx was not changed until 10/26/11, 8 days later. (Refer to F157)</p> <p>In addition, on 10/25/11, Resident #8 was assessed to have a blister to the left and right heel with physician orders to elevate/float bilateral heels; however, there was no evidence this order was implemented. Further review of the medical record revealed no evidence Resident #8's plan of care was revised to reflect the changes in the resident's skin integrity and/or interventions. (Refer to F280) Resident #8 was transferred to another facility on 11/14/11.</p> <p>The findings include:</p> <p>A review of the facility's policy and procedure, "Assessment: Identifying Residents at Risk of Skin Breakdown," undated, revealed, "When a resident arrives, the licensed nurse reviews the pre-admission screen and completes a head-to-toe assessment, documenting findings on the Nursing Assessment. This process provides the team with an accurate description of the resident's actual skin condition at the time of admission. If the resident has a pressure ulcer or other wound at the time of admission, treatment</p>	F 314	5. Completion Date	3/19/12

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F 314	Continued From page 35 begins promptly according to physician orders. The licensed nurse continues the evaluation process to determine the risk of additional skin breakdown, evaluates rehabilitation and nutritional needs, and prepares a plan of care for the existing condition and prevention of additional skin breakdown...After examining a resident's current skin condition, the licensed nurse next evaluates the resident's risk for skin breakdown using the Norton Plus Pressure Ulcer Scale...Regardless of any resident's total risk score; the licensed nurse and interdisciplinary care team are responsible for reviewing each risk factor and its potential causes and implementing preventive strategies, as applicable...Adequate nutrition and hydration are necessary for overall body function and skin health."	F 314		
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	<p>A closed record review Resident #8 was admitted to the facility on 06/24/11 and re-admitted to the facility on 09/30/11 with diagnoses to include Failure To Thrive, Psychosis, Anemia and Protein-calorie Malnutrition.</p> <p>A review of Resident #8's Admission Minimum Data Set (MDS), dated 07/06/11, revealed the facility assessed the resident to be cognitively independent, required total dependence for Activities for Daily Living (ADL's), had no identified behaviors, and no skin issues were identified.</p> <p>A review of the care plan "Potential for Skin Breakdown," dated 07/06/11, revealed to "Observe skin every shift for signs/symptoms of potential skin breakdown (e.g. redness/dyscoloration or open areas)." If breakdown was identified, the charge nurse</p>			
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F 314	Continued From page 36 should be alerted so the nurse could notify the physician if needed for treatment orders. A review of the nurse's notes, dated 09/30/11 at 12:45 PM, revealed Resident #8 was re-admitted to the facility from the hospital with excoriation to the resident's groin and buttocks noted. There was no documented evidence a formal skin assessment was completed to detail the skin integrity, nor was a Norton Plus Pressure Ulcer Scale completed to determine the risk for skin integrity issues, per the facility's policy. There was no evidence the resident's care plan was revised to address the identified excoriation. Additionally, a new non-pressure wound documentation form was not completed to monitor the progress of the identified completed excoriation.	F 314			
	An interview with Registered Nurse (RN) #4, on 01/19/12 at 10:14 AM, revealed she could not provide specific information regarding Resident #8's skin assessment upon re-admission to the facility on 09/30/11. She stated she was not sure who would be responsible for initiation of skin interventions, such as wheelchair cushions or air mattresses. An interview with the Director of Nursing (DON) on 01/19/12 at 3:45 PM, revealed on admission, the admitting nurse should have completed a head-to-toe assessment along with a Norton Pressure Ulcer Scale and the resident's care plan should have been revised on 09/30/11 to address the excoriated areas. Additionally, a new non-pressure ulcer documentation form should have been initiated on 09/30/11, upon identification of the excoriated areas.				

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F 314	<p>Continued From page 37</p> <p>Further review of the closed medical record revealed a physician's order, dated 10/02/11 after re-admission, for "Border gauze to open area on coccyx, change as needed (prn)." However, there was no documented evidence of an open area or a skin assessment completed at that time.</p> <p>A review of a Medical Nutrition Therapy Assessment, dated 10/04/11, revealed the resident's needs were increased to promote wound healing. A MVI was recommended to improve overall nutritional status and to aid in wound healing. However, there was no evidence the physician was notified of this dietary recommendation.</p> <p>An interview with the Registered Dietician (RD), on 01/20/12 at 10:15 AM, revealed copies of the recommendations were given to the DON, Assistant Director of Nursing (ADON), Dietary Manager, and the respective nursing station. If a resident was given a dietary recommendation, she expected the nurse to contact the physician for an order. She stated a MVI provided extra nutrients to aid in wound healing which the resident may not have received by po intake.</p> <p>Further interview with the DON on 01/19/12 at 3:45 PM, revealed when the multi-vitamin was not ordered, on 10/04/11, she expected the staff to contact the physician with dietary recommendations.</p> <p>A review of the Treatment Administration Record (TAR), dated October 2011, revealed a weekly skin assessment was completed on 10/07/11. However, there was no documented evidence of</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>the findings of the skin assessment in either the nurse's notes or on a pressure wound documentation form, even though the physician had ordered a treatment on 10/02/11 for an open area to the resident's coccyx.</p> <p>A review of the nurses' notes, dated 10/08/11 at 6:30 AM, revealed the DON documented "Resident has been up all night, refusing to lay down, refusing medications. Educated resident on need to lay down to relieve pressure off his/her buttocks. Resident continues to refuse. Spoke with daughter this AM. States she and her husband may try to come up today." Further review of a nurses' note, dated 10/09/11 at 11:00 AM, revealed "Daughter here, helped resident back to bed....."</p>	F 314		
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	<p>An interview with the DON, on 01/19/12 at 3:45 PM, revealed she was the nurse who worked night shift on 10/09/11. She received report about Resident #8's refusal to lay down during day shift. She was unsure of the exact time the resident sat up in the wheelchair prior to her arrival. She stated she did not contact the daughter or the physician that evening because she felt she could convince the resident to go to bed. She stated she was aware of the resident's history of paranoid behavior, which she believed contributed to the resident's refusal to lay down. She stated she contacted the resident's daughter, for assistance, prior to the end of the shift. She stated she explained the risks of being up all night in the wheelchair and documented it. She further explained that being up in a wheelchair for the entire shift could contribute to the worsening of a pressure ulcer. She stated the resident had a pressure-relieving cushion in the wheelchair</p>			
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F 314	<p>Continued From page 39 during this incident; however, there was no documented evidence of a cushion in place.</p> <p>A review of Resident #8's "Pressure Wound and Skin Documentatton Form," completed on 10/11/11, revealed a new Stage II wound on the coccyx, measuring 7.9 centimeters (cm) length by 4.1 cm width, by 0.1 cm depth. However, there was no documented evidence the physician was notified of the new pressure sore or consulted to alter treatment.</p> <p>A review of Resident #8's significant change Minimum Data Set (MDS), dated 10/14/11, revealed the facility assessed Resident #8 was cognitively independent, and required extensive assistance to total dependence for Activities of Dally Living (ADL's). Resident #8 was identified</p>	F 314		
	<p>to be incontinent of bowel, with a urinary catheter. The facility assessed Resident #8 to have one Stage II pressure ulcer that was noted to be present upon admission/reentry.</p> <p>Review of Resident #8's skin assessment completed on 10/18/11, revealed the coccyx wound had increased in size, measuring 8.9 cm length by 4.8 cm width by 0.1 cm depth. The facility faxed the physician notification, on 10/18/11, of the wound worsening; however, there was no evidence the physician received the fax and no change in treatment was received.</p> <p>A review of the physician's progress notes, dated 10/19/11, revealed the Nurse Practitioner (NP) ordered a wound care consultation due to the nurse's concern that the wound on the resident's sacral area was not healing and that wound continued to grow in size and had developed a</p>			

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F 314	<p>Continued From page 40</p> <p>dark center. However, the wound care consultation was scheduled for 10/31/11, twelve days later. Record review revealed the NP did not change the treatment orders on 10/19/11 and the facility did not notify the physician for a change in treatment until seven days later, on 10/26/11. On 10/26/11, a physician's order was received to discontinue the border gauze treatment, and start Dakin's solution, wet to dry dressings, to be changed daily.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 01/20/12 at 2:39 PM, revealed she completed wound assessments on Resident #8 and if there was a change in the wound, such as worsening or odor, she contacted the physician by phone and/or fax. She was unable to recall specifics of the worsening of the wound from 10/11/11 through 10/18/11.</p>	F 314			
	<p>Further record review revealed, on 11/01/11, a wound odor was identified by the DON; however, there was no documented evidence the physician was notified at that time. Per record review, the resident's treatment was not changed until 11/07/11, when the wound care center discontinued the Dakin's solution and ordered Santyl (Collagenase) 250 units/gram (gm) ointment topical (external) - on day shift and evening shift everyday: soap and water, wash wound to coccyx area, apply Santyl gel then saf-gel, cover with dry gauze and secure with medipore tape twice daily.</p> <p>An interview with Resident #8's physician, on 01/20/12 at 4:00 PM, revealed he expected the staff to contact him regarding dietary recommendations. Additionally, he expected the</p>				

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F 314	Continued From page 41 staff to intensify treatment if the wound deteriorated. He expected the staff to re-evaluate, adjust treatment according to the facility's protocol, and notify him if there was a change in wound status. Further review of Resident #8's medical record revealed in the nurses' notes, dated 10/09/11 at 6:30 AM, the DON documented "Daughter voiced concern over edema and 'blisters' on peri-area and upper thighs." Further review revealed a change in condition form was faxed to the physician about the edema; however, it did not include the daughter's concern regarding the blistered areas. There was no documented evidence that a care plan was revised to reflect the new "blisters," or a non-pressure wound documentation form was completed at this time.	F 314			
	A review of Resident #8's comprehensive care plan, dated 10/14/11, revealed the facility identified a problem of, "Swelling to all extremities," with interventions to include medications as ordered, monitoring for new or worsened condition, and to notify the MD of any changes. There was no documented evidence an intervention was put into place to prevent altered skin integrity to the extremities. A review of the non-pressure wound and skin condition documentation form, dated 10/25/11 (sixteen days after the daughter expressed concern about blister areas), revealed a new blister was identified to the left heel that measured 4 cm length by 5 cm width, and a new blister to the right heel, that measured 5 cm length X 6 cm width. A physician's order dated 10/26/11, revealed the staff were to, "Elevate/float				

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F 314	Continued From page 42 bilateral heels, check every two hours." However, neither Resident #8's comprehensive care plan nor nursing aide care plan was revised to reflect the new interventions to elevate/float bilateral heels or to check every two hours. Further interview with the Director of Nursing (DON) on 01/19/12 at 3:45 PM, revealed when the swelling was identified to extremities, on 10/14/11, a care plan should have been initiated to protect the skin integrity. She could not provide an explanation as to why an intervention such as heel boots was not implemented to prevent alteration in skin integrity per the physician's order.	F 314			