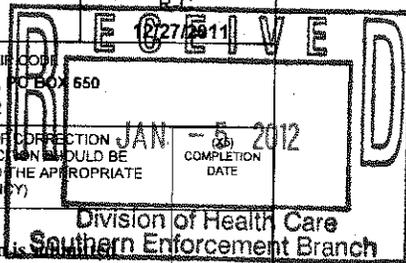


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/27/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
(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)	COMPLETION DATE
{F 000}	INITIAL COMMENTS On 12/27/11, an on-site revisit to the abbreviated survey (12/12/11) was conducted, which determined Immediate Jeopardy (IJ) had been removed at F-224, F-282, F-314 and F-490, as alleged in the acceptable Allegation of Compliance (AOC) received on 12/22/11. While the IJ was removed at F-224, F-282, F-314, and F-490, continued noncompliance remained as follows: F-224, F-282, F-314 and F-490 at a S/S of "D." The facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff monitoring, analysis of monitoring, results of audits, and the development and implementation of the Plan of Correction (POC) to prevent the recurrence of noncompliance.	{F 000}	This Plan of Correction is under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.	JAN -- 5 2012
{F 224} SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION 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, record review, review of the Allegation of Compliance and the facility's file it was determined that Immediate Jeopardy identified during the abbreviated survey (12/12/11) had been removed related to neglect. However, noncompliance continued to exist at a S/S of "D" as the facility had not completed the Quality Assessment and Assurance (QAA)	{F 224}	F 224 Corrective action accomplished for residents found to have been affected by the deficient practice: 1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility that require a trach collar at this time. The primary physician will be notified upon resident #1's	



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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

01-05-12

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

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(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 224}	<p>Continued From page 1</p> <p>Initiative related to staff monitoring, analysis of monitoring, results of audits, and the development and implementation of the Plan of Correction (POC) as related to neglect.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 12/22/11, revealed the facility conducted assessments on all current residents on 12/12/11. On 12/13/11, the nursing management team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, and Unit Manager) reassessed all current residents for risk factors related to pressure ulcer development.</p> <p>Review of facility in-services revealed staff was re-educated on 12/13/11. Staff not available on 12/13/11, would not be allowed to work until they had completed the in-service offering. The in-service placed an emphasis on pressure ulcer education, Neglect and Abuse education, and the Elder Justice Act.</p> <p>Interviews were conducted on 12/27/11, with the Executive Director, the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS), the Minimum Data Set (MDS) Coordinator, four State Registered Nursing Assistants (SRNAs), three Licensed Practical Nurses (LPNs), and two Registered Nurses (RNs). All interviews revealed staff had received re-education related to facility policies and procedures and demonstrated a working knowledge of their responsibilities.</p>	{F 224}	<p>return to the facility after a nurse manager has completed a full skin assessment, care plans with preventions, interventions, causative factors, and treatments. The primary physician will give any treatment orders that are identified as needed.</p> <p>The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>2) Nursing administration completed a 100% skin assessment and observation of all residents with pressure wounds on 12/13/11 to ensure no other residents had devices that were causing pressure and to ensure all resident treatments were being completed per physician orders. Any skin issues identified, the primary physician was notified, new orders obtained, treatments completed, care plans revised, and care guides updated. (See attachment)</p>		

Tag # F 224

This was to ensure wound care policy, guidelines, assessments, and treatments were provided per policy and physician order.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

- 3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, **abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.**

The Regional Director of Clinical Services in-serviced the ED, Social Services

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Director, DON, ADON, AND SDC on the policy and procedure of investigation related to care and services provided to residents on 12/29/11. Emphasis was placed on the importance of determining the cause of injuries and the prevention and interventions needed.

The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy and procedure which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, **abuse, neglect, and a post test was completed.** **Emphasis was placed on neglect and reporting of allegations of abuse or neglect.**

The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes

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prevention of infections, treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.

The SDC will in-service all new employees on abuse, neglect, and a post test will be completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.

How the facility plans to monitor its performance to ensure that solutions are sustained:

- 4) Nurse Administration will complete 2 times weekly skin assessments observation of licensed nurses completing skin assessments. This is to ensure all licensed nurses are adequately trained to complete skin assessments, treatments, and wound assessments to ensure care and services are

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being provided per policy and procedure per state and federal regulations.

Skin assessments will be observed 2x weekly x 30days, then wkly x4 months, then monthly x2 months, then randomly x 2months.

Daily observations and audits of wounds, treatments, and devices will be completed by Nursing Administration of licensed nurses performing wound treatments, assessments, and observation of devices that can cause pressure wounds. This is to ensure treatments, preventions, interventions, causative factors, healing, documentation, care plans, care guide revisions, are completed accurately.

Nursing Administration will complete daily observation daily x30 days, then wkly x4 months, then monthly x2 months, then randomly x2 months.

The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement

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Committee determines
compliance.

5) Date of Compliance 1/9/2012.

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522		
(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 224}	Continued From page 2 Review of the facility's file revealed the facility had not submitted their plan of correction for the identified deficiencies from the abbreviated survey of 12/12/11. Additionally, interviews conducted with the RDCS on 12/27/11, at 4:50 PM, with the Executive Director on 12/27/11, at 4:45 PM, and with the DON on 12/27/11, at 4:10 PM, revealed performance improvement activities had been initiated; however, the facility needed to continue quality assurance activities to ensure compliance with established policies and procedures related to abuse/neglect, after the provision of staff re-education.	{F 224}	F 282 Corrective action accomplished for residents found to have been affected by the deficient practice; 1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility that require a trach collar at this time. The primary physician will be notified upon resident #1's return to the facility after a nurse manager has completed a full skin assessment, care plans with preventions, interventions, causative factors, and treatments. The primary physician will give any treatment orders that are identified as needed. The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note. Address how the facility will identify other residents having the potential to		
{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 interview, record review, review of the Allegation of Compliance and the facility's file it was determined the Immediate Jeopardy identified during the abbreviated survey (12/12/11) had been removed related to the failure to provide resident care in accordance with the individualized care plan. However, noncompliance continued to exist at a S/S of "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff monitoring, analysis of monitoring audit results, and development and implementation of the Plan of Correction (POC) to ensure care was provided in accordance with	{F 282}			

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 946 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
(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 282}	<p>Continued From page 3 each resident's individualized care plan.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 12/22/11, revealed on 12/12/11, the facility conducted assessments on all current residents and reviewed all current residents' medical records to identify any issues related to the provision of care.</p> <p>Record review revealed the facility provided education for all staff on 12/13/11, 12/14/11, 12/22/11, and 12/23/11, which included the requirement to provide care based on the resident's individual care plan. Emphasis was placed on the need to provide care and services to prevent pressure ulcers and promote healing of current pressure ulcers.</p> <p>Interviews were conducted on 12/27/11, with the Executive Director (ED), Director of Nursing (DON), Regional Director of Clinical Services (RDCS), the Minimum Data Set (MDS) Coordinator, four State Registered Nursing Assistants (SRNAs), three Licensed Practical Nurses (LPNs), and two Registered Nurses (RNs). All interviews revealed staff had received re-education related to providing care in accordance with the individualized care plan and each staff member demonstrated a working knowledge of their responsibilities for residents at risk for the development of pressure ulcers.</p> <p>Review of the facility's file revealed the facility had not submitted their plan of correction for the identified deficiencies from the abbreviated</p>	{F 282}	<p>be affected by the same deficient practice:</p> <p>2) A 100% care plan audit was completed on 12/13/11 by Nursing Administration for all residents requiring skin treatments, skin issues, pressure wounds, at risk for skin breakdown, requiring any device that can cause skin breakdown, ie: trach collars, oxygen collars, oxygen therapy, braces, etc. Care plan revisions were made to reflect interventions, preventions, treatments, causative factors as indicated. This will ensure the written plan of care has been revised or a written plan of care is in place for care and services of all residents.</p> <p>The nurse management team completed a 100% skin assessment audit and updated Braden scales for all residents residing in the facility to ensure all residents were receiving necessary treatment and services to promote healing and prevention of infection to pressure wounds. The primary physician was notified for treatment orders for any skin issues identified. The responsible party, POA, family etc were notified as well. Nurse (See Attachment)</p>	

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management ensured skin issues identified had treatments, care plans, interventions, preventions, documentation, and pressure or non-pressure measurements recorded in the resident's records. This ensured the resident's written plan of care and services are provided.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- 3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy, guidelines which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.

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The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy, guidelines which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.

The SDC in-serviced the licensed nurses on 12/29/11 and 12/30/11 on when and how to revise care plans and the implementation of acute care plans when an order is written for any skin issue, treatment, application of a device, pressure wound treatment or change of treatment to an existing skin issue or pressure wound and following care plans in accordance to facility policies and procedures.

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Nursing Administration will review 24 hour shift reports and all physician orders daily to ensure any change of treatment, new treatments, and /or devices ordered are care planned. This will ensure treatments, interventions, preventions, causative factors, and devices have been care planned, orders are implemented, documented, and care guides have been updated.

The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.

The SDC will in-service all new employees on abuse, neglect, and a post test will be completed. Emphasis will be

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placed on abuse, neglect, and reporting of allegations of abuse or neglect.

How the facility plans to monitor its performance to ensure that solutions are sustained:

- 4) Daily observations and audits will be performed by Nursing Administration of licensed nurses performing skin assessments, wound treatments, wound observation, and observation of devices that can cause pressure wounds. This is to ensure treatments, preventions, interventions, healing, documentation, care plans, care plan revisions, and care guide revisions, are implemented per care plan and in accordance to facility policies and procedures. Daily observations and audits will be daily x30 days, then wkly x4 months, then monthly x2 months, then randomly x2 months.

Nursing Administration will reviewing 24 hour shift reports, all physician orders, and care plans to ensure any change of treatment, new treatments, and /or devices ordered are care planned. This will ensure treatments, interventions,

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preventions, causative factors, and devices have been care planned, orders are implemented, documented, and care guides have been updated. Nursing Administration will perform observations and audits daily x30 days, then wkly x4 months, then monthly x2 months, then randomly x2 months.

The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance

5) Date of Compliance 1/9/2012.

Tag # F 282

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
(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 282}	Continued From page 4 survey of 12/12/11. Interviews conducted with the ED, DON, and RDCS on 12/27/11, from 4:10 PM to 4:50 PM, revealed quality assurance activities had been initiated; however, the facility needed to continue quality assurance activities to ensure compliance with established policies and procedures related to the provision of care after staff re-education was provided.	{F 282}	F 314 Corrective action accomplished for residents found to have been affected by the deficient practice;	
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's Allegation of Compliance and the facility's file it was determined the Immediate Jeopardy identified during the abbreviated survey (12/12/11) had been removed related to the failure to provide necessary care and services for a resident with a pressure ulcer. However, noncompliance continued to exist at a S/S of "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff monitoring, analysis of audit results, and the development and implementation of the Plan of Correction (POC) related to the provision of care for pressure ulcer management.	{F 314}	1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility at this time requiring a trach collar. The primary physician will be notified upon resident #1's return to the facility after a nurse manager has observed the licensed nurse completing a full skin assessment, documentation, and care plan. The primary physician will give any treatment orders that are identified as needed. Nursing Administration will ensure the orders obtained are implemented, documented, and care plan revisions initiated. The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET, PO BOX 650 ELKHORN CITY, KY 41522	
(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 314}	Continued From page 5 The findings include: Review of the acceptable Allegation of Compliance (AOC) received on 12/22/11, revealed the facility conducted assessments on all current residents on 12/12/11. On 12/13/11, nursing administration (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, and Unit Managers) observed all licensed nurses perform wound treatments to ensure the documentation and assessment of wounds was accurate in regards to wound status, staging, treatment, and measurements. All residents were reassessed on 12/13/11, by the nurse management team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, and Unit Managers) utilizing the Braden scale for risk factors related to the development of pressure ulcers. Record review revealed the facility provided in-service education for all staff on 12/12/11, 12/13/11, 12/22/11, and 12/23/11, with an emphasis on pressure ulcers, wound care policy, guidelines, correct staging of wounds, and assistive devices that could cause pressure wounds. Interviews were conducted on 12/27/11, with the Executive Director (ED), Director of Nursing (DON), Regional Director of Clinical Services (RDCS), the Minimum Data Set (MDS) Coordinator, four State Registered Nursing Assistants (SRNAs), three Licensed Practical Nurses (LPNs), and two Registered Nurses	{F 314}	Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 2) The nurse management team completed a 100% skin assessment audit and updated Braden scale for all residents residing in the facility to ensure all residents were receiving necessary treatment and services to promote healing and prevention of infection to pressure wounds. Any skin issues identified, the primary physician was notified for treatment orders. The responsible party, POA, family etc were notified as well. Nurse management ensured skin issues identified had treatments, care plans, interventions, preventions, documentation, and pressure or non-pressure measurements recorded in the resident's records. No signs and symptoms of infection were noted during these assessments. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; 3) The Regional Director of Clinical Services in-serviced (See Attachment)	

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the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.

The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy which includes prevention of infections, interventions to promote wound healing, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds,

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completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.

The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.

The SDC will in-service all new employees on abuse, neglect, and a post-test will be completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.

The SDC in-serviced the licensed nurses on 12/29/11 and 12/30/11 on when and how to

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revise care plans and the implementation of acute care plans when an order is written for any skin issue, treatment, application of an device, pressure wound treatment or change of treatment to an existing skin issue or pressure wound and following care plans in accordance to facility policies and procedures.

How the facility plans to monitor its performance to ensure that solutions are sustained:

- 4) Nursing Administration will complete 2 times weekly observations of licensed nurses performing skin and wound assessments and treatments. Daily observations will be performed by Nursing Administration daily x30 days then 2x weekly x30days, then wkly x4 months, then monthly x2 months, then randomly x2months to ensure licensed nurses are providing treatments and services to promote healing and prevent infection of pressure wounds.

Nurse Administration will review 24 hour shift reports and all physician orders to ensure any new wounds identified have physician orders, treatments, detection of signs and

Tag # F 314

symptoms of infection, care plans, care plan revisions with any change in wound treatments
Review of 24 hour reports and physician orders will be completed by Nursing Administration daily x30 days, then M-F ongoing.

The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.

5) Date of Compliance 1/9/2012

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{F 314}	Continued From page 6 (RNs). All interviews revealed staff had received re-education related to providing care in accordance with the individualized care plan and each staff member demonstrated a working knowledge of their responsibilities for residents at risk for the development of pressure ulcers. Additionally, licensed staff received education related to accurate wound documentation, wound care policy, correct staging of wounds, and assistive devices that may cause pressure wounds. Review of the facility's file revealed the facility had not submitted their plan of correction for the identified deficiencies from the abbreviated survey of 12/12/11. Interviews conducted with the Administrator, the DON, and the RDCS on 12/27/11, from 4:10 PM to 4:50 PM, revealed quality assurance activities had been initiated; however, the facility needed to continue quality assurance activities to ensure compliance with established policies and procedures related to pressure ulcer management after the provision of staff re-education.	{F 314}	F 490 Corrective action accomplished for residents found to have been affected by the deficient practice; 1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility at this time requiring a trach collar. The primary physician will be notified upon resident #1's return to the facility after a nurse manager has observed the licensed nurse completing a full skin assessment, documentation, and care plan. The primary physician will give any treatment orders that are identified as needed. Nursing Administration will ensure the orders obtained are implemented, documented, and care plan revisions initiated. The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.	
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the	{F 490}		

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{F 490}	<p>Continued From page 7</p> <p>Allegation of Compliance, and the facility's file it was determined that Immediate Jeopardy identified during the abbreviated survey (12/12/11) had been removed related to neglect, care plan implementation, and pressure ulcer management. However, noncompliance continued to exist at S/S of "D" as the facility had not completed the Quality Assessment and Assurance (QAA) initiative related to staff monitoring, analysis of monitoring, results of audits, and the development and implementation of the Plan of Correction (POC) to prevent recurrence of noncompliance.</p> <p>The findings include:</p> <p>Review of the acceptable Allegation of Compliance (AOC) received on 12/22/11, revealed the facility conducted assessments on all current residents on 12/12/11. On 12/13/11, the nursing management team (Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, RAI Coordinator, and Unit Manager) reassessed all current residents for risk factors related to pressure ulcer development. The Executive Director received education from the Regional Director of Clinical Services related to QAA activities.</p> <p>Review of facility provided in-services revealed staff was re-educated on 12/13/11, and any staff not available on 12/13/11, would not be allowed to work until they had completed the in-service offering. The in-services placed an emphasis on pressure ulcer education, Neglect and Abuse education, and the Elder Justice Act. Additionally, licensed staff received education related to accurate wound documentation, wound</p>	{F 490}	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>2) Social Services and Nursing Administration will complete a risk worksheet for abuse, neglect and exploitation on all residents residing in the facility by 1/6/11. Care plans will be initiated or revised for any residents identified to be at risk for abuse, neglect, or exploitation.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds,</p>		

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{F 490}	<p>Continued From page 8</p> <p>care policy, correct staging of wounds, and assistive devices that may cause pressure wounds.</p> <p>Interviews were conducted on 12/27/11, with the Executive Director, the Director of Nursing (DON), the Regional Director of Clinical Services (RDCS), the Minimum Data Set (MDS) Coordinator, four State Registered Nursing Assistants (SRNAs), three Licensed Practical Nurses (LPNs), and two Registered Nurses (RNs). All interviews revealed staff had received re-education related to facility policies and procedures for wound care, assistive devices, oxygen administration, skin assessments, and Abuse/Neglect and demonstrated a working knowledge of their responsibilities.</p> <p>Review of the facility's file revealed the facility had not submitted their plan of correction for the identified deficiencies from the abbreviated survey of 12/12/11. Additionally, interviews conducted with the RDCS on 12/27/11, at 4:50 PM, with the Executive Director on 12/27/11, at 4:45 PM, and the DON on 12/27/11, at 4:10 PM, revealed performance improvement activities had been initiated; however, the facility needed to continue quality assurance activities to ensure compliance with established policies and procedures related to abuse/neglect, provision of care through care plan implementation, and pressure ulcer management after further re-education of staff.</p>	{F 490}	<p>completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy which includes prevention of infections and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>Nursing administration completed a 100% skin assessment audit and observation of all residents with pressure wounds on 12/13/11 to ensure no other residents had devices that were causing pressure and to ensure all (See Attachment)</p>		

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resident treatments were being completed per physician orders. Any skin issues identified the primary physician was notified, new orders obtained, treatments completed, care plans completed, care plans revised, and care guides updated. This was to ensure wound care policy, guidelines, assessments, and treatments were provided per policy and physician order.

How the facility plans to monitor its performance to ensure that solutions are sustained:

- 4) Nursing Administration will complete 2 times weekly observations of licensed nurses performing skin and wound assessments and treatments. Daily observations will be performed by Nursing Administration daily x30 days then 2x weekly x30days, then wkly x4 months, then monthly x2 months, then randomly x2months to ensure licensed nurses are providing treatments and services to promote healing and prevent infection of pressure wounds.

Nurse Administration will review 24 hour shift reports and all physician orders to ensure any new wounds identified have physician orders, treatments,

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detection of signs and symptoms of infection, care plans, care plan revisions with any change in wound treatments
Review of 24 hour reports and physician orders will be completed by Nursing Administration daily x30 days, then M-F ongoing.

The Executive Director will conduct a weekly Performance Improvement meeting with the Interdisciplinary Team which includes the Medical Director for the next 4 weeks to ensure residents are receiving care and services to attain and maintain highest practicable physical well being. Any concerns or issues identified will be discussed and a plan of action put in place to address concerns or issues.

Increased Performance Improvement meetings will be conducted weekly x30 days, then monthly x6 months for care and services to attain and maintain highest practicable physical well being.

The Executive Director will conduct a weekly wound meeting for residents with skin issues, pressure wounds, or requiring devices that may cause pressure wounds will be discussed. Any concerns or

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issues identified will be discussed and a plan of action put in place to address concerns or issues.

Weekly wound meetings will be conducted weekly to ensure skin issues, pressure wounds, and devices that may cause pressure are being addressed weekly.

The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting.

Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.

- 5) Date of Compliance 1/9/12.

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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey was initiated on 12/06/11, and a partial extended survey was conducted on 12/12/11. The survey began with the investigation of KY17365 and KY17435 on 12/06/11. KY17365 was substantiated with deficient practice identified. KY17435 was unsubstantiated with no deficient practice identified.</p> <p>Immediate Jeopardy was identified on 12/12/11, was determined to exist on 11/04/11, and is ongoing based on the facility's failure to identify as neglect staff failure to implement facility policy/procedure related to assessment of wounds and providing wound treatment. Although the facility was made aware of an allegation of neglect of Resident #1 by Adult Protective Services on 11/07/11, the facility failed to investigate to ensure care and services were being provided in accordance with facility policy and procedure. In addition, the facility failed to monitor staff practice to ensure wounds were assessed per policy/procedure and treated per the resident's care plan. The facility was notified on 12/12/11.</p> <p>The facility failed to ensure resident #1's wound was assessed weekly per the facility's policy and failed to monitor to ensure treatments were provided. In addition, the facility failed to protect residents by determining the cause of the injury to Resident #1 and developing interventions to prevent further injury. On 11/04/11 at 9:00 AM, the facility transferred Resident #1 to the hospital for an elevated temperature. Paramedic interview revealed that during the 35 minute ambulance transport to the hospital he did not</p>	F 000	<div data-bbox="1047 451 1453 703" style="border: 2px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>JAN - 3 2012</p> <p>Division of Health Care Southern Enforcement Branch</p> </div> <div data-bbox="998 1312 1429 1606" style="border: 2px solid black; padding: 5px; text-align: center; margin-top: 200px;"> <p>RECEIVED</p> <p>JAN - 3 2011</p> <p>Division of Health Care Southern Enforcement Branch</p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rand Danner</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12-30-11</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 remember a covering/dressing applied to the left side of Resident #1's neck. Upon arrival to the hospital, hospital physician and ENT surgeon interviews revealed Resident #1 arrived at the hospital in the following condition: Resident #1 had a tracheostomy collar strap (a strap used to hold the device that delivers oxygen to a resident with a tracheostomy in place) which had "lacerated the skin, the skin was like a flap...the laceration was from the strap pressure." Review of the Hospital photograph of the neck wound revealed Resident #1's trach strap had incised into the resident's neck and a flap of skin lay over a portion of the neck strap. The Emergency Room Physician stated it looked like the strap "had grown into the skin." He stated that it "looked like abuse, neglect...there was no dressing to the wound upon arrival to the hospital, had to be "at least seven (7) days" for the collar to have made the incision into the skin. "The severity could [have been] avoided." Hospital physicians revealed the wound was "neglected," Furthermore the Hospitalist (Hospital Physician) stated the hospital admitted Resident #1 with the diagnosis of "sepsis, the neck [wound] was the source of the sepsis" (sepsis - blood stream infection caused by bacteria, infectious microorganisms, or toxins). Review of the hospital laboratory results revealed the resident's wound to the neck contained three (3) infectious organisms; a heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA), a heavy growth of Providencia stuartii (often found in urinary tract infections), and a heavy growth of MDR (multi-drug resistant) Acinetobacter Baumannii (organism that can cause various skin and wound infections). The resident was treated with Vancomycin 1300 milligrams (mg) given	F 000		

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F 000	Continued From page 2 intravenously every twelve (12) hours. Resident #1 remained in the hospital until 11/10/11. Deficiencies were cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F224), 42 CFR 483.20 Resident Assessment (F282), 483.25 Quality of Care (F314), and 42 CFR 483.75 Administration (F490) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices and 42 CFR 483.25 Quality of Care.	F 000	<p>This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by that facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.</p> <p style="text-align: center;"><u>F 224</u></p> <p>Corrective action accomplished for residents found to have been affected by the deficient practice:</p> <p>1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility that require a trach collar at this time.</p> <p>The primary physician will be notified upon resident #1's</p>	
F 224 SS=J	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and hospital record review, it was determined the facility failed to implement policies/procedures that prohibit neglect of residents was implemented for one (1) resident (Resident #1) in the sample of thirteen (13) residents. The facility failed to ensure staff followed the Resident Abuse and Neglect policy/procedure to ensure residents received the necessary care and services to avoid physical harm. The facility had assessed Resident #1 as at risk for pressure sores, previously identified a</p>	F 224		

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F 224	Continued From page 3 wound to the left side of the resident's neck; however, the facility failed to identify the tracheostomy collar strap as a causal factor for the development of a pressure sore on the neck, failed to implement interventions and failed to ensure staff provided care and services to protect the resident's skin from injury related to pressure from the tracheostomy collar strap. On 11/04/11 at 9:00 AM, the facility transferred Resident #1 to the hospital for an elevated temperature. During the 35 minute ambulance transport, Paramedic interview revealed the resident had no covering/dressing applied to the left side of Resident #1's neck. Upon arrival to the hospital, hospital staff assessed Resident #1 as having a tracheostomy collar strap (a strap used to hold the device that delivers oxygen to a resident with a tracheostomy in place) which had incised into the neck with a flap of skin which lay over the strap. Hospital physicians revealed the "severity of the injury was avoidable"; the wound was "neglected", had to be "at least seven days" for the collar to have made the incision into the skin, which resulted in the resident's admission to the hospital with a diagnoses of sepsis which the neck wound had been determined the source of the sepsis (sepsis - blood stream infection caused by bacteria, infectious microorganisms or toxins). The failure to ensure care and services were provided to protect residents from injury has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy was determined to exist on 11/04/11 and is ongoing. (Refer to F314)	F 224	return to the facility after a nurse manager has completed a full skin assessment, care plans with preventions, interventions, causative factors, and treatments. The primary physician will give any treatment orders that are identified as needed. The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 2) Nursing administration completed a 100% skin assessment and observation of all residents with pressure wounds on 12/13/11 to ensure no other residents had devices that were causing pressure and to ensure all resident treatments were being completed per physician orders. Any skin issues identified, the primary physician was notified, new orders obtained, treatments completed, care plans revised, and care guides updated.	

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F 224	<p>Continued From page 4</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure for Resident Abuse and Neglect (no date provided) revealed neglect must be identified and corrected quickly. The facility policy/procedure defined neglect as the failure to provide the necessary care to meet each resident's needs. Further review revealed, "Associates want to take good care of our resident's needs. Regardless of the cause, neglect must be identified and corrected quickly."</p> <p>Interview, on 12/09/11 at 12:50 PM, with the paramedic who transported Resident #1 to the hospital on 11/04/11 revealed he was notified of a resident at the facility that needed transportation to the hospital due to a fever. The paramedic stated the trip from the facility to the hospital took approximately thirty five (35) minutes. The paramedic also stated he had suctioned the resident during the trip but had not removed the tracheostomy collar and did not remember a covering/dressing applied to the left side of Resident #1's neck.</p> <p>Interview with the Emergency Department (ED) Registered Nurse (RN) on 12/09/11, at 10:04 AM, revealed she had provided care for Resident #1 upon the resident's arrival to the ED on 11/04/11. According to the RN, the ambulance personnel assisted the resident onto a stretcher. She turned the resident to the side to obtain a rectal temperature, and observed the wound to the resident's neck. The RN stated a section of the strap that secured the resident's tracheostomy collar could not be observed, was covered with</p>	F 224	<p>This was to ensure wound care policy, guidelines, assessments, and treatments were provided per policy and physician order.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The Regional Director of Clinical Services in-serviced the ED, Social Services Director, DON, ADON, AND</p>	

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F 224	<p>Continued From page 5</p> <p>skin, and had yellow drainage. According to the RN, the strap appeared to have grown into the resident's skin. The RN obtained pictures and notified the ED physician and the Charge Nurse of the assessment. The RN was instructed by the physician and the Charge Nurse to notify Social Services because the wound did not appear to have received care. A review of the emergency department physician's notes revealed the tracheostomy strap that was applied to Resident #1's neck had incised into the resident's neck with a flap of skin which had grown over the tracheostomy strap. Social Services was contacted due to the appearance of the resident's neck, and a photograph was obtained.</p> <p>Review of the Hospital photograph of Resident #1's neck wound, dated 11/04/11 at 12:07, revealed Resident #1's trach strap had incised into the resident's neck and a flap of skin lay over a portion of the neck strap. A review of the hospital admission physician notes, dated 11/04/11 at 4:45 PM, revealed the resident was assessed, upon admission to the hospital, with a wound on the left side of the neck from the tracheostomy collar. A review of the surgical consultation dated 11/04/11 revealed the tracheostomy collar had "eroded through the resident's neck."</p> <p>Interview with the Emergency Department physician, on 12/09/11 at 10:35 AM, confirmed Resident #1 was received in the Emergency Department (ED) on 11/04/11 and, according to the ED physician, there had not been a dressing on the resident's tracheostomy wound and the tracheostomy (tracheostomy) collar strap</p>	F 224	<p>SDC on the policy and procedure of investigation related to care and services provided to residents on 12/29/11. Emphasis was placed on the importance of determining the cause of injuries and the prevention and interventions needed.</p> <p>The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy and procedure which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes prevention of infections,</p>		

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F 224	<p>Continued From page 6</p> <p>appeared to have grown into the skin. The ED physician stated he informed the ED nurse that he felt the resident had suffered "abuse" and a report should be made to Social Services. The ED physician stated a tracheostomy collar would occasionally cause a little redness or a small ulcer and, according to the ED physician, the "severity of the injury could have been avoided."</p> <p>Interview, on 12/06/11 at 11:40 AM, with the physician that admitted Resident #1 to the hospital revealed the physician consulted a surgeon when he saw the condition of the resident's neck. The physician stated the tracheostomy collar was too tight and the strap had gone into the skin on the resident's neck. The physician stated the injury did not happen quickly, in his opinion it was neglected for "a couple of weeks." The physician stated the resident was "admitted to the hospital with sepsis and the neck wound was the source of the sepsis." Review of the hospital record for Resident #1 revealed the resident's wound on the neck had been cultured and the results revealed a heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA), a heavy growth of Providencia Sturtii (an organism found in complicated urinary tract infections), and a heavy growth of MDR (multi-drug resistant) Acinetobacter Baumannii (an organism that can cause skin and wound infections). The resident was treated at the hospital with Vancomycin 1300 milligrams (mg), intravenously every 12 hours.</p> <p>Interview with the surgeon, on 12/07/11 at 9:25 AM and again on 12/09/11 at 10:58 AM, revealed he had been consulted to evaluate Resident #1 related to the tracheostomy collar. The surgeon</p>	F 224	<p>treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC will in-service all new employees on abuse, neglect, and a post test will be completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>4) Nurse Administration will complete 2 times weekly skin assessments observation of licensed nurses completing skin assessments. This is to ensure all licensed nurses are adequately trained to complete skin assessments, treatments, and wound assessments to ensure care and services are being provided per policy and</p>		

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F 224	<p>Continued From page 7</p> <p>stated he removed the tracheostomy collar at the resident's bedside and that the tracheostomy collar was "upside down" and was "too tight." The surgeon stated the tracheostomy collar strap had made an incision into the resident's skin from the pressure of the strap. According to the surgeon, the injury "could not have happened overnight" and would have taken "at least seven days" to make an incision into the skin. The surgeon stated the tracheostomy collar could not have been checked in "any normal period of time." According to the surgeon, the standard of care for a tracheostomy would include suctioning along with cleaning and removal of the tracheostomy collar. The surgeon also stated it was "unlikely routine tracheostomy care had been conducted."</p> <p>Additionally, interview with Resident #1's primary physician, on 12/09/11 at 3:15 PM, revealed the physician had been informed by nursing facility staff (he did not remember the date) that the resident had returned from the hospital and the tracheostomy strap had become embedded into the skin of the resident's neck. The physician confirmed he did not visualize the resident's pressure sore at that time. After a review of the photograph of Resident #1's neck that had been taken by hospital staff on 11/04/11, the physician stated he was unaware the resident's neck was in that condition. According to the physician, it would have taken "a while" for the pressure sore to develop in to that condition, probably longer than seven days.</p> <p>Medical record review revealed the nursing facility admitted Resident #1 on 09/10/10 with diagnoses that included Tracheostomy, Dysphagia, Seizure</p>	F 224	<p>procedure per state and federal regulations.</p> <p>Skin assessments will be observed 2x weekly x 30days, then wkly x4 months, then monthly x2 months, then randomly x 2months.</p> <p>Daily observations and audits of wounds, treatments, and devices will be completed by Nursing Administration of licensed nurses performing wound treatments, assessments, and observation of devices that can cause pressure wounds. This is to ensure treatments, preventions, interventions, causative factors, healing, documentation, care plans, care guide revisions, are completed accurately.</p> <p>Nursing Administration will complete daily observation daily x30 days, then wkly x4 months, then monthly x2 months, then randomly x2 months.</p> <p>The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p>	

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F 224	<p>Continued From page 8</p> <p>disorder, and Diabetes Mellitus Type 2. Review of the Comprehensive Admission assessment with an assessment reference date of 01/12/11 (no signed completion date) revealed the facility assessed Resident #1 as at risk for pressure ulcers, having a tracheostomy and requiring oxygen via a tracheostomy collar. On 05/15/11, the facility documented the resident returned to the facility after a hospitalization with a Stage II pressure ulcer to the left side of the neck.</p> <p>Review of the plan of care for Resident #1 dated 06/29/11, revealed the resident was to receive tracheostomy care every shift and as needed and staff was to change the oxygen tubing every week on Wednesday. The resident's care plan also revealed staff was to turn and reposition the resident every two hours and to assess the decubitus (pressure sore) size, stage, depth, and the absence or presence of infection. On 10/21/11 an intervention was added for staff to apply DuoDerm to the Stage II pressure ulcer on the left neck and change every three days.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 12/07/11, at 4:25 PM, revealed the LPN provided care for Resident #1 on her scheduled work days. LPN #2 stated she had provided care for Resident #1 on Monday, 10/31/11, at which time she stated the pressure sore on the resident's neck was not open and was "just scabbed over"; however, during an interview on 12/09/11, at 4:15 PM, LPN #2 stated she could not remember what the wound looked like. According to LPN #2, facility policy/procedure stated staff was to document the wound's appearance but she did not document the appearance of the wound. LPN #2 stated she</p>	F 224	5) Date of Compliance 1/9/2012.	

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F 224	<p>Continued From page 9</p> <p>performed tracheostomy care for Resident #1 several times a shift. The LPN stated she removed the tracheostomy collar during tracheostomy care and when the straps were secured back she would pad the straps to keep them away from the resident's skin.</p> <p>Interview with Registered Nurse (RN) #1, on 12/07/11 at 1:15 PM and on 12/12/11 at 3:20 PM, revealed she provided care for Resident #1 on her scheduled work days and had last provided cared for the resident on 10/31/11. RN #1 stated the resident had a pressure sore on the left side of the neck that had been present for several months and had received treatments at the facility. RN #1 stated she assumed the pressure sore was due to the tracheostomy collar straps. According to RN #1, the resident's tracheostomy collar straps were usually padded to keep them away from the resident's skin. RN #1 was unsure if all staff kept the straps padded.</p> <p>Care plan and record review revealed no evidence the facility had developed and implemented an intervention to include padding the tracheostomy strap for Resident #1 to prevent the occurrence of or to prevent worsening of the neck wound.</p> <p>Interview, on 12/08/11 at 10:05 AM, with the Speech Therapist (ST) revealed the ST had worked with Resident #1 on 10/31/11, 11/02/11 and 11/04/11. According to the ST, she would unbuckle the tracheostomy collar by unsnapping the green straps and letting them fall to the sides. The ST was unaware of a wound on the left side of the resident's neck. The ST stated she had not routinely observed a dressing on the</p>	F 224		
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F 224	<p>Continued From page 10</p> <p>resident's neck or under the tracheostomy collar.</p> <p>Interview with LPN #1, on 12/07/11 at 4:08 PM and on 12/09/11 at 2:40 PM, revealed LPN #1 had been the nurse responsible for the care of Resident #1 on 11/04/11 at which time she had performed tracheostomy care for Resident #1.</p> <p>Interview with the Director of Nursing (DON), on 12/07/11 at 2:10 PM and on 12/09/11 at 4:50 PM, revealed she had observed the pressure sore on Resident #1's neck on 11/04/11 and described the pressure sore as "beefy red" and having a skin flap prior to the facility transferring Resident #1 to the hospital on 11/04/11 due to an elevated temperature.</p> <p>While continued interviews with the nursing facility staff (LPN #1, LPN #2, RN #1, and the DON) revealed the facility denied having observed Resident #1 with the tracheostomy strap incised into the resident's neck, review of the hospital photograph of Resident #1 taken on 11/04/11 revealed the tracheostomy strap had incised into the resident's neck and a flap of skin laid over a portion of the neck strap. Continued interview with the Emergency Room Physician, on 12/09/11, revealed that the neck looked like the hospital picture. It was "one of the worst things I've seen come from a nursing home," as the resident "arrived in the [hospital] in that condition."</p> <p>Interview with the Unit Supervisor, on 12/07/11 at 2:00 PM, revealed she did not know if staff had delivered the care and services for Resident #1 because she had asked staff if they had performed tracheostomy/wound care to the</p>	F 224		

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F 224	<p>Continued From page 11</p> <p>resident's neck; however, had not actually observed staff provide the care.</p> <p>Interview with the Director of Nursing (DON) on 12/07/11, at 2:10 PM and on 12/09/11, at 4:50 PM, revealed the DON stated staff performed tracheostomy care every shift and removed the tracheostomy collar every day. The DON also stated staff kept the tracheostomy straps padded with gauze. The DON could not confirm the tracheostomy straps were padded with gauze prior to the resident's transfer to the hospital on 11/04/11.</p> <p>Interview with the facility Administrator, on 12/12/11, at 3:11 PM, revealed the Administrator relied on the DON and the unit managers to ensure care was delivered to residents. The Administrator stated the DON had the responsibility to ensure pressure ulcers were monitored/tracked, and to verify staff competency. According to the Administrator, the unit managers were responsible for monitoring staff practice. The Administrator stated she became aware of the physician's report from the 11/04/11 hospital admission for Resident #1 which indicated the strap of the tracheostomy collar had become embedded in the resident's skin and that Adult Protective Services had initiated and investigation related to Resident #1 on 11/07/11. The Administrator stated she questioned staff about the resident's condition and had determined the resident returned from the hospital "in that condition." The Administrator stated the tracheostomy collar strap had become embedded in the resident's skin at the hospital. While the Administrator detailed she had questioned staff regarding the resident's pressure</p>	F 224		
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F 224	Continued From page 12	F 224	F 282	
F 282 SS=J	<p>ulcer to the neck, there was no documented evidence that the facility had identified suspected neglect, conducted an investigation or followed the facility policy and procedure related to abuse and neglect.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and review of facility policy/procedure for wound and tracheostomy care, it was determined the facility failed to ensure services were provided by staff in accordance with the written plan of care for one (1) of thirteen (13) sampled residents (Resident #1). The facility failed to ensure the resident's pressure ulcer had been assessed and treatment provided in accordance with the care plan and facility policy. The facility assessed Resident #1 as having a pressure sore to the left side of the neck and the plan of treatment was to apply a dry, protective dressing to the site. On 11/04/11, the facility transferred Resident #1 to the hospital due to an elevated temperature. Interview with the Paramedic who transported Resident #1 to the Emergency Department of the hospital on 11/04/11, revealed the Paramedic could not recall a dressing to the left side of the resident's neck. Upon admission to the hospital it was discovered the strap for the resident's tracheostomy collar was embedded into the</p>	F 282	<p>Corrective action accomplished for residents found to have been affected by the deficient practice;</p> <p>1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility that require a trach collar at this time.</p> <p>The primary physician will be notified upon resident #1's return to the facility after a nurse manager has completed a full skin assessment, care plans with preventions, interventions, causative factors, and treatments. The primary physician will give any treatment orders that are identified as needed.</p> <p>The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.</p> <p>Address how the facility will identify other residents having the potential to</p>	

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F 282	<p>Continued From page 13</p> <p>resident's neck. The resident had no dressing to the wound upon arrival to the hospital and interviews with the ED physician, Hospitalist, and surgeon confirmed the tracheostomy collar strap was embedded in the resident's skin due to staff failure to provide routine care. This failure placed Resident #1 and other residents at risk for serious injury harm impairment or death. Immediate Jeopardy was identified on 12/12/11, was determined to exist on 11/04/11, and is ongoing due to the facility's failure to identify that staff did not implement facility policy/procedure related to surveillance of wounds and the provision of wound care.</p> <p>The findings include:</p> <p>Interview on 12/09/11, at 12:50 PM, with the Paramedic who transported Resident #1 to the Emergency Department of the hospital on 11/04/11, revealed the Paramedic could not recall a dressing to the left side of the resident's neck on 11/04/11.</p> <p>Resident # 1's hospital record was reviewed and revealed the resident had been transported from the facility to the hospital due to an elevated temperature on 11/04/11 at 9:58 PM. A review of the photograph taken in the hospital Emergency Department of Resident #1's neck wound on 11/04/11 revealed the wound was on the left side of the resident's neck. A green strap was observed attached to a tracheostomy collar (a device for oxygen delivery placed over a tracheostomy) and proceeded around the resident's neck. A measurement device present in the photograph revealed an approximate four and one-half (4.5) centimeter (cm) area of the</p>	F 282	<p>be affected by the same deficient practice:</p> <p>2) A 100% care plan audit was completed on 12/13/11 by Nursing Administration for all residents requiring skin treatments, skin issues, pressure wounds, at risk for skin breakdown, requiring any device that can cause skin breakdown, ie: trach collars, oxygen collars, oxygen therapy, braces, etc. Care plan revisions were made to reflect interventions, preventions, treatments, causative factors as indicated. This will ensure the written plan of care has been revised or a written plan of care is in place for care and services of all residents.</p> <p>The nurse management team completed a 100% skin assessment audit and updated Braden scales for all residents residing in the facility to ensure all residents were receiving necessary treatment and services to promote healing and prevention of infection to pressure wounds. The primary physician was notified for treatment orders for any skin issues identified. The responsible party, POA, family etc were notified as well. Nurse management ensured skin</p>	

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F 282	<p>Continued From page 14</p> <p>green strap obscured by a yellow substance in the middle of the area, strings of a yellow/pink substance was on the left of the area and a flesh colored substance was on the right of the wound. Review of the physician's hospital admission documentation, dated 11/04/11, revealed the resident had an area on the left side of the neck "what appears that his/her tracheostomy collar has been eroding into the left side of the neck."</p> <p>Interviews on 12/07/11 and 12/09/11 with the hospital Emergency Department (ED) physician, ED Registered Nurse, Resident #1's admitting physician, and the consultant surgeon revealed the wound to the left side of the Resident's neck was not covered with a dressing when the resident arrived to the hospital. Interview with the consultant surgeon on 12/07/11, at 9:25 AM, revealed it would have taken at least seven days for the tracheostomy collar strap to incise the resident's skin. According to the consultant surgeon, it was unlikely routine tracheostomy care had been provided and it did not appear that the area had been checked in any normal period of time.</p> <p>A review of the facility policy/procedure Wound Care/Treatment Guidelines (no date provided) revealed licensed staff was to complete a weekly assessment of all wounds. The assessment was to include measurements and a description of the wound.</p> <p>Review of the medical record of Resident #1 revealed the facility admitted the resident on 09/10/10 with diagnoses that included Tracheostomy, Dysphagia, Seizure Disorder, and Diabetes Mellitus Type 2. Documentation on a</p>	F 282	<p>issues identified had treatments, care plans, interventions, preventions, documentation, and pressure or non-pressure measurements recorded in the resident's records. This ensured the resident's written plan of care and services are provided.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy, guidelines which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p>	

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F 282	<p>Continued From page 15</p> <p>Comprehensive Assessment (01/21/11) revealed Resident #1 was dependent upon staff for all activities of daily living and was at risk for the development of pressure sores. The assessment revealed Resident #1 had a Stage I pressure sore to the left heel.</p> <p>Review of the comprehensive care plan for Resident #1 dated 06/29/11, revealed interventions developed for the resident's tracheostomy included the provision of oxygen at 40% via tracheostomy mask, tracheostomy care every shift, and as needed, and to change the resident's oxygen tubing every week (on Wednesday). Further review of the comprehensive care plan revealed interventions related to the resident's pressure sores and included an assessment of the decubitus (pressure sore) size, stage, depth, absence or presence of infection and location. Staff was to turn and reposition the resident every two hours, and as needed, and to assess progress toward wound healing and the need to alter the treatment regimen.</p> <p>Based on documentation, the facility readmitted Resident #1 on 05/14/11 after a hospitalization for an elevated temperature. Upon readmission to the facility, facility staff assessed Resident #1 and noted the resident had a pressure sore to the left side of the neck. Review of the facility's Pressure Ulcer Status Record revealed staff were to document the stage of the pressure ulcer, measurements, drainage, odor, color, tunneling if present, appearance of the wound, response to treatment and the date the physician and/or dietary were notified. However, a review of the Pressure Ulcer Status Records revealed no</p>	F 282	<p>The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy, guidelines which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC in-serviced the licensed nurses on 12/29/11 and 12/30/11 on when and how to revise care plans and the implementation of acute care plans when an order is written for any skin issue, treatment, application of an device, pressure wound treatment or change of treatment to an existing skin issue or pressure wound and following care plans in accordance to facility policies and procedures.</p> <p>Nursing Administration will review 24 hour shift reports and</p>	

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F 282	<p>Continued From page 16</p> <p>evidence the facility had completed the form for 05/20/11 or 06/05/11. Review of the interim care plan for Resident #1, dated 05/31/11, revealed the Stage II pressure ulcer on the back of the neck was to be cleaned with normal saline and triple antibiotic ointment was to be applied twice daily for 14 days.</p> <p>Review of the Quarterly Assessment reference date 07/11/11 revealed Resident #1 had one Stage II pressure ulcer (unidentified location) and one Stage III pressure ulcer (unidentified location). Review of the Weekly Skin Integrity Data Collection form dated 07/10/11, revealed the resident had an open area to the left side of the neck. A review of the Pressure Ulcer Status Record revealed no evidence staff had completed the form for 07/10/11. On 08/05/11 an intervention was added to the care plan to apply wound gel to the left side of the neck and under the tracheostomy collar each shift, apply a dry protective dressing for 10 days and re-evaluate. Review of the Weekly Skin Integrity Data Collection form dated 08/12/11 and 08/19/11 revealed the resident had an open area to the left side of the neck. Review of the Pressure Ulcer Status Record revealed no wound assessment for 08/12/11 or 08/19/11. On 08/18/11 an intervention was added to apply triple antibiotic ointment and a dry protective dressing to the left side of the neck for ten days and then re-evaluate the wound. Further review of the Pressure Ulcer Status Records revealed there was no documentation of an assessment/status of the pressure sore to the resident's neck until 08/24/11. Skin assessments were not completed on 06/12/11, 06/19/11, 06/26/11, 07/17/11, 07/24/11, or 07/31/11, due to the resident being</p>	F 282	<p>all physician orders daily to ensure any change of treatment, new treatments, and /or devices ordered are care planned. This will ensure treatments, interventions, preventions, causative factors, and devices have been care planned, orders are implemented, documented, and care guides have been updated.</p> <p>The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC will in-service all new employees on abuse, neglect, and a post test will be completed. Emphasis will be placed on abuse, neglect, and</p>	
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F 282	<p>Continued From page 17 out of the facility.</p> <p>On 09/09/11, an intervention was added to the care plan and included the application of a triple antibiotic ointment and a dry protective dressing to the left side of the resident's neck for ten days and then to re-evaluate the wound. An intervention was added on 10/21/11 to apply DuoDerm to the Stage II ulcer on the left side of the resident's neck and to change the dressing every three days for fourteen days. On 10/24/11, documentation revealed the treatment to the left side of the resident's neck had been changed to application of a dry protective dressing each day.</p> <p>Documentation on the treatment record revealed staff provided wound care as ordered.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/07/11, at 4:08 PM, and again on 12/09/11, at 2:40 PM, revealed the LPN had provided wound care to Resident #1 on the day the resident was transferred to the Emergency Department (ED) of an acute care facility on 11/04/11. According to LPN #1, she had placed a gauze pad to the pressure ulcer on the left side of the resident's neck, had changed the tracheostomy collar, and had put padding under the tracheostomy collar straps.</p> <p>Interview with Registered Nurse (RN) #1 on 12/07/11, at 1:15 PM and again on 12/12/11, at 3:20 PM, revealed RN #1 provided wound care to Resident #1 on 10/31/11. According to RN #1, she changed the dressing to the wound on the left side of Resident #1's neck on 10/31/11 and had used gauze and pads to pad the tracheostomy collar strap.</p>	F 282	<p>reporting of allegations of abuse or neglect.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>4) Daily observations and audits will be preformed by Nursing Administration of licensed nurses performing skin assessments, wound treatments, wound observation, and observation of devices that can cause pressure wounds. This is to ensure treatments, preventions, interventions, healing, documentation, care plans, care plan revisions, and care guide revisions, are implemented per care plan and in accordance to facility policies and procedures. Daily observations and audits will be daily x30 days, then wkly x4 months, then monthly x2 months, then randomly x2 months.</p> <p>Nursing Administration will reviewing 24 hour shift reports, all physician orders, and care plans to ensure any change of treatment, new treatments, and /or devices ordered are care planned. This will ensure treatments, interventions, preventions, causative factors,</p>	
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F 282	<p>Continued From page 18</p> <p>Interview with LPN #2 on 12/07/11, at 4:25 PM and again on 12/09/11, at 4:15 PM, revealed LPN #1 had measured the pressure ulcer of Resident #1 on 10/31/11 (four days prior to the resident's hospitalization). The LPN stated on 12/07/11, that the wound was "scabbed over" on 10/31/11, but on 12/09/11 the LPN stated she could not remember the appearance of the pressure ulcer on the day of the assessment, 10/31/11. According to LPN #2, staff kept the resident's tracheostomy collar padded and changed the dressing to the wound each day.</p> <p>Interview with the facility's Speech/Language Therapist (SLP) on 12/08/11, at 10:05 AM, revealed the SLP had conducted speech therapy with Resident #1 on 10/31/11, 11/02/11, and 11/03/11, and had not noticed a wound on the resident's neck. According to the SLP, she would "unbuckle" the tracheostomy collar to access the tracheostomy but did not remove the tracheostomy collar straps. The SLP stated on some occasions there were dressings in place to the resident's neck, but not on a routine basis. The SLP also stated she did not remember seeing anything (padding) around the straps of the tracheostomy collar.</p> <p>Interview with the Unit Supervisor on 12/07/11, at 2:00 PM, confirmed Resident #1 had a pressure sore the left side of the neck for approximately three to four months. According to the Unit Supervisor, the resident had been assessed to have the pressure area on the resident's return from a hospitalization but could not recall the date. The Unit Supervisor stated she did not know if staff had delivered the care and services</p>	F 282	<p>and devices have been care planned, orders are implemented, documented, and care guides have been updated. Nursing Administration will perform observations and audits daily x30 days, then wklly x4 months, then monthly x2 months, then randomly x2 months.</p> <p>The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance</p> <p>5) Date of Compliance 1/9/2012.</p>	

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F 282	<p>Continued From page 19</p> <p>for resident #1 because she had asked staff if they had performed tracheostomy/wound care to the resident's neck and had not actually observed staff provide the care in accordance with the resident's care plan.</p> <p>Interview with the Director of Nursing (DON) on 12/07/11, at 2:10 PM, and again on 12/09/11, at 4:50 PM, revealed, to her knowledge, staff provided wound care each day to the left side of Resident #1's neck and kept the area padded with gauze. The DON stated she monitored the hallways "all" day to verify resident's received care and services as planned and observed wound care on a "random" basis. The DON stated she had observed Resident #1 on 11/04/11, the day the resident was hospitalized due to an elevated temperature, and the wound to the resident's neck was "beefy" red in color and she also observed a "skin flap" over the wound.</p> <p>Interview conducted on 12/09/11 at 3:15 PM with Resident #1's attending physician at the facility revealed the physician was unaware of the condition of the resident's pressure ulcer until he had viewed the photograph obtained by the hospital. According to the physician, it would have taken more than seven days for the condition of the wound at that time to occur.</p> <p>While the facility staff interviews and record reviews revealed staff conducted assessments and provided treatment to Resident #1's neck wound, Paramedic and hospital staff interviews revealed the resident arrived at the hospital without a dressing to the wound. Additionally, interviews with physicians revealed that appropriate tracheostomy care required removal</p>	F 282		

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F 282	Continued From page 20 and cleaning daily; however, the appearance of the resident's wound would have taken at least seven days without care to have occurred.	F 282	<p><u>F 314</u></p> <p>Corrective action accomplished for residents found to have been affected by the deficient practice;</p> <p>1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility at this time requiring a trach collar.</p> <p>The primary physician will be notified upon resident #1's return to the facility after a nurse manager has observed the licensed nurse completing a full skin assessment, documentation, and care plan. The primary physician will give any treatment orders that are identified as needed. Nursing Administration will ensure the orders obtained are implemented, documented, and care plan revisions initiated.</p> <p>The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.</p>	
F 314 SS=J	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the clinical record, review of hospital records and the facility Wound Care/Treatment Guidelines policy, it was determined the facility failed to ensure one (1) of thirteen (13) residents received necessary treatment and services to promote healing and prevent infection of pressure sores. Upon admission, the facility assessed Resident #1 to be at risk for pressure sore development; however, the facility failed to implement interventions to prevent infection and/or promote healing after the development of a pressure ulcer to the resident's neck. In addition, the facility failed to perform weekly wound assessments according to their policy, failed to follow the care plan, and supervisory staff failed to ensure the necessary care was provided to the resident. The facility transferred the resident to the hospital on 11/04/11 due to an elevated temperature.</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>Interview with the Paramedic who transported Resident #1 on 11/04/11 revealed no dressing to the wound on the resident's neck. Upon admission to the hospital, hospital staff found the resident's tracheostomy collar strap had embedded into the skin on the left side of the neck with no dressing in place when the resident arrived in the hospital Emergency Department. The hospital admitted Resident #1 with a diagnosis of Sepsis and determined the source of the sepsis was from the neck wound. The laboratory results identified the neck wound had three microorganisms which included, Methicillin Resistant Staphylococcus Aureus, Providencia stuartii, and MDR (multi-drug resistant) Acinetobacter Baumanni. Interviews with the hospital physicians revealed the resident's wound had been "neglected" for at least seven days and the severity of the injury could have been avoided. Due to the facility's failure to provide the necessary care and services the resident required hospitalization to treat the sepsis due to the neck wound resulting in wound treatment and antibiotic therapy. The facility's failure to provide treatment to the resident's pressure ulcer has caused, or is likely to cause, serious injury, harm, impairment, or death to Resident #1 and other residents in the facility. Immediate Jeopardy was determined to exist on 11/04/11 and is ongoing due to the facility's failure to identify the incident as neglect and failure to identify that facility staff were not assessing or providing treatment to Resident #1 in accordance with facility policy/procedure.</p> <p>The findings include:</p> <p>Interview on 12/09/11, at 12:50 PM, with the</p>	F 314	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>2) The nurse management team completed a 100% skin assessment audit and updated Braden scale for all residents residing in the facility to ensure all residents were receiving necessary treatment and services to promote healing and prevention of infection to pressure wounds. Any skin issues identified, the primary physician was notified for treatment orders. The responsible party, POA, family etc were notified as well. Nurse management ensured skin issues identified had treatments, care plans, interventions, preventions, documentation, and pressure or non-pressure measurements recorded in the resident's records. No signs and symptoms of infection were noted during these assessments.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>3) The Regional Director of Clinical Services in-serviced the nurse management team</p>	

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F 314	<p>Continued From page 22</p> <p>Paramedic who transported Resident #1 to the hospital on 11/04/11 revealed the only care the paramedic rendered en route to the hospital was monitoring the resident's vital signs and suctioning the resident as needed. The paramedic did not remember seeing a dressing on the resident's neck. The paramedic stated he did not observe any padding to the tracheostomy collar straps.</p> <p>Interview on 12/09/11, at 10:04 AM, with the Emergency Department (ED) RN who initially assessed Resident #1 revealed the RN had started an assessment of the resident; she observed the straps from the tracheostomy collar and noted the strap on the left side appeared to be embedded into the resident's skin. The RN stated there was no protective dressing on the wound when the resident arrived in the ED. The RN photographed the resident's wound in accordance with hospital policy.</p> <p>A review of the photograph taken in the hospital Emergency Department of Resident #1's neck wound on 11/04/11, at 12:07 PM, revealed the wound was on the left side of the resident's neck. A green strap was observed attached to a tracheostomy collar (a device for oxygen delivery placed over a tracheostomy) and proceeded around the resident's neck. A measurement device present in the photograph revealed an approximate 4.5 centimeter (cm) area of the green strap obscured by a yellow substance in the middle of the area, strings of a yellow/pink substance was on the left of the area and a flesh colored substance was on the right of the wound. Review of the physician's hospital admission documentation dated 11/04/11, revealed the</p>	F 314	<p>(DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy which includes prevention of infections, interventions to promote wound healing, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation,</p>	

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F 314	<p>Continued From page 23</p> <p>resident had an area on the left side of the neck "what appears that her tracheostomy collar has been eroding into the left side of the neck."</p> <p>Interview on 12/09/11, at 10:35 AM, with the ED physician who treated Resident #1 on 11/04/11 revealed upon assessment of the resident in the ED the tracheostomy collar straps "appeared to have grown into the resident's skin." The ED physician stated he spoke with the nurse and informed the nurse to notify social services. According to the ED physician, he felt the resident had suffered "abuse." The ED physician stated tracheostomy collar straps "could cause some redness to the neck with wear." The ED physician stated he not see a dressing on the resident's neck upon admission to the ED. According to the ED physician, "the severity of the pressure ulcer could have been avoided."</p> <p>Interview on 12/06/11, at 11:40 AM, with the Hospitalist (a physician employed by the hospital who admits and treats patients in the hospital who do not have a primary physician with admitting privileges at the hospital) revealed he admitted the resident to the hospital and consulted a surgeon immediately when he observed the condition of the resident's pressure ulcer on the neck. The Hospitalist stated in his opinion the injury was the result of the tight tracheostomy collar and that it had taken more than a couple of days for the pressure ulcer to get in "that condition." The Hospitalist stated he admitted the resident to the hospital with a diagnosis of sepsis and the "neck wound was the source of the sepsis."</p> <p>Interview with the surgeon on 12/07/11, at 9:25</p>	F 314	<p>abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC will in-service all licensed nurses and certified nursing assistants upon hire during orientation on wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infections, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC will in-service all new employees on abuse, neglect, and a post test will be completed. Emphasis will be placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC in-serviced the licensed nurses on 12/29/11 and 12/30/11 on when and how to revise care plans and the</p>	
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F 314	<p>Continued From page 24</p> <p>AM and on 12/09/11, at 10:58 AM, revealed the pressure ulcer on the left side of Resident #1's neck was more of a laceration due to pressure from the tracheostomy collar strap. According to the surgeon, the pressure from the strap had lacerated (cut) the skin of the resident's neck and the wound contained yellow drainage and a "flap" of skin over the strap. According to the surgeon, the tracheostomy collar was on too tight and upside down. The surgeon stated it would have taken "at least seven days" for the strap to have made an incision into the skin. The surgeon stated it was unlikely routine tracheostomy care was done for the resident and that the tracheostomy collar had not been checked in any normal period of time. According to the surgeon, he "unsnapped and pulled out" the tracheostomy collar strap.</p> <p>Review of the laboratory results for Resident #1 obtained at the hospital revealed a culture of the wound on the left side of the resident's neck, collected on 11/04/11, contained a heavy growth of three organisms; methicillin resistant staphylococcus Aureus (MRSA), Providencia Stuartii (most often found in complicated urinary tract infections), and MDR (Multi-Drug Resistant) Acinetobacter Baumannii (can cause various infections including skin and wound infections). The resident was treated with Vancomycin 1300 milligrams (mg) intravenously every 12 hours for the organisms.</p> <p>Review of the nursing facility policy/procedure Wound Care/Treatment Guidelines (revised 05/21/04), revealed a licensed professional was to conduct a weekly skin assessment and the skin was to be observed for pressure damage</p>	F 314	<p>implementation of acute care plans when an order is written for any skin issue, treatment, application of an device, pressure wound treatment or change of treatment to an existing skin issue or pressure wound and following care plans in accordance to facility policies and procedures.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>4) Nursing Administration will complete 2 times weekly observations of licensed nurses performing skin and wound assessments and treatments. Daily observations will be performed by Nursing Administration daily x30 days then 2x weekly x30days, then wkly x4 months, then monthly x2 months, then randomly x2months to ensure licensed nurses are providing treatments and services to promote healing and prevent infection of pressure wounds.</p> <p>Nurse Administration will review 24 hour shift reports and all physician orders to ensure any new wounds identified have physician orders, treatments, detection of signs and symptoms of infection, care</p>	
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F 314	<p>Continued From page 25</p> <p>caused by medical devices. The assessments were to include measurement and a description of the wound. The policy stated the results of the skin assessment were required to be documented on the Weekly Skin Integrity Data Collection Form and the Weekly Pressure Ulcer Record was required to be used for weekly assessment of existing wounds. In addition, the policy revealed the care plan should reflect the current status of the wound and appropriate goals.</p> <p>Review of the medical record of Resident #1 revealed the facility admitted the resident on 09/10/10 with diagnoses that included Tracheostomy, Dysphagia, Seizure disorder and Diabetes Mellitus, Type 2. Review of the Admission Minimum Data Set (MDS) Assessment with a completion date of 04/16/11 revealed the resident had been readmitted to the facility after a hospital stay for an elevated temperature. The resident was assessed as at risk for pressure sores and had two Stage II pressure ulcers (one on the sacrum and one on the left heel) with the most severe type of tissue in the ulcer bed to be epithelial tissue (new skin growing in a superficial ulcer). Review of the Nursing Service Data Collection Tool (completed upon a resident's return from the hospital), completed by facility staff, dated 05/15/11, after return from another hospital admission (05/02/11 to 05/15/11), revealed the resident returned to the facility with a Stage III pressure ulcer to the back of the neck. However, according to the Pressure Ulcer Status Record, completed by facility staff, dated 05/15/11, the pressure ulcer was a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed,</p>	F 314	<p>plans, care plan revisions with any change in wound treatments Review of 24 hour reports and physician orders will be completed by Nursing Administration daily x30 days, then M-F ongoing.</p> <p>The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5) Date of Compliance 1/9/2012</p>	
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F 314	<p>Continued From page 26</p> <p>without slough) and measured 3 cm long by 0.4 cm wide by 0.1 cm deep. Review of the interim care plan for Resident #1 dated 05/31/11, revealed the Stage II pressure ulcer on the back of the neck was to be cleaned with normal saline and triple antibiotic ointment was to be applied twice daily for 14 days.</p> <p>A review of the Quarterly MDS Assessment with an assessment reference date of 07/11/11, revealed Resident #1 had one Stage II pressure ulcer (unidentified location) and one Stage III pressure ulcers (unidentified location). The assessment revealed the Stage III pressure ulcer was present upon admission/reentry to the facility after a hospital stay from 06/19/11 to 06/29/11. The assessment further revealed the Stage III pressure ulcer was 3 cm long by 1 cm wide and slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous) was the most severe type of tissue present in the pressure ulcer bed.</p> <p>A review of the Weekly Skin Integrity Data Collection forms for resident #1 dated 05/20/11, 06/05/11, 07/10/11, 08/12/11, and 08/19/11) revealed resident #1 had an area to the left side of the neck. The Weekly Skin Integrity Data Collection form stated "If Open Area, proceed to appropriate skin condition record". Review of the facility's Pressure Ulcer Status Record revealed staff were to document the stage of the pressure ulcer, measurements, drainage, odor, color, tunneling if present, appearance of the wound, response to treatment and the date the physician and/or dietary were notified. However, a review of the Pressure Ulcer Status Records revealed no evidence the facility had completed the form for</p>	F 314		
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F 314	<p>Continued From page 27</p> <p>05/20/11 or 06/05/11. Review of the care plan for Resident #1 dated 06/29/11 revealed the resident had a Stage III pressure ulcer (no site documented) and was at risk for complications such as poor/delayed wound healing, infection or further deterioration. The goal was for the pressure ulcer to demonstrate progression towards healing as evidenced by reduction in size and to remain free from signs and symptoms of infection with the following interventions: (1) assess decubitus size, stage, depth, absence or presence of infection and location and report to physician (2) turn and reposition every 2 hours and as needed (3) keep clean and dry (4) assess progress towards healing and need to alter treatment regimen (5) notify physician as needed for new orders or changes in skin condition. Further review of the Weekly Skin Integrity Data Collection form dated 07/10/11, revealed the resident had an open area to the left side of the neck. A review of the Pressure Ulcer Status Record revealed no evidence staff had completed the form for 07/10/11. On 08/05/11 an intervention was added to the care plan to apply wound gel to the left side of the neck and under the tracheostomy collar each shift, apply a dry protective dressing for 10 days and re-evaluate. Review of the Weekly Skin Integrity Data Collection form dated 08/12/11 and 08/19/11 revealed the resident had an open area to the left side of the neck. Review of the Pressure Ulcer Status Record revealed no wound assessment for 08/12/11 or 08/19/11. On 08/18/11 an intervention was added to apply triple antibiotic ointment and a dry protective dressing to the left side of the neck for ten days and then re-evaluate the wound. Further review of the Pressure Ulcer Status Records revealed there was no</p>	F 314		
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F 314	<p>Continued From page 28</p> <p>documentation of an assessment/status of the pressure sore to the resident's neck until 08/24/11. Skin assessments were not completed on 06/12/11, 06/19/11, 06/26/11, 07/17/11, 07/24/11, or 07/31/11, due to the resident being out of the facility.</p> <p>According to the 08/24/11 Pressure Ulcer Status Record, the pressure ulcer to the left side of the "neck at tracheostomy collar" was a Stage II and measured 1 cm by 1.5 cm. There was no documentation of the wounds depth, drainage, odor, color, appearance, or response to treatment. There was no further documentation the facility assessed the pressure ulcer utilizing the Pressure Ulcer Status Record until 09/12/11 when the pressure ulcer was documented as a Stage II pressure ulcer that measured 3 cm by one 1 cm, indicating the wound had become larger since 08/24/11. Further review of the Pressure Ulcer Status Record for Resident #1 dated 09/22/11 revealed the pressure ulcer was a Stage II that measured 3.5 cm long by 1 cm wide, but no documentation of the appearance of the wound or response to treatment was documented and the wound measurement was 0.5 cm larger. Further review of the Pressure Ulcer Status Record dated 09/26/11 revealed the Stage II pressure ulcer had increased in size and measured 6.5 cm long by 1.5 cm wide. A review of the physician orders, dated 09/26/11, revealed the treatment was changed and staff was to apply Santyl ointment with a dry protective dressing, then re-evaluate in 14 days.</p> <p>Further review of the Pressure Ulcer Status Record revealed on 10/3/11, Resident #1's Stage II pressure ulcer to the neck had decreased in</p>	F 314		
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F 314	Continued From page 29 size and measured 3.5 cm by 1 cm. According to the documentation, there was a scant amount of drainage, no odor or tunneling and the wound was pink. On 10/10/11, staff documented on the Pressure Ulcer Status Record that the pressure ulcer was a Stage III (a full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue). According to the documentation, the pressure ulcer measured 4 cm by 1 cm. There was no documentation of the wound depth, drainage, odor, color, appearance, or response to treatment, and no documentation the physician was notified of the increase in the size of the wound, even though the order dated 09/26/11, stated to reevaluate the treatment in 14 days. According to the 10/17/11 Pressure Ulcer Status Record, resident #1's pressure ulcer to the neck continued to be a Stage III and had increased in size and measured 4 cm by 2 cm, with no depth. There was no documentation of the wound's appearance, drainage, color, odor, or response to treatment. However, the record revealed the pressure ulcer had improved, and the physician was not notified. A review of the physician orders dated 10/21/11 for resident #1 revealed the treatment was changed to apply a DuoDerm dressing to the Stage II pressure sore every three days for fourteen days, and then reassess. However, the treatment to the neck was changed three days later on 10/24/11 to a dry protective dressing every shift and as needed. Review of the physician's progress notes in the medical record of Resident #1 from 05/17/11 through 11/12/11 revealed no documentation of a pressure ulcer to the resident's neck until 11/12/11.	F 314			

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F 314	<p>Continued From page 30</p> <p>Further review of the Pressure Ulcer Status Records for 10/25/11 and 10/31/11, revealed resident #1's pressure ulcer was assessed as a Stage III, but decreased in size to 2.5 cm by 1 cm on 10/31/11. There was no documentation of pressure ulcers odor, color, or appearance.</p> <p>Staff had documented a Stage III to the left side of the resident's neck on 10/10/11, 10/17/11, 10/25/11, and 10/31/11. Facility staff had documented stage and measurements of the pressure sore, but did not document appearance of the wound, odor, color, or response to treatment as required by the facility policy.</p> <p>In addition, a review of the Initial Data Collection Tool/Nursing Service forms completed when the resident returned from a hospital stay on 05/31/11, 06/15/11, 06/29/11, 08/06/11, 09/08/11, 09/22/11, 10/03/11 revealed staff was to indicate size, and depth of all pressure sores and vascular ulcers. Staff had not documented size and/or depth of the documented pressure sores on the form.</p> <p>Review of the treatment record for Resident #1 dated October 2011, revealed staff documentation from 10/24/11 to 10/31/11 that a dry protective dressing was applied to the resident's pressure ulcer on the left side of the neck. The November 2011 treatment record documented that staff had applied a dry protective dressing to the pressure ulcer on the resident's neck from 11/01/11 to 11/04/11.</p> <p>Interview on 12/07/11, at 4:08 PM and 12/09/11, at 2:40 PM, with Licensed Practical Nurse (LPN)</p>	F 314		

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F 314	<p>Continued From page 31</p> <p>#1 revealed she had been responsible for the care of Resident #1 on 11/04/11. According to LPN #1, she had provided wound care the morning of 11/04/11 prior to the resident's transfer to the hospital. LPN #1 stated she placed a dry protective dressing onto the pressure ulcer on the resident's neck and put padding under the tracheostomy collar straps.</p> <p>Interview with Registered Nurse (RN) #1 on 12/07/11, at 1:15 PM and on 12/12/11, at 3:20 PM revealed the RN had provided care for Resident #1 on 10/31/11. According to RN #1, she had provided wound care to the pressure ulcer on the resident's neck on 10/31/11, and stated the wound was a "cut" and had a "flap" of skin in the cut. RN #1 stated she assumed the pressure ulcer came from the straps on the tracheostomy collar. The RN stated she kept the straps padded with gauze to keep the straps from direct contact with the resident's skin. RN #1 stated she was unaware if all staff kept the straps padded.</p> <p>Interview with LPN #2 on 12/07/11, at 4:25 PM, and 12/09/11, at 4:15 PM, revealed the LPN had assessed and measured the wound on 09/26/11, 10/10/11, 10/17/11, 10/25/11, and 10/31/11. The LPN could not recall the wound's appearance on 10/31/11, but stated the wound did not appear the same as in the photograph taken at the hospital on 11/04/11. The LPN stated she was aware of the facility policy/procedure to document the wound's appearance but she had failed to document the appearance. The LPN stated she kept the tracheostomy collar straps padded to keep them off the resident's skin. According to LPN #2, the resident's pressure ulcer was</p>	F 314		

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F 314	<p>Continued From page 32 probably caused by the tracheostomy collar straps.</p> <p>Interview with the facility's Speech/Language Therapist (SLP) on 12/08/11, at 10:05 AM, revealed the SLP had conducted speech therapy with Resident #1 on 10/31/11, 11/02/11, and 11/03/11. The SLP stated she did not notice a wound on the resident's neck. According to the SLP, she would unbuckle the tracheostomy collar to access the tracheostomy but did not remove the tracheostomy collar straps. The SLP stated on some occasions there would be a lot of dressings but not routinely. The SLP stated she did not remember seeing anything around the tracheostomy collar straps.</p> <p>Interview with the Unit Supervisor on 12/07/11, at 2:00 PM, revealed she monitored staff performance by asking staff if they had completed wound care and/or tracheostomy care. The Unit Supervisor stated she did not visually monitor staff and did not know if the treatments had actually been completed but relied on staff documentation and did not monitor to ensure staff completed skin/wound assessments per the facility policy. According to the Unit Supervisor, the resident had been treated for a pressure ulcer to the neck for approximately three to four months. The Unit Supervisor stated the resident's pressure ulcer "had never been completely healed since August 2011."</p> <p>Interview with the Director of Nursing (DON) on 12/07/11, at 2:10 PM, revealed the DON had visualized Resident #1's pressure ulcer to the neck on 11/04/11 prior to the resident's transfer to the hospital. According to the DON, the pressure</p>	F 314		
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F 314	Continued From page 33 ulcer was a "beefy" color with a skin flap. The DON stated staff kept the tracheostomy straps padded to keep them off the resident's skin. According to the DON, staff was required to assess and document resident wounds each week. The DON stated she "flipped" through the documentation of the wounds every three to four weeks but did not check to ensure the assessments had been completed in accordance with facility policy. Interview on 12/09/11, at 3:15 PM, with the primary physician for Resident #1 at the facility revealed he was unaware of the condition of the resident's pressure ulcer to the neck until he saw the photographs taken at the hospital. The physician stated he had been informed several months ago (could not remember the exact date) by facility staff that the resident had returned from the hospital with the pressure ulcer; however, the physician stated he had not visualized the pressure ulcer at that time. The physician stated he did not recall if staff "told me what it looked like" when he ordered a dressing change but staff would inform him of the need to change treatment due to not healing well. The physician stated he normally would document in the physician's progress notes if he had visualized the wound. According to the physician, the condition of the pressure ulcer at the time of admission to the hospital on 11/04/11 "had taken a while to develop, probably longer than seven days."	F 314	F490 Corrective action accomplished for residents found to have been affected by the deficient practice; 1) Resident #1's primary physician was notified and is aware of the trach collar strap incident that occurred on 11/4/11. Resident #1 was discharged to the hospital on 12/6/11 and continues to be in the hospital at this time. There are no other residents in the facility at this time requiring a trach collar. The primary physician will be notified upon resident #1's return to the facility after a nurse manager has observed the licensed nurse completing a full skin assessment, documentation, and care plan. The primary physician will give any treatment orders that are identified as needed. Nursing Administration will ensure the orders obtained are implemented, documented, and care plan revisions initiated. The primary physician will complete a skin assessment on resident #1 with his next scheduled visit and document any identified skin issues in a Physician progress note.	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 490		

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F 490	<p>Continued From page 34</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, physician interviews, record review, and a review of facility policies, it was determined the facility failed to be administered in an effective and efficient manner to ensure that one (1) of thirteen (13) residents received care and services to attain or maintain their highest practicable physical well-being. The facility failed to ensure one (1) of thirteen (13) sampled residents (Resident #1) received care and services for the treatment of pressure ulcers in accordance with the plan of care and failed to have an effective system in place to ensure policies and procedures were implemented. On 11/04/11 the facility transferred Resident #1 to the hospital due to an elevated temperature. Interview on 12/09/11, at 12:50 PM, with the Paramedic who transported Resident #1 to the Emergency Department of the hospital on 11/04/11, revealed the Paramedic could not recall a dressing to the left side of the resident's neck on 11/04/11. Upon arrival to the hospital, hospital staff assessed the resident and determined the strap to the resident's tracheostomy collar had become embedded into the skin on the left side of the resident's neck. The resident's attending physician at the facility had prescribed a wound treatment that included a dry protective dressing to the left side of the resident's neck on a daily basis; however, upon the resident's arrival to the hospital, there was not a protective dressing covering the wound. Interview with Resident #1's</p>	F 490	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>2) Social Services and Nursing Administration will complete a risk worksheet for abuse, neglect and exploitation on all residents residing in the facility by 1/6/11. Care plans will be initiated or revised for any residents identified to be at risk for abuse, neglect, or exploitation.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>3) The Regional Director of Clinical Services in-serviced the nurse management team (DON/ADON/SDC/MDS/UNIT MANAGERS/ED) on 12-13-11. The in-service included wound care policy which includes prevention of infections, treatments, and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds,</p>	
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F. 490	<p>Continued From page 35</p> <p>physician revealed, based on observation of the photograph taken at the hospital, facility staff could not have provided care to the resident's neck wound for "more than seven days."</p> <p>The facility's failure to ensure Resident #1 received care and services to promote healing and worsening for a pressure ulcer placed residents in the facility at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/12/11 and determined to exist on 11/04/11 and is ongoing due to the facility's failure to identify neglect and that staff did not implement the facility policy/procedure related to wound surveillance and wound treatment.</p> <p>Deficiencies were cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F224), 42 CFR 483.20 Resident Assessment (F282), 483.25 Quality of Care (F314), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices and 42 CFR 483.25 Quality of Care. (Refer to F314 and F224.)</p> <p>The findings include:</p> <p>A review of the photograph obtained by hospital staff in the hospital Emergency Department on 11/04/11 revealed Resident #1 had a wound on the left side of the resident's neck. A green strap was observed attached to a tracheostomy collar (a device for oxygen delivery placed over a tracheostomy) and continued around the resident's neck. A measurement device present</p>	F 490	<p>completing documentation, abuse, neglect, Elderly abuse justice act, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>The SDC in-serviced the licensed nurses and certified nursing aides on 12/13/11 and 12/14/11. The in-service included wound care policy which includes prevention of infections and assessment of wounds for signs and symptoms of infection, guidelines, correct staging of wounds, care planning, prevention, intervention, causative factors, oxygen therapy, assistive devices that may cause pressure wounds, completing documentation, abuse, neglect, and a post test was completed. Emphasis was placed on neglect and reporting of allegations of abuse or neglect.</p> <p>Nursing administration completed a 100% skin assessment audit and observation of all residents with pressure wounds on 12/13/11 to ensure no other residents had devices that were causing pressure and to ensure all resident treatments were being</p>	

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F.490	<p>Continued From page 36</p> <p>in the photograph revealed an approximate 4.5 centimeter (cm) area of the green strap obscured by a yellow substance in the middle of the area, strings of a yellow/pink substance was on the left of the area and a flesh colored substance was on the right of the wound. Review of the physician's hospital admission documentation dated 11/04/11, revealed the resident had an area on the left side of the neck "what appears that her tracheostomy collar has been eroding into the left side of the neck."</p> <p>According to interviews on 12/07/11 and 12/09/11 with the Emergency Department (ED) staff, ambulance paramedic, consulting surgeon and review of a photograph of Resident #1 obtained in the ED, the resident did not have a dressing intact to the left side of the neck and the tracheostomy strap was embedded into the residents skin upon arrival to the hospital. Interviews with the consultant surgeon on 12/07/11 and again on 12/09/11 revealed, in his opinion, the resident could not have received care to the wound area on the neck for at least seven days. Interview on 12/09/11 with the resident's attending physician at the facility revealed the wound area identified in a photograph taken by hospital staff on 11/04/11 would have taken more than seven days to get into a condition with the strap of the tracheostomy embedded into the resident's skin.</p> <p>A review of the facility policy/procedure Wound Care/Treatment (undated) revealed staff was to complete a weekly assessment on all wounds. The assessment was to include measurement and a description of the wound.</p>	F 490	<p>completed per physician orders. Any skin issues identified the primary physician was notified, new orders obtained, treatments completed, care plans completed, care plans revised, and care guides updated. This was to ensure wound care policy, guidelines, assessments, and treatments were provided per policy and physician order.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>4) Nursing Administration will complete 2 times weekly observations of licensed nurses performing skin and wound assessments and treatments. Daily observations will be preformed by Nursing Administration daily x30 days then 2x weekly x30days, then wkly x4 months, then monthly x2 months, then randomly x2months to ensure licensed nurses are providing treatments and services to promote healing and prevent infection of pressure wounds.</p> <p>Nurse Administration will review 24 hour shift reports and all physician orders to ensure any new wounds identified have physician orders, treatments, detection of signs and</p>

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F 490	<p>Continued From page 37</p> <p>Review of the facility policy/procedure Tracheostomy Care (undated) revealed the area around a tracheostomy stoma required cleansing/treatment, the inner cannula of the tracheostomy required cleaning and/or changed to meet hygiene protocol, and drain sponges and tracheostomy "ties" required changing secondary to soiling.</p> <p>Review of the facility policy/procedure Resident Abuse and Neglect revealed neglect was usually not intentional and that, although Associates wanted to take good care of residents, but for a number of reasons, the necessary care was not always provided to meet the resident's needs. According to the policy, neglect must be identified and corrected quickly.</p> <p>Review of the Pressure Ulcer Status Record for Resident #1 from 05/15/11 through 10/31/11 revealed staff had conducted weekly wound documentation. Review of the documentation revealed staff had documented the stage of the wound and measurement but did not provide a description of the wound. Review of the Pressure Ulcer Status Record for Resident #1 dated 10/03/11 revealed the resident had a Stage II pressure ulcer to the neck that measured 3.5 centimeters (cm) by 1.0 centimeters. On 10/10/11 staff documented the wound was a Stage III pressure ulcer that measured 4.0 cm by 1.0 cm (larger and a worsening stage than the previous week) and documented "no change."</p> <p>Review of the medical record of Resident #1 revealed the resident had been transferred to the hospital on 11/04/11 for an elevated temperature. Based on documentation by hospital staff,</p>	F 490	<p>symptoms of infection, care plans, care plan revisions with any change in wound treatments Review of 24 hour reports and physician orders will be completed by Nursing Administration daily x30 days, then M-F ongoing.</p> <p>The Executive Director will conduct a weekly Performance Improvement meeting with the Interdisciplinary Team which includes the Medical Director for the next 4 weeks to ensure residents are receiving care and services to attain and maintain highest practicable physical well being. Any concerns or issues identified will be discussed and a plan of action put in place to address concerns or issues.</p> <p>Increased Performance Improvement meetings will be conducted weekly x30 days, then monthly x6 months for care and services to attain and maintain highest practicable physical well being.</p> <p>The Executive Director will conduct a weekly wound meeting for residents with skin issues, pressure wounds, or requiring devices that may cause pressure wounds will be discussed. Any concerns or issues identified will be</p>	

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F 490	<p>Continued From page 38</p> <p>Resident #1 was found to have a strap that secured the tracheostomy collar embedded into the skin on the left side of the resident's neck.</p> <p>Interviews with Licensed Practical Nurse (LPN) #2 on 12/07/11 at 4:25 PM and 12/09/11 at 4:15 PM; with Registered Nurse (RN) #1 on 12/07/11 at 1:15 PM and 12/12/11 at 3:20 PM; and with LPN #1 on 12/07/11 at 4:08 PM and 12/09/11 at 2:40 PM, revealed they had provided care to Resident #1 from 10/31/11 to 11/04/11 and had applied a dry protective dressing to the wound on the left side of the resident's neck and had also padded the straps to the tracheostomy collar.</p> <p>Interview with the Unit Supervisor on 12/07/11, at 2:00 PM, confirmed Resident #1 had a pressure sore the left side of the neck that had been assessed on the resident's return from a hospitalization in May 2011 (exact date unknown). The Unit Supervisor stated she could not confirm that staff had delivered the care and services for resident #1 because she had only "asked" staff if they had performed tracheostomy/wound care to the resident's neck, and had not actually observed the provision of the care.</p> <p>Interview with the Director of Nursing (DON) on 12/07/11, at 2:10 PM, 12/09/11, at 4:50 PM and on 12/12/11, at 5:00 PM, revealed the Unit Supervisor had the responsibility to ensure staff provided wound treatments. The DON stated a weekly pressure ulcer tracking report had been developed for documentation of the status of pressure ulcers and that she relied on accurate documentation of the pressure ulcers by staff for the report. The DON stated that she reviewed</p>	F 490	<p>discussed and a plan of action put in place to address concerns or issues.</p> <p>Weekly wound meetings will be conducted weekly to ensure skin issues, pressure wounds, and devices that may cause pressure are being addressed weekly.</p> <p>The results of the audits and observations will be reviewed in the monthly Performance Improvement Meeting. Revisions will be made to the system as indicated. Audits will continue until the Performance Improvement Committee determines compliance.</p> <p>5) Date of Compliance 1/9/12.</p>	

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F 490	<p>Continued From page 39</p> <p>the information on a weekly basis then forwarded her report to the corporate Regional Director of Clinical Services. According to the DON, she did not review the Pressure Ulcer Status Reports on a regular basis. The DON stated she "flipped" through the reports every three to four weeks and was not aware that staff had not completed the reports in accordance with facility policy.</p> <p>Interview on 12/12/11, at 3:40 PM, with the Corporate Regional Director of Clinical Services revealed the DON had the responsibility to ensure care was delivered to residents in accordance with the resident's care plan.</p> <p>Interview with the facility Administrator on 12/12/11, at 3:11 PM, revealed the Administrator relied on the DON and the unit managers to ensure care was delivered to residents. The Administrator stated the DON had the responsibility to ensure pressure ulcers were monitored/tracked, and to verify staff competency. According to the Administrator, the unit managers had the responsibility to monitor staff practice. In addition, the Administrator acknowledged she was aware of the physician's report of Resident #1's hospitalization which indicated the strap of the tracheostomy collar had become embedded in the resident's skin.</p> <p>The Administrator stated she questioned staff about the resident's condition and had determined, based on the interviews, the resident had returned from the hospital "in that condition." The Administrator stated the tracheostomy collar strap had become embedded in the resident's skin during the resident's hospitalization.</p>	F 490			

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F 490	Continued From page 40 The Administrator could provide no documented evidence of a formal investigation of neglect conducted by the facility or action taken to ensure neglect would not recur despite being notified by Adult Protective Services of their investigation into the allegation of neglect.	F 490			