

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2012
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 39 FERNDAL APARTMENTS ROAD PINEVILLE, KY 40977
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY19518) was conducted on 12/18-19/12. The complaint was substantiated with deficient practice identified at "G" level.	F 000	Mountain View Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance.	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Mountain View response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor is that any deficiency accurate. Further, Mountain View Nursing and Rehabilitation reserves the right to refute any of the deficiencies through informal dispute resolution, formal appeal procedures and/or any other administrative or legal proceeding.	

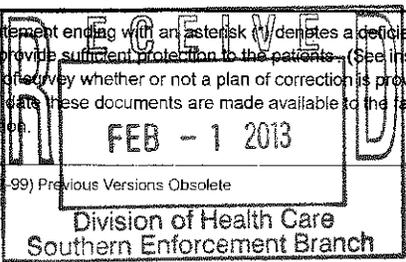
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kelley M. Gaudin Administrator

TITLE

(X6) DATE

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.



01-31-2013

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy, it was determined the facility failed to ensure the resident's physician was notified when a need to alter treatment occurred for two of three sampled residents (Residents #2 and #1). 1) Observations conducted on 12/18/12, of stoma care for Resident #2's colostomy (an abdominal opening surgically created to allow intestinal waste to leave the body) revealed the skin surrounding the resident's colostomy stoma was red, irritated, and had two small blisters present to the irritated area. Further observations revealed facility staff had placed a bath towel over the resident's colostomy stoma to collect the resident's intestinal waste. Staff stated Resident #2 had behaviors of removing colostomy bags and, as a result, the skin tissue that surrounded the resident's colostomy stoma had been red and irritated "off and on" for approximately three years. However, interviews with facility staff and a review of Resident #2's medical record revealed facility staff failed to contact the resident's physician of the ongoing skin irritation to the resident's colostomy stoma and failed to ensure the physician was aware of the resident's behaviors of removing the colostomy bag. 2) Interviews and a review of Resident #1's facility and hospital records revealed the resident developed open and black areas to the sacrum area at the facility and facility staff failed to notify the resident's physician of the change in the resident's status. Based on documentation in the hospital record, Resident #1 was observed to	F 157	F157 Resident #1 was discharged from the facility on 12/10/12. Prior to discharge resident #1 was being treated for a denuded area and excoriation to the sacrum. Resident #1 was assessed and the physician was contacted prior to discharge. Resident #2 was being treated for redness and excoriation to the colostomy stoma. On 12/18/2012 the physician was notified and a change in stoma treatment was ordered. On 12/21/2012 the physician was notified of Resident #2 behavior of removing the colostomy bag. The physician changed the stoma treatment and Resident #2 was seen by psychology services on 12/21/2012.		

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F 157	<p>Continued From page 2</p> <p>have a Stage 4 pressure ulcer, with necrotic (black) tissue which covered fifty percent of the resident's wound, the day following the resident's admission to the hospital from the facility. Interviews with facility staff revealed the resident developed open areas to the sacrum on 12/07/12. Further interviews revealed facility staff also observed open and black areas to Resident #1's sacrum on 12/08/12 and 12/09/12; however, based on record reviews and interviews, the facility failed to ensure the physician was notified of the changes in the resident's skin condition and, as a result, failed to ensure treatment was provided to the areas.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Notification of Physician for Change in Resident's Condition," dated August 2012, revealed staff was to notify the residents' physician when a significant change in a resident's condition occurred.</p> <p>1. A review on 12/18/12 of Resident #2's medical record revealed the facility admitted the resident on 03/03/09 with diagnoses that included a history of Intestinal Obstruction and Colostomy placement, a History of Gastroenteritis and Colitis, and Type II Diabetes. A review of the Quarterly Minimum Data Set Assessment (MDS) dated 10/16/12, revealed the facility assessed the resident had the ability to make his/her self understood, the ability to understand others, and was interviewable. The MDS revealed the resident required extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. In addition, the MDS</p>	F 157	<p>The facility will identify other residents with the potential to be affected by reviewing: in house residents' charts for past 30 days to verify physician/responsible party notifications were completed appropriately. The review, to include notification of changes in wounds, was completed 1/10/2013 by the director of nursing, assistant director of nursing, treatment nurse, MDS nurse, QI nurse and/or staff facilitator.</p> <p>Systemic changes put into place to ensure the practice does not recur include:</p> <p>A) Registered Nurse #1 is no longer employed by the facility.</p> <p>B) All licensed nurses were in-serviced by the director of nursing beginning on 12/14/2012 and completed on 12/20/2012 related to their responsibility to notify physicians and responsible parties anytime 1) there is a change in</p>	

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F 157	<p>Continued From page 3</p> <p>revealed Resident #2 had Moisture Associated Skin Damage (MASD) and required applications of ointments/medications other than to the feet. The MDS provided no evidence that Resident #2 had exhibited any behavioral symptoms, or rejection of care during the assessment period.</p> <p>A review on 12/18/12 of the Comprehensive Care plan for Resident #2, last updated 10/25/12, revealed the resident had an alteration in bowel elimination and had a permanent colostomy. According to the care plan, facility staff was to report any changes in the resident's skin integrity or skin impairment to the physician. The care plan further directed staff to observe and report any changes which occurred in the resident's mood or behavior to the physician.</p> <p>A review of the Behavior Observation sheets, utilized by facility staff to document behaviors exhibited by Resident #2 in October 2012, November 2012, and December 2012 revealed no documented evidence that Resident #2 exhibited behaviors.</p> <p>A review on 12/18/12 of Resident #2's weekly skin assessments conducted on 12/03/12, 12/10/12, and 12/17/12 revealed treatments were provided daily to the resident's colostomy stoma site. Further review revealed no evidence that staff had documented the appearance of the resident's skin or assessed the stoma related to worsening in appearance. Documentation revealed Resident #2's physician had prescribed Nystatin Cream (topical anti-infective) to be applied to Resident #2's stoma on a daily and "as needed" basis on 12/19/11 (approximately one year prior to the date of the review, interview, and</p>	F 157	<p>resident's physical mental or psychosocial status 2) there is a need to change or begin a new treatment (medication, wound, diet, etc.) 3) there is a need to transfer or discharge a resident 4) there is an incident.</p> <p>C) The director of nursing, assistant director of nursing, treatment nurse, MDS nurse, Qi nurse and staff facilitator were in-serviced by the wound consultant on 1/9/2013. The in-service covered daily chart audits conducted for physician and responsible party notification for any change in residents' condition/status/new physician orders. Competency was determined by the wound consultant at the end of the training through question and answer period.</p> <p>The facility plans to monitor its performance to ensure solutions are sustained by:</p>	

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F 157	<p>Continued From page 4 observation). A review of the Treatment Administration Record (TAR) revealed staff had applied Nystatin Cream to the resident's colostomy stoma as ordered.</p> <p>Observations conducted at 8:30 AM on 12/18/12 revealed a bath towel had been placed over Resident #2's colostomy stoma to collect intestinal wastes. Observations of the skin around the resident's stoma revealed the skin was red, irritated, and had two small blisters. Further observations revealed Resident #2 had facial grimacing and verbalized "that hurts, that burns" when Certified Nurse Aide (CNA) #1 and CNA #2 provided the resident with colostomy care. At the completion of the colostomy care, CNA #1 applied a colostomy bag over the resident's red, irritated skin and colostomy stoma; however, the CNAs failed to ensure nursing staff applied the prescribed Nystatin Cream to the resident's colostomy stoma prior to the application of the colostomy bag.</p> <p>During an interview conducted on 12/18/12 at 9:00 AM, Resident #2 stated, "My skin burns like fire around my colostomy; they put medicine on it but it's not helping." The resident continued to state he/she was unaware of how long the skin irritation had been present, and stated, "They leave the bag off of me at times, because it hurts so bad when it's on me because of my skin."</p> <p>Interview with CNA #1 on 12/18/12 at 8:40 AM revealed Resident #2's skin had been red and irritated around the colostomy site for "a year," and that Resident #2 had behaviors of removing the colostomy bag. According to the CNA, Resident #2's skin "looks a lot better now than</p>	F 157	<p>A) Reviewing daily progress notes. The review will be documented on the Chart Review & Follow Up form. The director of nursing will determine ongoing competency through monitoring of the completed Chart Review and Follow Up forms.</p> <p>B) The director of nursing, assistant director of nursing, treatment nurse, MDS nurse, QI nurse and staff facilitator will complete daily chart reviews. Daily chart reviews will be documented using the Chart Review & Follow Up form. Identified physician notification issues will be addressed by the auditor.</p> <p>C)The RN director of nursing, RN assistant director of nursing, staff facilitator will visually conduct skin observations with the treatment nurse of all wounds to determine if there are any needs that have not been identified and reported to the resident's physician. The RN</p>		

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F 157	<p>Continued From page 5</p> <p>what it did look like." The CNA stated the nursing staff had been made aware of the resident's skin condition and behaviors of removing the colostomy bag.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM confirmed Resident #2 had behaviors of "scratching" at his/her colostomy site. The CNA stated she had reported to the facility nursing staff "numerous" times of the irritation to the skin around the resident's colostomy stoma.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 12/18/12 at 2:45 PM revealed she had observed Resident #2's colostomy stoma on 12/07/12 to be red and irritated, and that the stoma was covered with a towel. LPN #2 stated she had not documented or reported the resident's skin condition to the resident's physician.</p> <p>An interview with LPN #3 on 12/18/12 at 3:30 PM revealed she had provided care to Resident #2 for three years and facility staff had "always had a problem" with the skin around the resident's colostomy stoma. The LPN stated the resident puts his/her fingers "in and around the stoma site all the time." The LPN stated she had discussed the resident's ongoing skin irritation with the Director of Nursing one or two days prior to the interview conducted on 12/18/12. LPN #3 acknowledged she had not contacted the resident's physician related to the resident's behaviors, or the ongoing skin irritation present to the resident's colostomy stoma and stated "someone probably should have."</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM</p>	F 157	<p>weekly skin observation of wounds and oversight of the wound care and wound care documentation performed by the treatment nurse will serve as validation of the treatment nurse's accurate description of a wound, proper physician and responsible party notification of a wound, administration of proper treatment and care of the wound as ordered by the physician, and follow-up with the physician if there is a change in the resident's and/or wound condition, including if the wound does not show improvement. Any concerns or discrepancies will be addressed by the RN at the time of observation.</p> <p>C) The results of the administrative nurse's observations will be reviewed and discussed at the monthly and quarterly QI meetings.</p> <p>The results of the Chart Review & Follow Up form will be reviewed in a</p>	

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F 157	<p>Continued From page 6</p> <p>revealed Resident #2 "picks" at his/her colostomy constantly, and has had irritated skin surrounding his/her colostomy for "one year." The LPN confirmed she failed to document the resident's behavior on the behavior sheet and stated she had not contacted the resident's physician related to the resident's ongoing skin irritation because "it was the treatment nurse's responsibility."</p> <p>An interview with the facility's full time treatment nurse, Registered Nurse (RN) #1, on 12/18/12 at 3:00 PM, revealed Resident #2 had behaviors of "unhooking" the colostomy bag his/herself, and RN #1 stated she failed to document the resident's behaviors. The RN stated the resident's skin was red and inflamed and the RN was unsure of when the resident's skin irritation initially developed. The RN stated she notified the resident's physician related to the resident's behaviors of removing the colostomy bag and the skin irritation, but was unable to recall when or to provide documentation of the physician contact.</p> <p>Continued review of the resident's medical record revealed no evidence facility staff notified the resident's physician of the ongoing skin irritation at the colostomy stoma site.</p> <p>Interview with the Director of Nursing (DON) on 12/19/12 at 8:30 AM revealed facility staff received physician's orders in July 2012 for the application of Calmoseptine ointment (a moisture barrier) to the resident's stoma and applied the ointment to the resident's colostomy stoma as directed. A review of physician's orders revealed Calmoseptine was prescribed on 07/09/12, and staff was directed to apply the Calmoseptine to the resident's groin and lower abdominal areas;</p>	F 157	<p>weekly QI committee meeting consisting of The administrator, DON ADON, QI nurse, staff facilitator, MDS and any other Interdisciplinary Care Plan Team members, as appropriate. The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective action is completed and date the completion is due.</p> <p>D) The Executive QI Committee will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.</p>		02-02-2013

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F 157	<p>Continued From page 7</p> <p>however, it could not be determined by a review of documentation that staff had been directed by the physician to apply the Calmoseptine to the resident's colostomy stoma site.</p> <p>Interview with Resident #2's physician on 12/19/12 at 2:00 PM revealed staff had notified him of the resident's skin irritation in the past; however, the physician could not recall when the notification occurred. In addition, the physician would not acknowledge if staff had or had not notified him of the resident's behavior of removing the colostomy bag, and stated, "I'll take care of it."</p> <p>2. A review on 12/18/12, of the medical record for Resident #1 revealed the facility readmitted the resident from an acute hospital stay on 11/07/12 with diagnoses of Chronic Airway Obstruction, Convulsions, and Pneumonia. A review of a 14-day Minimum Data Set (MDS) assessment dated 11/21/12 revealed facility staff assessed the resident to be at risk for the development of pressure sores and to have Moisture Associated Skin Damage (MASD). Facility staff assessed Resident #1 to be totally dependent and required the assistance of two staff members for bathing, toileting, bed mobility, and personal hygiene. In addition, staff documented the resident was incontinent of bowel and bladder.</p> <p>A review on 12/18/12, of the admission skin assessment conducted for Resident #1 on 11/07/12 revealed RN #1 identified excoriation and redness to the resident's sacrum and bilateral buttocks. Further review of RN #1's documentation revealed Resident #1 had a small denuded area, with the appearance of redness/excoriation (MASD), to the sacral area.</p>	F 157			

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F 157	<p>Continued From page 8</p> <p>Continued review of the skin assessment revealed the RN had not identified any open areas to Resident #1's sacral area or buttocks upon admission to the facility.</p> <p>A review on 11/07/12, of Resident #1's physician's orders revealed the physician had prescribed Calmoseptine (a moisture barrier ointment) to be applied to excoriated areas on the resident's bilateral buttocks daily and as needed. Continued review of the physician's orders revealed facility staff was to cleanse the denuded areas to the resident's sacrum with normal saline (a sodium based water solution) and to apply a wound gel and dressing to the area daily and as needed. Continued review of the medical record revealed no evidence that facility staff had documented or notified the resident's physician of any open or discolored areas to the resident's sacral area. Documentation revealed the resident was transferred to the hospital on 12/10/12 when the resident became unresponsive.</p> <p>A review of the resident's hospital record on 12/18/12, revealed hospital staff admitted the resident on 12/10/12, the day the resident was transferred from the facility. Further review revealed on 12/11/12 (the day after the resident was admitted to the hospital) hospital staff assessed Resident #1 to have a Stage 4 pressure ulcer to the sacrum. Documentation also revealed hospital staff assessed 50 percent of the resident's pressure ulcer wound beds were necrotic (black) in color.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM revealed she had provided care to Resident #1 on 12/07/12 and noted the resident's sacral area</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>was "purple" in color and an open area was present to the sacral area. The CNA stated she notified the treatment nurse, LPN #2, and the resident's nurse, LPN #4, at that time of the change observed in the resident's skin condition. The CNA continued, stating she provided personal care for the resident again on 12/09/12, noted the resident's sacral area was black in color, and notified the treatment nurse (LPN #1).</p> <p>Interview with LPN #1 on 12/18/12 at 11:20 AM revealed she had provided treatment to Resident #1's sacral and bilateral buttocks on 12/08/12 and 12/09/12. Continued review revealed the LPN stated the resident had two open and blackened areas to the sacrum. The LPN stated she had not provided care to the resident prior to 12/08/12, therefore, was unaware if a change had occurred in the appearance of the resident's skin integrity impairment. The LPN stated "wound care" was "new" for her, and she acknowledged she had not contacted the resident's physician to obtain further treatment related to the change in the resident's skin condition.</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM confirmed she was notified of a change in the skin status of Resident #1 and observed on 12/07/12 that Resident #1 had developed an open area to the sacrum; however, according to LPN #4, she did not contact the resident's physician to obtain further treatment orders for the resident. The LPN stated she discussed the change in the resident's skin condition with the treatment nurse (LPN #2), and stated the treatment nurse was responsible to contact the resident's physician to obtain a change in treatment orders when a change in skin condition</p>	F 157		

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F 157	<p>Continued From page 10 occurred.</p> <p>Interview with LPN #2 on 12/18/12 at 2:45 PM revealed she provided wound care to Resident #1 on 12/07/12. The LPN stated the resident's sacral area appeared to be a deep dark red color and open areas were observed to the resident's sacral area. The LPN stated she does not "do treatments enough to know if a change had occurred or not," and just followed the current orders. The LPN acknowledged she had not contacted the resident's physician related to the status of the resident's skin condition.</p> <p>Registered Nurse (RN) #1 stated in interview conducted on 12/18/12 at 3:00 PM that she provided wound care to Resident #1 on 12/10/12 (the same day the resident was transferred to the hospital). The RN stated she observed that the excoriation to the resident's buttock/sacrum appeared more "pronounced." However, RN #1 stated she had not identified any open areas or other appearance changes to the resident's sacral/buttock area that would have required a change in the current treatment for the resident.</p> <p>Interview with the Director of Nursing on 12/18/12 at 6:30 PM revealed staff should have contacted the physician when Resident #1 experienced a change in skin condition. The DON stated she ensured a resident's physician was contacted appropriately related to treatment of pressure ulcers by information obtained from the monthly wound meetings and through random chart audits conducted daily.</p> <p>Interview with Resident #1's physician on 12/18/12 at 4:00 PM revealed facility staff should</p>	F 157		

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F 157	Continued From page 11 have contacted her when the resident developed necrotic tissue to the sacrum.	F 157		
F 272 SS=G	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	<u>F272</u> Resident #2 was being treated for redness and excoriation to the colostomy stoma. On 12/18/2012 the physician was notified and a change in stoma treatment was ordered. On 12/21/2012 the physician was notified of Resident #2's behavior of removing the colostomy bag. The physician changed the stoma treatment order and Resident#2 was seen by psychology services on 12/21/2012. On 12/18/2012 Resident #2's care plan was reviewed by the MDS nurse. The MDS nurse made changes to reflect the current treatment plan. For Resident #2, the MDS nurse will complete a significant change assessment with an ARD date of 1/10/2013. The comprehensive assessment will include CAAS and care plan,	

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F 272	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity was initially and periodically conducted for one of three sampled residents (Resident #2). Observations conducted on 12/18/12, of colostomy (an abdominal opening surgically created to allow intestinal waste to leave the body) care for Resident #2 revealed the colostomy was not covered by a colostomy bag and the skin surrounding the resident's colostomy was red, irritated, and had two small blisters present to the irritated area. Further observations revealed facility staff had placed a bath towel over the resident's colostomy to collect the resident's intestinal waste. Staff stated Resident #2 had behaviors of removing colostomy bags and the skin tissue that surrounded the resident's colostomy had been red and irritated "off and on" for approximately "three years." However, facility staff failed to document Resident #2's behaviors on the Minimum Data Set Assessment (MDS). The findings include: An interview with the Minimum Data Set Assessment (MDS) and Care Plan Coordinator on 12/18/12 at 6:20 PM revealed they followed the guidelines provided on the MDS document for completion of the assessment.	F 272	reflecting Resident #2's skin condition and exhibited behaviors. The facility will identify other residents with the potential to be affected by: A) All Interdisciplinary Care Plan Team members were re-educated by the facility consultant beginning on 1/10/2013 and completed on 1/18/2103. The re-education included comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. Competency was determined by the facility consultant by post testing. B) The Interdisciplinary Care Plan Team will complete a review of all current in house residents' comprehensive assessments including care plans and CAAS. The review, to include all behaviors was completed on 1/18/2013.	

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F 272	Continued From page 13 An interview with the Director of Nursing (DON) at 6:30 PM on 12/18/12 revealed the facility did not have a specific policy related to resident behaviors. The DON stated staff was responsible to document any behaviors exhibited during their shift. A review on 12/18/12 of Resident #2's medical record revealed the facility admitted the resident on 03/03/09 with diagnoses that included a history of Intestinal Obstruction and Colostomy placement, a History of Gastroenteritis and Colitis, and Type II Diabetes. A review of the Quarterly Minimum Data Set Assessment (MDS) dated 10/16/12, revealed the facility assessed the resident had the ability to make his/her self understood, the ability to understand others, and was interviewable. The MDS revealed the resident required extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. The MDS provided no evidence that Resident #2 had exhibited any behavioral symptoms or rejection of care during the assessment period. The MDS also revealed Resident #2 had Moisture Associated Skin Damage (MASD) and required applications of ointments/medications other than to the feet. A review on 12/18/12 of the Comprehensive Care plan for Resident #2, last updated on 10/25/12, revealed the resident had an alteration in bowel elimination with a permanent colostomy. According to the care plan, facility staff was to report any redness, inflammation, or drainage at the resident's colostomy site to a nurse. Facility staff also identified that Resident #2 "picks at bag and around and in stoma site." Interventions	F 272	C) Any assessments identified as incorrect will have a significant change assessment completed by the Interdisciplinary Care Plan Team. Any corrections will be completed by 1/31/2013. D) Additional in-servicing with SRNAs, KMAs, LPNs, RNs was initiated on 1/10/2013 and completed on 1/18/2013 by the facility consultant related to resident documentation of behaviors and refusal of care. Competency was determined through post testing by facility consultant. Competency in documentation is necessary for identifying residents' with the potential to be affected by the deficient practice. Systemic changes that will be put into place to ensure the practice does not recur will include: A) The director of nursing, the assistant director of nursing, and /or	

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F 272	<p>Continued From page 14</p> <p>identified on the care plan related to the resident's behaviors included to use one-piece clothing outfits for the resident to prevent the resident from picking at the stoma site, and to provide a colostomy bag change as needed. The care plan further directed staff to observe and report to the physician any changes that occurred in the resident's mood or behavior.</p> <p>A review of the Behavior Observation sheets, utilized by facility staff to document behaviors exhibited by Resident #2 in October 2012, November 2012, and December 2012 provided no documented evidence that Resident #2 had exhibited behaviors.</p> <p>Interview with CNA #1 on 12/18/12 at 8:40 AM revealed Resident #2 had behaviors of removing the colostomy bag and that the resident's skin had been red and irritated for a "year." According to the CNA, the nursing staff had been made aware of the resident's behaviors of removing the colostomy bag.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM confirmed Resident #2 had behaviors of "scratching" at his/her colostomy site, however, interview revealed the CNA had failed to document the behaviors. The CNA stated she had reported to the facility nursing staff "numerous" times the resident's refusal to wear the one-piece outfits.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on 12/18/12 at 2:45 PM revealed she was unaware of why staff had not provided a colostomy bag for the resident and stated, "I think the resident's bag overflows." LPN #2 stated she</p>	F 272	<p>facility consultant will audit all comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity is initially and periodically conducted.</p> <p>Comprehensive assessments completed in the next 90 days will be reviewed, starting with the plan of correction completion date of 2/2/2013. Ongoing MDS nurse competency to complete accurate assessment will be verified through this review process.</p> <p>B) Any identified issues will be addressed by the director of nursing with the appropriate staff member, to include additional training.</p> <p>C) The MDS coordinators will visually observe all wounds during the residents' MDS observation period.</p>	

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F 272	<p>Continued From page 15</p> <p>had not inquired why facility staff had not provided the resident with a colostomy bag, and had not documented or reported the resident's behaviors to the MDS nurse.</p> <p>An interview with LPN #3 on 12/18/12 at 3:30 PM revealed she had provided care to Resident #2 for three years and the resident puts his/her fingers "in and around the stoma site all the time." The LPN stated she had not documented the resident's behaviors, had not notified the resident's physician of the resident's behaviors, and had not informed the MDS staff of the resident's behaviors in order for an assessment to be updated.</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM revealed Resident #2 "picks at" his/her colostomy "constantly." The LPN confirmed she failed to document the resident's behaviors on the behavior sheet, and stated she should have.</p> <p>An interview with the facility's full time treatment nurse, Registered Nurse (RN) #1, on 12/18/12 at 3:00 PM, revealed Resident #2 had behaviors of "unhooking" the colostomy bag his/herself. The RN stated she should have documented the resident's behaviors, but failed to do so.</p> <p>Continued interview with the MDS and Care Plan Coordinator on 12/18/12 at 6:20 PM revealed she reviewed and relied on documentation by facility staff to aid in obtaining information needed to complete and update the Resident Assessment Instrument (included in the MDS assessment) and to update the resident's care plans.</p> <p>The Director of Nursing (DON) stated in an</p>	F 272	<p>D) The Social worker will observe any resident behaviors during the residents' assessment period.</p> <p>The facility will monitor its performance to ensure solutions are sustained to include:</p> <p>A) The RN director of nursing, RN assistant director of nursing, staff facilitator, and/or facility consultant will visually observe all wounds during a weekly skin observation.</p> <p>B) The RN weekly visual observation of wounds will be compared to the residents' MDS, CAAS and care plans. Oversight of the MDS, CAAS and care plans documentation performed by the MDS nurses will serve as validation of the MDS nurses' accurate inclusion of wounds and behaviors in the residents' MDS CAAS and care plans.</p>	

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F 272	Continued From page 16 interview conducted on 12/18/12 at 6:30 PM that she reviewed resident behavior sheets, in addition to random chart audits, on a daily basis. The DON stated she had not identified that Resident #2 exhibited behaviors or that the MDS assessment had not been updated to include the resident's behaviors of removing the colostomy bag. The DON confirmed that staff should have documented Resident #2's behaviors related to his/her colostomy in order for the MDS assessment to be updated.	F 272	C) Any concerns found by the MDS coordinators or the social worker related to wounds or behaviors will be addressed by the Interdisciplinary team member at the time of observation.	
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	D) The results of the Administrative nurses' observations will be reviewed and discussed at the weekly, monthly and quarterly QI meetings. The results of the comprehensive assessment review will be discussed in the weekly QI committee meeting consisting of The administrator, DON, ADON, QI nurse staff facilitator, MDS nurse and any other Interdisciplinary Care Plan Team member as appropriate. The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective is completed and date completion is due. The Executive QI Committee	

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F 280	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy, it was determined the facility failed to ensure the comprehensive plan of care was developed, reviewed, and revised based on staff assessment for one of three sampled residents (Resident #2). Observations conducted on 12/18/12 of colostomy (an abdominal opening surgically created to allow intestinal waste to leave the body) care for Resident #2 revealed the resident's skin surrounding the colostomy stoma was red, irritated, and had two small blisters present to the irritated skin. Observation revealed facility staff had placed a cloth towel directly over the resident's colostomy stoma to collect the intestinal waste. Interviews with facility staff on 12/18/12 revealed the resident had behaviors of removing the colostomy bag his/herself. The staff further stated the resident's skin surrounding the resident's stoma had been red and irritated "off and on" for approximately three years. A review of the Comprehensive Care Plan revealed Resident #2 had skin integrity impairment around the colostomy stoma, and staff had developed interventions that included the use of a colostomy bag and one-piece clothing items to prevent the resident from "picking" at the stoma site. However, facility staff failed to ensure Resident #2's plan of care was reviewed/revised to reflect the continued redness/irritation of the skin around the resident's colostomy stoma. (Refer to F309.) The findings include: A review of the facility's policy titled Resident Care Plan, dated August 2012, revealed the	F 280	will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.	02- 02- 2013

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F 280	<p>Continued From page 18</p> <p>development of a resident's care plan would be an ongoing process, and would include current problems and problems identified between the scheduled care plan reviews. The policy revealed modifications to a resident's care plan would be completed as the Care Plan Coordinator directed.</p> <p>A review of Resident #2's medical record on 12/18/12 revealed the facility admitted the resident on 03/03/09 with diagnoses including Type II Diabetes, a history of Intestinal Obstruction and Colostomy placement, and a History of Gastroenteritis and Colitis. A review of the physician's orders dated 12/19/11, revealed staff was to clean around the resident's colostomy stoma with soap and water and apply Nystatin Cream (topical anti-infective) daily and as needed.</p> <p>A review of the Quarterly Minimum Data Set Assessment (MDS) dated 10/16/12, revealed facility staff had assessed the resident to be interviewable and to have the ability to make his/her self understood and to understand others. In addition, the MDS revealed facility staff had assessed the resident to require the extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. Continued review of the MDS revealed no evidence that the resident had exhibited any behavioral symptoms or rejection of care during the assessment period.</p> <p>A review on 12/18/12 of the Comprehensive Care Plan for Resident #2, updated on 10/25/12, revealed staff had identified the resident to have an alteration in bowel elimination with placement of a permanent colostomy. Facility staff also</p>	F 280	<p><u>F280</u></p> <p>Resident #2 was being treated for redness and excoriation to the colostomy stoma. On 12/18/2012 the physician was notified and a change in stoma treatment was ordered. On 12/21/2012 the physician was notified of Resident #2's behavior of removing the colostomy bag.</p> <p>The physician changed the stoma treatment order and Resident#2 was seen by psychology services on 12/21/2012.</p> <p>On 12/18/2012 Resident #2's care plan was reviewed by the MDS nurse. The MDS nurse made changes to reflect the current treatment plan. For Resident #2, the MDS nurse will complete a significant change assessment with an ARD date of 1/10/2013. The comprehensive assessment will include CAAS and care plan,</p>		

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F 280	<p>Continued From page 19</p> <p>noted the resident "picks at bag and around and in stoma site" and developed interventions that included dressing the resident in one-piece outfits in an effort to prevent the resident from picking at the stoma site, and to ensure the colostomy bag was changed as needed.</p> <p>Observations conducted on 12/18/12 at 8:30 AM of Resident #2's colostomy care revealed a towel, used for bathing, had been placed over the resident's colostomy to collect intestinal wastes. Observations of the resident's skin surrounding the stoma, revealed the resident's skin was red, irritated, and had two small blisters present. Resident #2 was observed to have facial grimacing and verbalized, "That hurts, that burns," when Certified Nursing Assistant (CNA) #1 and CNA #2 provided the resident with stoma site care. After CNA #1 cleansed the resident's skin surrounding the colostomy, the resident was observed to have facial grimacing when the CNA applied a colostomy bag over the resident's red, irritated skin.</p> <p>An interview conducted on 12/18/12 at 9:00 AM with Resident #2 revealed, "My skin burns like fire around my colostomy; they put medicine on it, but it's not helping." The resident continued to state he/she was unaware of how long the skin irritation had been present, and stated, "They leave the bag off of me at times, because it hurts so bad when it's on me because of my skin."</p> <p>Interview on 12/18/12 at 8:40 AM with CNA #1 revealed she had been assigned to provide care to Resident #2 on 12/18/12. CNA #1 stated Resident #2's skin had been red and irritated for a "year" and that the resident's skin "looks a lot</p>	F 280	<p>Reflecting Resident #2's skin condition and exhibited behaviors.</p> <p>The facility will identify other residents with the potential to be affected by:</p> <p>A) All Interdisciplinary Care Plan Team members were re-educated by the facility consultant beginning on 1/10/2013 and completed on 1/18/2103. The re-education included comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. Competency was determined by the facility consultant by post testing.</p> <p>B) The Interdisciplinary Care Plan Team will complete a review of all current in house residents' comprehensive assessments including care plans and CAAS. The review, to include all behaviors was completed on 1/18/2013.</p>	

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F 280	<p>Continued From page 20</p> <p>better now than what it did look like." According to the CNA, nursing staff had been made aware of the resident's skin condition. The CNA also stated staff frequently left the resident's colostomy bag off during the night because the resident's skin was red and irritated and the resident had a history of taking the colostomy bag off his/herself.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM revealed Resident #2's colostomy bag had frequently been left off because it would not stick to the resident's "raw skin." The CNA stated the resident had one-piece outfits to wear to keep the resident from "picking" at the colostomy bag but the resident had refused to wear the one-piece clothing. The CNA stated she had reported the status of the resident's skin to facility nursing staff and had also reported that the resident refused to wear one-piece outfits "numerous" times.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 12/18/12 at 11:30 AM revealed she provided treatment to Resident #2's colostomy on 12/15/12 and 12/16/12. The LPN stated she observed the resident's colostomy stoma to be red and irritated on 12/15/12 and 12/16/12, but failed to review and revise the resident's plan of care.</p> <p>An interview with LPN #2 on 12/18/12 at 2:45 PM revealed she had provided treatment to Resident #2's colostomy on 12/07/12 and had observed the resident's colostomy stoma to be red and irritated. The LPN stated she cleansed the resident's colostomy and applied Nystatin and a colostomy bag to the resident's irritated skin surrounding the stoma. LPN #2 stated she had</p>	F 280	<p>C) Any assessments identified as incorrect will have a significant change assessment completed by the Interdisciplinary Care Plan Team. Any corrections will be completed by 1/31/2013.</p> <p>D) Additional in-servicing with SRNAs, KMAs, LPNs, RNs was initiated on 1/10/2013 and completed on 1/18/2013 by the facility consultant related to resident documentation of behaviors and refusal of care. Competency was determined through post testing by facility consultant. Competency in documentation is necessary for identifying residents' with the potential to be affected by the deficient practice.</p> <p>Systemic changes that will be put into place to ensure the practice does not recur will include:</p> <p>A) The director of nursing, the assistant director of nursing, and /or</p>	

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F 280	<p>Continued From page 21</p> <p>not revised or updated the resident's plan of care related to the resident's skin condition because she had not been educated in treatments and had "just followed the current physician orders."</p> <p>An interview with LPN #3 on 12/18/12 at 3:30 PM revealed she had provided care to Resident #2 for three years and facility staff had "always" had a problem with the skin surrounding the resident's stoma. The LPN further stated the skin around the resident's stoma had been irritated and red "off and on" since the LPN's employment began "three years ago." The LPN stated she had discussed the resident's skin irritation and redness, and other treatments that could be attempted for the resident, with the Director of Nursing (DON) approximately one or two days prior to the interview; however, LPN #3 stated she had not revised the resident's care plan to reflect the ongoing skin irritation and redness.</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM revealed she was aware that Resident #2's colostomy had been irritated for approximately a "year." The LPN acknowledged the treatment to the resident's colostomy was not effective and should have been changed. LPN #4 stated the treatment nurse and/or the MDS staff was to develop changes in the care plan related to residents' wounds and treatments.</p> <p>An interview with the facility's full time treatment nurse, Registered Nurse (RN) #1, on 12/18/12 at 3:00 PM, revealed she was aware Resident #2's skin surrounding the colostomy had been red and inflamed but was unsure of when the resident's skin irritation had initially developed. The RN stated she was unaware that staff had provided</p>	F 280	<p>facility consultant will audit all comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity is initially and periodically conducted. Comprehensive assessments completed in the next 90 days will be reviewed, starting with the plan of correction completion date of 2/2/2013. Ongoing MDS nurse competency to complete accurate assessment will be verified through this review process.</p> <p>B) Any identified issues will be addressed by the director of nursing with the appropriate staff member, to include additional training.</p> <p>C) The MDS coordinators will visually observe all wounds during the residents' MDS observation period.</p>		

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F 280	<p>Continued From page 22</p> <p>only a towel to the resident's colostomy and stated the irritation around the resident's colostomy would have increased with contact from intestinal waste. RN #1 acknowledged she had not updated the resident's plan of care related to concerns with the colostomy.</p> <p>Documentation revealed Resident #2's physician had prescribed Nystatin Cream to be applied to the resident's stoma on a daily and "as needed" basis on 12/19/11 (approximately one year prior to the date of the review, interview, and observation). A review of the Treatment Administration Record revealed staff had applied the Nystatin Cream to the resident's stoma as ordered. However, a review of Resident #2's Plan of Care revealed staff failed to update the resident's plan of care to include application of the Nystatin Cream to the skin surrounding the colostomy.</p> <p>Interview with the Director of Nursing (DON) on 12/19/12 at 8:30 AM revealed facility staff had received physician's orders in July 2012 for application of Calmoseptine ointment (a moisture barrier) to the resident's colostomy. A review of physician's orders revealed the Calmoseptine had been prescribed on 07/09/12, and staff had been directed to apply the Calmoseptine to the resident's groin and lower abdominal areas. However, it could not be determined by a review of the physician's orders if staff was to apply the Calmoseptine to the resident's stoma site. Continued review of the resident's plan of care revealed no evidence the plan of care had been updated to include the use of the Calmoseptine.</p> <p>The MDS Coordinator stated in interview</p>	F 280	<p>D) The Social worker will observe any resident behaviors during the residents' assessment period.</p> <p>The facility will monitor its performance to ensure solutions are sustained to include:</p> <p>A) The RN director of nursing, RN assistant director of nursing, staff facilitator, and/or facility consultant will visually observe all wounds during a weekly skin observation.</p> <p>B) The RN weekly visual observation of wounds will be compared to the residents' MDS, CAAS and care plans. Oversight of the MDS, CAAS and care plans documentation performed by the MDS nurses will serve as validation of the MDS nurses' accurate inclusion of wounds and behaviors in the residents' MDS CAAS and care plans.</p>		

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F 280	Continued From page 23 conducted on 12/18/12 at 6:20 PM that she was not aware of Resident #2's ongoing irritation of the skin surrounding the resident's colostomy site prior to 12/18/12 and, as a result, had not updated the resident's care plan. The MDS Coordinator stated she relied on staff documentation in each resident's medical record to identify behaviors and treatments being provided in order to update the plan of care. The MDS Coordinator stated she was not aware that facility staff had utilized only a cloth towel to cover Resident #2's colostomy site prior to 12/18/12, and had added the intervention of using a towel on the resident's stoma, instead of a colostomy bag, on the morning of 12/18/12. An interview with the Director of Nursing (DON) on 12/18/12 at 6:30 PM revealed she attended wound care meetings monthly and conducted chart reviews on a random basis to ensure resident care plan interventions had been provided and/or revised. The DON stated she had not been made aware of the ongoing irritation of the skin surrounding Resident #2's colostomy. The DON stated the MDS staff received copies of all physician's orders and utilized that information to review and revise the plan of care. The DON stated Resident #2's care plan interventions should have been updated based on staff assessment of the resident's condition.	F 280	C) Any concerns found by the MDS coordinators or the social worker related to wounds or behaviors will be addressed by the Interdisciplinary team member at the time of observation. D) The results of the Administrative nurses' observations will be reviewed and discussed at the weekly, monthly and quarterly QI meetings. The results of the comprehensive assessment review will be discussed in the weekly QI committee meeting consisting of The administrator, DON, ADON, QI nurse staff facilitator, MDS nurse and any other Interdisciplinary Care Plan Team member as appropriate. The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective is completed and date completion is due. The Executive QI Committee		
F 282 SS=G	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.	F 282			

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F 282	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one of three sampled residents (Resident #2). Observations conducted on 12/18/12 of colostomy (an abdominal opening surgically created to allow intestinal waste to leave the body) care for Resident #2 revealed the resident's skin surrounding the colostomy stoma was red, irritated, and had two small blisters present to the irritated skin. Observation revealed facility staff had placed a cloth towel directly over the resident's colostomy stoma to collect the intestinal waste. Interviews with facility staff on 12/18/12 revealed the resident had behaviors of removing the colostomy bag his/herself. The staff further stated the resident's skin, surrounding the resident's stoma, had been red and irritated "off and on" for approximately three years. A review of the Comprehensive Care Plan revealed staff noted Resident #2 had skin integrity impairment around the colostomy stoma, and staff had developed interventions that included the use of a colostomy bag and one-piece clothing items to prevent the resident from "picking" at the stoma site. In addition, based on a review of the care plan, staff was to monitor and report changes in the resident's skin integrity and behaviors to the resident's physician. Interviews conducted with facility staff on 12/18/12, revealed Resident #2's skin around the stoma site had been red and irritated "off and on"</p>	F 282	<p>will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.</p> <p><u>F282</u></p> <p>Resident #2 was being treated for redness and excoriation to the colostomy stoma. On 12/18/2012 the physician was notified and a change in stoma treatment was</p>	<p>02- 02- 2013</p>

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F 282	<p>Continued From page 25</p> <p>for approximately three years. However, based on interviews and record reviews, facility staff failed to notify the resident's physician of the resident's skin condition or behaviors. (Refer to F157.)</p> <p>The findings include:</p> <p>A review of the facility's policy titled Resident Care Plan, dated August 2012, revealed the development of a resident's care plan would be an ongoing process, and would include current problems and problems identified between the scheduled care plan reviews. The policy revealed modifications and the implementation of a resident's care plan would be completed as the Care Plan Coordinator directed.</p> <p>A review of Resident #2's medical record on 12/18/12 revealed the facility admitted the resident on 03/03/09 with diagnoses including Type II Diabetes, a history of Intestinal Obstruction and Colostomy placement, and a History of Gastroenteritis and Colitis. A review of the physician's orders dated 12/19/11, revealed staff was to clean around the resident's colostomy stoma with soap and water and apply Nystatin Cream (topical anti-infective) daily and as needed.</p> <p>A review of the Quarterly Minimum Data Set Assessment (MDS) dated 10/16/12 revealed facility staff had assessed the resident to be interviewable and to have the ability to make his/herself understood and to understand others. In addition, the MDS revealed facility staff had assessed the resident to require the extensive assistance of two staff members for bed mobility,</p>	F 282	<p>ordered. On 12/21/2012 the physician was notified of resident #2's behavior of removing the colostomy bag.</p> <p>The physician changed the stoma treatment and Resident #2 was seen by psychology services on 12/21/2012.</p> <p>On 12/18/2012 Resident #2 care plan was reviewed by the MDS nurse. The MDS nurse made changes to reflect the current treatment plan. For Resident #2, the MDS nurse will complete a significant change assessment with an ARD date of 1/10/2013. The comprehensive assessment will include CAAS and care plan, reflecting Resident #2's skin condition and exhibited behaviors.</p> <p>The facility will identify other residents with the potential to be affected by:</p>	

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F 282	<p>Continued From page 26</p> <p>dressings, toilet use, and personal hygiene. Continued review of the MDS revealed no evidence that the resident had exhibited any behavioral symptoms or rejection of care during the assessment period.</p> <p>A review on 12/18/12 of the Comprehensive Care plan for Resident #2, updated on 10/25/12, revealed staff had identified the resident to have an alteration in bowel elimination with placement of a permanent colostomy. Facility staff also noted the resident "picks at bag and around and in stoma site" and developed interventions that included dressing the resident in one-piece outfits in an effort to prevent the resident from picking at the stoma site. In addition, staff was to ensure the colostomy bag was changed as needed. Facility staff was also to report any redness, inflammation, or drainage at the resident's colostomy site to the physician.</p> <p>Observations conducted on 12/18/12 at 8:30 AM of Resident #2's colostomy care revealed a towel, used for bathing, had been placed over the resident's colostomy to collect intestinal wastes. Observations of the resident's skin surrounding the stoma, revealed the resident's skin was red, irritated, and had two small blisters present. Resident #2 was observed to have facial grimacing and verbalized, "That hurts, that burns," when Certified Nursing Assistant (CNA) #1 and CNA #2 provided the resident with stoma site care. After CNA #1 cleansed the resident's skin surrounding the colostomy, the resident was observed to have facial grimacing when the CNA applied a colostomy bag over the resident's red, irritated skin.</p>	F 282	<p>A) All Interdisciplinary Care Plan Team members were re-educated by the facility consultant beginning on 1/10/2013 and completed on 1/18/2013. The re-education included comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. Competency was determined by the facility consultant through post testing.</p> <p>B) Additional in-servicing with SRNAs, KMAs, LPNs, and RNs was initiated on 1/10/2013 and completed on 1/18/2013 by the facility consultant related to documentation of resident behaviors, refusal of care, skin integrity impairment, stoma changes, changes in conditions, assessments responsible party</p>	

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F 282	<p>Continued From page 27</p> <p>An interview conducted on 12/18/12 at 9:00 AM with Resident #2 revealed, "My skin burns like fire around my colostomy; they put medicine on it, but it's not helping." The resident continued to state he/she was unaware of how long the skin irritation had been present, and stated, "They leave the bag off of me at times, because it hurts so bad when it's on me because of my skin."</p> <p>Interview on 12/18/12 at 8:40 AM with CNA #1 revealed she had been assigned to provide care to Resident #2 on 12/18/12. CNA #1 stated Resident #2's skin had been red and irritated for a "year" and that the resident's skin "looks a lot better now than what it did look like." According to the CNA, nursing staff had been made aware of the resident's skin condition. The CNA also stated staff frequently left the resident's colostomy bag off during the night because the resident's skin was red and irritated and the resident had a history of taking the colostomy bag off his/herself.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM revealed Resident #2's colostomy bag had frequently been left off because it would not stick to the resident's "raw skin." The CNA stated the resident had one-piece outfits to wear to keep the resident from "picking" at the colostomy bag but the resident refused to wear the one-piece clothing. The CNA stated she had reported the status of the resident's skin to facility nursing staff "numerous" times.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 12/18/12 at 11:30 AM revealed she provided treatment to Resident #2's colostomy on 12/15/12 and 12/16/12. The LPN stated she had</p>	F 282	<p>notification, physician notification and physician re-notification. Competency was determined through post testing.</p> <p>C) The Interdisciplinary Care Plan Team will complete a review of all current in house residents' comprehensive assessments including care plans and CAAS. The review, to include all behaviors, was completed on 1/18/2013. Any assessments identified as incorrect will have a significant change assessment completed by the Interdisciplinary Care Plan Team. Any corrections will be completed by 1/31/2013.</p> <p>Systemic changes will be put into place to ensure the practice does not recur to include:</p> <p>A) All Interdisciplinary Care Plan Team members were re-educated by the facility consultant beginning on 1/10/2013 and completed on 1/18/2013. The re-education</p>	

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F 282	<p>Continued From page 28</p> <p>observed the resident's colostomy stoma to be red and irritated on 12/15/12 and 12/16/12, but failed to notify the resident's physician of the appearance of Resident #2's colostomy site as directed in the resident's plan of care.</p> <p>An interview with LPN #2 on 12/18/12 at 2:45 PM revealed she had provided treatment to Resident #2's colostomy on 12/07/12 and had observed the resident's colostomy stoma to be red and irritated. The LPN stated she cleansed the resident's colostomy and applied Nystatin and a colostomy bag to the resident's irritated skin surrounding the stoma. LPN #2 stated she had not contacted the resident's physician related to the resident's skin condition because she had not been educated in treatments and had "just followed the current physician orders."</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM revealed she was aware that Resident #2's colostomy had been irritated for approximately a "year." The LPN acknowledged the treatment to the resident's colostomy was not effective and should have been changed. LPN #4 stated she had not contacted the resident's physician or notified MDS staff of the resident's skin condition in order for them to direct care plan changes. The LPN further stated the treatment nurse and/or the MDS staff was to develop changes in the care plan related to residents' wounds and treatments.</p> <p>An interview with the facility's full time treatment nurse, Registered Nurse (RN) #1, on 12/18/12 at 3:00 PM, revealed she was aware Resident #2's skin surrounding the colostomy had been red and inflamed but was unsure of when the resident's</p>	F 282	<p>included comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. Competency was determined by the facility consultant through post testing.</p> <p>B) Additional in-servicing with SRNAs, KMAs, LPNs, and RNs was initiated on 1/10/2013 and completed on 1/18/2013 by the facility consultant related to documentation of resident behaviors, refusal of care, skin integrity impairment, stoma changes, changes in conditions, assessments, responsible party notification, physician notification and physician re-notification. Competency was determined through post testing.</p> <p>C) Registered Nurse #1 no longer is employed at the facility.</p>	

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F 282	Continued From page 29 skin irritation had initially developed. The RN stated she was unaware that staff had provided only a towel to the resident's colostomy and stated the irritation around the resident's colostomy would have increased with contact from intestinal waste. RN #1 acknowledged it was her responsibility to contact the resident's physician related to any concerns with wounds or current treatment orders and to assist with updating the resident's plan of care; however, RN #1 stated she had not contacted the resident's physician related to the ongoing irritation of the resident's colostomy. An interview with the Director of Nursing (DON) on 12/18/12 at 6:30 PM revealed she attended wound care meetings monthly and conducted chart reviews on a random basis to ensure resident care plan interventions had been implemented. The DON stated she had not been made aware of the ongoing irritation of the skin surrounding Resident #2's colostomy and acknowledged staff should have informed the resident's physician of the continued skin irritation surrounding the resident's colostomy.	F 282	The facility will monitor its performance to ensure services are provided in accordance with each resident's written plan of care by: A) The director of nursing, the assistant director of nursing, the QI nurse and the facility consultant will audit comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity is initially and periodically conducted. comprehensive assessments completed in the next 90 days will be reviewed, starting with the plan of correction completion date of 2/2/2013. Ongoing competency will be verified through this review process. Any identified issues will be addressed by the director of nursing with the appropriate staff member. The director of nursing, assistant director of nursing, treatment nurse, MDS nurse, QI nurse and staff	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, for one of three sampled residents (Resident #2). Observations conducted on 12/18/12, of Resident #2's colostomy (an abdominal opening surgically created to allow intestinal waste to leave the body) care revealed facility staff had placed a cloth towel directly over the resident's stoma site to collect the intestinal waste which was being secreted from the resident's body. Further observations revealed the resident's skin surrounding the stoma site was red, irritated, and had two small blisters present to the irritated skin. Interviews with facility staff on 12/18/12 revealed the resident's skin, surrounding the resident's colostomy, had been red and irritated, off and on, for approximately three years. However, the facility failed to ensure staff informed Resident #2's physician of the ongoing irritation of the skin surrounding the resident's colostomy as indicated in the plan of care in order for the physician to determine if the prescribed treatment needed to be altered, and failed to ensure the resident's plan of care was updated, as needed, related to the facility's assessment of the improvement/lack of improvement of the skin irritation. A review of the plan of care also revealed facility staff failed to inform the resident's physician of the resident's resistance to comply with the use of a colostomy bag to cover the stoma based on the facility's observations/assessment of the resident.</p>	F 309	<p>facilitator were in-serviced by the wound consultant on 1/9/2013.</p> <p>The in-service covered daily chart audits conducted for physician and responsible party notification for any change in residents' condition/status/new physician orders. Competency was determined by the wound consultant at the end of the training through question and answer period. Review will be completed by reviewing daily progress notes. The review will be documented on the Chart Review & Follow Up form. The director of nursing will determine ongoing competency through monitoring of the completed Chart Review and Follow Up forms.</p> <p>The results of the comprehensive assessment audits and the Chart Review and Follow Up forms will be discussed in the weekly QI committee meeting consisting of</p>	

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F 309	<p>Continued From page 31</p> <p>The findings include:</p> <p>An interview with the Minimum Data Set Assessment (MDS) and Care Plan Coordinator on 12/18/12 at 6:20 PM revealed they followed the guidelines provided on the MDS document for completion of the assessment.</p> <p>A review of the facility's policy titled Resident Care Plan, dated August 2012, revealed the development of a resident's care plan would be an ongoing process, and would include current problems and problems identified between the scheduled care plan reviews. The policy revealed modifications to a resident's care plan would be completed as the Care Plan Coordinator directed. In addition, a review of the facility's policy entitled Notification of Physician for Change in Resident's Condition, dated August 2012, revealed staff was to notify the resident's physician when a significant change in a resident's condition occurred. Continued review of policies revealed the facility's policy titled Colostomy and Ileostomy Care, dated February 2007. Based on the policy, the facility's objective was to maintain cleanliness and provide good skin care to the facility residents.</p> <p>An interview with the Director of Nursing (DON) at 6:30 PM on 12/18/12 revealed the facility did not have a specific policy related to resident behaviors. The DON stated staff was responsible to document any behaviors exhibited during their shift.</p> <p>A review of Resident #2's medical record on 12/18/12 revealed the facility admitted the resident on 03/03/09 with diagnoses that included</p>	F 309	<p>The administrator, DON, ADON, QI nurse staff facilitator, MDS nurse and any other Interdisciplinary Care Plan Team member as appropriate. The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective is completed and date completion is due. The Executive QI Committee will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facilities progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.</p>	02-02-2013

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F 309	<p>Continued From page 32</p> <p>a history of Intestinal Obstruction and Colostomy placement, a History of Gastroenteritis and Colitis, and Type II Diabetes. A review of the physician's orders revealed staff was to clean around the resident's colostomy with soap and water and apply Nystatin Cream (topical anti-infective) daily and as needed.</p> <p>A review of the Quarterly Minimum Data Set Assessment (MDS) dated 10/16/12, revealed facility staff had assessed the resident to have the ability to make his/herself understood, and to understand others, and was interviewable. Further review of the MDS revealed facility staff had assessed the resident to require the extensive assistance of two staff members for bed mobility, dressing, toilet use, and personal hygiene. The MDS provided no evidence that the resident had exhibited any behavioral symptoms or rejection of care during the assessment period.</p> <p>A review on 12/18/12 of the Comprehensive Care Plan for Resident #2 last updated on 10/25/12 revealed staff had identified the resident to have an alteration in bowel elimination with placement of a permanent colostomy. Facility staff also noted the resident "picks at bag and around and in stoma site." Interventions included dressing the resident in one-piece outfits to prevent the resident's access to the colostomy site and prevent the resident from picking at the colostomy stoma. In addition, staff was to ensure the colostomy bag was changed as needed. Facility staff was also to report any redness, inflammation, or drainage at the resident's colostomy site to the nurse.</p> <p>A review conducted on 12/18/12 of the weekly</p>	F 309	<p>F309</p> <p>Resident #2 was being treated for redness and excoriation to the colostomy stoma. On 12/18/2012 the physician was notified and a change in stoma treatment was ordered. On 12/21/2012 the physician was notified of resident #2's behavior of removing the colostomy bag.</p> <p>The physician changed the stoma treatment order and Resident #2 was seen by psychology services on 12/21/2012.</p> <p>On 12/18/2012 Resident #2 care plan was reviewed by the MDS nurse. The MDS nurse made changes to reflect the current treatment plan. For Resident #2, the MDS nurse will complete a significant change assessment with an ARD date of 1/10/2013. The comprehensive assessment will</p>		

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F 309	<p>Continued From page 33</p> <p>skin assessments conducted by facility staff of Resident #2 on 12/03/12, 12/10/12, and 12/17/12 revealed staff had performed the daily treatment to the resident's colostomy. Further review revealed no evidence staff had documented the appearance of the resident's skin surrounding the colostomy or assessed the area related to healing or worsening in appearance.</p> <p>Observations conducted of Resident #2's colostomy care on 12/18/12 at 8:30 AM revealed a towel, used for bathing, had been placed over the resident's colostomy to collect the intestinal wastes. Observations of the resident's skin surrounding the colostomy revealed the resident's skin was red, irritated, and had two small blisters present. Resident #2 was observed during colostomy care to have facial grimacing and verbalized, "That hurts, that burns," when Certified Nursing Assistant (CNA) #1 and CNA #2 provided the resident with stoma site care. After CNA #1 cleansed the resident's skin surrounding the colostomy, the CNA applied a colostomy bag over the resident's red, irritated skin and the resident was observed to have facial grimacing while the CNA applied the colostomy bag. Observations further revealed staff failed to ensure the Nystatin Cream was applied to the resident's irritated skin surrounding the colostomy as prescribed by the physician.</p> <p>An interview conducted on 12/18/12 at 9:00 AM with Resident #2 revealed, "My skin burns like fire, around my colostomy; they put medicine on it, but it's not helping." The resident continued to state he/she was unaware of how long the skin irritation had been present, and stated, "They leave the bag off of me at times, because it hurts</p>	F 309	<p>include CAAS and care plan, reflecting Resident #2's skin condition and exhibited behaviors</p> <p>The facility will identify other residents in the facility with a potential to be affected by:</p> <p>A) All Interdisciplinary Care Plan Team members were re-educated by the facility consultant beginning on 1/10/2013 and completed on 1/18/2013. The re-education included comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity. Competency was determined by the facility consultant through post testing.</p> <p>B) Additional in-servicing with SRNAs, KMAs, LPNs, and RNs was initiated on 1/10/2013 and completed on 1/18/2013 by the facility consultant related to documentation of resident</p>	

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F 309	<p>Continued From page 34 so bad when it's on me because of my skin."</p> <p>Interview on 12/18/12 at 8:40 AM, with CNA #1, assigned to provide care to Resident #2 on 12/18/12, revealed Resident #2's skin around the colostomy had been red and irritated for a "year." CNA #1 stated the resident's skin "looks a lot better now than what it did look like." The CNA stated staff frequently left the resident's colostomy bag off during the night because the resident's skin was red and irritated and the resident had a history of taking the colostomy bag off his/herself. The CNA continued to state the facility nursing staff had been made aware of the resident's skin condition.</p> <p>Interview with CNA #3 on 12/18/12 at 4:15 PM revealed Resident #2's colostomy bag had frequently been left off because it would not stick to the resident's "raw skin." The CNA stated the resident had one-piece outfits to wear to keep the resident from "picking" at the colostomy bag, when it was applied, but the resident refused to wear them. The CNA stated she had reported the status of the resident's skin to nursing staff and that the resident refused to wear one-piece outfits "numerous" times. The CNA also stated the nursing staff was aware that a towel was used to cover the resident's colostomy site.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 12/18/12 at 11:30 AM revealed she had been assigned to provide treatment to Resident #2's colostomy on 12/15/12 and 12/16/12. The LPN stated she had observed the skin surrounding resident's colostomy to be red and irritated on 12/15/12 and 12/16/12, and was aware staff had not provided the resident with a</p>	F 309	<p>behaviors, refusal of care, skin integrity impairment, stoma changes, changes in conditions, assessments, responsible party notification, physician notification and physician re-notification. Competency was determined through post testing.</p> <p>C) Registered Nurse #1 no longer is employed at the facility.</p> <p>D) The Interdisciplinary Care Plan Team will complete a review of all current in house residents' comprehensive assessments including care plans and CAAS. The review, to include all behaviors, was completed on 1/18/2013. Any assessments identified as incorrect will have a significant change assessment completed by the Interdisciplinary Care Plan Team members. Any corrections will be completed by 1/31/2013.</p>	

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F 309	<p>Continued From page 35</p> <p>colostomy bag to collect the resident's intestinal wastes. The LPN stated she had applied Nystatin Cream (topical anti-infective) and a colostomy bag to the resident's colostomy on 12/15/12 and 12/16/12. LPN #1 stated she was "new" at providing treatments, and didn't know if the treatment ordered for Resident #2 was "appropriate or not," and stated she had not contacted the resident's physician related to the appearance of Resident #2's colostomy as directed in the plan of care.</p> <p>An interview with LPN #2 on 12/18/12 at 2:45 PM revealed she had provided treatment to Resident #2's colostomy on 12/07/12 and observed the resident's colostomy stoma to be red and irritated. The LPN stated she had observed "just a towel" to be present to the resident's colostomy and was unsure why a colostomy bag had not been provided for the resident. The LPN stated she cleansed the resident's colostomy and applied Nystatin and a colostomy bag to the resident's irritated skin. The LPN also stated she had not contacted the resident's physician related to the resident's skin condition as directed in the plan of care because she had not been educated in treatments and had "just followed the current physician orders."</p> <p>An interview with LPN #3 on 12/18/12 at 3:30 PM revealed she had provided care to Resident #2 for three years and facility staff had "always had a problem with the resident's skin surrounding the resident's stoma." The LPN further stated the resident's skin which surrounded his/her colostomy stoma had been irritated and red off and on, approximately "three years." The LPN stated she had discussed the resident's skin</p>	F 309	<p>Systemic changes that have been put into place to ensure the practice did not recur:</p> <p>A) MDS nurse, QI nurse and staff facilitator were in-serviced by the wound consultant on 1/9/2013. The in-service covered daily chart audits conducted for physician and responsible party notification for any change in residents' condition/status/new physician orders. Competency was determined by the wound consultant at the end of the training through question and answer period. Review will be completed by reviewing daily progress notes.</p> <p>B) Daily chart audits will be documented on the Chart Review & Follow up form. The director of nursing will determine ongoing competency through monitoring of the completed Chart Review and Follow Up forms.</p>	

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F 309	<p>Continued From page 36</p> <p>irritation, redness, and other treatments that could be attempted for the resident with the Director of Nursing (DON) approximately one or two days prior to the interview; however, the LPN stated she wasn't aware of any further assessment or treatment that had been provided to Resident #2. The LPN acknowledged, based on documentation, staff failed to contact the resident's physician related to the status of the resident's skin around the stoma as directed in the plan of care and stated "someone probably should have."</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM revealed she was aware that Resident #2's skin had been irritated for approximately a year. Although the LPN stated the resident's skin treatment should have been changed because it had not been effective, the LPN acknowledged she had not contacted the resident's physician because it was the responsibility of the treatment nurse.</p> <p>An interview with the facility's full time treatment nurse, Registered Nurse (RN) #1 on 12/18/12 at 3:00 PM, revealed Resident #2's skin surrounding the colostomy had been red and inflamed and she was unsure of when the resident's skin irritation had initially developed, or when staff had contacted the resident's physician related to the condition of the resident's skin surrounding the colostomy. RN #1 stated she thought Nystatin had been an "appropriate treatment" in the past for the resident's skin condition and had not contacted the resident's physician related to the status of the resident's skin. The RN stated she was unaware that staff had provided only a towel to the resident's colostomy site, and confirmed</p>	F 309	<p>C) The director of nursing, the assistant director of nursing, the QI nurse and the facility consultant will audit comprehensive assessments to ensure a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity is initially and periodically conducted. Comprehensive assessments completed in the next 90 days will be reviewed, starting with the plan of correction completion date of 2/2/2013. Ongoing competency will be verified by this review process. Any identified issues will be addressed by the director of nursing with the appropriate staff member.</p> <p>D) The MDS coordinators will visually observe all wounds during the residents' MDS observation period.</p> <p>E) The Social worker will observe any resident behaviors during the residents' assessment period.</p>		

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F 309	<p>Continued From page 37</p> <p>the intestinal wastes in direct contact with the resident's skin would have increased the resident's skin irritation.</p> <p>Based on documentation, staff had applied Nystatin Cream to Resident #2's colostomy on a daily and "as needed" basis; however, observation on 12/19/12 revealed the resident's skin surrounding the colostomy was red, irritated, and had two small blisters present. A review conducted on 12/18/12 and 12/19/12 of documentation in the medical record revealed staff had not contacted/informed the resident's physician of the ongoing redness/irritation of the skin surrounding Resident #2's colostomy as directed in the resident's plan of care.</p> <p>Interview with the Director of Nursing (DON) revealed on 12/19/12 at 8:30 AM facility staff had received physician's orders in July 2012 for the application of Calmoseptine ointment (a moisture barrier) to the resident's colostomy and had applied the ointment to the resident's colostomy as directed. A review of physician's orders revealed Calmoseptine had been prescribed on 07/09/12, and staff had been directed to apply the Calmoseptine to the resident's groin and lower abdominal areas; however, it could not be determined by a review of documentation that staff had been directed by the physician to apply the Calmoseptine to the resident's colostomy stoma site. In addition, a review of the resident's comprehensive plan of care provided no evidence that staff had completed any modifications related to the resident's ongoing skin redness/irritation.</p> <p>An interview with the Director of Nursing (DON) on 12/18/12 at 6:30 PM revealed she attended</p>	F 309	<p>The facility will monitor its performance to ensure solutions are sustained to include:</p> <p>A) The RN director of nursing, RN assistant director of nursing, staff facilitator, and/or facility consultant will visually observe all wounds during a weekly skin observation.</p> <p>B) The RN weekly visual observation of wounds will be compared to the residents' MDS, CAAS and care plans. Oversight of the MDS, CAAS and care plans documentation performed by the MDS nurses will serve as validation of the MDS nurses' accurate inclusion of wounds and behaviors in the residents' MDS CAAS and care plans.</p> <p>C) Any concerns found by the MDS coordinators or the social worker related to wounds or behaviors will be addressed by the</p>	

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F 309	Continued From page 38 the monthly wound care meetings and conducted chart reviews of charts selected at random. The DON stated she had not been made aware of the ongoing skin irritation and redness to Resident #2's colostomy or that staff had failed to contact the resident's physician as directed in the plan of care. The DON stated she had not assessed the resident's skin prior to 12/18/12 and had relied on the facility's treatment nurse to intervene appropriately for the residents.	F 309	Interdisciplinary team member at the time of observation.	
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 and record review it was determined the facility failed to ensure that a resident having pressure sores received the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for one of three sampled residents (Resident #1). Interviews with facility staff and a review of Resident #1's medical record on 12/18/12 revealed the resident developed open and blackened areas to his/her coccyx while at the facility. However, interviews and record review revealed facility staff failed to	F 314	D) The results of the Administrative nurses' observations will be reviewed and discussed at the weekly, monthly and quarterly QI meetings. The results of the comprehensive assessment audits and the Chart Review and Follow Up forms will be discussed in the weekly QI along with committee meeting consisting of The administrator, DON, ADON, QI nurse staff facilitator, MDS nurse and any other Interdisciplinary Care Plan Team member as appropriate. The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective is completed and date completion is due. The Executive QI Committee will review monthly	

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F 314	<p>Continued From page 39</p> <p>ensure treatment was provided for Resident #1's newly developed pressure areas.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled Pressure Sore Prevention, dated November 2012, revealed the skin condition of each resident was to be inspected by licensed personnel and Certified Nurse Aides (CNAs) during daily care. The policy further stated inspections of the skin condition of each resident were also to be completed by treatment nurses during treatments, and that appropriate personnel were to be notified of any abnormalities.</p> <p>A review conducted on 12/18/12 of the medical record for Resident #1 revealed the facility readmitted the resident on 11/07/12, from an acute hospital stay with diagnoses including Chronic Airway Obstruction, Convulsions, and Pneumonia. A review of a 14-day Minimum Data Set (MDS) assessment dated 11/21/12 revealed facility staff assessed the resident to be at risk for the development of pressure sores, and had Moisture Associated Skin Damage (MASD). Record review also revealed Resident #1 was totally dependent, incontinent of bowel and bladder functions, required two staff members for assistance with toileting and bathing, and the extensive assistance of two staff members for bed mobility and personal hygiene.</p> <p>A review on 12/18/12 of an admission skin assessment conducted on 11/07/12 for Resident #1 revealed RN #1 identified the resident had excoriation and redness to the sacrum and bilateral buttocks. Further review of RN #1's</p>	F 314	<p>compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facilities progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.</p> <p>F314</p> <p>Resident #1 was discharged from the facility on 12/10/2012. Prior to discharge, Resident #1 was being treated for a denuded area and excoriation to the sacrum. Resident #1 was assessed and physician contacted prior to discharge.</p>	02-02-2013

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F 314	<p>Continued From page 40</p> <p>documentation revealed Resident #1 had a small denuded area, with the appearance of redness/excoriation (MASD), to the sacral area. At the time of Resident #1's readmission, there was no documentation that the resident had any open areas to the buttocks or sacral area.</p> <p>A review of Resident #1's physician's orders dated 11/07/12 (the day of the resident's readmission) revealed the physician had prescribed Calmoseptine (a moisture barrier ointment) to be applied to the excoriation on the resident's buttocks, bilaterally, daily and as needed. Continued review of the physician's orders revealed facility staff was to cleanse the denuded areas to the resident's sacrum with normal saline (a sodium based water solution) and apply a wound gel and dressing to the area on a daily and as needed basis. Further review of Resident #1's physician's orders revealed Resident #1 was transferred to the Emergency Department of a hospital on 12/10/12 related to becoming nonresponsive.</p> <p>A review on 12/18/12, of Resident #1's hospital record revealed the resident was admitted to the hospital on 12/10/12 (the day the resident was transferred from the facility), and on 12/11/12 (the day after the resident was admitted to the hospital) hospital staff assessed Resident #1 to have a Stage 4 pressure ulcer to the sacrum. Documentation further revealed hospital staff assessed 50 percent of the resident's wound to be necrotic (black) in color.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/18/12 at 11:20 PM revealed she had provided treatment to Resident #1's sacral and</p>	F 314	<p>No further action was taken related to the resident's wound. Resident #1 did not return to the facility.</p> <p>Facility will identify other resident in the facility with the potential to be affected:</p> <p>A) A new treatment nurse has been hired and trained by the wound and facility consultants on wound staging and appropriate treatments per facility wound program. The director of nursing, assistant director of nursing or QI nurse will visually review all skin issues weekly.</p> <p>B) MDS nurse, QI nurse and staff facilitator were in-serviced by the wound consultant on 1/9/2013. The in-service covered daily chart audits conducted for physician and responsible party notification for any change in residents' condition/status/new physician orders. Competency was determined by the wound consultant at the end of the</p>		

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F 314	<p>Continued From page 41</p> <p>bilateral buttocks on 12/08/12 and 12/09/12 while the resident was at the facility. Continued interview with the LPN revealed the resident had two open and blackened areas to the sacrum. The LPN stated she had not provided care to Resident #1 prior to 12/08/12 and the resident's wound care was "new" to her. According to LPN #1, she was not aware if a change had occurred in the appearance of the resident's skin integrity and, as a result, had not contacted the resident's physician to obtain further treatment orders.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 12/18/12 at 4:15 PM revealed she had provided care to Resident #1 on 12/07/12 and noted the resident's sacral area was "purple" in color and an open area was present to the sacral area. The CNA stated she notified the treatment nurse, LPN #2, and the resident's nurse, LPN #4, at that time of the change observed in the resident's skin condition. The CNA continued to state she provided personal care for the resident again on 12/09/12, noted the resident's sacral area was black in color, and notified the treatment nurse (LPN #1).</p> <p>Interview with LPN #4 on 12/18/12 at 4:30 PM confirmed she had been notified of a change in the resident's skin status and had observed on 12/07/12 that Resident #1 had developed an open area to the sacrum; however, according to LPN #4, she did not contact the resident's physician to obtain further treatment orders for the resident. The LPN stated she discussed the change in the resident's skin condition with the treatment nurse (LPN #2), and stated the treatment nurse was responsible to contact the resident's physician to obtain a change in</p>	F 314	<p>training through question and answer period. Review will be completed by reviewing daily progress notes.</p> <p>C) A 100% review of current treatment plans for wounded residents was completed on 12/18/2012. For all resident discrepancies in wounds and wound care, physicians were notified and responsible parties were made aware of changes on 12/18/2012 and 12/19/2012 by the director of nursing, assistant director of nursing & QI nurse. Ulcer and non-ulcer flow sheets have been completed on all identified skin concerns. Care plans and care guides have been updated for all wounded residents.</p> <p>Systemic changes have been put into place to ensure the practice did not recur:</p> <p>A) The Registered Nurse #1 no longer is employed at the Facility.</p>	

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F 314	<p>Continued From page 42</p> <p>treatment orders when a change in skin condition occurred.</p> <p>Interview with LPN #2 on 12/18/12 at 2:45 PM revealed she had provided wound care to Resident #1 on 12/07/12. The LPN stated the resident's sacral area appeared to be a deep dark red color and open areas were observed to the resident's sacral area. However, according to LPN #2, she was unable to recall how many open areas were observed at that time. The LPN stated she had not been educated in treatments, and just followed the current orders. The LPN also stated she does "not do treatments enough to know if a change had occurred or not," and acknowledged she had not contacted the resident's physician related to the status of the resident's skin condition. The LPN stated if she had been aware the Resident #1 had experienced a change in the condition of skin, she would have contacted the resident's physician.</p> <p>An interview with Registered Nurse (RN) #1 on 12/18/12 at 3:00 PM revealed she had provided wound care to Resident #1 on 12/10/12 (the same day the resident was transferred to the hospital). The RN stated she observed that the excoriation to the resident's buttock/sacrum had appeared more "pronounced." However, RN #1 stated she had not identified any open areas or other appearance changes to the resident's sacral/buttock area that would have required a change in the current treatment for the resident.</p> <p>Interview with the Director of Nursing (DON) on 12/18/12 at 6:30 PM revealed staff should have contacted Resident #1's physician to obtain</p>	F 314	<p>B) In-servicing with SRNAs, KMAs, LPNs, and RNs was initiated on 12/20/2012 by the director of nursing and completed on 1/18/2013. This re-education included turning and positioning and notifying the nurse if a resident is refusing their treatment plan.</p> <p>C) All new licensed staff will be trained in orientation on the facility wound program by the staff facilitator.</p> <p>D) All current licensed staff have been re-educated on the wound program by the staff facilitator. Licensed staff will be responsible for completing weekly skin assessments.</p> <p>E) A wound/skin meeting will be held weekly. Attendees include the director of nursing or assistant director of nursing, QI nurse, treatment nurse, MDS nurse along with the dietary manger. The registered dietician is available by telephone.</p> <p>The facility planned to monitor its performance to ensure each resident received the necessary care and services:</p>	

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F 314	Continued From page 43 treatment orders for the newly developed open areas and change in the appearance of Resident #1's sacral area when the change occurred.	F 314	<p>A)The results of the skin wound meeting will be discussed in the weekly, monthly and quarterly QI committee meeting consisting of The administrator, DON, ADON, QI nurse staff facilitator, MDS nurse and any other Interdisciplinary care Plan Team member as appropriate.</p> <p>B) The QI committee will assess for trends and identify corrective actions required, including the position responsible for assuring the corrective is completed and date completion is due. The Executive QI Committee will review monthly compiled QI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QI Committee will validate the facilities progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator or DON will report back to the Executive QI Committee at the next scheduled meeting.</p>	02-02-2013