

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WYOMING ROAD OWINGSVILLE, KY 40360
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 314: Continued From page 78

take care of the resident so she did not know if the wound was worse because she had no comparison. Continued interview revealed she forgot to chart on the resident and talked to LPN #7 later that evening and asked LPN #7 to chart for her related to notification to the Physician and the orders received. Further interview revealed during her conversation with LPN #7, she was told the resident's wound was having a lot of drainage and she told LPN #7 there was no drainage from the wound during her shift.

There was no subsequent Nurse's Note related to an assessment of the resident after the 06/06/15 at 2410 (12:10 AM) notation until 06/07/15 at 2200 (10:00 PM), over forty-six (46) hours, even though the resident was running a temperature during this time period. On 06/07/15 at 2200 (10:00 PM), LPN #7 documented the Physician was notified by LPN #8 about the increased temperature and increased redness around the sacral wound and a new order was received to culture the wound and then start the Levaquin 750 mg every day for seven (7) days until the culture report returned. Per the Note, the sacral wound was cleaned and a culture was obtained and antibiotics were started as ordered. Further review revealed the resident had a 1 cm open area approximately 2 cm from the rectum on the left lower buttock with a copious amount of drainage noted, temperature 99.4, pulse 113, respirations 20, and blood pressure 118/74.

Interview with LPN #7 on 06/07/15 at 10:00 AM, revealed on 06/07/15 it was reported to her by LPN #8 that she had called the physician related to the wound change and temperature. She stated on her shift on 06/07/15 the resident was having a copious amount of drainage which was

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F 314 Continued From page 104
cm x 7 cm x 2 cm with yellow slough with no stage mentioned, a Stage II to the left upper thigh measured as 2.0 cm only (no length/width measurement) with yellow slough and the left great toe nail was missing.

Review of Resident #5's August 2015 monthly Physician Orders revealed there was no wound treatment ordered to the right upper thigh. Post survey phone interview, on 08/28/15 at 4:00 PM, with the DON revealed the August Monthly Physician Orders were supposed to include the wound treatment ordered to the right upper thigh. She reported Pharmacy had already generated the August Monthly Orders when Resident #5 was re-admitted on 07/27/15, and the order was supposed to be handwritten onto the August orders because the treatment continued.

Observation of a skin assessment, on 08/11/15 at 5:50 PM, revealed the resident was on contact isolation precautions, had bilateral gel boots, a boggy left heel, and wound dressing treatments to the lower left buttock and Coccyx/Sacral area. The dressings were clean/dry/intact and were not due to be changed in order to observe the wounds. In addition the resident had an old blood blister site to the top of left great toe with toe nail removed.

Review of the WCS dated 08/14/15 revealed the coccyx wound was noted to be a Stage IV Pressure Ulcer measuring 8.0 cm by 11.2 cm length by 1.7 cm depth with undermining at 9 o'clock, the wound bed had 25% slough and a small area of bone noted, and had purulent drainage blue-green in color with no odor.

Further review of the WCS, dated 08/14/15,

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F 314	Continued From page 105 revealed the resident had a unstageable wound to the lower right buttock measuring 0.8 cm x 1.1 cm x 0.2 cm with 100 % slough in wound bed and perineal wound description. Continued interview, on 08/20/15 at 3:05 PM and 5:50 PM, with LPN #4 revealed she was usually assigned to Resident #5. She explained there was an assignment change in who performed resident skin assessments/wound treatments, previously one person to routinely perform these tasks; however, sometime around the end of April or beginning of May the floor nursing staff assumed the responsibility and the forms to be completed were not mentioned when the change was discussed. The LPN revealed they had another meeting, on 05/22/15, and they went into more depth about skin assessments and wound forms to be completed: 1. Weekly head to toe skin assessment and any area of abnormal skin was documented, but only had to document the type and location of the wound on this form. 2. The Wound Care Summary form was completed if the resident had wound(s) each wound was supposed to be described in detail on the form and weekly progress notes were completed until healed so you knew the progress of the wound. 3. The weekly Skin Report was also completed weekly which allowed QA to monitor the wounds progress. Continued interview revealed the weekly skin assessment was completed the same day the wound(s) were assessed and the wound was also described in the nursing notes. LPN #4 further revealed the facility's wound process was not followed because Resident #5's wounds were not monitored closely. 4. Review of Resident #7's medical record revealed the resident was admitted by the facility	F 314			

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F 314	<p>Continued From page 106</p> <p>on 07/13/15 with diagnoses which included Schizophrenia (mental disorder), Acute Respiratory Failure, Muscle Weakness, Wound Infection, Surgical Wound, Ischemic Bowel Syndrome (medical condition in which inflammation and injury of the large intestine result from inadequate blood supply to the intestines), and Status Post Cecostomy (a surgically formed connection between the large intestine and the outside that is made through an opening in the front abdominal wall).</p> <p>Review of the admitting Nurse's Notes, dated 07/13/15 at 1910 revealed the resident had Methicillin Resistant Staphylococcus (MRSA- a multi-drug resistant organism) cultured from the Cecostomy surgical wound.</p> <p>Review of Physician Admission Orders, dated 07/13/15, revealed Resident #7 had an order for Isolation Precautions (Contact Precautions - used to reduce the spread of organisms from direct or indirect contact with the resident or resident items).</p> <p>Review of the facility's Admission MDS Assessment, dated 07/20/15, revealed the resident was admitted with no pressure sores, but was at risk. Review of the Braden Scale (used to predict pressure risk) revealed the resident was assessed as being at mild risk.</p> <p>Review of Resident#7's Comprehensive Care Plan revealed a Skin Integrity, Impaired related to immobility, obesity care plan with interventions which included: Dietician consult as indicated; monitor for skin intolerance to two (2) hour turning schedule; nursing staff to monitor for indication of skin impairment during daily ADL</p>	F 314		
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F 314	Continued From page 107 care; report any red or open area; use turn sheet to decrease friction shearing when repositioning; weekly skin assessments by licensed staff for skin breakdown. Review of weekly skin assessments completed on 07/13/15, 07/25/15, 08/01/15 revealed no pressure ulcers. Review of Resident #7's WCS documentation revealed the resident developed facility acquired pressure ulcers: two (2) Stage II to the left buttock and one (1) Stage II to the right buttocks identified on 08/04/15. However, there was no measurement or descriptions or assessment of the wound bed/peri-wound per the facility's Wound Protocol. Review of the 08/04/15 Nurse's Note revealed no documentation about the newly identified pressure wounds. Record review of an Acute Care Plan: Pressure Ulcer related to immobility, dated 08/04/15, revealed the interventions included Braden Scale Assessments, keep the skin clean warm and dry, promote nutritional status and monitor intake, assess for signs and symptoms of worsening, of infection or complications daily, treatments as ordered, assess skin daily, Registered Dietician to evaluate and assess per policy, staff to assist with mobility needs, and pressure relief device to bed and /or chair. The care plan was updated, no dates, to include: Proximal left mid-buttock-Stage II measured 0.5 cm x 0.8 cm x 0.0 cm and assessment - beefy red granulation with no odor/drainage, Distal mid back stage II measured 0.4 cm x 0.5 cm with no depth/odor, and Left mid-abdomen healing surgical incision 0.4 cm x	F 314:		
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F 314	<p>Continued From page 108</p> <p>1.5 cm x 0.1 cm.</p> <p>Further review of Physician orders revealed a verbal order, dated 08/04/15 at 0500 (5:00 AM), for a Aquacel AG Foam dressing to the left and right buttocks, change every three (3) days related to pressure.</p> <p>Review of the August TAR revealed a scheduled wound treatment was performed on 08/07/15, but no scheduled dressing change was performed to the site on 08/10/15 per the ordered three (3) day scheduled changes.</p> <p>Observation of skin assessment performed by LPNs # 1 and #2, on 08/11/15 at 6:25 PM, revealed two open wounds on Resident #7's left buttock, measured by LPN #1 as being 1.0 cm in length x 0.4 cm in width (distal wound) and 0.4 cm length x 0.6 cm width (proximal wound) with no wound dressing in place or observed near the resident. Further observation revealed no open wound on the resident's right buttock.</p> <p>Interview, on 08/11/15 with LPN #1 at 7:00 PM and LPN #2 at 7:10 PM, revealed wounds on the left buttock had no dressing treatment in place and were open to air. LPN #1 revealed the right buttock also had no treatment in place, but the wound was closed. The LPNs reported the open wounds on the left buttock had a potential risk of worsening or becoming infected with MRSA because there was no dressing.</p> <p>Interview, on 08/20/15 at 3:05 PM, with LPN #3 revealed she routinely cared for Resident #7, who had MRSA, and the open wounds to the left buttock were supposed to be covered with a dressing treatment. Continued interview revealed</p>	F 314		

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F 314	<p>Continued From page 109</p> <p>the wound treatment was supposed to have been changed on 08/10/15, as ordered, but there was no documentation the treatment was completed.</p> <p>Interview, on 08/24/15 at 4:09 PM, with the DON revealed she had no explanation why Resident #7's left buttock wound treatment was not in place, per observation on 08/11/15, as ordered by the Physician. The DON revealed the treatment order was not followed because it was last done on 08/07/15 and the ordered treatment of every three (3) was not performed on 08/10/15. She revealed any time there was an open wound, there was a risk of infection.</p> <p>Interview, on 08/25/15 at 9:55 AM, with the Administrator revealed the wound treatment orders were not followed because the wound treatment was not performed on 08/10/15 as scheduled and the wounds were uncovered.</p> <p>5. Review of Resident #6's medical record revealed the resident was admitted by the facility on 07/09/15 with diagnoses which included Deep Vein Thrombosis (formation of a blood clot in a deep vein), Hypertension, Chronic Heart Failure, Chronic Renal Insufficiency, Hypothyroidism (body lacks sufficient thyroid hormone), Anxiety State, Joint Pain, Muscle Weakness, and Arthritis.</p> <p>Review of the facility's Admission Nurse Note, dated 07/09/15 at 1545 (3:45 PM) revealed Resident #6 was admitted with a Stage II Pressure Ulcer on the Left Buttock which was measured to be 0.5 centimeters (cm) in length by 0.4 cm in width, but no depth measurement.</p> <p>Review of the Admission MDS Assessment,</p>	F 314		
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F 314	Continued From page 110 dated 07/20/15, revealed Resident #6 mental status was assessed as severely impaired. Review of the MDS section Skin Conditions revealed the resident was at risk of developing pressure ulcers and had a Stage II Pressure Ulcer, with granulation tissue. Review of the Braden Scale Predicting Pressure Sore Risk revealed the facility initially assessed the resident as moderate risk, on 07/09/15 and review of additional Braden Scale assessments on 07/16/15, 07/20/15, and 07/29/15 revealed the resident was high risk. Review of Resident #6's Comprehensive Care Plan revealed the resident had a Skin Integrity Impaired: Potential related to decreased mobility, undated, which included the following interventions: Follow facility policies/protocols for the prevention/treatment of skin breakdown; heel protectors to bilateral heels while in bed; nursing staff to observe for indication of skin impairment during daily ADL care; provide assistance with turning/repositioning as needed; report any red or open area; treatments as ordered; weekly skin assessments by Licensed Staff. Further review of the Comprehensive Care Plan revealed another care plan: Skin Integrity Problem, undated, under Goal noted Actual Pressure Ulcer with interventions: administer Medications as ordered; administer treatments as ordered and monitor for effectiveness; assess wound healing by a licensed nurse and measure length, width, and depth where possible; assess and document status of wound perimeter, wound bed, and healing progress; bed mobility with use of assistive device; educate the resident to causes of skin breakdown; follow facility	F 314			

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F 314	<p>Continued From page 111</p> <p>policies/protocols for prevention/treatment of skin breakdown; monitor nutritional status/intake and record; observe daily for changes in skin status; obtain and monitor lab/diagnostic work as ordered; and treatments as ordered-see TAR.</p> <p>Additional review of Resident #6's care plans revealed an Acute Care Plan: Pressure Ulcer to Right Buttock related to immobility, dated 07/31/15. The care plan interventions included: Braden Scale Assessment to assess risks per policy; keep skin clean warm and dry; promote nutritional status and monitor meal intakes; assess for sings and symptoms of worsening, of infection or complications daily; treatments as ordered to the wound care area; assess skin daily during care and report any changes; Registered Dietician to evaluate and assess per policy; staff to assist with mobility needs of transfers and bed; and pressure relief device to bed/chair.</p> <p>Review of Physician's orders revealed an order, dated 07/09/15, to apply DuoDerm to the Stage II Pressure Ulcer on the Left Buttock and change every three (3) days.</p> <p>Review of Resident #6's WCS document revealed the facility documented the Stage II Pressure Ulcer, 07/09/15 admission, with measurements (0.5 cm x 0.4 cm) but no assessment of the wound bed or peri-wound area per the facility's Wound Protocol. Further review of the WCS revealed no documentation of the wound's progress after 07/09/15 on the weekly progress notes.</p> <p>Interview, on 08/21/15 at 3:05 PM, with LPN # 4 revealed the Stage II Pressure Ulcer to the left buttocks was on the WCS, discovered at</p>	F 314		
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F 314	Continued From page 112 admission on 07/09/15 with measurements, but they needed to document more wound description/detail as they were told to do and there was no documentation of the wound on the WCS progress notes to track and trend the wound's progress to see if it was getting better. Review of Nurse's Notes revealed a Note on 07/12/15 at 0520 (5:20 AM) documented the dressing change was done to the left buttock as ordered and there was no open areas, no bleeding, and no drainage. Continued interview, on 08/21/15 at 3:05 PM, with LPN #4 revealed the 07/12/15 nurse note showed no open area, but the order was not discontinued and they kept doing the wound treatment so can't tell if the wound was healed. Review of weekly Skin Assessments completed on 07/10/15, 07/17/15, 07/24/15, 07/31/15, and 08/07/15 revealed no measurements or assessment of the left buttock Stage II Pressure Ulcer. Review of the facility's QA wound monitoring tool, the weekly Skin Report, revealed Resident #6's Stage II Pressure Ulcer to the left buttock, identified on 07/09/15, was not listed on the report until 07/29/15. In addition, the wound description included a measurement of 0.2 cm- the length/width were not identified. Interview, on 08/21/15 at 3:05 PM, with LPN #4 revealed Resident #6 was not mentioned on the QA wound monitoring tool, weekly Skin Report until 07/29/15 and the wound was not properly measured.	F 314		

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F 314	<p>Continued From page 113</p> <p>Further review of the weekly Skin Assessments revealed the 07/31/15 and 08/07/15 assessments documented Resident #6 had an SDTI to the right buttock area. Record review revealed no WCS form was generated related to the SDTI.</p> <p>Continued interview with LPN #4 revealed the 07/31/15 and 08/07/15 skin assessments documented Resident #6 had an SDTI to his/her right buttock, but there was no measurement of the site and there was no WCS initiated and the SDTI was not documented on the weekly Skin Report.</p> <p>Interview, on 08/12/15 at 6:30 PM, with the former interim Administrator/Nurse Consultant revealed she was not aware Resident #6's wound was not assessed on the QA weekly Skin Report, per the QA process until 07/29/15, and she was unable to explain why it was not on QA's wound monitor earlier.</p> <p>6. Review of Resident #11's medical record revealed the facility admitted the resident on 01/07/05 with diagnoses which included Dementia, Psychotic Disorder, Arthritis, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>Review of the Quarterly (MDS), dated 07/27/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring limited assist of one (1) for bed mobility and ambulation, extensive assist of one (1) for transfers and toilet use, and as continent of bowel and bladder. Continued review revealed the facility assessed the resident as having one (1)</p>	F 314		

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F 314	Continued From page 114 Stage II pressure ulcer and one (1) unstageable pressure ulcer. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 07/27/15 revealed Resident #1 was considered to be mild risk for pressure sores, scoring a fifteen (15) with fifteen (15) to eighteen (18) indicating mild risk per the scale. Further review revealed the risk factors included; slightly limited sensory perception, occasionally moist, walks occasionally, slightly limited mobility, probably inadequate nutrition, and friction and shear. Review of the Comprehensive Care Plan, undated, revealed Resident #11 had the a potential skin integrity problem related to immobility, chronic right knee/elbow excoriation, self inflicted scratches and a history of rashes. The goal stated the resident would have intact skin free of redness, blisters or discoloration. The interventions included assist to turn and reposition at least every two (2) hours, follow facility policies/protocols for the prevention and treatment of skin breakdown, inform the resident and family of new areas of skin breakdown, monitor nutritional status, and treatments per TAR. Review of the weekly Skin Assessments for Resident #11, revealed none were completed in April 2015, and none were completed for May 2015 until 05/25/15. On 05/25/15 a weekly Skin Assessment was completed that revealed the resident had redness to the buttocks, with no measurement and no indication if the area was blanching. Further review of the medical record revealed	F 314		
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F 314	Continued From page 115 there was a weekly Skin Assessment, dated 06/04/15, which revealed the resident had pink and white areas to the right inner ear, blanchable redness to the coccyx, and redness to the breasts, naval, abdominal skin folds and groin. Weekly Skin Assessments were completed on 06/05/15, 06/15/15, and 06/22/15. However, further review revealed there was no weekly Skin Assessment from 06/22/15 until 07/09/15 (over two (2) weeks). The weekly Skin Assessment, dated 07/09/15, revealed there were no pressure ulcers. Further medical record review revealed there was no weekly Skin Assessment completed after 07/09/15 until (over three (3) weeks), when a weekly Skin Assessment was completed on 08/03/15. Review of the Nurse's Noted dated 07/26/15 at 4:25 AM, completed by LPN #14, revealed Resident #11 had a Stage II to the left upper inner buttocks measuring 0.8 cm x 0.6 cm and a SDTI to the coccyx measuring 0.5 cm x 0.5 cm. Review of the Physician's Orders dated 07/26/15 revealed orders for Aquacef foam to the Stage II to the left upper inner buttocks and SDTI to the coccyx, change every three (3) days and prn. Review of the Acute Care Plan dated 07/26/15 revealed Resident #11 had a left inner buttock and coccyx pressure ulcer related to immobility. The goal stated the resident's pressure ulcer would decrease in size. The interventions included promote nutritional status, assess for signs and symptoms of worsening or infection daily, treatments as ordered, assess skin daily during care, RD to evaluate and assess, and staff to assist with mobility needs of transfer and bed mobility, and pressure relief device to bed and	F 314		

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F 314 Continued From page 116

chair. However, the care plan did not identify the stages of the wounds in order to evaluate the progression or evaluate for healing of the wound.

Also, there was no documented evidence a Wound Care Summary was completed for the wounds identified on 07/26/15 in order to monitor the progress of the wound as per facility's protocol. In addition, the weekly Skin Assessment completed, on 08/03/15 after the wound was found on 07/26/15, did not address these pressure ulcers.

Interview with LPN #14 on 08/20/15 at 12:00 PM, revealed she started as a nurse at the facility in July 2015. She stated when she found the wounds for Resident #11 on 07/26/15 she was unaware of the process related to documenting wounds and did not know which forms to use. Further interview revealed when she received orientation at the facility as a new nurse she did not receive education related to skin assessments; however, was shown by a nurse on the floor how to measure and stage a wound. She stated she was not comfortable at that point with measuring and staging wounds. Continued interview revealed, a week ago there was a meeting and the nurses were told which forms to fill out if a resident had a new wound, or if doing a weekly skin assessment for a resident with a wound. She stated they were told to use the Wound Care Summary, the weekly Skin Assessment and the weekly Skin Report. She further stated in the meeting last week they were also educated on how to measure, stage, and describe a wound and now she was comfortable doing this.

F 314

7. Review of Resident #2's clinical record

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F 314	<p>Continued From page 117</p> <p>revealed the facility admitted the resident on 04/09/14 with diagnoses of Peripheral Neuropathy, Hypertension, Chronic Back Pain, Insulin Dependent Diabetes Mellitus, Paraplegia, Osteoporosis and Rheumatoid Arthritis.</p> <p>Review of Resident #2's Braden Scale for Predicting Pressure Sore Risk, dated 04/06/15, revealed the resident was evaluated to be at moderate risk for pressure sores. The resident's risk factors included; slightly limited sensory perception, occasionally moist, bedfast, very limited mobility, and potential for friction and shear.</p> <p>Review of Resident #2's Physician Orders revealed an order dated 04/08/15 for Bilateral Heel Protectors while in bed.</p> <p>Review of the Resident #2's Quarterly MDS Assessment dated 07/06/15 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out fifteen (15), indicating Resident #2 was cognitively intact. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for bed mobility, dressing, toilet use and personal hygiene. Continued review of the MDS revealed the facility assessed the resident as being at risk for developing pressure ulcers with a history of pressure ulcers noted during the last MDS assessment.</p> <p>Review of Resident #2's Comprehensive Care Plan, initiated 04/21/14, revealed the resident had a problem of skin integrity, impaired: potential related to impaired mobility, Diabetes, Arthritis, chronic pain, incontinence, declined to turn and</p>	F 314		
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F 314	<p>Continued From page 118</p> <p>reposition in bed or wheelchair. The goal stated the resident would have intact skin. The interventions included weekly skin assessments by licensed staff and monitor for any indication of skin breakdown, RD consult, gel cushion to wheelchair, reposition in wheelchair and chair frequently, treatments per orders-see TAR, turn and reposition every two (2) hours, and bilateral heel protectors to feet when in bed.</p> <p>Review of the weekly Skin Assessment dated 08/02/14, revealed the resident had blanchable redness to the coccyx and perianea.</p> <p>Observation of Resident #2 during a skin assessment on 08/06/15 at 11:10 AM, revealed the resident had a Stage II wound to the left buttock measuring 4 cm x 3 cm, and three (3) Stage II ulcers to the coccyx area measuring 0.3 cm x 10.4 cm, 0.4 cm x 0.3 cm and 0.4 cm x 0.5 cm.</p> <p>Further review of Resident #2's record revealed Nurse's Notes dated 08/04/15, which stated there was three (3) stage II's ulcers noted to the resident's coccyx.</p> <p>Review of the Physician's Orders dated 08/04/15 revealed orders for Aquacel foam to the three (3) stage II areas on the coccyx, change every three (3) days and pm.</p> <p>Review of the Nurse's Notes dated 08/06/15, revealed a new area was noted to the left upper buttock.</p> <p>Review of the Physician's Orders dated 08/06/15 revealed orders for Aquacel foam to the left upper buttocks, change every three (3) days and PRN.</p>	F 314		
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F 314

Continued From page 119

Review of Resident #2's weekly Skin Assessments revealed there was an entry on 08/06/15 which described the Stage II ulcer to the left upper as 0.5 cm x 1 cm with 100% granulation with 1 x 1 cm purple discoloration surrounding the area, dry peeling skin to the surrounding tissue and slight serosanguinous drainage. However, there was no entry related to the three (3) Stage II's areas which were noted to the coccyx on 08/04/15.

Review of Resident #2's Wound Care Summary (WCS) initiated on 08/06/15 for the Stage II ulcer to the left upper buttock, revealed the area measured 0.5 cm x 1 cm with 100% granulation with 1 x 1 cm purple discoloration surrounding the area, dry peeling skin to the surrounding tissue and slight serosanguinous drainage. However, there was no documented evidence a WCS was initiated for the three (3) Stage II wounds to the coccyx identified on 08/04/15.

Interview on 08/10/2015 at 6:45 PM with the DON in regards to Resident #2, revealed it would be hard to determine if wounds were getting better or worse if the Wound Care Summaries were not completed.

Review of the Acute Care Plan dated 08/05/15, revealed the resident had a Stage II Pressure Ulcer to the coccyx; however, did not specify there was three (3) stage II areas to the coccyx and did not specify the resident had a stage II ulcer to the left upper buttock.

Interview with LPN #2, MDS Nurse, on 08/12/15 at 9:15 AM, revealed MDS Nurses checked Physician's Orders daily and updated the Care

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F 314	Continued From page 120 Plans accordingly. She further stated the wounds changed daily so wound sites and stages did not have to be on the care plan. Further interview revealed nurses could look at the skin assessment book to see all wound progress. Observation of Resident #2 during a skin assessment on 08/06/15 at 11:10 AM, also revealed the bilateral heel protectors were not in place and Resident #2 had a soft boggy left heel. Interview on 08/06/15 at 1:50 PM with CNA #9, revealed she was assigned to Resident #2 and she carried a pocket flow sheet as a reference for care for the resident. She stated she did not see the intervention for the heel protectors on the flowsheet; however, she was aware the resident was to wear the heel protectors. She stated she was assigned to the resident all week and the resident had not been wearing the heel protectors because the resident refused. Continued interview revealed the CNAs were to tell the nurses if a resident refused an intervention; however, she did not remember telling the nurses about the resident refusing heel protectors. Review of the current Nurse Aide Care Plan revealed the resident was to have heel protectors in bed. Interview on 08/06/15 at 2:10 PM with LPN #12, revealed she was assigned to Resident #2 and she did rounds during medication pass and while doing treatments to ensure safety devices and skin devices were in place and she used the TAR as a reference. She stated she was aware the resident was to wear heel protectors and the CNAs would sometimes tell her he/she refused to wear them; however, she was not told the resident refused them today.	F 314			

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F 314 Continued From page 121

F 314

Review of the TAR for Resident #2 revealed during the month of July 2015, the intervention for bilateral heel protectors while in bed was circled nine (9) times without any notes on the back of the TAR as an explanation as to why the resident was not wearing the heel protectors.

Interview on 08/10/15 at 5:30 PM, on 08/11/15 at 2:50 PM, and on 08/12/15 at 9:15 AM with the DON revealed if a resident refused care on a regular basis the nurses should write a Nurses Note, notify the physician, circle their initials on the MAR or TAR, turn the sheet over and write a note. The DON further revealed the facility had no policy on refusal of care from residents. She further stated expectation was to do what general nursing practice expects. Further interview with the DON revealed if a resident was well known to refuse, then staff should contact the doctor and get new interventions in place. She stated the goal of the intervention of the heel protectors for he/she was prevention, and if there were problems with that intervention than an alternate intervention needed to be put in place.

Observation on 08/10/15 at 7:00 PM revealed Resident #2 was in bed with bilateral heel protectors in place. The resident stated he/she wore the heel boots night and day. Interview with Resident #2 on 08/11/15 at 12:00 PM, revealed, "I always have them (heel protectors) on, sometimes they fall off, but I don't take them off".

8. Review of Resident #4's clinical record revealed the facility admitted the Resident on 04/20/10 with diagnoses of Cardiovascular Accident (CVA) with left Hemiparesis, Hypertension, Aphasia, Dementia with Behaviors,

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F 314 Continued From page 122
Diabetes Mellitus II and Difficulty in Walking.

Review of Resident #4's Comprehensive Care Plan, initiated 06/04/12, revealed the resident had a skin integrity problem due to a history of recurrent skin tears on the buttocks that develop into ulcers and immobility. The goal stated the resident would have intact skin. The interventions included; assess wound healing by a licensed nurse, measure length, width and depth where possible and assess and document status of wound perimeter, wound bed and healing progress, assist to turn and reposition at least every two (2) hours, and follow facility protocol for the prevention/treatment of skin breakdown.

Review of Resident #4's Nurse's Notes dated 04/28/15 revealed a new Stage II area to the right buttock measuring 0.8 cm x 0.8 cm, red, no odor and a scant amount of serosanguinous drainage. Review of the Physician's Orders dated 04/28/15 revealed an order for Aquacel foam to the Stage II on right buttock, change every three (3) days and as needed.

However, further review revealed there was no Wound Care Summary initiated for the new stage II area to the right buttock identified on 04/28/15.

Review of the weekly Skin Report dated 04/29/15 revealed the resident had a Stage II ulcer to the right buttock measuring 0.8 cm x 0.8 cm.

Further review of Resident #4's Nurse's Notes dated 05/06/15, revealed the resident had a new Stage II ulcer to the right upper posterior thigh measuring 1.5 cm x 0.5 cm, red, no odor with serosanguinous drainage. Physician's Orders dated 05/06/15 revealed orders for Aquacel Foam

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F 314	<p>Continued From page 123</p> <p>to the stage II on the right upper posterior thigh, change every three (3) days and as needed</p> <p>However, further review revealed there was no Wound Care Summary initiated for the new wound identified on 05/06/15 for the right upper posterior thigh.</p> <p>The weekly Skin Assessment, dated 05/08/15 revealed Resident #4 had a stage II ulcer to the buttocks; however, did not indicate which buttock or the measurement and did not reveal the resident had a pressure ulcer to the right upper posterior thigh. The Skin Assessment dated 05/15/15 did not mention the pressure ulcer to the right buttock or the right upper posterior thigh but stated the resident had a Stage II to the coccyx which almost healed. The Skin Assessment dated 05/22/15, 05/29/15, and 06/05/15 revealed the resident had a Stage II to the right buttocks and a stage II to the right upper thigh with no measurements. The Skin Assessment, dated 06/12/15 revealed the resident had a stage II area to the right buttock measuring 2 cm x 2 cm and a stage II to the right upper thigh measuring 2 cm x 2 cm.</p> <p>Further review revealed no further weekly Skin Reports were completed related to the stage II ulcer to the right buttock from 04/29/15 until 05/28/15, (almost four (4) weeks later) when the wound was described as a right buttock stage II pressure ulcer measuring 2 cm x 1 cm with four (4), 0.2 cm x 0.2 open areas. The weekly Skin Report dated 05/28/15 also revealed the resident had a stage II pressure ulcer to the right upper posterior thigh measuring 1.5 cm x 1.5 cm with green tinged serosanguinous drainage; however, this was the first time the weekly Skin Report</p>	F 314	

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F 314	Continued From page 124 mentioned the pressure ulcer to the right upper thigh even though the wound was identified on 05/06/15, three (3) weeks prior. Review of the weekly Skin Assessment dated 06/12/15 and 06/19/15 revealed the resident had a stage II pressure ulcer to the right upper thigh measuring 2 cm x 2 cm and a stage II pressure ulcer to the right buttocks measuring 2 cm x 2 cm. Review of Resident #4's Annual MDS Assessment, dated 06/22/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15). Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance of one (1) for bed mobility, dressing and personal hygiene and as requiring extensive assistance of two (2) for transfers, and toilet use. According to the MDS, the facility further assessed the resident to be frequently incontinent of urine and occasionally incontinent of bowel, and as having two (2) Stage II Pressure Ulcers at the time of the assessment which had not been present on the prior assessment. Review of Resident #4's Braden Scale dated 06/22/15 revealed the resident was evaluated to be a moderate risk with a score of thirteen (13) with a score of thirteen (13) to fourteen (14) indicating moderate risk. The risk factors included slightly limited sensory perception, often moist, chair fast, slightly limited mobility, probably inadequate nutrition, and risk of friction and shear. Further review revealed the care plan was not	F 314			

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F 314	<p>Continued From page 125</p> <p>revised to indicate the resident had the pressure ulcers to the right buttocks and right posterior thigh. There was an Acute Care Plan initiated 06/24/15 which stated the resident had a pressure ulcer; however, it did not specify the sites or stages of the wounds.</p> <p>Review of Physician's orders dated 06/24/15 revealed orders for Aquacel AG and Duoderm to the SDTI on the left buttock, change every three (3) days and prn. Review of the Nurse's Notes dated 06/25/15 at 0100 (1:00 AM), revealed the resident had a left buttock SDTI measuring 1.3 cm x 0.6 cm purple/maroon in color.</p> <p>Further review revealed there was no weekly Skin Report for this resident from 05/28/15 until 06/26/15 (over three (3) weeks). Review of the weekly Skin Report dated 06/26/15, revealed the resident had stage II pressure ulcer to the right posterior thigh measuring 1 cm x 1.5 cm with serosanguinous drainage, an area to the right buttock described as stage II measuring 2 cm x 1.5 cm and an area to the left buttock described as a SDTI measuring 1.3 cm x 0.6 cm purple in color.</p> <p>Review of a WCS, dated 07/17/15, described a right buttock wound with no date the wound was discovered, as measuring one (1) cm x 0.4 cm stage II pressure area with a small amount of bloody drainage and the periwound was light purple in color; however, there was no tracking of the wound per the WCS from 04/28/15 until 07/17/15. There was a WCS initiated on 07/17/15 for an ulcer to the right posterior thigh which was described as measuring 0.6 cm x 0.4 cm with a pink wound base, no stage of the ulcer was noted; however, per record review this</p>	F 314		
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wound was identified on 05/06/15 and there was no tracking of the wound per the WCS until 07/17/15, over ten (10) weeks. Also, the WCS dated 07/17/15 identified the resident to have an area to the left buttock measuring 0.1 cm x 0.1 cm with a pink base.

The weekly Skin Report dated 07/17/15 revealed the resident had a pressure ulcer to the left buttock measuring 0.1 cm x 0.1 cm with no staging of the area, and stage II pressure ulcer to the right buttock measuring 1 cm x 0.4 cm, and a stage II pressure ulcer to the right posterior thigh measuring 0.6 cm x 0.4 cm. There was no further weekly Skin Reports noted although the resident continued to have pressure ulcers.

The next WCS was dated 08/07/15, three (3) weeks later from the previous WCS dated 07/17/15. The WCS dated 08/07/15 for the right buttock wound revealed the resident had a 1 cm x 1 cm Stage II pressure ulcer with no drainage or odor. The next WCS related to the right posterior thigh was dated 08/07/15 when the wound was described as a stage II ulcer measuring 1 cm x cm. However, there was no WCS for this date related to the left buttock wound.

Observation of a Skin Assessment for Resident #4, on 08/11/15 at 10:50 AM, completed by LPN #15, revealed the dressing was removed from the right buttock and there were no open areas but the skin was pink. The resident was noted to have two (2) stage II areas to the fold of the right upper buttock/right posterior right upper thigh measuring 0.5 cm x 0.5 cm with a pink wound bed, and 1.2 cm x 1.0 cm with a pink wound bed.

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9. Review of Resident #8's clinical record

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F 314	<p>Continued From page 127</p> <p>revealed the facility admitted the Resident on 05/02/14 with diagnoses of Abnormal Posture, Dysphagia Unspecified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase, Pain in Joint (Multiple Sites), Chronic Diastolic Heart Failure and Chronic Airway Obstruction.</p> <p>Review of Resident #8's Significant Change MDS Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of 15 indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) persons for bed mobility, transfer, toilet use, personal hygiene and bathing. Continued review revealed the facility assessed the resident as having an indwelling urinary catheter, as occasionally incontinent of bowel and as having two (2) stage II pressure ulcers.</p> <p>Review of Resident #8's Care Plan, undated, revealed a problem of impaired skin integrity related to immobility. The goal stated the resident would not develop complications related to pressure ulcers. The interventions included weekly skin assessments by licensed staff to monitor for any indication of skin breakdown, turn and reposition every two (2) hours, report any red or open areas, and float heels in bed.</p> <p>Review of Resident #8's Braden Scale for Pressure Sores dated 04/13/15, revealed the resident was at mild risk for pressure sores.</p> <p>Review of the weekly Skin Assessments revealed an assessment on 04/09/15 with no wounds noted, redness to the groin area and a blanchable reddened area to the coccyx; however, no WCS</p>	F 314			

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for this date. Continued review revealed a weekly Skin Assessment, dated 04/16/15 which noted blanchable redness to the buttocks and a small area of dry skin to the upper left buttock and redness to the groin with no WCS for that date.

Further review revealed no further weekly Skin Assessments nor WCSs until 06/20/15; even though review of Resident #8's Nurse's Notes dated 05/06/15 revealed the resident was noted to have a 0.8 cm x 0.9 cm Stage II to the posterior upper left thigh with a 3 cm x 2 cm SDTI (Suspected Deep Tissue Injury) purple/maroon area to the distal end of the Stage II, no odor or drainage. Further review revealed the coccyx had a 0.5 cm x 0.3 cm Stage II to red, no odor or drainage. New Physician Orders were received on 05/06/15 for Aquacei Foam to the upper posterior thigh, change every three (3) days and as needed, and Aquacei foam to the coccyx, change every three (3) days and as needed.

Review of the Wound Care Summaries and weekly Skin Assessments revealed zero (0) Summaries or Assessments were completed for the entire month of May 2015 and the resident was not placed on the weekly Skin Report, the document used for monitoring and QA, in May 2015.

Review of Physician's Orders dated 06/27/15, revealed the treatment to the coccyx was discontinued due to the area had healed.

Further review of the medical record revealed there were no weekly Skin Assessments until 06/20/15, nine (9) weeks later and no Wound Care Summaries for the entire month of June 2015. Additionally, review of the weekly Skin

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F 314	<p>Continued From page 129</p> <p>Report, used for QA monitoring, revealed no evidence Resident #8 was placed on the Report until 06/20/15.</p> <p>Review of the weekly Skin Assessment dated 07/11/15 revealed a Stage II to the left medial buttocks measured at 1 cm x 0.6 cm and the coccyx had blanchable redness; however, there was no evidence of a WCS per the facility's protocol. An Acute Care Plan was initiated on 07/11/15 related to the left medial buttock; however, it did not specify the stage of the ulcer.</p> <p>Review of Physician's Orders dated 07/11/15 revealed orders to cleanse area to left medial buttocks with NS, apply Aquacel Foam, and change every three (3) days and PRN until healed.</p> <p>Further review revealed there were zero (0) Wound Care Summaries completed for the entire month of July 2015.</p> <p>Review of the weekly Skin Assessment, dated 07/18/15 noted a stage II to the left medial buttock measuring 1 cm x 0.6 cm, with the coccyx and scrotum red and blanchable; however, there was no documented evidence of a WCS per the protocol.</p> <p>Continued review of the weekly Skin Assessment, dated 07/31/15, revealed a stage II to the left medial buttock measuring 1 cm x 0.75 cm and a stage II to the right medial buttock measuring 2 cm x 2 cm; however, there was no documented evidence of a WCS for these wounds as per the facility's protocol.</p> <p>10. Review of Resident #9's clinical record</p>	F 314		
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revealed the facility admitted the Resident on 03/13/15 with diagnoses of Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase and Insomnia. Review of the Acute Care Plan dated 03/13/15 revealed the resident had a Stage II to the coccyx on admission.

Review of the Admission MDS Assessment, dated 03/23/15, revealed the facility assessed the resident to require two (2) person assist for bed mobility and one (1) person assist for personal hygiene. Further review of the assessment revealed Resident #9 had a Stage II pressure ulcer to the coccyx/left buttocks on admission.

Review of Resident #9's Initial Care Plan, dated 03/13/15, revealed a problem of impaired skin integrity, related to decreased mobility, Stage II pressure ulcer to the coccyx/left buttocks. The goal stated the resident 's pressure ulcer will show signs of healing and remain free from infection through the review period. The Intervention included: weekly skin assessment by licensed staff to monitor for any indication of skin breakdown, turn and reposition every two (2) hours, and nursing staff to monitor for indication of skin impairment during daily Activities of Daily Living (ADL) care, staff to provide extensive assistance to turn and reposition in bed, observe daily for changes in skin status, administer treatments as ordered and monitor for effectiveness.

Review of Resident #9's Braden Scale for Predicting Pressure Sore Risk, dated 04/03/15 revealed the resident scored a fifteen (15) indicating mild risk. The risk factors included: slightly limited sensory perception, often moist, walks occasionally, slightly limited mobility, and

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F 314	<p>Continued From page 131 risk of friction and shear.</p> <p>Review of Resident #9's Care Plan Progress Notes dated 04/01/15 revealed the resident had a Stage II on the coccyx since admission. Further record review revealed there was no Wound Care Summary related to the coccyx ulcer initiated until 04/08/15, and there was no weekly Skin Assessment noted for the coccyx ulcer until 04/14/15.</p> <p>Further review of the weekly Skin Assessments revealed on 04/14/15 the resident developed two (2) new areas on the coccyx. Review of the WCS, dated 04/15/15 revealed coccyx with three (3) stage II's 1) left 0.8 cm x 0.7 cm, 2) 1.1 cm x 0.5 cm x 0.2 cm-original, 3) right 0.5 cm x 0.7 cm-wound beds red.</p> <p>Further record review revealed no weekly Skin Assessment was conducted for Resident #9 on 04/21/15 and 04/28/15. Review of the WCS's further revealed no documented evidence WCS's were completed concerning the coccyx wound from 04/22/15 through 04/30/15.</p> <p>Record review revealed no Skin Assessments were conducted on 05/06/15, 05/13/15, or 05/20/15.</p> <p>Review of the WCS's further revealed zero (0) were completed concerning the coccyx wound from 05/01/15 until 05/27/15. On 05/27/15 there was one (1) measurement for a Stage II to the coccyx/right buttock with a description of skin red and excoriated with several small open areas, with no measurements or descriptions of the several small open areas per the facility's wound care protocol.</p>	F 314		

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Review of Resident #9's Physician's Orders dated 06/01/15 revealed a new order for Aquacel Ag Fiber cover with DuoDerm change every three (3) days and as needed to the Stage II to right upper buttock, 2.2 cm x 1 cm. The Acute Care Plan was initiated, undated for a right buttock Stage II ulcer. Further record review revealed no Wound Care Summary was initiated and there was no entry on the weekly Skin Report for the Stage II to the right upper buttock found on 06/01/15.

Further review revealed there were no Wound Care Summaries for the following dates concerning the wounds found on Resident #9's coccyx/right buttock area: 06/04/15, 06/24/15, 06/30/15, 07/08/15, 07/15/15, and 07/22/15.

Further record review revealed no weekly Skin Assessments for Resident #9 on 07/16/15, 07/23/15 and 07/30/15.

Further record review revealed zero (0) weekly Skin Reports, used for QA monitoring, for Resident #9 from 04/29/15 until 05/27/15 and then there were no further entries on the weekly Skin Report log until 06/23/15.

Observation of a skin assessment on 08/11/15 for Resident #9, revealed a stage II pressure ulcer to the left coccyx measuring 0.7 cm x 0.6 cm.

11. Review of Resident #12's clinical record revealed the facility admitted the Resident on 01/26/15 with diagnoses of Down's Syndrome, Abnormality of Gait, Muscle Weakness (Generalized), Difficulty in Walking, Pressure Ulcer Unspecified Site, Dysphagia Oropharyngeal Phase, Alzheimer's Disease and Sleep Apnea.

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F 314	Continued From page 133 Review of the Admission MDS Assessment, dated 02/02/15 revealed the facility assessed the resident to require one (1) person assist for bed mobility and personal hygiene, as being at risk for developing pressure ulcers and having a stage III pressure ulcer measuring 3.2 cm x .9 cm. Review of Resident #12's Braden Scale for Predicting Pressure Sore Risk, completed 01/27/15 and 02/02/15 revealed the resident scored as mild risk. The risk factors for the form included: slightly limited sensory perception, often moist, walks occasionally, probably adequate nutrition, and potential problem for shear and friction. Review of Resident #12's Comprehensive Care Plan, initiated on 02/27/15 revealed the resident had impaired; potential for impaired skin integrity related to limited mobility, and incontinence. The goal stated the resident would not develop pressure ulcers. The interventions were for nursing staff to monitor for indication of skin impairment during ADL care, report any red or open area, weekly skin assessment by licensed staff to monitor for any indications of skin breakdown, pressure relieving device to bed/chair-Gel overlay to bed, monitor for intolerance to two (2) hour turning schedule, and dietician consult and follow up as indicated. Continued review of the Comprehensive Care Plan revealed a care plan for Pressure Ulcer, no date, with a goal that the pressure ulcer will decrease in size by the next review period. The interventions included: Gel cushion to wheel chair, Prostat, Vitamin C, keep skin warm and dry, promote nutritional status, assess for signs	F 314		
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F 314	Continued From page 134 and symptoms of worsening, of infection or complications daily, treatments as ordered by the physician to wound care area, assess skin daily during care for changes and report to nursing supervisor, dietitian to evaluate and assess per policy and staff to assist with mobility needs of transfers and bed mobility as needed to promote pressure relief. Review of Resident #12's Wound Care Summaries revealed a lower right buttock SDTI discovered on 02/04/15 with no documented evidence of a Wound Care Summary from 04/22/15 until 08/14/15, over three (3) months and the wound was not evaluated from 04/22/15 until 05/27/15 on the weekly Skin Report used for QA and wound tracking. Review of the weekly Skin Assessment revealed an assessment on 04/08/15 and a Wound Care Summary (WCS) dated 04/08/15 which revealed the resident had a Stage III pressure ulcer to the posterior left thigh measuring 1.8 cm x 1.9 cm x 0.4 cm with tunneling from 12 o'clock to 2 o'clock (the wound was discovered on 02/04/15, according to the WCS dated 04/08/15). The next weekly Skin Assessment and Wound Care Summary was completed for this pressure ulcer on 04/14/15 in which the wound measured 1.2 cm x 2 cm with yellow slough in the wound bed with serosanguinous drainage. Continued review revealed a weekly Skin Assessment and WCS dated 04/22/15 which described the wound; however, there was no documented evidence of weekly Skin Assessments and Wound Care Summaries from 04/22/15 until 06/08/15, over four (4) weeks.	F 314		

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F 314	<p>Continued From page 135</p> <p>Further record review revealed Resident #12's posterior upper thigh wound was not evaluated from 04/29/15 until 05/27/15 on the weekly Skin Report used for QA and wound tracking.</p> <p>Review of the weekly Skin Assessment revealed an assessment on 06/08/15 which documented the wound; however, there was no documented evidence of a WCS with a description of the wound. There was no weekly Skin Assessment or WCS for 06/15/15.</p> <p>Continued review revealed weekly Skin Assessments from 06/22/15 through 08/03/15; however, there was no documented evidence of the WCS for this period with descriptions of the wound.</p> <p>Review of the weekly Skin Assessment dated 08/09/15 revealed documentation of scar to the left buttock and an open area to the right buttocks with yellow drainage, measuring 2.5 cm x 3.5 cm x .5 cm; however, there was no documented evidence of a WCS for this date as per the facility's protocol.</p> <p>Observation of a skin assessment of Resident #12 on 08/11/15 at 4:11 PM, performed by LPN #1, revealed the resident had dressing over the right buttock ulcer which was not due to be changed. LPN #1 stated the wound was unstageable.</p> <p>Interview with the DON on 08/12/15, 08/13/15 at 5:30 PM, 08/19/15 at 5:30 PM, revealed the Skin Assessments included; checking skin head to toe, looking, feeling skin, and checking for abnormal areas or bruising. The DON stated a</p>	F 314		
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Skin Assessment would also entail measuring, staging, and describing wounds for the wound bed and the periwound area, and stating if there was drainage noted. She further stated measuring the wound was the only way to have proof of the progress of the wound and it was necessary to do the weekly Skin Assessments in order to monitor the wounds. The DON revealed the Wound Care Summary was to be initiated with each new wound and continued weekly until the wound healed. She further stated this document and the weekly Skin Reports which were to be done weekly were the forms used to take to the weekly Quality of Care (QOC) meeting in order to discuss the wounds and evaluate the effectiveness of the treatment. She acknowledged the Wound protocol in reference to Wound Care Summaries and weekly Skin Reports was not followed for the residents if the weekly documentation was missing. Further interview revealed the weekly Skin Assessment was also to be completed weekly and was to include staging, measurements and descriptions of the wounds.

Interview with the former Interim Administrator/Nurse Consultant on 08/10/15 at 3:50 PM and 08/12/15 at 3:00 PM, when she identified there was an issue with wound documentation she scheduled a nurse's meeting for 05/22/15 as an in-service to re-iterate what the expectations were for wound care. She stated the expectation was for wounds to be described, staged, and measured on the weekly Skin Assessment, the Wound Care Summary and the weekly Skin Report. Per interview, the facility still had issues with Skin Assessments not done weekly, and the weekly Wound Assessments were important in order to see if wounds were

F 314

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314 : Continued From page 137
improving or declining.

F 490 : 483.75 EFFECTIVE
SS=H : ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of in-service documentation, and review of the facility's policy, it was determined the facility's Administration failed to develop and implement an effective plan of action to ensure skin assessments were accurate, detailed and completed weekly, and to ensure wound assessments and wound monitoring were completed weekly after Administration made a decision to re-assign those duties from a designated staff person to the floor nursing staff at the end of April 2015. Survey findings revealed floor nursing staff failed to perform weekly Skin Assessments, failed to complete Wound Care Summary forms, and failed to complete weekly Skin Reports per the facility's Wound Protocol. Interview and record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. Substandard Quality of Care with actual harm was identified related to the facility's systemic failure. This failure affected eleven (11) of

F 314 :

F 490 :
F490 :
Ridgeway Nursing and Rehabilitation Facility administers their resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident.
1. Resident #1 was an 87 year old female, who was admitted to Ridgeway Nursing and Rehabilitation on March 11, 2015 following a fall in an assisted living facility (Dementia Unit), which resulted in a right intertrochanteric hip fracture. Her other diagnoses include severe dementia, hypothyroidism, thrombocytopenia (which could have been a factor in the tissue destruction) and acute on chronic blood loss anemia. It was noted at the facility that her hemoglobin dropped to 8.1 on March 13, 2015. On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360		
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F 490	Continued From page 138 fourteen (14) sampled residents (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12). (Refer to F314 and F520) The findings include: Record review of the facility's policy: "Administrator", dated 08/01/13, revealed a licensed Administrator was responsible for the day-to-day functions of the facility. Further policy review revealed the Administrator was responsible to evaluate and implement recommendations from the facility's committees, including Quality Assurance. Review of the facility's "Wound Protocol" document, undated, revealed "on any resident who is assessed to be at risk for skin breakdown, the protocol for early intervention should be implemented". Continued review revealed the Wound Care Summary should be initiated for any resident who was assessed to have a wound and continued with weekly "updates" until the wound was healed, with the Summary to be reviewed weekly in the Quality of Care (QOC) meetings for each resident who was identified as having a wound. Further review of the Summary revealed the Weekly Skin Report should provide a summary of all wounds in the facility and progression of those wounds. Continued review revealed the Weekly Skin Report should be copied for members of the Quality of Care Committee to review each week. Interview, on 08/10/15 at 3:50 PM and on 08/12/15 at 3:00 PM, with the facility's Nurse Consultant, who was also the Interim Administrator in charge of the facility until 07/24/15, revealed in April 2015 the designated	F 490	made to Wound Care Clinic. The order for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecalorie, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to be monitored (specifically for Hemoglobin level). On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a		

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NAME OF PROVIDER OR SUPPLIER RIDGEMAN NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

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F 490 Continued From page 139

wound nurse was re-assigned to the floor and the facility made a procedural change to assign floor nursing staff the responsibility to perform weekly skin/wound assessments and document observations on the designated forms. Per interview, Skin Assessments were to be documented on the weekly Skin Assessment document and, when applicable, wounds were assessed weekly and documented on the Wound Care Summary and also the QA's weekly Skin Report form. The Nurse Consultant revealed nurses were informed they were responsible to perform the weekly skin/wound assessments and complete the forms utilized by the facility on 04/24/15, but it was not a formal in-service and no signatures were required. She further revealed she was not sure exactly what information was communicated, or who communicated this to the nurses, but stated the nurses voiced no concerns or wanted re-training on skin assessments. She further reported nurses were trained in school and at orientation on how to properly perform a skin assessment. Per interview, no monitoring was conducted at the time of the process change; however, she stated they should have ensured a monitoring process was initiated and it would have been her responsibility to ensure the monitoring was done.

Record review revealed the facility provided no documentation of the April 2015 meeting with the floor nurses which discussed the change in responsibility on the weekly performance of skin/wound assessments and the related forms.

Interview with Licensed Practical Nurse (LPN) #13, on 08/11/15 at 6:15 PM and 08/12/15 at 7:00 PM, revealed they had a nurses meeting which was not an in-service and were told they would be

F 490

superficial sacral lesion, which improved, and a small fissure at 11 o'clock in the anorectal area. Continue same treatment - Anusol HC Suppository TID for anal fissure. On May 08, 2015 it was noted that the skin, where the Tegaderm covered around the wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Ceftin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered with Aquacel AG Foam. Multi Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate

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F 490	<p>Continued From page 140</p> <p>doing their own skin assessments sometime several months ago. She stated there was no in-service given related to how to measure and stage wounds and she was not comfortable staging wounds. In addition, she revealed she did not consistently work the same unit and most nurses at the facility floated to different units.</p> <p>Interview with LPN #9, on 08/21/15 at 9:45 AM, revealed during an in-service in May 2015 the nurses were told all assessments related to skin and wounds were now their responsibility and she didn't understand what forms they were to use at that time. In addition, the LPN also revealed it was difficult to follow a wound if there was missing information from the previous assessment.</p> <p>Interview with LPN #6, on 08/11/15 at 5:00 PM, 08/12/15 at 10:51 AM, and 08/20/15 at 4:00 PM, revealed there was a staff meeting in April and the staff nurses were told they would be doing their own skin assessments weekly, but were not told which forms to use. She said it was not an in-service where they had to sign and she did not receive full instructions on what to do related to skin assessments.</p> <p>Continued interview, on 08/10/15 at 3:50 PM and 08/12/15 at 11:15 AM, and 3:00 PM, with the Nurse Consultant revealed she became aware of a problem, on 05/07/15, when she identified the weekly Skin Report was not being completed. She further revealed based the identified problem, an action plan was put in place which included an audit of every chart in the building for current weekly wound documentation. After the audit was completed, an in-service with nursing staff was conducted on 05/22/15 to discuss</p>	F 490	<p>and treat. On May 15, 2015, diet order changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer. New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal saline wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015 Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately</p>		

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F 490	Continued From page 141 skin/wound assessments and which forms were to be used. Record review revealed a nurse's meeting took place on 05/22/15, and the topics included wounds, schedule of weekly skin assessments, and sign-in sheet, but no content of the education was provided other than the forms. Interview, on 08/12/15 at 11:30 AM, with the Assistant Director of Nursing (ADON) revealed she in-serviced nurses, on 05/22/15, and discussed skin assessments, the wound care documentation protocol and forms, and also discussed wound measurements, staging, and description. Interview with LPN #10, on 08/11/15 at 7:00 PM, revealed she started at the facility in May or June 2015 and was told the nurses were to do their own skin assessments when they did the Weekly Nurses Notes; however, she was unaware she was to do the Wound Care Summary or weekly Skin Report for residents with wounds when she did the weekly Skin Assessments. Further interview revealed she did not receive any in-service when hired related to how to do the skin assessments. Interview, on 08/21/15 at 6:20 PM, with current Administrator and the Nurse Consultant revealed the Administrator was unaware there were still concerns with the completion of the Wound Care Summaries, Skin Assessments and the weekly Skin Report. The Nurse Consultant revealed after the State Survey Agency's findings more follow-up was needed.	F 490	2cm from rectum on lower left buttocks with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage. Physician notified and order obtained to send to ER. Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility. Resident #2 Resident #2 is an 85yr old female with diagnosis of CHF, insulin dependent diabetes, paraplegia, neuropathy and hypertension. Resident #2 was admitted to Ridgeway on 04/09/14 from Edgewood Nursing Home. On admission Resident #2 had red areas to left breast and groin that appeared to be with yeast. On 06/07/15, a stage II area, 1 X 1cm, was noted, no odor, no drainage. This area healed on 06/28/15. On 07/01/15 area to posterior thigh healed. On 08/04/15 three Stage II areas were noted 1.2cm x1.2cm, medial coccyx, 1.3cm x0.2cm, right side 0.5cm x0.4cm, no foul odor or drainage, scant amount of bleeding noted. Aquacel foam was applied and order to be changed every three days and PRN. On	
F 514	483.75(I)(1) RES	F 514		

F490

8/14/15 all areas to coccyx and left buttock healed. A scab, 0.5cm x 0.5cm, was noted to left anterior foot. She continues to have blanchable redness to bilateral buttocks. It should be noted that per the care plan progress notes, Resident #2 refuses to turn and reposition in bed or chair. Resident #2 continues to receive Prostat 30cc BID X 30 days, Vitamin C 250mg QD and Zinc Sulfate 220mg x14 days. Her weight on admission was 201 lbs and 209 lbs currently. Her BUN currently is 38 (7-25), total protein 5.7 (6-8.3) and albumin 3.4 (3.5-5.5). Her hemoglobin 9.8 (12-16) and hematocrit 31.1 (36-48) are low. Despite the above mentioned complication her wounds are healed.

Resident #4

Resident #4 is a 62 year old male, who was admitted on 4/10/10 from the hospital. Resident #4 was admitted with Stage II to his right buttock, 1cm x 1cm diameter and left hip with area measuring 6cm x 7cm and approx. 1cm diameter. On 6/14/10 pressure reducing mattress to be was ordered. Vitamin C 250mg was ordered on 12/13/15. Vitamin D3 50,00units was ordered on 05/14/12. Coccyx cutout quadra gel cushion for wheelchair positioning ordered 4/30/13. Sencare protect ointment 113gm 2 times a day was

ordered 5/29/13. Zinc Sulfate 220mg
ordered 7/5/15 for wound healing.
Aquacel AG and Duoderm to SDTI on
left buttock, change every 3 days ordered
6/24/15. Aquacel AG and Duoderm to
posterior upper Right thigh ordered
6/24/15. Admitting weight 123lbs, 5'9"
tall and current weight 176lbs as of
8/10/15. Resident #4 refuses to be
repositioned at times and sits up in his
wheelchair for long period of times
during the day. At times he refuses his
meals and will not allow staff to clip his
nails. Resident #4 has self inflicted areas
that heal and reopen. Resident #4
posterior right thigh wound and right
buttock wound healed as of 8/10/15.
Skin is intact as of 9/10/15. Resident #4
is a smoker and has diagnosis of HTN,
Dementia with behaviors, diabetes type
2, anxiety and GERD. Resident #4
continues on vistanl related to itching,
multivitamin, Vitamin C, Vitamin D3
and Coumadin.

Resident #5

Resident #5 was admitted to Ridgeway
Nursing and Rehabilitation on 2/14/13.
She is an 89 year old female who has
suffered from CVA, G-Tube placement,
HTN, Dementia, dysphagia,
hyperlipidemia, muscular degeneration,
blindness, colon carcinoma with
colostomy, renal and bladder concerns
and functional quadriplegia. On

admission in 2013 Resident #5's coccyx was slightly red and she had multiple issues with yeast infections. On 7/15/13 Resident #5 was noted to an abrasion to her coccyx which was treated with Duoderm. On 7/16/13 the area healed and the Duoderm was discontinued. Resident #5's health has continued to decline over the next two years. She has had numerous hospitalization and the facility and hospital have discussed Hospice/Palliative care with the daughter. The daughter continues to decline Hospice services. The coccyx area reopened in March 2015. Following the area reopening Resident #5 was hospitalized in April 2015, May 2015, June 2015 and July 2015. The area to her coccyx now measures Stage IV 7cm x 11.2cm x 1.9cm with 25% slough and small area to bone exposure, no odor. Stage II right upper thigh/buttocks healed and scabbed over 9/06/15. Stage II to right lower buttocks duoderm ordered. Resident #5 continues to be very ill patient as exhibited by her labs dated 05/07/15; Hemoglobin 8.8 (12-16), Hematocrit 28.5 (36-48), BUN 30 (7-25), total protein 5.4 (6-8.3), albumin 2.6 (3.5-5.5). on 7/13/15 Her BUN elevated to 81 (7-25). On 7/20/15 her wound culture showed MRSA pseudomonas aeruginosa and enterococcus faecium which were treated as ordered. On 9/2/15 her BUN was 63 (7-35mg). This again shows the fragile nature of Resident #5's condition.

Resident #5 continues to receive treatments as ordered.

Resident #6

Resident #6 is an 88yr old admitted from St. Joseph's Mt. Sterling on 7/9/15. Upon admission resident's weight was 146lbs. Resident was incontinent of bowel and bladder upon admission with a catheter in place. She had a Duoderm in place to her stage II to her left buttock. Heal protectors were applied upon admission. On 8/7/15 the left buttock was measuring as a 0.05cm open area. On 7/31/15, a SDTI was noted on her right buttock with no open areas and no drainage. On 8/13/15, the left buttock and right buttock SDTI were healed. Vitamin D3 2000 unit capsules were ordered on 7/9/15, Benacal 45ml, cyponoheppeter 2mg were ordered on 7/30/15, Prostat was ordered on 8/4/15, zinc ordered on 8/4/15, Vitamin C ordered on 8/4/15 and cyprohetatine ordered on 8/4/15. Vitamin B12 and Vitamin D was upon admission. Met with family about appetite and refusing meal on 7/29/15, a feeding tube placement discussion was put into place on 8/21/15 for decreased intake and Hospice services. A Hospice consult was ordered 8/21/15. Resident was sent to ER on 8/24/15 at 08:30 and passed away there on hospice. At the time of discharge to ER resident's skin was

intact and weight at discharge was 132.lbs.

Resident #7

Resident #7 was admitted to Ridgeway Nursing and Rehabilitation on 07/13/15 with diagnosis of acute respiratory failure, pneumonia, vocal cord edema, schizophrenia and chronic renal insufficiency. She had prolonged hospital stay due to a bowel obstruction and surgery. She is a 68 year old female. On admission it was noted she had MRSA to her incision and was placed on Contact Isolation. She had blanchable redness to sacral area and buttocks area. She had multiple scratches and bruises to arms and hands and thighs. On 8/04/15 Resident #7 was noted to have a Stage II area to left medial buttock measuring 0.4cm x 0.2cm, wound bed was pink with no slough, no odor or drainage noted. Four days later a distal area was noted stage II, measuring 0.5cm X 0.2cm x 1.2 cm blanchable redness between wounds. Both areas healed on 8/14/15. Her labs on 07/20/15 revealed a protein level of 5.4 (6-8.3), albumin 3.2 (3.5-5.5), Hemoglobin 10.5 (12-18) and Hematocrit 33.2 (38-48). Her weight on admission was 266lbs and height 56 inches. She was seen by the dietician on 8/12/15 and was noted to have a healing stage II's. The areas healed on 8/14/15.

Resident #7 was transferred to the hospital on 8/25/15 in an emergency and died a few hours later.

Resident #8

Resident #8 is a 90 year old who was admitted to Ridgeway Nursing and Rehabilitation on 5/2/14 following a hospital stay. His diagnosis include atrial fibrillation, chronic history of UTI, dysphagia, pain in joints, abnormal posture and muscle weakness, prostate cancer with bone mets, encephalopathy, aortic valve stenosis, BPH, heart failure, bladder cancer, lung nodule, urinary retention and dementia. On 8/8/15 it is noted a stage II area measuring 1cm x 0.5cm was discovered. Aquacel AG Fiber and duoderm ordered. The area is described as a SDTI to upper posterior thigh and stage II areas to left and right medial buttocks. On 8/14/15 the area to the posterior right thigh healed and orders were discontinued. On 8/12/15 area to right medial buttocks healed and treatments discontinued. Resident #8's labs are as follows; BUN 35 (7-25), Creatinine 1.5 (0.6-1.3) on 6/9/15, on 06/25/15 albumin 3.4 (3.5-5.5), Hemoglobin 11.5 (14-18) and Hematocrit 33.2 (42-54). Resident #8 continues on Hospice Services with comfort P.O.C. in place. Skin is intact at this time.

Resident #9

Resident #9 is a 93yr old female admitted to Ridgeway from home on 3/13/15. She was admitted with a stage II to her right mid buttock x 2, the upper measuring 0.3cm x 0.4cm and the lower 0.4cm x 0.5cm. She had a Aquacel treatment in place upon admission her family reported. She was living alone and had family to stay with her 24 hours a day. Family stated she would stay in her recliner all day and sleep there at night. On 6/17/15 the right buttock was healed. On 5/27/15 a stage II was noted to the coccyx left buttock measuring 1.8cm x 2 x 0.2cm. On 6/4/15 and 6/11/15 the measurements were noted to be smaller. On 6/23/15 the left buttock was measuring 0.1cm x 0.1cm with no drainage or odor. As of 9/8/15 the coccyx stage II wound is measuring 0.2cm x 0.2cm with no depth or no drainage. The left buttock wound stage II measuring 0.4cm x 0.4cm with no depth, odor or drainage. On 4/15/15, an Aquacel AG treatment to the coccyx was put into place convening with duoderm. On 4/21/15 a cushion was ordered for the resident's recliner. Resident #9 is in continent of urine. Resident has a diagnosis of hypertension and edema. Resident is currently taking Prostat 30ml twice daily for wound healing which was ordered 3/20/15.

Resident #10 continues to reside in the facility. His physician had been made aware of his current status.

Resident #10 is an 85 year old was admitted to Ridgeway Nursing and Rehabilitation on 2/2/15. His diagnosis include urinary retention, BPH, Parkinson disease, dementia with behaviors, HTN, DM stage II, chronic kidney disease, dysphagia, hyperlipidemia, generalized weakness, hematuria with unclear etiology. On 2/16/15 upon readmission to the facility a stage II area to right sacrum measuring 1cm x 0.8cm, red, no odor or drainage was noted with 6cm non-blanching redness to 12:00. Aquacel foam ordered and applied. On 3/12/15 this area healed. On 3/22/15 the right buttock/sacral area 1cm x 1cm, red, no odor, serous drainage surrounding skin with blanchable redness. Duoderm ordered and applied. This area healed on 4/14/15. On 4/21/15 a suspected deep tissue injury 1cm x 1cm non-blanching, no odor or drainage was noted to right coccyx. This area continues to be treated. On 2/16/15 upon readmission a 4.5cm x 4 cm, red/purple blister was noted to his right heel. This was diagnosed as MRSA and treated. The right heel continues to be open despite wound care clinic consultation on several dates and several debridements. Current wounds' measurements are right heel stage IV, 6.8cm x 6.7cm x 1.2cm with 1.7cm tunneling at 6:00 and 8:00, coccyx unstageable 3cm x 1.7cm x

1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac to be changed every 2 days to each area. Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Ceflin, Bactrim and Ampicillin. It should be noted that Resident #10 has 1plus edema to lower extremities and requires Lasix 60mg daily to keep the edema to 1 plus.

Resident #11

Resident #11 was admitted on 1/7/2005 to Ridgeway Nursing and Rehabilitation. She has diagnosis of dementia, bipolar, anxiety and depression. Documented on 7/26/15 her left inner upper buttock was a stage2 measuring 0.8cm x 0.6cm with a Aquacel foam dressing. This area along with the STDI measuring 0.5cm x 0.5cm on 7/26/15 were healed on 8/10/15. Sencicare was applied twice daily as needed. Resident has a wheelchair cushion ordered while up in wheelchair on 8/19/15. Resident takes a multivitamin daily as of 1/11/12. Baza protective cream was ordered 3/11/13. Nystatin to groin and bilateral breast. Resident has been receiving Benecalorie 45ml and Prostat 30ml. Resident #11 is up in her wheelchair daily. Since

resident's skin is so fragile her area opens and closes often while being moved or repositioned. Resident #11 continues to receive treatment as ordered

Resident #12

Resident #12 is a 57 year old female who was admitted to Ridgeway Nursing and Rehabilitation on 01/26/15. Her diagnosis include Down's syndrome, COPD, HTN, Mood disorder, sleep apnea, neurocognitive disorder due to Alzheimer's disease with behavioral issues, hyperlipidemia, and osteoarthritis. On admission, 01/26/15, it was noted that Resident #12 had a stage III area with foul odor, eschar and slough which measured 3cm x 2cm x 0.9cm. She had a rash to her right foot and multiple small scratches. It was noted she had MRSA infections to the wound on admission. An ulcer developed on 02/04/15 to posterior left thigh. Aquacel AG and Aquacel foam applied. This area healed on 5/28/15 and reopened and healed again on 9/14/15. The coccyx area has decreased in size since admission to stage II. On 8/16/15 the area measured 1cm x 2cm with no measurable depth, slight yellow drainage and pink wound bed. Her labs include pre albumin 13 (16-45mg/dl) on 5/14/15, total protein 5.2 (6-8.3) on 4/9/15, albumin 2.5 (3.5-5.5) on 4/9/15. This

resident has multiple behaviors noted. Resident #12 has a gel overlay to bed and continues to improve. This resident continues to receive treatment as ordered by the physician.

2. All nurses (with the exception of one on FMLA and a PRN nurse) were educated on August 13, 2015 concerning weekly skin assessments, wound documentation, measuring wounds (width, length, and depth) staging, describing peri wound area and wound bed. Wound documentation procedure, photos on admission and discharge (non-emergent). Dressing change procedure, washing hands and infection control. Each nurse was required to measure wound examples and document their assessment. This in-service was conducted by Sally Baxter, RN, Vice-President of Clinical Services. On August 14, 2015 skin assessments were performed and documented on all residents by the Director of Nursing and four RN's with the assistance of four LPN's. No skin issues were identified that had not been identified on previous skin assessments. In addition, on August 14, 2015, Sally Baxter, R.N., Vice-President of Clinical Services, and Lauren Sword, Administrator, completed a comprehensive review of all care plans to ensure they are updated as appropriate and care plan approaches are in place and being followed. Physician orders are reviewed daily with the facility's

inter-disciplinary team and the care plans updated as appropriate. The Administrator, Director of Nursing, Charge Nurses, Rehab Director and MDS Coordinator are all part of this meeting. On the weekends, the RN Charge Nurse will be responsible for updating the care plans.

3. The Administrator and Director of Nursing were in-serviced on August 13, 2015 by Sally Baxter, RN, Vice-President of Clinical Services, reviewing weekly skin assessments, documentation of wounds (including width, length and depth of wound, peri wound, wound bed drainage and odor), scheduling of wound treatments and orders for wound cleansing. A copy of the facility's Wound Care Documentation Protocol was reviewed with both the Administrator and Director of Nursing. Daily for one month the Director of Nursing or her designee will audit two (2) residents' skin conditions and related documentation, which will include care plan and associated interventions. In addition, physician orders are reviewed daily in the facility's inter-disciplinary team meeting with care plans being revised, as appropriate, immediately after the meeting by the Charge Nurses. In the absence of the Director of Nursing, the MDS Coordinator will assume the responsibility for overseeing the wound care and care planning process and documentation.

4. As part of the facility's ongoing Quality Assurance Program, monthly the Director of Nursing, or her designee, will audit 5% of the residents by conducting a head to toe skin assessment and compare their assessment to what is documented in the Clinical Record. Any deviations will be reported to the Administrator immediately and the nurse will be re-educated. In addition, care plans and wounds will be a focus of the facility's continuous Quality Improvement Committee for the next six (6) months. Either the Vice-President of Clinical Services or the Executive Vice President will be in attendance at Continuous Quality Improvement meetings for the next six (6) months. Any identified problems will be addressed and followed up by the Committee with the nursing staff and re-education provided as appropriate.

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4. All resident's skin was reassessed by licensed staff on 08-24-15 and 08-25-15. Wounds were documented and care planned according to the assessment. Treatments were reviewed and compared to physician orders. Weekly the Director of Nursing will review two randomly selected residents to physically audit their skin condition, review their current plan of care, required documentation and ensure ordered treatments are in place following a daily audit of two residents for thirty days encompassing the above audit items.

Daily the Administrator, Director of Nursing, MDS staff, Staff Development Nurse, Unit Coordinators, Medical Records, Social Services and therapy staff will review the 24 hour reports and physician orders for significant changes in resident condition requiring Physician notification for significant change. Labs, appointments, 72 hour follow up, incidents, new admissions and possible discharges are reviewed. Monthly the Administrator will audit 15 resident records to ensure notification was conducted for residents who have a significant change in status. This audit will be conducted by reviewing nurse's notes and physician orders.

In addition, the Quality Assurance nurse will audit 5 percent of all residents care plans to ensure interventions are being implemented as ordered. This will require physical assessment of the resident, their environment, MAR, TAR and care plan. If concerns are identified the Unit Coordinator will be made aware and the concern corrected. Monthly 5 percent of all medical records will be audited by the Director of Nursing or her designee to ensure records are complete and accurate.

5. August 25, 2015 /

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 514 Continued From page 142
SS=H RECORDS-COMplete/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of facility's policy and protocol revealed the facility failed to have an effective system to ensure clinical records were maintained in accordance with accepted professional standards and practices which were complete and accurately documented, for eleven (11) of fourteen (14) sampled residents (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12). (Refer to F314)

Interview with staff and record review revealed on 04/24/15, the facility delegated all wound care assessments and treatments to the staff nurses and the Wound Care Nurse was reassigned as a staff nurse. However, record review revealed there was no documented evidence these assessments were consistent, complete and accurately documented. Additionally, staff failed

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It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible and systematically organized.

1.) Resident #1 was an 87 year old female, who was admitted to Ridgeway Nursing and Rehabilitation on March 11, 2015 following a fall in an assisted living facility (Dementia Unit), which resulted in a right intertrochanteric hip fracture. Her other diagnoses include severe dementia, hypothyroidism, thrombocytopenia (which could have be a factor in the tissue destruction) and acute on chronic blood loss anemia. It was noted at the facility that her hemoglobin dropped to 8.1 on March 13, 2015. On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral made to Wound Care Clinic. The order

for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecalorie, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to be monitored (specifically for Hemoglobin level).

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F 514	Continued From page 143 to document the treatment orders for Resident #5's right upper thigh wound. In addition, review of Resident #1's clinical record revealed staff failed document related to the resident's elevated temperature and the effectiveness of the medication that was administered. The findings include: Review of the facility's "Wound Protocol" document, undated, revealed the Wound Care Summary should be initiated for any resident who was assessed to have a wound and continued with weekly "updates" until the wound was healed. Further review revealed the Summary to be reviewed weekly in the Quality of Care (QOC) meetings for each resident who was identified as having a wound. Continued review revealed the weekly Skin Report should provide a summary of all wounds in the facility and progression of those wounds and the weekly Skin Report should be copied for members of the Quality of Care Committee to review each week. Review of the facility "Wound Care Documentation Protocol", undated, revealed upon admission or re-entry, if a resident had a wound present of any type, the Wound Care Summary Sheet was to be started. Further review, revealed each wound was to have its own sheet and there could not be multiple wound sites listed on any one (1) wound care summary sheet. The Protocol stated, the Wound Care Summary was to be completed at a minimum of weekly by a licensed nurse and the assessment was to include measurements and a narrative wound description as directed on the sheet.	F 514	On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a superficial sacral lesion, which improved, and a small fissure at 11 o'clock to the anorectal area. Continue same treatment - Anusol HC Suppository TID for anal fissure. On May 08, 2015 it was noted that the skin, where the Tegaderm covered around the wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Ceftin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered with Aquacel AG Foam. Muli Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate		

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NAME OF PROVIDER OR SUPPLIER RIDGEMAN NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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F 514 Continued From page 144

Review of the "Change in a Resident's Condition" Policy, dated 08/01/13, revealed the Nurse Supervisor/Charge Nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 03/11/15 with diagnoses including Dementia, Alzheimer's Disease, Hip Fracture, and Muscle Weakness.

Record review revealed Resident #1 developed a Stage II area measuring two (2) centimeters (cm) length by one (1) cm width with yellow slough noted extending for an undetermined amount into the rectum identified on 04/06/15. On 04/09/15 the resident's left buttock pressure ulcer measured 1.5 cm by 3.0 cm and there was an open wound with gray/pale slough, slight odor, and purulent drainage. On 04/14/15 the resident's left buttock had an open wound measuring 1.5 cm by 3.0 cm by 0.3 cm and was red with less than twenty-five percent (25%) slough in the wound bed and purulent drainage with slight odor. On 04/21/15 the resident's left buttock wound measured 1.0 cm by 3 cm by 0.3 cm and was an open wound that extended into the rectum with decreased slough, slight odor and purulent drainage. On 04/21/15 Resident #1 had a new area to the coccyx described as a Stage II pressure ulcer measuring 0.6 cm by 0.4 cm, with red surrounding skin with blanching discoloration, no odor, and scant serosanguinous drainage.

Further review of Resident #1's clinical record revealed there was no documented evidence of a

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and treat. On May 15, 2015, diet order changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer. New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal saline wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015 Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately

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F 514	<p>Continued From page 145</p> <p>Wound Care Summary to include staging, measurements, and descriptions of the wounds after 04/21/15 and no documented evidence Resident #1 received a weekly Skin Assessment from 04/14/15 until 05/26/15, more than five (5) weeks later, even though the facility's Wound Protocol stated the Wound Care Summaries would be updated weekly. In addition, there was no documented evidence Resident #1's wounds were transcribed to the weekly Skin Report to be taken to the weekly QOC meeting from 04/21/15 until 05/28/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #6 on 08/11/15 at 5:00 PM, on 08/12/15 at 10:51 AM, and on 08/20/15 at 4:00 PM, revealed she had completed the weekly Nurses Notes for Resident #1 for 04/28/15, 05/05/15, 05/19/15, and 06/02/15 and was to have completed the weekly Skin Assessments, Wound Care Summaries, and weekly Skin Reports when she did the weekly Nurses Notes. However, she revealed she was a "lost ball in high weeds" in May and did not understand she was to do this.</p> <p>Review of the weekly Skin Assessment, dated 05/26/15 and completed by LPN #10, revealed the resident was assessed as having a small healing area to the right heel area; however, there was no documentation related to the coccyx pressure ulcer and therefore no documented evidence the coccyx ulcer was assessed.</p> <p>Interview with LPN #10 on 08/11/15 at 7:00 PM, revealed she did not know she was to complete the Wound Care Summary or weekly Skin Report for residents with wounds when she did the weekly Skin Assessments. Further interview with LPN #10, revealed she should have included all</p>	F 514	<p>2cm from rectum on lower left buttocks with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage. Physician notified and order obtained to send to ER. Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility.</p> <p>Resident #2</p> <p>Resident #2 is an 85yr old female with diagnosis of CHF, insulin dependent diabetes, paraplegia, neuropathy and hypertension. Resident #2 was admitted to Ridgeway on 04/09/14 from Edgewood Nursing Home. On admission Resident #2 had red areas to left breast and groin that appeared to be with yeast. On 06/07/15, a stage II area, 1 X 1cm, was noted, no odor, no drainage. This area healed on 06/28/15. On 07/01/15 area to posterior thigh healed. On 08/04/15 three Stage II areas were noted 1.2cm x 1.2cm, medial coccyx, 1.8cm x 0.2cm, right side 0.5cm x 0.4cm, no foul odor or drainage, scant amount of bleeding noted. Aquacel foam was applied and order to be changed every three days and PRN. On</p>	

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F 514	<p>Continued From page 168</p> <p>Summary initiated for the new Stage II area to the resident's right buttock identified on 04/28/15.</p> <p>Review of the weekly Skin Report dated 04/29/15 revealed the resident had a Stage II ulcer to the right buttock measuring 0.8 cm x 0.8 cm.</p> <p>Further review of Nurse's Notes dated 05/06/15, revealed Resident #4 had a new Stage II ulcer to the right upper posterior thigh measuring 1.5 cm x 0.5 cm, red, no odor with serosanguinous drainage.</p> <p>However, further review revealed there was no documented evidence of a Wound Care Summary initiated for the new wound identified on 05/06/15 to the resident's right upper posterior thigh.</p> <p>The weekly Skin Assessment, dated 05/08/15 revealed Resident #4 had a stage II ulcer to the buttocks; however, did not indicate which buttock or the measurement and did not indicate the resident had a pressure ulcer to the right upper posterior thigh. The Skin Assessment dated 05/15/15 did not mention the pressure ulcer to the right buttock or the right upper posterior thigh but revealed the resident had a Stage II to the coccyx which almost healed. The Skin Assessment dated 05/22/15, 05/29/15, and 06/05/15 revealed the resident had a Stage II pressure ulcer to the right buttocks and a stage II pressure ulcer to the right upper thigh; however, there was no measurements.</p> <p>Further review revealed no documented evidence of further weekly Skin Reports completed related to the Stage II ulcer to the right buttock from 04/29/15 until 05/28/15, (almost four (4) weeks</p>	F 514	

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F 514	<p>Continued From page 169</p> <p>later) when the wound was described as a right buttock stage II pressure ulcer which measured 2 cm x 1 cm with four (4), 0.2 cm x 0.2 open areas. The weekly Skin Report dated 05/28/15 also revealed the resident had a stage II pressure ulcer to the right upper posterior thigh which measured 1.5 cm x 1.5 cm with green tinged serosanguinous drainage; however, this was the first time the weekly Skin Report mentioned the pressure ulcer to the right upper thigh even though the wound was identified on 05/06/15, three (3) weeks prior.</p> <p>Review of the weekly Skin Assessment dated 06/12/15 and 06/19/15 revealed Resident #4 had a stage II pressure ulcer to the right upper thigh measuring 2 cm x 2 cm and a stage II pressure ulcer to the right buttocks measuring 2 cm x 2 cm.</p> <p>Review of the Nurse's Notes dated 06/25/15 at 0100 (1:00 AM), revealed Resident #4 had a left buttock SDTI measuring 1.3 cm x 0.6 cm purple/maroon in color.</p> <p>Further review revealed there was no documented evidence of a weekly Skin Report for Resident #4 from 05/28/15 until 06/26/15 (over three (3) weeks). Review of the weekly Skin Report dated 06/26/15, revealed the resident had stage II pressure ulcer to the right posterior thigh which measured 1 cm x 1.5 cm with serosanguinous drainage, an area to the right buttock described as stage II which measured 2 cm x 1.5 cm and an area to the left buttock described as a SDTI which measured 1.3 cm x 0.6 cm purple in color.</p> <p>Review of a WCS, dated 07/17/15, described a</p>	F 514		

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F 514	Continued From page 170 right buttock wound; however, there with no date the wound was discovered. The wound measured one (1) cm x 0.4 cm and was described as a stage II pressure area with a small amount of bloody drainage and the periwound was described as light purple in color. However, there was no documented evidence of tracking the wound per the WCS from 04/28/15 until 07/17/15 (over ten (10) weeks). There was a WCS initiated on 07/17/15 for an ulcer to the right posterior thigh which was described as measuring 0.6 cm x 0.4 cm with a pink wound base; however no stage of the ulcer was noted. Per record review this wound was identified on 05/06/15; however there was no tracking of the wound per the WCS until 07/17/15, over ten (10) weeks. Also, the WCS dated 07/17/15 identified the resident to have an area to the left buttock measuring 0.1 cm x 0.1 cm with a pink base. The weekly Skin Report dated 07/17/15 revealed Resident #4 had a pressure ulcer to the left buttock measuring 0.1 cm x 0.1 cm with no staging of the area, and stage II pressure ulcer to the right buttock measuring 1 cm x 0.4 cm, and a stage II pressure ulcer to the right posterior thigh measuring 0.6 cm x 0.4 cm. However, there was no further weekly Skin Reports noted although the resident continued to have pressure ulcers. The next WCS was dated 08/07/15, which was three (3) weeks later from the previous WCS dated 07/17/15. The WCS dated 08/07/15 for the right buttock wound revealed the resident had a 1 cm x 1 cm Stage II pressure ulcer with no drainage or odor. The next WCS related to the right posterior thigh was dated 08/07/15 when the wound was described as a stage II ulcer measuring 1 cm x cm. However, there was no	F 514		
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

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F 514	<p>Continued From page 171</p> <p>documented evidence of a WCS for this date related to the left buttock wound.</p> <p>9. Review of Resident #8's clinical record revealed the facility admitted the Resident on 05/02/14 with diagnoses of Abnormal Posture, Dysphagia Unspecified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase, Pain in Joints, Chronic Diastolic Heart Failure and Chronic Airway Obstruction.</p> <p>Review of the weekly Skin Assessments revealed an assessment on 04/09/15 with no wounds noted, redness to the groin area and a blanchable reddened area to the coccyx; however, there was no documented evidence of a WCS for this date. Continued review revealed a weekly Skin Assessment, dated 04/16/15 which noted blanchable redness to the buttocks and a small area of dry skin to the upper left buttock and redness to the groin; however, there was no documented evidence of a WCS for that date.</p> <p>Further review revealed no documented evidence of further weekly Skin Assessments nor WCSs until 06/20/15; even though review of the Nurse's Notes dated 05/06/15 revealed the resident was noted to have a 0.8 cm x 0.9 cm Stage II to the posterior upper left thigh with a 3 cm x 2 cm SDTI (Suspected Deep Tissue Injury) purple/maroon area to the distal end of the Stage II, no odor or drainage. Further review revealed the resident's coccyx had a 0.5 cm x 0.3 cm Stage II to red, no odor or drainage.</p> <p>Review of the Wound Care Summaries and weekly Skin Assessments revealed zero (0) Summaries or Assessments were completed for the entire month of May 2015 and there was no</p>	F 514		
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F 514	Continued From page 172 documented evidence the resident was placed on the weekly Skin Report, the document used for monitoring and QA, in May 2015 even though the resident was identified to have pressure ulcers. Further review of the medical record revealed there were no documented evidence of weekly Skin Assessments until 06/20/15, nine (9) weeks later and no documented evidence of Wound Care Summaries for the month of June 2015. Also, review of the weekly Skin Report, used for QA monitoring, revealed no documented evidence Resident #8 was placed on the Report until 06/20/15. Review of the weekly Skin Assessment dated 07/11/15 revealed a Stage II to the resident's left medial buttocks measured at 1 cm x 0.6 cm and the coccyx had blanchable redness; however, there was no documented evidence of a WCS per the facility's protocol. Continued review revealed there were zero (0) Wound Care Summaries completed for the entire month of July 2015. Review of the weekly Skin Assessment, dated 07/18/15 described a stage II to the left medial buttock measuring 1 cm x 0.6 cm, with the coccyx and scrotum red and blanchable; however, there was no documented evidence of a WCS per the protocol. Continued review of the weekly Skin Assessment, dated 07/31/15, revealed a stage II to the resident's left medial buttock measuring 1 cm x 0.75 cm and a stage II to the resident's right medial buttock measuring 2 cm x 2 cm; however, there was no documented evidence of a WCS for	F 514		

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F 514	Continued From page 174 were conducted on 05/06/15, 05/13/15, or 05/20/15. Review of the WCS's revealed zero (0) were completed concerning the coccyx wound from 05/01/15 until 05/27/15. On 05/27/15 there was one (1) measurement for a Stage II to the coccyx/right buttock with a description of the skin described as red and excoriated with several small open areas. However, there was no documented evidence of measurements or descriptions of the several small open areas per the facility's wound care protocol. Review of Resident #9's Physician's Orders dated 06/01/15 revealed orders for Aquacel Ag Fiber cover with DuoDerm change every three (3) days and as needed to the Stage II to right upper buttock, 2.2 cm x 1 cm. However, there was no documented evidence of a Wound Care Summary initiated and there was no entry on the weekly Skin Report for the Stage II to the right upper buttock found on 06/01/15. Continued review revealed there were no documented evidence of Wound Care Summaries for the following dates concerning the wounds found on Resident #9's coccyx/right buttock area on 06/04/15, 06/24/15, 08/30/15, 07/08/15, 07/15/15, and 07/22/15. Also, there was no documented evidence of weekly Skin Assessments completed for Resident #9 on 07/16/15, 07/23/15 and 07/30/15. Further review revealed zero (0) weekly Skin Reports, used for QA monitoring, for Resident #9 from 04/29/15 until 05/27/15 and then there were no further entries on the weekly Skin Report log	F 514			

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F 514	Continued From page 175 until 06/23/15. 11. Review of Resident #12's clinical record revealed the facility admitted the resident on 01/26/15 with diagnoses including Down's Syndrome, Abnormality of Gait, Muscle Weakness (Generalized), Difficulty in Walking, Pressure Ulcer Unspecified Site, Dysphagia Oropharyngeal Phase, Alzheimer's Disease and Sleep Apnea. Review of the Admission MDS Assessment, dated 02/02/15 revealed the facility assessed Resident #12 as being at risk for developing pressure ulcers and having a Stage III pressure ulcer measuring 3.2 cm x .9 cm. Review of Resident #12's Wound Care Summaries revealed a lower right buttock SDTI discovered on 02/04/15; however there was no documented evidence of a Wound Care Summary from 04/22/15 until 08/14/15, over three (3) months. In addition, there was no documented evidence the wound was not evaluated from 04/22/15 until 05/27/15 on the weekly Skin Report used for QA and wound tracking. Review of the weekly Skin Assessment revealed an assessment on 04/08/15 and a Wound Care Summary (WCS) dated 04/08/15 which revealed the resident had a Stage III pressure ulcer to the posterior left thigh measuring 1.8 cm x 1.9 cm x 0.4 cm with tunneling from 12 o'clock to 2 o'clock (the wound was discovered on 02/04/15, per the WCS dated 04/08/15). The next weekly Skin Assessment and Wound Care Summary was completed for this pressure	F 514			

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F 514	<p>Continued From page 176</p> <p>ulcer on 04/14/15 which described the wound as measuring 1.2 cm x 2 cm with yellow slough in the wound bed with serosanguinous drainage.</p> <p>Further review revealed a weekly Skin Assessment and WCS dated 04/22/15 which described the wound; however, there was no documented evidence of weekly Skin Assessments and Wound Care Summaries from 04/22/15 until 06/08/15, over four (4) weeks.</p> <p>Further record review revealed there was no documented evidence Resident #12's posterior upper thigh wound was evaluated from 04/29/15 until 05/27/15 on the weekly Skin Report used for QA and wound tracking.</p> <p>Review of the weekly Skin Assessment revealed an assessment on 06/08/15 which documented the wound; however, there was no documented evidence of a WCS with a description of the wound. In addition, there was no documented evidence of a weekly Skin Assessment or WCS for 06/15/15.</p> <p>Continued review revealed weekly Skin Assessments from 06/22/15 through 08/03/15; however, there was no documented evidence of the WCS for this period with descriptions of the wound.</p> <p>Review of the weekly Skin Assessment dated 08/09/15 revealed documentation of scar to the left buttock and an open area to the right buttocks with yellow drainage, measuring 2.5 cm x 3.5 cm x 0.5 cm; however, there was no documented evidence of a WCS for this date as per the facility's protocol.</p>	F 514			

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F 514	Continued From page 177 Interview with the DON on 08/12/15, 08/13/15 at 5:30 PM, 08/19/15 at 5:30 PM, revealed the documentation of Skin Assessments and Wound Care Summaries would entail measuring, staging, and describing wounds for the wound bed and the periwound area, and stating if there was drainage noted. The DON acknowledged the Wound protocol in reference to Wound Care Summaries and weekly Skin Reports was not followed for the residents if the weekly documentation was missing. Interview with the former Interim Administrator/Nurse Consultant on 08/10/15 at 3:50 PM and 08/12/15 at 3:00 PM, revealed the expectation related to documentation was for the wounds to be described, staged, and measured on the weekly Skin Assessment, the Wound Care Summary and the weekly Skin Report. According to interview, the facility still had issues with documentation; with Skin Assessments and Wound Assessments not completed weekly.	F 514			
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520	It is and was the policy of Ridgeway Nursing and Rehabilitation a facility must maintain a Quality Assessment and Assurance Committee.		

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F 520	<p>Continued From page 178 action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of Quality Assurance (QA) Audits and review of the facility's policy, it was determined the facility failed to develop and implement an effective plan of action when Quality Assurance identified a problem, in May 2015, with skin assessments not being completed weekly, and wound assessment documentation and wound monitoring forms not being completed weekly. Interview and record review revealed the QA action plan failed to implement a skin sweep of all residents to ensure all wounds were identified and documented, failed to ensure skin assessments were completed weekly and were accurate, failed to ensure appropriate descriptions/documentation of wound assessments were completed, failed to ensure wounds were tracked on the facility's Wound Care Summary form and failed to ensure all residents with wounds were listed on the Quality of Care (QOC) monitor- the Weekly Skin Report. Substandard Quality of Care with actual harm was identified related to the facility's systemic failure. This failure affected eleven (11)</p>	F 520	<p>1. Resident #1 was an 87 year old female, who was admitted to Ridgeway Nursing and Rehabilitation on March 11, 2015 following a fall in an assisted living facility (Dementia Unit), which resulted in a right intertrochanteric hip fracture. Her other diagnoses include severe dementia, hypothyroidism, thrombocytopenia (which could have be a factor in the tissue destruction) and acute on chronic blood loss anemia. It was noted at the facility that her hemoglobin dropped to 8.1 on March 13, 2015. On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral made to Wound Care Clinic. The order for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecalorie, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to</p>	
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F 520	Continued From page 179 of fourteen (14) sampled residents (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12). (Refer to F314 and F490) The findings include: Review of the facility's policy: "Quality Assurance", dated 08/01/13 revealed the purpose of the program was to ensure a standard of excellence was maintained. Policy review revealed the quality assurance program measured the level of quality services, identified specific deficiencies, and aided in the facility taking corrective action. Interview, on 08/10/15 at 3:50 PM and 08/12/15 at 3:00 PM, with the Nurse Consultant and Former Interim Administrator, who was in charge of the facility until 07/24/15, revealed in April 2015, the designated skin nurse was re-assigned to the floor and the facility made a procedural change and assigned floor nursing staff the responsibility to perform weekly skin assessments, and complete the Wound Care Summaries and the weekly QA's Weekly Skin Report form. The Weekly Skin Report was used to monitor resident wounds week to week, and the report was reviewed at the weekly Quality of Care (QOC) meeting. Interview, on 08/12/15 at 11:30 AM, with Quality Assurance Nurses: Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Nurse #2, and MDS Nurse #4 revealed they were aware of the re-assignment of resident skin/wound assessments to floor nurses, but the change had not been discussed at the weekly QOC or monthly QA committee and they were unaware of any related action plan to ensure floor nurses	F 520	be monitored (specifically for Hemoglobin level). On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a superficial sacral lesion, which improved, and a small fissure at 11 o'clock in the anorectal area. Continue same treatment - Anusol HC Suppository TID for anal fissure. On May 08, 2015 it was noted that the skin, where the Tegaderm covered around the wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Cefitin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician		

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F 520	<p>Continued From page 180 were aware of what was required.</p> <p>Continued interview, on 08/10/15 at 3:50 PM and 08/12/15 at 11:15 AM, and 3:00 PM, with the Nurse Consultant revealed she was unable to attend the QOC meeting at the end of April, but at the next QOC weekly meeting, on 05/07/15, she became aware of a problem with the lack of documentation related to the wound monitoring when she noticed the Weekly Skin Report was not submitted to the QOC meeting. She revealed they identified the problem, and put an action plan in place which included a QA audit performed by herself, the current Administrator, and the Assistant Director of Nursing (ADON), from 05/08/15 through 05/17/15, and every chart in the building was audited for current weekly wound documentation. She stated it was a paper audit and they did not perform a skin sweep and look at residents' skin with this audit. She further revealed they looked at Nurse's Notes, completeness of documentation of skin assessments, analyzed the information, and felt it was a documentation problem. She reported an in-service with nursing staff was conducted on 05/22/15 to discuss skin/wound assessments and which forms were to be used. The Nurse Consultant revealed after the in-service was completed they became aware not all residents with wounds were being included on the QA weekly skin reports.</p> <p>Continued interview, on 08/12/15 at 11:30 AM, with the ADON revealed they identified an issue of skin assessments not being documented on the QA Weekly Skin Report for all residents and she was involved in an audit of all charts. The ADON revealed she audited charts and found skin assessments were not being done or charted.</p>	F 520	<p>was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered with Aquacel AG Foam. Muli Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate and treat. On May 15, 2015, diet order changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer. New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal</p>		

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appropriately. Per interview, the nurse completed the Wound Care Summary but had not put the wound on the QA Weekly Skin Report or vice versa and not all wounds were measured, staged or described such as including the color or drainage.

Interview, on 08/12/15 at 6:20 PM, with the leaders of the QA committee: the Nurse Consultant, the current Administrator, and the Director of Nursing (DON) revealed they performed the audit and reviewed documentation of skin assessments, Wound Summaries, and the Weekly Skin Reports. Continued interview revealed they had the 05/22/15 in-service and talked about wound assessments, what was expected, and the three (3) forms to complete, as well as how to describe, measure, and stage wounds. Further interview revealed after the 05/22/15 in-service, all residents who had wounds were supposed to have been on the Weekly Skin Report and the QOC committee looked at this Report to ensure all residents with wounds were on the report.

Record review of a QA document, undated, revealed documentation showing a QA audit was completed and all charts reviewed for current weekly wound documentation. Review of the attached audit information revealed the audit period was from 05/08/15 thru 05/17/15 and included wound documentation concerns identified, but no actual skin assessments performed. The document also included a plan which had the DON audit 5% (five percent) of wounds monthly and review the QOC Weekly Skin Reports.

Continued interview, on 08/10/15 at 3:50 PM and

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saline/wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015 Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately 2cm from rectum on lower left buttocks with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage; Physician notified and order obtained to send to ER.

Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility.