

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

PRINTED: 06/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2015
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SENECA PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205		
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F 000	INITIAL COMMENTS An Abbreviated Survey was initiated on 06/04/15 and concluded on 06/05/15 to investigate KY23337 and KY23338. The Division of Health Care unsubstantiated KY23338 and substantiated KY23337 with deficiencies cited.	F 000	This plan of correction constitutes Diversicare of Seneca Place's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violation of state and federal statutes, regulations or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an abbreviated survey. F279 1. The care plans for both residents #2 and #4 have been reviewed by the DNS and Wound Care Coordinator (WCC) and updated to reflect the current status on 6/5/15. 2. Those residents with pressure ulcers have the potential to be affected. Those residents who currently have pressure ulcers have had their care plan reviewed by the MDS Coordinator, Wound Care Coordinator and DNS to assure that the skin integrity problem is addressed on the care plan with appropriate interventions. Those residents identified have had their care plans updated.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to revise two (2) care plans for Resident #2 and Resident #4 out of the seven (7) sampled residents. Resident #2 and Resident #4 had problems for the potential for	F 279		7.14.15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 7.8.2015

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

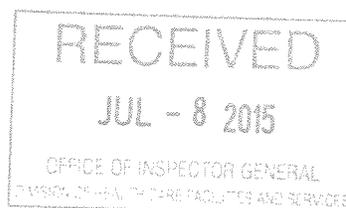
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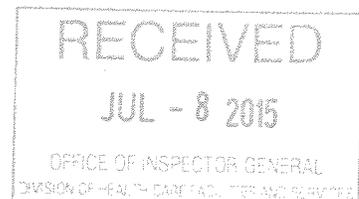
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F 279	Continued From page 1 impaired skin integrity, however the care plan was not revised after the development of a pressure ulcer. The findings included: Review of the facility's Care System Guidelines, not dated, revealed when an open area was identified a plan of care should be initiated and individual interventions for each problem should be implemented. Those interventions should also be placed on the Certified Nursing Assistant (CNA) care card. 1. Review of Resident #2's Quarterly Minimum Data Set (MDS), dated 04/29/15, revealed he/she was assessed as having an unstageable pressure ulcer. Review of the Comprehensive Care Plan, dated 02/10/15, and revised on 05/21/15 revealed an assessment for potential for impaired skin integrity was listed. One goal was for the resident to have no breakdown in skin from pressure or stasis. Another goal was for the rash from Sweets Syndrome to resolve through the next review. Review of the wound assessment report, dated 04/22/15, revealed a white blister was identified on the left heel. Review of the wound assessment report, dated 04/24/15, revealed the left heel had necrotic tissue (unstageable) pressure ulcer. Review of the care plan, dated 05/21/15, revealed a new problem for a pressure ulcer had not been addressed. 2. Review of the Annual MDS, dated 04/03/15, for Resident #4 revealed a Stage two (2) pressure sore was identified on Section M, skin conditions. Review of the wound assessment report for Resident #4, dated 04/07/15, revealed	F 279	3. On 6/8/15 the Wound Care Coordinator and the MDS nurse were educated by DNS on reviewing and updating the care plan when there is a change in condition, treatment or status of the resident. Changes in the resident overall plan of care, treatment or, physician orders are reviewed daily during the Morning Connect Meeting (Stand Up Meeting) which is attended by the Adm, DNS, MDS, Nurse Supervisor, Dietary and Social Services. During the weekly skin review meeting, attended by DNS, ADNS/Wound care Coordinator, MDS nurse and HIM (Health Information Manager) the current status of wounds, treatments and care plans will be reviewed and updated as necessary. 4. To ensure continued compliance, during the weekly skin review meeting, attended by DNS, ADNS/Wound Care Coordinator, MDS Nurse and the HIM (Health Information Manager), the current status of wounds, current treatment plans and care plans will be reviewed and updated as necessary. The results of the weekly skin review meeting will be presented to the QAPI committee meeting, attended by the Adm, Medical Director, DNS, and two or more of the following: ADNS/Wound Care Coordinator, MDS Nurse, Dietary, Social Services and Activities, monthly x3 or until the committee determines compliance has been sustained. Any additional interventions to maintain compliance will be addressed and included in the weekly review.		



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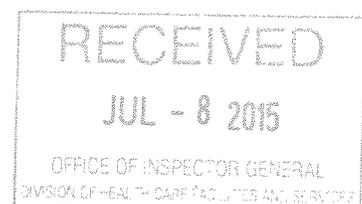
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F 279	Continued From page 2 a Stage 2 pressure ulcer was identified on the sacrum on 03/25/15. Review of Resident #4's Comprehensive Care Plan, dated 10/15/14 and revised on 04/09/15, revealed the care plan had a problem for potential for impaired skin integrity and the goal was to maintain intact skin integrity. An intervention was added on 03/27/15 to cleanse the sacral wound with normal saline and apply silver alginate and a colloid dressing; however, no new problem was added to the comprehensive care plan to reflect the newly identified pressure ulcer. Interview with the Minimum Data Set (MDS) Coordinator, on 06/05/15 at 9:00 AM, revealed Resident #2 and Resident #4 should have care plan problems to address actual impairment of skin integrity that included goals and interventions. Review of the comprehensive care plan by the MDS Coordinator revealed there were no problems of actual skin impairment on the care plans. The Coordinator stated the MDS Coordinators were the people responsible for updating the care plan to reflect an actual open area. The nurses on the unit updated the care plans with the treatments as they were changed.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			



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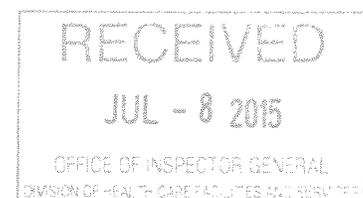
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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide adequate pain control for one (1) of seven (7) sampled residents. (Resident #2). The facility staff failed to offer as needed pain medication order by the physician when Resident #2 voiced complaints of pain. The staff further failed to assess for increased pain when the resident developed an unstageable pressure sore. The findings included: Review of the facility's Pain Management and Assessment policy and procedure, dated 08/01/12, revealed residents would be evaluated for pain on admission, quarterly, with a significant change in condition, the day of discharge and any new complaints of pain. A pain evaluation would be done with a standardized format using verbal, nonverbal and observation for proper scoring. Pain management would be added to the care plan addressing the type of pain, therapy/medications regimens and non-pharmacological interventions. Documentation would be included on the resident's pain management flow sheet. Review further revealed incident pain was pain that was typically predictable and was related to a precipitating event such as movement and wound care. Review of Resident #2's clinical record revealed the facility admitted the resident on 01/31/13 with	F 309	F309 1. The pain management program for Resident #2 has been revised to include pain medication administered 30 minutes prior to start of treatment, three times a day. Tylenol Extra Strength once daily for general discomfort and pain is continued and the resident has an additional order for Tylenol as needed for break through pain. The pain evaluation for Resident #2 has been updated to reflect the current status. The attending physician will be notified if it is noted by staff that the residents' current regimen is not controlling their pain for additional interventions. 2. By 7/13/15, those residents with pressure ulcers will have their pain evaluation updated. By 7/13/15, the DNS and ADNS/Wound Care Coordinator will have evaluated all residents with pressure ulcers during the weekly skin review including treatment plan and pain management interventions. The attending MD will be notified for any changes to the pain management plan as appropriate. By 7/13/15, licensed staff will have completed an updated pain evaluation on all residents to assure that current pain management interventions are being effective.	7/14/15	



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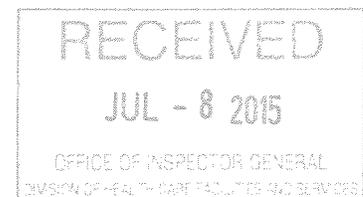
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F 309	<p>Continued From page 4</p> <p>diagnoses of Multiple Sclerosis, Sweets Syndrome, Muscle Weakness, Dementia and Osteoporosis.</p> <p>Review of the Quarterly Minimum Data Set (MDS), dated 04/29/15, revealed the resident had a Brief Interview for Mental Status (BIMS) of five (5) which meant the resident was not interviewable. Review further revealed facility assessed Resident #2 with an unstageable pressure area and there were no indications that Resident #2 had experienced pain. However, the Medication Administration Record (MAR) for April 2015 revealed the resident had expressed pain on 04/26/15. Review of the wound assessment revealed a blister on the left heel was first identified on 04/22/15. The wound assessment for 04/24/15 revealed the left heel had a necrotic unstageable pressure ulcer.</p> <p>Review of the April 2015 MAR revealed Tylenol Extra Strength five hundred (500) milligram (mg.) was to be given once a day at 8:00 AM for general discomfort/pain. Review revealed Tylenol Extra Strength 500 mg. one tablet to be given every four hours as needed for mild pain was ordered. Review of the MAR revealed no as needed Tylenol had been given. However, the resident had expressed pain on five different days, 04/01/15, 04/11/15, 04/12/15, 04/26/15, and 04/29/15 in the afternoon. Review of the Treatment Administration Record (TAR) for April 2015 revealed a treatment had been obtained for the right heel on 04/24/15 and it was to be done at 2:30 PM. A new order was obtained on 05/09/15 which revealed the treatment was to be done twice a day.</p> <p>Review of the May 2015 MAR revealed the</p>	F 309	<p>3. By 7/13/15 SDC will educate licensed staff on completing pain evaluations for residents annually, quarterly, upon readmission from acute care setting with a change in resident condition and with a noted significant change in condition. This education will also be included in the new hire orientation. M.D. will be notified when interventions are noted to be less effective or not effective for their review and direction.</p> <p>The IDCP team consisting of, MDS Coordinator, Dietary, Activities, Social Services, Nursing and the resident/responsible party, when available, will review the pain evaluations upon admission, annually and quarterly during care plan meetings to review for any change from the previous evaluation, if applicable and review the current interventions with changes as needed to manage the resident's pain level, including non-pharmacological interventions. Care plans will be updated at this time, by the MDS Coordinator, to reflect current interventions.</p> <p>The DNS will audit the pain evaluations and care plans for 5 residents weekly, reviewing for current evaluation and appropriate interventions being included on the care plan x 4 months to monitor continued compliance. Any immediate actions required will be reviewed with the licensed nurse completing the evaluation by the DNS.</p>



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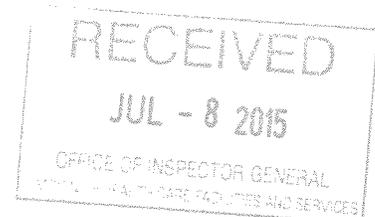
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F 309	<p>Continued From page 5</p> <p>resident continued with the routine Tylenol and the as needed Tylenol. Review also revealed the resident had received the as needed Tylenol on 05/27/15 at 8:42 PM and 05/31/15 at 5:52 PM. Review of the MAR revealed the resident had expressed pain on five days, 05/04/15, 05/05/15 at 2:30 PM, 05/15/15 at 2:30 PM, 05/19/15 at 10:30 PM and 05/29/15 at 2:30 PM.; however, there was no evidence the as needed Tylenol had been given.</p> <p>Review of the June 2015 MAR revealed Resident #2 continued to receive Tylenol Extra Strength routinely and Tylenol as needed. An order, dated 06/01/15, for Ultram fifty (50) mg. was to be given three times a day as needed was obtained. The MAR revealed the resident received one dose on 06/01/15, two doses on 06/02/15 and one dose on 06/03/15. On 06/03/15 an order was obtained for Tramadol 50 mg. three times a day routinely. One tab was to be given one half hour before wound dressing changes at 6:00 AM and 2:00 PM and one tab at 8:00 PM. Review of the MAR revealed the resident expressed pain on 06/02/15, 06/03/15, and 06/04/15 at 2:30 PM.</p> <p>Observation of Resident #2, on 06/04/15 at 1:50 PM, revealed LPN #4 was doing the treatment to the left heel and during that treatment the resident was grimacing and moving. At one point the resident yelled out, stop doing that. Interview with LPN #4 revealed Tramadol had been given to the resident prior to the treatment. Observation further revealed the resident continued to express pain even though Tramadol and the routine Tylenol had been administered prior to treatment.</p>	F 309	<p>4. To ensure continued compliance, the IDCP team, consisting of the MDS Coordinator, Dietary, Activities, Social Services, Nursing and the Resident/Responsible Party when available to attend, will continue to review the pain evaluation upon admission, annually and quarterly during care plan review for any change in the resident's pain status/level. Also reviewing the care planned interventions for efficacy. The tracking log and results of the DNS review will be presented to the QAPI committee meeting, which is attended by: Adm, Medical Director, DNS, and at least 2 of the following: ADNS/Wound Care Coordinator, MDS Nurse, Dietary, Social Services and Activities, monthly x3 or until the committee determines that compliance has been sustained. Any further interventions or suggestions made during the monthly QAPI meeting will be implemented to assist in maintaining continued compliance.</p>		



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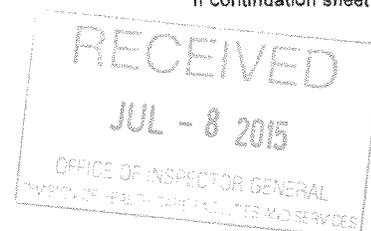
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F 309	Continued From page 6 Interview with the Director of Nursing (DON), on 06/05/15 at 11:30 AM, revealed Resident #2 did not receive the as needed Tylenol for pain in April and May, even though it was ordered, and the resident expressed pain.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure that one (1) of seven (7) sampled residents, (Resident #2) received necessary treatment and services to promote healing. The facility assessed Resident #2 as having a blister area on the left heel on 04/22/15. Two days later the area was noted as being an unstageable pressure ulcer. The findings included: Review of the facility's Care System Guideline policy, not dated, for skin care revealed when an open area was identified a care plan should be initiated and individual interventions for each problem should be established. The policy further	F 314	F314 1. For Resident # 2, both the physician and POA were notified on 4/22/15 when the blister was first identified. The attending physician was notified on 4/24/15 when a change of the left heel was noted and a treatment was ordered. The resident has had a specific treatment order for the left heel since 4/24/15. The resident has recently been evaluated by the centers in-house Wound Care Physician on 5/29, 6/5, 6/12, 6/18 and will continue until wound resolution.. Following each of these visits, the POA has been called with progress report. Resident #2 is also being followed at the wound care clinic with appointments on 6/11 and 6/18. Also an appointment with a vascular podiatrist on 6/8/15. 2. Those residents with complicated pressure ulcers/wounds are reviewed weekly by the DNS, ADNS/Wound Care Coordinator and the centers Wound Care Physician. Any additional interventions, recommendations or treatment changes made by the Wound Care Physician are included on the resident care plan and the POA is made aware of any change by the center staff. The Wound Care Physician makes weekly rounds at the center.	7/14/15	



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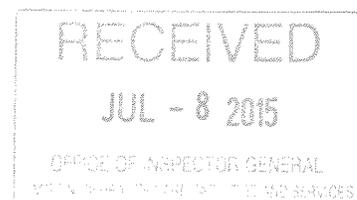
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F 314	<p>Continued From page 7</p> <p>revealed resident specific interventions should be implemented immediately, including treatments as ordered.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident on 01/31/13 with diagnoses of Multiple Sclerosis, Sweets Syndrome, Muscle Weakness, Dementia and Osteoporosis.</p> <p>Review of the Annual Minimum Data Set (MDS), dated 02/05/15, revealed the facility assessed Resident #2 as not having any pressure ulcer. Review of the Quarterly MDS, dated 04/29/15, revealed the resident had developed an unstageable pressure ulcer to the left heel. Review of the comprehensive care plan, revised on 05/21/15, revealed the facility assessed the resident as being at risk for skin breakdown, but no care plan had been initiated for an actual pressure sore that was identified on 04/22/15.</p> <p>Review of the Departmental Notes, dated 04/22/15, revealed the resident had developed a 5 centimeter (cm) x 2 cm white fluid-filled blister to the bottom of the left heel. The resident's heels were to be off the cushion and no shoes or socks were to be used until evaluated by the wound nurse. The family and MD were notified. However, the Resident Incident Report, dated 04/22/15, revealed the physician was called at 10:00 PM, but there was no time as to when the physician responded. There was no documentation that a treatment order had been obtained. However the wound nurse was to be consulted. It was documented the family was notified, on 04/22/15 at 10:10 PM, and they responded at 10:10 PM. Developmental Notes for 04/23/05 revealed no shoes had been worn that</p>	F 314	<p>3. By 7/13/15 the SDC will educate licensed staff on notifying the attending physician for any change noted in the residents' skin integrity and POA notification. During the weekly skin review meeting, attended by DNS, ADNS/Wound Care Coordinator, MDS nurse and HIM (Health Information Manager) the current status of wounds, treatments, care plans and the Wound Care Physicians progress notes will be reviewed to assist in maintaining continued compliance.</p> <p>4. The DNS, ADNS/Wound Care Coordinator, MDS Nurse and HIM(Health Information Manager) participate in the weekly skin review meeting that reviews the current status of wounds, current treatment plans, care plan interventions and the Wound Care Physicians progress notes to ensure that skin issues are being monitored and to maintain compliance. The results of the weekly skin review meeting will be presented to the QAPI committee meeting, attended by the Adm, Medical Director, DNS, and at least 2 of the following: ADNS/Wound Care Coordinator, MDS Nurse, Dietary, Social Services and Activities, monthly x3 or until the committee determines that compliance has been sustained. Any additional interventions to maintain compliance will be addressed and included in the weekly review.</p>		



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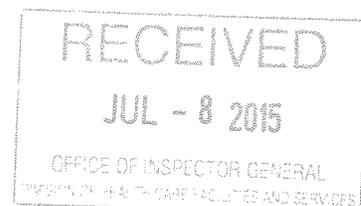
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F 314	Continued From page 8 day secondary to a fluid filled blister and they were awaiting the wound nurse consult. Review of the Wound Assessment Report, dated 04/22/15, completed by the nurse on the hall, revealed a 5 cm x 2 cm white blister was assessed on the left bottom heel. Review of the Wound Assessment Report, dated 04/24/15, done two days later by the Assistant Director of Nursing (ADON)/Wound Nurse, revealed the pressure ulcer to the left bottom of heel was now unstageable due to suspected deep tissue injury and the dimensions were 3 cm x 7 cm. The notes portion of the assessment revealed the left heel was a necrotic tissue (unstageable) pressure ulcer and had received a status of not healed. The house wound physician was notified on 04/24/15 and a treatment was obtained. The treatment portion of the assessment revealed the right heel was to be cleansed with saline and covered liberally with Bactroban two (2) percent (%) and wrapped twice a day. However, review of the wound key revealed the left heel was the affected heel, not the right. Review of the April 2015 TAR revealed the treatment order continued to be to the right heel. However, on the May 2015 TAR the treatment had been corrected to reflect the left heel. Review of the May TAR revealed an order for Bactroban ointment was to be continued on 05/01/15 and was to be applied to the left heel twice a day and it was to be covered with a dry gauze. The treatment was to be done at 2:30 PM and 10:30 PM. Review of the May TAR revealed a new order for Santyl ointment was obtained on 05/09/15. The May TAR continued to revealed the left heel was to be cleansed with normal saline and Santyl was to be applied to the wound base.	F 314			



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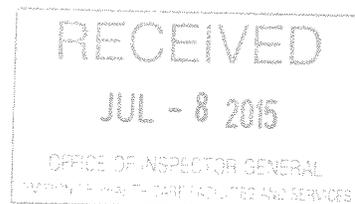
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F 314	<p>Continued From page 9</p> <p>The wound was to be covered with a normal saline wet gauze and secured with kerlix and it was to be done twice a day. Review of the TAR revealed the treatment was completed at 2:30 PM. and 10:30 PM. Review of the TAR revealed another order was obtained on May 23, 2015 to clean the left heel with normal saline and apply Betadine moist gauze/wrap with a kerlix and change twice a day.</p> <p>Review of the wound assessment, dated 05/22/15, revealed the pressure ulcer had deteriorated. The wound had a light amount of fresh blood drainage noted with no odor. The wound bed was 75% moist, black eschar, 25% adherent, yellow slough with granulation. Review of the departmental notes for 05/29/15 revealed the resident was sent to the emergency room due to the left heel being necrotic and cellulitic. The resident was transported back to the facility and was to go to the wound care center for evaluation.</p> <p>Observation of Resident #2, on 06/04/15 at 1:15 PM, revealed the resident was sitting up in the high back wheelchair with a padded foot on the legs of the wheelchair and a blue boot on the left foot. The resident was unable to say his/her name. Observation of Resident #2, on 06/04/15 at 1:50 PM, revealed LPN #4 was doing the treatment to the left heel and during that treatment the resident was grimacing and moving. At one point the resident yelled out, stop doing that. Interview with LPN #4 revealed Tramadol had been given to the resident prior to the treatment. Observation further revealed the resident continued to express pain even though the Tramadol and the routine Tylenol had been</p>	F 314			



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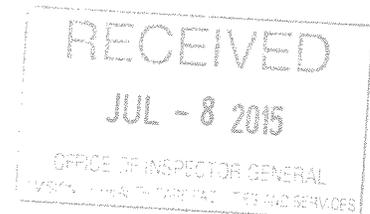
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F 314	<p>Continued From page 10 administered prior to treatment.</p> <p>Interview with the Certified Nursing Assistant (CNA) #3, on 06/04/15 at 2:35 PM, revealed she had taken care of the resident numerous times. The CNA stated she had noticed a flaky area on the left heel somewhere around the end of March or the first part of April and reported it to the nurse. The resident started utilizing a boot at that time. The CNA stated the area turned into a purplish red blister.</p> <p>Interview with the DON, on 06/05/15 at 11:45 AM, revealed it was reported to the nurse on 04/22/15 that the resident had a blister on his/her left heel. The resident was assessed for the blister and the physician and the Wound Nurse were notified on 04/22/15. The Wound Nurse saw the resident on 04/24/15 and the wound physician was notified. A treatment was obtained at this time to cleanse the left heel with saline and apply Bactroban twice a day and wrap. The DON stated she did not see where a treatment had been ordered previously until the wound physician ordered a treatment. The DON revealed the resident had Sweets Syndrome and got lots of wounds and blisters as his/her skin was fragile. The DON stated the resident may have scooted their feet and caused friction and the pressure ulcer did worsen substantially between 04/22/15 and 05/28/15.</p> <p>Review of the wound assessment, dated 04/24/15, revealed the wound to the left heel went from a white blister on 04/22/15 to a necrotic tissue (unstageable) pressure ulcer on 04/24/15. No treatment was obtained until 04/24/15 when the wound nurse contacted the wound physician.</p>	F 314			



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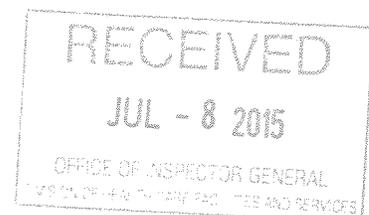
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F 441 F 441 SS=D	Continued From page 11 483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	F441 1. On 6/5/15 and ongoing, licensed staff observed Resident 2 and unsampled Resident A and confirmed that there were no negative outcomes to Resident #2 following the nurse dropping the towel on the floor nor for unsampled Resident A following the nurse failing to change gloves. The charts of both residents were reviewed by the DNS on 6/30/15 with neither resident exhibiting signs of infection and neither being treated with antibiotics for infections since the initial observations and until that time. On 6/5/15 the DNS re-educated the nurses involved on infection control practices during treatments and hand hygiene; and they and other licensed staff will be re-educated on dressing change infection control practices during treatments and hand hygiene by the SDC on or before 7/13/15. 2. Residents that have current treatment orders for wound care may have the possibility of being effected. By 7/13/15, the SDC will re-educate licensed staff on dressing change technique and infection control practices and hand hygiene. This education will also be included in the new hire orientation. 3. The SDC, ADNS and/or the Nurse Supervisor will continue to monitor staff compliance by observing treatment technique with licensed	7.14.15



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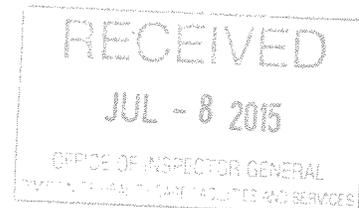
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F 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to maintain infection control practices for one (1) of one (1) unsampled residents, (Unsampled Resident A), During the wound treatment for Resident #2 the nurse dropped a towel on the floor that had been under the resident's heel. The nurse then scooted the towel across the floor with his foot to the bathroom and put it in a plastic bag. During the wound treatment for Unsampled Resident A, the nurse did not change gloves when going from one wound site to another. The findings included: Review of the facility's Infection Control Policy and Procedures, dated August 2014, revealed the objectives were to maintain a safe and sanitary environment for personnel and residents. Review of the policy and procedure Wound Care Manual, dated 03/01/13, for a dressing change revealed the staff were to wash their hands and apply gloves prior to the treatment. After the soiled dressing was changed the staff should remove the soiled gloves and wash their hands. New gloves were to be applied before application of the new dressing. Review of Resident #2's physician orders revealed the wound to the left heel was to be cleaned with normal saline and then a Betadine moist gauze was to be applied. The wound was to	F 441	nurses using "Clean Dressing Change-Care Audit" and the "Hand Hygiene-Care Audit" 3x weekly x 8 weeks, followed by 2x weekly x 4 weeks. The licensed staff being observed will be provided immediate 1:1 education if needed for any issues noted during the observation, to maintain continued compliance. 4. To ensure continued compliance, the Staff Development Coordinator will use the 'Clean Dressing Change-Care Audit' and the 'Hand Hygiene -Care Audit' during new hire orientation and annually for licensed staff. The results of the care audit observations for hand hygiene and clean dressing changes for the licensed staff will be reviewed by the DNS and presented to the QAPI committee meeting, attended by the Adm, Medical Director, DNS, and at least 2 of the following: ADNS/Wound Care Coordinator, MDS Nurse, Dietary, Social Services and Activities, monthly x3 or until the committee determines that compliance has been sustained. Any further interventions or suggestions made during the monthly QAPI meeting will be implemented to assist in maintaining continued compliance.	



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F 441	<p>Continued From page 13 be wrapped with Kerlix.</p> <p>Observation, on 06/04/15 at 2:05 PM, of Resident #2 revealed LPN #4 had placed a towel under the residents heel prior to doing the wound treatment. Observation during the wound treatment revealed the heel was in contact with the towel and the solution used in the treatment had drained on the towel. Upon completion of the treatment the nurse removed the towel and threw it on the floor. The nurse took his foot and scooted the towel on the floor, into the bathroom, where he picked it up and put it in the plastic container.</p> <p>Interview with the LPN #4, on 06/04/15 at 2:30 PM, revealed the floor was the dirtiest part of the room and the only other option was to put the towel on the bedside table.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/05/15 at 2:32 PM, revealed putting the towel on the floor imposed infection control problems. If a bug was in the wound it would be introduced to the floor and increase the risk for infection to others. He stated it was not proper to scoot the towel across the floor.</p> <p>Interview with the Director of Nursing (DON), on 06/05/15 at 11:35 AM, revealed the towel should have been bagged in dirty linens. She further stated it was not proper technique to throw the dirty towel on the floor.</p> <p>Observation of Unsampled Resident A, on 06/05/15 at 10:20 AM, during the wound treatment, revealed LPN #3 had applied gloves to remove the dressing from the left foot. After partially removing the dressing the nurse touched her keys and scissors and went out of the room</p>	F 441		



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F 441	Continued From page 14 to the treatment cart and got a new gauze. The nurse came back into the room and took the gauze off the wound and put it in the gloved hand and threw it away. The nurse helped the Certified Nursing Assistant (CNA) transfer the resident to the bed with the help of a lift. The nurse went out of the room without washing her hands. The nurse went to the medicine cart and placed a pain pill into a cup for Unsampled Resident A. The nurse used sanitizer on her hands after putting the medication into the cup. The nurse went back to the room and gave the resident the medication and proceeded to do the treatment. She put gloves on and soaked the left knee in warm water. The nurse unwrapped the gauze to a different wound on the left foot and threw the old bandage into the garbage can. The nurse applied normal saline to the gauze on the wound to loosen it. The nurse then removed the bandage to the left foot without changing gloves or washing her hands. The nurse applied a Hibiclens soak to the left knee without changing gloves. Interview with the nurse, on 06/05/15 at 10:45 AM, revealed she had forgotten to change the gloves and that put the resident at risk for contamination from one wound to the other. Interview with the DON, on 06/05/15 at 11:35 AM, revealed the proper technique for changing a dressing was to wash your hands, put on gloves, remove the dressing and discard it. The DON stated the staff should change gloves before they go to another wound and wash their hands. She further stated it was a risk for infection to go to the medication cart without washing your hands or sanitizing them before getting medication from the cart.	F 441			

