

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

PRINTED: 05/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
(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
F 000	INITIAL COMMENTS  Abbreviated surveys KY00016059 and KY00016140 were initiated on 04/06/11 and concluded on 04/08/11. KY00016140 was determined to be substantiated and deficiencies were cited. KY00016059 was determined substantiated with no regulatory findings. After a state agency review the investigation was reopened on 04/26/11 and concluded on 04/27/11 with no additional finding.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged, or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy for care plans, it was determined the facility failed to provide care in accordance with the written plan of care for three (3) of five (5) sampled residents. 1. The Care Plan for Resident #1 detailed an intervention to 'perform treatment to opened area as ordered,' to address skin breakdown. Wound care to the pressure ulcer was not initiated as completed on the Treatment Administration Record (TAR). 2. The Care Plan for Resident #2 detailed an intervention to 'treat open area as ordered,' to address skin breakdown to coccyx and detailed an intervention to provide a Roho seat cushion when up in the geri-chair. Daily wound care for Resident #2 was initiated as completed by on two occasions, but it was found the wound care was	F 282	F-282 Following Plan of Care  I. Resident #1 is no longer in the facility. Resident #2 is utilizing the chair cushion as per plan of care and is receiving treatment as per plan of care. Resident #4's treatments are being signed off when completed as per plan of care.  II. Resident treatment records and care plans have been reviewed. Residents with chair cushions as interventions have them in place. Nurses are completing treatments and initialing on the TAR (Treatment Administration Record) after completion.  III. Nursing staff has been re-educated on reviewing and following resident care plan interventions and use of skin prevention devices. Licensed nurses have been re-educated on completion of treatments and documentation  continued	

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

*A. Ronald Beal*

TITLE

*X. Administrator*

(X6) DATE

*5-16-2011*

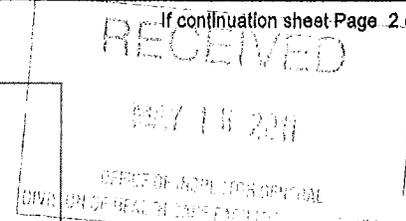
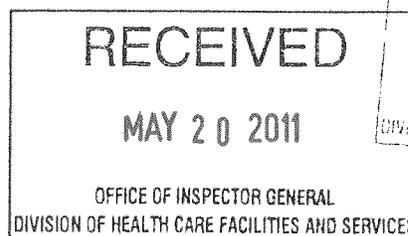
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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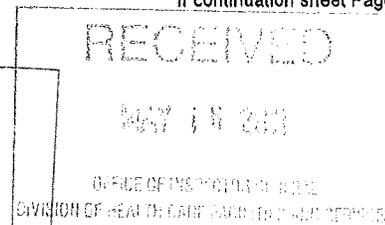
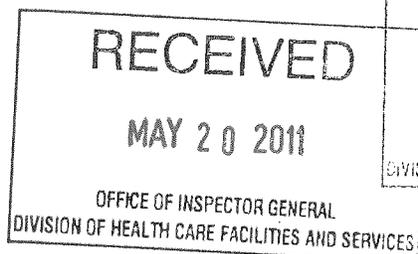
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F 282	Continued From page 1 not provided. 3. The Care Plan for Resident #4 detailed an intervention to 'treat open area as ordered,' to address skin breakdown of the right buttock, wound care was not performed for Resident #4 on two days. Wound care was not documented for Resident #4 for two shifts after a physician order increased it to twice daily.  The findings include:  Record review of the facility policy for Care Plans revealed the facility had a list of recommendations with no date, rather than an a policy for developing a Care Plan. The recommendations suggested the use of the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS), review by the Interdisciplinary team, observations available in the Matrix (computerized program utilized by the facility), and care conferences to complete the resident assessment and care planning process.  1. Closed record for Resident #1 revealed the TAR and Nurse's Notes indicated a Weekly Skin Assessment was completed on 10/14/10; however, no other Weekly Skin Assessments were completed until the stage IV pressure ulcer was documented on 01/28/11. A physician order dated 01/18/11, for daily wound care to a stage IV pressure ulcer. Record review of the Care Plan for Resident #1 detailed an Intervention to 'observe skin daily with care; skin assessment by licensed nurse, dated 12/02/10 and an intervention to 'perform treatment to opened area as ordered,' to address skin breakdown and was dated 01/28/11. Review of the Treatment Administration Record (TAR) revealed wound care was not documented as completed, and	F 282	IV. The Director of Nursing and/or Designee will complete random audits of care plan interventions, treatment records and wound dressings for residents with wounds 4 times a week for 3 weeks, weekly for 2 months, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	5/12/2011



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F 282	<p>Continued From page 2</p> <p>review of Nurse's Notes did not reveal wound care was performed on 01/29/11, 02/05/11, or 02/13/11.</p> <p>Interview, on 04/26/11 at 1:25pm, with the MDS Coordinator revealed that the Unit Managers are responsible for initiating Care Plans, then the MDS Coordinator reviews the Care Plan for accuracy.</p> <p>Interview, on 04/26/11 at 3:25pm, with LPN #5 revealed she did not recall how often she refers to the Care Plan when providing resident care and said she was confused about the purpose of the Care Plan.</p> <p>Interview, on 04/26/11 at 3:50pm, with LPN #6 revealed that when a CNA informed her on 01/28/11 of an open area on the coccyx of Resident #1, she looked for the Weekly Skin Assessment which was due to be completed on the day before and could not find it in the chart. LPN #6 stated that she did not often review Care Plans for the residents because she relied on physician orders and shift report to obtain the most current information.</p> <p>Interview on 04/27/11 at 1:40pm with the DON revealed there are no facility guidelines to suggest how often staff should review the care plan, and said all staff are responsible for initiating and updating the Care Plans. The DON said she audits the TAR to ensure the treatments are completed as ordered as part of the Quality Assessment and Assurance Program. The DON stated she thought some of the missing documentation of wound care treatments for Resident #1 were the result of nurses who</p>	F 282			



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F 282	<p>Continued From page 3</p> <p>neglected to initial the treatment as completed, rather than the treatment having not been completed.</p> <p>2. Review of the record for Resident #2 revealed the Care Plan for Resident #2 detailed an intervention to 'treat open area as ordered,' to address skin breakdown to coccyx with a start date of 03/02/10. The Care Plan also detailed an intervention to provide a Roho seat cushion when the resident sat in the geri-chair, with a start date of 06/07/10. A physician order dated 08/13/10 indicated daily wound care of a stage IV pressure ulcer on the coccyx. Review of the TAR revealed that daily wound care for Resident #2 was initialed as completed by LPN #4 on 04/08/11 and LPN #5 on 04/07/11.</p> <p>Review of the treatment record revealed LPN #5 initialed that the wound care to the coccyx was completed on 04/07/11 and LPN #4 had initialed wound care completion for 04/08/11. However, on 04/08/11 at 10:20am, wound care observation performed by the WCN, revealed the coccyx dressing was intact and dated 04/06/11. The WCN said she performed the wound care and dressing change on 04/06/11, and acknowledged the dressing wasn't changed on 04/07/11.</p> <p>Interview on 04/26/11 at 3:25pm with LPN #5 revealed that the TAR was initialed on 04/07/11 before the treatment was completed. LPN #5 became busy near the end of the shift on that date, and forgot to complete the treatment. LPN #5 said she did not remember being told during orientation to initial the TAR only after the treatment is completed. LPN #5 stated it could become confusing when treatments are initialed before being performed; as it would be difficult to</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>determine which treatments remain to be completed.</p> <p>Interview on 04/08/11 at 10:55am with LPN #4 revealed that she didn't know the WCN was going to do wound care for Resident #2, and she had already initialed the treatment as completed. LPN #4 stated she was trained to initial the treatments after the care is provided, but sometimes she signs them off early to ensure all treatments are signed. She avoids confusion by keeping a handwritten note of treatments to be completed during the shift, but admits it could become confusing when her note does not correspond with the initialed treatments on the TAR.</p> <p>Observation, on 04/06/11 at 3:15pm, revealed Resident #2 sitting in a geri-chair with no Roho cushion in place.</p> <p>Interview, on 04/06/11 at 3:30pm, with the Wound Care Nurse (WCN) revealed that the WCN was not aware Resident #2 had an order for the use of a Roho seat cushion when seated in the geri-chair. The WCN reviewed the Care Plan intervention for use of a Roho seat cushion for Resident #2 and stated the cushion would be found in the resident room. The WCN was unable to locate the Roho seat cushion.</p> <p>Interview, on 04/06/11 at 3:45pm, with the House Manager revealed that she was unaware Resident #2 had an order for a Roho seat cushion when seated in the geri-chair, and she did not know the location of the Roho seat cushion.</p>	F 282		

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F 282	<p>Continued From page 5</p> <p>Interview, on 04/06/11 at 3:45pm, with the House Manager revealed that she was unaware Resident #2 had an order for a Roho seat cushion when seated in the geri-chair, and she did not know the location of the Roho seat cushion.</p> <p>Interview, on 04/27/11 at 9:15am, with CNA #7 revealed that she was aware of a Care Plan Intervention to use a Roho seat cushion when Resident #2 was seated in a geri-chair, and said the Roho seat cushion had not been used for the last month.</p> <p>Interview on 04/27/11 at 1:40pm with the DON revealed that staff was unable to find the Roho seat cushion for Resident #2 on 04/06/11 and a new seat cushion was ordered. The DON said staff was aware of the Care Plan Intervention for use of the Roho seat cushion, but did not know how long the seat cushion had been missing.</p> <p>3. Review of the record for Resident #4, revealed a physician order dated 03/21/11 for once daily wound care of a stage IV pressure ulcer. Review of the Care Plan for Resident #4 detailed an intervention to 'treat open area as ordered,' to address skin breakdown of the right buttock, with a start date of 03/21/11. A physician order dated 04/04/11 instructed the nursing staff to increase the wound care to twice daily. Review of the TAR revealed the wound care treatment was not initialed as completed on 03/31/11, 04/01/11, 04/15/11 (first shift), and 04/19/11 (second shift).</p> <p>Interview, on 04/08/11 at 2:40pm, with LPN #3 revealed she told the second shift nurse in shift report that the treatment needed to be completed</p>	F 282		

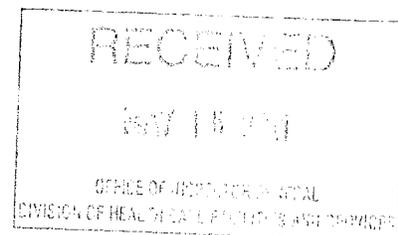
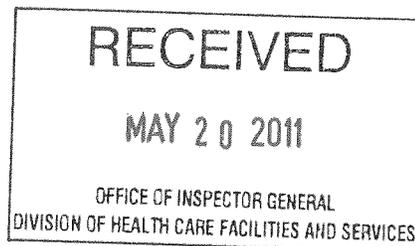
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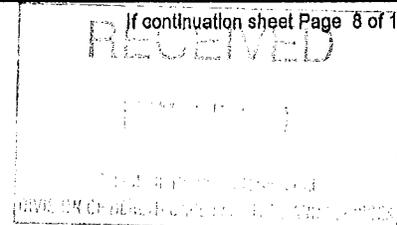
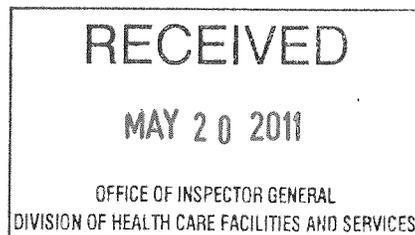
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F 282	Continued From page 6 for Resident #4 on 03/31/11 and 04/01/11 during second shift. LPN #3 said she did not document in the Nurse's Notes that she reported to the second shift nurse the wound care had not been completed for Resident #4 on 03/31/11 and 04/01/11. Facility staff were not able to provide documentation to confirm that the wound care was completed on second shift.  Interview, on 04/08/11 at 2:20pm, with the DON revealed that it would not be appropriate to neglect a dressing change due to a resident's busy therapy schedule. The DON said when a resident is not available for a wound care treatment during first shift, it is the facility's expectation that the treatment would be completed during a later shift. The DON was not aware that the wound treatment to a stage IV ulcer for Resident #4 was not completed for two (2) consecutive days (03/31/11 and 04/01/11). Neglected wound care treatments would have a negative effect on wound healing. Continued interview on 04/27/11 at 1:40pm with the DON revealed she was unaware that wound care was not provided on 04/15/11 and 04/19/11.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the 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.	F 314	F-314 Pressure Wounds  I. Residents #1 is no longer in the facility. Resident #2 is receiving wound care treatments as ordered by the physician and per plan of care. Resident #2's treatments are being signed off by the nurse after completion of the treatment. Resident #2 is utilizing the chair cushion as per plan of care. Resident #4 is receiving wound treatments as per physician orders and plan of care.  continued	



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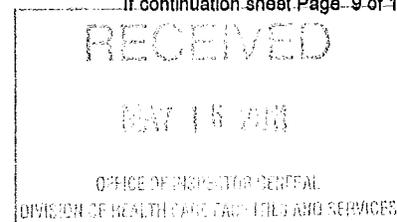
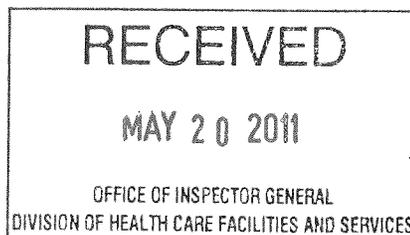
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F 314	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the record and the Skin Care Assessment Policy. It was determined the facility failed to follow the skin care assessment policy, failed to complete physician ordered wound care treatments, failed to accurately document in the medical record pressure/skin assessments and completion of treatments for three (3) of five (5) sampled residents (Resident's #1, #2, and #4). On 01/28/11, the facility identified Resident #1 as having a stage IV pressure ulcer. The facility failed to conduct weekly skin assessments since 10/14/10. The facility failed to accurately document wound treatments on the Treatment Administration Record (TAR) for Resident #2. The facility failed to document wound treatments for two days for Resident #4's stage IV pressure area in the Nurse's Notes or on the TAR and failed to document wound treatments in the Nurse's Notes or on the TAR for two shifts after the physician ordered it increased to twice a day.  The findings include:  Record review of the Skin Care Assessment Policy (undated), detailed that upon admission, a head-to-toe skin assessment should be completed by a licensed professional nurse, then weekly as needed. The Pressure Ulcer Risk Assessment should be done upon admission, then quarterly to coincide with the Minimum Data Set (MDS) assessment.  Interview on 04/08/11 at 2:20pm with the DON revealed that staff are trained to perform a	F 314	II. Residents with wound treatments have been assessed and are receiving treatments as ordered by the physician and as per plan of care. Treatments are being initiated after completion. Wound prevention devices have been reviewed and are being used as per plan of care.  III. Licensed nurses have been re-educated on completion of wound treatments, following care plan interventions, initialing wound treatments after completion, physical assessment of wounds and documentation of skin assessments. Nursing staff has been re-educated on wound prevention measures.  IV. The Director of Nursing and/or Designee will complete random audits of treatment records, wound prevention devices, wound dressings and skin assessment documentation 4 times a week for 3 weeks, weekly for 2 months, then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.  V. Completion Date:	5/12/2011



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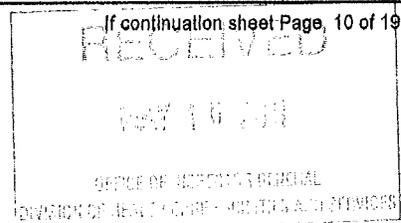
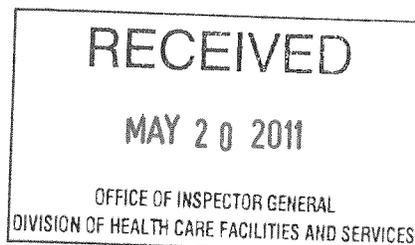
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F 314	<p>Continued From page 8</p> <p>treatment and then initial the treatment as completed on the TAR. The DON said when a resident is not available for a wound care treatment during first shift, it is the facility's expectation that the treatment would be completed during a later shift.</p> <p>1. Closed record review revealed the facility admitted Resident #1 on 03/26/07 with diagnoses of Traumatic Brain Injury, Cerebrovascular accident (stroke), and Immobility Syndrome. The facility completed a Pressure Ulcer Risk Assessment on 03/26/07 which detailed Resident #1 was at high risk for developing a pressure ulcer. The Minimum Data Set (MDS) admission assessment dated 04/09/07 revealed Resident #1 was admitted with no wounds, was totally dependent on staff for transfers and mobility, required a two person assist to transfer, and demonstrated a cognitive ability as moderately impaired. Review of the treatment record and Nurse's notes revealed on 10/14/10 weekly skin assessment documentation detailed, "no new skin issues." The Pressure Ulcer Risk Assessment dated 11/24/10 indicated Resident #1 was at high risk for pressure ulcer, with a score of twelve (12) on a scale of twenty-four (24). The MDS admission assessment dated 12/02/11, revealed Resident #1 was at risk to develop pressure ulcers, and did not have any unhealed pressure ulcers.</p> <p>Interview on 04/27/11 at 10:30am with LPN #2 revealed that she completed Weekly Skin Assessments for Resident #1, and verified that she initialed the assessments as completed on the TAR for 12/02/10, 12/09/10, and 12/23/10. LPN #2 stated it was her practice to document</p>	F 314		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
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F 314	<p>Continued From page 9</p> <p>Weekly Skin Assessments on the TAR Treatment Notes Sheet. LPN #2 said she remembered performing the Weekly Skin Assessments for Resident #1; however, review of the (TAR) Treatment Notes Sheets were not completed during the month of December, 2010, and review of the Weekly Skin Assessments for 12/02/10, 12/09/10, and 12/23/10 were not documented in the Nurse's Notes.</p> <p>Interview on 04/26/11 at 2:55pm with CNA #5 revealed that she observed a red area on the coccyx and reported the redness to a LPN in mid-December. CNA #5 could not remember the LPN she reported to, but was told by that LPN that the redness had been previously discovered and documented. CNA #5 said she continued to observe the red area on the coccyx through December and into the month of January until she saw a dressing on the coccyx.</p> <p>Interview on 04/26/11 at 2:45pm, with CNA #4, revealed he was responsible for providing showers and incontinent care for Resident #1. CNA #4 said while providing care for Resident #1, he found a red-purple area on the coccyx which he said "looked like a bruise." CNA #4 said he thought this could lead to a skin ulcer, and reported the finding to the LPN, but was unable to remember the exact date the wound was located or which LPN he advised. CNA #4 said he did not notice any change in treatment for Resident #1, until he noticed a dressing on the coccyx and was told that Resident #1 was receiving wound care to the area.</p> <p>There was no evidence the facility had identified through CNA report or skin assessment that</p>	F 314		



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F 314	<p>Continued From page 10</p> <p>Resident #1 had developed an area to the coccyx. However, interview with LPN #6, on 04/26/11 at 3:50pm, revealed a CNA told her Resident #1 had an open wound of the coccyx on 01/28/11 at 5:00am. LPN #6 said she was surprised to find an open wound, and said, "I couldn't believe this wasn't found earlier." LPN #6 said after observing the wound, she left a message for the WCN on the 24 hour report, and then looked for the last Weekly Skin Assessment which she could not find.</p> <p>Review of the Nurse's Notes for Resident #1, revealed the Wound Care Nurse (WCN) documented a stage IV pressure ulcer of the coccyx on 01/28/11. The stage IV pressure ulcer was described in the Nurse's Notes as, "coccyx to left buttock-stage IV-3.9cm long x 8.4cm wide with area of black eschar 2.5cm long x 3.8cm wide, rest of wound bed is dark red in color with small amount of S/A drainage and slight odor," which was documented on 01/28/11. Review of the WCN wound assessment dated 02/18/11 revealed, "coccyx-stage IV-6cm long x 9cm wide-thick softening brown/dark yellow eschar covered," with large amount of brown drainage and foul odor, wound culture results were reported to MD, awaiting an order for antibiotic, and increased frequency of wound care to twice daily due to increased drainage.</p> <p>Interview with the Wound Care Nurse (WCN) on 04/07/11 at 10:45am, revealed Resident #1 was identified by the facility to be at risk for pressure ulcers. The WCN said Resident #1 was on a low air-loss mattress, and was difficult to keep positioned off of the back. The WCN said on 01/28/11, she was notified by a LPN that</p>	F 314			

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F 314	Continued From page 11 Resident #1 had a wound on the coccyx. The WCN assessed the wound and documented the wound in the Nurse's Notes on 01/28/11. The WCN said her next day of work was 02/02/11, when she completed the wound assessment, she found the wound "much worse" with the presence of slough and odor. The WCN stated on the weekly wound assessments she performed, the pressure ulcer developed a foul odor and had more drainage, and that the wound was cultured, and an IV antibiotic was ordered for Resident #1. The WCN stated that Resident #1 was transferred to the hospital in February, and did not return to the nursing facility. The WCN was not aware that weekly skin assessments had not been performed since 10/14/11, prior to identification of the stage IV ulcer, and said the assessment should have been completed as Resident #1 was determined by the facility to be at risk for pressure ulcer. The WCN stated, she didn't know how the nursing staff could have missed the pressure ulcer in an earlier stage and said, "maybe they didn't know what they were looking at." The WCN said if the pressure ulcer was identified earlier, a better outcome could have been possible. Continued interview on, 04/07/11 at 2:30pm, with the WCN revealed she completed the Unavoidable Pressure Ulcer form on 01/18/11 which was signed by the physician on 02/04/11. The WCN said Resident #1 had other pressure ulcers since admission, which were deemed unavoidable due to the resident condition and were signed by the physician and placed on the chart.  Interview on 04/07/11 at 11:30am with the House Manager (HM) revealed that weekly skin assessments can be documented on the	F 314		

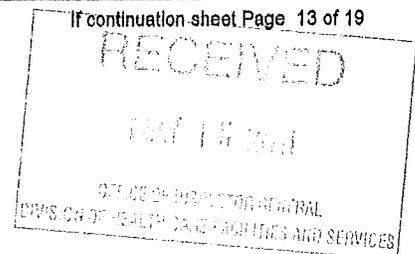
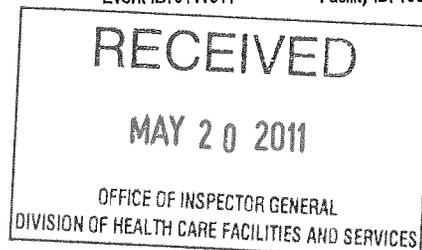
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F 314	<p>Continued From page 12</p> <p>TAR/Ulcer Documentation Form, or In the Nurse's Notes. The HM was not aware the weekly skin assessments for Resident #1 were not documented since 10/14/10, until a stage IV pressure ulcer was documented by the WCN on 01/28/11. The HM said the pressure ulcer should have been identified by staff prior to the wound reaching stage IV.</p> <p>Interview, on 04/07/11 at 11:55am, with the Director of Nursing (DON) revealed the facility identified Resident #1 was at risk for pressure ulcers. The DON described Resident #1 as difficult to turn and position, and said the resident was provided a specialty mattress for pressure reduction. The DON was not aware the weekly skin assessments were not completed for Resident #1 since 10/14/10. The DON said it was possible that Resident #1 developed a stage IV pressure ulcer on 01/28/11 which was not present on the shift before, and did not think it was unusual that the pressure ulcer was classified as a stage IV ulcer on the day the pressure ulcer was identified. The DON stated, "There has to be a first day a wound is found, and we would like to think we found it as soon as possible."</p> <p>Interview, on 04/27/11 at 1:40pm, with the DON revealed that she was surprised that no Weekly Skin Assessments were completed for Resident #1 since 10/14/10. The DON said LPN #2 did a good job and did not know why the Weekly Skin Assessments were not completed. The DON did not know why the Weekly Skin Assessments had not been completed since 10/14/10. The DON said if a CNA reported an area of pressure concern on Resident #1, the nursing staff would</p>	F 314			



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F 314	<p>Continued From page 13</p> <p>have documented it and initiated measures to promote skin integrity. The DON stated the two (2) CNA reports of a red or purple area on the coccyx may have been mistaken for scar tissue, as Resident #1 had a history of pressure ulcers. The DON said that she observed Resident #1 frequently, and was familiar with the skin condition, and stated, "I know he didn't open until January." The DON did not believe it would have been possible to identify the pressure wound prior to documentation as a stage IV pressure ulcer on 01/28/11.</p> <p>Interview, on 04/08/11 at 1:50pm, with the Physician revealed the facility staff complete the Unavoidable Skin Ulcer form and during rounds the form is reviewed, and the physician consults the chart and considers the resident's condition prior to signing the form. The Physician signed the form indicating it was unavoidable. The Physician said there were too many factors to consider in determining if the wound could have been identified in an earlier stage, before the pressure ulcer was staged as a stage IV ulcer. When the Physician was asked if Resident #1 could have experienced a better outcome and healing of the pressure ulcer if it was identified earlier, the Physician replied, "Yes, in theory."</p> <p>Interview, on 04/27/11 at 9:40am, with the Director of Medical Records revealed she was unable to locate Weekly Skin Assessments for the months of December, 2010 and January, 2011 after reviewing the closed record for Resident #1.</p> <p>Interview, on 04/27/11 at 10:30am, with LPN #2 revealed that she completed Weekly Skin</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>Assessments for Resident #1, and verified that she initialed the assessments as completed on the TAR for 12/02/10, 12/09/10, and 12/23/10. LPN #2 stated it was her practice to document Weekly Skin Assessments on the TAR Treatment Notes Sheet. LPN #2 said she remembered performing the Weekly Skin Assessments for Resident #1, however the TAR Treatment Notes Sheets were not completed during the month of December, 2010, and Weekly Skin Assessments for 12/02/10, 12/09/10, and 12/23/10 were not documented in the Nurse's Notes.</p> <p>2. Record review revealed the facility admitted Resident #2 on 08/08/08 with diagnoses of Cerebrovascular Accident (stroke), hemiplegia (paralysis), and Dysphagia (ineffective swallow). The Care Plan detailed an intervention to provide a Roho seat cushion when the resident sat in the geri-chair, with a start date of 06/07/10. Review of the resident record detailed a physician order dated 8/13/10, for daily wound care of the stage IV pressure ulcer on the coccyx. Review of Nurse's Notes dated 04/06/11 detailed a wound assessment documented by WCN which stated, "coccyx stage IV .5cm long x .5 cm wide x .4cm deep-red wound bed with no drainage and no odor." Review of the MDS assessment dated 05/17/11, revealed the facility assessed Resident #2 as totally dependent and required an assist of one to transfer and had a stage IV pressure ulcer of the coccyx that measured 1.4 cm in length by 1 cm in width with undermining.</p> <p>Review of the treatment record revealed LPN #5 initialed that the wound care to the coccyx was completed on 04/07/11 and LPN #4 had initialed wound care completion for 04/08/11. However,</p>	F 314		

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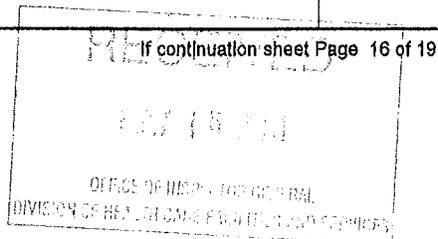
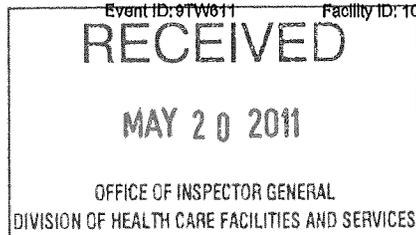
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F 314	<p>Continued From page 15</p> <p>on 04/08/11 at 10:20am, wound care observation performed by the WCN, revealed the coccyx dressing was intact and dated 04/06/11. The WCN said she performed the wound care and dressing change on 04/06/11, and acknowledged the dressing wasn't changed on 04/07/11.</p> <p>Interview on 04/26/11 at 3:25pm with LPN #5 revealed that the TAR was initialed on 04/07/11 before the treatment was completed. LPN #5 became busy near the end of the shift on that date, and forgot to complete the treatment. LPN #5 said she did not remember being told during orientation to initial the TAR only after the treatment is completed. LPN #5 stated it could become confusing when treatments are initialed before being performed, as it would be difficult to determine which treatments remain to be completed.</p> <p>Interview on 04/08/11 at 10:55am with LPN #4 revealed that she didn't know the WCN was going to do wound care for Resident #2, and she had already initialed the treatment as completed. LPN #4 stated she was trained to initial the treatments after the care is provided, but sometimes she signs them off early to ensure all treatments are signed. She avoids confusion by keeping a handwritten note of treatments to be completed during the shift, but admits it could become confusing when her note does not correspond with the initialed treatments on the TAR.</p> <p>Continued interview, on 04/08/11 at 2:20pm, with the DON revealed she spoke with LPN #5 about the wound care not provided for Resident #2 on 04/07/11 and was told that LPN #5 signed the</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>treatment off earlier in the day, then Resident #2 sat up longer than expected and LPN #5 didn't get to the wound care.</p> <p>Interview on 04/08/11 at 11:15am with the HM revealed the wound care for Resident #2 was not performed on 04/07/11. The HM was surprised that the treatments were initialed before completion as staff are trained to perform treatments, then initial the treatment as completed.</p> <p>Observation, on 04/06/11 at 3:15pm, revealed Resident #2 was sitting in a geri-chair in a common area near the South Nurse's Station. No Roho-cushion was on the seat of the geri-chair.</p> <p>Interview, on 04/06/11 at 3:30pm, with the Wound Care Nurse (WCN) revealed that the WCN was not aware Resident #2 had an order for the use of a Roho seat cushion when seated in the geri-chair.</p> <p>Interview, on 04/06/11 at 3:45pm, with the House Manager revealed that she was unaware Resident #2 had an order for a Roho seat cushion when seated in the geri-chair.</p> <p>Interview, on 04/27/11 at 9:15am, with CNA #7 revealed that she was aware of the use a Roho seat cushion when Resident #2 was seated in a geri-chair, and said the Roho seat cushion had not been used for the last month.</p> <p>Interview on 04/27/11 at 1:40pm with the DON revealed that staff was unable to find the Roho seat cushion for Resident #2 on 04/06/11 and a</p>	F 314		
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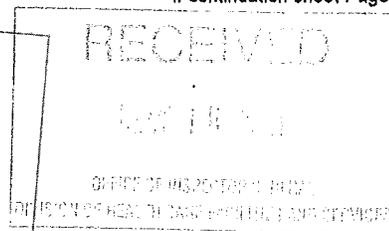
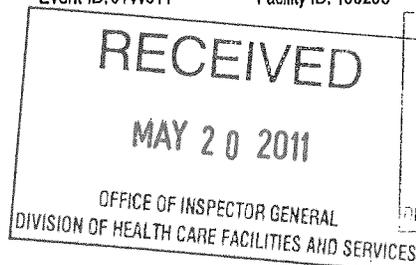
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F 314	Continued From page 17 new seat cushion was ordered.  3. Record review revealed the facility admitted Resident #4 on 03/21/11 from another nursing facility with diagnoses of Stage IV pressure ulcer, diabetes, and cerebrovascular accident (stroke). Record review of Nurse's Notes dated 03/21/11, detailed a wound assessment by the WCN that stated, "Right buttock stage IV, .9 cm long x 1.4 cm wide, white slough with small amount of s/a drainage and no odor." Review of Physician orders revealed an order dated 03/21/11, for once daily wound care to the stage IV pressure ulcer of the right buttock. Review of the Nurse's Notes and TAR revealed on 03/31/11 and 04/01/11, the daily wound care for Resident #4 was initialed and circled with a note, "PT." Record review of Nurse's Notes for 03/31/11 reveal no details of wound care, and Nurse's Notes dated 04/01/11 revealed LPN #3 noted, "dressing change not done due to resident being up in chair and in therapy all day," with no mention of the wound care.  Interview, on 04/08/11 at 2:40pm, with LPN #3 revealed Resident #4 spent most of first shift in Physical Therapy; therefore, she told the second shift nurse in shift report that the treatment needed to be completed on 03/31/11 and 04/01/11 during second shift. LPN #3 said she did not document in the Nurse's Notes that she advised the second shift nurse the wound care had not been completed for Resident #4 on 03/31/11 and 04/01/11, and facility staff was not able to provide documentation to confirm that the wound care was completed on second shift.  Review of the MDS dated 03/31/11, detailed	F 314		



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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/27/2011
NAME OF PROVIDER OR SUPPLIER  GEORGETOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 GAGEL AVENUE LOUISVILLE, KY 40216	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 documentation of a Stage III pressure ulcer which measured .9cm in length, 1.4cm in width, with slough. Record review of Nurse's Notes dated 04/04/11, detailed a wound assessment by the WCN that stated, "Right Buttock unstageable 1.3 cm long x 2.4 cm wide, area covered with grayish slough. Small amount of brownish drainage and no odor. Area with decline since last evaluation. Will notify MD." A Physician Order dated 04/04/11 increased the frequency of the wound care to be completed twice daily. Further review of the Nurse's Notes and TAR revealed wound care was not provided on 04/15/11 and 04/19/11.  Interview, on 04/08/11 at 2:20pm, with the DON revealed that it would not be appropriate to neglect a dressing change due to a busy resident therapy schedule. The DON was not aware that the wound treatment to a stage IV ulcer for Resident #4 was not completed for two (2) consecutive days (03/31/11 and 04/01/11), and stated neglected wound care treatments would have a negative effect on wound healing. Continued interview on 04/27/11 at 1:40pm with the DON revealed she was unaware that wound care was not provided on 04/15/11 and 04/19/11.	F 314		

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