

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: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 314	<p>Continued From page 84</p> <p>Resident #7 further stated staff encouraged the resident to stay off his/her right side, but stated, "Sometimes I forget." A second interview with Resident #7 on 10/30/12, at 7:50 PM revealed, it "would be nice if staff helped [her/him] turn."</p> <p>Interview with CNA #5 on 10/30/12, at 12:42 PM, and CNA #13 at 12:00 PM revealed they were not aware Resident #7 required assistance with turning and repositioning every two (2) hours. Both CNA #5 and CNA #13 stated Resident #7 turned her/himself in bed and were not aware Resident #7's care plan stated the resident required assistance with turning and repositioning every two (2) hours. However, the CNA care plan for Resident #7 revealed staff was required to reposition the resident every two (2) hours.</p> <p>Interview with Registered Nurse (RN) #2 on 10/30/12, at 3:15 PM revealed CNAs were required to review care plans daily for each resident and provide the care that the care plan required.</p> <p>In addition, a review of Resident #7's nurse's notes dated 10/28/12 revealed the resident had complained of pain to the right hip. Upon assessment by facility staff, an "abrasion" was observed on the resident's right hip.</p> <p>A review of physician orders, not dated, revealed an order to clean the abrasion to the right hip with normal saline, pat the area dry, apply "Bactroban," cover with "Telfa," and secure with "Hypafix" daily, for ten days.</p> <p>Observation during a wound care assessment, on 10/30/12, at 10:30 AM of Resident #7's right hip</p>	F 314	<p>staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #33</p> <p>Four (4) treatments per week will be observed by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of medication administration by licensed staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #34</p> <p>Four (4) med pass observations will be completed weekly by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits</p>		

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F 314	<p>Continued From page 85</p> <p>revealed a Stage II pressure sore that measured 1.6 cm x 1.8 cm, with no dressing in place. A review of Resident #7's October 2012 Treatment Administration Record (TAR) revealed the physician ordered treatment was documented on the TAR to be provided daily; however, no treatment was documented on 10/29/12.</p> <p>Interview with LPN #2 on 10/31/12, at 9:15 PM revealed she did not provide treatment to Resident #7's wound on 10/29/12. The LPN stated, "It was a crazy day" on 10/29/12, and she must have forgotten to perform the wound care.</p> <p>6. A review of Resident #8's medical record revealed the facility admitted the resident on 09/21/10, with diagnosis of Chronic Ischemic Heart Disease, Cerebral Vascular Accident, Kyphosis, and Anemia.</p> <p>Continued review of Resident #8's medical record revealed nurse's notes dated 08/31/12, which revealed staff notified the resident physician the resident had a Stage II pressure ulcer to the right buttock. Treatment orders were obtained to cleanse the resident's right buttock with normal saline, pat dry, apply Bactroban ointment (an antibacterial used to treat skin infections), cover with a "Telfa" (a non-adherent absorbent cotton dressing pad), and to secure the "Telfa" with a Hypafix (a self-adhesive, non-woven fabric for dressing retention). The treatment was to be performed every day. However, facility staff failed to document the appearance or size of the pressure wound until 09/16/12.</p> <p>Review of Resident #8's care plan revealed the care plan was revised on 09/04/12, and on</p>	F 314	<p>will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The results of all audits will be reported quarterly through CQ by Emily Jones-Gray Assistant Administrator or the person completing the audits. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>It is the policy of this facility that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>		

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F 314	<p>Continued From page 86</p> <p>09/16/12, to include the treatment as directed by the physician. Based on documentation, interventions had been added to the plan of care for staff to cleanse area to the resident's right buttocks with normal saline, apply Bactroban ointment, cover with a "Telfa" pad, and secure with "Hypafix," on a daily basis. The care plan required nursing to complete a skin assessment every week and to notify the physician of any alterations.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had failed to document the status of and/or treatment to Resident #8's pressure ulcer from 09/16/12 until 10/06/12 (twenty days later), when the ulcer measured "0.4 cm x 0.2 cm x 0.1 cm" on both dates. However, documentation revealed staff assessed the resident's wound on 10/19/12, (thirteen days after the previous assessment) and noted the ulcer measured "4.0 cm x 0.8 cm x 0.1 cm." Review of the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. However, based on documentation, the staff failed to conduct a wound assessment for several weeks.</p> <p>A review of Resident #8's Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse the resident's right buttock with normal saline, pat dry, apply Bactroban ointment (an antibacterial used to treat skin infections), cover with a "Telfa" (a non-adherent absorbent cotton dressing pad), and to secure the "Telfa" with a Hypafix (a self-adhesive, non-woven fabric for dressing retention). The TAR revealed wound care was</p>	F 314	<p>1. The MDS and Care Plan of resident #14 was reviewed by Crystal Cantrell, LPN MDS staff.</p> <p>The nurse aide was counseled on following the plan of care for Resident #14 and given a disciplinary a-warning on 4/20/12 as a result of the facility investigation. This was completed by Mary Arms, DON. The nurse aides last day of employment with the facility was 4/21/12.</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents and transferring residents. See Attachment 24</p> <p>No residents were identified as being affected by the elevated temperature in the sink or the switch to the stove being in an upper cabinet out of view of the residents in the unit.</p> <p>On 10/31/12 the hot water to the sink was turned off to prevent injury by James Adams, Maintenance.</p> <p>On 10/31/12 a box was placed over the switch to the stove and the cover was secured with a lock. This was completed by Tim Hayes, HMC Service Co. See attachment #41</p>	

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F 314	<p>Continued From page 87 performed as ordered by the physician.</p> <p>7. A review of Resident #9's medical record revealed the facility admitted the resident on 03/29/11, with diagnosis of Severe Degenerative Changes of L Spine, Weight Loss, Anemia, and Dementia.</p> <p>Review of Resident #9's care plan revealed the care plan was revised on 10/04/12, to include the Stage II pressure ulcer to the resident's right outer hip; however, at the time of the revision, there were no additional interventions added to the care plan to address the pressure area. Based on documentation on the care plan, staff was to complete a skin assessment every week and to notify the physician of any alterations in the resident's skin integrity.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff documented on 10/06/12 that the pressure area to Resident #9's right outer hip measured "3.2 cm x 2.0 cm x 0.1 cm." The next assessment was conducted on 10/20/12 (fourteen days after the previous assessment) and revealed the ulcer measured "2.5 cm x 2.5 cm x 0.1 cm."</p> <p>A review of Resident #9's Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse the resident's right buttock with normal saline, pat dry, apply Bactroban ointment (an antibacterial used to treat skin infections), cover with a "Telfa" (a non-adherent absorbent cotton dressing pad), and to secure the "Telfa" with a Hypafix (a self-adhesive, non-woven fabric for dressing retention) daily. The TAR revealed wound care</p>	F 314	<p>2. The MDS and care plans of all the residents in the secure unit were reviewed by Mary Arms, DON on 11/1/12. The total census for the secure unit on 10/31/12 was 13. Four residents were identified as cognitively impaired and/or wander and were identified as having the potential to be affected. Five residents are bedfast and do not have the potential to be affected. Two of the other residents are in wheel chairs when up and do not wander. One other resident had a fractured arm and is ambulatory with a walker and assistance. She does not wander.</p> <p>All CNA resident care plans and assignment sheets were reviewed to ensure that resident care needs were identified and that assignment sheets reflect how care is to be provided to each resident. This was completed by Roberta Thompson, MDS Coordinator and Crystal Cantrell, LPN MDS Staff on 12/29/12.</p> <p>A resident transfer audit was completed on 11/15/12 by Mary Arms, DON and Emily Jones Gray, Assistant Administrator. No other residents were identified as being affected.</p>	

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F 314	Continued From page 88 was performed as ordered by the physician. Interviews on 10/23/12, at 6:15 PM with the Administrator and the Director of Nursing (DON) revealed the nurse assigned to the resident on Friday of each week was required to assess wounds unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed staff was required to assess the wound, including measurements, and document the assessment on the Wound Evaluation Flow Sheet. The interview revealed the Quality Assurance (QA) nurses were to ensure wounds were assessed per facility policy and report any issues to the QA Committee. (Refer to F520.) Further interview on 11/01/12, at 2:30 PM with the Director of Nursing (DON) revealed staff should review physician's orders prior to treatments to ensure treatments were performed in accordance with physician's orders. Further interview with the Administrator on 11/01/12, at 3:45 PM revealed nurse are to follow physician's orders this is a nursing "standard of practice."	F 314	A water temperature audit was completed throughout all other resident care areas in the entire facility by the Maintenance Department on 11/1/12. No other residents were identified as being affected. 3. On 10/31/12 a box was placed over the switch to the stove and the cover was secured with a lock. This was completed by Tim Hayes, HMC Service Co. See attachment #41 On 11/1/12 a mixing valve was installed on the faucet in the unit in the kitchen area by Gary Mollett, HMC Service Co. The water temperature is set at 105 degrees. See attachment #42 On 11/6/12 the mixing valve for the unit was rebuilt by Gary Mollett, HMC Service Co. See Attachment #43 All water temperature monitoring sheets were reviewed and revised on 11/5/12. A separate sheet has been developed for each unit. This was completed by Deborah Fitzpatrick, Administrator, William Endicott, Maintenance Director and Madge Arnett, Stock Control. See attachment #44	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 89 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to ensure one of twenty-four sampled residents (Resident #14) received adequate supervision and assistive devices to prevent accidents. (Refer to F282.) The facility assessed Resident #14 to require the assistance of a minimum of two staff persons for transfers. However, on 04/09/12, one staff person transferred the resident from the bed to a wheelchair, and the resident sustained a soft tissue injury to the left ankle after reportedly hitting his/her ankle on the wheelchair. As a result of the injury, Resident #14 required evaluation at an Emergency Department on two separate occasions. On 04/09/12, Resident #14 was transferred to the emergency room for evaluation due to swelling, pain, and redness of the left ankle. On 04/18/12, Resident #14 experienced increased pain, (refused for staff to touch the ankle), swelling and developed a necrotic area at the injured site. On 04/18/12, Resident #14 was transferred to the emergency room for evaluation, was diagnosed with cellulitis, and was prescribed an antibiotic treatment. In addition, on 04/26/12, a hematoma formed at the injured site and wound care was required for the left ankle. The facility also failed to ensure the resident's environment remained as free of accident hazards as possible. A review of the facility policy titled Safety of Water Temperatures Dated 10/20/08, revealed water heaters that service	F 323	In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents, Infection control (specifically not sitting on the side of the bed while feeding). Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chantry Purcell, Staff Development. See Attachment #24 Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should	

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F 323	<p>Continued From page 90</p> <p>common areas shall be set to temperatures of no more than 110 degrees Fahrenheit. During environmental tour on 10/31/12 at 11:04 AM water temperatures at a sink in the secured unit was observed to be 138 degrees Fahrenheit. In addition, a switch that controlled and disabled the cooking stove was located in an unlocked cabinet near the stove.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Safety and Supervision of Residents (revised 10/20/09) revealed the resident's environment would be as free from accident hazards as possible. The policy indicated resident safety, supervision and assistance to prevent accidents was a facility wide priority. A review of the facility's policy titled, Care Plans-Comprehensive (revised 10/20/08) revealed the Certified Nursing Assistant (CNA) care plans would be developed from the comprehensive care plan and would identify specific care area needs and approaches necessary for the CNAs to provide daily care to individual residents.</p> <p>Review of an in-service conducted 01/31/12, revealed CNAs were instructed to review the CNA care plan/assignment sheet and carry it at all times. The in-service informed staff the care plan listed all the care needs of residents. The in-service stressed failure to follow the CNA assignment sheet could result in resident and employee injury and staff would be subject to written warnings or termination for not following the care plan/assignment sheet. Further review revealed resident safety was a priority and every effort should be made to avoid resident/staff</p>	F 323	<p>review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and completed on 11-23-12. See attachment #15</p> <p>All nursing staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #24 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. This in-service was started on and was completed on 12/17/12 and will be completed on 1/7/13 by Deborah Fitzpatrick, Administrator, Emily Jones Gray, Assistant Administrator and Mary Arms, DON.</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department.</p>	

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F 323	<p>Continued From page 91 injury during transfers.</p> <p>1. Review of the record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included a previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension, and Nonpsychotic Disorder.</p> <p>The Comprehensive Annual Assessment dated 01/10/12 and a Quarterly Minimum Data Set (MDS) Assessment dated 10/09/12 revealed Resident #14 was at risk for falls. Facility staff assessed Resident #14's risk for falls was related to environmental factors; impaired balance and coordination during transfers; the resident's unsteady gait and his/her decreased awareness for safety; impaired cognition, hearing problems, limited range of motion of the left upper extremity secondary to a previous CVA, incontinence, generalized weakness and the use of a wheelchair for mobility. The Quarterly MDS Assessment revealed the facility had assessed the resident to require extensive physical assistance of a minimum of two staff persons with transfers; the resident was to wear non-skid footwear for safety; and CNAs were to assist the resident with all transfers.</p> <p>Review of Resident #14's Comprehensive Care Plan developed on 01/27/11 and last reviewed/revised on 10/22/12, revealed the facility developed a plan of care for Resident #14's risk for falls with injury, his/her impaired mobility, generalized weakness with interventions which included staff assistance for transfers. In</p>	F 323	<p>4. Water temperatures for all areas will be monitored all least 3 times weekly in all units by maintenance and/or housekeeping and will be recorded. This will be ongoing. See Attachment #44</p> <p>The results of all water temperature audits will be reported quarterly through CQI by the William Endicott, Maintenance Supervisor. This will be ongoing.</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week for appropriate transfer to ensure that the resident care plan is followed. This will be completed for 6 months and then re-evaluated. This started on 11/28/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The facility conducts other resident safety audits as part of CQL. Some examples are:</p> <ul style="list-style-type: none"> Hand rails are checked daily by housekeeping and reported through CQI quarterly. This is ongoing. The results of these audits 	

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F 323	<p>Continued From page 92</p> <p>addition, a review of the CNA Care Record dated April 2012, and the most recent CNA Care Record dated October 2012, revealed the CNAs were instructed Resident #14 was at risk for falls, required the assistance of two staff for transfers, had weakness of the left hand and arm, and required the use of a gait belt with transfers. The CNA Care Record also directed staff to report any sign of injury to the nurse.</p> <p>A review of an Incident Report Tracking log, on 04/09/12 at approximately 9:30 AM, CNA #15 transferred Resident #14 from the bed to a wheelchair without assistance and Resident #14 sustained an injury to the left ankle. According to the nurse's note dated 04/09/12 at 1:50 PM, Resident #14 experienced "severe" pain of the left foot/ankle and refused for staff to touch the foot.</p> <p>Further review of the nurses' notes, Incident Report Tracking log, and a review of the Treatment Administration Record (TAR) revealed on 04/09/12, Resident #14 was transferred to the emergency room for evaluation due to the complaint of pain, redness, and swelling of the left foot. According to the Patient Transfer Form, Resident #14 was transferred as the result of hitting his/her left foot on the wheelchair and resident complained of "a lot of pain." The transfer form revealed the resident's left ankle was swollen.</p> <p>Continued review of the Incident Report Tracking log revealed Resident #14 was transferred from the facility to an Emergency Department on 04/09/12 at 2:00 PM and returned to the facility that evening. A review of the Emergency</p>	F 323	<p>are reported Quarterly through CQI by Aretta Harmon, Housekeeping Supervisor. This is ongoing.</p> <ul style="list-style-type: none"> Slings used in the transfer of residents are checked each time they are laundered (according to manufacturer guidelines) to ensure they are safe for resident use. This is completed by the laundry staff and recorded. Aretta Harmon, Housekeeping Supervisor is responsible for monitoring this and reporting the results quarterly through CQI. This is ongoing. <p>The results of all audits will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or by the person completing the audits.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Completion date 1/8/13</p>		

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F 323	<p>Continued From page 93</p> <p>Department's discharge instructions dated 04/09/12 revealed Resident #14 had a foot contusion with soft tissue injury and was to apply an ace bandage and keep the left foot elevated five days.</p> <p>Review of the Medication Administration Record (MAR) for April 2012, revealed following Resident #14's return to the facility from the Emergency Department, Resident #14 complained of pain on 04/11/12 at 9:00 AM, related to the injury to the left foot and required 5/500 milligrams of Lortab (analgesic/narcotic) and 500 milligrams of Extra Strength Tylenol for pain.</p> <p>On 04/18/12, nine days following the incident on 04/09/12, nurse's notes, and Patient Transfer Form dated 04/18/12, revealed Resident #14 experienced increased pain, (resident refused for staff to touch the ankle), swelling, and a necrotic area had developed at the previously injured site. The nurses' notes revealed the left ankle was "deep, dark red with a necrotic looking area on the outer ankle." Review of the Comprehensive Care Plan revealed a 1 centimeter by 5 centimeter blood blister was observed to have formed on the left outer foot on 04/18/12. Documentation revealed Resident #14 was again transferred to the Emergency Department on 04/18/12 for evaluation and was diagnosed with cellulitis, treated with intravenous Rocephin (an antibiotic), and returned to the facility with orders for 875 milligrams Augmentin (an antibiotic) twice each day for ten days.</p> <p>Continued review of nurses notes revealed on 04/24/12 facility staff observed a change in condition of Resident #14's left foot and</p>	F 323	<p>F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>It is the policy of this facility to obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. It is the policy of the facility to store all drugs and biological in locked compartments and to permit only authorized personnel to have access to the keys. It is the policy of the facility that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. These are evidenced by the following:</p> <ol style="list-style-type: none"> All resident medications identified on 11/1/12 (brought the facility by the family/resident) were disposed of by 11/6/12 by Christy Moore, RN and Yvette Short, RN. A list of the medications and the disposition of each is included. See attachment 45 <p>Narcotics were wasted by Christy Moore, RN and Yvette Short, RN on 11/1/12. See Attachment #46</p>	

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F 323	<p>Continued From page 94</p> <p>contacted Resident #14's physician to obtain wound care orders.</p> <p>A skin assessment was conducted of Resident #14 on 10/29/12, at 7:35 PM. A black eschar (dead tissue) area was observed on Resident #14's left outer ankle and the tissue surrounding the eschar area was deep red in color. LPN #2 cleansed the eschar/wound area with normal saline, applied Bactroban antibacterial ointment, covered the wound with a non-adherent pad, and secured the dressing with gauze wrap and tape. As the LPN cleansed the resident's wound, the black eschar detached from the wound onto the normal saline moistened gauze.</p> <p>Resident #14 was observed on 10/29/12, at 5:25 PM to be lying in bed with a dressing intact to the left foot. Resident #14 made no effort to respond to verbal prompts and an attempt to interview the resident was unsuccessful. In addition, a review of a quarterly assessment, dated 10/09/12, of Resident #14 revealed the resident was cognitively impaired.</p> <p>CNA #15 stated in interview conducted on 10/31/12, at 2:15 PM that she had been trained to review CNA Care Records to determine the resident's needs prior to providing assistance with care, and was aware Resident #14 required the assistance of two staff for transfers. CNA #15 confirmed she failed to obtain assistance with transferring Resident #14 from the bed to a wheelchair on 04/09/12, and stated during the transfer Resident #14 was unable to pivot to the wheelchair as well as he/she had done in the past. CNA #15 stated she was not aware of any injury to Resident #14 until the afternoon of</p>	F 323	<p>On 11/24/12 Mary Arms, DON reviewed the storage of Mycalcin spray in the medication cart. We have 2 residents receiving this. Both sprays were upright in the medication cart.</p> <p>Pharmacy was contacted by Mary Arms, DON regarding proper storage of Mycalcin on 11/24/12. Mycalcin in smaller packing so the container stands upright in the box.</p> <p>Nursing staff were in-serviced beginning 11/08/12 and completed on 11/23/12 regarding recommended storage of Mycalcin Spray. See Attachment 15</p> <p>2. A review of the medication rooms in all units was completed on 11/21/12 by Madge Arnett, CMA Stock Control. There were no other medications that were improperly stored or improperly reconciled.</p> <p>The narcotic books were reviewed and reconciled by Mary Arms, DON on 11/8/12, 11/19/12, 12/10/12 and 12/31/12 as part of CQI. No problems were identified.</p> <p>3. Licensed staff were in-serviced regarding notification of change,</p>	

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F 323	<p>Continued From page 95</p> <p>04/09/12, when the CNAs were asked about the resident's ankle swelling. CNA #15 stated Resident #14 must have hit the leg rest of the wheelchair and acknowledged she should not have transferred Resident #14 without assistance.</p> <p>Interview on 10/31/12, at 2:45 PM with CNA #13 revealed Resident #14 had been transported to the shower room by CNA #15 and she had assisted CNA #15 with the resident's shower. CNA #13 stated she and CNA #15 assisted the resident to stand after the shower was complete and stated the resident did not complain of any pain or discomfort. In addition, CNA #13 stated she did not observe an injury to the resident's leg when she assisted the resident to dress.</p> <p>Licensed Practical Nurse (LPN) #4 revealed in an interview conducted on 11/01/12 at 4:00 PM, that she had been responsible for directing the care of Resident #14 on 04/09/12. LPN #4 stated CNAs were provided a CNA plan of care at the beginning of each shift of resident care needs and were expected to follow the plan of care. LPN #4 stated she had requested the assistance of the Assistant Director of Nursing (ADON) on 04/09/12 and stated the ADON had asked her to assess Resident #14's foot and ankle. LPN #4 stated Resident #14 complained of left foot and ankle pain, the ankle was swollen and "a little red," and the resident complained of pain when the ankle was touched. LPN #4 stated she was not aware at the time of the resident's complaints on 04/09/12, that CNA #15 had failed to follow the plan of care for Resident #14 and had transferred the resident without assistance.</p>	F 323	<p>causes of skin breakdown, braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and completed on 11-24-12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff</p>		

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F 323	<p>Continued From page 96</p> <p>The Director of Nursing (DON) stated in an interview on 11/01/12, at 2:30 PM, that staff members were required to follow the resident plan of care. The DON confirmed CNA #15 failed to follow the plan of care and transferred Resident #14 from the bed to a wheelchair without assistance and Resident #14 sustained an injury to the left ankle.</p> <p>2. A review of the facility's policy titled Safety of Water Temperatures Dated 10/20/08, revealed water heaters that service common areas shall be set to temperatures of no more than 110 degrees Fahrenheit. Further review of the policy revealed maintenance staff was responsible for periodically monitoring tap water temperature and to record the water temperatures in a safety log.</p> <p>In addition, an interview conducted with the facility Maintenance Director revealed the facility did not have a policy regarding the maintenance/security of a control switch that disabled the cooking stove in the secured unit.</p> <p>Observations of water temperatures conducted during an environmental tour on 10/31/12, at 11:04 AM, revealed a hot water temperature of 138 degrees Fahrenheit in a sink in the common area of the secured unit where residents with dementia resided. Additional observation during the tour revealed a control switch that disabled the cooking stove located in the kitchen was located inside an unlocked cabinet next to the stove and as a result, residents in the unit had access to the switch.</p> <p>A review of the resident census for the secured unit revealed during the survey conducted</p>	F 323	<p>interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Any licensed staff of medical leave at the time of the in-service will be required to receive the in-service prior to returning to work.</p> <p>An audit sheet was developed to use in auditing the med rooms and the storage of Mycalcin Spray. This was developed by Madge Arnett, CMA Stock Control and Mary Arms, DON on 11/21/12. See Attachment #47</p> <p>A medication return form was developed by Mary Arms, DON On 11/24/12 for use in documenting that drugs brought in by family/residents have returned. See Attachment #48</p>	

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F 323	Continued From page 97 10/29-11/01/12, there were three (3) cognitively impaired residents who wandered through out the unit. An interview conducted with the Maintenance Director on 10/31/12, at 11:04 AM, revealed he periodically checked the water temperature in the secured unit but had not documented the water temperatures. The Maintenance Director stated he had never checked the water temperature at the sink in the common area and was not aware the hot water temperature was 138 degrees Fahrenheit. According to the Maintenance Director, the secured unit had been in use for approximately two (2) years and he had not considered checking the water temperature in the sink. Additional interview with the Maintenance Director revealed the control switch to the cook stove on the secured unit was placed in the cabinet to prevent unwanted resident use but was not aware the cabinet was not secured and could be accessed by residents. An interview conducted with the Facility Administrator on 10/31/12, at 4:30 PM, revealed the Administrator was not aware the Maintenance Director had failed to monitor or maintain a temperature log of the water temperatures in the Secure Unit. In addition, the Administrator stated she was not aware residents had access to the control switch that controlled the power to the cook stove.	F 323	This form will be placed in the admission packet for all new residents. The Medical Records clerk will be responsible for this effective 11/24/12. A notice was prepared and placed on the outside of the cabinet in the med room instructing nurses to return at home meds, to use the return form and where the form is located and to give a copy of the form the DON for auditing purposes. This was completed by Mary Arms, DON on 11/24/12. See Attachment #49 4. The medication rooms for each unit will be audited weekly by Madge Arnett, Stock Control. The results of the audits will be reported quarterly through CQI by Mary Arms, DON. This will be completed weekly for 6 months and then reevaluated. See Attachment #47 The DON will monitor the return of at home meds using the Medication Return Form. This will be ongoing. The results will be reported quarterly through CQI by Mary Arms, DON.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	<p>Continued From page 98</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to store all drugs in accordance with currently accepted professional principles and according to manufacturer's recommendations.</p>	F 431	<p>The Narcotic Books are audited bi-weekly by Mary Arms, DON to ensure proper documentation, handling and storage of narcotics. The results of the audits will be reported quarterly through CQI by Mary Arms, DON. This will be on-going</p> <p>The results of all audits will be reported quarterly through CQI by Emily Jones-Gray QA Coordinator or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>It is the policy of this facility to 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.</p>	

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F 431	<p>Continued From page 99</p> <p>The facility failed to ensure Calcitonin-Salmon Nasal Spray (used to treat osteoporosis) was stored in an upright position after opened as recommended by the manufacturer.</p> <p>In addition, on 11/01/12, at 10:55 AM, observation of the medication room on the second floor of the facility revealed eighty-two (82) boxes/containers of medications located in an unsecured cabinet. The unsecured medications belonged to one (1) out of twenty-four (24) sampled residents (Resident #21), and seven (7) unsampled residents (Resident A, Resident C, Resident G, Resident D, Resident E, Resident F, and Resident L).</p> <p>The findings include:</p> <p>Review of facility policy titled Recommended Minimum Medication Storage Parameters (revised 04/08/11) revealed Calcitonin-Salmon Nasal Spray should be stored in the refrigerator until opened. The policy directed staff that once the Calcitonin-Salmon Nasal Spray had been opened the medication should be stored in an upright position and discarded after thirty doses or thirty days.</p> <p>1. Observation of the North Hall medication cart on 10/30/12; at 12:45 PM, revealed a box that contained Calcitonin-Salmon Nasal Spray that had been opened, lying in the medication cart drawer. Further observation revealed the medication was prescribed for Resident #6. Review of the medication revealed the following instructions: Refrigerate until opened, store at room temperature in an upright position.</p>	F 431	<p>1. In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents, Infection control (specifically not sitting on the side of the bed while feeding). Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment #24</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse</p>	

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F 431	<p>Continued From page 100</p> <p>Review of the manufacturer's recommendation printed on the opened bottle of Calcitonin-Salmon Nasal Spray, revealed an opened bottle of Calcitonin-Salmon Nasal Spray should be stored at room temperature in an "upright" position.</p> <p>Interview on 11/01/12, at 9:15 AM, with Licensed Practical Nurse (LPN) #2 revealed the LPN had no knowledge of how Calcitonin-Salmon Nasal Spray should be stored. LPN #2 stated she tried to keep all inhalers and nasal sprays in the original box and in an upright position. LPN #1 stated she had not been instructed to store Calcitonin-Salmon Nasal Spray in the upright position and acknowledged the box used to contain the nasal spray was too large and the nasal spray would not stay in an upright position.</p> <p>Interview on 11/01/12, at 2:30 PM, with the Director of Nursing (DON) revealed Calcitonin-Salmon Nasal Spray should be stored in an upright position to maintain priming of the nasal spray pump. The DON stated the Calcitonin-Salmon Nasal Spray was usually dispensed with a plastic base that secured the nasal spray in an upright position.</p> <p>2. A review of the facility's policy titled, "Medications Brought To The Facility By The Resident/Family", with a revision date of April 2007, revealed medications brought into the facility that were not approved for the resident's use shall be returned to the family. The policy also stated if the family does not pick up those medications within thirty (30) days, the facility may destroy them in accordance with established policies.</p>	F 431	<p>should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and completed on 11-23-12. See attachment #15</p> <p>2. On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments provided to 8 residents to ensure that proper procedure were followed during dressing change including proper disposal of soiled dressings. Staff followed proper procedure during the treatments. No other residents were identified.</p> <p>Kitty Harmon, Housekeeping Supervisor conducted an auditing related to knocking on doors before entry, sitting on bed while feeding, and standing while feeding on 11/19/12.</p> <p>Amanda Sparks, Kitchen manager began monitoring dignity during meal times, standing while feeding, sitting on bed while feeding and knocking on doors on 11/16/12.</p> <p>3. Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order,</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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F 431	Continued From page 101 Observation of the medication room on the second floor of the facility on 11/01/12, at 10:55 AM, revealed eighty-two (82) bottles/containers of medication located in an unsecured cabinet. The following medications were observed in the cabinet which had been brought into the facility by the family: A. Medication bottles/containers labeled as belonging to Resident #21 and containing medication labeled as: -Neurontin 100 milligrams -Sodium Bicarbonate 650 milligrams -Metoprolol 50 milligrams -Lasix 20 milligrams -Aspirin 325 milligrams -Cozaar 100 milligrams -Lipitor 10 milligrams -Imdur 30 milligrams -Buspar 5 milligrams -Detrol La 4 milligrams B. Medication bottles/containers labeled as belonging to Resident A and containing medication labeled as: -Valium 5 milligrams -Cardura 4 milligrams -Aspirin 81 milligrams -Quinapril 40 milligrams -Zetia 10 milligrams -Pravachol 40 milligrams -Lortab 7.5/500 milligrams -Loratadine 10 milligrams -Albuterol Sulfate HFA 90 microgram Inhaler -Spiriva Handihaler 18 micrograms Inhaler C. Medication bottles/containers labeled as belonging to Resident C and containing	F 431	assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and completed on 11-23-12. See attachment #15 Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.	

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F 431	Continued From page 102 medication labeled as: -Ferrous Sulfate 325 milligrams -Ranexia 500 milligrams -Lipitor 80 milligrams -Theophylline 30 milligrams -Plavix 75 milligrams -Zantac 150 milligrams -Synthroid 75 micrograms -Carvedilol 3.25 milligrams -TriCor 145 milligrams -Glipizide 5 milligrams -Ramipril 2.5 milligrams -Potassium Chloride 20 milliequivalents -Dukes Mouthwash D. Medication bottles/containers labeled as belonging to Resident D and containing: -Antivert 25 milligrams -Levothyroxine .5 milligrams	F 431	In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents, Infection control (specifically not sitting on the side of the bed while feeding). Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment 24 4. CQI monitoring tool was developed on 11/16/12 by Kathy Meadows, Social Services to monitor dignity during meal times, infection control during meal times and knocking on doors. See Attachment #26		
	-Levothyroxine .25 milligrams -Aggrenox 25/200 milligrams (four bottles) -Geodon 20 milligrams -KlorCon 20 milliequivalents -Exelon Patches 9.5 milligrams (three boxes) -Vitamin D 1.25 milligrams -Fiomax 0.4 milligrams -Aggrenox 25/100 milligrams (two bottles) -Vitamin D 50,000 units E. Medication bottles/containers labeled as belonging to Resident E and containing: -Advair Diskus 100/50 -Pantoprazole Sodium Delayed release 40 milligrams -Gabapentin 100 milligrams -Digoxin 125 micrograms -Cyanocobalamin 1000 micrograms per milliliter -Celexa 40 milligrams		Kitty Harmon, Housekeeping Supervisor, Brandy Cooper, Dietary Manager, and Amanda Sparks, Kitchen manager are monitoring dignity during meal times, infection control during meal times and knocking on doors at different intervals throughout the day at a minimum of 3 times a week. If staff are observed during the audit to violate any of the above they are corrected by the person auditing immediately. The violation and the person committing the violation are reported to Mary Arms, DON further corrective action if necessary. This was started on 11/16/12 and will continue for 6 months and then be re-evaluated. Four (4) treatments per week will be observed by the QA nurse to ensure that		

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F 431	Continued From page 103 -Carvedilol 3.125 milligrams F. Medication bottles/containers labeled as belonging to Resident F and containing: -Aspirin 325 milligrams -Potassium Chloride Extended release 20 milliequivalents -Ranexa Extended release 500 milligrams -Losartan Potassium 30 milligrams -Donepezil Hydrochloride 10 milligrams -Januvia 100 milligrams -Plavix 75 milligrams -Nitrofurantoin MCR 30 milligrams -Isosorbide Mononitrate Extended Release 60 milligrams -Lansoprazole Delayed Release 30 milligrams -Furosemide 40 milligrams -Promethazine 25 milligrams -Simvastatin 40 milligrams	F 431	the individual resident care plan and physician orders are being followed and that soiled dressings are disposed of per facility policy. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future. Audit results are reported weekly in the QA committee meeting by the person completing the audit. All results will be reported quarterly through CQI by Emily Gray Assistant Administrator or the person completing the audits. Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.	
	-Welchol 625 milligrams -Enblex 7.5 milligrams (two bottles) -Novolog Mix 70/30 Insulin G. Medication bottles/containers labeled as belonging to Resident G and containing: -Albuterol Sulfate 0.083% for inhalation (three boxes) -Prednisone 5 milligrams -Advair Diskus 500 micrograms (two boxes) -Prednisone Dosepak -Ventolin HFA 90 microgram inhaler H. Medication bottle/container labeled as belonging to Resident L and containing: -Megace AC 40 milligrams per milliliter An interview conducted with the Nursing Supervisor (NS) on 11/01/12, at 11:05 AM,		5. Date of Completion 1/8/13 F 490 483.25 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING It is the policy of this facility to 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.	

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F 431	Continued From page 104 revealed the NS had been unaware there were medications in the cabinet and stated the medications should have been sent home with the resident's families. The NS stated she was unaware who had placed the medications in the cabinet. The NS the facility had not assigned any particular staff person to monitor the medication cabinets to ensure medications brought into the facility by family members were sent home with the families. An interview conducted with the Director of Nursing (DON) on 11/01/12, at 11:10 AM, revealed the DON had not been aware medications had been placed in the cabinet. The DON also stated, in accordance with facility policy, the medications should have been sent home with the resident's family members. The DON stated she was unsure who had placed the medications in the cabinet.	F 431	1. The attending physician and the family of resident #1 was notified on 10/17/12 by LPN #3 of the change in condition related to the wound on the left great toe. See attachment #1 The attending physician was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being sent transferred to KDMC to the physician that had previously done surgery on her other leg. See Attachment #2 Mary Arms, DON began reviewing the medical record of resident #1 on 10/18/12 and continued reviewing and investigating on 10/19/12. The attending physician was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3	
F 441 SS=E	483.65 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.	F 441	The medical record of resident #1 was reviewed on 10/20/12 by Mary Arms, DON to ensure that other appointments had not been missed. The MDS and care plan of resident #1 was reviewed on 10/19/12 by Roberta Thompson, RN MDS Coordinator. The family was notified on 10/20/12 by Mary Arms, DON of the missed appointments and that we had reported this to OIG. Resident #1 has not returned to this facility.	

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F 441	Continued From page 105 (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	The care plan for resident #14 was reviewed for accuracy on 11/23/12 by Crystal Cantrell, LPN MDS staff. All nursing staff was in-serviced 11/8/12 through 11/23/12 regarding following the resident care plan and transferring residents. This was completed by Emily Jones-Gray, Assistant Administrator, Mary Arms, DON and Chanity Purcell, LPN Staff Development. 2. The charts of all residents having weekly outside appointments for medical treatment outside the facility were reviewed to ensure they had not missed appointments due to transportation not being scheduled. This was completed by Mary Arms, DON and Christy Moore, RN on 10/20/12. There were no other appointments missed for failure to make transportation arrangements.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an effective Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for one (1) of twenty-four (24) sampled residents (Resident #14). Observation on 10/29/12, revealed staff failed to properly dispose of a soiled dressing during a wound treatment. LPN #3 removed a dressing from Resident #14's left foot and placed the soiled dressing directly on the resident's bed. Additionally, observation on 10/29/12 of the		All current residents with randomly scheduled appointments were reviewed to ensure that transportation arrangements had been made. This was completed by Ora Little, LPN and Jessica Wireman, RN on 10/21/12. On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of all residents. On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowerly LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.	

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F 441	Continued From page 106 evening meal and of the noon meal on 10/30/12, revealed staff sat on resident's beds while assisting the residents with the meal. The findings include: Review of the facility's policy titled Wound Care/Treatment Guidelines (not dated) revealed dressing supplies were never placed on the resident's bed. The policy directed staff to bag trash from dressing changes in a trash bag and dispose of the trash in the soiled utility room. 1. Observation during wound care for Resident #14 on 10/29/12, at 7:35 PM revealed LPN #2 prepared supplies for the wound care. LPN #2 removed a dressing from Resident #14's left foot. LPN #2 placed the soiled dressing directly on the resident's bed. Further observation revealed LPN	F 441	A copy of the skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their individual MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12. On 10/20/12 the individual wound monitoring records were reviewed and compared to the individual resident skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.		
	#2 cleansed Resident #14's ankle wound with gauge moistened with normal saline. A black scab detached from the wound during the cleansing process. LPN #2 placed the soiled moist gauge that contained the black scab on the resident's bed. Further observation revealed when LPN #2 completed the wound care, she removed the soiled dressing supplies from Resident #14's bed and carried the soiled dressing to the hallway and disposed of the soiled dressings in a waste receptacle on the treatment cart. Interview on 10/29/12, at 7:45 PM with LPN #2 revealed she was knowledgeable of the requirement to bag soiled dressing in a trash bag and stated she should not have placed the soiled dressings on Resident #14's bed. LPN #2 stated the treatment cart did not contain a trash bag and		All areas identified on the individual resident skin assessments completed on 10/19/12 were compared to the individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12. Any new areas or areas in question (identified on the individual skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12. All physicians were notified via fax on 10/22/12 of their respective residents		

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F 441	Continued From page 107 she failed to take the time to restock the cart. Interview with the Director of Nurses (DON) on 11/01/12, at 2:30 PM, revealed staff were trained to never place soiled items on resident beds. The DON stated to prevent transmission of germs; staff was required to take a garbage bag in the resident's room for disposal of the soiled dressing and should discard the garbage bag in the waste receptacle on the treatment cart. 2. The facility failed to provide a policy related to staff sitting on resident's bed; however, according to the Nursing Assistant Education website (www.nursingassistanteducation.com), sitting on resident's beds could "spread infections to patients and residents from our uniform." <u>Observation of the evening meal on 10/29/12,</u> revealed staff delivered dinner trays to residents that remained in their rooms for the evening meal. Observation revealed CNA #4 stood, during part of the meal, beside unsampled Resident J as she fed the resident. Further observation revealed CNA #4 sat on Resident J's bed to finish feeding the resident the evening meal. CNA #8 was observed to deliver a meal tray to unsampled Resident K. CNA #8 was observed to sit on Resident K's bed to feed the resident. Continued observation of the evening meal service, revealed CNA #9 assisted unsampled Resident I with the evening meal. CNA #9 was observed to sit on the resident's bed to feed the resident. <u>Observation of the noon meal on 10/30/12,</u>	F 441	wounds, the type and location. This was completed by Christy Moore, RN. See attachment #4 On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5 A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN. On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6 The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chanity Purcell LPN, Christy Moore RN and Brenda Humphries RN.	

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F 441	Continued From page 108 revealed CNA #5 delivered a meal tray to Resident I. CNA #5 sat the tray up for Resident I, who was sitting in a wheelchair. CNA #5 was observed to sit on the resident's bed to assist with the noon meal. Observation of the noon meal service on 10/30/12, at 12:55 PM, revealed CNA #14 was observed to sit on Resident #8's bed while continuing to feed the resident the meal. Interview on 10/30/12, at 12:50 PM with CNA #5, revealed staff should be at eye level when assisting residents with meals. CNA #5 stated staff was not permitted to sit on resident's bed if the resident occupied the bed. CNA #5 stated Resident I was sitting in a wheelchair for the meal therefore, it was acceptable for the CNA to sit on the resident's bed. CNA #5 stated she recalled	F 441	A resident transfer audit was completed on 11/15/12 by Mary Arms, DON and Emily Jones Gray, Assistant Administrator. No other residents were identified as being affected. All CNA resident care plans and assignment sheets were reviewed to ensure that resident care needs were identified and that assignment sheets reflect how care is to be provided to each resident. This was completed by Roberta Thompson, MDS Coordinator and Crystal Cantrell, LPN MDS Staff on 12/29/12. The nurse's notes for all residents were reviewed for the months of October, November and through December 15, 2012 for documented changes in resident condition and physician and family notification. This was completed by Mary Arms DON, Anna Caldwell ADON, Emily Jones-Gray Assistant Administrator, Brenda Humphries Quality Assurance, Kathy Meadows Social Services, Misty Pennington Social Services and Marie Pennington Activities Director.	
	being taught in nurse aide training to place a towel on the resident's bed prior to sitting on the bed to prevent staff from spreading germs. Interview on 10/30/12, at 3:10 PM with CNA #4, revealed staff were permitted to sit or stand at the residents' bedside. CNA #4 stated if staff sat on resident beds, germs could be spread from one residents' bed to another bed from staff clothing. Interview on 10/30/12, at 3:15 PM with CNA #8 stated she had been employed at the facility for three years and had always sat on resident beds during meals. CNA #8 stated "after thinking about it, it was "kinda gross" because germs could be spread from my uniform". Interview on 10/30/12, at 3:20 PM with CNA #9 staff were permitted to stand or sit when assisting		If it could not be determined by reviewing the nurse's notes that the family and MD were notified of changes in resident condition then the MD and family were contacted regarding the change. The respective physicians were faxed by Mary Arms, DON on December 18- 19, 2012 to ensure that they were aware. None of the physicians responded back to the facility indicating that they were unaware of any of the documented changes in the resident condition. Families were contacted on December 14	

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F 441	Continued From page 109 residents with meals. CNA #9 stated staff were not permitted to sit in resident's wheelchairs and probably should not sit on bed because could spread germs from one residents' bed to another. Interview on 10/30/12, at 3:30 PM with CNA #6 revealed staff could sit or stand to feed residents. CNA #6 stated because she was short in stature, she had to stand at residents' bedside when feeding for the resident to have full view of her. CNA #6 stated sitting on the bed could cause cross contamination and spread germs from resident's beds. An interview conducted with CNA #14 on 10/30/12, at 1:00 PM revealed she could either sit or stand to feed a resident and had never been told it was unacceptable to sit on a resident's bed when feeding a resident. However, the CNA acknowledged it was not a good idea to sit on a resident's bed due to the risk of spreading germs.	F 441	- 16, 2012 by Anna Caldwell, ADON, Chanity Purcell, LPN, Emily Gray, Assistant Administrator, Kathy Meadows, Social Services, and Misty Pennington, Social Services to ensure that families were aware of documented changes in resident condition. There was one documented change in one resident that the family was unaware of. All accident/ incident reports for September, October and through November 23, 2012 were reviewed and compared to the resident record to ensure that the MD and family had been notified. This was completed by November 23, 2012 by Mary Arms, DON. On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified.	
F 490 SS-J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	3. LPN #1 was terminated on 10/18/12 by Mary Arms, DON. LPN #3 was given a disciplinary warning and placed on probation on 10/20/12 by Mary Arms, DON. The nurse aide was counseled on following the plan of care for Resident #14 and given a disciplinary a-warning on 4/20/12 as a result of the facility investigation. This was completed by Mary Arms, DON. The nurse aides last day of employment with the facility was 4/21/12.	

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F 490	Continued From page 110 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined Administration failed to ensure the facility was administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical wellbeing for two (2) of twenty-four (24) sampled residents (Resident #1 and #14). The Administration failed to ensure policy and procedures were implemented for wound care. Facility staff noted on 09/12/12, Resident #1 had a wound on the left great toe. However, Administration failed to ensure facility staff assessed and documented Resident #1's wound on a weekly basis in accordance with facility policy and procedures; failed to ensure necessary care and services were provided to Resident #1's wound in an effort to aide healing;	F 490	The facility process for making transportation arrangements for outside appointments was reviewed by Deborah Fitzpatrick, Administrator and Mary Arms, DON on 10/19/21. The facility transportation policy was reviewed and revised on 10/19/12 by Deborah Fitzpatrick Administrator and Mary Arms, DON on 10/19/12. The Medical Director is in agreement. See attachment #7 A transportation log was developed to track appointment and transportation arrangements. This was completed by Deborah Fitzpatrick, Administrator, Mary Arms, DON and Christy Moore, RN on 10/20/12. See attachment #8 An instruction sheet was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9		
	failed to ensure arrangements had been made for Resident #1 to be assessed at a Wound Care Clinic (WCC) as ordered by the resident's physician; and failed to ensure the physician was notified of a significant change in the wound on Resident #1's left great toe. Documentation revealed the wound on Resident #1's left great toe worsened and on 10/20/12, the resident's toe was amputated. (Refer to F157, F282, and F309). In addition, Administration failed to ensure policy and procedures were implemented related to care plans. Nurses failed to follow the care plan for Resident #14 to ensure adequate assistance was provided during the transfer and, as a result, Resident #14 sustained an injury to the left ankle that required wound care. (Refer to F282 and F323).		A list of transportation services, phone numbers, required forms and special requirements was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9 The system used to keep the appointment information and transportation arrangements was reviewed and revised on 10/19/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. Two books had been used to make appointments. The books were combined into one book. Each nursing unit has an		

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F 490	Continued From page 111 Administration also failed to ensure the Quality Assurance (QA) Committee identified quality deficiencies and implemented corrective actions related to weekly wound assessment/care. (Refer to F520). The failure of the facility to ensure the facility was administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical wellbeing placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12. The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.75 Administration, with a scope and severity of "D," while the facility develops and implements a Plan of Correction and the facility's Quality Assurance. The findings include: Review of the facility policy entitled "Change in a Resident's Condition or Status" (undated) revealed the facility was to notify the resident's attending physician and representative of changes in the resident's condition/status. The policy revealed Nursing Services would be responsible for notifying the resident's attending physician and representative when there had	F 490	appointment/transportation book with the following items: <ul style="list-style-type: none"> • Transportation Policy • Instructions for making appointments. • Phone numbers for the transportation services and notification requirements of each service. • Transportation Log • Appointment Calendar • Transportation Forms Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10 Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service. The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10 The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11	

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F 490	Continued From page 112 been a significant change in the resident's physical status, when there had been a need to alter the resident's treatment significantly or when deemed appropriate in the best interests of the resident. The review further revealed all notifications should be made as soon as practical, "but in no case shall such notification exceed twenty-four (24) hours." The policy also revealed, "All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our charting and documentation policies and procedures" Review of the facility policy entitled "Skin Care" revised September 2001, revealed staff were to measure and record wounds on a weekly basis. Review of the facility policy entitled "Wound	F 490	The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12 A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. See Attachment #13 On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.	
	Documentation" undated revealed pressure ulcers, diabetic ulcers and other wounds should be measured weekly by licensed staff. The policy revealed documentation should include wound location, stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, granulation, description of surrounding tissue, pain, and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified. Review of the facility policy entitled "Transportation Policy" dated May 2008; revealed staff would assist residents by making transportation arrangements for resident's scheduled appointments. The review revealed nursing staff was responsible to make		A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1) The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is	

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F 490	<p>Continued From page 113</p> <p>transportation arrangements as soon as they were aware of the resident's appointment. The policy further revealed staff should maintain a record of appointments should obtain confirmation of transportation arrangements and should check the appointment book daily to ensure appointments were kept.</p> <p>1. On 09/12/12, facility staff assessed Resident #1 and noted the resident had a scabbed area on the left great toe, the resident's physician was notified, and orders were received for wound care treatment and to arrange for the resident to be assessed at a Wound Care Clinic (WCC).</p> <p>Resident #1 was seen at the Wound Care Clinic (WCC) on 09/13/12, 09/20/12, and staff was to schedule a follow-up appointment for Resident #1 to be seen in the WCC on 09/27/12; however, staff (Licensed Practical Nurse [LPN] #1) failed to arrange transportation for the resident's follow up appointment on 09/27/12, and, as a result, the resident did not receive an assessment/treatment on that date by the WCC.</p> <p>An interview on 10/24/12, at 4:30 PM, with LPN #1 revealed the nurse had been responsible to make arrangements for Resident #1's transportation to appointments. LPN #1 stated she could not recall why she failed to make transportation arrangements for Resident #1's follow up appointment on 09/27/12 to the WCC.</p> <p>On 09/28/12, (15 days after the assessment of the wound on 09/13/12) staff documented an assessment of the wound on Resident #1's left great toe and noted the wound was red with pink surrounding tissue measuring 1.4 centimeters</p>	F 490	<p>in agreement with the revision. See Attachment #14 (2)</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents, and infection control.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment 24</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalim spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in</p>	

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F 490	Continued From page 114 (cm) X 0.2 cm X 0.1 cm. Although facility staff documented treatments were administered to the wound on Resident #1's left foot from 09/28/12, to 10/16/12, facility staff failed to document an assessment of the wound until 10/17/12, nineteen (19) days after the previous assessment of the wound on 09/28/12. A review of the nurses notes dated 10/17/12, revealed the wound to the resident's left toe had an odor was draining. The Minimum Data Set (MDS) Assistant revealed in an interview that she had conducted an assessment of Resident #1 on 10/15/12, and the resident's toe was moist with black necrotic tissue, brown purulent drainage, a foul odor, and redness to the first joint of the toe. The interview revealed the wound status was reported to LPN #1 to report to the resident's physician; however, the physician was not notified of the change in the resident's condition on that date. Documentation revealed LPN #1 assessed Resident #1's wound on 10/18/12, and documented the wound was red and inflamed, had a yellow sloughing and an odor, and was necrotic. Resident #1 was transported to an acute care facility on 10/18/12, and the resident's left great toe was amputated on 10/20/12, due to "wet" gangrene. Interviews on 10/23/12, at 6:15 PM and on 11/01/12, at 2:35 PM with the Director of Nursing (DON) revealed a resident's wound should be assessed/measured and documented at least once a week. The interview revealed although the facility did not conduct audits to ensure	F 490	the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON. A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week. Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week. The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQL Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.		

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F 490	Continued From page 115 physicians were notified of a change in a resident's condition, licensed nurses were to notify a resident's physician of any changes in the resident's condition. The DON stated the nurse caring for the resident was responsible for making transportation arrangements for resident's appointments. Interviews on 10/23/12, at 8:15 PM and on 11/01/12, at 3:45 PM with the Administrator revealed when a wound was identified, the nurse was required to notify the resident's physician, obtain orders for treatment, assess/measure the wound, and document the assessment on the Wound Evaluation Flow Sheet. The Administrator revealed the facility had monitored a sample of charts on a monthly basis to ensure staff conducted physician notification for all change in resident condition; however, the Administrator stated the monitoring had been discontinued due to staff compliance in meeting the goal established. The Administrator also stated the nurse caring for the resident was responsible for making transportation arrangements for the resident's appointments. An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician confirmed she had not been informed of the decline in the status of Resident #1's wound unit 10/17/12. According to the physician, she expected the nurses to follow physician's orders, to assess the resident's wounds while performing wound care and to be notified of any changes in the wound. 2. A review of the facility's policy titled, Care Plans-Comprehensive (revised 10/20/08) revealed it was the policy of the facility to develop	F 490	A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16 The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/23/12 4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.	
			On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments. The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4 A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to	

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F 490	Continued From page 116 a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs. Further review of the policy revealed the comprehensive care plan had been designed to incorporate identified problem areas, and to prevent declines in the resident's functional status and/or functional level. The policy revealed the Certified Nursing Assistant (CNA) care plans were developed from the comprehensive care plan and would identify specific care area needs and approaches necessary for the CNA to provide daily care to individual residents. The facility assessed and identified in a plan of care that Resident #14 required the assistance of a minimum of two staff for transfers. However, on 04/09/12, one staff person transferred the	F 490	provide quality assurance monitoring specifically for the nursing department. A QA subcommittee was formed by Deborah Fitzpatrick, Administrator and consists of the department managers. The committee meets weekly and reviews the results of the recently developed monitoring tools to improve the facility's QA program. This will be ongoing. The results will be reported quarterly through CQI by the person completing the audits. The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17		
	resident from the bed to a wheelchair and the resident sustained a soft tissue injury to the left ankle after reportedly hitting his/her ankle on the wheelchair. As a result of the injury, Resident #14 required evaluation at an Emergency Department on two separate occasions. On 04/09/12, Resident #14 was transferred to the Emergency Department for evaluation due to swelling, pain, and redness of the left ankle. On 04/18/12, Resident #14 experienced swelling of the ankle, increased pain (refused for staff to touch the ankle), and had developed a necrotic area at the injured site. On 04/18/12, Resident #14 was again transferred to the Emergency Department for evaluation, was diagnosed with cellulitis, and was prescribed an antibiotic treatment. In addition, on 04/26/12, a hematoma formed at the injured site and wound care was required for the left ankle.		A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18 All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment.		

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F 490	Continued From page 117 The Director of Nursing (DON) stated in an interview on 11/01/12, at 2:30 PM, that staff members were required to follow the resident plan of care. The DON confirmed Certified Nursing Assistant (CNA) #15 failed to follow the plan of care and transferred Resident #14 from the bed to a wheelchair without assistance and Resident #14 sustained an injury to the left ankle. 3. A review of the facility's policy titled "Quality Control," (undated) revealed the facility had a quality control program that that identified specific deficiencies, measured the level of quality services by each department, and continually furnish information that would aid the facility in taking corrective action for problems that were identified. In addition, the policy revealed quality control records would be maintained and would be discussed quarterly during committee meetings. The policy also stated any items requiring corrective action would be discussed with the Administrator as they arose. A review of the facility's Resident Roster Matrix revealed there were nineteen (19) residents in the facility with wounds. A review of medical records for ten (10) of the residents (Residents #2, #3, #4, #5, #6, #7, #8, #9, #12 and #14) with wounds revealed facility staff had not always conducted a weekly assessment of the wounds in accordance with facility policy. An interview with the Assistant Director of Nursing (ADON) on 10/23/12, at 7:10 PM and with Registered Nurse (RN) #2 on 10/23/12, at 7:30 PM revealed they had the responsibility to perform Quality Assurance (QA) activities related	F 490	This started on 10/22/12 and will be ongoing. A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment #19 Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12. If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary		

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F 490	<p>Continued From page 118</p> <p>to resident wounds and acknowledged staff had not always documented skin assessments of wounds on a weekly basis. The ADON and RN #2 stated they failed to ensure their findings were reported to the QA committee to ensure corrective actions were identified in an effort to prevent wound deterioration and promote wound healing.</p> <p>An interview on 11/01/12, at 1:10 PM with the Assistant Administrator revealed she was also the QA Coordinator. The Assistant Administrator stated she had not been informed that the weekly wound assessments had not been conducted.</p> <p>An interview on 10/25/12, at 5:45 PM with the Administrator revealed the facility monitored wound care by conducting Continuous Quality Improvement (CQI) of wounds. The interview</p>	F 490	<p>to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated.</p> <p>See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be</p>		
	<p>revealed facility policy was for the nurses to assess wounds once a week and record the assessment on the Wound Flow Sheet and the wound logbook. According to the Administrator, she was unaware nurses had not conducted weekly wound assessments until the facility initiated an investigation into the deterioration of Resident #1's wound, or that all results of staff monitoring, including wound care assessments, had not been reported to the QA committee.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An Extended Survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p>				

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F 490	Continued From page 119 --A review of the AOC revealed the following: On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate. Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures. On 10/19/12, the Administrator and the DON reviewed and revised the facility's transportation policy and procedure. The Medical Director was	F 490	reported quarterly through CQI by Mary Arms, Don. See attachment #20 The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21 As part of CQI the transportation logs		
	in agreement with the revision of the policy. The revisions included combining the appointment book and transportation book into one (1) book. The book is kept at each nurses' station and contains the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, and 6) Transportation Forms. On 10/20/12, the Administrator, the DON, and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff		will be reviewed weekly by Emily Gray Assistant Administrator, or a designee to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22 The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI		

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F 490	<p>Continued From page 120 reference.</p> <p>On 10/21/12, the Administrator and the DON reviewed the facility's Pressure Ulcer policy and the Wound Documentation policy and no revisions required. The Medical Director was also in agreement.</p> <p>On 10/21/12, the DON notified the Medical Director of the issues identified related to the investigation of Resident #1's wound and missed appointment with the WCC. The Medical Director was also notified and in agreement with the facility's corrective measures taken.</p> <p>On 10/22/12, RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p>	F 490	<p>Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>A form was created on 11/23/12 to use in evaluation of treatment procedures performed by licensed staff regarding following physician orders and the resident plan of care. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #33</p> <p>Four (4) treatments per week will be observed by the QA nurse to ensure that the individual resident care plan and physician orders are being followed and soiled dressings are disposed of per facility policy. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the</p>	
	<p>The Administrator formed a QA subcommittee which consists of each department head/manager that will meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>-The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and</p>			

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F 490	Continued From page 121 appointment issues. Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures. Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures. Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's transportation policy/procedure revealed the policy was revised on 10/19/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director and review of the facility's transportation policy/procedure revealed the	F 490	QA nurse. This audit may be delegated to other staff in the future. A shift report review will be completed at least 3 times weekly and compared with the resident nurses' notes to ensure that the MD and family have been notified of changes in resident condition. This will be ongoing and will be completed by Mary Arms DON, Anna Caldwell, ADON or the QA nurse. The results of this audit will be reported quarterly through CQI by the person completing the audit. 12/14/12 A chart audit will be completed on 4 charts per unit per week (48 charts per month) to ensure that MD and families are notified of changes in resident condition and that it is documented. This will be completed for 6 months and then re-evaluated. This will be completed by the QA nurse or Mary Arms, DON using the Call Log Audit Form. This started on 12/1/12. See Attachment #59 The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week to ensure that residents are transferred according to their plan of care. This will be completed for 6 months and then re-evaluated. This started on 11/28/12. The results of the audits	

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F 490	Continued From page 122 Medical Director was in agreement with the revision of the policy. Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the second floor and at 3:20 PM on the first floor revealed an Appointment/Transportation book kept at each nursing station. The book contained the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, 6) Transportation Forms and 7) instructional sheet. Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 revealed the licensed staff were knowledgeable of the contents and use of the Appointment/Transportation book. Interviews on 12/12/12, at 4:40 PM with the DON, on 12/12/12, at 11:00 AM with RN #2, on 12/13/12, at 2:55 PM with the Administrator, and review of the facility's transportation policy/procedure revealed on 10/20/12, the Administrator, the DON and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff reference.	F 490	will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future. The results of all audits will be reported quarterly through CQI by Emily Jones-Gray QA Coordinator or the person completing the audit. This will be ongoing. Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.	
			5. Date of Completion 1/8/13 F 514. 483.75(I)(1) RESIDENT RECORDS – COMPLETE/ACCURATE /ACCESSIBLE It is the policy 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. This is evidenced by the following: 1. The attending physician and the family of resident #1 was notified on 10/17/12 by LPN #3 of the change in	

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F 490	Continued From page 123 Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's policies revealed the Pressure Ulcer policy and the Wound Documentation policy were reviewed 10/21/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director was in agreement with not revising the policies. Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 1:30 PM with the Medical Director and review of an e-mail revealed on 10/21/12, the DON notified the Medical Director of the issues identified related to the investigation of Resident #1's wound and missed appointment with the WCC. The Medical Director was also notified and in agreement with the facility's corrective measures taken. Interviews on 12/12/12, at 11:00 AM with RN #2, on 12/13/12, at 1:30 PM with the Medical Director and review notification letters dated 10/22/12, revealed RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification. Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator, at 3:10 PM with the Assistant Administrator, at 1:40 PM with the Activity Director and review of the QA subcommittee meeting minutes for 10/23/12, revealed the Administrator formed a QA subcommittee which consists of each department head/manager that meet weekly to review the monitoring tools recently developed to improve	F 490	condition related to the wound on the left great toe. See attachment #1 The attending physician was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being sent transferred to KDMC to the physician that had previously done surgery on her other leg. See Attachment #2 Mary Arms, DON began reviewing the medical record of resident #1 and investigating. She continued to review the record and investigate the incident on 10/19/12. The attending physician was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3 The medical record of resident #1 was reviewed on 10/20/12 by Mary Arms, DON to ensure that other appointments had not been missed. The MDS and care plan of resident #1 was reviewed on 10/19/12 by Roberta Thompson, RN MDS Coordinator. The family was notified on 10/20/12 by Mary Arms, DON of the missed appointments and that we had reported this to OIG.	

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F 490	Continued From page 124 the facility's QA program.	F 490	Resident #1 has not returned to this facility.	
F 514 SS-J	483.75(l)(1) RES 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: The facility failed to ensure clinical records were complete and accurately maintained in accordance with accepted professional standards and practices for eight (8) out of twenty-four (24) sampled residents (Residents #1, #2, #3, #5, #8, #9, #14 and #16). Resident #1 developed a scabbed area to the left great toe on 09/12/12. Staff measured the wound on 09/12/12, and again on 09/28/12. The facility failed to assess the wound again until 10/17/12,	F 514	Individual skin assessments were completed on Residents #2, #3, #5, #8, #9 and #14 on 10/19/12 by Yvette Short, RN, Jessica Arnett, RN, Jeri Frazier, LPN and Heather Mowery, LPN to ensure that all resident wounds were identified. All areas identified on the individual skin assessments of residents #2, #3, #5, #8, #9 and #14 completed on 10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12. Any new areas or areas in question (identified on the individual skin assessments of resident #2, #3, #5, #8, #9 and #14 completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12. On 10/20/12 the individual wound monitoring records for residents #2, #3, #5, #8, #9, and #14 were reviewed and compared to their individual skin assessments	

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F 514	<p>Continued From page 125</p> <p>nineteen days later, when the area was noted to be draining and had a foul odor. On 10/18/12, Resident #1's family member asked to observe the resident's toe. The resident's toe was red and inflamed, had an odor, yellow slough (a mass or layer of dead tissue separated from the surrounding or underlying tissue), and a necrotic (dead tissue) area. Resident #1 was transported to an acute care facility on 10/18/12, for treatment to the left toe, at the insistence of the resident's family after the family member observed the resident's toe had worsened. Resident #1's left great toe was amputated on 10/20/12, due to wet gangrene (death of tissue due to a loss of blood supply with a bacterial infection). The facility also failed to ensure weekly wound assessments were conducted in accordance with facility policy and professional standards for Resident #2, #3, #5, #8, #9 and #14. (Refer to F309 and F314)</p> <p>In addition, Resident #16 had a physician's order for twenty (20) milliequivalents of Potassium Chloride (composed of potassium /chlorine) capsules to be administered orally every day. However, during the facility's changeover to a new computer system that had been implemented to develop the resident's Medication Administration Records (MAR), in June 2012, 20 milliequivalents of Potassium Citrate (potassium salt/citric acid) capsules was documented on Resident #16's MAR instead of (20) milliequivalents Potassium Chloride as prescribed by the physician. Documentation revealed from 06/07/12, through 07/13/12, staff documented twenty-two (22) out of thirty-seven (37) days that twenty (20) milliequivalents of Potassium Citrate was administered even though according to the pharmacist, Potassium Citrate had not been</p>	F 514	<p>completed on 10/19/12 to ensure that all wounds have been measured and are documented on their individual wound care monitoring sheets. This was completed by Christy Moore, RN.</p> <p>The attending physicians of resident #2, #3, #5, #8, #9, and #14 were notified via fax on 1/22/12 of their respective resident wounds, type and location. See Attachment #4</p> <p>A copy of the individual skin assessments for residents #2, #3, #5, #8, #9, and #14 completed on 10/19/12 was given to the MDS department for review. The individual MDS and care plans for these residents were reviewed and revised if needed by Donna Fannin, LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas were identified and care planned appropriately. This was completed on 10/24/12.</p> <p>A list of the current medications for resident #16 was obtained from pharmacy and compared to the electronic MAR to ensure that all medication orders were transcribed correctly. This was completed on 11/24/12 Christy Moore, RN</p> <p>2. On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two</p>		

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F 514	<p>Continued From page 126</p> <p>supplied to the facility and was not available for staff to administer. The MAR was corrected and the Potassium Citrate was changed to Potassium Chloride on 07/13/12.</p> <p>The failure of the facility to ensure clinical records were complete and accurately maintained in accordance with accepted professional standards and practices placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.75 Administration, with a scope and severity of "D," while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Documentation of Medication Administration," with a revision date of April 2007, revealed staff was required to document the name and strength of a drug.</p> <p>A review of the facility's policy titled, "Electronic Order Entry Policy", with a date of 09/19/12, revealed when a physician's order was received it should be transcribed onto the MAR in the electronic health record. The policy also stated</p>	F 514	<p>most recent MDS assessments and Care Plan of all residents identified as having a pressure area.</p> <p>On 10/19/12 an individual skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the individual skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified on their individual skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p> <p>On 10/20/12 the individual wound monitoring records of all residents were reviewed and compared to their individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the individual skin assessments completed on</p>		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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F 514	<p>Continued From page 127</p> <p>when staff was transcribing orders they should compare the electronic health record to the written order after transcribing the order to ensure the accuracy of the order.</p> <p>Review of the facility policy entitled "Change in a Resident's Condition or Status" (undated) revealed the facility was to notify the resident's attending physician and representative of changes in the resident's condition/status. The policy revealed Nursing Services would be responsible for notifying the resident's attending physician and representative when there had been a significant change in the resident's physical status, when there had been a need to alter the resident's treatment significantly or when deemed appropriate in the best interests of the resident. The review further revealed all notifications should be made as soon as practical, "but in no case shall such notification exceed twenty-four (24) hours." The policy also revealed, "All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our charting and documentation policies and procedures"</p> <p>Review of the facility policy entitled "Skin Care" revised September 2001, revealed all wounds were required to be measured and recorded weekly.</p> <p>Review of the facility policy entitled "Wound Documentation" undated revealed pressure ulcers, diabetic ulcers and other wounds deemed necessary to measure should be measured weekly by licensed staff. The policy revealed documentation should include wound location,</p>	F 514	<p>10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on their individual wound monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians were notified via fax on 10/22/12 of their respective residents with the type of wound. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of all individual resident wounds and the current treatments for each wound of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete individual skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have</p>	

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F 514	<p>Continued From page 128</p> <p>stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, granulation, description of surrounding tissue, pain, and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified.</p> <p>Interviews on 11/01/12, at 2:35 PM with the Director of Nursing (DON), and at 3:45 PM with the Administrator, revealed it was a nursing standard of practice to assess wounds at least once a week.</p> <p>1. Review of Resident #1's closed medical record revealed the resident was admitted 06/26/12, for rehabilitation after a Right Below the Knee Amputation (BKA) and diagnoses of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Resident #1's nurse's note dated 09/12/12, at 9:30 AM by Licensed Practice Nurse (LPN) #1 revealed the resident had a scabbed area to the left great toe measuring less than 0.1 centimeter (cm) in diameter.</p> <p>Review of Resident #1's facility Wound Evaluation Flow Sheet and a Wound Care Clinic note (note documented by staff at a Wound Care Clinic outside the facility) dated 09/13/12, revealed the wound to Resident #1's toe measured 2.2 cm x 1.8 cm x 0.1 cm. According to the Wound Care Clinic note, the wound was a diabetic ulcer. Further review of the Wound Care Clinic notes dated 09/20/12, revealed the wound to the resident's toe was a scabbed area with a pale, pink base, measuring 0.7 cm x 0.6 cm x 0.1 cm with no eschar, no yellow sloughing, no</p>	F 514	<p>been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard, LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/15/12 the physicians were notified again of all individual resident wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chanity Purcell LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>3. LPN #1 was terminated by Mary Arms, DON on 10/18/12 for failure to assess and document resident #1 wounds, failure to notify the MD of the change in condition and failure to make transportation arrangements to the wound care clinic for resident #1.</p>	

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F 514	<p>Continued From page 129</p> <p>drainage, and no odor. Review of the facility's Wound Evaluation Flow Sheet dated 09/28/12, revealed the wound to Resident #1's toe measured 1.4 cm x 0.2 x 0.1 cm. However, there was no documented evidence the physician was notified of the increase in size of the wound. Review of Resident #1's Treatment Administration Record (TAR) for September and October 2012, revealed staff documented the resident's toe was cleansed with Normal Saline and treated with Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) every forty-eight hours from 09/28/12 through 10/16/12. The TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12 and on 10/14/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12, and on 10/16/12. However, review of Resident #1's medical record revealed no evidence the resident's wound to the toe was assessed at least weekly as required by the facility's policy and the according to professional standards from 09/28/12 until 10/17/12, for a nineteen day period.</p> <p>Review of Resident #1's nurse's notes dated 10/17/12, at 2:50 PM by LPN #3 revealed the area to the resident's left great toe had an odor and drainage, the physician was notified, and new orders were obtained. A nurse's note dated 10/18/12 at 10:30 AM by LPN #1 revealed Resident #1's family member insisted on observing the resident's toe. LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing to reveal the toe was red and inflamed with a necrotic area, yellow sloughing, and a foul odor. Further review revealed the</p>	F 514	<p>LPN #3 was reprimanded and placed on probation for failure to assess and document the wound of resident #1 by Mary Arms, DON on 10/20/12.</p> <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p>	

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F 514	<p>Continued From page 130 resident was transported to an acute care facility on 10/18/12 at 3:15 PM.</p> <p>Review of Resident #1's Surgical Report dated 10/20/12, revealed the resident's left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview on 10/25/12, at 1:00 PM with the Minimum Data Set (MDS) Assistant revealed on 10/15/12, she conducted a head to toe assessment on Resident #1 during the completion of the resident's Discharge MDS assessment. The interview revealed the resident's wound to the left great toe was moist, with black necrotic tissue, brown purulent drainage, a foul odor, and redness to the first joint of the toe. The MDS Assistant stated she reported the findings to LPN #1, who was responsible for the resident's care, and assumed the LPN would assess the resident's wound and call the resident's physician. However, a review of Resident #1's medical record revealed no evidence the resident's wound was assessed until 10/17/12.</p> <p>An interview on 10/24/12, at 4:30 PM with LPN #1 and on 10/24/12, at 12:50 PM with LPN #3 revealed wounds were required to be assessed during every wound care for changes and every Friday the assessment was documented on a Wound Flow Sheet. LPN #1 and #3 were not able to explain why there was no documentation that Resident #1's wound was assessed for the first two (2) weeks of October, even though they had provided the wound care to Resident #1's toe every forty-eight (48) hours, according to the TAR. LPN #1 stated that the reason nothing was</p>	F 514	<p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the form. See Attachment #13</p> <p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1)</p>		

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F 514	<p>Continued From page 131</p> <p>documented might have been that staff was too busy.</p> <p>An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician revealed the physician expected the nurses to assess the resident's wounds while performing wound care.</p> <p>Interviews on 10/23/12, at 6:15 PM with the Administrator and the Director of Nursing (DON) revealed the nurse assigned to the resident on Friday of each week was required to assess residents' wounds unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed staff was required to assess the wound, including measurements, and document the assessment on the Wound Evaluation Flow Sheet. The interview revealed they were not aware Resident #1's wound to the toe had not been assessed at least weekly until the resident's son requested to see the resident's wound and the resident was transferred to the hospital.</p> <p>Interview on 10/24/12, at 7:30 PM with Registered Nurse (RN) #2 revealed all nurses were trained upon hire to assess and document all wounds on every Friday or the closes treatment day to Friday.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 10/31/11, with diagnoses of left buttock ulcer, sacral ulcer, Anemia, Peripheral Vascular Disease and Diabetes. Resident #2's medical</p>	F 514	<p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p> <p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that</p>		

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F 514	<p>Continued From page 132</p> <p>record revealed the resident was readmitted from an acute care facility on 08/06/12 with a pressure ulcer to the left buttock and blisters to both heels. The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 and the wound to the left buttock measured 3 cm x 3.5 cm x four cm, the left heel wound measured 5 cm x 5 cm, and the right heel wound measured 5 cm x 5 cm. On 08/19/12, the left heel measured 6.1 cm x 8.8 cm x UTD, the right heel had no measurements and the left buttocks measured 3 cm x 3.4 cm x 5 cm.</p> <p>Review of the Wound Evaluation Flow Sheet revealed the next assessment was on 09/07/12 (4 weeks later) the left buttock measured 3 cm x 3 cm x UTD. There was no evidence the resident's heels were assessed.</p> <p>Further review of the Wound Evaluation Flow Sheets revealed on 09/14/12, (5 weeks later) the left heels measured 2 cm x 2 cm and the right heel measured 2.5 cm x 1 cm. Physical Therapy was providing treatment to Resident #2's buttock, which was assessed by Physical Therapy. Review of the Wound Evaluation Flow Sheet revealed the next measurement for the left heel was not until a facility wide skin sweep was conducted on 10/21/12 (four weeks later), which measured the wound to be 3 cm x 1.8 cm.</p> <p>Observation on 10/23/12, at 3:40 PM, of Resident #2's wound care with LPN #2 revealed the left heel had a dark, dry, scabbed area with redness and a small amount of swelling around the wound. The wound measured 3 cm x 1.5 cm with no drainage or odor. The observation revealed the right heel had no wound and the resident's</p>	F 514	<p>documentation is being completed as part of CQL .</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk</p>	

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F 514	<p>Continued From page 133</p> <p>buttocks had a wound vacuum with an occlusive dressing.</p> <p>Interview on 10/23/12, at 7:30 PM, with Registered Nurse (RN) #2, revealed she was unsure why nurses had failed to document weekly wounds assessments for Resident #2.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12, with multiple Pressure Ulcers.</p> <p>Review of Resident #3's Wound Evaluation Flow Sheet revealed on 10/04/12, the resident had an area to a bunion on the left foot that measured 0.6 cm x 0.4 cm x unable to determine (UTD) the depth, an area to the left outer ankle with measurements of 0.4 cm x 0.4 cm x UTD, an area to the left heel that measured 1.7 cm x 2.3 cm x UTD, a Stage II to the coccyx with measurements of 3 cm x 3 cm x 0.2 cm, and an area to the right heel with no measurements.</p> <p>Further review of Resident #3's Wound Evaluation Flow Sheet revealed no other assessments of the wounds until the facility conducted a facility wide skin sweep during the weekend of 10/19-20/12. The flow sheet revealed on 10/20/12, the bunion to the resident's left foot measured slightly larger at 0.6 cm x 0.5 cm x UTD, the area to the left outer ankle measured slightly larger at 0.4 cm x 0.5 cm x UTD, the area to the left heel measured the same, the Stage II to the coccyx measured larger at 7 cm x 3.5 cm x UTD, the area to the right heel measured 3.4 cm x 4.1 cm x UTD and the area to the left third toe measuring 0.6 cm x 0.8 cm x UTD.</p>	F 514	<p>medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p>	

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F 514	<p>Continued From page 134</p> <p>Review of Resident #3's TARs for October 2012, revealed LPN #1 provided the resident's treatments on 10/04/12, 10/05/12, 10/09/12, 10/10/12, 10/14/12, 10/15/12 and on 10/18/12. The TAR further reviewed LPN #3 provided the resident's treatments on 10/06/12, 10/07/12, 10/08/12, 10/11/12, 10/12/12, 10/16/12, and on 10/17/12. According to the TAR, LPN #7 provided the resident's treatment on 10/13/12.</p> <p>Observation on 10/30/12, at 3:00 PM of Resident #3's wound care with LPN #3 revealed the area to the coccyx had red tissue surrounding the open wound which measured 8.3 cm x 6.2 cm, the opened wound measured 5.4 cm x 4.7 cm x 0.5 cm. The coccyx wound was pink with yellow/white sloughing noted. The right inner ankle was slightly red with no open wounds. The right heel was boggy and dark measuring 2.2 cm x 3.4 cm. The left outer ankle was yellow with a slight amount of yellow drainage noted on the old dressing and measured 1.2 cm x 1 cm x 0.1 cm. The left heel had a dark area that measured 1.5 cm x 1.2 cm. The bunion to the outer side of the left foot was dark and measured 0.4 cm x 0.4 cm and the third toe on the left foot had black edge on a dark area that measured 0.4 cm x 0.8 cm.</p> <p>Interviews on 10/24/12, at 12:50 PM with LPN #3, at 4:30 PM with LPN #1 and on 10/30/12, at 6:17 PM with LPN #7, revealed all wounds were to be assessed and documented once a week every Friday on the Wound Evaluation Flow Sheet. The LPNs were unable to explain why there were no weekly wound assessments of Resident #3's wounds documented once a week even though the LPNs had provided the resident's treatments.</p>	F 514	<p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>A list of the current medications for all residents was obtained from pharmacy and compared to the electronic MAR of each resident to ensure that all medication orders were transcribed correctly. This was completed on 11/24/12 by Mary Arms, DON, Christy Moore, RN, Anna Caldwell, ADON and Chanity Purcell, LPN.</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p>	

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F 514	Continued From page 135 4. Review of the medical record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included Previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension, and Nonpsychotic Disorder. A review of Resident #14's care plan revealed facility staff revised the care plan on 05/04/12, with additional interventions to include the following: 1) for staff to cleanse area to the left lateral ankle with normal saline, apply Santyl ointment (an active enzymatic therapy that removes necrotic tissue from wounds), apply a 4 x 4 gauze and wrap with "Kling" (a roll of gauze bandage) every day, and 2) for staff to cleanse the resident's bilateral breast folds with soap and water, dry the area, and apply Nystatin powder (a prescription anti-fungal medication used to treat fungal infections) twice a day. The care plan also stated nursing would complete a skin assessment every week and report any alterations to the physician. Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #14's wound measurements on 05/18/12, as "1.5 cm x 1.5 cm x 0.0 cm," and on 06/01/12 (fourteen days after the previous assessment) as "1.0 cm x 1.2 x 0.0 cm" then weekly for the next three weeks until 06/29/12. However, there were no other measurements documented on the flow sheet from 06/29/12, until 07/27/12, (a timeframe of twenty-eight days). Review of the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a	F 514	The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4 A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries and she is an RN with 19 years experience working in Quality Assurance. The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator or the person completing the audit. See Attachment #17 A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family	

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F 514	<p>Continued From page 136</p> <p>wound and at least weekly from the date of identification. However, based on documentation, the staff failed to conduct a wound assessment for weeks of 05/21/12, 07/02/12, 07/09/12, and 07/16/12.</p> <p>5. A review of Resident #5's medical record revealed the facility admitted the resident on 01/14/12, with diagnosis of Cerebral Vascular Accident, Congestive Heart Failure, Depression, and Failure to Thrive.</p> <p>Continued review of Resident #5's medical record revealed nurse's noted dated 09/05/12 that revealed the resident's physician was notified the resident had a Stage II pressure ulcer to the coccyx. Treatment orders were obtained to cleanse the coccyx with normal saline, pat dry, apply Aquacel AG then a 4 x 4 gauze, and secure with Hypafix every seventy-two (72) hours. However, there was no documentation of the appearance or size of the pressure wound.</p> <p>Review of Resident #5's care plan revealed facility staff revised the care plan on 09/05/12, and included the additional interventions for staff to cleanse the area to the resident's coccyx with normal saline, pat dry and apply Aquacel AG, then a 4 x 4 gauze and cover with Hypafix every seventy-two (72) hours.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff failed to document the status of Resident #5's pressure ulcer until 09/14/12 (eighteen days after first identified), when the ulcer measured "1.4 cm x 1.0 cm x 0.2 cm. Review of instructions on the Wound Evaluation Flow Sheet, the sheet was to be</p>	F 514	<p>notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment #19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p>		

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F 514	<p>Continued From page 137</p> <p>completed by a nurse upon identification of a wound and at least weekly from the date of identification. Based on a review of documentation on the Wound Evaluation Flow Sheet, staff failed to conduct a wound assessment for weeks of 08/26/12 and 09/02/12.</p> <p>A review of a Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse Resident #5's coccyx pressure ulcer with normal saline, pat dry, cover with Aquacel AG and a 4 x 4 gauze, and then secure with Hypafix the treatment was to be performed every seventy-two (72) hours. The TAR revealed wound care was performed as ordered by the physician; however failed to document an assessment weekly.</p> <p>6. A review of Resident #8's medical record revealed the facility admitted the resident on 09/21/10, with diagnosis of Chronic Ischemic Heart Disease, Cerebral Vascular Accident, Kyphosis, and Anemia.</p> <p>Continued review of Resident #8's medical record revealed nurse's notes dated 08/31/12 that revealed the physician was notified the resident had a Stage II pressure ulcer to the right buttock. Treatment orders were obtained to cleanse the resident's right buttock with normal saline, pat dry then apply Bactroban ointment (an antibacterial used to treat skin infections), cover the area with a Telfa (a non-adherent absorbent cotton dressing pad), then secure with Hypafix (a self-adhesive, non-woven fabric for dressing retention) every day. However, there was no documentation of the appearance or size of the pressure wound until 09/16/12.</p>	F 514	<p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated.</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident</p>		

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F 514	<p>Continued From page 138</p> <p>Review of Resident #8's care plan revealed the care plan was revised on 09/04/12, and 09/16/12 with additional interventions for staff to cleanse area to the right buttock with normal saline, apply Bactroban ointment then cover with Telfa pad and secure with Hypafix every day. The care plan revealed nursing staff was to complete a skin assessment every week and to notify the physician of any alterations.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had failed to document the status of Resident #8's pressure ulcer from 09/16/12 until 10/06/12 (a timeframe of twenty days) and, based on documentation, the ulcer measured "0.4 cm x 0.2 cm x 0.1 cm" on both dates. However, the next measurement on 10/19/12, (thirteen days after the previous assessment), revealed the ulcer measured "4.0 cm X 0.8 cm X 0.1 cm." Review of instructions the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. However, the staff failed to conduct an assessment of the wound on a weekly basis as instructed on the Wound Evaluation Flow Sheet, and failed to assess the wound for several weeks.</p> <p>A review of Resident #8's Treatment Administration Record (TAR) for September and October 2012, revealed staff to cleanse the resident's right buttock with normal saline, pat dry then apply Bactroban ointment (an antibacterial used to treat skin infections), cover the area with a Telfa (a non-adherent absorbent cotton dressing pad), then secure with Hypafix (a self-adhesive, non-woven fabric for dressing</p>	F 514	<p>skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator, or a designee to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified</p>	

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F 514	<p>Continued From page 139 retention) every day. The TAR revealed staff performed wound care as ordered by the physician; however failed to document an assessment weekly.</p> <p>7. A review of Resident #9's medical record revealed the facility admitted the resident on 03/29/11, with diagnosis of Severe Degenerative Changes of L Spine, Weight Loss, Anemia, and Dementia.</p> <p>Review of Resident #9's care plan revealed facility staff revised the care plan on 10/04/12, to include the Stage II pressure ulcer to the right outer hip; however, no additional interventions were noted at that time. According to the care plan, nursing staff was to complete a skin assessment every week and to notify the physician of any alterations.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented on 10/06/12, that the pressure ulcer to the resident's right outer hip measured "3.2 cm X 2.0 cm X 0.1 cm." The next assessment was conducted on 10/20/12 (fourteen days later) and revealed the ulcer measured "2.5 cm X 2.5 cm X 0.1 cm."</p> <p>A review of Resident #9's Treatment Administration Record (TAR) for September and October 2012, revealed staff performed wound care as ordered by the physician; however failed to document an assessment weekly.</p> <p>8. A review of the medical record for Resident #16 revealed the facility admitted the resident on 08/09/10, with diagnoses which included Alzheimer's, Cerebral Vascular Accident,</p>	F 514	<p>will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>All orders are checked daily (7 days per week) by nursing administrative staff to ensure that orders are transcribed/entered correctly as part of CQI. The attached form is used. The results of the audits will be reported quarterly through CQI by Mary Arms, DON or a designee. This is ongoing.</p> <p>The Assistant Administrator/QA Coordinator will report all</p>	

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F 514	<p>Continued From page 140</p> <p>Hypovolemia, Chronic Obstructive Pulmonary Disease, and Arthritis. A review of physician's orders dated 06/15/10 revealed the resident had a physician's order for twenty (20) milliequivalents of Potassium Chloride to be administered to every day.</p> <p>A review of the consultant pharmacist report for Resident #16 dated 07/10/12, revealed the pharmacist documented Resident #16 had been receiving twenty (20) milliequivalents of Potassium Chloride tablets. However, the pharmacist documented Potassium Citrate had been entered into the new computer system and the medications were not interchangeable. The pharmacist asked the facility to clarify the order.</p> <p>A review of the MAR for Resident #16 revealed on 06/07/12, facility staff had entered the physician's order on the resident's MAR as twenty (20) milliequivalents of Potassium Citrate to be administered daily. A review of the MAR for Resident #16 revealed staff documented the resident had received twenty (20) milliequivalents of Potassium Citrate on 06/07/12, 06/09/12, 06/10/12, 06/11/12, 06/12/12, 06/16/12, 06/22/12, 06/23/12, 06/24/12, 06/25/12, 06/27/12, 06/28/12, 06/29/12, 06/30/12, 07/01/12, 07/03/12, 07/04/12, 07/06/12, 07/09/12, 07/12/12, and 07/13/12.</p> <p>An interview conducted with Registered Nurse (RN) #5 on 10/31/12, at 1:50 PM, revealed she had administered medications to Resident #16 on 06/12/12, 06/16/12, 06/27/12, 06/30/12, and 07/01/12. The RN stated she had administered Potassium Chloride to Resident #16 on the dates identified. The RN stated she pulled the medication from the medication drawer, saw</p>	F 514	<p>monitoring results quarterly through CQI.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 520 483.75(o)(1)QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>It is the policy of this facility to 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. This is evidenced by the following:</p> <p>1. I cannot correct this as it relates to resident #1. The resident was transferred on 10/18/12 and has not returned to this facility. This record was reviewed on 10/18/12 and 10/19/12 by Mary Arms, DON during her investigation.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of residents #2, #3, #5, #6,</p>	

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F 514	<p>Continued From page 141</p> <p>"Potassium," and had assumed it was the correct medication. The RN stated she should have checked the MAR closer and was unsure how she had missed the Potassium Citrate being on the MAR instead of the Potassium Chloride.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #4 on 10/31/12, at 2:10 PM, revealed the LPN had been responsible for administering medications to Resident #16 on 06/21/12, and 06/25/12. The LPN stated she could not recall but had probably saw the word "potassium" written on the box and administered the medication. The LPN stated she knew she was required to check the MAR with the medication and should have observed the error.</p> <p>An interview conducted with Certified Medication Aide (CMA) #1 on 10/31/12, at 2:15 PM, revealed she had administered medications to Resident #16 on 06/07/12 and 07/09/12. The CMA stated she could not recall the dates and was unsure what medication she administered to the resident. The CMA stated she was required to check the MAR with the medication to ensure the correct medication was being administered.</p> <p>LPN #5 acknowledged in interview conducted on 10/31/12, at 5:35 PM that based on documentation she had administered medication for Resident #16 on 06/22/12. The LPN stated she would have given the drug that was in the drawer and could not recall if the medication was Potassium Citrate or Potassium Chloride.</p> <p>An interview conducted with RN #2 on 11/01/12, at 9:25 AM, revealed she had administered medications for Resident #16 on 06/23/12. The</p>	F 514	<p>#7, #8, #9 and #14 to ensure that identified pressure areas were care planned.</p> <p>On 10/19/12 an individual skin assessment was completed on resident #2, #3, #5, #6, #7, #8, #9 and #14. The staff names completing the assessments are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the individual skin assessments completed on 10/19/12 for resident #2, #3, #5, #6, #7, #8, #9 and #14 was given to the MDS department for review. All residents identified on their individual skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p> <p>On 10/20/12 the individual wound monitoring records of residents #2, #3, #5, #6, #7, #8, #9 and #14 were reviewed and compared to their individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are documented on their individual</p>	

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F 514	<p>Continued From page 142</p> <p>RN stated she was the Nursing Supervisor and had assisted in developing the MAR for the residents. The RN stated she had corrected the MAR after being notified of the error by the pharmacist. The RN stated Potassium was listed in several dosages and forms in the computerized system, and that when entering the physician's orders into the computerized system she thought Potassium Citrate had been keyed in by accident. The RN stated she had not caught the error during reviews of the MAR's.</p> <p>An interview conducted with RN #4 on 11/01/12, at 9:40 AM, revealed she had been administered medications to Resident #16 on 06/09/12, 06/10/12, 06/11/12, 06/24/12, 06/28/12, 06/29/12, 07/03/12, 07/04/12, 07/12/12, and 07/13/12. The RN stated she "guessed" she had just saw the word "Potassium" and had administered the medication that was in the resident's medication drawer. The RN acknowledged she should have checked the medication with the MAR to ensure the accuracy of the medication she was administered.</p> <p>An interview conducted with the Consultant Pharmacist (RPH) for the facility on 10/31/12, at 2:35 PM, revealed she had identified the transcription error on 07/10/12. The RPH stated the pharmacy had previously developed the facility's MAR's but the facility had implemented a new computer system for generating the resident MAR's. The RPH stated she had not reviewed the new MAR's until 07/10/12 and at that time the RPH printed what had previously been in the pharmacy system, compared that information with the facility's new MARs, and had identified the error. The RPH stated Potassium Citrate had</p>	F 514	<p>wound monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the individual skin assessments of residents #2, #3, #5, #6, #7, #8, #9 and #14 completed on 10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments of resident #2, #3, #5, #6, #7, #8, #9 and #14 completed on 10/19/12) were reviewed, re-measured if necessary and documented on their individual wound monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians of residents #2, #3, #5, #6, #7, #8, #9 and #14 were notified via fax on 10/22/12 of their respective residents wound, type and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of the individual wounds of resident #2, #3, #5, #6, #7, #8, #9 and #14 and the</p>		

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F 514	<p>Continued From page 143</p> <p>not been sent to the facility because it was not available for use, and that facility staff had actually administered the medication Potassium Chloride as prescribed by the physician.</p> <p>An interview conducted with the Director of Nursing (DON) on 11/01/12, at 9:45 AM, revealed the facility had begun utilizing the facility generated MAR's on 06/07/12. The DON stated RN #2 had been responsible for checking the MAR's on the second floor for accuracy prior to the facility utilizing the MAR's on 06/07/12. The DON stated when she received the RPH review of Resident #16's MAR; she immediately gave it to RN #2 to correct the error. The DON stated currently RN #2 and the Assistant Director of Nursing (ADON) were responsible for monitoring all new physician's orders every day, Monday through Friday, and the Minimum Data Set (MDS) nurses were responsible for checking all new physician orders on the weekends.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An Extended Survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>-A review of the AOC revealed the following:</p> <p>On 10/18/12, Licensed Practical Nurse (LPN) #1 was terminated by the Director of Nursing (DON) due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of the change in the resident's wound and the failure to make arrangements for the</p>	F 514	<p>current treatments for each wound of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete individual skin assessment was completed on residents #2, #3, #5, #6, #7, #8, #9 and #14 to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard, LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/16/12 the physicians were notified again of the individual resident wounds of resident #2, #3, #5, #6, #7, #8, #9 and #14 and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>2. The charts of all residents having weekly outside appointments for medical treatment outside the facility were reviewed to ensure they had not missed appointments due to</p>	

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F 514	<p>Continued From page 144 resident's transportation to the wound clinic.</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, the Minimum Data Set (MDS) Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>On 10/19/12, Registered Nurses (RN) #4, #6 and LPNs #2, #4, and #13 conducted skin/wound assessments on all residents.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>On 10/20/12, LPN #3 was reprimanded and placed on probation by the DON due to the failure to assess/document Resident #1's wound.</p> <p>On 10/20/12, RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p>	F 514	<p>transportation not being scheduled. This was completed by Mary Arms, DON and Christy Moore, RN on 10/20/12. There were no other appointments missed for failure to make transportation arrangements.</p> <p>All current residents with randomly scheduled appointments were reviewed to ensure that transportation arrangements had been made. This was completed by Ora Little, LPN and Jessica Wireman, RN on 10/21/12.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments of all residents.</p> <p>On 10/19/12 an individual skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the individual skin assessments completed on 10/19/12 was given to the MDS department for review. The individual skin assessments of all residents were compared to the most recent individual MDS and care plan of all residents by Donna Fannin LPN and Crystal Cantrell LPN (MDS)</p>		

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F 514	<p>Continued From page 145</p> <p>On 10/21/12, RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet, and TARs to ensure accuracy of the medical records. LPN #12 also compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>On 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets (utilized for in-service) were placed in the nursing policy/procedure manuals and in the wound care monitoring books kept at each nursing station for staff reference.</p> <p>On 10/21/12, the Administrator and the DON reviewed the facility's Pressure Ulcer policy and the Wound Documentation policy and no revisions required. The Medical Director was also in agreement.</p> <p>On 10/24/12, the Administrator and the DON reviewed and revised the Wound Documentation Flow Sheet which was larger, more organized, with descriptive terms used to describe wounds.</p> <p>On 10/24/12, the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The</p>	F 514	<p>Department) to ensure that all skin areas identified were coded on the MDS or if a significant change was needed and care planned appropriately. This was completed on 10/23/12.</p> <p>On 10/20/12 the individual wound monitoring records were reviewed and compared to the individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the individual skin assessments completed on 10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on their individual wound monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians were notified via fax on 10/22/12 of their respective</p>		

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F 514	<p>Continued From page 146</p> <p>Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>On 10/24/12, a new Wound nurse started employment and will be assessing and providing treatments to all wounds five (5) days a week. RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The Wound Nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description, and current treatment.</p> <p>As part of the facility's CQI for monitoring skin assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will</p>	F 514	<p>residents wounds, type and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A individual skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to</p>	

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F 514	<p>Continued From page 147</p> <p>notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #1's Employee Disciplinary Report dated 10/18/12, revealed the LPN was terminated due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of Resident #1 concerning the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>Interviews on 12/12/12, at 2:15 PM with LPN #4, on 12/13/12, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6, at 1:20 PM with LPN #13, and review of notes revealed</p>	F 514	<p>ensure they were aware of the wound and the treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chantry Purcell LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>3. The facility process for making transportation arrangements for outside appointments was reviewed by Deborah Fitzpatrick, Administrator and Mary Arms, DON on 10/19/21.</p> <p>The facility transportation policy was reviewed and revised on 10/19/12 by Deborah Fitzpatrick Administrator and Mary Arms, DON on 10/19/12. The Medical Director is in agreement. See attachment #7</p> <p>A transportation log was developed to track appointment and transportation arrangements. This was completed by Deborah Fitzpatrick, Administrator, Mary Arms, DON and Christy Moore, RN on 10/20/12. See attachment #8</p> <p>An instruction sheet was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>A list of transportation services, phone numbers, required forms and</p>	

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F 514	<p>Continued From page 148</p> <p>on 10/19/12, the above licensed staff conducted skin/wound assessments on all residents.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #3's Employee Disciplinary Report dated 10/20/12, revealed LPN #3 was reprimanded and placed on probation due to the failure to assess/document Resident #1's wound.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2,</p>	F 514	<p>special requirements was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>The system used to keep the appointment information and transportation arrangements was reviewed and revised on 10/19/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. Two books had been used to make appointments. The books were combined into one book. Each nursing unit has an appointment/transportation book with the following items:</p> <ul style="list-style-type: none"> • Transportation Policy • Instructions for making appointments. • Phone numbers for the transportation services and notification requirements of each service. • Transportation Log • Appointment Calendar • Transportation Forms <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation</p>		

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F 514	<p>Continued From page 149</p> <p>and review of notes dated 10/20/12, revealed RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets where in page protectors in the front of each nursing policy/procedure manuals and in the wound care</p>	F 514	<p>policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p> <p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the form. See Attachment #13</p>		

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F 514	<p>Continued From page 150 monitoring books for staff reference.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 revealed the licensed staff were knowledgeable of the contents and use of the Wound Care book.</p> <p>Interview on 12/12/12, at 11:00 AM with RN #2 and review of the nursing policy/procedure manuals and wound care books kept at each nurses' station revealed on 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets were placed manuals and books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's policies revealed the Pressure Ulcer policy and the Wound Documentation policy were reviewed 10/21/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director was in agreement with not revising the policies.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the old and new Wound Documentation Flow Sheet revealed the sheet was larger, organized, with descriptive terms used to describe wounds.</p> <p>Interview on 12/13/12, at 3:10 PM with the Assistant Administrator and review of notes dated</p>	F 514	<p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1)</p> <p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p>	

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F 514	<p>Continued From page 151</p> <p>10/24/12, revealed the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The interview also revealed the Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed an instructional sheet to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>Interview on 12/12/12, at 2:45 PM with the newly hired wound care nurse revealed she started employment on 10/24/12, and will be assessing and providing treatments to all wounds five (5) days a week. Interview on 12/12/12, at 11:00 AM with RN #2, revealed RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The interviews revealed the wound care nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description, and current treatment. Review of the newly hired wound care nurses' employee file revealed she started employment at the facility on 10/24/12. Further review of physician notifications letters revealed faxes were being sent bi-weekly to the resident's physician notifying the physician of the resident's wound type, location, description, and current treatment.</p>	F 514	<p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI.</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-</p>		

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F 514	Continued From page 152 Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 1025/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident. Interview on 12/12/12, at 4:40 PM with the DON, at 11:00 AM with RN #2 and review of their personal hand written notes revealed the DON and RN #2 will review all weekly nurses summaries of each resident, including skin assessment and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders. Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.	F 514	Gray, Assistant Administrator and Chantry Purcell, Staff Development. See Attachment 24 Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15 Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A	
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F 520 SS=J	<p>Continued From page 153</p> <p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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 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, and review of facility policies, it was determined the facility failed to ensure the Quality Assessment and Assurance Committee (QAAC) was effective to ensure nursing staff followed facility policies and procedures for the assessment of wounds weekly. On 09/12/12, facility staff assessed</p>	F 520	<p>form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>A CQI subcommittee was formed by the Administrator, Deborah Fitzpatrick on 10/23/12 to review and evaluate the monitoring tools recently developed to improve the facility's QA program.</p>	

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F 520	Continued From page 154 Resident #1 and documented the resident had a calloused area on the tip of the left great toe. Staff also conducted assessments of the area on 09/13/12 and 09/28/12. On 10/18/12, staff assessed Resident #1's wound to be red, inflamed, and necrotic with sloughing, and purulent drainage and an odor. Resident #1 was transported to an acute care facility on 10/18/12, and the resident's left great toe was amputated on 10/20/12. Interview with staff revealed there were nineteen residents in the facility with wounds, twelve (12) of the nineteen (19) residents were selected for record review and revealed facility staff did not consistently conduct a weekly assessment of the wound in accordance with facility policy for eight (8) resident (Residents #2, #3, #5, #6, #7, #8, #9, and #14). Interviews with the Assistant Director of Nursing (ADON) and Registered Nurse (RN) #2 revealed they had the responsibility to perform Quality Assurance (QA) activities related to resident wounds. Per interviews, they were aware nursing staff failed to consistently documented a skin assessment of wounds on a weekly basis; however, failed to ensure actions were identified as part of the QA that would be required to ensure staff assessed all wounds on a weekly basis, or as ordered, in an effort to prevent wound deterioration and promote wound healing. Further interview revealed no one was responsible for conducting QA activities related to resident wounds on the Secure Unit. (Refer to F282, F309, F314, and F514.) The failure of the facility to ensure the Quality Assessment and Assurance Committee (QAAC) was effective placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and	F 520	4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family. On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments. The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4 A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries. She is an RN with 19 years experience working in Quality Assurance. The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on	

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F 520	<p>Continued From page 155</p> <p>determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.75 Administration, with a scope and severity of "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Quality Control," (undated) revealed the facility had a quality control program that that identified specific deficiencies, measured the level of quality services by each department, and continually furnish information that would aid the facility in taking corrective action for problems that were identified. In addition, the policy revealed quality control records would be maintained and would be discussed quarterly during committee meetings. The policy also stated any items requiring corrective action would be discussed with the Administrator as they arose.</p> <p>A review of Resident #1's closed medical record revealed the facility admitted the resident on 06/26/12 for rehabilitation due to a Right below the Knee Amputation (BKA) and diagnosis of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Continued review of the medical record revealed Licensed Practical Nurse (LPN) #1 documented at 9:30 PM on 09/12/12</p>	F 520	<p>11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident.</p>	

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F 520	<p>Continued From page 156</p> <p>(approximately two and one-half months after admission) that Resident #1 had a scabbed area to the left great toe that measured less than 0.1 centimeter (cm) in diameter.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #1's wound measurements on 09/13/12 as "2.2 cm x 1.8 cm x 0.1 cm," and on 09/28/12 as "1.4 cm x 0.2 x 0.1 cm"; however, staff failed to conduct and document wound assessments on a weekly basis as required by facility policy.</p> <p>Continued review of the medical record revealed at 10:30 AM on 10/18/12, (twenty (20) days after the previous assessment) Resident #1's family member insisted on observing the resident's wound. Documentation revealed LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing from the resident's left great toe and the wound was observed to be red, inflamed, with a necrotic area, yellow sloughing and an odor. Further review of the medical record revealed the resident was transported to an acute care facility on 10/18/12, at 3:15 PM for further assessment and treatment.</p> <p>A review of a Surgical Report dated 10/20/12, revealed Resident #1's the left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview on 10/23/12, at 6:15 PM the Director of Nursing (DON) revealed staff should assess, measure, and document the status of the wounds of residents at least once a week. The interview revealed the facility provided nurses in-service training twice a year related to the assessment,</p>	F 520	<p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All</p>		

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F 520	<p>Continued From page 157</p> <p>measurement, and documentation of wounds.</p> <p>A review of the Wound Evaluation Flow Sheets for the eight (8) sampled residents (Residents #2, #3, #5, #6, #7, #8, #9, and #14) chosen from the nineteen (19) residents in the facility with wounds revealed the facility failed to ensure nursing staff consistently assessed/documented the status of the residents' wounds once a week in accordance with facility policy.</p> <p>An interview on 10/23/12, at 7:10 PM with the ADON revealed she gathered information on the first floor nursing unit of resident wounds for purposes of Quality Assurance (QA). The ADON stated she completed a Continuous Quality Indicator (CQI) assessment sheet once a month and had identified staff nurses failed to conduct weekly wound assessment as required. The ADON stated she had reported the problems to the former Assistant Administrator, but this problem was not discussed/addressed in the quarterly QAAC meetings.</p> <p>An interview on 10/23/12, at 7:30 PM with RN #2 revealed she gathered information on the second floor nursing unit of resident wounds for purposes of Quality Assurance (QA). RN #2 also stated she completed a CQI assessment sheet once a month and had also identified nurses had failed to conduct weekly wound assessments. The interview revealed she had not reported this problem to any Administrative staff or discussed/addressed the problem in the quarterly QAAC meetings.</p> <p>An interview on 10/25/12, at 5:10 PM with the Director of Nursing (DON) revealed the facility's</p>	F 520	<p>resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson,</p>	

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F 520	<p>Continued From page 158</p> <p>policy for wound assessments was to assess measure and document the wound assessment on the Wound Flow Sheet. According to the DON, staff was to conduct the assessments one time a week, on Fridays. The DON stated she had assisted with obtaining information for QA in September 2012, and had noticed several weekly wound assessments had not been completed. The DON stated she made a list of residents that needed a wound assessment, requested the week-end nurses obtain the assessments and had "followed up" to ensure all the assessments had been obtained. The DON stated she was unaware staff continued to fail to conduct weekly wound assessments until she started the investigation into the deterioration of Resident #1's wound on 10/18/12. According to the DON, she "knew it was missed at times but didn't realize it was such a big systems failure until the investigation was done." The interview confirmed the DON was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>An interview on 11/01/12, at 1:10 PM with the Assistant Administrator revealed she had been the Assistant Administrator for approximately one year and also functioned as the facility's QA Coordinator. The interview revealed the ADON and RN #2 had been given the responsibility to audit wound development and obtain information related to what contributed to the development of the wound. According to the Assistant Administrator, the ADON and RN #2 were also to determine the stage of wounds, ensure the wound was addressed on the resident's care plan, what the treatment was, if the treatment was effective, if there were nutritional interventions,</p>	F 520	<p>MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI</p>		

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F 520	<p>Continued From page 159</p> <p>physician/representative notification, changes in the wounds, or if there had been an increase in number of wounds. The Assistant Administrator stated she was not aware staff had not always conducted the weekly assessment of wounds in accordance to facility policy, or that staff had failed to report the information to the QAAC. The interview confirmed the Assistant Administrator was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>An interview on 10/25/12, at 5:45 PM with the Administrator revealed facility staff were to obtain information related to wounds and provide the information to the facility's Continuous Quality Improvement (CQI) program. The interview revealed nurses were to assess wounds once a week and record the assessment on the Wound Flow Sheet and the wound logbook in accordance with facility policy. According to the Administrator, she was unaware nurses had failed to conduct the weekly wound assessments until the facility initiated the investigation into the deterioration of Resident #1's wound. The Administrator acknowledged in interview conducted at 3:45 PM on 11/01/12, at 3:45 PM QA staff had not looked at the complete QA process to ensure the facility's QA program was completely effective. The interview confirmed the Administrator was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An</p>	F 520	<p>communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>All new orders are checked daily by nursing administrative staff to ensure that physician orders are entered correctly as part of CQI. The attached form is used. The results of the audits will be reported quarterly through CQI by Mary Arms, DON or the QA nurse. This will be ongoing.</p> <p>A CQI subcommittee was formed by the Administrator, Deborah Fitzpatrick on 10/23/12. The committee consists of the Administrator and all department managers. The Administrator will act as head of this committee and will meet weekly. The results of all audits monitored by this committee will be reported quarterly through CQI by the person completing the audit.</p> <p>The results of all audits will be reported quarterly through CQI by Emily Jones-Gray QA Coordinator or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 520	<p>Continued From page 160</p> <p>Extended Survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>--A review of the AOC revealed the following:</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>As part of the facility's CQI for monitoring skin assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>As part of the facility's CQI for monitoring the transportation arrangement, the Assistant Administrator or the Activity Director will review the transportation logs on each unit to ensure all</p>	F 520	<p>compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p>		

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F 520	<p>Continued From page 161</p> <p>transportation arrangements have been made and any problems identified will be reported to the nursing administration immediately for correction.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>The Administrator formed a QA subcommittee which consists of each department head/manager that will meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>A decision was made to hire a full time QA nurse with 19 years' experience, who will start employment on 11/19/12.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p>	F 520			

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F 520	<p>Continued From page 162</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 10/25/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the</p>	F 520		

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F 520	<p>Continued From page 163</p> <p>resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>Interviews on 12/13/12, at 3:10 PM with the Assistant Administrator, on 12/12/12, at 4:25 PM and on 12/13/12, at 1:40 PM with the Activity Director and review of the Activity Director's audit book revealed as part of the facility's CQI for monitoring the transportation arrangement, the Activity Director had been reviewing the transportation logs on each unit to ensure all transportation arrangements have been made and no problems have been identified; however, if a problem is identified it will be reported to the nursing administration immediately for correction.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON, at 11:00 AM with RN #2 and review of their personal hand written notes revealed the DON and RN #2 will review all weekly nurses summaries of each resident, including skin assessment and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator, at 3:10 PM with the Assistant Administrator, at 1:40 PM with the Activity Director and review of the QA</p>	F 520			

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F 520	Continued From page 164 subcommittee meeting minutes for 10/23/12, revealed the Administrator formed a QA subcommittee which consists of each department head/manager that meet weekly to review the monitoring tools recently developed to improve the facility's QA program. Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings. Interview on 12/13/12, at 11:45 AM with the newly hired QA nurse and review of her employee file revealed she started employment on 11/19/12, and will be working full time.	F 520			