

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

PRINTED: 03/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/29/2012
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NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301
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F 000	INITIAL COMMENTS	F 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 281 SS=D	<p>An abbreviated survey (KY #17803) was conducted on 02/21/12 through 02/29/12. KY #17803 was substantiated with deficiencies cited. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure review, it was determined the facility failed to follow the physician's orders for one resident (#4), in the selected sample of four residents. The facility failed to ensure Resident #4's left leg brace was removed three times a day (TID) for skin checks, as ordered.</p> <p>Findings include: A review of the facility's policy/procedure for Physician's orders, undated, related to Monthly Change over Workflow, revealed the Director of Nursing (DON) or designee compared new Medication Administration Records (MAR) with the existing MARs for the monthly change over workflow. An interview with Licensed Practical Nurse (LPN) #2, on 02/29/12 at 11:05 AM, revealed the facility followed the same procedure for the monthly change over for the Treatment Administration Records (TARs) as for the MARs.</p> <p>A record review revealed the facility admitted Resident #4 on 12/13/11 with diagnosis to include</p>	F 281	<ol style="list-style-type: none"> 1. Resident #4 was assessed by the Assistant Directors of Nursing on 2/23/12 to ensure no negative outcome was caused by the alleged deficient practice. Upon receiving the information the Director of Nursing on 2/28/12 corrected the treatment administration record to correlate the physician order with three specific times for the charge nurse to complete skin checks. 2. On 2/23/12 all other residents having a brace were reviewed to ensure if skin checks were ordered that they were correct on the treatment administration record with appropriate times as per physician order. The Director of Nursing on 3/20/12 reviewed all resident's treatment administration records for appropriate times. Head to 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator DATE 3-22-12

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

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F 281	<p>Continued From page 1</p> <p>a Closed Femur Fracture. The resident was admitted to the facility with a leg immobilizer on the left leg, which was changed to a custom brace on 12/21/11.</p> <p>A review of the physician's orders, dated 12/13/11, January 2012, and February 2012, revealed the staff were to remove the brace on the resident's left leg three (3) times each day for skin checks.</p> <p>A review of the TARs, dated January 2012 and February 2012, revealed "remove the brace on the left leg three times per day for skin checks;" however, the times listed on the TARs were "7:00 AM - 7:00 PM" and "7:00 PM - 7:00 AM." Further review of the February 2012 TAR revealed a single line was marked through the word "three," and "BID" (twice a day) was inserted.</p> <p>Observation of Resident #4, on 02/23/12 at 4:20 PM, revealed the custom brace was in place. The Assistant Director of Nursing (ADON) demonstrated removal of the brace from the resident's left leg, as well as the skin check/assessment which she confirmed should be completed by the charge nurses three (3) times each day.</p> <p>An interview with "D" hall charge nurse, Registered Nurse (RN) #1, on 02/29/12 at 8:10 AM, revealed if a new physician's order for a treatment was obtained and to be started immediately, then she would write it on the TAR; however, if there was an existing order, she would not alter the wording of that order. She stated that initials documented on the TAR indicated that the treatment was completed.</p>	F 281	<p>toe visual skin assessments were completed for 100% of facility residents and all residents with orthotic braces, splints, or devices were removed per physician orders and the skin assessments were completed on 2/23/12 and 2/24/12 by the Assistant Directors Of Nursing, Staff Development Coordinator, Admission Nurse, Restorative Manager, Minimum Data Set Coordinators, and the Central Supply Nurse. Wound re-assessments for all residents with wounds were completed simultaneously with the head to toe skin assessments. Any skin integrity concerns identified were communicated by the licensed nurses to the physician on 2/23/12 and 2/24/12, with new orders implemented as prescribed, with family notification, and treatment and care plans updated as appropriate by licensed nursing staff.</p> <p>3. Licensed nursing staff in-service was conducted on 3/16/12 by Director of Nursing and Staff Development Coordinator. The in-service included the following, physician's orders, physician orders at a glance protocol, appropriate times placed on treatment administration record if treatment was ordered more than twice a day.</p> <p>4. Assistant Directors of Nursing, Staff Development Coordinator, Restorative Manager, Admission Nurse, and Central Supply Nurse will audit</p>	

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F 281	Continued From page 2 An interview with LPN #1, on 02/29/12 at 10:10 AM, revealed when working the floor, she ensured the times on the TAR were accurate, and if not, she notified the physician for clarification. LPN #1 then explained the process utilized for the month-to-month changeover of information on the TAR. She stated the process was that the nurse was to fax any changes or updates on the TAR to the corporate pharmacy. The corporate pharmacy made the changes in the computer, printed a hard copy of the TARs, and sent the TARs back to the facility. LPN #1 stated the physician was to be notified for clarification if any changes were required. She further stated, to ensure accuracy of the TARs, there was a "nursing administrative person" assigned to check the TARs each month prior to utilization by the nurses. An interview with LPN #2, on 02/29/12 at 11:05 AM, revealed that she was responsible for checking the "D" hall TARs for accuracy each month prior to being utilized by the nurses. She stated the monthly changeover process involved taking the physician's orders and comparing those to any new orders, then verify the information printed on the TAR. LPN #2 explained that the nurses' initials on the TAR was an acknowledgement that two treatments were being completed on the 7:00 AM - 7:00 PM shift, and one treatment was being completed on the 7:00 PM - 7:00 AM shift. An interview with the DON, on 02/29/12 at 2:05 PM, revealed she expected the treatments to be completed three times per day (TID) as written. The DON reviewed the January 2012 and	F 281	treatment administration records weekly for thirty days, biweekly for thirty days, and monthly for thirty days for appropriate times for treatments to be completed. Administrative nurses will report findings to Director of Nursing weekly in the Clinical Whiteboard Meeting to ensure proper follow up. The Director of Nursing will report any discrepancies weekly, biweekly, and monthly to the Administrator. The Director of Nursing will report findings monthly to Quality Assurance team for three (3) months for monitoring and follow up. 5. Corrective Action Date: 3/21/12	3/21/12	

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F 281	Continued From page 3 February 2012 TARs and noted the discrepancy between the physician's order and the documented times of care. She explained that the standard times printed on the TAR were 7:00 AM - 7:00 PM and 7:00 PM - 7:00 AM. She stated that her expectations were for the information to be correctly transferred from one month's TARs to the next month's TARs.	F 281			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure one resident (#1), in the selected sample of four residents, with pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing. The facility failed to ensure their system for assessing, identifying and treating pressure sores/deep tissue injuries was effective. Findings include: An Interview with the Director of Nursing (DON),	F 314	1. Resident # 1 was assessed by the Assistant Director of Nursing on 2/23/12 to ensure no negative outcome was caused by the alleged deficient practice. Upon receiving the information the Director of Nursing reviewed resident's care plan on 2/23/12 with no updates determined necessary. 2. Head to toe visual skin assessments were completed for 100% of facility residents and all residents with orthotic braces, splints, or devices were removed per physician orders and the skin assessments were completed on 2/23/12 and 2/24/12 by the Assistant Directors of Nursing, Staff Development Coordinator, Admission Nurse, Restorative Manager, Minimum Data Set Coordinators, and the Central Supply Nurse. Wound re-assessments for all residents with wounds were completed simultaneously with the head to toe skin assessments. Any skin integrity concerns identified were communicated by the licensed nurses to the physician on 2/23/12 and 2/24/12,		

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F 314	<p>Continued From page 4</p> <p>on 02/22/12 at 3:00 PM, revealed the facility had no policy/procedure to address the prevention of pressure sores. A review of the facility's policy/procedure for Pressure Ulcer Management, dated December 2010, revealed if a wound was identified the nurse would notify the physician to obtain a treatment order. The nurse would document on the Individual Skin Report. The Assistant Director of Nursing/Designee/Supervisor should assess the wound the next day to verify the findings.</p> <p>A record review revealed the facility admitted Resident #1 on 12/21/11 with diagnoses to include Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease (PVD) and Fracture of the left proximal Tibia/Fibula.</p> <p>A review of the Nursing Admission Information, dated 12/21/11, revealed a Braden Scale for predicting pressure sore risk was completed and the staff assessed Resident #1 as a mild risk for pressure sores even though the resident had a history of PVD, required assistance of two staff for bed mobility, was non-weight bearing on the left leg and wore a brace on the left leg continuously.</p> <p>A review of the admission physician's orders, dated 12/21/11, revealed the staff should ensure the brace was in place to left lower extremity at all times, keep locked at zero, and to remove the brace and provide skin care daily.</p> <p>A review of the admission Minimum Data Set (MDS) assessment, dated 01/03/12, revealed the facility assessed Resident #1 as moderately cognitively impaired and required extensive</p>	F 314	<p>with new orders implemented as prescribed, with family notification, and treatment and care plans updated as appropriate by licensed nursing staff.</p> <p>3. Education was provided on 2/24/12, 2/25/12, 2/26/12, and 2/27/12 by the Director of Nursing and Staff Development Coordinator for the licensed nursing staff on the following topics: F-314, Skin Integrity Policy (Skin Clinical Seven) including assessment, identification, prevention, treatment, documentation, notification of physician and family, updating care plans, following physician orders, care of residents with braces splints, and devices to ensure skin integrity including removal of devices to visually inspect the skin beneath the brace. Assistant Directors of Nursing were in serviced on 3/21/12 by the Director of Nursing to ensure follow up is being done on all new pressure areas identified the day they are notified of the new area with documentation to be done either on individual skin report sheet or in the nurses notes.</p>		

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F 314	<p>Continued From page 5</p> <p>assistance of two staff for bed mobility.</p> <p>A review of the Comprehensive Care Plan for residents at risk for developing skin breakdown due to extensive/total assistance with bed mobility and a brace to the left lower leg secondary to a fracture, dated 01/04/12, revealed an intervention for the staff to ensure the brace was in place to the left lower extremity and to remove every day for skin care.</p> <p>A review of the Treatment Administration Record (TAR), dated December 2011 and January 2012, revealed the licensed staff initialed the brace as removed and skin care and an assessment was provided daily through 01/24/12; however, on 01/25/12, initials on the TAR, with a circle around the initials, were in the 7:00 AM - 7:00 PM box.</p> <p>Interview with Registered Nurse (RN) #2, on 02/28/12 at 1:15 PM, revealed she initialed the TAR and circled her initials, due to being unable to remove Resident #1's brace and provide a skin assessment/skin care, on 01/25/12. She revealed she was extremely busy, and told the 7:00 PM - 7:00 AM nurse that she was unable to complete the care.</p> <p>Further review of the TAR, dated January 2012, revealed the 7:00 PM - 7:00 AM nurse had not initialed the TAR to indicate removal of the resident's brace and provided the skin care and assessment on 01/26/12.</p> <p>A review of an Altered Skin Integrity Change in Condition Report, dated 01/26/12 at approximately 1:45 AM, revealed Resident #1 complained to the Certified Nurse Aide (CNA)</p>	F 314	<p>4. Administrative nursing will monthly complete head to toe assessments for 100% of facility residents. Skin alert forms will be completed by Administrative Nursing on all residents and all alterations in skin integrity will be reported to the Director of Nursing monthly in Clinical Whiteboard Meeting to ensure proper follow up. Director of Nursing will report findings monthly to Administrator. All findings will be reported to Quality Assurance team monthly for three (3) months for monitoring and follow up.</p> <p>5. Corrective Action Date: 3/21/12</p>	3/22/12.	

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F 314	<p>Continued From page 6</p> <p>regarding pain and burning on his/her left heel. The CNA asked RN #3 to look at the resident's left foot. RN #3 then assessed Resident #1's left foot and identified four wounds on the left foot to include a dark purple area (deep tissue injury) on the heel measuring nine (9) centimeters (cm) by three (3) cm, two (2) dark purple areas on the bottom of the left foot measuring one (1) cm by 0.6 cm and one (1) cm by 0.8 cm, and a dark purple area on the top of the left foot measuring four (4) cm by 0.6 cm.</p> <p>An interview with RN #3, on 02/29/12 at 9:25 AM, revealed she had not removed the brace and provided skin care or an assessment of the resident's leg until the resident complained about the heel pain and the burning sensation. (This would have resulted in the the brace not being removed and skin care and and an assessment not being completed between 30.5 hours to 42.5 hours.) Further interview revealed she completed the Altered Skin Integrity Change in Condition Report when she identified the wound and faxed the report to the physician. She also initiated a treatment to cleanse the wounds with a wound cleanser, apply granulex and foam and wrap with kerlix.</p> <p>A review of the Altered Skin Integrity Change in Condition Report, revealed the report was faxed back to the facility, on 01/26/12 at 1:26 PM, with an order for the Nurse Practitioner to assess the wounds on rounds the following day. An interview with the Nurse Practitioner, on 02/22/12 at 12:30 PM, revealed she did not see Resident #1's wounds.</p> <p>An interview with the DON, on 02/22/12 at 2:50</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>PM, revealed it was the facility's policy/procedure that once a new wound was identified, the nurse should document the wound on th 24-hour report, Change in Condition Report and the Individual Skin Sheet. The individual skin sheet was used to document the weekly wound assessments to track the condition of the wound. The next day, during morning meeting, all new wounds should be discussed, and following the meeting the Assistant Directors of Nursing (ADONs) should assess the wound to determine the condition of the wound and determine if an appropriate treatment was in place. A review of the record and an interview with RN #3, on 01/28/12 at 2:00 PM, revealed there was no skin report completed on any of the wounds to ensure the wounds were monitored weekly. Additionally, interviews with ADON #1 and ADON #2, on 02/23/12 at 12:30 PM, and on 02/28/12 at 5:26 PM, respectively, revealed they assessed the wounds, on 01/27/12 at approximately 4:50 PM, (approximately two days after the wound was identified). Further interviews with ADON #1 and ADON #2 revealed they felt the treatment was not appropriate for the wound because they identified slough on the wound, so they notified the physician and received a new treatment order to cleanse the left heel wound, apply Santyl, cover with foam, wrap with kerlix and secure in place with tape.</p> <p>A review of the physician's order and nurse's note, dated 01/27/12, revealed the Orthopedic Physician was contacted and orders were received to make an appointment with the wound care center "as soon as possible." The Wound Care Clinic was contacted and an appointment was obtained for 01/31/12.</p>	F 314		

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F 314	<p>Continued From page 8</p> <p>A review of the facility's investigation and the Incident Accident Tracking log, dated 01/31/12, revealed the facility conducted an investigation and determined the root cause of the wounds was from the foot portion of the brace. The facility did not take aggressive action when they identified the resident could not be seen by the wound care clinic for four days to try to prevent new wounds from developing, and/or to prevent the identified wounds from worsening.</p> <p>Interview with ADON #1, on 02/21/12 at 2:30 PM, revealed she identified the foot portion of the brace caused the wounds on the resident's foot, so she placed gauze and towels in the foot portion of the brace to try to protect the heel. A review of the Comprehensive Care Plan and January 2012 TAR revealed there were no interventions in place to protect the resident's foot from the foot portion of the brace to ensure all staff provided consistent and appropriate care.</p> <p>An Interview with the Wound Care Physician, on 02/21/12 at 1:15 PM, revealed that when the resident came to the Wound Care Center, on 01/31/12, there was a deep tissue injury on the heel and another area was developing to the side of that wound that appeared of be from the heel shifting in the brace and causing a new wound. She stated there was no padding in the foot portion of the brace and the resident's foot was directly against the plastic foot portion of the brace.</p> <p>A review of the nurses' notes, dated 02/01/12, revealed the resident was seen by the Orthopedic Surgeon and was directly admitted to the hospital. A review of the history and physical and the</p>	F 314			

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F 314	Continued From page 9 hospital records, revealed Resident #1 was admitted to the facility with an unstageable pressure sore on the left heel measuring two (2) cm by 5.5 cm by 0.5 cm. Aggressive treatment was attempted to the area to try to prevent surgery; however, on 02/08/12, surgery was conducted to debride the wound of the dead tissue. An observation of the wound, on 02/24/12 at 2:00 PM, revealed a Stage 4 pressure sore on the resident's left heel with a wound vac in place. After removal of the wound vac and dressing, the wound measured 4.5 cm x 4.5 cm by 0.3 cm. There was a small amount of thin, dark pink exudate with no odor. The secondary tissue was sloughing and the surrounding tissue was pink.	F 314			