

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

PRINTED: 04/05/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/22/2013
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Health Survey was conducted 03/19/13 through 03/22/13. Deficiencies were cited with the highest Scope and Severity of a "G", with the facility having an opportunity to correct deficiencies before remedies would be recommended for imposition.

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  
SS=G

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update

F 000

F 157

F157  
Resident #1 was discharged on 3/21/13 from the facility prior to this survey completion. No other residents were identified concerning this tag.

An audit of all residents identified with skin conditions will be completed by May 3, 2013 by the DON to ensure that the responsible parties and physicians have been notified.

Education regarding the policy and procedure for condition change of a resident will be provided to the nursing staff by the DON and completed by May 3, 2013

The DON/charge nurse will audit compliance with notification of change of condition by using the 24 hour report and nursing notes daily (Monday through Friday) for two weeks, then weekly for three months, then quarterly times twelve months. This will be initiated by May 3, 2013.

5/3/13

RECEIVED  
APR 18 2013  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Terry Wilkins</i>	TITLE  <i>Administrator</i>	(X8) DATE  4/17/13
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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 157 Continued From page 1  
the address and phone number of the resident's legal representative or interested family member.

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 the Physician was notified of a significant change in the resident's physical condition and a need to alter treatment for one (1) of eleven (11) sampled residents (Resident #1).

Resident #1 was identified to have a Suspected Deep Tissue Injury (SDTI) Pressure Ulcer to the Right Heel on 02/25/13; however, there was no documented evidence the Physician was notified to obtain orders for treatment to the ulcer. On 03/06/13, the Pressure Ulcer progressed to an unstageable Pressure Ulcer measured at 0.8 centimeter (cm) length and 1.0 cm width and described as having black/brown peeling eschar. (Refer to F314)

The findings include:

Review of the facility "Statement of Patient Rights" Policy, undated, revealed the facility must immediately inform the patient; consult with the patient's physician; and if known, notify the patient's legal representative or an interested family member when there was a significant change in the patient's physical, mental or psychosocial status or a need to alter treatment.

Review of Resident #1's clinical record revealed the facility admitted the resident, on 02/12/13.

F 157

The results of the audits will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MDS Manager, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, and Activity Director for review on May 3, 2013 and quarterly times twelve months.

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F 157 Continued From page 2  
with diagnoses which included Diabetes Mellitus, and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF).

Record review revealed an Initial Care Plan was developed on 02/12/13 and revised by Registered Nurse (RN) #1 on 02/25/13 to include that Resident #1 had a Suspected Deep Tissue Injury (SDTI) to the right outer heel.

Review of the Weekly Skin Check Sheet completed by RN #2, dated 02/26/13 and 03/05/13, revealed Resident #1 had a dark purple area to the right heel. Although the pressure ulcer to the resident's right heel was noted on 02/25/13, 02/26/13, and 02/06/13, there was no documented evidence the physician was notified to obtain treatment for the ulcer.

Review of the Wound/Pressure Ulcer Assessment completed by RN #1, dated 03/06/13, revealed the area to Resident #1's right heel was described as an unstageable area with black/brown peeling eschar which measured 0.8 centimeters (cm's) in length, 1.0 cm in width and no depth.

Review of the Physician's Orders, dated 03/07/13 (ten days after the ulcer was identified), revealed orders to cleanse the right lateral heel with Normal Saline, pat dry and paint with Betadine twice a day, Glucerna twice a day, Juven one (1) packet twice a day, liquid ProMod 30 (milliliter's) ml's per day, and multivitamin with minerals one tab daily.

Interview, on 03/21/13 at 9:30 AM, with RN #1 revealed she assessed the area on the heel

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F 157 Continued From page 3  
which was a purple spot and considered to be a SDTI on 02/25/13 and revised the Initial Care Plan. She stated she reported the area to the nursing staff, therapy staff, and to the resident; however, she was not sure if she had notified the Physician/Nurse Practitioner of the area.

Interview, on 03/21/13 at 5:00 PM, with RN #2 revealed at the time she found the dark purple spot on Resident #1's heel, it was not blanchable and presented as a SDTI on 02/26/13. She stated she also completed the Weekly Skin Check, dated 03/05/13, and the area again appeared as a SDTI. Further interview revealed if a new area of skin breakdown, such as a pressure ulcer, was identified staff was to call the physician for treatment. However, she stated she had received information in report regarding the SDTI and assumed the Physician had already been notified for treatment.

Interview with the Nurse Practitioner, on 03/21/13 at 11:40 AM, revealed she expected to be notified for an area which presented as a non-blanchable dark purple area and she would order Xenoderm as a treatment. The Nurse Practitioner stated she did not remember being notified of the resident's heel ulcer until 03/07/13 (ten days after the ulcer was first identified) when the order was written for treatment to the pressure ulcer. Per interview, if she had been notified earlier, there would have been an order written prior to that date.

Interview with the Director of Nursing (DON), on 03/21/13 at 10:40 AM, revealed it was her expectation that if a new dark purple area or SDTI was identified, it would be brought to the Nurse

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F 157	Continued From page 4 Practitioner's attention for treatment orders. She further stated "I would have expected nurses to find the area sooner and bring it to the attention of the nursing staff and Nurse Practitioner before it became unstageable".	F 157			
F 248 SS-E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident for four (4) out of eleven (11) sampled residents (Resident #4, #7, #1 and #5)  Attending religious services was assessed as being very important for Resident #7; however, staff did not ensure he/she attended the Church service on 03/17/13.  Resident #4 enjoyed participating in all activities because he/she did not like to be alone. However, the facility failed to provide the resident with activities he /she enjoyed.  Interview with the Activity's Director, on 03/20/13 at 12:20 PM, revealed he had tried to get	F 248	F248 Resident #1 was discharged on 3/21/13 from the facility prior to this survey completion.  Resident #7 was discharged on 3/23/13.  Resident #5 was discharged on 3/23/13.  Resident #4 has had an Activity assessment initiated and completed on 4/9/13. Resident #4 has been involved with Bingo and outside activities, such as talking with staff, viewing the garden, and recognizing flowers and insects. Resident #4 was provided a radio to listen to country music. On 4/8/13 he watched the Country Music Academy Awards. He was also provided with a deck of playing cards to play Solitaire. Resident #4 indicated he enjoyed Bingo and listening to his music. Resident #4 was discharged on 4/12/13.	4/17/13	

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F 248	<p>Continued From page 5</p> <p>Resident #4 to participate in more activities. However, he/she would only participate in some activities which involved music.</p> <p>Although Resident #1 preferred "in room" activities and his/her activities preferences included country music and news, staff did not ensure the resident had music available in the room. Also, staff failed to ensure Resident #1's television was set for the news and the resident was unable to find the channel himself/herself.</p> <p>Resident #5 was admitted to the facility, on 03/14/13, and had not received a visit by activities staff for information related to activities until 03/20/13 (6 days later) and expressed that she/he would have liked to have known about the activities from the time of admission.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 03/21/13 at 10:00 AM, revealed there was no policy related to activities and the facility did not have a guideline to follow related to activities.</p> <p>Review of the facility's activity calendar for the months of January and February 2013 revealed independent leisure activity was the only activity planned for Saturdays, and there was seven (7) days where "at bedside" activities were the only activities scheduled. Review of all three (3) calendars revealed every Sunday, Church service was held at 2:30 PM, the location was not listed on the January or the March calendar. Review of the three (3) activity calendars revealed on Wednesday, the activity was pet therapy at 10:30</p>	F 248	<p>To enhance the activities program, the facility has implemented the following:</p> <ol style="list-style-type: none"> <li>1. Activities calendars are posted in all residents' rooms. The activities calendars have been modified to include more activities which encourage residents' participation in activities. Examples of modifications include: Independent activities have been changed to group activities such as Bridge card game, painting craft models, etc.</li> <li>2. The Activity Director will make rounds to inform residents about activities for the day.</li> <li>3. The Resident computers located in activity areas on A Wing and on C Wing, have had icons for websites covering local and world news installed so that updated news is available for all residents.</li> <li>4. A calendar board containing upcoming activities for residents' is now also located on C and D Wings.</li> </ol>		

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F 248 Continued From page 6  
AM and at 6:30 PM the activity was current event, at bedside. Further review revealed Wednesday was the only day all three (3) calendars had more than one (1) activity per day listed.

1. Review of Resident #7's medical record revealed the facility admitted the resident, on 03/12/13 with diagnoses which included Bilateral Knee Replacement and Hypertension. Review of Resident #7's Activity Assessment, dated 03/15/13, revealed Resident #7 felt it was very important to have books, newspapers, and magazines to read, and to keep up with current events; as well as to participate in religious services.

Interview with Resident #7, on 03/19/13 at 2:00 PM, revealed when he/she first came to the facility he/she was given a packet which contained a calender which listed the activities; however, he/she was not for sure where this folder was. Further interview revealed he/she had heard staff announce Church service the past Sunday and he/she was very exclted because he/she missed going to Church. However, he/she was not familiar with the facility and the service was downstairs, therefore he/she was scared he/she would get lost. Continued interview revealed staff had never offered to take him/her to any activity or had anyone talked to him/her about activities.

Interview with the Activity's Director, on 03/20/13 at 12:20 PM, revealed he was not aware Resident #7 had missed the Church service because he /she was unfamiliar with the second floor and was scared he/she would get get. He further stated he was not at the facility on Sundays due to only

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- The location of Church Services will be posted at each nursing station. The Activity Director will be involved in planning activities on the weekend so that staff can engage residents' in leisure activities. We are providing maps to where activities are being held and how to get there by dotted lines and arrows. Staff will assist in transportation as needed.
- In the admission packet, activity calendars will be provided to all residents and the Activity Director will review the calendar with each resident to inform the resident of special events and activities occurring in the facility.

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F 248	<p>Continued From page 7</p> <p>being a part time staff member; therefore, he did not know how the residents were transported to the Church service.</p> <p>2. Review of Resident #4's medical record revealed the facility admitted the resident, on 01/10/13, with diagnoses which included Mild Mental Retardation, Spinal Stenosis in Cervical Region, and Tachycardia. Review of Resident #4's Activity Assessment, dated 01/14/13 revealed Resident #4 felt it was somewhat important to participate in all activities which were listed on the assessment sheet. Review of Resident #4's Minimum Data Set (MDS), dated 01/17/13, revealed the resident had a Brief Interview for Mental Status (BIMS) of fifteen (15) out of fifteen (15), meaning the resident was cognitively intact.</p> <p>Interview with Resident #4, on 03/19/13 at 3:15 PM, revealed the resident enjoyed to participate in all activities because he/she did not like to be alone. He/she further stated the facility did not have a lot of music activities and he/she wished they would offer more activities involving music. The resident further stated he/she could not recall a staff member coming to him/her to inform him/her of an upcoming activity and staff had never offered to take him/her to an activity.</p> <p>Interview with the Activity's Director, on 03/20/13 at 12:20 PM, revealed he had tried to get Resident #4 to participate in more activities. However, he/she would only participate in some activities which involved music.</p> <p>3. Review of Resident #1's medical record revealed the facility admitted the resident, on</p>	F 248	<p>The facility will implement a new activity policy and documentation tool on April 17<sup>th</sup>. All facility staff will be in-serviced during the week of April 17<sup>th</sup> 2013 on the activities policy and need to engage residents' in activity. Audits will be conducted by the Administrator and Activity Director weekly x 2 months on a random sample of residents participating in one-to-one and/or group activity in order to ensure documentation of participation is taking place. The results of the audit will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MDS Coordinator, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, Activity Director, and fellow staff members for review and follow up monthly for three months.</p>		

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F 248	<p>Continued From page 8</p> <p>02/12/13, with diagnoses which included Diabetes Mellitus, and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF) on 02/08/13.</p> <p>Review of the Admission Minimum Data Set (MDS), dated 02/24/13, revealed the facility assessed the resident as having a Brief Mental Status Interview (BIMS) of a nine (9) out of 15 (fifteen) and as requiring extensive assistance with bed mobility, transfers, and ambulation in the room. Continued review revealed the facility assessed the resident's activity's preferences as being very important to listen to music, and to keep up with the news.</p> <p>Further review of the clinical record revealed Activities did not trigger as an area on the MDS and a Care Area Assessment and Care Plan was not completed related to activities.</p> <p>Review of the Activity Assessment, completed on 02/15/13, revealed Resident #1 preferred activities in his/her own room and activity preferences included music, spiritual/religious activities, watching television and talking/visiting. Review of the Activity Progress Notes, dated 02/15/13, revealed Resident #1 was alert, oriented and verbal with leisure interests in country music, church, television, and western movies. Further review revealed the resident may require prompting to engage and was given the February calender.</p> <p>Observation of Resident #1, on 03/19/13 at 12 PM, revealed the resident was sitting in a wheelchair in his/her room not engaged in an activity. Observations at 12:30 PM and 12:40 PM</p>	F 248		

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F 248	<p>Continued From page 9</p> <p>revealed the resident was sitting in the wheelchair eating lunch in his/her room. Observations at 2:20 PM and 3:30 PM revealed the resident was in bed.</p> <p>Observation of Resident #1, on 03/20/13 at 9:00 AM, revealed the resident was sitting in the wheelchair in his/her room with eyes closed, observation at 9:45 AM revealed staff came to transport him/her to Physical Therapy. Observations at 10:30 AM, and 11:00 AM revealed the resident was sitting in a wheelchair in his/her room not engaged in an activity. Observations at 12:20 PM and 12:30 PM revealed the resident was sitting in a wheelchair eating lunch. Observation at 2:30 PM revealed the resident was in bed.</p> <p>Interview, on 03/20/13 at 9:30 AM and 03/21/13 at 9:20 AM, with Resident #1 revealed he/she liked the news and had watched it some while at the facility when someone had changed the channel for him/her. However, he/she was unaware to find the news channel without staff's assistance. Resident #1 stated, "That's why I'll be glad to go home tomorrow to have my television". Further interview revealed he/she liked country music; however, there was no music offered to him/her by activities staff.</p> <p>Interview with the Activities Director on 03/22/13 at 3:00 PM, revealed Resident #1 had attended one (1) group activity at the facility. He stated the resident did like music but had declined the music activities. However, he had not offered the resident the opportunity to have music in the room because currently there were no CD players. He further stated he had not instructed</p>	F 248			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/22/2013
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504
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F 248 Continued From page 10  
staff to turn the news on for the resident; however, felt it would be a good idea since the resident was not always able to find the news channel.

4. Review of Resident #5's medical record revealed the facility admitted the resident, on 03/14/13, with diagnoses including S/P Left Total Knee Replacement and Depression.

Review of the Activities Assessment, dated 03/20/13, revealed the resident's activities preferences were cards/games, music, reading/writing, puzzles, plants/gardens, visiting, and watching television. Further review revealed it was very important to have books, newspapers, and magazines to read.

Review of the Activities' Progress Notes, dated 03/20/13, revealed the resident was alert and oriented and initiated conversation and the resident's leisure interests included reading, walking, puzzles, plants and gardens. Further review revealed the resident was informed of leisure activities and given the March calendar.

Interview with Resident #5, on 03/21/13 at 9:15 AM, revealed she had attended a music activity with hand bells last night. She stated she was not sure she had met the Activities Director before last evening, and before yesterday she had not attended any activities because she did not know about them. Continued interview revealed she/he would have liked to have known about the activities before yesterday because she stayed in her/his room and "felt like crying".

Additional interview with Resident #5, on 03/22/13

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F 248	<p>Continued From page 11</p> <p>at 10:00 AM, revealed she/he had attended a game last night downstairs. The resident expressed he/she wished he/she knew about the activities from the time he/she was admitted because it took "(his/her) mind off health problems". Continued interview revealed she/he did not receive an activities calender until 03/20/13 although he/she was admitted on 03/14/13.</p> <p>Interview with the Activity Director, on 03/20/13 at 12:20 PM, revealed he was only hired on a part time basis and he did not have any staff working with him in the activity department. He further stated all of the resident's received an activity calender upon admission and he completed each resident's activity assessment as soon as he could, and it was at this time he told the resident's about the activities. He further stated he was not at the facility on Sundays due to only being a part time staff member; therefore, he did not know how the resident's were transferred to the Church services. He stated he did not keep any documentation related to what activities were held and who attended the activities. He further stated he had not documented in the resident's medical record if they had refused to go to an activity or if he had offered them an alternative activity. He further stated he had gone to the residents' rooms, which he knows were interested in and attended activities and invited them to the activities.</p> <p>Interview with the Administrator on 03/22/13 at 1:15 PM, revealed he was not aware of any documented evidence of activities held at the facility or of a list of residents who attended the activities. He further stated the Activity Director</p>	F 248		

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F 248 Continued From page 12  
should keep documentation of all the activities which were held and the residents who attended the activities, as well as document in the resident's medical chart if they refused to participate in an activity. He further stated staff should ask the residents if they needed assistance in going to an activity.

F 248

F 279  
SS=D Surveyor: Williams, Debra  
483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  
  
A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  
  
The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  
  
The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  
  
This REQUIREMENT is not met as evidenced

F 279

F279  
Resident #1 was discharged on 3/21/13 from the facility prior to this survey completion. No other residents were identified concerning this tag.  
  
The DON/MDS Manager/Assistant MDS Coordinator will conduct an audit of all current residents for compliance with comprehensive care plans to ensure all diagnoses identified on the CAAS form and comprehensive assessment are addressed. This will be completed by May 3, 2013.  
  
The policy for comprehensive care plans will be reviewed and revised by the DON on May 3, 2013.  
  
Education regarding the comprehensive care plan policy will be provided to nursing staff by the DON and completed by May 3, 2013.

5/3/13

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F 279	<p>Continued From page 13</p> <p>by: Based on interview, record review, and review of facility's policies it was determined the facility failed to ensure Comprehensive Plans of Care were developed for each resident to meet a resident's medical, and nursing needs that were identified in the comprehensive assessment for one (1) of eleven (11) sampled residents (Resident #1).</p> <p>The facility failed to develop a Comprehensive Plan of Care for Resident #1 related to the risks and complications associated with Diabetes Mellitus, and anticoagulants.</p> <p>The findings include:</p> <p>Review of the "Care Planning" Policy, dated 11/05, revealed the plan of care shall be individualized, based on the diagnosis, patient assessment and personal goals of the patient and his/her family.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Diabetes Mellitus, and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF) on 02/08/13.</p> <p>Review of the Admission Minimum Data Set (MDS) dated 02/24/13, revealed the facility assessed the resident as having a diagnosis of Diabetes Mellitus.</p> <p>Review of the Physician's Orders, dated 02/12/13 through 03/2013, revealed orders for Metformin (antidiabetic medication) 500 milligrams twice a day, and Sliding Scale Novolin R (Regular Human</p>	F 279	<p>The DON/Charge Nurse will audit compliance with completion of comprehensive care plans by reviewing ten care plans per week times one month, then monthly times three months, then quarterly times twelve months. This will be initiated by May 3, 2013.</p> <p>The results of the audits will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MDS Manager, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, and Activity Director for review on May 3, 2013 and quarterly times twelve months.</p>		

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F 279 Continued From page 14  
Insulin). Further review revealed orders written 02/12/13 for Fingerstick Blood Sugars three times a day which continued until a new order was received on 02/20/13 to change the FSBS to once a day.

Review of the Care Area Assessment Summary (CAAS), dated 02/25/13, revealed the resident stated he/she liked sweets a lot and did not follow a diabetic diet at home and did not remember how long he/she had been a diabetic. Further review revealed the resident was at risk for nutritional problems related to the therapeutic diet due to Diabetes. The CAAS stated the care plan would include monitoring Fingerstick Blood Sugars (FSBS) as ordered and administering Sliding Scale Insulin (SSI) and oral agents as ordered.

Review of Resident #1's Comprehensive Plan of Care revealed the facility failed to utilize the Care Area Assessment Summary (CAAS) in order to develop a Plan of Care for the resident related to managing the risk factors associated with Diabetes Mellitus.

Further review of Resident #1's Physician's Orders, dated 02/12/13 through 03/2013, revealed orders for Plavix 75 milligrams (mgs) every day (medication that keeps the blood from clotting with side effects of bleeding) and Lovenox 30 mgs subcutaneous every day (anti-coagulant medication which alters the blood's ability to clot with side effects of bleeding or hemorrhage).

Review of the Comprehensive Plan of Care revealed the facility failed to develop a Care Plan to address this resident's risk of bleeding

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F 279	Continued From page 15 associated with the medications.  Interview, on 03/21/13 at 9:30 AM, with Registered Nurse (RN) #4/MDS Coordinator revealed she had completed the MDS, CAAS and Comprehensive Plans of Care for Resident #1. She stated at the time she completed the Care Plan she did not think Diabetes was an active problem because the resident was only getting once a day Fingerstick Blood Sugars and was not requiring SSI coverage as opposed to receiving FSBS three (3) times a day from admission 02/12/13 through 02/20/13. She stated there should have been a Care Plan related to the anticoagulant medications and the risks for bleeding associated with these medications.	F 279			
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and nursing standard of practice, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality and failed to ensure care plans were sufficient for newly admitted residents for three (3) of eleven (11) sampled residents (Resident #1, #2 and #8).  Resident #1 was admitted to the facility on 02/12/13 and was assessed to be at risk for	F 281	F281 Resident # 1 was discharged on 3/21/13 from the facility prior to this survey completion.  Resident #8 was discharged on 4/1/13 from the facility prior to receiving this report.  Resident #2 did not have an Initial care plan for at risk for skin break down. The initial care plan was revised on April 3, 2013 to include at risk for skin breakdown. The comprehensive care plan was revised on April 3, 2013 to include at risk for skin breakdown.	5/3/13	

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F 281	<p>Continued From page 16</p> <p>pressure ulcers; however, there was no documented evidence an Initial Care Plan was developed in order to provide preventive interventions related to pressure ulcers. A Suspected Deep Tissue Injury (SDTI) of the right heel was identified and an Initial Care Plan was initiated on 02/25/13, thirteen (13) days after admission. The area was described as a dark purple area on 02/26/13 and 03/05/13 per the Weekly Skin check Sheet. However, there was no documented evidence of measurement of the heel ulcer until the area progressed. On 03/06/13 the area was described as an unstageable Pressure Ulcer measuring 0.8 length and 1.0 width with blackish brown peeling eschar. (Refer to F-314)</p> <p>Resident #2 had a Physician's order for Bunny Boots (heel offload device made of sheepskin which pad the heel, prevent friction and shearing, and remove some pressure from the heel to prevent heel pressure ulcers) to be worn while in bed; however, observations on 03/19/13 revealed the Bunny Boots were not applied while Resident #2 was in bed. In addition, an initial plan of care related to pressure was not developed for Resident #2.</p> <p>Resident #8 was admitted to the facility, on 03/17/13, and was assessed to be at risk for pressure ulcers; however, there was no documented evidence an Initial Care Plan was developed in order to provide preventive interventions related to pressure ulcers.</p> <p>The findings include:</p> <p>Review of the "Lippincott Manual of Nursing</p>	F 281	<p>On April 4, 2013 Resident # 2 was placed on turning and positioning Q2hrs. On April 11, 2013, Resident was placed on a STAT II air mattress and continue to monitor skin breakdown weekly.</p> <p>The policy for the Initial Plan of Care will be developed by the DON and will be completed by May 3, 2013.</p> <p>The policy for the Intershift Report will be reviewed and revised by the DON and will be completed by May 3, 2013.</p> <p>The policy for Skin Integrity Management/Pressure Ulcer Prevention/Management/Nursing Interventions Strategies will be reviewed and revised by the DON and will be completed by May 3, 2013.</p> <p>Education regarding the policy and procedure for Initial Plan of Care, Intershift Reporting and Skin Integrity Management/Pressure Ulcer Prevention/Management/ Nursing Interventions Strategies will be provided to the nursing staff by the DON and Nurse Educator and completed by May 3, 2013.</p>		

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F 281	<p>Continued From page 17</p> <p>Practice. Ninth Edition revealed the pressure ulcer should be staged so that appropriate treatment could be started.</p> <p>Review of the facility's protocol, untitled and undated, revealed all residents should be assessed for the potential for skin breakdown upon initial admission assessment using the Braden Scale. Further review revealed a resident scoring a 15-18 was at risk; upon finding a wound staff was to measure the wound length x width x depth; a picture of the wound was to be taken; wound sheets were to be completed; findings were to be documented in the Nurse's Notes and a wound consult was to be ordered. The wound assessment checklist included-location, size, stage, drainage, appearance picture, wound consult, wound sheets, note, and treatment order.</p> <p>Review of the facility "Care Planning" policy, dated 11/05, revealed care planning was based on data collected from resident assessments with integration of those assessment findings in the care planning process.</p> <p>1. Review of Resident #1's medical record revealed the facility admitted the resident, on 02/12/13, with diagnoses which included Diabetes Mellitus and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF).</p> <p>Review of the Braden Scale for Predicating Pressure Sore Risk, dated 02/12/13, revealed Resident #1 scored a 18 related to the following risks; only walks occasionally, very limited mobility, and had the potential for friction and shear. According to the Braden Scale a score of 18 indicated the resident was at risk for a</p>	F 281	<p>The DON/Charge Nurse will audit compliance with completion of initial care plans by reviewing ten care plans per week times one month, then monthly times three months, then quarterly times twelve months. This will be initiated by May 3, 2013.</p> <p>The DON/Charge Nurse will audit compliance with Intershift Report by reviewing ten care plans per week times one month, then monthly times three months, then quarterly times twelve months. This will be initiated by May 3, 2013.</p> <p>The DON/Charge Nurse will audit compliance with Skin Integrity Management/Pressure Ulcer Prevention/Management/Nursing Interventions Strategies by May 3, 2013.</p> <p>The results of the audits will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MDS Manager, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, and Activity Director for review on May 3, 2013 and quarterly times twelve months.</p>		

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F 281	<p>Continued From page 18 pressure ulcer.</p> <p>Review of the Initial Care Plan, dated 02/12/13, revealed there was no care plan in place related to the risk of skin breakdown from 02/12/13 through 02/24/13.</p> <p>Interview, on 03/22/13 at 12:45 PM, with Licensed Practical Nurse (LPN) #1 revealed he conducted the admitting nursing assessment for Resident #1 and developed an Initial Care Plans based on assessments such as the Braden Scale. He stated if the Braden Scale indicated Resident #1 was at risk for pressure ulcers, he should have developed an Initial Care Plan related to the risk of pressure ulcers.</p> <p>Interview, on 03/21/13 at 10:40 AM, with the Director of Nursing (DON), revealed Resident #1 should have had an Initial Care Plan developed related to the risk for pressure ulcers since the resident was noted to be at risk per the Braden Scale and due to Resident #1's decreased mobility.</p> <p>On 02/25/13, the Initial Care Plan was revised by Registered Nurse (RN) #1 related to Resident #1's Suspected Deep Tissue Injury (SDTI) to the right outer heel; however, there was no description or measurements of the area identified on 02/25/13 in the clinical record.</p> <p>Review of the Weekly Skin Check Sheet completed by RN #2, dated 02/26/13 and 03/06/13, revealed Resident #1 had a dark purple area to the right heel. However, there was no measurements noted on the Skin Check Sheet.</p>	F 281			

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F 281	<p>Continued From page 19</p> <p>Although the pressure ulcer was identified on 02/25/13, as per revision of the Initial Care Plan, and was again identified on 02/26/13, and 03/05/13 as per the Weekly Skin Check Sheets there was no documented evidence the facility implemented their wound protocol which would include measuring the wound in order to evaluate if the care plan interventions were effective. The area progressed on 03/06/13 from a SDTI to an unstageable area.</p> <p>Review of the Wound/Pressure Ulcer Assessment completed by RN #1, dated 03/06/13, revealed the area to the right heel was described as an unstageable area with black/brown peeling eschar which measured 0.8 centimeters (cm's) in length, 1.0 cm in width and no depth.</p> <p>Interview, on 03/21/13 at 9:30 AM, with RN #1 revealed she assessed the area on the heel which was a purple spot and would be considered a SDTI on 02/25/13. Further interview revealed although she revised the Initial Care Plan, she should have described and measured the area when it was found and completed a Wound Pressure Ulcer Assessment as per facility protocol.</p> <p>Interview, on 03/21/13 at 5:00 PM, with RN #2 revealed at the time she found the dark purple spot on Resident #1's heel, it was not blanchable and presented as a SDTI on 02/26/13 and she completed the Weekly Skin Check dated 03/05/13. Continued interview revealed if a new area of skin breakdown such as a pressure ulcer was identified staff were to measure and stage the area. She stated she had received</p>	F 281		
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F 281	<p>Continued From page 20</p> <p>information in report regarding the SDTI and assumed it had been measured, therefore she did not measure the area. She stated if the pressure ulcer was not a new wound, it would not necessarily have to be measured weekly.</p> <p>Interview, on 03/21/13 at 10:40 AM, with the Director of Nursing (DON) revealed when the SDTI was first noted, a measurement and a picture should have been obtained per the wound protocol. She further stated wound measurements were to be conducted weekly.</p> <p>2. Review of the medical record revealed the facility admitted Resident #2, on 03/11/13, with diagnoses which include Subdural/Subarachnoid Hemorrhage, Subdural Hematoma, Greater Trochanter Fracture, Coronary Artery Disease, Hypertension, and Urinary Retention. Review of Initial Nursing Assessment, dated 03/11/13, revealed Resident #2 was at risk for developing pressure.</p> <p>Review of Physician's Order, dated 03/16/13, for Granulex Spray (A topical product used to help relieve pain and help the healing of skin wounds, ulcers, and sunburns.) to be applied to heels every shift and as needed. Further review of Physician's Orders revealed Bunny Boots to be worn while in bed.</p> <p>Review of Resident #2's Initial Care Plan revealed there was no plan of care developed related to Resident #2's risk for skin breakdown or preventative treatment.</p> <p>Observation, on 03/19/13 at 11:40 AM, revealed Resident #2 was lying in bed with legs and heels</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 281	<p>Continued From page 21 resting on the mattress. Further observation revealed Bunny Boots were attached to the footboard of the bed.</p> <p>Additional observation, on 03/19/13 at 12:35 PM, revealed Resident #2 was lying in bed with legs and heels flat on the bed. Further observation revealed Bunny boots were attached to footboard of bed.</p> <p>Continued observation, on 03/19/13 at 2:40 PM, Resident #2 lying in bed with feet and heels on the mattress. Additional observation revealed Bunny boots were attached to footboard of bed.</p> <p>Observation and interview, on 03/20/13 at 08:55 AM, with State Registered Nursing Assistant (SRNA) #1 who provided care to Resident #2 revealed she was unaware Resident #2 was to have Bunny Boots applied while in bed because it was not listed on the care chart which was located at the foot of the bed in Resident #2's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/20/13 at 9:40 AM, revealed treatments for residents were on the report sheets and discussed at shift change. Further interview with LPN #2 revealed care plans were to be updated daily as needed for changes in a resident's condition or treatment; however, was not sure why a care plan was not developed for Resident #2 related to risk for pressure and the use of Bunny Boots.</p> <p>Interview with the Nurse Practitioner (NP), on 03/21/13 at 10:20 AM, revealed she assumed the nurses were ensuring Physician's orders were</p>	F 281			

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F 281	Continued From page 22 being followed as well as care plans developed related changes in Resident #2's treatment.  Interview with the Director of Nursing (DON), on 03/22/13 at 1:00 PM, revealed she would expect nurses to develop a care plan for changes in a resident's treatment or Physician's Orders. 3. Review of the medical record revealed the facility admitted Resident #8, on 03/17/13, with diagnoses which included Hypertension, History of Urinary Incontinence and Glucose Intolerance. Review of Resident #2's medical record revealed, upon admission, Resident #8 was assessed for potential skin breakdown utilizing the Braden Scale for Predicting Pressure Sore Risk. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 03/17/13, revealed Resident #8 scored sixteen (16), indicating Resident #8 was at risk for developing a pressure ulcer. Review of Resident #8's Care Plan revealed no interventions were initiated for being at risk for developing pressure ulcers.  Observation during a skin assessment of Resident #8, on 03/22/13 at 10:00 AM, revealed the resident's skin was intact and no evidence of pressure ulcers.  Interview with DON, on 03/22/13 at 1:00 PM, revealed an initial care plan for at risk for pressure ulcers should have been initiated due to the Braden Scale for Predicting Pressure Sore Risk to prevent any pressure ulcers from developing.	F 281			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a	F 314			

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F 314	Continued From page 23 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 facility policy, it was determined the facility failed to ensure 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 for two (2) of eleven (11) sampled residents (Resident #1, #2 and #8).  Resident #1 was admitted to the facility, on 02/12/13, with a red blanchable area to the right heel and was assessed to be at risk for pressure ulcers; however, there was no documented evidence an Initial Care Plan was developed in order to provide preventive interventions related to pressure ulcers. The area to the right heel progressed to a Suspected Deep Tissue Injury (SDTI) as per the Interim Care Plan initiated, on 02/25/13, and described as a dark purple area on 02/26/13 and 03/05/13 as per the Weekly Skin check Sheet. However, there was no documented evidence of measurement of the ulcer or notification to the Physician in order to obtain	F 314	<b>F314</b> Resident #1 was discharged on 3/21/13 from the facility prior to this survey completion. Resident #8 was discharged on 4/3/13 from the facility prior to receiving this report. Resident #2 did not have an initial care plan for at risk for skin break down. The initial care plan was revised on April 3, 2013 to include at risk for skin breakdown. The comprehensive care plan was revised on April 3, 2013 to include at risk for skin breakdown.  The policy for the Condition Change of a Resident was developed by the DON and will be completed by May 3, 2013.  The policy for the initial plan of care will be developed by the DON and completed by May 3, 2013.  The policy for Skin Integrity Management/Pressure Ulcer Prevention/Management/Nursing Interventions Strategies will be reviewed and revised by the DON and will completed on April 12, 2013.	5/3/13	

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F 314	<p>Continued From page 24</p> <p>orders for treatment to the ulcer. The Pressure Ulcer progressed to an unstageable Pressure Ulcer measured at 0.8 length and 1.0 width described as having black/brown peeling eschar per the Wound/Pressure Ulcer Assessment, dated 03/06/13. (Refer to F-157, F-281)</p> <p>Resident #2 had a Physician's order for Bunny Boots (heel offload device made of sheepskin which pad the heel, prevent friction and shearing, and remove some pressure from the heel to prevent heel pressure ulcers. ) to be worn while in bed; however, observations on 03/19/13 revealed the Bunny Boots were not applied while Resident #2 was in bed. In addition, an initial plan of care related to pressure was not developed for Resident #2.</p> <p>Resident #8 was admitted on 03/17/13 and triggered for at risk for pressure ulcers. There was no interim care plan developed for this resident regarding the risk for pressure ulcers.</p> <p>The findings include:</p> <p>Review of the facility's protocol, untitled and undated, revealed all patients should be assessed for the potential for skin breakdown upon initial admission assessment using the Braden Scale. Further review revealed a resident scoring a 15-18 was at risk. Upon finding a wound, staff were to measure the wound length x width x depth and a picture of the wound was to be taken, wound sheets were to be completed, findings were to be documented in the Nurse's Notes, and a wound consult was to be ordered. The wound assessment checklist included-location, size, stage, drainage,</p>	F 314	<p>Education regarding the policy and procedure for the Condition Change of a Resident, Initial Plan of Care, and Skin Integrity Management/Pressure Ulcer Prevention/Management/Nursing Interventions Strategies will be provided to the nursing staff by the DON and Nurse Educator and completed by May 3, 2013.</p> <p>The DON/Charge Nurse will audit compliance with notification of change of condition by using the 24 hour report and nursing notes daily (Monday through Friday) for two weeks, then weekly for three months, then quarterly times twelve months. This will be initiated by May 3, 2013.</p> <p>The DON/Charge Nurse will audit compliance with completion of initial care plans by reviewing five care plans per week times one month, then monthly times three months. This will be initiated by May 3, 2013.</p> <p>The DON/Charge Nurse will audit compliance with Skin Integrity Management/Pressure Ulcer Prevention/Management/Nursing Interventions Strategies by reviewing five assessments per week times one month, then monthly times three months. This will initiated by May 3, 2013.</p>		

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F 314	<p>Continued From page 25 appearance, picture, wound consult, wound sheets, note, and treatment order.</p> <p>1. Review of Resident #1's medical record revealed the resident was admitted to the facility, on 02/12/13, with diagnoses which included Diabetes Mellitus, and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF) on 02/08/13.</p> <p>Review of the Braden Scale for Predicating Pressure Sore Risk dated 02/12/13, revealed Resident #1 scored eighteen (18) related to the following risks; only walks occasionally, very limited mobility, and had the potential for friction and shearing. According to the Braden Scale a score of eighteen (18) indicated the resident was at risk for pressure ulcers.</p> <p>Review of the Weekly Skin Checklist, dated 02/12/13 (date of admission), revealed the resident had a small red blanchable area to the right heel.</p> <p>Review of the Initial Care Plan, dated 02/12/13, revealed there was no care plan developed related to the risk of skin breakdown from admission through 02/24/13.</p> <p>Review of the Admission Minimum Data Set (MDS), dated 02/24/13, revealed the facility assessed the resident as having a Brief Mental Status Interview (BIMS) of a nine (9) out of 15 (fifteen) and as requiring extensive assistance with bed mobility, transfers, and ambulation in the room. Further review revealed the facility assessed the resident as being at risk for pressure ulcers, and as currently having one (1)</p>	F 314	<p>The results of the audits will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MDS Manager, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, and Activity Director for review by May 3, 2013 and quarterly times twelve months.</p>		

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F 314	<p>Continued From page 26</p> <p>unstageable pressure ulcer/ suspected deep tissue injury not present on admission.</p> <p>Review of the Care Area Assessment Summary (CAAS) completed by RN #1, dated 02/25/13, revealed the facility admitted Resident #1 for rehabilitation following a Right Hip Fracture and an ORIF of the right hip and was receiving Physical Therapy and Occupational Therapy with a plan to return home. The CAAS further stated the pressure ulcer care plan would include: monitor current ulcer for healing, provide pressure relief to the right foot when in bed, encourage adequate food and fluid intake, provide protective treatments as ordered, and notify the Physician and Nurse Practitioner of new areas of skin breakdown.</p> <p>Further review of Resident #1's medical record revealed the Initial Care Plan was revised by RN #1, on 02/25/13, to include a Suspected Deep Tissue Injury (SDTI) to the right outer heel. The interventions included ensuring adequate food and fluids, keep skin clean and dry, prevent shear friction and pressure, float heels off mattress, and monitor for healing. There was no documented evidence of a measurement of this SDTI in the medical record.</p> <p>Review of the Weekly Skin Check Sheet completed by RN #2, dated 02/26/13 and 03/05/13, revealed Resident #1 had a dark purple area to the right heel with no measurements noted. Although the area was identified on 02/25/13 as per update of the Initial Care Plan and was again identified on 02/26/13, and 03/05/13 there was no documented evidence the facility implemented their wound protocol which</p>	F 314			

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F 314	<p>Continued From page 27</p> <p>would include measuring the wound, obtaining a picture of the wound, initiating a wound sheet, obtaining a wound consult, and notifying the Physician for an order for treatment.</p> <p>Review of the Wound/Pressure Ulcer Assessment completed by RN #1, dated 03/06/13, revealed the area to the right heel was described as an unstageable area with blackish and brown peeling eschar which measured 0.8 centimeters (cms) in length, 1.0 cm in width and no depth.</p> <p>Review of the Physician's Orders, dated 03/07/13 (ten days after the ulcer was identified), revealed orders to cleanse the right lateral heel with Normal Saline, pat dry and paint with Betadine twice a day, Glucerna twice a day, Juven one (1) packet twice a day, liquid ProMod 30 (milliliter's) ml's per day, and multivitamin with minerals one tab daily.</p> <p>Observation of a skin assessment for Resident #1, on 03/19/13 at 2:45 PM, with RN #3 revealed the pressure ulcer on the resident's left outer heel measured 0.25 cm x 0.75 cm and presented as an area of dry tan colored skin.</p> <p>Interview, on 03/21/13 at 9:30 AM, with RN #1 revealed she had heard Resident #1 tell the Physical Therapist (PT) that his/her heel felt tender and at that time she was suspicious because of the way the resident was lying in the bed without the heel being floated. She stated, on 02/25/13, she assessed the area on the heel which was a purple spot and would be considered to be a SDTI. She stated she revised the Initial Care Plan, reported the area to staff and advised</p>	F 314			

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F 314	Continued From page 28 them to float the heel as well as notified the resident of the area and educated the resident to keep the heel off the bed. She further stated she notified therapy of the area and advised therapy not to do heel slides. Further interview revealed she was not sure if she had notified the Physician/Nurse Practitioner of the area. She stated she should have measured the area when it was found and completed a Wound Pressure Ulcer Assessment with a full description of the wound.  Interview, on 03/21/13 at 5:00 PM, with RN #2 revealed at the time she found the dark purple spot on Resident #1's heel, it was not blanchable and presented as a SDTI on 02/26/13. She stated she completed the Weekly Skin Check, dated 03/05/13. Continued interview revealed if a new area of skin breakdown such as a pressure ulcer was identified staff was to measure and stage the area, call the physician for treatment, and complete a care plan related to the pressure ulcer. She stated she had received information in report regarding the SDTI and assumed the Physician had already been notified for treatment. She stated if the pressure ulcer was not a new wound, it would not necessarily have to be measured weekly.  Interview, on 03/21/13 at 11:40 AM, with the Nurse Practitioner revealed she would expect to be notified for an area which presented as a non-blanchable dark purple area and she would order Xenoderm as a treatment. Continued interview revealed she did not remember being notified of the resident's heel ulcer until 03/07/13 when the order was written for treatment to the pressure ulcer and if she had been notified	F 314			

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F 314 Continued From page 29  
earlier, there would have been an order written prior to that date.

Interview, on 03/22/13 at 12:45 PM, with Licensed Practical Nurse (LPN) #1 revealed he admitted Resident #1 to the facility and developed an Initial Care Plan based on assessments such as the Braden Scale. He stated if the Braden Scale indicated Resident #1 was at risk for pressure ulcers, he should have initiated an Initial Care Plan related to the risk of pressure ulcers.

Interview, on 03/21/13 at 10:40 AM, with the Director of Nursing (DON), revealed Resident #1 should have had an Initial Care Plan completed related to risk for skin breakdown since the resident was noted to be at risk per the Braden Scale and due to his/her decreased mobility. She stated it was her expectation that if a new dark area was identified, it would be brought to the Nurse Practitioner's attention for treatment orders. She further stated when the SDTI was first noted, a measurement and a picture should have been obtained per the wound protocol. "I would have expected nurses to find the area sooner and bring it to the attention of the nursing staff and the Nurse Practitioner before it became unstageable". The DON clarified the Nurse Practitioner was on the unit several days a week and was the Provider who was usually notified of changes in condition. Further interview revealed the Wound Nurse had not been at the facility for awhile due to being on leave; however, the facility was working on having someone to take that position. She stated in the past the wound consults were done with the Wound Nurse when a pressure ulcer was identified and the wound nurse would do weekly skin rounds for those

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F 314 Continued From page 30 residents with pressure ulcers.

2. Review of the medical record revealed the facility admitted Resident #2, on 03/11/13, with diagnoses which included Subdural/Subarachnoid Hemorrhage, Subdural Hematoma, Greater Trochanter Fracture, Coronary Artery Disease, Hypertension, and Urinary Retention. Review of Initial Nursing Assessment, dated 03/11/13, revealed Resident #2 was at risk for developing pressure.

Review of Physician's Order, dated 03/16/13, revealed an order for Granulex Spray (A topical product used to help relieve pain and help the healing of skin wounds, ulcers, and sunburns.) to be applied to the heels every shift and as needed. Further review of Physician's Orders revealed Bunny Boots to be worn while in bed.

Review of Resident #2's Initial Care Plan revealed there was no plan of care developed related to Resident #2's risk for skin breakdown or preventative treatment.

Observation, on 03/19/13 at 11:40 AM, revealed Resident #2 was lying in bed with legs and heels resting on the mattress. Further observation revealed Bunny Boots were attached to the footboard of the bed.

Additional observation, on 03/19/13 at 12:35 PM, revealed Resident #2 was lying in bed with legs and heels flat on the bed. Further observation revealed Bunny boots were attached to footboard of bed.

Continued observation, on 03/19/13 at 2:40 PM,

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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 31</p> <p>Resident #2 lying in bed with feet and heels on the mattress. Additional observation revealed Bunny boots were attached to footboard of bed.</p> <p>Observation and interview, on 03/20/13 at 8:55 AM, with State Registered Nursing Assistant (SRNA) #1 who provided care to Resident #2 revealed she was unaware Resident #2 was to have Bunny Boots applied while in bed because it was not listed on the care chart which was located at the foot of the bed in Resident #2's room.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/20/13 at 09:40 AM, revealed treatments for residents were on the report sheets and discussed at shift change. Further interview with LPN #2 revealed nursing was to document and update care plans daily, as needed for changes in a resident's condition or treatment; however, was not sure why a care plan was not developed for Resident #2 related to risk for pressure and the use of Bunny Boots.</p> <p>Interview with Nurse Practitioner (NP), on 03/21/13 at 10:20 AM, revealed she assumed nurses were ensuring Physician's orders were being followed as well as care plans developed related changes in Resident #2's treatment.</p> <p>Interview with the Director of Nursing (DON), on 03/22/13 at 1:00 PM, revealed she would expect nurses to develop a care plan for changes in a resident's treatment or Physician's Orders.</p> <p>3. Review of the medical record revealed the facility admitted Resident #8, on 03/17/13, with diagnoses which included Hypertension, History</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 314	Continued From page 32 of Urinary Incontinence and Glucose Intolerance. Review of Resident #8's medical record revealed, upon admission, revealed the facility Resident #8 for potential skin breakdown utilizing the Braden Scale for Predicting Pressure Sore Risk. Review of the Braden Scale for Predicting Pressure Sore Risk, dated 03/17/13, revealed Resident #8 scored sixteen (16), indicating Resident #8 was at risk for developing a pressure ulcer. Review of Resident #8's Care Plan revealed no interventions were initiated for being at risk for developing pressure ulcers.  Observation during a skin assessment of Resident #8, on 03/22/13 at 10:00 AM, revealed the resident's skin was intact and no evidence of pressure ulcers.  Interview with DON, on 03/22/13 at 1:00 PM, revealed a care plan for being at risk for pressure ulcers should have been initiated due to the Braden Scale for Predicting Pressure Sore Risk to prevent any pressure ulcers from developing.	F 314			
F 441 SS=D	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,	F 441	441 Resident #1 was discharged on 3/21/13 from the facility prior to this survey completion.  The hand hygiene policy will be reviewed and will be revised by the Infection Control Preventionist (ICP) by May 3, 2013.  The policy for TB Skin Testing will be reviewed and revised by the ICP by May 3, 2013.	5/3/13	

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F 441 Continued From page 33  
should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection  
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and facility policy review, it was determined the facility failed to provide a safe, sanitary environment to prevent the development and transmission of diseases for one (1) of eleven (11) sampled residents (Resident #1).

Observation of perineal care for Resident #1, revealed the Nurse completed the perineal-care, removed her gloves, and without washing her hands proceeded to don new gloves and continue

F 441  
The policy regarding food not being stored in work areas will be reviewed and revised by the ICP by May 3, 2013.

The DON will audit all patients to ensure TB skin testing has been completed by May 3, 2013.

The DON will assess all medication rooms to ensure food is removed by May 3, 2013.

Education regarding the policy and procedure for Hand Hygiene, TB Skin Testing and food not being stored in work areas will be provided to the nursing staff by the DON and Nurse Educator. Additionally, all nursing staff will complete a competency for hand hygiene. These will be completed by May 3, 2013.

The Infection Control Preventionist (ICP) will audit hand hygiene compliance and compliance with no food in work areas through direct observations. The ICP will perform five observations per week for one month, then ten observations per month times three months, then quarterly times twelve months. This will be initiated by May 3, 2013.

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F 441 Continued From page 34

the skin assessment and provide wound care to the resident's right heel pressure sore. In addition, although Resident #1 was admitted to the facility on 02/12/13, there was no documented evidence the facility provided Tuberculin (TB) Testing until 03/04/13.

Also, observation revealed an unopened container of Jello pudding and apple sauce sitting on the counter in the medication room, next to a container of Super Sani-Cloth Germicidal Disposable Wipes.

The findings include:

Review of the facility Hand Hygiene: Hand Washing and Hand Antisepsis Policy, revised 09/09, revealed hand hygiene was the single most important practice for preventing hospital acquired infections and was required by all personnel in the health care setting. Hand hygiene was defined either as handwashing, antiseptic hand wash, antiseptic hand rub or surgical hand antisepsis. Hand hygiene was required before and after touching wounds, between contacts with different anatomical sites of the same client, and after removing gloves.

1. Review of Resident #1's medical record revealed the facility admitted the resident, on 02/12/13, with diagnoses which included Diabetes Mellitus, and Status Post Right Hip Fracture with Open Reduction Internal Fixation (ORIF) and an unstageable Pressure Ulcer to the Right Heel.

Observation, on 03/19/13 at 2:45 PM, of a skin assessment, wound care, and perineal care revealed Registered Nurse (RN) #3 started the

F 441

The DON will audit compliance with TB Skin Testing by reviewing ten medical records per week times one month, then monthly times three months, then quarterly times twelve months. This will be initiated by May 3, 2013.

The results of the audits will be submitted to the Continuous Quality Improvement Committee (QAPI), which includes the Administrator, Director of Nursing (DON), MOS Manager, Assistant MDS Coordinator, Medical Director, Social Worker, Therapy Coordinator, random nursing staff, Nurse Practitioner, and Activity Director for review on May 3, 2013 and quarterly times twelve months.

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F 441 Continued From page 35

skin assessment and after noting the resident was incontinent of urine, removed the resident's pull ups and washed her hands. RN #3 then proceeded to perform perineal care and removed her gloves. RN #3 did not wash her hands after removing the gloves, but donned new gloves and proceeded to assess the resident's skin on the resident's arms, chest, legs, and feet. RN #3 then removed her soiled gloves, and without washing her hands, donned new gloves and proceeded to cleanse the right outer heel with Wound Cleanser. She then picked up the Betadine and stated she needed to check the order before proceeding, washed her hands and left the room.

Interview, on 03/19/13 at 3:00 PM, with RN #3 revealed she should have washed her hands after performing perineal care and prior to continuing with the skin assessment. She further stated she should have washed her hands prior to the wound care.

Interview with the Director of Nursing (DON), on 03/21/13 at 10:25 AM, revealed staff should wash their hands after providing perineal care and prior to completing skin assessment or treatments of wounds. She further stated staff should wash their hands each time gloves were removed.

Further review of Resident #1's medical record revealed an admission date of 02/12/13; however, review of the "Tuberculin PPD Skin Test Record" revealed the resident received the first step Tuberculin (TB) skin test on 03/12/13 which read negative on 03/14/13.

Interview, on 03/21/13 at 10:25 AM and 11:45

F 441

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NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504
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F 441	<p>Continued From page 36</p> <p>AM, with the DON revealed TB skin tests were to be administered within twenty-four hours of admission and a second step TB skin test was to be administered within ten (10) days after the first one was read. She stated she did "spot checks" of the Treatment Administration Record (TAR) to ensure the TB skin tests were completed timely. She stated Resident #1's TB skin test was not ordered on admission and she caught it through her audit and had the Provider write the order. Continued interview revealed there used to be a process in which the Nurse reviewed the Admission Physician's Orders using a checklist to ensure all orders were in place; however, the facility no longer used the checklist and she had been noticing things were being missed on the Admlssion Physician's Orders.</p> <p>2. Observation, on 03/19/13 at 9:05 AM, revealed an unopened container of Jello pudding and apple sauce sitting on the counter in the medication room next to a container of Super Sani-Cloth Germicidal Disposable Wipes. Review of the manufactures guidelines revealed the product could cause permanent eye damage including blndness, burns to mouth, throat and stomach, and may be fatal if swallowed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/20/13 at 10:00 AM, revealed the Jello pudding and the apple sauce containers were used to give crushed medications to residents who could not take their medications whole. She further stated she did not know who had put the Jello pudding and the apple sauce on the counter next to the container of Super Sani-Wipes; however, she felt the Jello pudding and the apple sauce could be stored next to the Super</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/22/2013
NAME OF PROVIDER OR SUPPLIER  CARDINAL HILL REHABILITATION UNIT			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 VERSAILLES ROAD LEXINGTON, KY 40504		
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F 441	Continued From page 37 Sani-Wipes because the containers were all closed. Interview with the DON, on 03/22/13 at 2:00 PM, revealed food items were never to be stored next to any type of chemical. She further stated even if the food was in a sealed container, it should never be stored in a place where it could come into contact with a chemical. She further stated, the container of Jello pudding and the container of apple sauce should not have been stored next to the container of Super Sani-Wipes.	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>CARDINAL HILL REHABILITATION UNIT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2050 VERSAILLES ROAD LEXINGTON, KY 40504</b>		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 10/22/1986</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type I (333) 2nd Floor contains rooms 279-299. 3rd floor contains rooms 362-379</p> <p>Smoke Compartment: Four (4)</p> <p>Fire Alarm: Complete fire alarm (software upgrade: 09/17/2008)</p> <p>Sprinkler System: Complete sprinkler system (wet)</p> <p>Generator: Two (2) Type I. Diesel installed 1998</p> <p>A standard Life Safety Code survey was conducted on 03/20/2013. Cardinal Hill Rehabilitation Unit was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was forty five (45). The facility is licensed for fifty (50) beds.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.