

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

PRINTED: 01/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(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 000	INITIAL COMMENTS An Abbreviated Survey investigating complaint #KY21058 was conducted on 12/09/13 through 12/13/13 to determine the facility's compliance with Federal requirements. KY21058 was substantiated with the highest Scope and Severity at a "G".	F 000	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees; agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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-157		

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

TITLE

(X6) DATE

Kathleen C. Evans

Admission Tracker

1/27/2014

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	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy and procedure review it was determined the facility failed to consult with the resident's physician and notify the family representative of the need to alter treatment for one (1) of four (4) sampled residents (Resident #1). Resident #1 was assessed as having a Stage II pressure sore to the left lateral aspect of the left foot on 12/09/13. The staff failed to notify the physician or family until 12/10/13.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure titled "Skin System Policy & Procedure, (no date) revealed when observed skin is compromised, the Nurse finding the problem will initiate a treatment using formulary product if possible and physician approval. The Physician and Family must be notified at the time of discovery and notification must be documented in the medical record according to regulatory guidelines.</p> <p>Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Muscle Weakness, Skin Sensation Disturbance, and Adult Failure to Thrive. Review of a quarterly Minimum Data Set (MDS) assessment, dated 11/12/13, revealed the facility assessed Resident #1's cognition as moderately impaired and required extensive assistance with activities of daily living.</p>	F 157	<p>F157</p> <ol style="list-style-type: none"> 1. The family for resident # 1 was notified of the wounds on 01-03-2014 by the Director of Nursing and the physician for resident # 1 was notified of the wound to the left foot on 12-10-2014 by the Unit Manager and a treatment ordered. 2. A 100% skin audit of all current residents was completed by 1-3-2014 by the Director of Nursing, Assistant Director of Nursing and new LPN wound nurse to identify any wounds and to assure all had physician and family notification. Any identified as not having physician and family notification had notification completed. 3. All Licensed Nurses will be re-educated by the Director of Nursing or the Assistant Director of Nursing on identification of wounds and physician and family notification of new or declining wounds. This education will be completed by 1-6-2014 with no Licensed Staff working after 1-6-2014 without having received this re-education. 4. The Director of Nursing or Assistant Director of Nursing will complete a follow up skin assessment on five (5) residents per week for 	

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F 157	<p>Continued From page 2</p> <p>Observation, on 12/10/13 at 9:28 AM of a skin assessment and wound treatment by Licensed Practical Nurse (LPN) #1 for Resident #1, revealed Biatain foam with Kerlix dressing, not dated or initialed, pulled off of wound to left lateral aspect of the left foot, and redressed.</p> <p>Interview with LPN #1, on 12/10/13 at 9:28 AM, revealed she had found the "open area" to the left lateral aspect of the left foot on 12/09/13. The LPN stated she did not notify the physician or family about the wound on 12/09/13 because she had an emergency and was called away and she was treating the wound according to the wound care guidelines. LPN #1 further revealed there was no order for the foam dressing applied to the wound on 12/09/13 or 12/10/13 and she should have notified the physician when she identified the wound on 12/09/13.</p> <p>Further record review revealed there was no evidence the physician and family were notified of the wound to the left lateral aspect of the left foot on 12/09/13.</p> <p>Interview with the Director of Nursing (DON), on 12/10/13 at 3:00 PM, revealed when staff find an area/wound the physician should be notified.</p> <p>Interview with Resident #1's Physician, on 12/11/13 at 3:30 PM, revealed he expected to be notified of a new wound immediately and felt this was a rule for all nursing facilities.</p>	F 157	<p>twelve (12) weeks to assure wounds are identified and the physician and family are notified timely of any new wound or declining wound. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will be convened to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Service Manager and the Social Services Director with the Medical Director attending at least quarterly.</p>	1/8/2014
F 280 SS=G	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be</p>	F 280	<p>F280</p> <ol style="list-style-type: none"> The Director of Nursing reviewed and revised the skin impairment care plan for resident # 1 on 1-3-2014 to assure that the care plan accurately reflects all wounds and interventions to meet the needs of the resident. On 1-3-2014, the Director of Nursing and the MDS Nurse reviewed all current resident's care plans to assure that all care plans 	

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F 280	<p>Continued From page 3</p> <p>Incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to revise the care plan for one (1) of four (4) sampled residents (Resident #1). Resident #1 was readmitted to the facility on 11/25/13 with orders to apply protective heelboots and the facility failed to revise the care plan to include the protective boots. Resident #1 developed Stage II pressure sores to the lateral aspect of the left and right foot. (Refer to F314)</p> <p>The findings include: Interview with the Director of Nursing (DON), on 12/10/13 at 4:02 PM, revealed the facility did not have a policy/procedure that addressed the revision of care plans.</p>	F 280	<p>were up to date and interventions listed to meet the needs of the resident. Any needed revisions were made on 1-3-2014.</p> <p>3. On 1-6-2014, the Regional Nurse Consultant re-educated the Director of Nursing and the Assistant Director of Nursing on the requirement to update a resident's care plan as a resident's condition changes including developing or declining wounds in the daily clinical meeting. The daily clinical meeting is a clinical meeting to review any resident changes in condition for further intervention and care plan updates.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will review five (5) resident records per week for twelve (12) weeks to assure that the care plans are up to date and accurately reflects the resident condition and interventions. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will be convened to review and make recommendations as needed. The Quality Assurance Committee will consist of, at a minimum the Director of Nursing,</p>	1/8/2014

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F 280	Continued From page 4 Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses to include Muscle Weakness, Skin Sensation Disturbance, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) assessment, dated 11/12/13, revealed the facility assessed Resident #1's cognition as moderately impaired and he/she required extensive assistance with activities of daily living. Review of a Physician Order, dated 11/25/13, revealed staff should apply protective boots every shift. Review of Resident #1's Comprehensive Care Plan for impaired skin integrity, initiated on 03/28/13, and the Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Plan of Care, dated 12/09/13, revealed the care plans were not revised to include the intervention to apply protective boots every shift. Further review of Resident #1's potential for impaired skin integrity care plan, initiated on 03/28/13, revealed the care plan was not revised to include the Stage II area to the lateral aspect of the left foot or the right foot. Observations on 12/09/13 at 1:22 PM and on 12/10/13 at 9:28 AM and 10:20 AM revealed Resident #1 was in bed and there were no protective boots on his/her feet. Further observation on 12/10/13 at 3:20 PM with the DON revealed Resident #1 was in bed with no protective boots on his/her feet. Interviews with CNA #7, CNA #8, and CNA #9, on 12/13/13 at 2:00 PM, 2:23 PM and 2:30 PM, respectively, revealed they were not aware	F 280		

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F 280	<p>Continued From page 5</p> <p>Resident #1 was supposed to wear protective boots. The CNAs stated if the resident was supposed to wear protective boots it should be on the CNA care plan.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 and LPN #3, on 12/12/13 at 10:40 AM, and on 12/13/13 at 2:55 PM and 3:28 PM, respectively, revealed the protective boots should be on the CNA care plan so the CNAs know what care to provide for the resident.</p> <p>Interview with LPN #4, on 12/13/13 at 3:36 PM, revealed the physician orders were supposed to be on the care plan and the nurses were responsible for updating the care plan. LPN #4 revealed if the physician order for the protective boots was not on the CNA care plan then the CNAs would not know what care to provide for the resident.</p> <p>Interview with the DON, on 12/12/13 at 10:50 AM and 11:00 AM and on 12/13/13 at 8:58 AM and 2:55 PM, revealed the purpose of the protective boot was to offload or to provide a pressure reducing surface to protect the skin integrity. The DON stated she expected the physician orders to be care planned and followed. She stated the whole Interdisciplinary Team (IDT) was responsible for updating the care plan.</p> <p>Review of Resident #1's Wound Assessment Report for left side of left foot, dated 12/10/13, revealed the facility identified a Stage II pressure sore with a scant amount of sanguineous drainage and measured 1.30 centimeters (cm.) x 1.30 cm. x 0.40 cm. Review of Resident #1's Wound Assessment Report for the right side of right foot, dated 12/10/13 revealed the facility</p>	F 280			

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F 280	Continued From page 6 Identified a Stage II pressure sore with a small amount of sanguineous drainage and measured 1.00 cm. x 1.00 cm. x 0.40 cm. on 12/10/13.	F 280	Administrator, Assistant Director of Nursing, Dietary Service Manager and the Social Services Director with the Medical Director attending at least quarterly.	
F 282 SS=G	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide care in accordance with each resident's written plan of care for one (1) of four (4) sampled residents (Resident #2). Resident #2 was care planned to wear heelboots every day however, observations revealed Resident #2 had no heelboots on. The facility identified an "open blister" to the tip of the resident's right great toe on 12/11/13. (Refer to F314) The findings include: Interview with the Director of Nursing (DON), on 12/10/13 at 4:02 PM, revealed the facility did not have a policy/procedure that addressed care plans. Record review revealed the facility admitted Resident #2 on 04/08/13 with diagnoses which included Late Effects Cerebrovascular Disease, Open Wound Site, Anemia, and Sepsis. Review of the significant change Minimum Data Set (MDS) assessment, dated 09/19/13, revealed the	F 282	F282 1. Resident # 2's care plans were reviewed by the Director of Nursing on 1-3-2014 to assure that all care planed interventions were in place. No concerns were identified. 2. On 1-3-2014, the Director of Nursing and the MDS Nurse reviewed all current resident's care plans to assure that all interventions were in place. Any identified concerns were immediately corrected. 3. All nursing staff, to include CNAs, will be re-educated by the Director of Nursing or Assistant Director of Nursing on following the resident's plan of care and notification of the nurse if you are a certified nursing assistant or physician if you are a nurse and unable to follow the resident's plan of care. This re-education will be completed by 1-6-2014 with no nursing staff working after 1-6-2014 without having received this re-education.	

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F 282	<p>Continued From page 7</p> <p>facility assessed Resident #2's cognition as severely impaired and he/she required extensive assistance with activities of daily living.</p> <p>Review of the Comprehensive Care Plan for impaired skin Integrity, Initiated on 04/09/13, and the Certified Nurse Aide (CNA) Activities of Daily Living (ADL) Plan of Care, dated 08/21/13, revealed an intervention for Resident #2 to wear bilateral heel float boots.</p> <p>Observations on 12/09/13 at 1:43 PM and on 12/10/13 at 9:07 AM and 10:05 AM, revealed Resident #2 was in bed and did not have bilateral heel float boots on his/her feet. Further observation, on 12/10/13 at 3:20 PM with the DON, revealed Resident #2 was in bed and did not have bilateral heel float boots on his/her feet.</p> <p>Interview with CNA #7, on 12/13/13 at 2:00 PM, revealed Resident #2's boots used to be put on by therapy. However, this was no indicated on the CNA ADL Plan of Care.</p> <p>Interview with CNA #8, on 12/13/13 at 2:23 PM, revealed Resident #2 did not need the heel floats or protective boots while in bed; even though bilateral heel float boots was listed on Resident #2's CNA ADL Plan of Care.</p> <p>Interview with CNA #9, on 12/13/13 at 2:30 PM, revealed the CNAs were supposed to put the boots on the resident. The CNA stated Resident #2's CNA ADL Plan of Care revealed he/she was care planned for heel float boots. However, the heel boots were not applied.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/12/13 at 10:40 AM and on 12/13/13 at 2:55</p>	F 282	<p>4. The Director of Nursing or Assistant Director of Nursing will review five (5) resident records per week for twelve (12) weeks to assure that all care plan interventions are in place. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or as the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will be convened to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Service Manager and the Social Services Director with the Medical Director attending at least quarterly.</p>	1/8/2014

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F 282	Continued From page 8 PM, revealed the CNAs were responsible for placing the heel float boots on the residents. Interview with the DON, on 12/12/13 at 11:00 AM, revealed the whole interdisciplinary Team (IDT) was responsible for updating the care plan, and she expected the staff to follow the care plan. Review of the Wound Healing Progress Report, (no date), revealed the facility identified an open blister to the tip of the right great toe on 12/11/13 measuring 2.20 cm. x 2.20 cm.	F 282			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy/procedure review it was determined the facility failed to ensure a resident who enters the facility without pressure sores does not develop pressure sores for two (2) of four sampled residents (Resident #1 and Resident #2). Resident #1 was readmitted to the facility on 11/25/13 with orders to apply protective boots to	F 314	F314 1. Resident # 1 and # 2 had a complete skin assessment completed by the Director of Nursing on 12/30/2013 to identify all wounds, measure the wounds and to assure there is an appropriate treatment in place and that the physician and family were notified as well as to assure all care plan interventions were in place. Any needed corrections were made by 01/04/2014. 2. A complete skin assessment was completed on all current residents by 01-03-2014 by the Director of Nursing, Assistant Director of Nursing and new LPN wound nurse to assure all residents with wounds had wound identified, measured and appropriate treatment in place and physician and family notification as well as a review of the skin care plan to assure care plan interventions were in place. Any identified concerns were immediately corrected.		

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F 314	<p>Continued From page 9</p> <p>his/her feet. The facility failed to revise the care plan to include the protective boots. Observations on 12/09/13 and 12/10/13 revealed there were no protective boots on Resident #1. Interviews with the Certified Nurse Aides (CNAs) revealed they were not aware the resident was supposed to wear protective boots. Interview with the Licensed Practical Nurse (LPN) #1 revealed she identified a Stage II pressure sore to the resident's lateral aspect of the left foot on 12/09/13 and the lateral aspect of the right foot on 12/10/13. However, the LPN failed to measure the resident's wounds when the wounds were identified. (Refer to F280)</p> <p>Resident #2 was care planned for bilateral heel float boots. Observations on 12/09/13 and 12/10/13 revealed Resident #2's heel float boots were not applied. The facility identified Resident #2 had an "opened blister" on the tip of the right great toe on 12/11/13. (Refer to F282)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Skin System Policy", (no date), revealed all residents would be assessed on admission, with each change in condition, and quarterly. Skin assessments would be completed weekly. Staging and measuring would be done exclusively by the skin Management Nurse assigned to that resident to maintain continuity in documentation of progression. On admission and when observed skin was compromised, the Nurse finding the problem would initiate a treatment using formulary product if possible and physician approval. Physician and Family must be notified at time of discovery and notification must be documented in medical record.</p>	F 314	<p>3. All nursing staff, to include CNAs, will be re-educated by the Director of Nursing or Assistant Director of Nursing on following the resident's plan of care and notification of the nurse if you are a certified nursing assistant or physician if you are a nurse and unable to follow the resident's plan of care. This re-education will be completed by 1-6-2014 with no nursing staff working after 1-6-2014 without having received this re-education.</p> <p>The Director of Nursing, Assistant Director of Nursing and new LPN wound Nurse were re-educated by the Regional Nurse Consultant/Wound Care Certified nurse on 01/02/2014 on the appropriate identification, measurement and treatment for wounds as well as physician and family notification. All Licensed Nurses will be re-educated by the Director of Nursing or the Assistant Director of Nursing on identification, measurement, staging and appropriate treatment for wounds to include notification of the physician for new or declining wounds and following the treatment plan of care. This re-education of the Licensed Nurses will be completed by 1-6-2014 with no Licensed Nurse working after 1-6-</p>		

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 314	<p>Continued From page 10</p> <p>1. Record review revealed the facility admitted Resident #1 on 07/01/12 with diagnoses which included Muscle Weakness, Skin Sensation Disturbance, and Adult Failure to Thrive. Review of a quarterly Minimum Data Set (MDS) assessment, dated 11/12/13, revealed the facility assessed Resident #1's cognition as moderately impaired and he/she required extensive assistance with activities of daily living. Additionally, the resident was assessed at risk of developing pressure ulcers.</p> <p>Review of the Nursing Notes revealed Resident #1 was transferred to the hospital on 11/22/13 and returned to the facility on 11/25/13. Review of Resident #1's Admission Skin Assessment, dated 11/25/13 at 12:00 noon, revealed there were no wounds identified to the lateral aspect of the left or right foot of the resident.</p> <p>Review of a Physician Order, dated 11/25/13, revealed staff should apply protective boots every shift. However, review of Resident #1's Comprehensive Care Plan for Impaired skin integrity, initiated on 03/28/13, and the CNA Activities of Daily Living (ADL) Plan of Care, dated 12/09/13, revealed the care plans were not revised to include the intervention to apply protective boots every shift.</p> <p>Review of Resident #1's December 2013 Treatment Administration Record (TAR) revealed to apply protective boots every shift with a start date of 11/25/13 and the TAR was initialed indicating the protective boots were applied.</p> <p>However, observations on 12/09/13 at 1:22 PM and on 12/10/13 at 9:28 AM, 10:20 AM, and 3:20</p>	F 314	<p>2014 without having received this re-education.</p> <p>4. The Director of Nursing or Assistant Director of Nursing will audit all residents with wounds weekly for twelve (12) weeks to assure that the wounds are appropriately measured, have appropriate treatment and have had physician and family notification if a new wound or declining wound as well as a care plan review to assure all interventions are in place. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or the committee deems appropriate. If at any time concerns are identified, a Quality Assurance Committee will be convened to review and make recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Service Manager and the Social Services Director with the Medical Director attending at least quarterly.</p>	1/8/2014	

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F 314	<p>Continued From page 11</p> <p>PM revealed Resident #1 was in bed and there were no protective boots on his/her feet.</p> <p>Interviews with CNA #7, CNA #8, and CNA #9, on 12/13/13 at 2:00 PM, 2:23 PM, 2:30 PM and 2:45 PM, respectively, revealed they were not aware Resident #1 was supposed to wear protective boots. The CNAs stated if the resident was supposed to wear protective boots it should be on the CNA care plan. CNA #7 stated Resident #1 never had any foot protectors.</p> <p>Observation, on 12/10/13 at 9:28 AM of a skin assessment and wound treatment by LPN #1 for Resident #1, revealed Blatain foam with Kerlix dressing, (not dated or initialed), were pulled off of a wound on the left lateral aspect of the left foot, and the LPN redressed the wound. LPN #1 examined the right foot and found an area on the lateral aspect of the right foot and dressed it with Blatain foam and kerlix dressing without measuring either area or notifying the physician for treatment. LPN #1 stated she had identified the wound on the lateral aspect of the resident's left foot on 12/09/13.</p> <p>Further record review revealed there was no evidence the physician and family were notified of the wound to the left lateral aspect of the left foot on 12/09/13. Interview with Resident #1's Physician, on 12/11/13 at 3:30 PM, revealed he expected to be notified of a new wound immediately and felt this was a rule for all nursing facilities.</p> <p>Further interview with LPN #1, on 12/10/13 at 9:28 AM and 12:24 PM, revealed she did not notify the physician or family about the wound on 12/09/13 because she had an emergency and</p>	F 314		

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F 314	<p>Continued From page 12</p> <p>was called away so she treated the wound according to the wound care guidelines. LPN #1 further revealed there was no order for the foam dressing applied to the lateral aspect of the left foot wound on 12/09/13 and 12/10/13 and no order for the dressing applied to the lateral aspect of the right foot on 12/10/13. She stated she should have notified the physician when she identified the wound on 12/09/13. The LPN further stated she should have measured the areas when she identified them so the wounds could be tracked to determine if they were healing or not. LPN #1 revealed the protocol for wounds was to do a skin assessment and if an open area was found to measure it and clean it, notify the health care provider, write order and put the order on the Medication Administration Record and the Treatment Administration Record.</p> <p>Review of Resident #1's Wound Assessment Report for left side of left foot, dated 12/10/13, revealed the wound was identified on 12/10/13, instead of 12/09/13, assessed as a Stage II with a scant amount of sanguineous drainage and measured 1.30 centimeters (cm.) x 1.30 cm. x 0.40 cm. The physician and family were notified on 12/10/13. Review of Resident #1's Wound Assessment Report for the right side of right foot, revealed the wound was identified on 12/10/13, assessed as a Stage II with small amount of sanguineous drainage and measured 1.00 cm. x 1.00 cm. x 0.40 cm.</p> <p>Further review of Resident #1's potential for impaired skin integrity care plan, initiated on 03/28/13, revealed the care plan was not revised to include the Stage II area to the lateral aspect of the left foot or the right foot.</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>Interviews with LPN #1, LPN #3, and LPN #4, on 12/12/13 at 10:40 AM and on 12/13/13 at 2:55 PM, 3:28 PM and 3:36 PM respectively, revealed the protective boots should be on the CNA care plan so the CNAs know what care to provide for the resident. LPN #4 revealed if the physician order for the protective boots was not on the CNA care plan then the CNAs would not know what care to provide for the resident.</p> <p>Interview with the Director of Nursing (DON), on 12/10/13 at 3:00 PM and 4:02 PM, on 12/12/13 at 10:50 AM and 11:00 AM and on 12/13/13 at 8:58 AM and 2:55 PM, revealed the purpose of the protective boot was to offload or to provide a pressure reducing surface to protect skin integrity. The DON stated she expected the physician orders to be care planned and followed. The DON revealed when licensed staff identify a wound she expected the staff to notify the physician. She stated if an open area was identified it should be measured, a treatment put in place specific to wound, and the wound should be documented on the wound healing progress sheet.</p> <p>2. Record review revealed the facility admitted Resident #2 on 04/08/13 with diagnoses which included Late Effects Cerebrovascular Disease, Open Wound Site, Anemia, and Sepsis. Review of the significant change MDS assessment, dated 09/19/13, revealed the facility assessed Resident #2's cognition as severely impaired and he/she required extensive assistance with activities of daily living. Review of Resident #2's Skin Assessment, dated 10/01/13, revealed there was no open wound to right great toe on admission.</p> <p>Review of the Comprehensive Care Plan for</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>impaired skin integrity, initiated on 04/09/13, and the CNA ADL Plan of Care, dated 08/21/13, revealed an intervention for Resident #2 to wear bilateral heel float boots.</p> <p>Observations on 12/09/13 at 1:43 PM and on 12/10/13 at 9:07 AM, 10:05 AM, and 3:20 PM, revealed Resident #2 was in bed and did not have bilateral heel float boots on his/her feet.</p> <p>Review of Resident #2's December 2013 TAR revealed to place heel float boot to both feet and encourage and monitor placement every shift to promote skin integrity. The TAR was initiated on 12/09/13 on day shift indicating the heel float boots were in place.</p> <p>Observation on 12/10/13 at 10:05 AM of skin assessment by LPN #1 for Resident #2 revealed the resident refused to allow the LPN to conduct the assessment.</p> <p>Review of the Wound Healing Progress Report, (no date), revealed the facility identified an open blister to the tip of the right great toe on 12/11/13 measuring 2.20 cm. x 2.20 cm.</p> <p>interview with CNA #9, on 12/13/13 at 2:30 PM, revealed the CNAs were supposed to put the boots on the resident. The CNA stated Resident #2's CNA ADL Plan of Care revealed he/she was care planned for heel float boots.</p> <p>interview with LPN #1, on 12/12/13 at 10:40 AM and on 12/13/13 at 2:55 PM, revealed the CNAs were responsible for placing the heel float boots on the residents and the nurse verified the heel float boots were in place every shift and initialed the TAR.</p>	F 314		
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F 314	<p>Continued From page 15</p> <p>Interview with LPN #3 and LPN #4, on 12/13/13 at 3:28 PM and 3:36 PM, revealed licensed staff initiated the TAR to verify CNAs have completed the task.</p> <p>Interview on 12/13/13 at 3:35 PM with Registered Nurse (RN) #2 revealed the CNAs were usually responsible for applying the heel protectors and the nurse verified they were in place. RN #2 revealed Resident #2 did not use heel protectors while in bed; however, heelboots were noted on the resident's TAR.</p> <p>Interview with the DON, on 12/12/13 at 11:00 AM, revealed she expected staff to follow the care plan. The DON stated the purpose of the air boots is to offload or to provide pressure reducing surface to protect the skin integrity.</p>	F 314		