

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

PRINTED: 11/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2015
NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

(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 AMENDED An Abbreviated Survey investigating Complaint #KY00023616 and Complaint #KY00023952 was conducted 08/03/15 through 08/12/15. An Partial Extended Survey was conducted 08/19/15 through 08/21/15 with Substandard Quality of Care identified at 42 CFR 483.25 Quality of Care, F314 at a Scope and Severity (S/S) of an "H". Complaint #KY00023616 and Complaint #KY00023952 was substantiated. Interview and record review revealed on 04/24/15, the facility reassigned the facility's Wound Care Nurse to the position of a staff nurse and delegated all wound care assessments and treatments to the staff nurses. Interview revealed training was not provided related to measuring and staging of wounds and nurses were not comfortable completing this type of wound assessment. In addition, interview revealed the nurses were not educated on the types of forms, related to pressure ulcers, utilized by the facility. Review of the facility's Wound Care Protocol revealed Wound Care Summaries would be updated weekly and weekly Skin Assessments would be completed. However, record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. Additional deficiencies were cited at 42 CFR 483.10 Resident Rights, F157 at a S/S of a "G"; 42 CFR 483.20 Resident Assessment, F280 and F282 at a S/S of a "H"; and, 42 CFR 483.75 Administration, F490, F514 and F520 at a S/S of	F 000	Ridgeway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist. Ridgeway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal disputes resolution, legal appeal proceedings or any administrative or legal proceeding. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgeway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance of self critical examination privileges which Ridgeway Nursing and Rehabilitation does not waive, and reserve the right to assert in any administrative, civil, or criminal claim, action, or proceeding. Ridgeway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to resident.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/13/2015
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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 : 483.10(b)(11) NOTIFY OF CHANGES
SS=G : (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 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 interview, record review, and review of the facility's policy, it was determined the facility

F 157:

F 157:
It is and was on the day of survey the policy of Ridgeway Nursing and Rehabilitation to 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 a significant change in the resident's physical, mental, or psychosocial status.

1. Resident #1 no longer resides in the facility.
Resident #10 continues to reside in the facility. His physician has been made aware of his current status.
Resident #10 is an 85 year old that was admitted to Ridgeway Nursing and Rehabilitation on 2/2/15. His diagnosis include urinary retention, BPH, Parkinson disease, dementia with behaviors, HTN, DM stage II, chronic kidney disease, dysphagia, hyperlipidema, generalized weakness, hematuria with unclear etiology. On 2/16/15 upon readmission to the facility a stage II area to right sacrum measuring 1cm x 0.8cm, red, no odor or drainage was noted with 6cm non-blanching redness to 12:00. Aquacel foam ordered and applied. On 3/12/15 this area healed. On 3/22/15 the right buttock/sacral area 1cm x 1cm, red, no odor, serous drainage surrounding skin with blanchable redness. Duoderm ordered and applied. This area healed on

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failed to notify the Physician when there was a significant change in the residents' physical status and a need to alter treatment significantly for two (2) of fourteen (14) sampled residents (Resident #1 and #10).

Resident #1 Resident #1 had a sacral wound which was deteriorating, had a foul odor, and showed signs and symptoms of infection. The resident experienced a fever starting on 06/06/15 at "00:10" (12:10) AM which continued; however, there was no documented evidence the Physician was notified of the fevers until 06/07/15 at 3:50 PM, over thirty-nine (39) hours later.

Resident #10 was assessed with an area on the left inner buttock, on 06/02/15, with blisters to the bilateral upper thighs and a Suspected Deep Tissue Injury (SDTI) to the left buttock, on 06/09/15, and with an area to the left lower coccyx, on 06/16/15; however, here was no documented evidence the Physician was notified of these areas in order to obtain a treatment.

The findings include:

Review of the facility "Change in a Resident's Condition", dated 08/01/13, revealed the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the residents' medical/mental condition. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On Call Physician when there has been a significant change in the resident's physical/emotional/mental condition or a need to alter the resident's physical/emotional/ mental condition.

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4/14/15. On 4/21/15 a suspected deep tissue injury 1cm x 1cm non-blanching, no odor or drainage was noted to right coccyx. This area continues to be treated. On 2/16/15 upon readmission a 4.5cm x 4 cm, red/purple blister was noted to his right heel. This was diagnosed as MRSA and treated. The right heel continues to be open despite wound care clinic consultation on several dates and several debridements. Current wounds' measurements are right heel stage IV, 6.8cm x 6.7cm x 1.2cm with 1.7cm tunneling at 6:00 and 8:00, coccyx unstageable 3cm x 1.7cm x 1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac to be changed every 2 days to each area. Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Cefin, Bactrim and Ampicillin. It should be noted that Resident #10 has I plus edema to lower extremities and requires Lasix 60mg daily to keep the edema to I plus.

2. All residents are reviewed daily in the morning meeting. Any changes in resident condition, will be verified, that the physician and responsible parties have been notified.

All twenty four hour reports have been reviewed for the last three months to identify any resident who has experienced a change in status which required MD notification or responsible party notification. Daily as part of the morning meeting the Administrator, Director of Nursing, Staff Development Nurse, MDS staff, Unit Coordinators, Medical records and therapy staff meet to discuss and review the 24 hour report which includes MD notification, skin conditions, Labs, Appointments, 72 hour follow up, incidents, new admissions and potential discharges.

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1. Review of Resident #1's clinical record revealed the facility admitted the resident on 03/11/15 with diagnoses including Dementia, Alzheimer's Disease, Hip Fracture, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) Assessment dated 03/18/15 revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating cognitive impairment. Further review revealed the facility assessed Resident #1 as requiring extensive assist of two (2) for bed mobility, transfers and toileting, as always incontinent of urine, frequently incontinent of bowel, and as having no pressure ulcers.

Review of the Significant Change MDS dated 04/23/15 revealed the facility assessed Resident #1 as having both short and long term memory loss, as requiring extensive assist of two (2) for bed mobility, transfers, and toileting and as always incontinent of bowel and bladder. Further review revealed the facility assessed Resident #1 as having one (1) Stage II pressure ulcer and having one (1) unstageable pressure ulcer.

Review of the Wound Care Clinic Note dated 06/04/15, revealed the resident had an enlarging decubitus ulcer of the left medial buttocks which was described as eighty percent (80%), red granulation to twenty (20%), and measured 10 cm by 6 cm by unknown depth.

Review of the Nurse's Notes, dated 06/06/15 at 2410 (12:10 AM), completed by Licensed Practical Nurse (LPN) #11, revealed Resident #1 was very hot to touch, her/his face was flushed and the resident's temperature was up to 102.4 degrees; Tylenol 500 milligrams (mg's) (medication for pain relief and fever reducer) was

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3. Daily the Director of Nursing will review the 24 hour report to verify there are not resident changes and to ensure the physician and responsible parties have been notified. On the weekends the charge nurse will perform the above duty.

All licensed staff were in-serviced on 08-13-15 related to physician notification and responsible party notification. This education was conducted by the Administrator, Director of Nursing and Vice President of Clinical Services. As part of all licensed nursing orientation each nurse hired will be educated on physician notification and responsible party notification related to a significant change in status.

4. As part of the facility's ongoing quality assurance program, monthly the Administrator will audit 15 resident records to ensure that all notifications of significant change have been made. These audits will continue for the next six months. As part of the audit the Administrator will review nurse's notes and physician orders to detect any significant changes in resident status requiring physician notification. The above mentioned audits will be made part of the facility's on-going quality assurance meetings for the next six months. If the Administrator identifies issues related to notification of significant changes an action plan for re-education for the specific nurse will be initiated and documented.

5. August 25, 2015

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administered and would continue to monitor.

Interview with LPN #11 on 08/20/15 at 9:30 AM, revealed she did not notify the Physician of the temperature because the resident had a standing order for Tylenol for temperature.

Review of the June 2015 MAR revealed on 06/06/15 at 1430 (2:30 PM) Tylenol 500 mg was administered for a temperature of 101.6 degrees and the resident's temperature decreased to 97.0 degrees at 1730 (5:30 PM).

Interview on 08/21/15 at 2:10 PM, with LPN #9 who cared for the resident on 06/06/15, revealed a temperature was a change in condition for the resident; however, she did not notify the Physician because the resident's temperature came down with Tylenol.

Further review of the June 2015 MAR revealed LPN #8 had documented on 06/07/15 at 10:45 AM Tylenol (no dosage noted) was administered for a temperature of 101.6 degrees and the resident's temperature came down to 99.2 degrees at 12:00 PM.

Review of the Physician's Orders dated 06/07/15 at 3:50 PM and received by LPN #8, revealed orders for a culture of the sacral wound with the next dressing change due to odor, temperature and drainage. After culture obtained start Levaquin (antibiotic medication) 750 milligrams every day for seven (7) days until the wound culture was received. Continued review of the June 2015 MAR revealed the resident again received Tylenol on 06/07/15 at 4:50 PM, for a temperature of 102 degrees.

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F 157	<p>Continued From page 5</p> <p>Review of the Nurse's Notes dated 06/07/15 at 10:00 PM, LPN #7 documented the Physician was notified by LPN #8 about the increased temperature and increased redness around the sacral wound and a new order was received to culture the wound and then start the Levaquin 750 Mg every day for seven (7) days until the culture report returned.</p> <p>Interview with LPN #7 on 08/07/15 at 10:00 AM, revealed on 06/07/15 it was reported to her by LPN #8 that she had called the physician related to the wound change and temperature. LPN #7 stated on her shift on 06/07/15 the resident was having a copious amount of drainage which was serosanguinous, and possibly some brown drainage but she could not remember if there was odor. She further stated there was no redness, open areas or drainage from the vagina. However, she stated there was redness surrounding the sacral wound bed. Continued interview revealed she did not call the Physician related to the wound having a lot of drainage because the Physician had been informed on the previous shift of the wound change and had ordered a culture and antibiotics.</p> <p>The subsequent Nurse's Notes dated 06/08/15 at 10:50 AM completed by LPN #9, revealed the physician was notified of the resident's sacral wound having redness and induration surrounding the wound spreading down the left buttock and up the left labia and there was a 1 cm open area on the left buttock producing a copious amount of gray/red purulent drainage, which was malodorous. According to the Note, new orders were received to send the resident to the hospital emergency room.</p>	F 157		

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F 157	Continued From page 8 Interview on 08/12/15 at 12:40 PM, 08/20/15 at 10:00 AM and 08/21/15 at 2:15 PM, with the Director of Nursing (DON), revealed she would not expect the Physician to be notified of a temperature if there was a standing order for Tylenol, unless the temperature did not come down after three (3) attempts of administering Tylenol. Further interview revealed a temperature could imply infection first and foremost and residents with invasive devices or wounds were more at risk for infections. Continued Interview revealed the Physician was to be notified if there was a change in condition and if the Tylenol did not work to bring down the temperature the Physician would need to be notified. Interview with the Attending Physician/Medical Director on 08/11/15 at 9:30 AM, revealed sometime between the wound clinic appointment on 06/04/15 and 06/08/15 the wound became infected because there was no mention in the wound clinic note on 06/04/15 of the need for the resident to be hospitalized related to the wounds. Continued interview revealed he should have been notified when Resident #1 ran a temperature of 102.4 degrees on 06/06/15 because the resident had wounds and he would have ordered a culture of the wounds and antibiotics at that time. 2. Review of Resident #10's medical record revealed the facility admitted the resident on 02/02/15 with diagnoses including Parkinson's Disease, Chronic Kidney Disease, and Diabetes Mellitus. Review of the Quarterly MDS Assessment dated 05/18/15, revealed the facility assessed the resident as having a Brief Interview for Mental	F 157		

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F 157 : Continued From page 7

Status (BIMS) of a 9x (6) out of fifteen (15). Continued review of the MDS, revealed the facility assessed the resident as requiring extensive assistance of two (2) for bed mobility, transfers, toilet use, as not rated for urinary incontinence, as always incontinent of bowel and as having one (1) unstageable pressure ulcer.

On 05/14/15 a Wound Care Summary was initiated related to a SDTI on the resident's left lower inner buttocks measuring 1.0 centimeter (cm) x 0.5 cm. New Physician's Orders were received on 05/14/15 for Aquacel fiber and cover with DuoDerm to the lower left inner buttock, change every three (3) days and prn.

On 06/02/15 a weekly Skin Assessment described the resident's left coccyx wound in which the resident was already being treated, as unstageable measuring 6.0 cm by 3.0 cm by 0.5 cm. Further review revealed the weekly Skin Assessment dated 06/02/15 completed by LPN #13, revealed the resident had a SDTI to the left inner buttock which was red and non blanchable measuring 6.0 cm by 5.0 cm. However, on the same date, 06/02/15, Physician's Orders were obtained to discontinue the DuoDerm to the SDTI to the lower left inner buttock related to the wound had healed. However, there was no documented evidence the Physician was notified of the new area on the left inner buttock identified on the 06/02/15 assessment in order to obtain a treatment.

Review of the weekly Skin Assessment and the weekly Skin Report, dated 06/09/15 and completed by LPN #13, described the resident as having fluid filled blisters to the bilateral upper thighs and a left buttock SDTI measuring 3.0 cm

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by 1.0 cm. However, there was no indication the Physician was notified of the blisters to the resident's bilateral upper thighs and the left buttock SDTI, even though there was no treatment ordered for these areas.

A post survey phone interview was conducted on 08/25/15 at 7:21 PM with LPN #13, who completed the skin assessment on 06/09/15. LPN #13 revealed if a new area of skin breakdown was found the Physician was to be notified for a treatment order but she could not remember the circumstances related to the SDTI to the resident's left buttock and the blisters to the resident's upper thighs in June 2015.

Review of the weekly Skin Assessment dated 06/16/15 completed by LPN #7, revealed the resident had a left coccyx ulcer which was described as Stage II measuring 4 cm x 2.2 cm x 1.5 cm with a 2 cm tunnel to 12 o'clock and the wound bed had 25% eschar in which the resident was already receiving treatment. However, the left lower coccyx wound was mentioned separately as a new area measuring 1.2 cm x 1 cm and described as a stage II. The left inner buttock area was not mentioned in this assessment. Additionally, the posterior left thigh area was described as having a stage II pressure ulcer measuring 6.0 cm by 2.5 cm, and there was dried blood blisters to the right thigh. However, there was no documented evidence of Physician's notification for treatment orders to the areas to the thighs or the left lower coccyx.

A post survey interview was conducted on 08/26/15 at 7:00 PM with LPN #7, who revealed if new areas of skin breakdown such as new pressure ulcers or blisters were identified, the

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Based on observation, interview, record review, and review of facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care/Acute Care Plan was evaluated and revised to accurately reflected the resident's status and needs related to Pressure Ulcers. The Care Plans were not being revised when new Pressure Ulcers were identified and were not being revised as Pressure Ulcers improved or deteriorated. This failure affected nine (9) of fourteen (14) sampled residents (Resident's #1, #2, #4, #5, #7, #8, #10, #11, #12). (Refer to F314)

The findings include:

Review of the facility "Care Plan Goal and Objectives" Policy, dated 08/01/13, revealed care plans should incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives were defined as the desired outcome for a specific resident problem. Goals and objectives were entered on the resident's care plan so that all disciplines had access to such information and were able to report whether or not the desired outcomes were achieved. Goals and objectives were reviewed and revised when there was a significant change in the resident's condition, and when the resident had been re-admitted from a hospital stay.

Review of the "Resident Assessment Instrument Version 3.0 Manual", (section 4.1) revealed the results of the assessment which must accurately reflect the resident's status and needs, were to be used to review and revise each resident's Comprehensive Plan of Care. Section 4.7 revealed the Care Plan must be reviewed and

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hemoglobin dropped to 8.1 on March 13, 2015. On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral made to Wound Care Clinic. The order for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecalorie, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to be monitored (specifically for Hemoglobin level). On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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F 280 : Continued From page 11
revised periodically and services provided or arranged must be consistent with each resident's written plan of care.

Interview on 08/19/15 at 12:30 PM, with MDS Coordinator #1 who was over the other MDS Nurses, revealed there were three (3) MDS Nurses in the facility who all completed MDSs and developed/revised care plans. She revealed acute care plans would be done for each wound for the date the wound was identified. Per interview, when the next MDS assessment was completed, if the wound was still there, the comprehensive care plan would include the wound. She further stated the care plan did not need to specify the site of the wound or the stage of the wound because the nurses could look at the Treatment Administration Record (TAR) for treatments and look at the skin assessments for stages of the wound to see if the wound was healing or deteriorating. Continued interview revealed the care plan could state the resident had impaired skin integrity, and did not have to specify the resident had a pressure ulcer.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 03/11/15 with diagnoses which included Dementia, Alzheimer's Disease, and Hip Fracture. Review of the Admission Minimum Data Set (MDS) Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief interview for Mental Status (BIMS) of a three (3) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring the extensive assist of two (2) for bed mobility, transfers and toileting. Continued review of the MDS, revealed the facility assessed the resident as always

F 280
Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a superficial sacral lesion, which improved, and a small fissure at 11 o'clock in the anorectal area. Continue same treatment - Anusol HC Suppository TID for anal fissure. On May 08, 2015-it was noted that the skin, where the Tegaderm covered around the wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Cefin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered

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incontinent of urine, frequently incontinent of bowel, and as having no pressure ulcers.

Review of the Significant Change MDS dated 04/23/15 revealed the facility assessed Resident #1 as having both short and long term memory impairment, as requiring extensive assist of two (2) for bed mobility, transfers, and toileting and as always incontinent of bowel and bladder. Further review of the MDS revealed the facility assessed the resident as having one (1) Stage II pressure ulcer and having one (1) unstageable pressure ulcer.

Review of the Comprehensive Plan of Care, dated 03/23/15, revealed Resident #1 had the potential for Impaired skin Integrity related to immobility. The goal stated the resident would not develop pressure ulcers. The interventions included monitoring for skin intolerance to two (2) hour turning schedule, reposition in wheelchair frequently, turn and reposition every two (2) hours, nursing staff to monitor for indication of skin impairment during daily care, report any red or open areas, and weekly skin assessments by the licensed staff to monitor for any indication of skin breakdown.

Review of the Nurse's Note dated 04/06/15 at 1545 (3:45 PM), revealed Resident #1 was identified to have a Stage II pressure ulcer measuring two (2) centimeters (cm) length by one (1) cm width with yellow slough noted extending for an undetermined amount into the rectum.

Review of the Wound Care Summary (WCS) dated 04/06/15 revealed the resident had a wound to the left buttock. The Acute Care Plan initiated 04/06/15 revealed the resident had a

F 280,

with Aquacel AG Foam. Muli Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate and treat. On May 15, 2015, diet order changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer. New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal saline wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015

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pressure ulcer related to decreased mobility, however, the care plan did not specify the site or the stage of the pressure ulcer.

Review of the WCS dated 04/09/15 revealed the resident's left buttock pressure ulcer measured 1.5 cm by 3.0 cm and there was an open wound with gray/pale slough, slight odor, and purulent drainage.

The WCS dated 04/21/15 revealed the resident's left buttock pressure ulcer measured 1.0 cm by 3 cm by 0.3 cm and was an open wound that extended into the rectum with decreased slough, slight odor and purulent drainage. Further review of the WCS dated 04/21/15 revealed the resident had a new pressure ulcer to the coccyx described as Stage II measuring 0.6 cm by 0.4 cm, with red surrounding skin with blanching discoloration, no odor, and scant serosanguinous drainage.

Further review of the clinical record revealed no documented evidence the resident's care plan was revised until 05/23/15, approximately four (4) weeks after the new area was identified. Review of the Acute Care Plan initiated on 05/23/15 revealed the care plan did not specify the stage of the pressure ulcers.

Review of the Resident Data Collection (RDC) dated 05/12/15, revealed Resident #1 was re-admitted to the facility and the resident was assessed to have a Sacral Stage II pressure ulcer, and a right heel Suspected Deep Tissue Injury (SDTI). However, the care plan was not revised related to the new SDTI of the right heel.

Review of the weekly Skin Report dated 05/26/15 revealed Resident #1 had a sacral wound, Stage

F 280
Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately 2cm from rectum on lower left buttocks with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage. Physician notified and order obtained to send to ER.

Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility.

Resident #2
Resident #2 is an 85yr old female with diagnosis of CHF, insulin dependent diabetes, paraplegia, neuropathy and hypertension. Resident #2 was admitted to Ridgeway on 04/09/14 from Edgewood Nursing Home. On admission Resident #2 had red areas to left breast and groin that appeared to be with yeast. On 06/07/15, a stage II area, 1 X 1cm, was noted, no odor, no drainage. This area healed on 06/28/15.

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11 2 cm by 3 cm x 1 cm depth with eschar noted in the wound bed, fluid filled blister on the right side of the wound, a right heel SDTI 2 cm by 2 cm which was dark purple, and an open area to the left buttock measuring 3 cm by 1 cm which was not staged.

Review of the Wound Care Clinic Note dated 06/04/15, revealed the decubitus (sacral and buttock) was now one (1) big ulcer, gray wound bed to 80%, red granulation to 20%, measures 10 cm by 6 cm by unknown depth. Although the sacral/left buttock continued to deteriorate, there was no documented evidence the care plan was evaluated and revised in order to assess the effectiveness of the interventions.

Interview on 08/10/15 at 5:45 PM with MDS Coordinator #1, revealed she reviewed the care plans for Resident #1 and stated the care plan related to the resident's left buttock wound on 04/06/15 should have revealed the site and stage of the wound and she did not know why "resolved" was written at the top of the care plan since the wound had not resolved. Continued interview revealed the care plan related to the resident's coccyx wound dated 04/21/15 should have revealed the stage of the pressure ulcer. In addition, MDS Coordinator #1 stated the care plan should have been updated related to the resident's SDTI to the right heel when the resident was re-admitted from the hospital on 05/12/15. Further interview revealed it would be important to be specific on the wound care plans to be able to show the tracking and trending and evaluate the effectiveness of the interventions.

2. Review of Resident #10's medical record revealed the facility admitted the resident on

F 280:

On 07/01/15 area to posterior thigh healed. On 08/04/15 three Stage II areas were noted 1.2cm x 1.2cm, medial coccyx, 1.8cm x 0.2cm, right side 0.5cm x 0.4cm, no foul odor or drainage, scant amount of bleeding noted. Aquacel foam was applied and order to be changed every three days and PRN. On 8/14/15 all areas to coccyx and left buttock healed. A scab, 0.5cm x 0.5cm, was noted to left anterior foot. She continues to have blanchable redness to bilateral buttocks. It should be noted that per the care plan progress notes, Resident #2 refuses to turn and reposition in bed or chair. Resident #2 continues to receive Prostat 30cc BID X 30 days, Vitamin C 250mg QD and Zinc Sulfate 220mg x14 days. Her weight on admission was 201 lbs and 209 lbs currently. Her BUN currently is 38 (7-25), total protein 5.7 (6-8.3) and albumin 3.4 (3.5-5.5). Her hemoglobin 9.8 (12-16) and hematocrit 31.1 (36-48) are low. Despite the above mentioned complication her wounds are healed. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.

Resident #4

Resident #4 is a 62 year old male, who was admitted on 4/10/10 from the hospital. Resident #4 was admitted with Stage II to his right buttock, 1cm x 1cm diameter and left hip with area measuring 6cm x 7cm and approx. 1cm diameter. On 6/14/10 pressure reducing

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F 280	<p>Continued From page 15</p> <p>02/02/15 with diagnoses including Parkinson's Disease, Chronic Kidney Disease, and Diabetes Mellitus. Review of the Quarterly MDS dated 05/18/15, revealed the facility assessed Resident #10 as having a Brief Interview for Mental Status (BIMS) of a six (6) out of fifteen (15). Further review revealed the facility assessed Resident #1 as requiring extensive assistance of two (2) for bed mobility, transfers, toilet use, as not rated for urinary incontinence, as always incontinent of bowel and as having one (1) unstageable pressure ulcer.</p> <p>Review of the Comprehensive Plan of Care, undated, revealed Resident #10 had potential impairment/actual impairment to skin integrity due to impaired mobility and multiple pressure sores. The goal stated the resident would have no complications related to skin injury. The interventions included pressure relieving cushion to wheelchair, follow skin care protocol, observe location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration to the Physician, report changes to charge nurse of any skin redness/ breakdown, and treatments to skin as ordered. There was a new intervention added on 05/04/15 to see TAR for treatments of skin tears and pressure areas and a new intervention added on 07/15/15 for gel boots.</p> <p>Review of the Nurse's Notes dated 02/18/15 on re-admission to the facility after hospitalization, revealed Resident #10 had a 1.3 cm by 1.0 cm open area to the left sacrum, a 1.7 cm by 0.8 cm open area to the right sacrum, and a 4.4 cm by 3.8 cm fluid filled purple area to the right heel. However, there was no documented evidence the Care Plan was revised related to the right and left</p>	F 280	<p>mattress to be was ordered. Vitamin C 250mg was ordered on 12/13/15. Vitamin D3 50,00units was ordered on 05/14/12. Coccyx cutout quadra gel cushion for wheelchair positioning ordered 4/30/13. Senscare protect ointment 113gm 2 times a day was ordered 5/29/13. Zinc Sulfate 220mg ordered 7/5/15 for wound healing. Aquacel AG and Duoderm to SDTI on left buttock, change every 3 days ordered 6/24/15. Aquacel AG and Duoderm to posterior upper Right thigh ordered 6/24/15. Admitting weight 123lbs, 5'9" tall and current weight 176lbs as of 8/10/15. Resident #4 refuses to be repositioned at times and sits up in his wheelchair for long period of times during the day. At times he refuses his meals and will not allow staff to clip his nails. Resident #4 has self inflicted areas that heal and reopen. Resident #4 posterior right thigh wound and right buttock wound healed as of 8/10/15. Skin is intact as of 9/10/15. Resident #4 is a smoker and has diagnosis of HTN, Dementia with behaviors, diabetes type 2, anxiety and GERD. Resident #4 continues on Vistaril related to itching, multivitamin, Vitamin C, Vitamin D3 and Coumadin. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.</p> <p>Resident #5 Resident #5 was admitted to Ridgeway Nursing and Rehabilitation on 2/14/13.</p>	

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heel ulcer measured 5.0 cm by 6.5 cm with greater than 75% eschar and brown drainage. Additionally, the WCS dated 04/21/15 revealed the resident had a new SDTI measuring 1.0 cm by 1.0 cm non blanching purple maroon in color to the right coccyx. However, again the care plan was not revised related to this new pressure ulcer to the coccyx.

On 05/14/15 a WCS was initiated related to a SDTI on the left lower inner buttocks measuring 1.0 cm x 0.5 cm. However, there was no care plan initiated for this pressure ulcer.

On 06/02/15 a weekly Skin Assessment described the resident's left coccyx wound as unstageable measuring 6.0 cm by 3.0 cm by 0.5 cm; the resident's right coccyx as a SDTI measuring 1.0 cm by 1.0 cm; and, the resident's right heel wound as unstageable measuring 6 cm by 8 cm with eschar.

Also, on the 06/02/15 weekly Skin Assessment, it was noted Resident #10 had a SDTI to the left inner buttock which was red and non blanchable measuring 6.0 cm by 5.0 cm. However, on the same date, 06/02/15, Physician's Orders were obtained to discontinue the DuoDerm to the SDTI to the left inner buttock related to the wound had healed. There was no indication the care plan was revised related to the area on the left inner buttock.

The weekly Skin Assessment dated 06/09/15 described the resident as having fluid filled blisters to the bilateral upper thighs and a left buttock SDTI measuring 3.0 cm by 1.0 cm. However, there was no indication the Physician was notified of the blisters to the resident's

F 280

81 (7-25). On 7/20/15 her wound culture showed MRSA pseudomonas aeruginosa and enterococcus faecium which were treated as ordered. On 9/2/15 her BUN was 63 (7-35mg). This again shows the fragile nature of Resident #5's condition. Resident #5 continues to receive treatments as ordered. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.

Resident #7

Resident #7 was admitted to Ridgeway Nursing and Rehabilitation on 07/13/15 with diagnosis of acute respiratory failure, pneumonia, vocal cord edema, schizophrenia and chronic renal insufficiency. She had prolonged hospital stay due to a bowel obstruction and surgery. She is a 68 year old female. On admission it was noted she had MRSA to her incision and was placed on Contact Isolation. She had blanchable redness to sacral area and buttocks area. She had multiple scratches and bruises to arms, hands and thighs. On 8/04/15 Resident #7 was noted to have a Stage II area to left medial buttock measuring 0.4cm x 0.2cm, wound bed was pink with no slough, no odor or drainage noted. Four days later a distal area was noted stage II, measuring 0.5cm X 0.2cm x 1.2 cm blanchable redness between wounds. Both areas healed on 8/14/15. Her labs on 07/20/15 revealed a protein level of 5.4 (6-8.3), albumin 3.2 (3.5-5.5), Hemoglobin 10.5 (12-18) and

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bilateral upper thighs and the left buttock SDTI, even though there was no treatment ordered for these areas. Also, there was no revision of the care plan related to these areas.

The weekly Skin Assessment dated 06/16/15 did not mention the resident's right coccyx wound. The resident's unstageable right heel ulcer was measured at 6.0 cm by 8.0 cm with eschar. The resident's left coccyx ulcer was described as Stage II measuring 4 cm x 2.2 cm x 1.5 cm with a 2 cm tunnel to 12 o'clock and the wound bed had 25% eschar. The resident's left lower coccyx was mentioned separately as 1.2 cm x 1 cm stage II. The resident's left inner buttock area was not mentioned in this assessment. Additionally, the resident's posterior left thigh area was described as 6.0 cm by 2.5 cm stage II and there was dried blood blisters to the right thigh. However, there was no documented evidence the Care Plan was revised.

The weekly Skin Report dated 06/23/15 also revealed the an unstageable area to the left posterior thigh and measured 4.5 cm x 2.8 cm but did not mention the left lower coccyx wound. There was no revision of the care plan related to the areas to the thighs or the left lower coccyx.

Review of the Wound Care Clinic Note dated 06/22/15, described the resident's coccyx decubitus as measuring 4.0 by 2.0 by 2.0 with pink granulation tissue and loose gray slough in the wound bed. Further review, revealed the resident's right heel had a large black eschar 5.5 cm x 9.5 cm with the odor of gangrene with some purulent drainage. Additionally, the Note stated the resident had a decubitus ulcer to the left ischium with thin eschar which measured 4.0 cm

F 280:

Hematocrit 33.2 (38-48). Her weight on admission was 266lbs and height 56 inches. She was seen by the dietician on 8/12/15 and was noted to have a healing stage II's. The areas healed on 8/14/15. Resident #7 was transferred to the hospital on 8/25/15 in an emergency and died a few hours later.

Resident #8

Resident #8 is a 90 year old who was admitted to Ridgeway Nursing and Rehabilitation on 5/2/14 following a hospital stay. His diagnosis include atrial fibrillation, chronic history of UTI, dysphagia, pain in joints, abnormal posture and muscle weakness, prostate cancer with bone mets, encephalopathy, aortic valve stenosis, BPH, heart failure, bladder cancer, lung nodule, urinary retention and dementia. On 8/8/15 it is noted a stage II area measuring 1cm x 0.5cm was discovered. Aquacel AG Fiber and Duoderm ordered. The area is described as a SDTI to upper posterior thigh and stage II areas to left and right medial buttocks. On 8/14/15 the area to the posterior right thigh healed and orders were discontinued. On 8/12/15 area to right medial buttocks healed and treatments discontinued. Resident #8's labs are as follows; BUN 35 (7-25), Creatinine 1.5 (0.6-1.3) on 6/9/15, on 06/25/15 albumin 3.4 (3.5-5.5), Hemoglobin 11.5 (14-18) and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2015
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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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F 280 : Continued From page 19
x 2.5 cm x unknown depth. However, there was no care plan initiated for the ischium pressure ulcer.

Further review of the record revealed the resident was followed in the Wound Care Clinic on 07/06/15, 07/13/15, and 07/20/15 related to the decubitus ulcers on the right heel, coccyx and left ischium. Review of the 07/20/15 Wound Care Clinic Note, revealed there was more necrosis in the resident's coccyx wound and ischial wound and bone was exposed in the right heel and would consult with General Surgery for further evaluation and treatment. However, there was no documented evidence the Care Plan was revised.

The WCS on 08/14/15 revealed the resident's coccyx wound had deteriorated, was unstageable and measured 5.0 cm by 3.0 cm by 1.0 cm with tunneling from 9 o'clock to 3 o'clock measuring 1.9 cm with the wound bed described as 25% slough, and wound edges with maceration, purulent drainage. Further review revealed the WCS dated 08/14/15 related to the resident's left ischium revealed the area was unstageable measuring 6.0 cm by 3.4 cm by 4.8 cm, wound bed with slough present and purulent drainage. Further review of the WCS dated 08/14/15 revealed the right heel wound was described as a Stage IV measuring 7.0 cm by 7.0 cm by 1.3 cm, with eschar noted along the 6 o'clock side of the wound and bone visible, white maceration to the wound edges and purulent drainage. Although the resident's pressure ulcers continued to deteriorate, there was no documented evidence of the facility utilizing the care plan to evaluate the effectiveness of the treatments or follow the progression of the wounds.

F 280 :
Hematocrit 33.2 (42-54). Resident #8 continues on Hospice Services with comfort P.O.C. in place. Skin is intact at this time. Resident #10 continues to reside in the facility. His physician had been made aware of his current status. Resident #10 is an 85 year old was admitted to Ridgeway Nursing and Rehabilitation on 2/2/15. His diagnosis include urinary retention, BPH, Parkinson disease, dementia with behaviors, HTN, DM stage II, chronic kidney disease, dysphagia, hyperlipidema, generalized weakness, hematuria with unclear etiology. On 2/16/15 upon readmission to the facility a stage II area to right sacrum measuring 1cm x 0.8cm, red, no odor or drainage was noted with 6cm non-blanching redness to 12:00. Aquacel foam ordered and applied. On 3/12/15 this area healed. On 3/22/15 the right buttock/sacral area 1cm x 1cm, red, no odor, serous drainage surrounding skin with blanchable redness. Duoderm ordered and applied. This area healed on 4/14/15. On 4/21/15 a suspected deep tissue injury 1cm x 1cm non-blanching, no odor or drainage was noted to right coccyx. This area continues to be treated. On 2/16/15 upon readmission a 4.5cm x 4 cm, red/purple blister was noted to his right heel. This was diagnosed as MRSA and treated. The right heel continues to be open despite wound care clinic consultation on

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3. Review of Resident #2's clinical record revealed the facility admitted the resident on 04/09/14 with diagnoses of Peripheral Neuropathy, Hypertension, Chronic Back Pain, Insulin Dependent Diabetes Mellitus, Paraplegia, and Osteoporosis.

Review of Resident #2's Quarterly MDS Assessment dated 07/06/15 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was cognitively intact. Further review revealed the facility assessed Resident #2 as requiring extensive assistance of two (2) persons for bed mobility, dressing, toilet use and personal hygiene. Further review of the MDS revealed the facility assessed the resident as being at risk for developing pressure ulcers with a history of pressure ulcers noted during the last MDS assessment.

Review of Resident #2's Comprehensive Care Plan, dated 04/21/14, revealed the resident had a problem of skin integrity, impaired: potential related to impaired mobility, Diabetes, Arthritis, chronic pain, incontinence, and declined to turn and reposition in the bed or wheelchair. The goal stated Resident #2 would have intact skin. The interventions included weekly skin assessments by licensed staff/ monitor for any indication of skin breakdown, RD consult, gel cushion to wheelchair, reposition in wheelchair and chair frequently, treatments per orders-see TAR, turn and reposition every two (2) hours, and bilateral heel protectors to feet when in bed.

Further review of Resident #2's record revealed Nurse's Notes dated 08/04/15, which stated there

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several dates and several debridements. Current wounds' measurements are right heel stage IV, 6.8cm x 6.7cm x 1.2cm with 1.7cm tunneling at 6:00 and 8:00, coccyx unstageable 3cm x 1.7cm x 1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac, to be changed every 2 days to each area. Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Cefin, Bactrim and Ampicillin. It should be noted that Resident #10 has 1plus edema to lower extremities and requires Lasix 60mg daily to keep the edema to 1 plus. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.

Resident #11
Resident #11 was admitted on 1/7/2005 to Ridgeway Nursing and Rehabilitation. She has diagnosis of dementia, bipolar, anxiety and depression. Documented on 7/26/15 her left inner upper buttock was a stage2 measuring 0.8cm x 0.6cm with a Aquacel foam dressing. This area along with the STDI measuring 0.5cm x 0.5cm on 7/26/15 were healed on 8/10/15. Seneicare was applied twice daily as needed. Resident has a wheelchair cushion ordered while up in wheelchair on 8/19/15. Resident takes a multivitamin daily as of 1/11/12. Baza protective cream was ordered 3/11/13.

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was three (3) stage II's ulcers noted to the resident's coccyx.

Review of the Acute Care Plan dated 08/05/15, revealed the resident had a Stage II Pressure Ulcer to the coccyx; however, did not indicate there was three (3) Stage II areas to the coccyx.

Review of Resident #2's weekly Skin Assessment revealed an entry on 08/06/15 which described the Stage II ulcer to the left upper buttock as 0.5 cm x 1 cm with 100% granulation with 1 cm x 1 cm purple discoloration surrounding the area, dry peeling skin to the surrounding tissue and serosanguinous drainage. Review of the resident's care plan revealed the care plan had not been revised to indicate the resident had a Stage II ulcer to the left upper buttock.

Interview with MDS Coordinator #4, on 08/12/15 at 9:15 AM, revealed the wounds changed daily so wound sites and stages did not have to be on the care plan. Continued interview revealed nurses could look at the skin assessment book to see all wound progress.

4. Review of Resident #4's clinical record revealed the facility admitted the resident on 04/20/10 with diagnoses including Cardiovascular Accident (CVA) with left Hemiparesis, Hypertension, Aphasia, Dementia with Behaviors, Diabetes Mellitus II and Difficulty in Walking.

Review of Resident #4's Annual MDS Assessment dated 06/22/15, revealed the facility assessed Resident #4 as having a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15). Continued review of the MDS revealed the facility assessed the resident as

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Nystatin to groin and bilateral breast. Resident has been receiving Benecalorie 45ml and Prostat 30ml. Resident #11 is up in her wheelchair daily. Since resident's skin is so fragile her area opens and closes often while being moved or repositioned. Resident #11 continues to receive treatment as ordered. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.

Resident #12

Resident #12 is a 57 year old female who was admitted to Ridgeway Nursing and Rehabilitation on 01/26/15. Her diagnosis include Down's syndrome, COPD, HTN, Mood disorder, sleep apnea, neurocognitive disorder due to Alzheimer's disease with behavioral issues, hyperlipedemia, and osteoarthritis. On admission, 01/26/15, it was noted that Resident #12 had a stage III area with foul odor, eschar and slough which measured 3cm x 2cm x 0.9cm. She had a rash to her right foot and multiple small scratches. It was noted she had MRSA infections to the wound on admission. An ulcer developed on 02/04/15 to posterior left thigh. Aquacel AG and Aquacel foam applied. This area healed on 5/28/15 and reopened and healed again on 9/14/15. The coccyx area has decreased in size since admission to stage II. On 8/16/15 the area measured 1 cm x 2 cm with no measurable depth, slight yellow drainage and pink wound bed. Her labs include

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F 280	<p>Continued From page 22</p> <p>requiring extensive assistance of one (1) for bed mobility, dressing and personal hygiene and and as requiring extensive assistance of two (2) for transfers, and toilet use. Per the MDS, the facility further assessed the resident to be frequently incontinent of urine and occasionally incontinent of bowel, and as having two (2) Stage II Pressure Ulcers at the time of the assessment which had not been present on the prior assessment.</p> <p>Review of Resident #4's Comprehensive Care Plan, dated 06/04/12, revealed the resident had a skin integrity problem related to a history of recurrent skin tears on the buttocks that develop into ulcers and immobility. The goal stated Resident #4 would have intact skin. The interventions included; assess wound healing by a licensed nurse, measure length, width and depth where possible and assess and document status of wound perimeter, wound bed and healing progress, assist to turn and reposition at least every two (2) hours, and follow the facility protocol for the prevention/treatment of skin breakdown.</p> <p>Review of Resident #4's Nurses Notes dated 04/28/15 revealed a new Stage II area to right buttock measuring 0.8 cm x 0.8 cm, red, no odor and a scant amount of serosanguinous drainage. However, there was no care plan initiated related to the Stage II pressure ulcer to the right buttock.</p> <p>Further review of Resident #4's Nurse's Notes dated 05/06/15, revealed the resident had a new Stage II ulcer to the right upper posterior thigh measuring 1.5 cm x 0.5 cm, red, no odor with serosanguinous drainage. However, there was no care plan initiated for the Stage II pressure ulcer to the right upper posterior thigh.</p>	F 280;	<p>pre albumin 13 (16-45mg/dl) on 5/14/15, total protein 5.2 (6-8.3) on 4/9/15, albumin 2.5 (3.5-5.5) on 4/9/15. This resident has multiple behaviors noted. Resident #12 has a gel overlay to bed and continues to improve. This resident continues to receive treatment as ordered by the physician. The care plan has been revised to reflect the location, current stage of the wound and treatment ordered.</p> <p>2. All nurses (with the exception of one on FMLA and a PRN nurse) were educated on August 13, 2015, concerning weekly skin assessments, wound documentation, measuring wounds (width, length, and depth) staging, describing peri wound area and wound bed. Wound documentation procedure, photos on admission and discharge (non-emergent). Dressing change procedure, washing hands and infection control. Each nurse was required to measure wound examples and document their assessment. This in-service was conducted by Sally Baxter, RN, Vice-President of Clinical Services. On August 14, 2015, skin assessments were performed and documented on all residents by the Director of Nursing and four RN's with the assistance of four LPN's. No skin issues were identified that had not been identified on previous skin assessments. In addition, on August 14, 2015, Sally Baxter, R.N., Vice-President of Clinical Services, and Lauren Sword, Administrator, completed a comprehensive review of all care plans to ensure they are updated as appropriate for those residents with wounds</p>	

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Further review revealed an Acute Care Plan was initiated 06/24/15 which stated the resident had a pressure ulcer. The goal stated the pressure ulcer would decrease in size. There were several interventions including keep skin clean, warm, and dry, promote nutritional status, assess for signs and symptoms of worsening, of infections or complications daily, treatments as ordered, assess skin daily during care for changes and report to nurse supervisor, Registered Dietician (RD) to evaluate and assess per policy, and staff to assist with mobility needs of transfers and bed mobility as needed to promote pressure relief. There was a new intervention, undated which stated prostat and zinc per orders. However, this care plan did not specify the sites or stages of the wounds, or indicate if the wounds were healing or deteriorating.

5. Review of Resident #8's clinical record revealed the facility admitted the resident on 05/02/14 with diagnoses including, Abnormal Posture, Dysphagia Unspecified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase, Pain In Join (Multiple Sites), Chronic Diastolic Heart Failure and Chronic Airway Obstruction.

Review of Resident #8's Significant Change MDS Assessment dated 03/18/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three (3) out of 15 indicating severe cognitive impairment. Further review revealed the facility assessed the resident to require extensive asslat of two (2) persons for bed mobility, transfer, toilet use, personal hygiene and bathing. Further review revealed the facility assessed Resident #8 as

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and care plan approaches are in place and being followed. Physician orders are reviewed daily with the facility's inter-disciplinary team and the care plans updated as appropriate. The Administrator, Director of Nursing, Charge Nurses, Rehab Director and MDS Coordinator are all part of this meeting. On the weekends, the RN Charge Nurse will be responsible for updating the care plans. All residents care plans were reviewed and revised by MDS staff, Vice President of Clinical Service and Administrator on 08-24 and 08-25-15.

3. Daily for one month the Director of Nursing, or her designee, will audit two (2) residents' skin conditions and related documentation, which will include care plan and associated interventions. In addition, physician orders are reviewed daily in the facility's inter-disciplinary team meeting with care plans being revised, as appropriate, immediately after the meeting by the Charge Nurses. On weekends, the RN Charge Nurse reviews the physician orders and updates the care plan as appropriate. All licensed nursing staff were educated on 08-13-15 by a representative from Convatec, The Director of Nursing and Vice President of Clinical Services. This inservice covered wound description, documentation requirements including updating the care plan with wound location, current treatment and description. All newly hired nurses are trained upon orientation related to wound documentation as part of the facility's licensed nurse orientation by Staff Development Nurse. This facility does not use agency staff.

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having a indwelling urinary catheter, as occasionally incontinent of bowel and as having two (2) stage II pressure ulcers.

Review of Resident #8's Care Plan, undated, revealed a problem of impaired skin integrity due to immobility. The goal stated Resident #8 would not develop complications related to pressure ulcers. The interventions included weekly skin assessments by licensed staff to monitor for any indication of skin breakdown, turn and reposition every two (2) hours, report any red or open areas, and float heels in bed, and reposition in wheelchair/chair frequently.

Review of Resident #8's Nurse's Notes dated 05/06/15 revealed the resident was observed to have a 0.8 cm x 0.9 cm Stage II to the posterior upper left thigh with a 3 cm x 2 cm SDTI (Suspected Deep Tissue Injury) purple/maroon area to the distal end of the Stage II, no odor or drainage. Further review of the Note, revealed the coccyx had a 0.5 cm x 0.3 cm Stage II which was red, no odor or drainage. However, there was no care plan inflated for the Stage II pressure ulcer to the posterior upper left thigh and the Stage II pressure ulcer to the coccyx.

Further review of the weekly Skin Assessment revealed on 07/04/15 the resident's right upper thigh healed and there were two (2) areas to the coccyx, with no measurements or staging of the areas, and there was no care plan initiated again for the coccyx areas.

The weekly Skin assessment dated 07/11/15 revealed a Stage II to the left medial buttocks measured at 1 cm x 0.6 cm and the coccyx had blanchable redness. An Acute care plan was

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4. As part of the facility's ongoing Quality Assurance Program, monthly an Administrative Nurse will audit 5% of the residents by conducting a head to toe skin assessment and compare their assessment to what is documented in the Clinical Record. Any deviations will be reported to the Administrator immediately and the nurse will be re-educated. In addition, care plans will be a focus of the facility's continuous Quality Improvement Committee for the

next six (6) months. Any identified problems will be addressed and followed up by the Committee with the nursing staff and re-education provided and assurance as appropriate, and that care is being provided as recorded in the plan of care and MD orders. This audit includes direct observation of the care being provided and care plan review. These audits will be made part of the facilities ongoing quality of assurance program for the next six months. If deficient care is noted or care plans are not updated then a re-education program will be initiated for the offending nurse.

5. August 25, 2015

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F 280	<p>Continued From page 25</p> <p>Initiated for the left medial buttock on 07/11/15; however, there was no stage of the ulcer noted.</p> <p>6. Review of Resident #12's clinical record revealed the facility admitted the resident on 01/26/15 with diagnoses including; Down's Syndrome, Abnormality of Gait, Muscle Weakness (Generalized), Difficulty in Walking, Pressure Ulcer Unspecified Site, Dysphagia Oropharyngeal Phase, Alzheimer's Disease and Sleep Apnea.</p> <p>Review of Resident #12's Quarterly Minimum Data Set (MDS) Assessment dated 07/20/15 revealed the facility assessed the resident as having both short and long term memory loss. Continued review revealed the facility assessed Resident #12 as requiring extensive assistance of one (1) person for bed mobility, and personal hygiene, and as requiring extensive assistance of two (2) persons for transfer, toilet use and bathing. Further review revealed the facility assessed the resident as Incontinent of urine and occasionally incontinent of bowel, and as having one (1) stage II pressure ulcer.</p> <p>Review of Resident #12's Care Plan, undated, revealed the resident had impaired; potential for impaired skin integrity related to mobility, and incontinence. The goal stated Resident #12 would not develop pressure ulcers. The interventions included nursing staff to monitor for indication of skin impairment during ADL care, report any red or open area, weekly skin assessment by licensed staff to monitor for any indications of skin breakdown.</p> <p>Review of the WCS dated 04/08/15 revealed the resident had a Stage III pressure ulcer to the</p>	F 280	

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F 280	<p>Continued From page 26</p> <p>posterior left thigh measuring 1.8 cm x 1.9 cm x 0.4 cm with tunnelling from 12 o'clock to 2 o'clock (the wound was discovered on 02/04/15, according to the WCS dated 04/08/15). However, there was no documented evidence the care plan was revised related to this pressure ulcer.</p> <p>Further review of Resident #12's Wound Care Summary dated 04/08/15, revealed a lower right buttock SDTI (discovered on 02/04/15) which was described as unstageable and measured 1.2 cm x 2 cm with yellow slough in the wound bed, purulent drainage and odor. There was no documented evidence the care plan was revised related to this pressure ulcer.</p> <p>7. Review of Resident #5's medical record revealed the resident was initially admitted by the facility on 02/14/13 and re-admitted on 07/03/15 with Diagnoses which included Hypertension, Non-Alzheimer's Dementia, Chronic Kidney Disease, Dysphagia, Dementia, and Cerebral Vascular Accident.</p> <p>Review of Resident #5's Comprehensive Care Plan revealed a Skin Integrity Care Plan which included interventions: float heels in bed, gel boots as tolerated, pressure reducing mattress, turn and reposition every two (2) hours, and weekly skin assessments. Further review revealed a Pressure Ulcer Care Plan related to Multiple Pressure Areas and referred to the TAR/Skin Assessments and included interventions to keep the skin warm and dry, supplements as ordered, treatments as ordered, assess for signs and symptoms of worsening of infection daily.</p>	F 280	

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Record review revealed Resident #5 had an Unstageable Sacral/Coccyx Wound developed/discovered 03/08/15. In August a weekly progress noted the Sacral / Coccyx wound was noted to be a Stage IV pressure ulcer and no longer an unstageable wound. However, review of the Pressure Ulcer Care Plan revealed the care plan was not updated to indicate the unstageable wound or the change in wound status to a Stage IV pressure ulcer.

Record review revealed a Stage II pressure ulcer on right lower buttock identified on 05/23/15 and review of the May 2015 TAR revealed a treatment order for an Aquacel foam dressing to the Stage II pressure ulcer on the right lower buttock to change every three (3) days. However, review of the Pressure Ulcer Care Plan revealed the care plan was not updated to indicate the new Stage II pressure ulcer or when the wound was healed.

Record review revealed a Suspected Deep Tissue Injury (SDTI) to Resident #5's left great toe "knuckle" area identified on the 06/16/15 re-admission note and review of Admission Physician orders, dated 06/16/15 revealed skin prep was to be applied to the left great toe site each shift. However, review of the Skin Integrity Care Plan and Pressure Ulcer Care Plan related to Multiple Pressure Areas revealed the care plan was not updated to include the newly identified SDTI or when it was healed.

Record review revealed Resident #5 had a newly identified a partially open SDTI to the lower right buttock on a Wound Care Summary Document, dated 07/03/15, which was later identified on 08/14/15 as an unstageable wound. However, review of the Pressure Ulcer Care Plan revealed

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NAME OF PROVIDER OR SUPPLIER RIDGEMAN NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD OWINGSVILLE, KY 40360
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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 280 | Continued From page 28
the care plan was not updated to indicate the newly identified wounds.

Record review of the Monthly Physician Orders, August 2015, revealed Resident #5 had an order, dated 07/27/15, to have a pressure reduction foam mattress to the bed.

Observation of a skin assessment, on 08/11/15 at 5:50 PM, revealed the resident had a low air loss mattress.

Interview, on 08/21/15 at 5:50 PM, with LPN #4 revealed Resident #5 had pressure ulcers and interventions included an air loss mattress.

Interview, on 08/10/15 at 6:35 PM, with MDS Coordinator #1 revealed they get a yellow copy of orders every morning and update the care plan as soon as they see the orders. However, Resident #5's care plan was not updated for the pressure reduction mattress ordered on 07/27/15.

8. Review of Resident #7's medical record revealed the resident was admitted by the facility on 07/13/15 with diagnoses which included Wound Infection, Surgical Wound, and Status Post Cecostomy (a surgically formed connection between the large intestine and the outside that is made through an opening in the front abdominal wall). Review of the facility's Admission Minimum Data Set, dated 07/20/15, revealed the resident was admitted with no pressure sores, but was at risk.

Review of Resident #7's Comprehensive Care Plan revealed a Skin Integrity care plan, undated, with interventions which included monitor indication of skin impairment during daily care.

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F 280 Continued From page 29
use a turn sheet, weekly skin assessment.

Observation of skin assessment performed by Licensed Practical Nurses (LPN) # 1 and #2, on 08/11/15 at 6:25 PM, revealed two open wounds on Resident #7's left buttock and no open wound on the resident's right buttock.

However, review of Resident #7's Wound Care Summary documents revealed the resident developed facility acquired pressure ulcers listed on the WCS forms as "developed/was discovered" 08/04/15. One WCS had a Stage II pressure ulcer to the left medial buttock, which on the 08/08/15 weekly progress note described two (2) Stage II wounds to the left buttock, and one WCS had a Stage II pressure ulcer to the right medial buttock.

Review of an acute care plan for Pressure Ulcer, dated 08/04/15, revealed interventions which included keep skin clean warm and dry, assess for signs and symptoms of worsening, treatments as ordered, and see treatment sheet.

Further review of the Pressure Ulcer care plan revealed it was revised to include a proximal left mid-buttock- Stage II pressure ulcer and a distal mid-back Stage II pressure ulcer. However, record review revealed the resident had no distal mid-back Stage II pressure ulcer identified on any other record, but had another Stage II PU to the left buttock. In addition, the Pressure Ulcer Care Plan was revised to include a surgical incision wound which was not a pressure ulcer wound and was not revised for the Stage II pressure ulcer to the right buttock, identified on 08/04/15 through the Wound Care Summary.

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F 280	Continued From page 30 9. Review of Resident #11's medical record revealed the facility admitted the resident on 01/07/05 with diagnoses including Dementia, Psychotic Disorder, Arthritis, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly (MDS), dated 07/27/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of a three (3) out of fifteen (15) indicating severe cognitive impairment. Further review revealed the facility assessed the resident to require limited assist of one (1) for bed mobility and ambulation, extensive assist of one (1) for transfers and toilet use, and as continent of bowel and bladder. Review of the Comprehensive Care Plan, undated, revealed Resident #11 had the a potential skin integrity problem related to immobility, chronic right knee/elbow excoriation, self inflicted scratches and a history of rashes. The goal stated Resident #11 would have intact skin free of redness, blisters or discoloration. The interventions included assist to turn and reposition at least every two (2) hours, follow facility policies/protocols for the prevention and treatment of skin breakdown, inform the resident/family of new areas of skin breakdown, and monitor nutritional status, and treatments per TAR. Review of the Nurse's Noted dated 07/26/15 at 4:25 AM, revealed Resident #11 had a Stage II to the left upper inner buttocks measuring 0.8 cm x 0.6 cm and a SDTI to the coccyx measuring 0.5 cm x 0.5 cm. Review of the Acute Care Plan dated 07/26/15 revealed Resident #11 had a left inner buttock and coccyx pressure ulcer related to immobility.	F 280		
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F 280 : Continued From page 31

The goal stated the resident's pressure ulcer would decrease in size. The interventions included promote nutritional status, assess for signs and symptoms of worsening or infection daily, treatments as ordered, assess skin daily during care, RD to evaluate and assess, and staff to assist with mobility needs of transfer and bed mobility, and pressure relief device to bed and chair. However, the care plan did not identify the stages of the wounds in order to evaluate the progression or evaluate for healing of the wound.

Phone interview, on 08/10/15 at 1:30 PM, with MDS Coordinator #3 revealed the MDS Coordinators revised the care plans from the new Physician's Orders and information obtained from the Morning Meetings. Further interview revealed care plans should be specific and individualized and an acute care plan was to be initiated if a resident had a new wound. However, she revealed she did not feel it was necessary to name the site and stage of a wound on the care plan because staff could refer to the TAR or the skin assessments to obtain that kind of information.

Interview with the Director of Nursing (DON) on 08/12/15 at 3:30 PM, on 08/13/15 at 5:30 PM, and on 08/19/15 at 5:30 PM, revealed the care plan was generated from the MDSs and the MDS Coordinators were ultimately responsible for revising the care plans from the Physicians' Orders. She further stated the purpose of the care plan was to lead and guide the care for the residents. The DON stated they could do an acute problem care plan or update the existing care plan related to skin/pressure ulcers. Continued interview revealed the care plan needed to be individualized and specific but not to

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F 280 Continued From page 32
the point where there would need to be documentation of the stage or location of the pressure ulcers. The DON stated the goals of the care plan needed to be evaluated for effectiveness, but staff could reference the skin assessments or TAR to see if the goal was being met, or to find out the stages and site of the wound. She further revealed the only time she was aware of care plans being reviewed, was in the care plan meetings with the residents and families.

Interview on 08/12/15 at 3:00 PM with the former Interim Administrator/Nurse Consultant, revealed if a resident had a pressure ulcer, the care plan did not have to specify the resident had a pressure ulcer or state the resident had impaired skin integrity. Per interview, the care plan would just need to state the resident had the "potential" for impaired skin integrity and this would lead the nurse to check the other resources such as skin assessments and the TAR to see what kind of impairment of skin the resident had or if the resident had impaired skin integrity. Further interview revealed if a resident already had a care plan in place that stated "potential" for impaired skin integrity and developed skin breakdown such as pressure ulcer, the goals or interventions would need to be reviewed to see if they needed to be revised.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=H

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

F 280

F 282
F282

It is and was on the day of the survey the policy of Ridgeway Nursing and Rehabilitation to provide care to each resident according to their written plan of care.

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F 282 : Continued From page 33

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and policy review, it was determined the facility failed to have an effective system in place to ensure services were provided in accordance with each resident's written plan of care. There was no documented evidence the residents' care plans were implemented to ensure the facility's wound care protocol was implemented and/or weekly skin assessments were conducted for ten (10) of fourteen (14) sampled residents (Resident's #1, #2, #4, #5, #6, #7, #8, #9, #10 and #12). In addition, Resident #2's care plan was not followed related to wearing heel protectors in bed and the resident was observed to have a boggy left heel. (Refer to F314)

The findings include:

Interview, on 08/25/15 at 9:55 AM, with the Administrator revealed the facility had no policy which addressed following the care plan; however, it was her expectation staff followed residents' care plan.

Interview, on 08/20/15 at 11:54 AM, with Minimum Data Set (MDS) Coordinator #1 revealed the purpose of the care plan was to identify care needs and communicate to staff what interventions needed to be provided to meet the care needs.

1. Review of Resident #1's clinical record revealed the facility admitted the resident on 03/11/15 with diagnoses which included Dementia, Alzheimer's Disease, Hip Fracture, and Muscle Weakness. Review of the Admission

F 282

1. Resident #1 was an 87 year old female, who was admitted to Ridgeway Nursing and Rehabilitation on March 11, 2015 following a fall in an assisted living facility (Dementia Unit), which resulted in a right intertrochanteric hip fracture. Her other diagnoses include severe dementia, hypothyroidism, thrombocytopenia (which could have be a factor in the tissue destruction) and acute on chronic blood loss anemia. It was noted at the facility that her hemoglobin dropped to 8.1 on March 13, 2015. On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral made to Wound Care Clinic. The order

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Minimum Data Set (MDS) Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating severe cognitive impairment. Further review revealed the facility assessed Resident #1 as requiring extensive assist of two (2) for bed mobility, transfers and toileting, always incontinent of urine, frequently incontinent of bowel, and as having no pressure ulcers.

Review of the Admission Minimum Data Set (MDS) Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating severe cognitive impairment. Further review revealed the facility assessed the resident as requiring the extensive assist of two (2) for bed mobility, transfers and toileting. Continued review of the MDS, revealed the facility assessed the resident as always incontinent of urine, frequently incontinent of bowel, and as having no pressure ulcers.

Review of the Comprehensive Care Plan, dated 03/23/15 revealed Resident #1 had the potential for Impaired skin integrity related to immobility with a goal stating the resident would not develop pressure ulcers. The interventions included monitor for skin intolerance to two (2) hour turning schedule, reposition in wheelchair frequently, turn and reposition every two (2) hours, nursing staff to monitor for indication of skin impairment during daily care, report any red or open areas, and weekly skin assessments by the licensed staff in order to monitor for any indication of skin breakdown.

Review of the Significant Change MDS dated

F 282

for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecalorie, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to be monitored (specifically for Hemoglobin level). On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a superficial sacral lesion, which

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F 282	Continued From page 35 04/23/15 revealed the facility assessed Resident #1 as having both short and long term memory impairment, as requiring extensive assist of two (2) for bed mobility, transfers, and toileting and as always incontinent of bowel and bladder. Further review of the MDS revealed the facility assessed the resident as having one (1) Stage II pressure ulcer and having one (1) unstageable pressure ulcer. Review of the Nurse's Note dated 04/06/15 at 1545 (3:45 PM), revealed Resident #1 had a Stage II area measuring 2 centimeters (cm) length x 1 cm width with yellow slough noted and the ulcer extended for an undetermined amount into the rectum. Review of the Wound Care Summary (WCS) dated 04/06/15 revealed Resident #1 had a wound to the left buttock. Review of the WCS dated 04/09/15 revealed Resident #1's left buttock pressure ulcer measured 1.5 cm x 3.0 cm and there was an open wound with gray/pale slough, slight odor, and purulent drainage. The WCS dated 04/14/15 revealed the resident's left buttock had an open wound measuring 1.5 cm x 3.0 cm x 0.3 cm and was red with less than twenty-five percent (25%) slough in the wound bed and purulent drainage with slight odor. The WCS dated 04/21/15 revealed the resident's left buttock wound measured 1.0 cm x 3 cm x 0.3 cm and was an open wound that extended into the rectum with decreased slough, slight odor and purulent drainage. Further review of the WCS dated 04/21/15 revealed Resident #1 had a new area to the coccyx described as a Stage II pressure ulcer	F 282	improved, and a small fissure at 11o'clock in the anorectal area. Continue same treatment - Anusol HC Suppository TID for anal fissure. On May 08, 2015 it was noted that the skin, where the Tegaderm covered around the wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Ceftin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered with Aquacel AG Foam. Muti, Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate and treat. On May 15, 2015, diet order		

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measuring 0.6 cm by 0.4 cm, with red surrounding skin with blanching discoloration, no odor, and scant serosanguinous drainage.

Review of the Resident Data Collection (RDC) dated 05/12/15, revealed Resident #1 was re-admitted to the facility from the hospital with a sacral Stage II, and right heel Suspected Deep Tissue Injury (SDTI).

Continued review of Resident #1's clinical record revealed there was no documented evidence Resident #1 received another skin assessment to include all the resident's wounds from 04/21/15 until 05/26/15, more than five (5) weeks later, even though the resident's care plan stated weekly skin assessments would be completed.

Interview with Licensed Practical Nurse (LPN) #6 on 08/11/15 at 5:00 PM, on 08/12/15 at 10:51 AM, and on 08/20/15 at 4:00 PM, revealed she had completed the weekly Nurses Notes for Resident #1 on 04/28/15, 05/05/15, 05/19/15, and 06/02/15 and should have completed the weekly Skin Assessments, Wound Care Summaries, and weekly Skin Reports when she did the weekly Nurses Notes. However, she stated at the time she did not understand she needed to do this.

Further review revealed there were no more weekly Skin Assessments completed for this resident after 05/28/15. However, review of the Weekly Skin Report (document which was to be completed weekly for all residents with wounds to take to the weekly Quality of Care (QOC) Meeting), dated 06/04/15, revealed the resident had a sacral/left buttock wound which measured 9.5 cm x 6 cm by 0.5 cm with seventy five percent (75%) eschar and twenty-five percent (25%)

F 282
changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer. New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal saline wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015 Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levvaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately 2cm from rectum on lower left buttocks

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red/purple wound bed with purulent drainage and the Report indicated this wound had worsened.

Interview with LPN #7 on 08/10/15 at 7:00 PM, revealed she had documented the measurements on the weekly Skin Report dated 06/04/15, and the measurement and assessment performed was for the sacral ulcer only. She stated she had measured the right heel and had documented the right heel wound on 06/04/15 as a SDTI 2 cm x 2.8 cm purple on the weekly Skin Report, which was not dated. However, LPN #7 stated she had failed to document the ulcer to the left buttock. Further interview revealed she had not followed through with documenting the wounds on the Wound Care Summary as per protocol or on the weekly Skin Assessment per the resident's care plan.

2. Review of Resident #10's medical record revealed the facility admitted the Resident #10 on 02/02/15 with diagnoses which included Parkinson's Disease, Chronic Kidney Disease, and Diabetes Mellitus. Review of the Quarterly MDS dated 05/18/15, revealed the facility assessed Resident #10 as having a Brief Interview for Mental Status (BIMS) of a six (6) out of fifteen (15). Further review revealed the facility assessed the resident as requiring the extensive assistance of two (2) for bed mobility, transfers, toilet use, as not rated for urinary incontinence, as always incontinent of bowel and as having one (1) unstageable pressure ulcer.

Review of the Quarterly MDS dated 05/18/15, revealed the facility assessed Resident #10 as having a Brief Interview for Mental Status (BIMS) of a six (6) out of fifteen (15). Further review revealed the facility assessed Resident #1 as

F 282 with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage. Physician notified and order obtained to send to ER.

Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility.

Resident #2

Resident #2 is an 85yr old female with diagnosis of CHF, insulin dependent diabetes, paraplegia, neuropathy and hypertension. Resident #2 was admitted to Ridgeway on 04/09/14 from Edgewood Nursing Home. On admission Resident #2 had red areas to left breast and groin that appeared to be with yeast. On 06/07/15, a stage II area, 1 X 1cm, was noted, no odor, no drainage. This area healed on 06/28/15. On 07/01/15 area to posterior thigh healed. On 08/04/15 three Stage II areas were noted 1.2cm x 1.2cm, medial coccyx, 1.8cm x 0.2cm, right side 0.5cm x 0.4cm, no foul odor or drainage, scant amount of bleeding noted. Aquapel foam was applied and order to be changed every three days and PRN. On 8/14/15 all areas to coccyx and left

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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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requiring extensive assistance of two (2) for bed mobility, transfers, toilet use, as not rated for urinary incontinence, as always incontinent of bowel and as having one (1) unstageable pressure ulcer.

Review of the Comprehensive Plan of Care, undated, revealed Resident #10 had potential impairment/actual impairment to skin integrity related to impaired mobility and multiple pressure sores. The goal stated the resident would have no complications related to the skin injury. There were several interventions including pressure relieving cushion to wheelchair, follow skin care protocol, observe location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration to the Physician, report changes to charge nurse of any skin redness or breakdown, and treatments to skin as ordered. There was a new intervention added on 05/04/15 to see TAR for treatments of skin tears and pressure areas and a new intervention added 07/15/15 for gel boots.

Review of the Nurse's Note on 02/02/15, the date of the resident's admission to the facility, revealed the resident had scabs noted to left cheek, left ear and right ear, left fourth finger left hand, and second finger right hand. However, there was no indication of pressure ulcers.

Review of the Nurse's Notes dated 02/16/15 on re-admission to the facility after hospitalization, revealed Resident #10 had a 1.3 centimeter (cm) x 1 cm open area to the left sacrum, a 1.7 cm x 0.8 cm open area to the right sacrum, and a 4.4 cm x 3.8 cm fluid filled purple area to the right heel.

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buttock healed. A scab, 0.5cm x 0.5cm, was noted to left anterior foot. She continues to have blanchable redness to bilateral buttocks. It should be noted that per the care plan progress notes, Resident #2 refuses to turn and reposition in bed or chair. Resident #2 continues to receive Prostat 30cc BID X 30 days, Vitamin C 250mg QD and Zinc Sulfate 220mg x14 days. Her weight on admission was 201 lbs and 209 lbs currently. Her BUN currently is 38 (7-25), total protein 5.7 (6-8.3) and albumin 3.4 (3.5-5.5). Her hemoglobin 9.8 (12-16) and hematocrit 31.1 (36-48) are low. Despite the above mentioned complication her wounds are healed.

Resident #4
Resident #4 is a 62 year old male, who was admitted on 4/10/10 from the hospital. Resident #4 was admitted with Stage II to his right buttock, 1cm x 1cm diameter and left hip with area measuring 6cm x 7cm and approx. 1cm diameter. On 6/14/10 pressure reducing mattress to be was ordered. Vitamin C 250mg was ordered on 12/13/15. Vitamin D3 50,000units was ordered on 05/14/12. Coccyx cutout quadra gel cushion for wheelchair positioning ordered 4/30/13. Sencare protect ointment 113gm 2 times a day was ordered 5/29/13. Zinc Sulfate 220mg ordered 7/5/15 for wound healing.

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360	

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drainage with nonblanchable skin surrounding the ulcer. Further review of the WCS dated 04/21/15 revealed the resident's right heel ulcer measured 5 cm x 6.5 cm with greater than seventy-five percent (75%) eschar and brown drainage. Additionally, the WCS dated 04/21/15 revealed Resident #10 had a new SDTI measuring 1 cm x 1 cm non blanching purple maroon in color to the right coccyx.

There was no further documented evidence of a WCS for the left coccyx pressure ulcer, the right coccyx pressure ulcer, or the right heel ulcer from 04/21/15 until 08/14/15 (over three (3) months) as per the facility's wound care protocol. Additionally, these areas were not documented on the Weekly Skin Report from 04/29/15 until 06/09/15 (over five (5) weeks) and there was no Weekly Skin Assessments noted from 04/14/15 until 06/02/15 (seven (7) weeks). The facility failed to implement the skin care protocol per the resident's plan of care.

3. Review of Resident #7's medical record revealed the resident was admitted by the facility on 07/13/15 with diagnoses which included Schizophrenia (mental disorder), Acute Respiratory Failure, Muscle Weakness, Wound Infection, Surgical Wound, Ischemic Bowel Syndrome (medical condition in which inflammation and injury of the large intestine result from inadequate blood supply to the intestines), and Status Post Cecostomy (a surgically formed connection between the large intestine and the outside that is made through an opening in the front abdominal wall).

Review of the facility's Admission Minimum Data Set, dated 07/20/15, revealed the resident was

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issues with yeast infections. On 7/15/13 Resident #5 was noted to an abrasion to her coccyx which was treated with Duoderm. On 7/16/13 the area healed and the Duoderm was discontinued. Resident #5's health has continued to decline over the next two years. She has had numerous hospitalization and the facility and hospital have discussed Hospice/Palliative care with the daughter. The daughter continues to decline Hospice services. The coccyx area reopened in March 2015. Following the area reopening Resident #5 was hospitalized in April 2015, May 2015, June 2015 and July 2015. The area to her coccyx now measures Stage IV 7cm x 11.2cm x 1.9cm with 25% slough and small area to bone exposure, no odor. Stage II right upper thigh/buttocks healed and scabbed over 9/06/15. Stage II to right lower buttocks Duoderm ordered. Resident #5 continues to be very ill patient as exhibited by her labs dated 05/07/15; Hemoglobin 8.8 (12-16), Hematocrit 28.5 (36-48), BUN:30 (7-25), total protein 5.4 (6-8.3), albumin 2.6 (3.5-5.5). on 7/13/15 Her BUN elevated to 81 (7-25). On 7/20/15 her wound culture showed MRSA pseudomonas aeruginosa and enterococcus faecium which was treated as ordered. On 9/2/15 her BUN was 63 (7-35mg). This again shows the fragile nature of Resident #5's condition. Resident #5 continues to receive treatments as ordered and as documented in the resident's plan of care. Resident #5's skin assessment, care plans and interventions have been updated to reflect her current clinical condition.

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admitted with no pressure sores, but was at risk.

Review of the medical record revealed Resident #7 had Physician Admission Orders, dated 07/13/15, which included an order for Isolation Precautions (Contact Precautions - used to reduce the spread of organisms from direct or indirect contact with the resident or resident items) due to Methicillin Resistant Staphylococcus (MRSA- a multi-drug resistant organism) cultured from the Cecostomy surgical wound. Further review of Physician Orders revealed a verbal order, dated 08/04/15 at 0500 (5:00 AM), for Aquacel AG Foam dressing to the left and right buttock, change every three (3) days related to pressure.

Review of the Medical Record revealed a Comprehensive Care Plan: "MRSA to surgical wound" plan of care, undated, which included an intervention for open wounds to be covered, and not open to air.

Further review of the care plans revealed a Pressure Ulcer Care Plan, dated 08/04/15, which included an intervention for treatments as ordered by the Physician to the wound care area and see treatment sheet.

Observation of a skin assessment performed by LPNs # 1 and #2 on 08/11/15 at 6:25 PM, revealed two (2), open to the air wounds on Resident #7's left buttock, and the ordered wound dressing was not in place. The wounds were measured by LPN #1 as being 1.0 cm in length x 0.4 cm in width (distal wound) and 0.4 cm length x 0.6 cm width (proximal wound).

Interview, on 08/11/15 at 7:00 PM, with LPN #1

F 282
Resident #6
Resident #6 is an 88yr old admitted from St. Joseph's Mt. Sterling on 7/9/15. Upon admission resident's weight was 146lbs. Resident was incontinent of bowel and bladder upon admission with a catheter in place. She had a Duoderm in place to her stage II to her left buttock. Heal protectors were applied upon admission. On 8/7/15 the left buttock was measuring as a 0.05cm open area. On 7/31/15, a SDTI was noted on her right buttock with no open areas and no drainage. On 8/13/15, the left buttock and right buttock SDTI were healed. Vitamin D3 2000 unit capsules were ordered on 7/9/15, Benacal 45ml, cyponhepeter 2mg were ordered on 7/30/15, Prostat was ordered on 8/4/15, zinc ordered on 8/4/15, Vitamin C ordered on 8/4/15 and cyprohetatine ordered on 8/4/15. Vitamin B12 and Vitamin D was upon admission. Met with family about appetite and refusing meal on 7/29/15, a feeding tube placement discussion was put into place on 8/21/15 for decreased intake and Hospice services. A Hospice consult was ordered 8/21/15. Resident was sent to ER on 8/24/15 at 08:30 and passed away there on hospice. At the time of discharge to ER resident's skin was intact and weight at discharge was 132.lbs.

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revealed wounds on the left buttock had no dressing in place and were open to air. LPN #1 reported the ordered wound treatment was not in place, as per the care plan, and there was a potential risk of the wounds worsening or becoming infected, because the resident had an MRSA infection.

Interview, on 8/11/15 at 7:10 PM, with LPN #2 revealed Resident #7 had an infection of MRSA to the abdominal surgical wound site and the open wounds on the left buttock were at risk of potential infection without the dressing in place.

Interview, on 08/20/15 at 3:05 PM, with LPN #3 revealed she routinely cared for Resident #7 and the open wounds to the left buttock, observed on 08/11/15, were supposed to be covered. The LPN revealed the resident had MRSA and was care planned to cover open wounds; however, the care plan was not followed if the wound treatment was not in place and the wounds were open to air.

Interview, on 08/24/15 at 4:09 PM, with the Director of Nursing (DON) revealed she had no explanation why Resident #7's left buttock wound treatment was not in place as ordered. The DON reported the resident's MRSA care plan was not followed because wounds were open to air and not covered and the wound treatment was not followed because the wound treatment was scheduled every three (3) days and was last done on 08/07/15, was not performed on 08/10/15, and the dressing was not in place on 08/11/15.

Interview, on 08/25/15 at 9:55 AM, with the Administrator revealed the MRSA Care plan intervention was not followed by staff, because

F 282,

Resident #7

Resident #7 was admitted to Ridgway Nursing and Rehabilitation on 07/13/15 with diagnosis of acute respiratory failure, pneumonia, vocal cord edema, schizophrenia and chronic renal insufficiency. She had prolonged hospital stay due to a bowel obstruction and surgery. She is a 68 year old female. On admission it was noted she had MRSA to her incision and was placed on Contact Isolation. She had blanchable redness to sacral area and buttocks area. She had multiple scratches and bruises to arms, hands and thighs. On 8/04/15 Resident #7 was noted to have a Stage II area to left medial buttock measuring 0.4cm x 0.2cm, wound bed was pink with no slough, no odor or drainage noted. Four days later a distal area was noted stage II, measuring 0.5cm X 0.2cm x 1.2 cm blanchable redness between wounds. Both areas healed on 8/14/15. Her labs on 07/20/15 revealed a protein level of 5.4 (6-8.3), albumin 3.2 (3.5-5.5), Hemoglobin 10.5 (12-18) and Hematocrit 33.2 (38-48). Her weight on admission was 266lbs and height 56 inches. She was seen by the dietician on 8/12/15 and was noted to have a healing stage II's. The areas healed on 8/14/15. Resident #7 was transferred to the hospital on 8/25/15 in an emergency and died a few hours later

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wounds, to the left buttock, were not covered and the scheduled treatment was not performed on 08/10/15 as ordered.

4. Review of Resident #6's medical record revealed the resident was admitted by the facility on 07/09/15 with diagnoses which included Deep Vein Thrombosis (formation of a blood clot in a deep vein), Hypertension, Chronic Heart Failure, Chronic Renal Insufficiency, Hypothyroidism (body lacks sufficient thyroid hormone), Anxiety State, Joint Pain, Muscle Weakness, and Arthritis. Review of the facility's Admission Nurse Note dated 07/09/15, revealed Resident #6 was admitted to the facility with a Stage II Pressure Ulcer on the Left Buttock which was measured to be 0.5 cm in length by 0.4 cm in width, but no depth measurement.

Review of the Admission MDS Assessment, dated 07/20/15, revealed Resident #6 mental status was assessed as severely impaired. Review of the MDS section for Skin Conditions revealed the resident was at risk of developing pressure ulcers and had a Stage II pressure ulcer, not measured on MDS, with granulation tissue.

Review of Physician's orders revealed an order, dated 07/09/15, to apply DuoDerm to the Stage II pressure ulcer on the Left Buttock and change every three (3) days.

Review of Resident #6's Comprehensive Care Plan revealed a skin integrity problem care plan, undated, with interventions which included assess wound healing: measure the wound's length, width, depth, and to assess/document the status of the wound perimeter, wound bed and healing

F 282
Resident #8
Resident #8 is a 90 year old who was admitted to Ridgeway Nursing and Rehabilitation on 5/2/14 following a hospital stay. His diagnosis include atrial fibrillation, chronic history of UTI, dysphagia, pain in joints, abnormal posture and muscle weakness, prostate cancer with bone mets, encephalopathy, aortic valve stenosis, BPH, heart failure, bladder cancer, lung nodule, urinary retention and dementia. On 8/8/15 it is noted a stage II area measuring 1cm x 0.5cm was discovered. Aquacel AG Fiber and DuoDerm ordered. The area is described as a SDTI to upper posterior thigh and stage II areas to left and right medial buttocks. On 8/14/15 the area to the posterior right thigh healed and orders were discontinued. On 8/12/15 area to right medial buttocks healed and treatments discontinued. Resident #8's labs are as follows; BUN 35 (7-25), Creatinine 1.5 (0.6-1.3) on 6/9/15, on 06/25/15 albumin 3.4 (3.5-5.5), Hemoglobin 11.5 (14-18) and Hematocrit 33.2 (42-54). Resident #8 continues on Hospice Services with comfort P.O.C. in place. Skin is intact at this time.

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progress.

Review of the Treatment Administration Record (TAR) revealed the wound treatment was changed on: 07/12/15, 07/15/15, 07/18/15, 07/21/15, 07/24/15, 07/27/15, 07/30/15, 08/02/15, 08/05/15, 08/08/15, and 08/10/15. Review of the Nurse's Notes, on dates the wound treatment was changed revealed the Nurse's Note dated 07/12/15 at 5:20 AM, documented the dressing change was performed and there was no open areas, no bleeding or drainage, and no signs/symptoms of infection. However, the dressing changes continued and review of Nurse's Notes on treatment change dates: 07/15/15, 07/18/15, 07/21/15, 07/24/15, and 07/27/15 revealed no wound measurements, assessment of the wound bed or perineal wound and healing process as per the care plan intervention.

Continued interview, on 08/20/15 at 11:54 AM, with MDS Coordinator #1 revealed Resident #6's skin integrity care plan included documenting the status of the wound bed/perimeter and healing process and the care plan was not followed if the nurses who provided wound treatments did not document the information. Further interview revealed if the resident had a skin integrity problem, the nurses were to measure the wound per the care plan intervention.

Review of the facility's WCSs for Resident #6, revealed no documentation after 07/09/15. Review of the Weekly Skin Assessments done on 07/10/15, 07/17/15, 07/24/15, 07/31/15, and 08/07/15 revealed no measurements, assessment of the wound bed or perineal wound and healing process as per the care plan

F 282:
Resident #9
Resident #9 is a 93yr old female admitted to Ridgway from home on 3/13/15. She was admitted with a stage II to her right mid buttock x 2, the upper measuring 0.3cm x 0.4cm and the lower 0.4cm x 0.5cm. She had a Aquacel treatment in place upon admission her family reported. She was living alone and had family to stay with her 24 hours a day. Family stated she would stay in her recliner all day and sleep there at night. On 5/27/15 a stage II was noted to the coccyx left buttock measuring 1.8cm x 2 x 0.2cm. On 6/17/15 the right buttock was healed. On 6/4/15 and 6/11/15 the measurements were noted to be smaller. On 6/23/15 the left buttock was measuring 0.1cm x 0.1cm with no drainage or odor. As of 9/8/15 the coccyx stage II wound is measuring 0.2cm x 0.2cm with no depth or no drainage. The left buttock wound stage II measuring 0.4cm x 0.4cm with no depth, odor or drainage. On 4/15/15, an Aquacel AG treatment to the coccyx was put into place covering with Duoderm. On 4/21/15 a cushion was ordered for the resident's recliner. Resident #9 is incontinent of urine. Resident has a diagnosis of hypertension and edema. Resident is currently taking Prostat 30ml twice daily for wound healing which was ordered 3/20/15. This resident continues to receive treatments as ordered and that documented in the resident's plan of care. Resident #9's skin assessment, care plans and interventions have been updated to reflect her current clinical condition

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Intervention.

Interview, on 08/21/15 at 3:15 PM, with LPN # 4 revealed Resident #6 had a skin impairment care plan which included an intervention to measure and assess wounds. The LPN reported, after review of available nursing notes/skin assessments/wound summary documents (dates from 07/09/15 to 08/07/15), the wound's progress was not monitored according to the care plan because there were no wound measurements or documentation of the wound site. The LPN further reported the documentation was confusing and she was unable to tell if the wound improved. In addition, she reported the Suspected Deep Tissue Injury (SDTI) reported on the 07/31/15 and 08/07/15 skin assessments was not measured per the care plan.

Interview, on 08/21/15 at 6:20 PM, with the DON, Administrator, Interim Administrator/Nurse Consultant revealed care plan interventions were individualized and to be followed by staff. If the care plan intervention included documentation of wound measurements/site/progress they had not followed the intervention process of documentation.

5. Review of Resident #5's medical record revealed the resident was initially admitted by the facility on 02/14/13 and re-admitted on 07/03/15 with Diagnoses which included Hypertension, Non-Alzheimer's Dementia, Chronic Kidney Disease, Dysphagia, Dementia, and Cerebral Vascular Accident.

Review of the Admission MDS Assessment, dated 02/21/13, revealed the facility assessed the resident to be at risk for pressure ulcers only and

F 282
Resident #10 continues to reside in the facility. His physician had been made aware of his current status.
Resident #10 is an 85 year old was admitted to Ridgeway Nursing and Rehabilitation on 2/2/15. His diagnosis include urinary retention, BPH, Parkinson disease, dementia with behaviors, HTN, DM stage II, chronic kidney disease, dysphagia, hyperlipidema, generalized weakness, hematuria with unclear etiology. On 2/16/15 upon readmission to the facility a stage II area to right sacrum measuring 1cm x 0.8cm, red, no odor or drainage was noted with 6cm non-blanching redness to 12:00. Aquacel foam ordered and applied. On 3/12/15 this area healed. On 3/22/15 the right buttock/sacral area 1cm x 1cm, red, no odor, serous drainage surrounding skin with blanchable redness. Duoderm ordered and applied. This area healed on 4/14/15. On 4/21/15 a suspected deep tissue injury 1cm x 1cm non-blanching, no odor or drainage was noted to right coccyx. This area continues to be treated. On 2/16/15 upon readmission a 4.5cm x 4 cm, red/purple blister was noted to his right heel. This was diagnosed as MRSA and treated. The right heel continues to be open despite wound care clinic consultation on several dates and several debridements. Current wounds' measurements are right heel stage IV, 6.8cm x 6.7cm x 1.2cm with 1.7cm tunneling at 6:00 and 8:00, coccyx unstageable 3cm x 1.7cm x

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Addendum for 10/22/15
Accepted
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/21/2015
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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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 282 Continued From page 46

no pressure ulcers were identified. Continued review of the MDS revealed the resident was assessed as moderately cognitively impaired.

Review of Resident #5's Comprehensive Care Plan revealed a Skin Integrity Care Plan, undated, with an intervention to complete a weekly skin assessment for any indication of skin breakdown.

Review of Resident #5's "Weekly Skin Assessment" documents, requested from April 2015 through 08/11/15, revealed documentation of weekly skin assessments on 07/10/15, 07/17/15, 07/31/15, and 08/07/15 only. Record review of nursing notes, for the same period, revealed no documentation a head to toe skin assessment was performed weekly per the care plan intervention.

Interview, on 08/2/15 at 3:05 PM, with LPN # 4, who cared for Resident #6 revealed resident skin assessments were supposed to be documented on the weekly Skin Assessment form and were to include any area of abnormal skin identified on the weekly head to toe skin assessment. The LPN revealed the form was supposed to be completed each week.

Further review of Resident #5's Comprehensive Care Plan revealed an individual care plan on Pressure Ulcer related to immobility, Multiple Pressure Areas with an intervention to assess for signs and symptoms of worsening, of infection, or complications daily.

Review of Nurse's Notes revealed a Note dated 07/19/15 at 4:30 PM and 5:30 PM which revealed Resident #5 had a temperature of 101 degrees

F 282

1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac to be changed every 2 days to each area. Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Ceftin, Bactrim and Ampicillin. It should be noted that Resident #10 has 1plus edema to lower extremities and requires Lasix 60mg daily to keep the edema to 1 plus. Resident # 10 continues to receive treatments as ordered and documented in the plan of care. Resident #10's skin assessment, care plans and interventions have been updated to reflect her current clinical condition. Resident #12s skin assessment, care plans and interventions have been updated to reflect her current clinical condition.

2. On August 14, 2015, Sally Baxter, R.N., Vice-President of Clinical Services, and Lauren Sword, Administrator, completed a comprehensive review of all care plans to ensure they are updated as appropriate and care plan approaches are in place and being followed. Physician orders are reviewed daily with the facility's inter-disciplinary team and the care plans updated as appropriate. The Administrator, Director of Nursing, Charge Nurses, Rehab Director and MDS Coordinator are all part of the morning meeting. On the weekends, the RN Charge Nurse will be responsible for updating the care plans. In addition, all nurses (with the exception of one on FMLA and a PRN nurse) were re-educated on updating the care plan, as appropriate, and following the care plan. On August 13, 2015, the in-service was conducted by Sally Baxter, RN, Vice-

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no pressure ulcers were identified. Continued review of the MDS revealed the resident was assessed as moderately cognitively impaired.

Review of Resident #5's Comprehensive Care Plan revealed a Skin Integrity Care Plan, undated, with an intervention to complete a weekly skin assessment for any indication of skin breakdown.

Review of Resident #5's "Weekly Skin Assessment" documents, requested from April 2015 through 08/11/15, revealed documentation of weekly skin assessments on 07/10/15, 07/17/15, 07/31/15, and 08/07/15 only. Record review of nursing notes, for the same period, revealed no documentation a head to toe skin assessment was performed weekly per the care plan intervention.

Interview, on 08/2/15 at 3:05 PM, with LPN # 4, who cared for Resident #6 revealed resident skin assessments were supposed to be documented on the weekly Skin Assessment form and were to include any area of abnormal skin identified on the weekly head to toe skin assessment. The LPN revealed the form was supposed to be completed each week.

Further review of Resident #5's Comprehensive Care Plan revealed an individual care plan on Pressure Ulcer related to immobility, Multiple Pressure Areas with an intervention to assess for signs and symptoms of worsening, of infection, or complications daily.

Review of Nurse's Notes revealed a Note dated 07/19/15 at 4:30 PM and 5:30 PM which revealed Resident #5 had a temperature of 101 degrees

F 282

1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac to be changed every 2 days to each area.

Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Cefitin, Bactrim and Ampicillin. It should be noted that Resident #10 has 1plus edema to lower extremities and requires Lasix 60mg daily to keep the edema to 1 plus. Resident # 10 continues to receive treatments as ordered and documented in the plan of care.

Resident #10's skin assessment, care plans and interventions have been updated to reflect her current clinical condition.

Resident #12s skin assessment, care plans and interventions have been updated to reflect her current clinical condition.

2. On August 14, 2015, Sally Baxter, R.N., Vice-President of Clinical Services, and Lauren Sword, Administrator, completed a comprehensive review of all care plans to ensure they are updated as appropriate and care plan approaches are in place and being followed. Physician orders are reviewed daily with the facility's inter-disciplinary team and the care plans updated as appropriate. The Administrator, Director of Nursing, Charge Nurses, Rehab Director and MDS Coordinator are all part of the morning meeting. On the weekends, the RN Charge Nurse will be responsible for updating the care plans. In addition, all nurses (with the exception of one on FMLA and a PRN nurse) were re-educated on updating the care plan, as appropriate, and following the care plan. On August 13, 2015, the in-service was conducted by Sally Baxter, RN, Vice-

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F 282	<p>Continued From page 47</p> <p>and was assessed to have increased drainage and odor when a dressing change was performed. The Note indicated the Physician had been notified and a wound culture was ordered. However, further review of the Nurse's Notes revealed no documented assessment of a worsening wound infection with wound care treatments. The next Nurse's Note documentation was 07/23/15 at 4:54 AM which revealed a new order was received to refer the resident to wound care and at 10:00 AM which indicated the Physician was notified of the wound culture results and antibiotics medications were ordered (Linezolid and Gentamicin).</p> <p>Further Interview with LPN #4, on 08/21/15 at 5:50 PM, after review of the 07/19/15 4:30 PM Nurse's Note, revealed there was supposed to be follow-up charting and wound assessments when the wound condition change was identified. The LPN revealed the resident should have been placed on seventy-two (72) hour charting and monitored more closely.</p> <p>Interview, on 08/21/15 at 6:20 PM, with the DON, Administrator, Interim Administrator/Nurse Consultant revealed they had no standard process for monitoring of residents when a condition change was identified, it was nursing judgement to determine if closer monitoring was needed and they charted by exception.</p> <p>6. Review of Resident #2's clinical record revealed the facility admitted the resident on 04/09/14 with diagnoses of Peripheral Neuropathy, Hypertension, Chronic Back Pain, Insulin Dependent Diabetes Mellitus, Paraplegia, Osteoporosis and Rheumatoid Arthritis.</p>	F 282	<p>President of Clinical Services. Those nurses indicated above, who were not educated, will be educated prior to returning to work</p> <p>3. Daily for one month, the Director of Nursing, or her designee, will audit two (2) resident care plans to ensure they are updated as appropriate and that resident care is being completed as indicated in the plan of care. RN Charge Nurse will complete the audits on the weekends. If no ongoing problems are identified after one month, then the Director of Nursing, or her designee, will audit two (2) resident care plans weekly to ensure compliance with care as directed by the care plan. As part of the licensed nursing orientation all newly hired nurse's will be educated on updating and following the plan of care.</p> <p>4. As part of the facility's ongoing Quality Assurance Program the facility will audit 5 % of the residents to ensure that the care plan is being followed as written. In addition, care plans will be a focus of the facility's continuous Quality Improvement Committee for the next six (6) months. Any identified problems will be addressed and followed up by the Committee with the nursing staff and re-education provided as appropriate. Daily for one month the Director of Nursing will audit at least two residents care plans to ensure appropriate care is being provided as recorded in the plan of care and MD orders. This audit includes direct observation of the care being provided and care plan review. These audits will be made part of the facilities ongoing quality of assurance program for the next six months. If deficient care is noted or care plans are not updated then a re-education program will be initiated for the offending nurse.</p> <p>5. August 25, 2015</p>	

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F 282: Continued From page 48

Review of Resident #2's Quarterly MDS Assessment dated 07/06/15 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), which indicated Resident #2 was cognitively intact. Further review revealed the facility assessed the resident as requiring the extensive assistance of two (2) persons for bed mobility, dressing, toilet use and personal hygiene. Continued review of the MDS revealed the facility assessed the resident as being at risk for developing pressure ulcers.

Review of Resident #2's Comprehensive Care Plan, initiated 04/21/14, revealed the resident had a problem of skin integrity, impaired: potential related to: impaired mobility, Diabetes, Arthritis, chronic pain, incontinence, and declined to turn and reposition in bed/wheelchair. The goal stated Resident #2 would have intact skin. The interventions included: weekly skin assessments by licensed staff and monitor for any indication of skin breakdown, RD consult, gel cushion to the wheelchair, reposition in wheelchair and chair frequently, treatments per orders-see TAR, turn and reposition every two (2) hours, and bilateral heel protectors to feet when in bed.

Review of Resident #2's Physician Orders revealed an order dated 04/08/15 for Bilateral Heel Protectors while in bed.

Observation of Resident #2, during a skin assessment on 08/06/15 at 11:10 AM, revealed the bilateral heel protectors were not on the resident's feet as per the care plan, and Resident #2 had a soft boggy left heel.

Interview, on 08/06/15 at 1:50 PM, with CNA #9

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revealed she was assigned to Resident #2 and she carried a pocket flow sheet as a reference for care for the resident. However, after review of the flow sheet, she stated she did not see the intervention for the heel protectors on the flow sheet, even though, review of the current Nurse Aide Care Plan revealed Resident #2 was to have heel protectors in bed. CNA #9 then stated she was aware the resident was to have heel protectors; however, the resident refused to wear them. Continued interview revealed the CNAs were to inform the nurses if a resident refused an intervention; however, she did not remember telling the nurses about the resident refusing heel protectors.

Interview, on 08/06/15 at 2:10 PM, with LPN #12, revealed she was assigned to Resident #2 and she did rounds during medication pass and while performing treatments to ensure safety devices and skin devices were in place and she used the Treatment Administration Record (TAR) as a reference. She further stated she was aware the resident was to wear heel protectors and the CNAs would sometimes tell her he/she refused to wear them; however, she was not told the resident refused them today.

Review of the TAR for Resident #2 revealed during the month of July 2015, the intervention for bilateral heel protectors while in bed was ordered nine (9) times without any notes documented on the back of the TAR as an explanation as to why the resident was not wearing the heel protectors.

Observation, on 08/10/15 at 7:00 PM revealed Resident #2 was in bed with the bilateral heel protectors in place. Resident #2 stated he/she wore the heel boots night and day. Interview with

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F 282	<p>Continued From page 50</p> <p>Resident #2, on 08/11/15 at 12:00 PM, revealed, "I always have them (heel protectors) on sometimes they fall off but I don't take them off".</p> <p>Interview, on 8/10/15 at 5:30 PM, 8/11/15 at 2:50 PM, and 08/12/15 at 9:15 AM with the DON revealed if a resident refused care on a regular basis the nurses should document a Nurses Note, notify the physician, circle their initials on the Medication Administration Record (MAR) or TAR, turn the MAR/TAR over and document a note. The DON further revealed the facility had no policy on refusal of care from residents. The DON stated, "If a resident is well known to refuse, then nursing should contact the doctor and get new interventions in place is what should happen". She further stated the goal of the intervention of the heel protectors for he/she was prevention, and if there were problems with that intervention than an alternate intervention needed to be put in place. She further stated that if there was a care plan intervention for the heel protectors and the resident was not wearing them, the care plan was not followed.</p> <p>Further review of Resident #2's record revealed Nurse's Notes dated 08/04/15, which stated there was three (3) Stage II ulcers noted to the resident's coccyx. Review of the Nurse's Notes dated 08/06/15, revealed a new area was noted to the left upper buttock.</p> <p>Review of Resident #2's Weekly Skin Assessments revealed there was an entry on 08/06/15 which described the Stage II ulcer to the resident's left upper buttock as measuring 0.5 cm x 1 cm with one hundred percent (100%) granulation with one (1) x 1 cm purple discoloration surrounding the area, dry peeling</p>	F 282		
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F 282	<p>Continued From page 51</p> <p>skin to the surrounding tissue and slight serosanguinous drainage. However, there was no entry related to the three (3) Stage II areas which were noted to the resident's coccyx on the Nurse's Note dated 08/04/15, or on the weekly Skin Assessment dated 08/06/15.</p> <p>Review of Resident #2's WCS's revealed a WCS was initiated on 08/06/15 for the Stage II ulcer to the resident's left upper buttock which measured 0.5 cm x 1 cm with one hundred percent (100%) granulation with a 1 cm x 1 cm purple discoloration surrounding the area, dry peeling skin to the surrounding tissue and slight serosanguinous drainage. However, there was no documented evidence a WCS was initiated for the three (3) Stage II wounds to the resident's Coccyx, as per the care plan.</p> <p>Interview on 08/10/2015 at 6:45 PM with the DON in regards to Resident #2, revealed it would be hard to determine if the wounds were getting better or worse if the WCS's weren't completed accurately.</p> <p>7. Review of Resident #4's clinical record revealed the facility admitted the Resident on 04/20/10 with diagnoses which included Cardiovascular Accident (CVA) with left Hemiparesis, Hypertension, Aphasia, Dementia with Behaviors, Diabetes Mellitus II and Difficulty in Walking.</p> <p>Review of Resident #4's Annual MDS Assessment dated 06/22/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of fifteen (15). Further review of the MDS revealed the facility assessed Resident #4 as</p>	F 282		
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F 282	<p>Continued From page 52</p> <p>requiring extensive assistance of one (1) for bed mobility, dressing and personal hygiene and as requiring extensive assistance of two (2) for transfers, and toilet use. Per the MDS, the facility further assessed the resident to be frequently incontinent of urine and occasionally incontinent of bowel, and as having two (2) Stage II Pressure Ulcers at the time of the assessment which had not been present on the prior assessment.</p> <p>Review of Resident #4's Comprehensive Care Plan, initiated 06/04/12, revealed the resident had a skin integrity problem related to a history of recurrent skin tears on the buttocks which developed into ulcers and immobility. The goal stated Resident #4 would have intact skin. The interventions included; assess wound healing by a licensed nurse, measure length, width and depth where possible and assess and document status of wound perimeter, wound bed and healing progress, assist to turn and reposition at least every two (2) hours, and follow facility protocol for the prevention/treatment of skin breakdown.</p> <p>Review of Resident #4's Nurses Notes dated 04/28/15 revealed the resident had a new Stage II area to right buttock measuring 0.8 cm x 0.8 cm, red, no odor and a scant amount of serosanguinous drainage.</p> <p>However, further review revealed there was no WCS initiated for the new Stage II area to the resident's right buttock identified on 04/28/15. There was a WCS dated 07/17/15 which described a right buttock wound with no date the wound was discovered, and a WCS dated 08/07/15 related to the right buttock wound. However, there was no tracking of the wound</p>	F 282		
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weekly from 04/28/15, as per the care plan, and it could not be determined if this was the same wound on all these dates.

Also, there was no weekly Skin Assessments completed related to this wound until 05/08/15. The weekly Skin Assessment dated 05/08/15 revealed Resident #4 had a stage II ulcer to the buttocks; however, did not indicate which buttock or the measurement. The weekly Skin Assessment dated 05/15/15 had no documentation related to the wound to the buttocks. The weekly Skin Assessments afterward were done weekly for the area to the right buttocks; however, many of the assessments did not indicate measurements and descriptions of the wound, as per the care plan interventions.

Further review of Resident #4's Nurse's Notes dated 05/06/15, revealed the resident had a new Stage II ulcer to the right upper posterior thigh measuring 1.5 cm x 0.5 cm, red, no odor with serosanguinous drainage.

However, further review revealed there was no WCS initiated for the new wound identified on 05/06/15 to the resident's right upper posterior thigh. There was a WCS initiated on 07/17/15 related to an ulcer to the right posterior thigh and the next WCS for the right posterior thigh was dated 08/07/15. However, there was no tracking of the right posterior thigh wound weekly from 06/06/15, as per the care plan.

The weekly Skin Assessment dated 05/08/15 revealed a stage II to the buttocks but there was no mention of the new Stage II to the right upper posterior thigh identified on 05/06/15. The next

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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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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documentation on the weekly Skin Assessment for this wound to the right posterior thigh was on 05/22/15 and then the assessments were done weekly for this wound; however many of these assessments did not have measurements and descriptions of the wounds.

Observation of a skin assessment for Resident #4, completed by LPN #15 on 08/11/15 at 10:50 AM, revealed the dressing was removed from the right buttock and there was no open area. The resident was noted to have two (2) stage II areas to the right posterior right upper thigh measuring 0.5 cm x 0.5 cm with a pink wound bed, and 1.2 cm x 1 cm with a pink wound bed.

Review of the weekly Skin Reports, used by the facility as part of the wound care protocol for Quality Assurance monitoring, revealed no reports were found for Resident #4 from 04/29/15 until 05/28/15 and the Weekly Skin Report dated 05/28/15 revealed the stage II to the posterior upper right thigh now measured 1.5 cm x 1.5 cm, red, no odor, scant green tinged serosanguinous drainage.

Review of the weekly Skin Report dated 04/29/15 revealed Resident #4 had a Stage II ulcer to the right buttock measuring 0.8 cm by 0.8 cm. Further review revealed no further weekly Skin Reports were completed related to this ulcer until 05/28/16, (almost four (4) weeks later).

There was no weekly Skin Report related to the resident's right upper posterior thigh pressure ulcer identified on 05/06/15, until 05/28/15, almost three (3) weeks later. The next weekly Skin Report was dated 06/26/15 which was over three (3) weeks later. Then there was weekly Skin

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 WYOMING ROAD OWINGSVILLE, KY 40360
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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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| Reports documented on 07/03/15, 07/10/15, and 07/17/15. However, there was no further documented evidence of weekly Skin Reports after 07/17/15 even though record review revealed the resident continued to have pressure ulcers; therefore, the wounds were not monitored and assessed weekly as per the care plan.

| B. Review of Resident #8's clinical record revealed the facility admitted the resident on 05/02/14 with diagnoses which included Abnormal Posture, Dysphagia Unspecified, Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase, Pain in Joint (Multiple Sites), Chronic Diastolic Heart Failure and Chronic Airway Obstruction.

| Review of Resident #8's Significant Change MDS Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15) indicating the resident had severe cognitive impairment. Further review revealed the facility assessed Resident #8 as requiring extensive assist of two (2) persons for bed mobility, transfer, toilet use, personal hygiene and bathing. Continued review revealed the facility assessed Resident #8 as having a indwelling urinary catheter, as occasionally incontinent of bowel and as having two (2) Stage II pressure ulcers.

| Review of Resident #8's Comprehensive Care Plan, undated, revealed the resident had a problem of Impaired skin integrity related to immobility. The goal stated Resident #8 would not develop complications related to pressure ulcers. The interventions included weekly skin assessments by licensed staff to monitor for any

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NAME OF PROVIDER OR SUPPLIER RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD OWINGSVILLE, KY 40360
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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 282	<p>Continued From page 56</p> <p>indication of skin breakdown, turn and reposition every two (2) hours, report any red or open areas, and float heels when in bed.</p> <p>Review of Resident #8's Nurse's Notes dated 05/06/15 revealed the resident was noted to have a 0.8 cm x 0.9 cm Stage II pressure ulcer to the posterior upper left thigh with a 3 cm x 2 cm SDTI (Suspected Deep Tissue Injury) purple/maroon area to the distal end of the Stage II, with no odor or drainage. Further review revealed the resident's coccyx had a 0.5 cm x 0.3 cm Stage II pressure ulcer which was red, with no odor or drainage.</p> <p>Review of the WCSs and weekly Skin Assessments for Resident #8, revealed zero (0) Summaries or Assessments were completed for the entire month of May 2015 and Resident #8 was not placed on the weekly Skin Report for May 2015. Further review revealed there was no weekly Skin Assessments until 06/20/15, no WCS's for the entire month of June 2015 and the resident was not placed on the Weekly Skin Report until 06/20/15.</p> <p>Review of the weekly Skin Assessment, dated 07/04/15, revealed there were two (2) areas to the coccyx, with no measurements or staging of the areas, as per the care plan. The weekly Skin Assessment dated 07/11/15 revealed a Stage II to the left medial buttocks measured at 1 cm x 0.6 cm and the coccyx had blanchable redness. Further review revealed there was zero (0) WCSs completed for the entire month of July 2015. An Acute Care Plan was initiated on 07/11/15 related to the left medial buttock; however, it did not specify the stage of the ulcer. The care plan was not followed related to weekly skin assessments</p>	F 282		
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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
F 282	<p>Continued From page 57 by licensed staff.</p> <p>9. Review of Resident #9's clinical record revealed the facility admitted the Resident on 03/13/15 with diagnoses which included Muscle Weakness (Generalized), Dysphagia Oropharyngeal Phase and Insomnia.</p> <p>Review of Resident #9's Care Plan, undated, revealed a problem of impaired skin integrity, related to decreased mobility. The goal stated the Resident #9 would have intact skin. The interventions included: weekly skin assessments by licensed staff to monitor for skin breakdown, turn and reposition every two (2) hours, and nursing staff to monitor for indication of skin impairment during daily Activities of Daily Living (ADL) care.</p> <p>Review of the Acute Care Plan, dated 03/13/15, revealed Resident #9 had a Stage II to the coccyx on admission. Review of Resident #9's Care Plan Progress Notes, dated 04/01/15, revealed the resident had a Stage II pressure ulcer on the coccyx since admission. Further record review revealed there was a WCS related to the coccyx ulcer on 04/08/15; however, there was no Weekly Skin Assessment noted for the coccyx ulcer until 04/14/15, as per the care plan.</p> <p>Review of the weekly Skin Assessments revealed on 04/14/15 the resident had three (3) stage II pressure ulcers to the coccyx measuring 0.8 cm x 0.7 cm, 1.1 cm x 0.5 cm x 0.2 cm, and 0.5 cm x 0.7 cm. There was no further Weekly Skin Assessments, as per the care plan, until 05/27/15, over five (5) weeks later. On 05/27/15 a weekly Skin Assessment was completed which stated the resident had a 1.8 x 2.0 x 0.2 cm stage</p>	F 282	

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Il pressure ulcer to the coccyx/left buttocks, with surrounding skin red and excoriated with several small open areas with no measurements of the small open areas.

Review of the WCS's further revealed zero (0) were completed, as per the care plan and the facility's protocol, concerning the coccyx wound from 04/22/15 until 05/27/15. On 05/27/15 there was one (1) measurement for a Stage II to the coccyx/right buttock with a description of skin red and excoriated with several small open areas, with no measurements or descriptions of the several small open areas.

Further record review revealed zero (0) weekly Skin Reports for Resident #9 from 04/29/15 until 05/27/15. The 05/27/15 Weekly Skin Report revealed one (1) wound to the coccyx/left buttock and there was no further entries on the Weekly Skin Report log until 06/23/15, although the May 2015 TAR showed a continued treatment being administered from 05/01/15 until 05/30/15 for Aquacel AG to Stage II on coccyx and cover with DuoDerm change every three (3) days and as needed.

Review of Resident #9's Physician's Orders dated 06/01/15 revealed a new order for Aquacel Ag Fiber, cover with DuoDerm and change every three (3) days and as needed to the Stage II to the resident's right upper buttock, 2.2 cm x 1 cm ulcer. The Acute Care Plan was initiated; however, was undated, for a right buttock Stage II ulcer. Further record review revealed no WCS was initiated and there was no entry on the Weekly Skin Report for the Stage II to the right upper buttock found on 06/01/15.

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360		
(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 282	Continued From page 59 Further review revealed there was no documented evidence the WCSs were completed weekly. There were (0) WCS's for the following dates concerning the wounds found on Resident #9's coccyx/right buttock area: 06/04/15, 06/24/15, 06/30/15, 07/08/15, 07/15/15, and 07/22/15. Further record review revealed zero (0) Weekly Skin Assessments for Resident #9 on the following dates: 07/16/15, 07/23/15 and 07/30/15. 10. Review of Resident #12's clinical record revealed the facility admitted the Resident on 01/26/15 with diagnoses of Down's Syndrome, Abnormality of Gait, Muscle Weakness (Generalized), Difficulty in Walking, Pressure Ulcer Unspecified Site, Dysphagia Oropharyngeal Phase, and Alzheimer's Disease. Review of Resident #12's Care Plan, undated, revealed the resident had impaired; potential for impaired skin integrity related to incontinence and mobility. The goal stated Resident #12 would not develop pressure ulcers. The interventions included nursing staff to monitor for indication of skin impairment during ADL care, report any red or open area, and weekly skin assessment by licensed staff to monitor for any indications of skin breakdown. Review of the WCS dated 04/08/15 revealed Resident #12 had a stage III pressure ulcer to the posterior left thigh measuring 1.8 cm x 1.9 cm x 0.4 cm with tunneling from 12 o'clock to 2 o'clock (the wound was discovered on 02/04/15, according to the WCS dated 04/08/15). The next WCSs were completed for this pressure ulcer on 04/14/15 and 04/22/15; however, there was no	F 282			

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 408 WYOMING ROAD OWINGSVILLE, KY 40360
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F 282 : Continued From page 60

documented evidence of WCSs from 04/22/15 until 05/28/15, which was over four (4) weeks, as per the care plan. Further record review revealed Resident #12's posterior upper thigh wound was not evaluated from 04/29/15 until 05/27/15 on the weekly Skin Report used for QA and wound tracking.

Further review of Resident #12's WCSs revealed a WCS dated 04/08/15 describing a unstageable ulcer to the lower right buttock measuring 1.2 cm x 2 cm with yellow slough and purulent drainage and odor (discovered on 02/04/15) with no documented evidence of WCSs from 04/22/15 until 08/14/15, over three (3) months and the wound was not evaluated from 04/22/15 until 05/27/15, over four (4) weeks on the weekly Skin Report used for QA and wound tracking, as per the care plan.

Also, there was no documented evidence of weekly Skin Assessments for the following dates; 04/21/15, 04/28/15, 05/06/15, 05/12/15, 05/19/15, 05/26/15, 06/02/15, 06/15/15, 08/22/15 and 07/27/15.

Interview with the DON, on 08/12/15 at 3:30 PM, 08/13/15 at 5:30 PM, 08/19/15 at 5:30 PM, revealed the Care Plan was not followed if there was an intervention for a weekly skin assessment, and the weekly skin assessments were not completed. The DON further stated each nurse was responsible for ensuring the care plan was followed.

Interview with the former Interim Administrator/Nurse Consultant and the current Administrator, on 08/12/15 at 3:00 PM, revealed if the residents' care plans stated the residents

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360
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were to have weekly skin assessments done and the skin assessments were not completed weekly, the care plans would not be followed. Further interview revealed the care plans would need to be followed related to weekly skin assessments/wound assessments in order to follow the progression of the wounds to evaluate if the wounds were healing or deteriorating.

F 314 483.25(c) TREATMENT/SVCS TO SS=H PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policy and protocol, it was determined the facility failed to have an effective system in place to ensure the facility's protocol was implemented related to pressure ulcers to ensure a resident at risk for pressure ulcers or a resident with pressure ulcers, received the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing for eleven (11) of fourteen (14) sampled residents (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12).

Interview and record review revealed on

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It is, and was on the day of the survey, the policy of Ridgeway Nursing and Rehabilitation Facility to have measures in place to ensure that residents, who enter the facility without pressure ulcers, do not develop pressure ulcers, unless the resident's clinical condition demonstrates that the pressure area is unavoidable. It is also the policy that each resident with a pressure ulcer receives necessary treatment and services to promote healing, prevent infection and prevent new pressure sores from developing.

1. Resident #1 was an 87 year old female, who was admitted to Ridgeway Nursing and Rehabilitation on March 11, 2015 following a fall in an assisted living facility (Dementia Unit), which resulted in a right intertrochanteric hip fracture. Her other diagnoses include severe dementia, hypothyroidism, thrombocytopenia (which could have be a factor in the tissue destruction) and acute on chronic blood loss anemia. It was noted at the facility that her hemoglobin dropped to 8.1 on March 13, 2015.

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NAME OF PROVIDER OR SUPPLIER RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD OWINGSVILLE, KY 40360		
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F 314	Continued From page 62 04/24/15, the facility reassigned the facility's Wound Care Nurse to the position of a staff nurse and delegated all wound care assessments and treatments to the staff nurses. Interview revealed training was not provided related to measuring and staging of wounds and nurses were not comfortable completing this type of wound assessment. In addition, Interview revealed the nurses were not educated on the types of forms, related to pressure ulcers, utilized by the facility. Review of the facility's Wound Care Protocol revealed Wound Care Summaries would be updated weekly and weekly Skin Assessments would be completed. However, record review revealed these assessments were not consistently completed and there was no documented evidence of consistent monitoring of the progress of the residents' wounds. Substandard Quality of Care with actual harm was identified related to the facility's systemic failure. The findings include: Review of the facility's "Wound Protocol" document, undated, revealed "on any resident who is assessed to be at risk for skin breakdown, the protocol for early intervention should be implemented". Continued review revealed the Wound Care Summary should be initiated for any resident who was assessed to have a wound and continued with weekly "updates" until the wound was healed, with the Summary to be reviewed weekly in the Quality of Care (QOC) meetings for each resident who was identified as having a wound. Further review of the Summary revealed the weekly Skin Report should provide a summary of all wounds in the facility and progression of those wounds. Continued review	F 314	On April 06, 2015 at 3:45 P.M. a Stage II area, measuring 2 x 1 cm yellow slough, was noted and extended from an undetermined length into rectum. The Physician was notified, Aquacel AG Foam applied and a wound care clinic referral order was obtained and referral made to Wound Care Clinic. The order for Aquacel AG Foam to (L buttock) Stage II was to be changed every three (3) days and PRN. Care Plan was initiated for pressure ulcer. On April 09, 2015 an order was obtained to trial a coccyx cutout gel cushion for pressure relief and comfort. On April 10, 2015 the cushion was discontinued due to resident leaning. Patient was ordered a reclining wheelchair with elevating leg rests and pressure relieving cushion. During this time the resident was receiving numerous nutritional interventions, including Benecaloric, Prostat, and snacks at 10A.M. and 2 P.M. On April 14, 2015, Mirtazapine 7.5mg was ordered for appetite. Labs continued to be monitored (specifically for Hemoglobin level). On April 21, 2015, Physician was notified of a new Stage II area to her coccyx with new treatment. An order was received for Duoderm to coccyx every three days and PRN. On April 23, 2015, the resident was sent to the Wound Care Clinic for a scheduled appointment. New orders were received to cleanse sacral decubitus with Normal Saline and apply a small piece of foam dressing over the ulcer and secure with Tegaderm, to be changed every shift and PRN. Impression from OUC Wound Care states superficial decubitus ulcer to sacral area. No other areas were noted on this visit, which is indicative of just one area. On May 07, 2015, the resident returned to the Wound Care Clinic and upon examination was noted to have a superficial sacral lesion, which improved, and a small fissure at 11 o'clock in the anorectal area. Continue same treatment - Anusol HC Suppository TTD for anal fissure. On May 08, 2015 it was noted that the skin, where the Tegaderm covered around the		

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revealed the weekly Skin Report should be copied for members of the Quality of Care Committee to review each week.

Review of the facility "Wound Care Documentation Protocol", undated, revealed if a wound exists on admission, re-entry or discharge, a photo of the wound was to be taken of the area. A narrative description of all bony prominences was to be recorded in the medical record if photographs were unable to be taken or if nothing existed on that bony prominence that justified taking a photograph. Upon admission or re-entry, if a resident had a wound present of any type, the Wound Care Summary Sheet was to be started. Each wound was to have its own sheet and there could not be multiple wound sites listed on any one (1) wound care summary sheet. The Wound Care Summary was to be completed at a minimum of weekly by a licensed nurse and the assessment was to include measurements and a narrative wound description as directed on the sheet.

Interview with the Director of Nursing (DON) on 08/12/15 at 1240 PM, on 08/13/15 at 5:30 PM, and on 08/19/15 at 5:30 PM, revealed Licensed Practical Nurse (LPN) #7 had completed the skin assessments, Wound Care Summaries, and weekly Skin Reports for at least two (2) years. She stated toward the end of April, LPN #7 was needed to work the floor and was no longer in charge of the skin assessments, and the staff nurses were to do their own skin assessments, Wound Care Summaries and weekly Skin Reports. She stated the nurses were informed of this during a staff meeting, but she was unsure who informed the nurses.

F 314:
wound, was tender and becoming more fragile due to removing Tegaderm BID. Physician aware and an order obtained to change treatment to daily. On May 9, 2015 at 11:55 P.M. guardian was notified of resident's increased temperature. Physician notified and orders obtained to collect urine and start Cefin 250mg P.O. BID for seven days. At 3:45 A.M. resident's oxygen saturation decreased to 73%. Physician was called and orders obtained to send to ER for evaluation. O2 on resident at 3/Liters O2 sat at 90%. On May 10, 2015, the resident was admitted to St. Claire Regional Medical Center with a suspected UTI and confirmed pneumonia. She was placed on Levofloxacin 750mg. Returned to facility on May 12, 2015 with a suspected deep tissue injury to her right heel. Bulky Kerlix ordered to heel to protect. Wound to sacral area covered with Aquacel AG Foam. Muli Podus boots on bilateral heels/feet. Care Plan in place for impaired skin integrity potential. On May 13, 2015, Physician at bedside, new orders received. Prostat 30cc P.O. BID due to low albumin, Potassium 20m EQ QD. On May 14, 2015, speech therapy was to evaluate and treat. On May 15, 2015, diet order changed to Pureed. On May 20, 2015, Physician notified of lab results. On May 21, 2015, dressing change to coccyx and heel per Physician order, tolerated well. On May 23, 2015, increased drainage noted to Stage II sacral ulcer.

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Interview with LPN #7 on 08/20/15 at 10:00 AM, revealed she was the previous skin nurse in the building which meant she did head to toe skin assessments on every resident in the building each week and documented this on the weekly Skin Assessment. Further interview revealed she also measured, staged and described each wound in the building each week and documented this on the Wound Care Summary and the weekly Skin Report when she was the skin nurse. However, sometime in April, she was moved to a floor nurse position and all nurses were responsible for conducting skin assessments.

Interview with the former Interim Administrator/Nurse Consultant on 08/10/15 at 3:50 PM and on 08/12/15 at 3:00 PM revealed the DON was going on leave starting 05/01/15 and they realized they needed additional nursing staff. She stated the facility decided to let the staff nurses do their own skin assessments, leaving LPN #7 who was the skin nurse, to be free to function as a staff nurse. Further interview revealed on 04/24/15 it was explained to the nurses during a staff meeting that they would be doing the staging, measuring and description of wounds with their head to toe skin assessments weekly. She stated she was unsure who communicated this to the nurses and was unsure of exactly what information was conveyed to the nurses. Interview revealed she was unaware of any nurses voicing concerns or wanting training related to completing skin assessments. Continued interview revealed the weekly Skin Reports was a form that went to the weekly Quality of Care (QOC) Meeting and this form was to list all the wounds in the building with measurements and descriptions of the wounds.

F 314

New order noted. Change dressing every other day. On May 28, 2015, resident scheduled for follow up appointment with Wound Care Clinic. Wound progressed to Stage III decubitus to sacral area in addition to the development of an anal fissure. Sacral wound measured 2.0 x 2.0 x 0.5 with stringy grey tissue to wound bed. Santyl ordered, normal saline wet to dry and cover site daily. Left buttock, normal saline wet to dry and cover site. Wound measures 3.5 x 4.0 x 0.1 yellow and dry red tissue to wound bed. Dressing change ordered daily. Referred to OT for wedge for positioning off buttocks. Physician notified of eleven (11) pound weight loss in one week. On June 6, 2015 at 12:10 A.M. temperature noted. Temperature was 102.4, Tylenol given. Note: The date was 12:10 A.M. on June 7, 2015 as verified by the nurse and time record. On June 7, 2015 Physician notified of elevated temperature and increased wound redness around sacral wound. New order obtained to culture wound and start Levaquin 750mg P.O. for seven days until culture report returns. Wound cleansed and antibiotic started as ordered. 1cm open area approximately 2cm from rectum on lower left buttocks with copious amount of drainage noted. Dressing applied. On June 8, 2015 at 10:50 A.M., Physician notified of a sacral wound with redness and induration spreading down left buttock and up left labia and 1cm open area on left buttock with copious amount of grey/red purulent, malodorous drainage. Physician notified and order obtained to send to ER.

Resident #1 had a comprehensive care plan developed. Resident #1 is no longer a resident at Ridgeway Nursing and Rehabilitation Facility.

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F 314: Continued From page 65

However, on 05/07/15 and the following week, she realized she had not received the weekly Skin Report. Further interview revealed she, the Assistant DON, and the current Administrator audited every chart in the building from 05/07/15 through 05/18/15. The audit consisted of a review of the Nurse's Notes and the completion of the skin assessments. However, they did not do a skin sweep or look at residents' skin because they felt it was just a documentation problem. Per interview, after the process change took place where the staff nurses were to do their own skin assessments to include measuring and staging the wounds, there was no immediate monitoring to ensure the facility wound protocol was followed. However, monitoring should have been implemented.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 03/11/15 with diagnoses which included Dementia, Alzheimer's Disease, Hip Fracture, and Muscle Weakness. Review of the Admission Minimum Data Set (MDS) Assessment dated 03/18/15 revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assist of two (2) for bed mobility, transfers and toileting, always incontinent of urine, frequently incontinent of bowel, and as having no pressure ulcers.

Review of the Braden Scale for Predicting Pressure Sore Risk dated 03/12/15 revealed the facility assessed the resident as being mild risk for pressure sores related to slightly limited sensory perception, often moist, chairfast, slightly

F 314

Resident #2

Resident #2 is an 85yr old female with diagnosis of CHF, insulin dependent diabetes, paraplegia, neuropathy and hypertension. Resident #2 was admitted to Ridgeway on 04/09/14 from Edgewood Nursing Home. On admission Resident #2 had red areas to left breast and groin that appeared to be with yeast. On 06/07/15, a stage II area, 1 X 1cm, was noted, no odor, no drainage. This area healed on 06/28/15. On 07/01/15 area to posterior thigh healed. On 08/04/15 three Stage II areas were noted 1.2cm x 1.2cm, medial coccyx, 1.8cm x 0.2cm, right side 0.5cm x 0.4cm, no foul odor or drainage, scant amount of bleeding noted. Aquacel foam was applied and order to be changed every three days and PRN. On 8/14/15 all areas to coccyx and left buttock healed. A scab, 0.5cm x 0.5cm, was noted to left anterior foot. She continues to have blanchable redness to bilateral buttocks. It should be noted that per the care plan progress notes, Resident #2 refuses to turn and reposition in bed or chair. Resident #2 continues to receive Prostat 30cc BID X 30 days, Vitamin C 250mg QD and Zinc Sulfate 220mg x14 days. Her weight on admission was 201 lbs and 209 lbs currently. Her BUN currently is 38 (7-25), total protein 5.7 (6-8.3) and albumin 3.4 (3.5-5.5). Her hemoglobin 9.8 (12-16) and hematocrit 31.1 (36-48) are low. Despite the above mentioned complication her wounds are healed.

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F 314	Continued From page 66 limited mobility, adequate nutrition, and potential for friction and shear. A score of fifteen (15) was given and according to the Scale, fifteen (15) to eighteen (18) was considered to be mild risk. Review of the Comprehensive Plan of Care dated 03/23/15 revealed Resident #1 had the potential for impaired skin integrity related to immobility with a goal stating the resident would not develop pressure ulcers. The interventions included; monitor for skin intolerance to two (2) hour turning schedule, reposition in wheelchair frequently, turn and reposition every two (2) hours, nursing staff to monitor for indication of skin impalment during daily care, report any red or open areas, and weekly skin assessments by the licensed staff to monitor for any indication of skin breakdown. Review of the Nurse's Note dated 04/06/15 at 1545 (3:45 PM), revealed Resident #1 had a Stage II area measuring two (2) centimeters (cm) length by one (1) cm width with yellow slough noted extending for an undetermined amount into the rectum and the Physician was notified. Review of the Physician's Orders dated 04/06/15 revealed orders for Aquacel AG foam to the left buttock Stage II, change every three (3) days and prn (as needed), and wound clinic referral. Review of the Wound Care Summary (WCS) dated 04/06/15 revealed Resident #1 had a wound to the left buttock. The Acute Care Plan dated 04/06/15 revealed the resident had a pressure ulcer related to decreased mobility; however the care plan did not specify the site or the stage of the pressure ulcer. The goal stated the pressure ulcer would decrease in size and the interventions included; keep skin clean warm and	F 314	Resident #4 Resident #4 is a 62 year old male, who was admitted on 4/10/10 from the hospital. Resident #4 was admitted with Stage II to his right buttock, 1cm x 1cm diameter and left hip with area measuring 6cm x 7cm and approx. 1cm diameter. On 6/14/10 pressure reducing mattress to be was ordered. Vitamin C 250mg was ordered on 12/13/15. Vitamin D3 50,00units was ordered on 05/14/12. Coccyx cutout quadra gel cushion for wheelchair positioning ordered 4/30/13. Senscare protect ointment 113gm 2 times a day was ordered 5/29/13. Zinc Sulfate 220mg ordered 7/5/15 for wound healing. Aquacel AG and Duoderm to SDTI on left buttock, change every 3 days ordered 6/24/15. Aquacel AG and Duoderm to posterior upper Right thigh ordered 6/24/15. Admitting weight 123lbs, 5'9" tall and current weight 176lbs.		

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F 314 Continued From page 67

dry, promote nutritional status, assess for signs and symptoms of worsening of infection or complications daily, treatments as ordered, assess skin daily during care for changes and report to nurse supervisor, Registered Dietitian (RD) to evaluate and assess per policy, and staff to assist with mobility needs of transfers and bed mobility.

Review of the WCS dated 04/09/15 revealed the resident's left buttock pressure ulcer measured 1.5 cm by 3.0 cm and there was an open wound with gray/pale slough, slight odor, and purulent drainage. The WCS dated 04/14/15 revealed the left buttock had an open wound measuring 1.5 cm by 3.0 cm by 0.3 cm and was red with less than twenty-five percent (25%) slough in the wound bed and purulent drainage with slight odor.

The WCS dated 04/21/15 revealed the left buttock wound measured 1.0 cm by 3 cm by 0.3 cm and was an open wound that extended into the rectum with decreased slough, slight odor and purulent drainage.

Further review of the WCS dated 04/21/15 revealed the resident had a new area to the coccyx described as a Stage II pressure ulcer measuring 0.6 cm by 0.4 cm, with red surrounding skin with blanching discoloration, no odor, and scant serosanguinous drainage.

Review of the Physician's Orders dated 04/21/15 revealed orders for DuoDerm to the Stage II ulcer to the coccyx, change every three (3) days and prn.

Review of the resident's care plan revealed no Acute Care Plan was developed for the pressure

F 314

Resident #5

Resident #5 was admitted to Ridgeway Nursing and Rehabilitation on 2/14/13. She is an 89 year old female who has suffered from CVA, G-Tube placement, HTN, Dementia, dysphagia, hyperlipidemia, muscular degeneration, blindness, colon carcinoma with colostomy, renal and bladder concerns and functional quadriplegia. On admission in 2013 Resident #5's coccyx was slightly red and she had multiple issues with yeast infections. On 7/15/13 Resident #5 was noted to an abrasion to her coccyx which was treated with Duoderm. On 7/16/13 the area healed and the Duoderm was discontinued. Resident #5's health has continued to decline over the next two years. She has had numerous hospitalization and the facility and hospital have discussed Hospice/Palliative care with the daughter. The daughter continues to decline Hospice services. The coccyx area reopened in March 2015. Following the area reopening Resident #5 was hospitalized in April 2015, May 2015, June 2015 and July 2015. The area to her coccyx now measures Stage IV 7cm x 11.2cm x 1.9cm with 25% slough and small area to bone exposure, no odor. Stage II right upper thigh/buttocks healed and scabbed over 9/06/15. Stage II to right lower buttocks duoderm ordered. Resident #5 continues to be very ill patient as exhibited by her labs dated 05/07/15; Hemoglobin 8.8 (12-16), Hematocrit 28.5 (36-48), BUN 30 (7-25), total protein 5.4 (6-8.3), albumin 2.6 (3.5-5.5). on 7/13/15 Her BUN elevated to 81 (7-25). On 7/20/15 her wound culture showed MRSA pseudomonas aeruginosa and enterococcus faecium which were treated as ordered. On 9/2/15 her BUN was 63 (7-35mg). This again shows the fragile nature of Resident #5's condition. Resident #5 continues to receive treatments as ordered.

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ulcer identified on 04/21/15.

Review of the Wound Care Clinic Note dated 04/23/15, revealed the resident had a superficial sacral decubitus ulcer and to continue with a hydrocolloid patch, change every three (3) days.

However, review of the Physician's Orders dated 04/23/15, revealed orders to cleanse the sacral decubitus with Normal Saline, apply small piece of foam dressing over the ulcer and secure with Tegaderm, change every shift and pm (as needed).

Review of the Wound Care Clinic Note, dated 05/07/15, revealed the resident's superficial sacral lesions had improved, and the resident had a small fissure at eleven (11) o'clock, continue with hydrocolloid patches and Anusol HC suppository three (3) times a day pm for anal fissure and return in three (3) weeks.

However, review of Physician's Orders dated 05/07/15 revealed orders for Anusol HC suppository one (1) per rectum three (3) times a day pm and review of Physician's Orders dated 05/08/15 revealed orders to cleanse the sacral decubitus with Normal Saline (NS), apply a small piece of foam over the decubitus ulcer, secure with Tegaderm daily.

Review of the Nurse's Notes dated 05/10/15 at 0355 (3:55 AM) revealed Resident #1's oxygen saturation was seventy-three percent (73%) on room air, the physician was notified and the resident was sent to the hospital emergency room.

Review of the Resident Data Collection (RDC)

F 314 Resident #6
Resident #6 is an 88yr old admitted from St. Joseph's Mt. Sterling on 7/9/15. Upon admission resident's weight was 146lbs. Resident was incontinent of bowel and bladder upon admission with a catheter in place. She had a Duoderm in place to her stage II to her left buttock. Heal protectors were applied upon admission. On 8/7/15 the left buttock was measuring as a 0.05cm open area. On 7/31/15, a SDTI was noted on her right buttock with no open areas and no drainage. On 8/13/15, the left buttock and right buttock SDTI were healed. Vitamin D3 2000 unit capsules were ordered on 7/9/15, Benecal 45ml, cyponoheppoter 2mg were ordered on 7/30/15, Prostat was ordered on 8/4/15, zinc ordered on 8/4/15, Vitamin C ordered on 8/4/15 and cyprohetafine ordered on 8/4/15. Vitamin B12 and Vitamin D was upon admission. Met with family about appetite and refusing meal on 7/29/15, a feeding tube placement discussion was put into place on 8/21/15 for decreased intake and Hospice services. A Hospice consult was ordered 8/21/15. Resident was sent to ER on 8/24/15 at 08:30 and passed away there on hospice. At the time of discharge to ER resident's skin was intact and weight at discharge was 132.lbs.

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dated 05/12/15, revealed Resident #1 was re-admitted to the facility and the skin condition was as follows; sacral Stage II, right heel Suspected Deep Tissue Injury (SDTI), and Stage II to sacral area. There was no documented measurements or a description of the ulcers. In addition, the care plan was not revised related to the new SDTI of the right heel.

Review of the Physician's Orders dated 05/12/15, revealed orders to clean the sacral Stage II area with NS, apply Aquacel Foam, change every three (3) days and prn, right heel SDTI bulky dressing secure with Kerlex and change every shift, reclining wheelchair pressure relieving cushion and multipodus boots bilateral to feet when in bed.

Interview with LPN #6, on 08/20/15 at 4:00 PM, revealed she had re-admitted Resident #1 on 05/12/15 and had completed the RDC. She stated she normally would measure the wounds for a re-admission, and she was not sure why she had not done this on 05/12/15. She stated she did check the resident's skin that day and the resident only had the SDTI to the right heel and the Stage II ulcer to the sacrum, and the resident did not have a wound to the left buttock. Continued interview revealed she had not photographed the wounds and only learned last week that she needed to photograph a resident's wounds when they returned to the facility after a hospitalization.

Interview with the DON on 08/19/15 at 5:30 PM, revealed in reference to Resident #1, LPN #6 should have measured and taken photographs of the resident's wounds when the resident was re-admitted to the facility on 05/12/15 because it

F 314 Resident #7

Resident #7 was admitted to Ridgeway Nursing and Rehabilitation on 07/13/15 with diagnosis of acute respiratory failure, pneumonia, vocal cord edema, schizophrenia and chronic renal insufficiency. She had prolonged hospital stay due to a bowel obstruction and surgery. She is a 68 year old female. On admission it was noted she had MRSA to her incision and was placed on Contact Isolation. She had blanchable redness to sacral area and buttocks area. She had multiple scratches and bruises to arms and hands and thighs. On 8/04/15 Resident #7 was noted to have a Stage II area to left medial buttock measuring 0.4cm x 0.2cm, wound bed was pink with no slough, no odor or drainage noted. Four days later a distal area was noted stage II, measuring 0.5cm X 0.2cm x 1.2 cm blanchable redness between wounds. Both areas healed on 8/14/15. Her labs on 07/20/15 revealed a protein level of 5.4 (6-8.3), albumin 3.2 (3.5-5.5), Hemoglobin 10.5 (12-18) and Hematocrit 33.2 (38-48). Her weight on admission was 266lbs and height 56 inches. She was seen by the dietician on 8/12/15 and was noted to have a healing stage II's. The areas healed on 8/14/15. Resident #7 was transferred to the hospital on 8/25/15 in an emergency and died a few hours later.

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F 314	<p>Continued From page 70</p> <p>was policy to take pictures of wounds before a emergency room or hospital visit, if there was time and not a true emergency, and on return from the emergency room or hospital. In addition, she stated all the resident's wounds should have been measured on return from the hospital on 05/12/15.</p> <p>Interview with LPN #13 on 08/11/15 at 6:15 PM and 08/12/15 at 7:00 PM and review of the Treatment Administration Record (TAR) dated May 2015, revealed LPN #13 did the resident's wound treatments on 05/15/15. She stated, she did not remember if the resident had an area on the left buttock on return from the hospital on 05/12/15; however, stated if there was an area there when she did the treatment on 05/15/15, she would have notified the Physician.</p> <p>Review of a Nurse's Note dated 05/23/15 at 0200 (2:00 AM), revealed there was increased drainage to the Stage II pressure ulcer on the resident's sacrum and new orders were received.</p> <p>Review of the Physician's Orders dated 05/23/15, revealed orders for Aquacel AG fiber and non adherent, cover with Tegaderm, change every other day and prn to the sacral ulcer.</p> <p>Review of the Acute Care Plan dated 05/23/15, revealed the resident had a pressure ulcer to the coccyx related to Immobility and Incontinence with a goal stating the resident's pressure ulcer would decrease in size. The interventions included; keep skin clean warm and dry, promote nutritional status, assess for signs and symptoms of worsening of infection or complications daily, treatments as ordered, assess skin daily during care for changes and report to nurse supervisor,</p>	F 314;	<p>Resident #8</p> <p>Resident #8 is a 90 year old who was admitted to Ridgeway Nursing and Rehabilitation on 5/2/14 following a hospital stay. His diagnosis include atrial fibrillation, chronic history of UTI, dysphagia, pain in joints, abnormal posture and muscle weakness, prostate cancer with bone mets, encephalopathy, aortic valve stenosis, BPH, heart failure, bladder cancer, lung nodule, urinary retention and dementia. On 8/8/15 it is noted a stage II area measuring 1cm x 0.5cm was discovered. Aquacel AG Fiber and duoderm ordered. The area is described as a SDTI to upper posterior thigh and stage II areas to left and right medial buttocks. On 8/14/15 the area to the posterior right thigh healed and orders were discontinued. On 8/12/15 area to right medial buttocks healed and treatments discontinued. Resident #8's labs are as follows; BUN 35 (7-25), Creatinine 1.5 (0.6-1.3) on 6/9/15, on 06/25/15 albumin 3.4 (3.5-5.5), Hemoglobin 11.5 (14-18) and Hematocrit 33.2 (42-54). Resident #8 continues on Hospice Services with comfort P.O.C. in place. Skin is intact at this time.</p>

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P 314	<p>Continued From page 71</p> <p>RD to evaluate and assess per policy, and staff to assist with mobility needs of transfers and bed mobility.</p> <p>Continued review of Resident #1's clinical record revealed there was no documented evidence of a Wound Care Summary to include staging, measurements, and descriptions of the wounds after 04/21/15 and no documented evidence Resident #1 received a weekly Skin Assessment to from 04/14/15 until 05/26/15, more than five (5) weeks later, even though the facility's Wound Protocol stated the Wound Care Summaries would be updated weekly and the resident's care plan stated weekly skin assessments would be completed. Also, there was no documented evidence Resident #1's wounds were transcribed to the weekly Skin Report to be taken to the weekly QOC meeting from 04/21/15 until 05/28/15.</p> <p>Interview with LPN #6 on 08/11/15 at 5:00 PM, on 08/12/15 at 10:51 AM, and on 08/20/15 at 4:00 PM, revealed LPN #7 had been completing the weekly Skin Assessment for the facility and she (LPN #6) would complete the weekly Nurses Notes, check the skin and only complete a weekly Skin Assessment if she found a new area of skin breakdown. However, she stated there was a staff meeting in April and the staff nurses were told they would be doing their own skin assessments weekly, but were not told which forms to use. She said it was not an in-service where they had to sign and she did not receive full instructions on what to do related to skin assessments. Further Interview revealed she had completed the weekly Nurses Notes for Resident #1 on 04/28/15, 05/06/15, 05/19/15, and 06/02/15 and was supposed to have completed the weekly</p>	F 314	<p>Resident #9</p> <p>Resident #9 is a 93yr old female admitted to Ridgeway from home on 3/13/15. She was admitted with a stage II to her right mid buttock x 2, the upper measuring 0.3cm x 0.4cm and the lower 0.4cm x 0.5cm. She had a Aquacel treatment in place upon admission her family reported. She was living alone and had family to stay with her 24 hours a day. Family stated she would stay in her recliner all day and sleep there at night. On 6/17/15 the right buttock was healed. On 5/27/15 a stage II was noted to the coccyx left buttock measuring 1.8cm x 2 x 0.2cm. On 6/4/15 and 6/11/15 the measurements were noted to be smaller. On 6/23/15 the left buttock was measuring 0.1cm x 0.1cm with no drainage or odor. As of 9/8/15 the coccyx stage II wound is measuring 0.2cm x 0.2cm with no depth or no drainage. The left buttock wound stage II measuring 0.4cm x 0.4cm with no depth, odor or drainage. On 4/15/15, an Aquacel AG treatment to the coccyx was put into place convening with duoderm. On 4/21/15 a cushion was ordered for the resident's recliner. Resident #9 is in continent of urine. Resident has a diagnosis of hypertension and edema. Resident is currently taking Prostat 30ml twice daily for wound healing which was ordered 3/20/15.</p>		

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Skin Assessments, Wound Care Summaries, and weekly Skin Reports when she did the weekly Nurses Notes. However, she stated she was a "lost ball in high weeds" in May and did not understand she was to do this. In addition, she stated, in May she was not comfortable with staging and measuring wounds.

Review of the weekly Skin Assessment, dated 05/26/15 and completed by LPN #10, revealed the resident was assessed as having a small healing area to the right heel area; however, there was no documentation related to the coccyx ulcer.

Interview with LPN #10 on 08/11/15 at 7:00 PM, revealed she started at the facility in May or June 2015 and was told the nurses were to do their own skin assessments when they did the weekly Nurses Notes; however, she was unaware she was to do the Wound Care Summary or weekly Skin Report for residents with wounds when she did the weekly Skin Assessments. Further interview revealed she was not sure why she did not include all the resident's wounds on the weekly Skin Assessment she completed on 05/26/15; however, stated she did not receive any in-service when hired related to how to do the skin assessments.

Review of the next weekly Skin Assessment completed by LPN #13, dated 05/28/15, revealed the resident had a Stage II pressure ulcer to the sacrum which measured 2 cm by 3 cm by 1 cm depth with eschar (dead tissue) noted in the wound and a fluid filled blister on the right side of the wound; a SDT to the right heel which measured 2 cm by 2 cm and was dark purple. However, review of the weekly Skin Report

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Resident #10 continues to reside in the facility. His physician had been made aware of his current status.

Resident #10 is an 85 year old was admitted to Ridgeway Nursing and Rehabilitation on 2/2/15. His diagnosis include urinary retention, BPH, Parkinson disease, dementia with behaviors, HTN, DM stage II, chronic kidney disease, dysphagia, hyperlipidema, generalized weakness, hematuria with unclear etiology. On 2/16/15 upon readmission to the facility a stage II area to right sacrum measuring 1cm x 0.8cm, red, no odor or drainage was noted with 6cm non-blanching redness to 12:00. Aquacel foam ordered and applied. On 3/12/15 this area healed. On 3/22/15 the right buttock/sacral area 1cm x 1cm, red, no odor, serous drainage surrounding skin with blanchable redness. Duoderm ordered and applied. This area healed on 4/14/15. On 4/21/15 a suspected deep tissue injury 1cm x 1cm non-blanching, no odor or drainage was noted to right coccyx. This area continues to be treated. On 2/16/15 upon readmission a 4.5cm x 4 cm, red/purple blister was noted to his right heel. This was diagnosed as MRSA and treated. The right heel continues to be open despite wound care clinic consultation on several dates and several debridements. Current wounds' measurements are right heel stage IV, 6.8cm x 6.7cm x 1.2cm with 1.7cm tunneling at 6:00 and 8:00, coccyx unstageable 3cm x 1.7cm x

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completed by LPN #13, dated 05/28/15 revealed the resident had an open area to the left buttock measuring 3 cm by 1 cm which was not staged.

Interview with LPN #13 on 08/11/15 at 6:15 PM and 08/12/15 at 7:00 PM revealed when she completed the Skin Assessment on 05/28/15, the resident was noted to have a Stage II to the left buttock and she should have documented the stage of the ulcer on the weekly Skin Report and should have documented this area on the weekly Skin Assessment. She stated she did not consistently work the same unit and most nurses at the facility floated to different units. Further interview revealed they had a nursing meeting which was not an in-service and were told they would be doing their own skin assessments sometime several months ago. She stated there was no in-service given related to how to measure and stage wounds and she was not comfortable staging wounds.

Review of the Wound Care Clinic Note dated 05/28/15, revealed the wound status had declined for the sacral decubitus which measured 2.0 by 2.0 by 0.5 with stringy gray tissue to the wound bed, the left buttock measured 3.5 by 4.0 by 0.1 cm with yellow and dry red tissue to the wound bed with a superficial ulcer in area. The recommendations revealed apply Santyl Ointment to sacral decubitus, cover with NS wet to dry and cover site daily and NS wet to dry and cover site daily to the left buttock.

New Physician's Orders were received on 05/28/15 to clean the left buttock Stage II with NS, wet to dry dressing, and coverderm every day and pm and to irrigate the sacral decubitus ulcer with Normal Saline, Santyl Ointment and

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1.2cm depth, 3.2cm tunneling at 12:00, right ischael ulcer 3.8cm x 4cm x 3.6cm with foul odor and current treatment is a wound vac to be changed every 2 days to each area. Resident# 10's weight on admission was 174.5lbs; his weight on 9/2/15 was 179lbs. He has been treated with numerous antibiotics including Vancomycin, Ceftin, Bactrim and Ampicillin. It should be noted that Resident #10 has Iplus edema to lower extremities and requires Lasix 60mg daily to keep the edema to 1 plus.

Resident #11
Resident #11 was admitted on 1/7/2005 to Ridgeway Nursing and Rehabilitation. She has diagnosis of dementia, bipolar, anxiety and depression. Documented on 7/26/15 her left inner upper buttock was a stage2 measuring 0.8cm x 0.6cm with a Aquacel foam dressing. This area along with the STDI measuring 0.5cm x 0.5cm on 7/26/15 were healed on 8/10/15. Sencicare was applied twice daily as needed. Resident has a wheelchair cushion ordered while up in wheelchair on 8/19/15. Resident takes a multivitamin daily as of 1/11/12. Baza protective cream was ordered 3/11/13. Nystatin to groin and bilateral breast. Resident has been receiving Benecalorie 45ml and Prostat 30ml. Resident #11 is up in her wheelchair daily. Since resident's skin is so fragile her area

opens and closes often while being moved or repositioned. Resident #11 continues to receive treatment as ordered

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cover with NS wet to dry dressing, coverderm every day and prn. Refer to Occupational Therapy for wedge for positioning off buttocks.

Further review revealed there was no more weekly Skin Assessments completed for this resident after 05/28/15. However, review of the weekly Skin Report dated 06/04/15 (document which was to be completed weekly for all residents with wounds to take to the weekly Quality of Care (QOC) Meeting), revealed the resident had a sacral/left buttock wound which measured 9.5 cm by 6 cm by 0.5 cm with 75% eschar and 25% red/purple wound bed with purulent drainage and the Report indicated this wound had worsened.

Interview with LPN #7 on 08/10/15 at 7:00 PM, revealed she had documented the weekly Skin Report dated 08/04/15 and the measurement performed was for the sacral area only. She stated she had measured the right heel and had documented the right heel wound on 06/04/15 as SDTI 2 cm by 2.8 cm purple on the weekly Skin Report, which was not dated. However, she had forgotten to document the area to the left buttock. Further interview revealed she had not followed through with documenting the wounds on the Wound Care Summary as per protocol or on the weekly Skin Assessments. She stated she noted the sacral/buttocks wound had worsened but she did not feel the need to notify the Physician because it was not an emergency such as a cardiac concern. Per interview, the resident would be going to the wound clinic later that day and she decided to pass the information on in report.

Review of the Wound Care Clinic Note dated

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Resident #12
Resident #12 is a 57 year old female who was admitted to Ridgeway Nursing and Rehabilitation on 01/26/15. Her diagnosis include Down's syndrome, COPD, HTN, Mood disorder, sleep apnea, neurocognitive disorder due to Alzheimer's disease with behavioral issues, hyperlipedemia, and osteoarthritis. On admission, 01/26/15, it was noted that Resident #12 had a stage III area with foul odor, eschar and slough which measured 3cm x 2cm x 0.9cm. She had a rash to her right foot and multiple small scratches. It was noted she had MRSA infections to the wound on admission. An ulcer developed on 02/04/15 to posterior left thigh. Aquacel AG and Aquacel foam applied. This area healed on 5/28/15 and reopened and healed again on 9/14/15. The coccyx area has decreased in size since admission to stage II. On 8/16/15 the area measured 1cm x 2cm with no measurable depth, slight yellow drainage and pink wound bed. Her labs include pre albumin 13 (16-45mg/dl) on 5/14/15, total protein 5.2 (6-8.3) on 4/9/15, albumin 2.5 (3.5-5.5) on 4/9/15. This resident has multiple behaviors noted. Resident #12 has a gel overlay to bed

and continues to improve. This resident continues to receive treatment as ordered by the physician.

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06/04/15, revealed the decubitus was now one (1) big ulcer, gray wound bed to 80%, red granulation to 20%, measures 10 by 6 by unknown depth. The recommendations were to apply Santyl to wound bed twice a day, cover with NS wet to dry and foam dressing to secure today, evaluate nutritional status, and evaluate for Foley catheter.

New Physician's Orders were received 06/05/15 to change the treatment to the sacral decubitus to twice a day.

Continued record review, revealed Resident #1 experienced a fever starting on 06/06/15 at "00:10" (12:10) AM and the physician was not notified of the fevers until 06/07/15 at 3:50 PM, over thirty-nine (39) hours later, although the fever continued.

Review of the Nurse's Notes dated 06/06/15 at 2410 (12:10 AM), completed by LPN #11, revealed Resident #1 was very hot to touch and her/his face was flushed and the resident's temperature was checked which was up to 102.4 degrees, Tylenol 500 milligrams (mg's) (medication for pain relief and fever reducer) was administered and the nurse would continue to monitor.

Review of the Medication Administration Record (MAR) dated June 2015, revealed the Tylenol 600 mg was administered on 06/06/15 at 2410; however, there was no documentation on the MAR or further documentation in the Nurse's Notes to indicate if the medication was effective.

Interview with LPN #11 on 08/20/15 at 9:30 AM, revealed at the time she wrote the Note on 06/06/15 she obtained a full set of vital signs, but

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2. All nurses (with the exception of one on FMLA and a PRN nurse) were educated on August 13, 2015 concerning weekly skin assessments, wound documentation, measuring wounds (width, length, and depth) staging, describing peri wound area and wound bed. Wound documentation procedure, photos on admission and discharge (non-emergent). Dressing change procedure, washing hands and infection control. Each nurse was required to measure wound examples and document their assessment. This in-service was conducted by Sally Baxter, RN, Vice-President of Clinical Services. On August 14, 2015, skin assessments were performed and documented on all residents by the Director of Nursing and four RN's with the assistance of four LPN's. No skin issues were identified that had not been identified on previous skin assessments. In addition, on August 14, 2015, Sally Baxter, R.N., Vice-President of Clinical Services, and Lauren Sword, Administrator, completed a comprehensive review of all care plans to ensure they are updated as appropriate and care plan approaches are in place and being followed. Physician orders are reviewed daily with the facility's inter-disciplinary team and the care plans updated as appropriate. The Administrator, Director of Nursing, Charge Nurses, Rehab Director and MDS Coordinator are all part of this meeting. On the weekends, the RN Charge Nurse will be responsible for updating the care plans

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did not document them. She further stated she did the wound dressing that shift and although she could not remember what the wound looked like, she would have notified the Physician if she had noted a change in the wound. Further interview revealed she did not notify the Physician of the temperature because the resident had a standing order for Tylenol for temperature. Continued interview revealed she always followed up with taking another temperature after she had given Tylenol for a fever, and just failed to document the effectiveness of the medication.

There was no Nurse's Note on the subsequent shift (day shift for 06/06/15) and no documented evidence the nurse on the day shift 06/06/15 assessed this resident except for obtaining a temperature which was recorded on the MAR.

Review of the June 2015 MAR revealed on 06/06/15 at 1430 (2:30 PM) Tylenol 500 mg was administered for a temperature of 101.6 and the resident's temperature decreased to 97.0 at 1730 (5:30 PM).

Interview with LPN #9 on 08/21/15 at 2:10 PM, revealed she would normally assess the resident if the resident had a temperature from the shift before and in this case it would include assessing the resident's wound and obtaining vital signs. She stated she checked the resident's wound when she did the dressing on that shift and there was no redness or induration around the wounds and the wounds did not look infected. Continued interview revealed a temperature was a change in condition for the resident; however, she did not notify the Physician because the resident's temperature came down with Tylenol. Further interview revealed she failed to write a note

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3. Daily for one month the Director of Nursing, or her designee, will audit two (2) residents' skin conditions and related documentation. On the weekends, the RN Charge Nurse will complete this audit. If no further problems are identified, then on a weekly basis, the Director of Nursing, or her designee, will audit two (2) residents' skin condition and documentation related to the residents' skin condition. All licensed nursing staff were educated on 08-13-15 by a Convatec representative, the Director of Nursing, Administrator and Vice President of Clinical Services. Wound description, documentation including updating the plan of care and treatment records were reviewed in the session.

As part of the licensed nursing orientation wound care will be reviewed this review will include documentation requirements and updating the plan of care. Competency will be ensured for all nurses during quarterly competency check off's. This facility does not utilize agency staff.

4. As part of the facility's ongoing Quality Assurance Program, monthly an Administrative Nurse will audit 5% of the residents by conducting a head to toe skin assessment and compare their assessment to what is documented in the Clinical Record. Any deviations will be reported to the Administrator immediately and the nurse will be re-educated. In addition, pressure ulcers will be a focus of the facility's continuous Quality Improvement Committee for the next six (6) months. Any identified problems will be addressed and followed upon by the Committee with the nursing staff and re-education provided as appropriate. In addition, nurse competency testing will

be completed quarterly for the next year, this includes nurses from all shifts, relating to wound assessment, measurement and staging, as another Quality Improvement Measure. If there are concerns identified during the audits related to documentation, transcribing orders or updating the resident's plan of care the Director of Nursing will provide re-education to the offending nurse or nurses.

5. August 25, 2015

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related to her assessment of the resident.

Continued review of the June 2015 MAR revealed LPN #8 had documented on 06/07/15 at 1045 (10:45 AM) Tylenol (no dosage noted) was administered for a temperature of 101.6 and the resident's temperature came down to 99.2 at (1200) 12:00 PM.

Review of the Physician's Orders dated 06/7/15 at 1550 (3:50 PM), received by LPN #8 revealed orders for a culture of the sacral wound with the next dressing change due to odor, temperature, and drainage. After culture obtained start Levaquin (antibiotic medication) 750 milligrams every day for seven (7) days until the wound culture was received.

Further review of the June 2015 MAR revealed the resident again received Tylenol on 06/07/15 at 1650 (4:50 PM), for a temperature of 102 degrees, and there was no notation on the MAR to indicate if the medication was effective for the temperature.

Although the physician was notified of a change in the sacral wound and the resident having a temperature on 06/07/15 at 1550 (3:50 PM), there was no documentation in the Nurse's Notes of an assessment of the resident related to the wound and the temperature on that shift by LPN #8.

Interview with LPN #8 on 08/11/15 at 7:00 PM revealed she had looked at the wound on 06/07/15 and it looked bad so she called the Physician for orders. She said the skin around the wound was red and inflamed and the wound looked infected but there was no drainage. Further interview revealed she did not usually

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