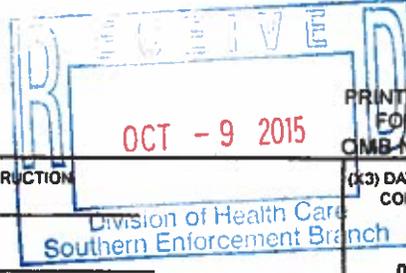


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SCD



PRINTED: 10/05/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/06/2015
NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p><b>*AMENDED*</b></p> <p>An abbreviated survey (complaints KY23355 and KY23637) was initiated on 06/16/15 and concluded on 06/23/15. KY23355 was substantiated with no deficient practice identified. KY23637 was substantiated; however, no deficient practice was identified.</p> <p>After supervisory review, complaints KY23355 and KY23637 were reopened on 07/21/15 for further investigation and complaint KY23545 was initiated on 07/21/15. The investigation concluded on 08/06/15. KY23355 was substantiated with no deficient practice identified. KY23545 and KY23637 were substantiated with deficient practice identified. Immediate Jeopardy was identified on 07/29/15 and determined to exist on 02/23/15 at 42 CFR 483.20 Resident Assessment (F280 - "J"), 42 CFR 483.25 Quality of Care (F314 - "J"), and 42 CFR 483.75 Administration (F514 - "J"). Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F314). The facility was notified of the Immediate Jeopardy on 07/29/15.</p> <p>A recertification survey was initiated on 08/04/15 and concluded on 08/06/15. A life safety code survey was conducted on 08/05/15. Additional deficient practice was identified at 42 CFR 483.15 Quality of Life (F246 - "D" and F253 - "E"), 42 CFR 483.25 Quality of Care (F309 - "D" and F323 - "E"), and 42 CFR 483.65 Infection Control (F441 - "D"), 42 CFR 483.70 Physical Environment (F469 - "E").</p> <p>The facility failed to identify tissue injury on</p>	F 000	<p>The response provided is not an agreement with the findings but is provided to meet State and Federal requirements under regulation.</p> <p><b>F246</b></p> <p><b>What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?</b></p> <p>Resident #8 was discharged to home on 7/21/15.</p> <p><b>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</b></p> <p>Residents have the right to reside and receive services in the facility</p>	F246 Sept 21 2015

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

TITLE  
NHA

(X6) DATE  
09/18/2015

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 60 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 000	<p>Continued From page 1</p> <p>Resident #1's heels prior to his/her transfer to the hospital on 02/23/15, where the Physician and the nurse documented the presence of necrotic tissue on both heels. After Resident #1 returned to the facility on 02/25/15, several pressure areas were tracked with regular assessments; however, on 04/15/15, the resident was again transferred to the hospital, where five (5) additional unidentified pressure ulcers were photographically documented. Facility records revealed no documented evidence these five (5) areas had been identified, assessed, monitored, or treated according to the facility's policy while Resident #1 resided at the facility.</p> <p>Resident #1's Care Plan identified the resident to be at risk for skin impairment, but the care plan was not revised to show the actual problem of "denuded skin" on the resident's buttocks, which was documented in the Nurse's Notes and was determined to exist from 10/19/14 until 02/23/15, when Resident #1 was admitted to the hospital. In addition, after the facility readmitted the resident on 02/25/15, Care Plan revisions did not include specific interventions for monitoring multiple pressure ulcers, which were identified to exist while the resident was hospitalized, nor did it reflect the status of the ulcers when they deteriorated and signs of infection were present.</p> <p>In addition, Resident #1's medical record was not complete and accurate as it related to pressure sores when staff did not follow the facility's policies and procedures for documentation of wounds. Furthermore, according to the "Assessment Date," all Body Map Assessments provided by the facility for the period of time between 02/25/15 and 04/15/15 appeared to have been completed on 07/28/15, the day they were</p>	F 000	<p>with reasonable accommodation of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered. The facility does and will continue to provide services for individual needs and preferences. A review of all treatment time for wound care patients will be conducted by September 20, 2015 to determine the level of satisfaction for each patient. The review of these times will be conducted by interviewing each wound patient to determine if any patient dissatisfaction exists. The reviews will be conducted by the Director of Nursing, Nurse Educator, Wound Nurse,</p>	F 24 <sup>th</sup> Sept 21 2015	

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F 000	Continued From page 2 requested by the State Survey Agency.  An extended survey was conducted on 08/06/15. An acceptable Allegation of Compliance (AOC) was received on 08/06/15, which alleged removal of the Immediate Jeopardy on 08/05/15. The State Survey Agency determined the Jeopardy was removed on 08/05/15, as alleged. The scope and severity of the Immediate Jeopardy tags was lowered to "D" at 42 CFR 483.20 Resident Assessment (F280), 42 CFR 483.25 Quality of Care (F314), and 42 CFR 483.75 Administration (F514) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	or Social Worker. Any concern about treatment time will be provided to the Director of Nursing and Administrator to ensure physician notification by the licensed nurse for reasonable accommodation for treatment times for the resident.		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  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 failed to ensure each resident received services in the facility with reasonable accommodation of individual needs and preferences for one (1) of twenty-four (24) sampled residents (Resident #8). The facility failed to provide Resident #8 with twice per day scheduled wound care, per the	F 246	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  Licensed nursing staff will be educated by the Director of Nursing and/or Nurse Educator beginning on	F 246 Sept 21 2015	

#472 P.004/112

10/08/2015 10:20

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10/14/13 3:11 PM 10-09-2015

From: Stanton Nursing and Rehab.

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F 246	<p>Continued From page 3 resident's preferred hours.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan Policy Statement," undated, revealed an individual comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs would be developed for each resident. Continued review of the policy revealed the care plan should reflect the resident's expressed wishes regarding care and treatment goals. Further review of the policy revealed the resident had the right to refuse to participate in the development of his/her care plan and medical and nursing treatment; however, when refusals were made, appropriate documentation would be entered into the resident's clinical record in accordance with established protocols.</p> <p>Review of the facility's policy titled "Refusal of Treatment," revised November 2010, revealed if a resident refused treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services would interview the resident to determine what and why the resident was refusing in order to try to address the resident's concerns and explain the consequences.</p> <p>Review of the clinical record revealed the facility admitted Resident #8 on 07/14/15 with diagnoses which included severe Hidradenitis Suppurativa of Bilateral Axillary and undemeath Pannus region with Cellulitis and small abscesses, Anxiety, Depression, Possible Urinary Tract Infection, and Anemia. Review of the Nursing Admission Assessment dated 07/14/15, revealed Resident #8 was alert and oriented with no memory</p>	F 246	<p>September 11, 2015 and completed by September 20, 2015 in regards to documentation of any resident refusals of treatment, including the reason given for refusal and that the licensed nurse shall contact the physician to make reasonable changes to treatment hours per resident request. The Director of Nursing, Unit Manager or MDS Nurse will update the plan of care to communicate the resident requests for change in treatment times. This education also includes discussion of accommodation of needs by providing wound treatment in compliance with the</p>	<p>F 246 Sept 21 2015</p>	

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F 246	<p>Continued From page 4 problems.</p> <p>Review of the Physician's Orders dated 07/14/15, revealed an order for wound care to cleanse the left axilla and right groin with Normal Saline, pack with Aquacel AG (wound dressing), and cover areas with Mepilex AG (wound dressing) twice each day.</p> <p>Review of the Comprehensive Care Plan dated 07/14/15, revealed Resident #8 was care planned for impaired skin to the axilla and right groin. Further review revealed the interventions included for the nurse to document daily on any aspect of wound healing and treatments as ordered.</p> <p>Review of Resident #8's Treatment Administration Record (TAR) dated July 2015, revealed the resident had an order for wound care to be performed BID (twice each day). Continued review revealed the wound care was scheduled on the TAR to be performed once during the 7:00 AM shift and once during the 7:00 PM shift. Further review revealed wound care was refused on 07/15/15 during the 7:00 AM shift, and was not performed on 07/14/15, 07/15/15, 07/16/15, 07/17/15, or 07/20/15 on the 7:00 PM shift. However, there was no documented evidence to indicate why the care was refused or not performed.</p> <p>Interview with Resident #8 on 07/23/15 at 8:59 PM, revealed the facility would perform wound care once per day around 4:00 PM or 5:00 PM. Continued interview revealed staff would come in very late at night around midnight or very early in the morning around 5:00 AM, and she would tell staff it was too late at night or too early in the morning to do the wound care. Resident #8</p>	F 246	<p>corresponding physician orders, updating care plans to reflect preferences for treatment including providing care in respect to normal sleeping hours of the residents and notifying the resident physician in the event the resident continues to refuse treatment after reasonable accommodations have been made. How will the facility monitor its performance to ensure that solutions are sustained? The Social Worker, Wound Nurse or Director of Nursing will conduct five interviews weekly for four weeks to determine resident satisfaction with current treatment times.</p>	F 246 Sept 21 2015	

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F 246	<p>Continued From page 4 problems.</p> <p>Review of the Physician's Orders dated 07/14/15, revealed an order for wound care to cleanse the left axilla and right groin with Normal Saline, pack with Aquacel AG (wound dressing), and cover areas with Mepilex AG (wound dressing) twice each day.</p> <p>Review of the Comprehensive Care Plan dated 07/14/15, revealed Resident #8 was care planned for impaired skin to the axilla and right groin. Further review revealed the interventions included for the nurse to document daily on any aspect of wound healing and treatments as ordered.</p> <p>Review of Resident #8's Treatment Administration Record (TAR) dated July 2015, revealed the resident had an order for wound care to be performed BID (twice each day). Continued review revealed the wound care was scheduled on the TAR to be performed once during the 7:00 AM shift and once during the 7:00 PM shift. Further review revealed wound care was refused on 07/15/15 during the 7:00 AM shift, and was not performed on 07/14/15, 07/15/15, 07/16/15, 07/17/15, or 07/20/15 on the 7:00 PM shift. However, there was no documented evidence to indicate why the care was refused or not performed.</p> <p>Interview with Resident #8 on 07/23/15 at 8:59 PM, revealed the facility would perform wound care once per day around 4:00 PM or 5:00 PM. Continued interview revealed staff would come in very late at night around midnight or very early in the morning around 5:00 AM, and she would tell staff it was too late at night or too early in the morning to do the wound care. Resident #8</p>	F 246	<p>Any identified issue will be addressed with the physician by the licensed nurse. Results of the interviews will be forwarded to the QA Committee for review and appropriate response. The Quality Assurance Committee is comprised of the Administrator, Director of Nursing, Unit Managers, Social Services, MDS Nurse, Medical Director, Therapy Director, Dietary Manager, and Activities Director. Documentation of wound care treatment will be reviewed by the QA Committee twice weekly for four weeks and then</p>	<p>F246 sept 21 2015</p>	

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F 246	Continued From page 5 stated she slept at night and did advise staff they should not wake her up to do wound care.  Review of the Nurse's Notes for Resident #8 revealed no documented evidence wound care was refused or not performed per the Physician's orders. Continued review revealed no documented evidence the facility attempted to accommodate the resident's treatments and care per Resident #8's preference of not being awakened during his/her sleep for twice-daily wound care to be performed.  Interview with Licensed Practical Nurse (LPN) #4 on 07/24/15 at 6:56 AM, revealed she was Resident #8's Primary Nurse on the 7.00 PM shift. Further interview revealed she would normally perform wound care between 10:30 PM and 7:30 AM. Continued interview revealed Resident #8 had refused his/her wound care, reporting to LPN #4 that he/she was already tired and it was too late. LPN #4 stated she was too busy with her medication pass to perform Resident #8's wound care while the resident was awake.  Interview with the Director of Nursing (DON) on 08/03/15 at 6:25 PM revealed she was unsure whether staff should accommodate a resident's preference in accordance with the resident's customary daily routine regarding wound care. The DON further stated it was very important for the residents to receive the wound care and treatments that were ordered by the physician, but the nursing staff was very busy with the medication pass at the start of the shift.	F 246	weekly for four weeks.  Findings will be summarized and appropriate response taken by the QA Committee to assure compliance.  Compliance Date: September 21, 2015	F246 Sept 21 2015	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	F253  46What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?	F253 Sept 21 2015	

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F 253	<p>Continued From page 6</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's maintenance policy and work orders, it was determined the facility failed to provide maintenance services to ensure an orderly interior for thirteen (13) of forty-six (46) resident rooms. Observations on 08/06/15 revealed resident rooms had scarred walls, holes in the drywall, missing baseboard, rusted doors/doorframes, and loose fixtures.</p> <p>The findings include: Review of the facility's policy titled "Maintenance Protocol," undated, revealed the facility utilized the TELS system (a computerized work order and preventive maintenance system) to identify items for needed repair.</p> <p>Observations conducted during a tour on 08/06/15 at 10:30 AM with the Maintenance Supervisor revealed the following items in resident rooms to be in disrepair: a missing section of baseboard on the corner near the sink in room 111; a loose bathroom door handle fixture in room 112; scarred and chipped drywall near the window and heat/air unit in room 110; a rusted doorframe going into the bathroom at floor level of room 107; scarred and scratched walls in room 108; a missing baseboard and rusted/scratched closet door in room 104; chipped drywall under the sink in room 101; chipped drywall by the sink</p>	F 253	<p>No residents were found to have been negatively impacted by the deficient practice. The facility has a continuing maintenance program that addresses scarred walls, holes in drywall, missing baseboard, rusted door frames and loose fixtures.</p> <p>The following repairs have been made as of September 20, 2015:</p> <ol style="list-style-type: none"> <li>1) Replace missing baseboard in room 111</li> <li>2) Repair loose bathroom door handle in room 112</li> <li>3) Repair scarred and chipped drywall in room 110</li> <li>4) Repair rusted doorframe in room 107</li> <li>5) Repair walls in room 108</li> <li>6) Repair baseboard and closet door in room 104</li> <li>7) Repair drywall in room 101</li> <li>8) Repair drywall and broken tile in room 121</li> <li>9) Repair drywall in front dining room</li> <li>10) Repair drywall near entry door of room 222</li> <li>11) Replace missing baseboard in rom 201</li> <li>12) Repair drywall and baseboard in room 202</li> <li>13) Repair drywall in room 204</li> <li>14) Repair toilet seat in room 206</li> </ol>	<p>F253 Sept 21 2015</p>	

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F 253	<p>Continued From page 6</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's maintenance policy and work orders, it was determined the facility failed to provide maintenance services to ensure an orderly interior for thirteen (13) of forty-six (46) resident rooms. Observations on 08/06/15 revealed resident rooms had scarred walls, holes in the drywall, missing baseboard, rusted doors/doorframes, and loose fixtures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Maintenance Protocol," undated, revealed the facility utilized the TELS system (a computerized work order and preventive maintenance system) to identify items for needed repair.</p> <p>Observations conducted during a tour on 08/06/15 at 10:30 AM with the Maintenance Supervisor revealed the following items in resident rooms to be in disrepair: a missing section of baseboard on the corner near the sink in room 111; a loose bathroom door handle fixture in room 112; scarred and chipped drywall near the window and heat/air unit in room 110; a rusted doorframe going into the bathroom at floor level of room 107; scarred and scratched walls in room 108; a missing baseboard and rusted/scratched closet door in room 104; chipped drywall under the sink in room 101; chipped drywall by the sink</p>	F 253	<p>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</p> <p>All residents could have the potential to be affected by the deficient practice. A room-to-room audit was completed by the Administrator and Maintenance Director by September 20, 2015 to update the repair schedule and prioritize any identified needed repairs not already identified.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>All employees were educated by the Education Nurse in regards to use of the TELS system for reporting needed repairs in resident areas and work areas, including the need to</p>	<p>F 253 2/14 21 2015</p>	

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F 253	<p>Continued From page 6</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's maintenance policy and work orders, it was determined the facility failed to provide maintenance services to ensure an orderly interior for thirteen (13) of forty-six (46) resident rooms. Observations on 08/06/15 revealed resident rooms had scarred walls, holes in the drywall, missing baseboard, rusted doors/doorframes, and loose fixtures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Maintenance Protocol," undated, revealed the facility utilized the TELS system (a computerized work order and preventive maintenance system) to identify items for needed repair.</p> <p>Observations conducted during a tour on 08/06/15 at 10:30 AM with the Maintenance Supervisor revealed the following items in resident rooms to be in disrepair: a missing section of baseboard on the corner near the sink in room 111; a loose bathroom door handle fixture in room 112; scarred and chipped drywall near the window and heat/air unit in room 110; a rusted doorframe going into the bathroom at floor level of room 107; scarred and scratched walls in room 108; a missing baseboard and rusted/scratched closet door in room 104; chipped drywall under the sink in room 101; chipped drywall by the sink</p>	F 253	<p>promptly report areas or room or equipment needing repair. This education began on 9/15/15 and continued through 9/20/15. From 9/20/15 on, no existing employee assumed work duties until education received and this education has been included for all new hires.</p> <p>Department managers were educated by the Administrator concerning the scope and reporting of issues identified during rounds and proper utilization of the room round audit sheet. This education was completed by 9/15/15.</p> <p>How will the facility monitor its performance to ensure that solutions are sustained? The Administrator will monitor the TELS system daily during the work week to review work orders for repair and completion.</p>	F253 Sept 21 2015	

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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 253	<p>Continued From page 6</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's maintenance policy and work orders, it was determined the facility failed to provide maintenance services to ensure an orderly interior for thirteen (13) of forty-six (46) resident rooms. Observations on 08/08/15 revealed resident rooms had scarred walls, holes in the drywall, missing baseboard, rusted doors/doorframes, and loose fixtures.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Maintenance Protocol," undated, revealed the facility utilized the TELS system (a computerized work order and preventive maintenance system) to identify items for needed repair.</p> <p>Observations conducted during a tour on 08/06/15 at 10:30 AM with the Maintenance Supervisor revealed the following items in resident rooms to be in disrepair: a missing section of baseboard on the corner near the sink in room 111; a loose bathroom door handle fixture in room 112; scarred and chipped drywall near the window and heat/air unit in room 110; a rusted doorframe going into the bathroom at floor level of room 107; scarred and scratched walls in room 108; a missing baseboard and rusted/scratched closet door in room 104; chipped drywall under the sink in room 101; chipped drywall by the sink</p>	F 253	<p>The Administrator and Maintenance Director will complete walking rounds of the facility weekly for four week to validate that work orders marked as completed in TELS have been completed satisfactorily and to identify any new potential repair issues. Room rounds will be conducted by Department Managers five times a week on an on-going basis. The results of both the Administrator and Maintenance Director review, as well as the Department Director findings will be provided to the QA Committee for review and appropriate response.</p> <p>Compliance Date: September 21, 2015</p>		

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F 253	Continued From page 7 and a broken floor tile by the bathroom in room 121; scarred/chipped drywall in the front dining room; chipped drywall near the entry door of room 222; missing baseboard by the sink in room 201; chipped drywall and missing baseboard by the sink in room 202; scarred drywall by the sink in room 204; and a loose toilet seat fixture in the bathroom of room 206.  Review of work orders on 08/06/15 in the TELS Maintenance System revealed the items in disrepair identified on the tour did not have a work order generated or had not been placed in the TELS Maintenance System to schedule for repair.  Interview conducted with the Maintenance Supervisor on 08/06/15 at 11:10 AM, revealed the Department Heads make room rounds daily to identify items in need of repair and the items in need of repair were entered into the TELS Maintenance System. Further interview with the Maintenance Supervisor revealed he made rounds weekly to identify items in need of repair. The Maintenance Supervisor stated he had maintenance concerns with higher priority, and had not been able to complete the above noted repairs.	F 253		F253 Sept 21 2015	
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed	F 280	F280 What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?	F280 Sept 21 2015	

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F 280	<p>Continued From page 8</p> <p>within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised to reflect changes in the resident's skin condition, for one (1) of twenty-four (24) sampled residents (Resident #1).</p> <p>Resident #1's Care Plan identified the resident to be at risk for skin impairment, but was not revised to show the actual problem of "denuded skin" on the buttocks, which was documented in the Nurse's Notes to exist from 10/19/14 until 02/23/15, when Resident #1 was admitted to the hospital.</p> <p>After the resident was readmitted to the facility on 02/25/15, the care plan revisions did not include specific interventions for monitoring the multiple pressure ulcers, which the facility had not identified prior to the resident going to the hospital (they were identified upon admission to the</p>	F 280	<p>Resident #1 was discharged from the facility on 4/15/15.</p> <p>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</p> <p>All residents are at risk for developing pressure ulcers due to physical dependency, decreased cognition, decreased mobility and age-related comorbidities.</p> <p>A 100% audit of the current resident census (71 residents) was completed on August 4, 2015 by the Director of Nursing, Unit Managers, Nurse Educator, and Wound Nurse with no additional unidentified pressure ulcers found. All residents were assessed using the skin assessment worksheet,</p>	F 280 Sept 21 2015	

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F 280	<p>Continued From page 9 hospital). Nor did the Care Plan reflect the status of the ulcers when they deteriorated and signs of infection were present.</p> <p>The facility's failure to revise the Comprehensive Care Plan for each resident having pressure sores to ensure the necessary treatment and services was provided to promote healing, prevent infection, and prevent new sores from developing caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/29/15, and was determined to exist on 02/23/15. The facility was notified of the Immediate Jeopardy on 07/29/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/06/15, alleging removal of the Immediate Jeopardy on 08/05/15. The State Survey Agency determined the Immediate Jeopardy was removed on 08/05/15 as alleged, which lowered the scope and severity to "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's "Care Plan Policy Statement," undated, revealed a comprehensive care plan designed to meet the medical, nursing, mental, and psychological needs was developed for each resident. Continued review revealed any licensed nurse or interdisciplinary team member could update the care plan to reflect changes. Continued review revealed resident assessments were ongoing and care plans were to be revised as information about the resident and the</p>	F 280	<p>Braden tool, Stop and Watch Tool, and review of current medical history to ensure that risks had been identified and interventions implemented to promote healing and prevent further breakdown of skin on the resident plan of care.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Licensed nursing staff received in-service education by the Director of Nursing, Unit Manager and/or Nurse Educator beginning on 8/3/15 with a completion date of 8/4/15 on how to identify risk factors for developing pressure ulcers and how to develop a</p>	F280 sept 21 2015

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F 280	<p>Continued From page 10 resident's condition changed.</p> <p>Review of the facility's "Skin System Policy &amp; Procedure," revised 08/14/15, revealed for a resident with a pressure ulcer or other skin compromise, the Care Plan would be reviewed and updated each week until the wound healed.</p> <p>Review of the clinical record revealed Resident #1 was admitted by the facility on 10/02/13 with diagnoses that included Dementia, Depression, Hypertension, Chronic Pain, and Delusional Disorder.</p> <p>Review of the Nurse's Notes for October 2014 through February 2015 revealed Resident #1 had "denuded skin" to the buttocks, beginning 10/19/14 and continuing through 02/22/15.</p> <p>Review of the Wound Assessment Reports, beginning 02/25/15 when Resident #1 was readmitted following a hospitalization, revealed the presence of multiple pressure ulcers, abrasions, and a suspected deep tissue injury (SDTI). Continued review of the Wound Reports for the period between 02/25/15 and 04/13/15, revealed multiple smaller Stage II ulcers on the resident's bilateral buttocks merged to become one large pressure ulcer over the coccyx. Continued review revealed the coccyx ulcer deteriorated when it became larger and deeper, and developed purulent (pus-like) and foul-smelling drainage. On 04/13/15, Resident #1's coccyx ulcer measured 12 cm (centimeters) by 10 cm.</p> <p>Review of Resident #1's Comprehensive Care Plan revealed a problem onset date of 12/10/13, with the resident being assessed by the facility to</p>	F 280	<p>comprehensive care plan that addresses: prevention for skin breakdown or further skin breakdown, interventions to promote healing and prevent infection, assessment monitoring and updating the comprehensive care plan with changes in residents condition that may indicate an improvement or worsening of the wound that prompts a potential change in treatment interventions. This education included use of the Braden scale tool and the residents' relevant medical history to develop a comprehensive plan of care for pressure ulcers upon admission, readmission or changes in condition. A</p>	F280 Sept 21 2015

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F 280	<p>Continued From page 11</p> <p>be at risk for skin impairment. Continued review revealed treatment goals included the following: skin will remain intact; and resident will be free from skin breakdown/irritation, with a goal date of 05/31/15. Interventions included the following: weekly skin checks; turn and reposition every two (2) hours; keep skin clean and dry; and treatments as ordered by the Physician. Further review revealed the Care Plan was not revised as ulcers worsened to include interventions related to monitoring or tracking of the ulcers, observing for signs of infection, or any specific directives related to the individual wounds.</p> <p>Continued review of the Care Plan revealed Resident #1's denuded skin, present between October 2014 and February 2015 was not documented on the Care Plan. Further review revealed the Care Plan did not show healing of the SDTI and the abrasions. In addition, the Care Plan did not reflect any wound measurements or changes in character of the identified wounds, including the development of purulent, foul-odor drainage as the coccyx wound deteriorated.</p> <p>The facility's failure to follow its policies related to skin assessments and care planning resulted in the development of five (5) new pressure ulcers, which were not identified by the facility, but were documented by written description and photographs upon the admission of Resident #1 to the hospital on 04/15/15.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 07/24/15 at 5:00 PM, revealed attendees at morning clinical meetings discussed the care plan, and the former Director of Nursing (DON) made recommendations for new interventions. However, the ADON could not say</p>	F 280	<p>post-test was provided to validate comprehension of content. As of end of day on 8/4/15, a total of 15 out of 20 licensed nurses had received the education and completed the post test. At that time, none of the additional 5 nurses or any new hires began their shift without first receiving this education. 100% of all current licensed nurses had received this education by September 20, 2015. How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>The Quality Assurance Committee developed a tool on 7/31/15 to validate that skin assessments are being completed and subsequent</p>	<p>F280 sept 21 2015</p>	

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F 280	<p>Continued From page 12</p> <p>whether the interventions actually made it to the Care Plan; and review of the written interventions revealed the only dated revisions after the first pressure ulcers were documented on 02/25/15 were related to "treatments as ordered," a positioning device, and replacement of the standard mattress with an air mattress.</p> <p>Subsequent interview with the ADON and the Assistant Minimum Data Set (MDS) Coordinator on 08/03/15 at 12:40 PM revealed any nurse, the Unit Manager, or the DON could update the Care Plan between MDS assessments when the MDS Coordinator or her Assistant entered changes. The ADON further stated the care plan book was brought to daily clinical meetings for review and updates, but she stated Resident #1's Care Plan was not as specific as it could have been, and did not meet the intent of the facility's policies related to skin assessments and care planning.</p> <p>Interview with the Administrator on 07/22/15 at 11:00 AM revealed the MDS staff updated the care plans as scheduled MDS assessments were completed. He stated "off-cycle" updates were made daily during the clinical meetings. During interview, on 08/03/15 at 3:40 PM, the Administrator revealed that during the survey, he was "finding out" the former DON had failed to share information with the management team, and the facility was just becoming aware of the problems related to wound assessment and tracking. Continued interview revealed it was the Administrator's expectation for any new pressure ulcers to be identified and "reported up" to the Unit Manager and the DON. In addition, he stated his expectation was for all wounds to be communicated to the Quality Assurance team for investigation and tracking, and for care plan</p>	F 280	<p>care plans being developed and utilized per policy. This tool is reviewed a minimum of 5 times per week by the DNS, and/or Wound Nurse, Unit Manager or Nurse Educator. This was implemented on 7/31/15 and remains on-going. In addition, the Director of Nursing, Unit Managers, Nurse Educator and/or Wound Nurse will reassess 5 residents per week to ensure that skin has been accurately assessed and that the resident care plan accurately reflects risk factors, interventions, and status update. This began on August 4, 2015 and will continue</p>	F280 Sept 21 2015

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10/09/2015 10:24

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From: Stanton Nursing and Rehab.

606 663 8040

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10.14.13 a.m. 10-09-2015

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F 280	<p>Continued From page 13 updates. He further stated the facility had recognized staff education was needed related to the entire process for skin assessments and wound management, including the care planning process related to pressure ulcers, and training of staff was in progress.</p> <p><b>**The facility provided an acceptable Allegation of Compliance (AOC) on 08/08/15. The facility implemented the following actions to remove Immediate Jeopardy:</b></p> <p>1) Resident #1 had a Pressure Ulcer Care plan developed which was in place and reflected interventions for protection of Skin and Skin Integrity, to promote healing, to prevent infection and development of further pressure ulcers; however, there was undocumented evidence that the resident's care plan was not followed and/or revised for any identified pressure ulcer.</p> <p>It was reported the clinical record of Resident #1 was incomplete. The count of the pressure ulcers noted on Resident #1 did not match the photographic evidence, and documentation needed to validate care and treatment was provided for these pressure ulcers was not provided and had to be considered as lost or nonexistent. There was no documented evidence of a Comprehensive Skin Assessment for Resident #1 prior to discharge.</p> <p>2) One hundred percent of the resident census (71) had head to toe skin assessments completed by 08/04/15 by the Director of Nursing, Unit Managers, Staff Development RN, and Wound Nurse. No additional unidentified pressure ulcers were identified.</p>	F 280	<p>weekly for 3 months until 10/30/15. Any issues identified shall be corrected immediately and reviewed at the next scheduled QA Meeting for review and revised plan of action if warranted.</p> <p><b>Compliance Date: September 20, 2015</b></p>	F280 Sept 21 2015	

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F 280	Continued From page 14 3) The Weekly Skin Assessment Sheet (exhibit A) was reviewed and approved by the QA Committee on 07/30/15; the QA Committee consists of the Administrator, Director of Nursing, MDS, Social Services, Unit Managers, Rehabilitation Therapy Director, Staff Development RN, and the Medical Director. It is to be used weekly by the Charge Nurse, Wound Care Nurse, and/or Unit Manager for each in-house resident to identify any newly developed and/or existing pressure ulcers. Any new pressure ulcers identified will be communicated to the physician for potential treatment orders and to the Director of Nursing and to the Interdisciplinary Team (IDT) to implement interventions and update the comprehensive plan of care. The IDT consists of the Director of Nursing, Unit Managers, Dietary Manager, Rehabilitation Therapy Manager, and Social Services. The results of the Weekly Skin Assessment sheets will be reviewed a minimum of five (5) times per week by the Director of Nursing and/or the Assistant Director of Nursing and the Administrator. Any newly developed pressure ulcers will be reported immediately to the Director of Nursing and the Administrator. Staff responsible for the use of the Weekly Skin Assessment Sheet includes but is not limited to the Charge Nurse, Unit Manager, Weekend Manager, and the Director of Nursing. The Administrator will be responsible for oversight and to report to the QA Committee at least monthly or as outlined in this plan.  4) Licensed Nursing Staff have been in-serviced by the DON, Unit Managers, and Staff Development RN with a completion date of 08/04/15 on how to identify risk factors for developing pressure ulcers and how to develop a	F 280		F280 Sept 21 2015	

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F 280	Continued From page 15 comprehensive care plan to address: prevention for breakdown or further breakdown, interventions to promote healing and prevent infection, and interventions to include assessment, monitoring, and updating the comprehensive care plan with changes in residents' condition that may indicate a comprehensive review to update interventions as indicated and healing or decline of pressure ulcers, which is included in the Facility Skin System. The Braden Scale tool and the resident's medical history will be reviewed with the licensed nurses to assist in developing a comprehensive plan of care for pressure ulcers upon admission, readmission, and/or changes in the resident's condition. In addition, the Director of Nursing, Unit Managers, and or RN Staff Development Coordinator provided re-education for the Certified Nursing Assistants on skin reporting utilizing the Stop and Watch Form during bathing and ADL care by 08/04/15.  5) All residents have been assessed for the potential of skin breakdown using the Skin Assessment Worksheet (exhibit A), the Braden Tool, and the Stop and Watch tool (exhibit B), and current medical history with review and update of their comprehensive care plans to ensure risks have been identified and interventions were implemented to promote healing and prevent further breakdown, infection, and any unidentified pressure ulcers. This was completed on 08/04/15 by the DON, Unit Managers, Staff Development RN, and/or RN Supervisor. Information from the evaluation will determine if additional assessment and interventions would be necessary for each resident in the facility. Appropriate interventions were implemented and Care Plans updated initially by the DON and Staff	F 280		F280 Sept 21 2015	

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F 280	Continued From page 16 Development RN, and thereafter by the RN Unit Managers and Charge Nurse by 08/04/15. Skin assessments were completed on the total in-house census of 71 residents and no unidentified pressure ulcers were found.  6) The Regional Quality Manager for Preferred Care Partners Management Group provided education regarding the Weekly Skin Management Guidelines on or before 08/04/15 for the Interdisciplinary Team (IDT) which consisted of the DON, Unit Managers, Wound Nurse, Dietary Manager, Therapy Manager, and Social Services Director.  7) Initial education for the Director of Nursing, Staff Development, and Unit Managers was provided by the Preferred Care Partners Management Group, Regional Quality Manager by 08/04/15 regarding use of the Care Plan as a communication tool to direct resident care and to follow the comprehensive plan of care related to pressure ulcers, and consistently following the skin care protocol which included the following: accurate weekly skin assessments, reporting of new or existing identified pressure ulcers, accurate pressure wound assessments to identify detection of decline or healing process, to identify risk issues to prevent breakdown and to promote healing and to effectively implement a comprehensive care plan and interventions, to accurately document pressures regarding healing or decline to include measurement and description, and to obtain Physician's Orders for treatments to assist in healing and infection, and to prevent further wound decline.  8) The remaining Licensed Facility Nursing Staff education was educated by the DON, Unit	F 280		F280 Sept 21 2015	

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F 280	Continued From page 17 Managers, and Staff Development RN with a completion date of 08/04/15 with a post-test given. As of 08/04/15, a total of 15 of 20 licensed nurses have received this education and as of 08/04/15, a total of 22 of 34 nurse aides received the education by the Staff Development RN, DON, Unit Managers, or Wound Nurse. All nursing staff received the required wound education prior to working their next shift by the Staff Development RN, Unit Managers, Wound Nurse, or DON. All new nursing hires have been educated during general orientation, with a post-test given by the Staff Development RN prior to their working on a unit regarding following the comprehensive care plan interventions, reporting skin breakdown to licensed nurses and the Stop and Watch Tool, communication with the physician in developing a plan of care, including treatment if indicated, to promote healing, prevent infection, and prevent further breakdown. Education also included how to perform an accurate wound assessment and identification of causal factors of breakdown in order to implement effective interventions.  9) The Quality Assurance Committee members (Administrator, Director of Nursing, MDS, Unit Managers, and Staff Development RN) reviewed and approved the education material on 08/04/15. Records of the in-service on the educational materials included signatures of attendance, signature of in-services received, and copies of testing for efficacy of the training. Nursing in-service education on the subjects noted was completed by 08/04/15.  10) Members of the QA Committee developed a tool on 07/31/15 to validate assessments and Care Plans were being utilized per policy protocol.	F 280		F280 Sept 21 2015	

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F 280	<p>Continued From page 18</p> <p>This was implemented on 07/31/15 and is ongoing.</p> <p>In addition, the DON, Unit Managers, Staff Development RN, or Wound Nurse are responsible to reassess 5 resident skin assessments per week to ensure accuracy of licensed nurses' skin assessment within 24 hours of the resident's scheduled 7-day assessment. This will be updated to the QA Committee approved pressure ulcer tracking tool as completed by the DON, Staff Development RN, Unit Managers, and Wound Nurse. Any concerns identified with accuracy of the skin assessment will have re-education provided by the Director of Nursing, Unit Managers, Staff Development RN, or Wound Nurse to the licensed nurse weekly for 3 months until 10/30/15. The Director of Nursing will discuss the results of accuracy and if any education should be provided regarding the reassessments during the next scheduled QA Meeting.</p> <p>11) Monitoring will be done by the Administrator, DON, Staff Development RN, RN Unit Managers, and Wound Nurse. Any issues identified will be corrected immediately and taken to the next scheduled QA meeting for review and a revised plan of action if warranted. The Administrator will provide oversight on a weekly basis and this practice will become effective on 07/31/15.</p> <p>12) QA Meetings will be held with two or more team members in attendance daily 5 days a week and on weekends if necessary for review of data to ensure compliance: completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. Any findings of newly developed or existing</p>	F 280		F280 Sept 21 2015

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F 280	<p>Continued From page 19</p> <p>pressure ulcers and the interventions implemented will be reviewed for effectiveness or need for additional interventions until the situation is controlled.</p> <p>QA Committee members will review minimally 5 days a week for 30 days or additionally as necessary until 09/01/15; then one time weekly until 09/30/15 or as needed; then monthly thereafter or as needed sooner.</p> <p>***The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1) Resident #1 was no longer in the facility.</p> <p>2) Review of the facility's documentation dated 07/30-08/04/15, and interviews with Unit Manager (UM) #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>3) Review of the facility's 100% skin assessment sheets revealed facility staff utilized the Weekly Skin Assessment Sheet approved by the QA committee on 07/30/15. Interviews with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the DON on 08/06/15 at 4:40 PM, Licensed Practical Nurse (LPN) #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, and LPN #3 on 08/06/15 at 3:25 PM, revealed the Weekly Skin Assessment Sheet was being utilized to conduct weekly skin assessments and to conduct skin assessments for new or</p>	F 280			

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F 280	<p>Continued From page 20 readmitted residents to the facility.</p> <p>Per interview with LPN #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, LPN #3 on 08/06/15 at 3:25 PM, UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM, revealed any concerns identified with a newly developed pressure ulcer and/or existing pressure ulcers would be reported to the physician, to the DON, and to the IDT to implement interventions and to update the resident's comprehensive plan of care. According to staff interviews, no new pressure ulcers have been identified since 07/29/15.</p> <p>Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/06/15 at 3:00 PM, revealed he provided oversight to ensure the skin assessments were done correctly in accordance with the facility's protocols and training.</p> <p>4) Review of the In-service Training related to risk factors for the development of pressure ulcers and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the residents' comprehensive care plan. Interview conducted on 08/06/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3:25 PM with LPN #3, 08/06/15 at</p>	F 280		F280 Sept 21 2015	

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F 280	<p>Continued From page 21</p> <p>1:20 PM with UM #1, and 08/06/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15, at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility's skin care protocols during orientation when hired by the facility.</p> <p>Further review of the In-service Training dated 08/03-05/15, revealed the Staff Development RN provided education for the Certified Nurse Aides (CNAs) regarding skin reporting utilizing the "Stop and Watch" form during bathing and ADL care. Interviews conducted on 08/06/15 with CNA #16 at 1:21 PM, CNA #20 at 1:28 PM, CNA #1 at 1:41 PM, CNA #5 at 1:47 PM, CNA #15 at 1:55 PM, CNA #7 at 2:00 PM, CNA #22, at 2:05 PM, CNA #23 at 2:07 PM, CNA #18 at 2:20 PM, and CNA #24 at 3:40 PM verified each staff member had attended the training and was knowledgeable about the use of the "Stop and Watch" form and reporting any changes in a resident's skin condition.</p> <p>5) Review of the facility's documentation dated 07/30-08/04/15, and interviews with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at</p>	F 280		F280 Sept 21 2015	

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F 280	<p>Continued From page 22</p> <p>2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>6) Review of In-service Training dated 08/03/15, revealed the Preferred Care Partners Management Group provided training regarding the Weekly Skin Management Guidelines for the Interdisciplinary Team (IDT) which consisted of the DON, Unit Managers, Wound Nurse, Dietary Manager, Therapy Manager, and Social Services Director. Interviews conducted with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM revealed each of the IDT members attended the training and had knowledge of the Weekly Skin Management Guidelines.</p> <p>7) Review of In-service Training dated 08/03/15, revealed the Regional Quality Manager provided training for the DON, Staff Development Nurse, and Unit Managers related to use of the care plan as a communication tool and following the comprehensive care plan and to consistently follow the facility skin care protocols. Interviews on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM, confirmed each of the staff members attended the in-service training and had knowledge of the care plan process and the facility skin care protocols. In addition, a post-test was provided.</p> <p>8) Review of the In-service Training related to risk factors for the development of pressure ulcers</p>	F 280		F280 Sept 21 2015	

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F 280	Continued From page 23 and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the resident's comprehensive care plan. Interview conducted on 08/06/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3:25 PM with LPN #3, 08/06/15 at 1:20 PM with UM #1, and 08/06/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15 at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility skin care protocols during orientation when hired by the facility.  9) Review of the Daily QA Meeting Sign-In Sheets revealed the QA Committee met on 08/04/15 and review of the in-service records revealed the educational materials included signatures of attendance, signature of in-services received, and copies of efficacy of the training.  10) The Pressure Ulcer tool was reviewed on 08/06/15 and verified the tool was being utilized	F 280		F280 Sept 21 2015	

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F 280	<p>Continued From page 24</p> <p>to validate skin assessments and care planning for residents with pressure ulcers. The QA Committee members were reviewing the tool daily. Interviews conducted on 08/06/15 with the Administrator at 3:00 PM, UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, the MDS Nurse at 3:35 PM, and the DON at 4:40 PM confirmed the tool was being used to validate skin assessments were conducted and documented correctly and care plans were being updated and followed for residents with pressure ulcers.</p> <p>Interviews conducted on 08/06/15 with LPN #1 at 1:25 PM, with RN #1 at 2:55 PM, and with LPN #3 at 3:25 PM, revealed licensed nurses were responsible to complete a head to toe skin assessment for residents weekly as assigned on the skin assessment schedule. LPN #1, RN #1, and LPN #3 stated the skin assessment was documented on the Skin Assessment Sheet with the "man" figure on it. Interviews conducted on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM revealed they were responsible to reassess 5 resident skin assessments weekly to ensure the skin assessments had been completed accurately by the licensed nurse who was assigned to complete the scheduled skin assessment. The reassessment had been done within 24 hours of the resident's scheduled 7-day assessment. The UMs, Staff Development RN, and DON stated no problems had been identified with the reassessments they had completed.</p> <p>11) Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/06/15, at 3:00 PM, revealed he provided</p>	F 280			

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F 280	Continued From page 25 oversight to ensure the skin assessments were done correctly in accordance with the facility's protocols and training.  12) Review of the facility's documentation dated 08/04-08/15 revealed daily QA meetings were conducted to review the completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. No newly developed pressure ulcers have been identified since 07/29/15. Interviews conducted on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Therapy Manager at 2:30 PM, the Staff Development RN at 2:45 PM, the Administrator at 3:00 PM, the Social Services Director at 3:15 PM, and the DON at 4:40 PM, confirmed daily QA meetings were held to review the completion and accuracy of skin assessments and comprehensive care plans for any new and/or existing pressure ulcers.	F 280		F280 Sept 21 2015	
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  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 failed to ensure the necessary care and services	F 309	<b>F309</b>  What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  Resident #8 was discharged to home on 7/21/15.	F309 Sept 21 2015	

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F 309	Continued From page 26 were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care in accordance with the resident's customary daily routine for one (1) of twenty-four (24) sampled residents (Resident #8). The facility failed to provide dressing changes for Resident #8's surgical incision sites in accordance with the plan of care.  The findings include:  Review of the facility's policy titled "Care Plan Policy Statement," undated, revealed an individual comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs would be developed for each resident. Continued review revealed each resident's comprehensive care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, build on the resident's strengths, reflect the resident's expressed wishes regarding care and treatment goals, identify the professional services, aid in preventing or reducing declines in the resident's functions, enhance the optimal functioning of the resident by focusing on a rehabilitative program, and reflect currently recognized standards of practice for problem areas and conditions. Further review of the policy revealed the resident had the right to refuse to participate in the development of his/her care plan and medical and nursing treatment; however, when refusals were made, appropriate documentation would be entered into the resident's clinical record in accordance with established protocols.	F 309	How you will identify other residents/patients having the potential to be affected by the same deficient practice?  Residents have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered.  The facility does and will continue to provide services for individual needs and preferences. A review of all treatment time for wound care patients will be conducted by September 20, 2015 to determine the level of satisfaction for each patient, and including	F309 Sept 21 2015	

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F 309	<p>Continued From page 27</p> <p>Review of the facility's policy titled "Refusal of Treatment," revised November 2010, revealed if a resident refused treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services would interview the resident to determine what and why the resident was refusing in order to try to address the resident's concerns and explain the consequences. Continued review of the policy revealed if the resident refused to accept treatment, detailed information related to the refusal should be entered into the resident's medical record to include at least the date and time the staff tried to give a medication or treatment, the medication or treatment refused, the resident's response and reason(s) for the refusal, the name of the person attempting to administer the treatment, that the resident was informed of the purpose of the treatment and the consequences of not receiving the medication or treatment, the resident's condition and any adverse effects due to such refusal, the date and time the physician was notified as well as the physician's response, and the signature and title of the person recording the data.</p> <p>Review of the clinical record revealed the facility admitted Resident #8 on 07/14/15 with diagnoses which included severe Hidradenitis Suppurativa of Bilateral Axillary and underneath Pannus region with Cellulitis and small abscesses, Anxiety, Depression, Possible Urinary Tract Infection, and Anemia. Review of the Nursing Admission Assessment dated 07/14/15, revealed Resident #8 was alert and oriented with no memory problems.</p> <p>Review of the Comprehensive Care Plan dated 07/14/15 revealed Resident #8 was care planned for impaired skin to the Axilla and right groin.</p>	F 309	<p>documentation review to determine any potential missing documentation or evidence of resident refusal. The review will be conducted by interviewing each wound patient and review of the medical treatment record to determine if any patient dissatisfaction or opportunities exists. The reviews will be conducted by the Director of Nursing, Nurse Educator, Wound Nurse, or Social Worker. Any concern about treatment time will be provided to the Director of Nursing and Administrator to ensure physician notification by the licensed nurse for reasonable accommodation</p>	<p>F309 Sep 21 2015</p>	

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F 309	<p>Continued From page 28</p> <p>Further review revealed the goals were for the areas to the Axilla and right groin to decrease in size and be free of infection with interventions to include the nurse to document daily on any aspect of wound healing and treatments as ordered. Review of the Physician's Orders dated 07/14/15, revealed an order for wound care to cleanse the left axilla and right groin with Normal Saline, pack with Aquacel AG (wound dressing), and cover areas with Mepilex AG (wound dressing) twice each day.</p> <p>Review of Resident #8's Treatment Administration Record (TAR) dated July 2015 revealed the resident had an order for wound care to be performed BID (twice each day). Continued review revealed the wound care was scheduled on the TAR to be performed once during the 7:00 AM shift and once during the 7:00 PM shift. Further review revealed wound care was refused on 07/15/15 during the 7:00 AM shift, and was not performed on 07/14/15, 07/15/15, 07/16/15, 07/17/15, or 07/20/15 on the 7:00 PM shift. However, there was no documented evidence to indicate why the care was refused or not performed.</p> <p>Interview with Resident #8 on 07/23/15 at 8:59 PM, revealed the facility would perform wound care once per day around 4:00 PM or 5:00 PM. Continued interview revealed staff would come in very late at night around midnight or very early in the morning around 5:00 AM, and she would tell them it was too late at night or too early in the morning to do the wound care. Resident #8 stated she slept at night and did advise staff they should not wake her up to do wound care.</p> <p>Interview with Licensed Practical Nurse (LPN) #4</p>	F 309	<p>for treatment times for the resident.</p> <p>Any identified documentation issues will be addressed immediately by the licensed nurse.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Licensed nursing staff will be educated by the Director of Nursing and/or Nurse Educator beginning on September 11, 2015 and completed by September 20, 2015 in regards to documentation of any resident refusals of treatment, including the reason given for refusal and that the licensed nurse shall contact the physician to</p>	F309 Sept 21 2015

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F 309	Continued From page 29 on 07/24/15 at 6:56 AM, revealed she was Resident #8's Primary Nurse on the 7:00 PM shift. Further interview revealed she would normally perform wound care between 10:30 PM and 7:30 AM. Continued interview revealed Resident #8 had refused his/her wound care, reporting to LPN #4 that he/she was already tired and it was too late. However, there was no documented evidence the facility attempted to accommodate the resident's needs in accordance with the resident's customary daily routine.  Interview with the Director of Nursing (DON) on 08/03/15 at 6:25 PM revealed she was unsure whether staff should accommodate a resident's preference in accordance with the resident's customary daily routine regarding wound care. The DON further stated it was very important for the residents to receive the wound care and treatments that were ordered by the physician, but the nursing staff was very busy with the medication pass at the start of the shift. Continued interview revealed her expectations would be for the physician to be notified when a resident refused a treatment.	F 309	four weeks. Findings will be summarized and appropriate response taken by the QA Committee to assure compliance.  Compliance Date: September 21, 2015	F309 Sept 21 2015	
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314  What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  Resident #1 was discharged from the facility on 4/15/15.  Resident #11 was discharged from the Facility on 6/3/15.	F314 Sept 21 2015	

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F 314	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility policy, and review of professional literature including the website for the National Pressure Ulcer Advisory Panel and the online version of The Journal for Ostomy Wound Management, it was determined the facility failed to ensure newly developed pressure ulcers were identified promptly, and appropriate treatments implemented, for two (2) of twenty-four (24) sampled residents (Residents #1 and #11).</p> <p>The facility failed to identify tissue injury on Resident #1's heels prior to his/her transfer to the hospital on 02/23/15, where the Physician and the nurse documented the presence of necrotic tissue on both heels. After Resident #1 returned to the facility on 02/25/15, several pressure areas were tracked with regular assessments; however, on 04/15/15, the resident was again transferred to the hospital, where five (5) previously unidentified pressure ulcers were photographically documented. Facility records review revealed no documented evidence that these five (5) areas had been identified, assessed, monitored, or treated by the facility, while Resident #1 resided in the facility, as they should have been according to the facility's policy. (refer to F280 and F514).</p> <p>In addition, observation of a skin assessment for Resident #11 on 07/24/15 revealed the resident had a deep tissue injury to the left heel that had not previously been identified by the facility.</p> <p>The facility's failure to ensure each resident having pressure sores received the necessary treatment and services to promote healing,</p>	F 314	<p><b>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</b></p> <p>All residents are at risk for developing pressure ulcers due to physical dependency, decreased cognition, decreased mobility and age-related comorbidities. A 100% audit of the current resident census (71 residents) was completed on August 4, 2015 by the Director of Nursing, Unit Managers, Nurse Educator, and Wound Nurse with no additional unidentified pressure ulcers found. All residents were assessed using the skin assessment worksheet, Braden tool, Stop and Watch Tool, and review of current medical history to ensure that risks had been identified and interventions implemented to promote healing and prevent further breakdown of skin on the resident plan of care.</p>	<p><i>F314</i> <i>Sept 21, 2015</i></p>	

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F 314	<p>Continued From page 31</p> <p>prevent infection and prevent new sores from developing caused or was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/29/15, and was determined to exist on 02/23/15. The facility was notified of the Immediate Jeopardy on 07/29/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/06/15, alleging removal of the Immediate Jeopardy on 08/05/15. The State Survey Agency determined the Immediate Jeopardy was removed on 08/05/15 as alleged, which lowered the Scope and Severity to "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's "Skin System Policy &amp; Procedure," revised August 2014, revealed the facility would ensure the provision of treatment and services to "promote healing, prevent infection, and prevent new sores from developing." Continued review revealed steps in the procedure included the following: all residents were to be assessed for skin needs upon admission or readmission and weekly thereafter; the Skin Committee would meet at least weekly to review the care of residents with pressure ulcers; staging and measuring would be performed by the assigned nurse to maintain continuity in documentation of progression of wound healing; and the assigned nurse manager would provide oversight of the resident's skin care and report to the Skin Committee on a weekly basis. Further review revealed upon</p>	F 314	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Licensed nursing staff received in-service education by the Director of Nursing, Unit Manager and/or Nurse Educator beginning on 8/3/15 with a completion date of 8/4/15 on how to identify risk factors for developing pressure ulcers and how to develop a comprehensive care plan that addresses: prevention for skin breakdown or further skin breakdown, interventions to promote healing and prevent infection, assessment monitoring and updating the comprehensive care plan with changes in residents condition that may indicate an improvement or worsening of the wound that prompts a potential change in treatment interventions.</p> <p>This education included use of the Braden scale tool and the residents' relevant</p>	<p>F 314 Sept 21 2015</p>	

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F 314	<p>Continued From page 32</p> <p>identification of skin impairment the nurse would obtain treatment orders from the Physician; update the Treatment Administration Record (TAR); and notify the assigned nurse manager and the Skin Committee of the change in the resident's skin condition requiring additional oversight and monitoring.</p> <p>Review of the facility's "Skin Committee Process Guidelines," reviewed August 2014, revealed all residents with pressure sores or other complex wounds would be reviewed by the Skin Committee. Continued review revealed the Skin Committee would provide documentation to support their findings and recommendations.</p> <p>Review of the facility's Quick Reference Guide, titled "Pressure Ulcer Assessment," undated, revealed pressure ulcers were to be assessed at least weekly after identified, and results of the assessments were to be documented to include the following: location; category or stage of the wound; size, including length, width, and depth; type of tissue and color of the wound; condition of the surrounding skin; a description of wound edges, sinus tracts, undermining, or tunneling; the presence of any drainage; and odor.</p> <p>1. Review of the closed clinical record revealed the facility admitted Resident #1 on 10/02/13 with diagnoses which included Dementia, Depression, Hypertension, Chronic Pain, and Delusional Disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/09/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.</p>	F 314	<p>medical history to develop a comprehensive plan of care for pressure ulcers upon admission, readmission or changes in condition. A post-test was provided to validate comprehension of content. As of end of day on 8/4/15, a total of 15 out of 20 licensed nurses had received the education and completed the post test. At that time, none of the additional 5 nurses or any new hires began their shift without first receiving this education. 100% of all current licensed nurses had received this education by 8/8/2015. A weekly skin assessment is completed for each resident by a licensed nurse to identify any new skin concern, or change in status from an existing concern. Any newly identified pressure area is communicated to the attending physician for potential treatment order. Certified Nursing</p>	F314 Sept 21 2014

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F 314	<p>Continued From page 33</p> <p>Review of Section G for functional status revealed Resident #1 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Review of Section H for bowel and bladder function revealed Resident #1 was "frequently incontinent." Review of Section M for skin condition revealed the facility did not assess Resident #1 to have any Stage I or higher pressure ulcers, or to be at risk for developing a pressure ulcer.</p> <p>Review of the Nurse's Notes for 10/19/14, revealed Resident #1 had "denuded skin" to the left buttock which was being treated with Calmoseptine ointment. Review of the Note dated 10/25/14, revealed the resident's skin was intact; however, on 10/29/14, the Nurse's Notes reflected "denuded skin" to the bilateral buttocks with a new Physician's Order for Baza cream to be applied. On 11/01/14, the resident was documented to have skin intact. Continued review of the Nurse's Notes revealed daily, between 11/08/14 and 12/07/14, Resident #1 had denuded skin to the buttocks. Further review revealed the presence of denuded skin on 12/13/14, 12/20/14, 12/27/14, 01/09/15, 01/11/15, 01/17/15, and 01/24/15.</p> <p>Interview with Registered Nurse (RN) #2 on 06/18/15 at 2:52 PM revealed she described "denuded" skin to be superficial, irregular in shape, and caused by friction, not pressure. She stated the treatment was a barrier cream.</p> <p>Interview with the Director of Nursing (DON) on 06/23/15 at 10:40 AM, revealed she described "denuded" skin to be related to moisture, like diaper rash. She stated it was not a pressure sore.</p>	F 314	<p>Assistants were re-educated by the Director of Nursing, Unit Managers and/or Nurse Educator on skin reporting guidelines using the Stop and Watch tool while providing personal care beginning on 8/3/15 with a completion date of 8/4/15, with a post-test given to validate content comprehension. As of end of day on 8/4/15, a total of 22 of 34 nurse aides had received the education. At that time, none of the additional 11 CNAs or any new hires began their shift without first receiving this education. How will the facility monitor its performance to ensure that solutions are sustained? The Quality Assurance Committee developed a tool on 7/31/15 to validate that skin assessments are being completed and subsequent care plans being developed and utilized per policy. (Please see attachment A)</p>	<p>F314 Sept 21 2015</p>	

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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 314	Continued From page 34  According to Medicinenet.com, denuded skin refers to erosion of some or all of the epidermis (the thin outermost layer of the skin), leaving a denuded surface.  Review of the Comprehensive Care Plan for Resident #1 revealed the problem of "risk for skin impairment" with an onset date of 12/10/13. There was no documented revision date after that date. Continued review revealed the stated goals included the following: the resident would remain intact and free of skin breakdown or irritation for 90 days, with the stated goal date of 05/31/15. Further review of the Care Plan revealed an intervention for weekly skin checks; however, the Care Plan did not contain documented evidence to reflect any specific skin problems prior to 02/25/15 when Resident #1 was re-admitted from the hospital, although according to the Nurses Notes, the resident had "denuded skin" on the buttocks beginning 10/19/14. In addition, the Care Plan did not include interventions related to monitoring of any identified skin concerns through utilization of the Body Map Assessments or Wound Assessment Reports. (The Body Map Assessments were utilized by the facility to document the location of areas with non-intact skin)  Interview with RN #4, on 07/29/15 at 2:40 PM, revealed the assigned nurse was to perform a head-to-toe skin assessment for each resident weekly. She explained the weekly documentation was first completed on the Skin Inspection Report, where the nurse selected one of the following options: skin intact; skin not intact-existing; or skin not intact-new. Continued interview revealed if the resident's skin was intact,	F 314	This tool is reviewed a minimum of 5 times per week by QA Committee. This was implemented on 7/31/15 and remains on-going. In addition, the Director of Nursing, Unit Managers, Nurse Educator and/or Wound Nurse will reassess 5 residents per week to ensure that skin has been accurately assessed and that the resident care plan accurately reflects risk factors, interventions, and status update. This began on 8/4/15 and will continue weekly for 3 months until 10/30/15. Any issues identified shall be corrected immediately and reviewed at the next scheduled QA Meeting for review and revised plan of action if warranted.  Compliance Date: September 21, 2015		

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F 314	<p>Continued From page 35</p> <p>the nurse did not have to document further. If the skin was not intact, the nurse was responsible for completing or updating the Body Map Assessment for a visual indicator of where the problem areas were located on the body, and a Wound Assessment Report where the wound characteristics such as type of wound, pressure-ulcer staging, measurements, and the presence of any drainage or odor was documented. Further interview revealed complete documentation was important to allow for tracking of new and existing wounds to evaluate improvement or deterioration in the wounds, and to determine if treatment regimens were effective.</p> <p>Review of the Skin Inspection Report generated by the facility's computer charting system revealed Resident #1 was assessed on 01/03/15, 01/09/15, 01/11/15, 01/17/15, 01/24/15, 02/07/15, 02/14/15, and 02/21/15 for skin status of "Skin Not Intact - Existing", which indicated there were no new pressure areas or skin problems.</p> <p>Review of the Body Map Assessments dated 12/23/14, 01/23/15, and 02/23/15 revealed Resident #1 was assessed to have excoriation to the left buttock area, which was "non-pressure." Continued review revealed no documented evidence any other Body Map Assessments were completed in conjunction with the weekly Skin Inspection Reports between 12/23/14 and 02/23/15.</p> <p>Review of the Wound Assessment Report, dated 10/19/14, revealed Resident #1 was assessed to have a new area of denuded skin on the left inner buttock. The wound was assessed to be 0.3 centimeters (cm) by 0.2 cm. Continued review of</p>	F 314			

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F 314	<p>Continued From page 36</p> <p>the Wound Assessment Reports provided by the facility revealed the next report was dated 12/02/14. The report indicated an area of "irritation/excoriation" on the coccyx was newly identified and measured 2.8 cm by 2.0 cm. Further review revealed the "irritation/excoriation" was described to be "denuded skin." Although the area was classified as newly identified, the status was documented as "deteriorated." Neither Wound Assessment Report gave an indication of whether the areas identified were open or not opened. Further interview with the Director of Nursing (DON), on 06/23/15 at 10:40 AM, revealed the "denuded" areas were not open wounds but were very superficial, like diaper rash. No other areas, including the left inner buttock identified on 10/19/14 were mentioned. Furthermore, no documented evidence of any other Wound Assessment Reports completed between 10/19/14 and 02/23/15 were provided by the facility.</p> <p>Interview with RN #4 on 07/29/15 at 2:40 PM, revealed each weekly Skin Inspection Report for non-intact skin should have a corresponding Body Map Assessment and Wound Assessment Report. However, there was no documented evidence these assessment forms were completed according to the facility's policy and practices.</p> <p>Review of the Nurse's Notes for February 2015 revealed Resident #1 continued to have denuded skin to the buttocks, as documented on 02/08/15, 02/14/15, 02/21/15, and 02/22/15. Further review of the Nurse's Notes, for this time period, revealed no reference to any other skin concerns. Continued review of the Nurse's Notes for 02/23/15 revealed the resident exhibited</p>	F 314			

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F 314	<p>Continued From page 37</p> <p>increased pain and screaming out, "Lord, kill me," and labored respirations with decreased oxygen saturation. Resident #1 was transported from the facility to the Emergency Department (ED) of the hospital, a distance of 27.8 miles, by Emergency Medical Services (EMS) for evaluation and treatment. The travel from the facility to the hospital was twenty-eight (28) minutes.</p> <p>Review of the EMS transport record, dated 02/23/15, revealed the transport crew arrived on the scene at the facility at 4:09 AM, and departed with Resident #1 en route to the hospital at 4:18 AM. Continued review revealed the EMS arrived at the hospital ED with the resident 28 minutes later, at 4:46 AM. Further review revealed no skin assessment was documented by the EMS staff during the transport from the facility to the hospital.</p> <p>Review of the ED record revealed Resident #1 was clocked in at 4:53 AM on 02/23/15, 44 minutes after EMS arrived on the scene at the facility. Review of the ED Physician's documented physical examination, dated 02/23/15 at 5:26 AM, revealed the presence of "multiple grade II decubitus ulcers and patches of skin excoriation in the lumbosacral and buttocks area," and "necrotic tissue over the heels." ("Necrotic" refers to tissue death due to irreversible injury of the cells in a specific area.) The total elapsed time between EMS arriving at the facility to transport the resident and evaluation of the resident by the ED Physician was one (1) hour and seventeen (17) minutes.</p> <p>Continued interview with the DON on 06/23/15 at 10:40 AM, revealed she believed Resident #1's ulcers, including the necrotic ulcers on the heels,</p>	F 314			

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F 314	<p>Continued From page 38</p> <p>occurred at the hospital, or en route to the hospital. She stated based on the facility's documented skin assessments and her conversations with staff, the resident had nothing on the heels prior to transfer and admittance to the hospital on 02/23/15. She further stated Resident #1 only had denuded skin on the buttocks prior to 02/23/15. The DON described denuded to be excoriation related to moisture, similar to diaper rash. Continued interview revealed the resident's heels were "brownish, leathery" upon return to the facility on 02/25/15.</p> <p>A review of professional literature from the website of the National Pressure Ulcer Advisory Panel (NPUAP), the online version of the Ostomy Wound Management (OWM) journal, and review of guidance for surveyors published by the Centers for Medicare and Medicaid Services, revealed it was difficult to determine the exact amount of time it takes for a pressure ulcer to develop depending on a variety of factors. It is clear from the literature that a stage I or stage II pressure ulcer can develop in a matter of 2-6 hours; however, it is very important that pre-existing signs which suggest that deep tissue damage (suspected deep tissue injury) has already occurred, such as intact purple or very dark areas surrounded by deep redness, are identified in order to prevent progression to a stage III or stage IV ulcer. Further review revealed eschar, one form of necrotic tissue, can develop in a matter of days.</p> <p>Interview with the ED Physician, on 07/15/15 at 3:15 PM, revealed he had documented the Note describing Resident #1's necrotic heels. He stated the wounds were not newly acquired. Continued interview revealed his assessment</p>	F 314		

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F 314	<p>Continued From page 39</p> <p>was conducted at the time of the documentation, i.e., on 02/23/15 at 5:26 AM.</p> <p>Review of the ED Nurse's Notes for 02/23/15 at 6:43 AM revealed Resident #1 was assessed by the nurse to have redness and excoriation on the perineal area and inner thighs, unstageable decubiti on the bilateral heels, Stage I areas on the left outer leg and the left upper arm near the shoulder, a Stage I decubitus (pressure sore or ulcer) covering most of the left and right buttocks area, and multiple Stage II areas over the coccyx. (Staging of pressure sores is a method of characterizing the severity of the wound, with Stage I being the most superficial and Stage IV indicating full thickness tissue involvement with exposed muscle, tendon, and/or bone). Further review of the ED record revealed Resident #1 was admitted to the hospital for further care. According to the NPUAP, an unstageable ulcer indicates full thickness skin or tissue loss; however, the depth of the ulcer cannot be measured because the wound bed is obscured by slough or eschar, two forms of necrotic, or dead tissue.</p> <p>Interview on 07/15/15 at 2:55 PM with the ED Nurse, who performed and documented the skin assessment on 02/23/15 at 6:43 AM revealed she did recall Resident #1. She stated she did not remember all of the specifics about the assessment, but knew the resident's heels were very dark in color, necrotic in appearance, as if the wounds had been there "a while."</p> <p>Review of the hospital's Admission Assessment, dated 02/23/15 at 8:45 AM and electronically signed by the admitting RN, revealed Resident #1 was admitted to the nursing unit from the ED at</p>	F 314		F 314 sept 21 2015

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F 314	<p>Continued From page 40</p> <p>8:15 AM. Continued review revealed a "yes" response to the question, "Is there an indication of a pressure ulcer present on admission?". Further review revealed the reader was directed to refer to photographs taken on admission.</p> <p>Review of photographs taken at the hospital upon admission revealed multiple areas of Stage I and Stage II skin breakdown on the buttocks. Continued photographic review revealed visual evidence of black, necrotic tissue on both heels. In addition, the right great toe exhibited signs of a suspected deep tissue injury (SDTI), an injury characterized by purplish-red skin caused by damage of underlying soft tissue due to prolonged pressure and/or friction.</p> <p>Review of the Hospital Discharge Summary, dated 02/25/15, revealed Resident #1 was discharged from the hospital and transferred back to the facility with diagnoses including Sepsis Syndrome, Urinary Tract Infection, and Multiple Pressure Ulcers to the bilateral lower extremities and to the sacro-coccygeal area, which were present upon admission.</p> <p>Telephone interview with Registered Nurse (RN) #3 on 06/23/15 at 11:18 AM, revealed she no longer worked at the facility, but she did remember taking care of Resident #1. She stated the resident returned from the hospital in February with several wounds. She further stated she did not recall seeing any pressure sores on the resident's heels before he/she went to the hospital on 02/23/15.</p> <p>Interview with Certified Nursing Assistant (CNA) #8 on 07/23/15 at 3:45 PM revealed she was familiar with and had cared for Resident #1</p>	F 314		F 314 Sept 21 2015	

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F 314	<p>Continued From page 41</p> <p>before being hospitalized in February 2015. She stated the resident was ambulatory prior to the hospitalization, and always wore socks and tennis shoes. She further stated the resident was afraid the shoes would be stolen if he/she took them off, and sometimes wore them to bed. Continued interview revealed CNA #8 did not recall Resident #1 having black heels, but acknowledged there were probably days when the resident's shoes were never removed.</p> <p>Interview with CNA #12 on 07/24/15 at 2:35 PM revealed she remembered Resident #1 from early in the year, before he/she went to the hospital in February. She stated the resident sometimes wore his/her shoes and socks to bed, but sometimes she could talk the resident into letting her remove them. She stated she did not remember what the resident's heels looked like before going to the hospital in February.</p> <p>Interview with CNA #13 on 07/29/15 at 10:02 AM revealed she was familiar with Resident #1, both before and after the hospitalization in February 2015, until his/her discharge from the facility on 04/15/15. She stated the resident always wore socks and tennis shoes before going out to the hospital in February 2015. She further stated she removed the resident's shoes when he/she got into bed, but he/she usually kept his/her socks on. She stated she did not recall seeing anything wrong with the resident's feet.</p> <p>Review of the facility's Nurse's Notes revealed Resident #1 was readmitted by the facility on 02/25/15 with multiple areas of skin breakdown. According to the Wound Assessment Report completed on that date, the resident's skin was assessed as follows: abrasion, 3.0 cm by 2.3 cm</p>	F 314		

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F 314	<p>Continued From page 42</p> <p>on the left rear shoulder; two Stage II pressure ulcers on the left buttock, measuring 0.7 cm by 1.7 cm and 1.5 cm by 2.0 cm, two Stage II pressure ulcers on the right buttock, 0.5 cm by 0.5 cm and 1.3 cm by 1.0 cm; unstageable pressure ulcer with slough (dead tissue that is shed by a wound) and eschar (hard, leathery brown/black tissue formed of dead cells) on the right heel, 4.5 cm by 9.5 cm; unstageable SDTI on the left heel, 5.7 cm by 5.5 cm; and SDTI to the right great toe, 1.5 cm by 1.0 cm. Review of the Wound Assessment Report, dated 02/28/15, revealed Resident #1 was assessed to have an abrasion to the left shin measuring 4.0 cm by 4.5 cm.</p> <p>On 07/28/15, the State Survey Agency requested a copy of all Body Map Assessments completed between 02/23/15 and 04/15/15. The facility provided a reprint of all Wound Assessment Reports during the time period. The Wound Assessment Reports themselves were identical to those previously provided by the facility; however, they had been reprinted and now included a Body Map Assessment printed on the back of each Wound Report. Review of the Reports revealed each Wound Assessment Report included the specific date the assessment was completed and the date it was printed (07/28/15); however, review of the Body Map Assessments on the back of each Wound Report revealed all were identical, and each included an "Assessment Date" of 07/28/15, in addition to the print date of 07/28/15.</p> <p>The same four (4) pressure areas, including the left hip, left buttock, and the bilateral heels, were pinpointed on each Body Map Assessment and printed on the Wound Assessments Reports</p>	F 314		7314 Sept 21 2015	

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From: Stanton Nursing and Rehab.

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10/14/13 a.m. 10-09-2015

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F 314	<p>Continued From page 43</p> <p>beginning 02/26/15 through 04/13/15; however, according to the Wound Reports, the left hip ulcer was not identified until 03/16/15. In addition, each Body Map reflected an area on the left buttock, the same area documented as excoriation/denuded skin prior to 02/23/15, although the color-coded symbol was changed from green to red, which indicated the wound progressed from a non-pressure area to a pressure ulcer. Furthermore, there was no documented evidence on the Body Map Assessments to reflect the merging of multiple pressure areas on the buttocks into one large pressure ulcer over the coccyx.</p> <p>Review of the Progress Notes, dated 03/26/15 and signed by the Advanced Practice Registered Nurse, revealed Resident #1 had non-specified skin lesions and ulcers to the bilateral heels and left buttock, and a Stage IV area to the coccyx.</p> <p>Review of subsequent Wound Assessment Reports revealed the following significant findings: on 03/05/15, the assessment did not address the pressure ulcers on the left and right buttocks, but did describe an 8.0 cm by 2.5 cm area of excoriation on the coccyx; on 03/10/15, the assessment only referred to the SDTI on the right great toe; on 03/11/15, the assessment addressed the ulcers on the heels but no other areas; on 03/16/15, two (2) new wounds to the left hip were identified as a 2.0 cm by 1.5 cm Stage II pressure ulcer, and a 13 cm by 9.2 cm Stage I pressure ulcer - no other wounds were documented on this date; on 03/17/15, twelve (12) days after the coccyx area was described on 03/05/15, the area was reassessed to have deteriorated to a 10.75 cm by 7.0 cm pressure ulcer which was unstageable due to the presence</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 44</p> <p>of slough and eschar, on 03/25/15, the facility assessed and documented the coccyx and heel ulcers but the left hip ulcer was not assessed again until 03/31/15, fifteen (15) days after it was identified on 03/16/15, when the two (2) original ulcers had merged into one Stage II ulcer at 5.5 cm by 1.5 cm. The last Wound Assessment Report completed by the facility, on 04/13/15, addressed four (4) areas, the coccyx at 12.0 cm by 10.0 cm, the left hip at 7.0 cm by 3.5 cm, the left heel at 5.0 cm by 5.5 cm, and the right heel at 8.5 cm by 4.0 cm. The left hip wound was characterized as a Stage II ulcer, while the coccyx and heel wounds were described as "unstageable."</p> <p>Review of the Nurse's Notes dated, between 03/05/15 and 04/15/15 revealed no reference to any wounds other than those documented on the Wound Assessment Reports. Further review of the Nurse's Notes for 04/15/15 revealed Resident #1 was transferred to the ED at the request of the state-appointed Guardian, for an evaluation of the resident's wounds.</p> <p>Interview with the facility's Medical Director, who was also the Attending Physician for Resident #1, on 06/19/15 at 3:50 PM revealed he was aware of Resident #1's wounds identified when the resident returned from the hospital on 02/25/15. He acknowledged the wounds did worsen over time and stated in his opinion the wounds would never have healed. He further stated he attempted multiple interventions, including changes in wound treatments and the addition of nutritional supplements. He further stated he observed the sores soon after the resident returned from the hospital in order to determine the appropriate approach to treatment. He</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 45</p> <p>explained subsequent inspections of the wounds were made by his Advanced Registered Nurse Practitioner (ARNP). Further interview revealed the ARNP was on emergency leave from the practice with an unknown date of return. (Due to the tragic nature of the emergency, no attempt was made to interview the ARNP).</p> <p>Interview with the state-appointed Guardian, on 07/14/15 at 3:00 PM, revealed she could not recall the date, but reported she visited Resident #1 and observed the nurse performing the resident's dressing changes to the heels and to the coccyx. She stated she couldn't believe what she saw, and reported "the stench was horrible". Continued interview revealed the Guardian notified her supervisor and the decision was made to transfer Resident #1 to the ED per EMS.</p> <p>Review of the ED Note signed by the Physician on 04/15/15 at 11:46 PM revealed Resident #1 was evaluated and admitted for management of multiple ulcers, including a "large sacral wound" which was the probable source of the resident's sepsis (a complication of an infection, which spreads through the bloodstream, potentially affecting every body system).</p> <p>Review of the Hospital History and Physical, signed 04/16/15 at 12:00 AM, revealed Resident #1 was admitted with diagnoses which included "Sepsis, likely secondary to multiple chronic decubitus ulcer wounds."</p> <p>Review of photographs taken at the hospital, digitally dated, and timed for 04/16/15 between 9:49 AM and 10:02 AM, and review of Wound Assessment Notes electronically entered on 04/16/15 between 10:46 AM and 10:56 AM,</p>	F 314		

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F 314	<p>Continued From page 46</p> <p>revealed a total of nine (9) wounds were documented. Four (4) of the wounds had been identified at the facility prior to the resident's transfer to the hospital on 04/15/15 and were documented as follows: an unstageable right heel ulcer which was covered with 100% black eschar; an unstageable left heel ulcer which was covered with 100% black eschar; an unstageable sacral/coccygeal ulcer, with the wound bed consisting of 100% wet necrotic tissue, and characterized by a purulent (pus-like) and foul-smelling drainage; and a left hip ulcer of 100% black eschar. In addition to these wounds, five (5) previously unidentified wounds were photographically documented with accompanying notes: an unstageable 1.0 cm by 0.8 cm ulcer with a small area of black eschar on the right lateral foot; an unstageable 1.5 cm by 1.0 cm ulcer on the right lateral fifth toe; a 2.0 cm by 1.5 cm SDTI on the left lateral ankle; an unstageable 2.2 cm by 3.5 cm ulcer with 100% black eschar on the right lateral ankle; and a 1.5 cm by 1.0 cm SDTI on the left great toe.</p> <p>Subsequent interview with the facility's Medical Director on 07/29/15 at 11:45 AM revealed he received a copy of all Wound Assessment Reports as they were completed by the facility and had personal collaboration with his ARNP regarding Resident #1's status. Upon reviewing the photographs taken at the hospital on 04/15/15, the Medical Director stated the wounds to the coccyx, left hip and bilateral heels were about what he expected based on the information he had received from the facility. Continued interview revealed he had no evidence the additional ulcers evident in the photographs were identified by the facility or had been communicated to him. The Medical Director,</p>	F 314		F314 sept 21 2015	

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F 314	<p>Continued From page 47</p> <p>based on the photographs taken at the hospital ED, described the ulcers on Resident #1's right foot and bilateral ankles as Stage II ulcers that had probably been present a "couple of weeks." He further stated it was difficult to know exactly how long the SDTI to the left great toe had been present, but probably less than two (2) weeks.</p> <p>Review of the facility's April 2015 TAR for Resident #1 revealed treatments were in place for the Stage II ulcer on the left hip, and the unstageable ulcers to the coccyx and both heels, prior to the resident being transferred to the hospital on 04/15/15. (Resident #1 did not return to the facility.) Continued review of the TAR revealed no documented evidence of ulcers on the right and left lateral ankles, right lateral foot, right fifth toe, or left great toe being identified or treated at the facility.</p> <p>Review of the Comprehensive Care Plan revealed no documented evidence the facility had identified the ankle, foot, and toe ulcers, or had developed interventions for monitoring or treating the wounds at any time prior to 04/15/15 when Resident #1 was discharged to the hospital.</p> <p>Continued interview with RN #2, on 06/18/15 at 2:52 PM, revealed she was responsible for measuring all known ulcers on the weekends. She stated she usually did the measurements on Sunday, and charted her findings on Monday. She further stated she was provided a list by the DON of the wounds/ulcers she was responsible for measuring, and her focus was on those wounds identified on the list. Continued interview revealed she remembered Resident #1, but could not recall the details of his ulcers.</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 48</p> <p>Further review of the Wound Assessment Reports for Resident #1, dated 04/06/15 and 04/13/15, revealed they were signed by RN #2.</p> <p>Interviews with RN #2 on 07/24/15 at 3:00 PM and 5:01 PM revealed she only measured areas noted on the list provided by the DON (who was no longer employed by the facility). She stated the areas she assessed each weekend were those the DON instructed her to measure. She explained the unit nurses were responsible for performing and documenting a weekly head-to-toe skin assessment; any new areas should be indicated on a Body Map Assessment and a Wound Assessment Report should be initiated. RN #2 thought the lists the DON provided her came from the Wound Assessment Reports, so if new areas did not make it to the Wound Report, they might not show up on the list she worked from when she did her measurements. She further stated she sometimes mentioned any concerns she had with the former DON, but could not be certain she had talked to the DON about Resident #1. RN #2 explained she felt "weak" in identifying and describing pressure ulcers, and had asked the former DON and the Education Nurse for specialized training related to wounds but she had not received it. She reported she did her own research on-line, and looked at pictures, to make sure she was describing wounds accurately. Continued interview revealed RN #2 did not save the lists she worked from each week. She reported since the DON no longer worked at the facility, she did not have access to the lists. Furthermore, RN #2 revealed she was no longer responsible for the weekly wound measurements and did not know who was responsible.</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 49</p> <p>Interview with the Education Nurse on 07/28/15 at 5:25 PM revealed she provided training on the facility's policies related to skin assessments, including documentation, for new hires during the orientation process. She stated the training should continue as the new nurse worked on the unit with oversight while transitioning to working independently. She further stated she did not recall, and did not provide documented evidence of a specific in-service related to the staging of wounds, or providing accurate wound descriptions. She stated she had done one-on-one training with staff when they had questions. Continued interview revealed she encouraged the nurses to refer to their nursing textbooks. The Education Nurse was unaware if RN #2 had asked for training related to assessing and staging pressure ulcers.</p> <p>Interview with RN #1 on 07/28/15 at 3:30 PM revealed she recalled Resident #1 and knew he had pressure ulcers, but she did not remember well enough to describe specific wounds. She explained the facility's process for performing and documenting skin assessments as follows: each resident was to have a head-to-toe skin assessment conducted weekly; skin concerns included bruises, red areas, or open areas; results of each skin assessment were to be documented in the computer; if any new areas were identified, the Physician was to be notified; if orders were received, the treatment was to be added to the TAR; in order to determine if an area was "new" or "existing," the nurse performing the assessment should look at the previous week's Body Map; for any problem areas observed on the skin assessment, the Body Map should be marked "update" to note improvement or deterioration in an area, or marked "new" to</p>	F 314		F314 Sept 21 2015

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F 314	<p>Continued From page 50</p> <p>describe an area not previously identified. RN #1 stated the nurse was responsible to note all problem areas, classify them according to the type of wound, e.g., bruise, or pressure ulcer, measure any areas and stage pressure ulcers, and document all of the above. Continued interview revealed it was important to identify new areas promptly in order to initiate treatment. RN #1 further stated detailed documentation was necessary for monitoring and tracking of any pressure ulcers. Additionally, RN #1 stated there was not much point in completing a skin assessment if the process for assessing and documenting was not followed.</p> <p>Interview with RN #4 on 07/29/15 at 2:40 PM revealed since RN #2 was no longer responsible for the weekly wound measurements each nurse was responsible to do their own measurements when they did their wound treatments. She described the facility's process for skin assessments, measurements and wound descriptions, and documentation requirements, in the same manner as described by RN #1. She stated she had seen problems with the documentation, including seeing areas that did not appear to be new, but which were not previously documented on the Wound Assessment Reports or on the TAR. She further stated she had seen wounds that had an intact dressing, but there was not an order in place and/or the treatment orders were not on the TAR. RN #4 explained there had been a lot of nursing staff to leave the facility's employment, and it made it hard to maintain continuity of care as it applied to skin assessments, documentation, and treatments. Review of the Skin Inspection Report for 02/25/15 revealed it was signed by RN #4; however, although she acknowledged it was her</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 51</p> <p>signature, she stated she had never done a skin assessment for Resident #1. She further stated someone else may have been logged into the system under her name, explaining new staff sometimes has to chart under another nurse until they get computer access. Continued interview revealed she had assisted other nurses with turning and positioning Resident #1 while they did their treatments, but she had never done the treatments herself. She recalled a large wound on Resident #1's coccyx, but she did not remember anything about his/her feet. Review of the TAR for April 2015 with RN #4 revealed she initialed having completed treatments for Resident #1 on 04/10/15, only five (5) days before the resident was transferred to the hospital; she stated she did not recall doing the treatment and did not know why she had initialed it. Continued interview revealed she might have signed off on the treatment if a new staff nurse had completed it.</p> <p>A follow-up interview was attempted unsuccessfully with RN #3, a former staff nurse who signed off on daily treatments for Resident #1 on the last three (3) days he/she resided at the facility.</p> <p>Repeated attempts to conduct a telephone interview with the nurse (a former employee of the facility) who completed the last two (2) weekly skin assessments on 04/03/15 and 04/10/15, before Resident #1 was discharged to the hospital, were also unsuccessful.</p> <p>Subsequent interview with the ADON, on 08/03/15 at 12:40 PM, revealed she became the DON on 07/31/15. She stated the facility did have a Skin Committee that met weekly. The</p>	F 314			

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F 314	<p>Continued From page 52</p> <p>new DON reported she did attend those meetings but she did not remember if every resident with wounds was discussed each week. She further stated she was not aware if there was a specific form utilized by the committee, but thought the former DON had kept notes. Continued interview revealed there was discussion about Resident #1; the DON recalled the resident's coccyx, hip, and heel wounds, but did not remember anything about any other wounds on the resident's feet or ankles. Review of the TAR for April 2015 with the DON revealed no treatment orders were in place for any wounds other than the coccyx, left hip, and heels. Additionally, she acknowledged the additional wounds present when Resident #1 arrived at the hospital on 04/15/15 were not documented in facility records. The DON could think of no reason for how the wounds were missed other than the nurses assumed they were existing, and they failed to follow the facility's policies related to assessing, measuring, and documenting newly identified sores. She further acknowledged the wounds on the resident's right foot, left toe, and bilateral ankles were new at some point; however, with the lack of documentation it was impossible to know when they developed. (The DON was unable to locate or provide any notes from SKin Committee meetings.)</p> <p>2. Review of the medical record revealed Resident #11 was originally admitted by the facility on 11/06/12, and readmitted on 04/04/13, with diagnoses that included Joint Replaced Hip, Blindness, Anemia, Acquired Limb Deformity, and Protein Calorie Malnutrition.</p> <p>Review of the Annual MDS Assessment dated 07/11/15, revealed Resident #11 was assessed</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 53</p> <p>by the facility to have short and long-term memory problems. Review of Section G for functional status, revealed Resident #11 required extensive assistance with bed mobility, dressing, eating, toileting, and personal hygiene. Review of Section H for bowel and bladder function, revealed Resident #11 was "frequently incontinent." Review of Section M for skin condition revealed the facility did assess Resident #11 to be at risk for pressure ulcers; however, the resident did not have any Stage I or higher pressure ulcers.</p> <p>Review of the Nurse's Notes, dated 07/20/15, revealed Resident #11 had a diabetic foot ulcer to the left second toe measuring 1.5 cm by 0.7 cm, which had scabbed over, without odor or drainage, and without signs or symptoms of infection. Review of the Nurse's Notes, dated 07/21/15, revealed the weekly skin assessment was completed, and the reader was referred to the Wound Manager.</p> <p>Review of the Wound Healing Progress Report, dated 07/20/15, revealed Resident #11 had a diabetic foot ulcer to the left second toe measuring 1.5 cm by 0.7 cm, an abrasion to the left lateral shin measuring 7.0 cm by 1.5 cm, and the toenail off the right great toe.</p> <p>Observation of a skin assessment for Resident #11, performed by Licensed Practical Nurse (LPN) #3 on 07/24/15, revealed a wound (possible deep tissue injury) to the left heel measuring 0.5 cm by 0.4 cm that had not previously been identified by the facility.</p> <p>Interview with LPN #3 on 07/24/15 at 3.30 PM, revealed the wound on the left heel was new and</p>	F 314		F314 Sept 21 2015
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F 314	<p>Continued From page 54 had not previously been identified by the facility.</p> <p>Interview with the Assistant DON (ADON) on 07/24/15 at 5:00 PM, revealed she had assumed the role of ADON when the DON left the facility's employment on 07/09/15, and the Assistant MDS Coordinator became the acting DON at that time. Continued interview revealed weekly skin assessments were to be completed on every resident. She stated a good assessment included direct observation of the resident's body underneath the clothes, from head to toe. She further stated the results of the assessment were to be documented in the computer, with newly identified areas added to the Wound Assessment Report. Continued interview revealed the former DON had oversight of the facility's wound management processes, reviewed the weekly skin assessments and Wound Reports, and directed RN #2 on the identified wounds she was to measure each week. The ADON stated before the DON left the facility's employment, she was not involved in the process at all. Further interview revealed the ADON was Unit Manager (UM) before assuming her new role. She explained as UM, and as ADON, she had not been involved in any tracking or monitoring of pressure ulcers in the facility. Furthermore, the ADON reported she was not aware of any of the nursing staff had receiving specialized training related to wound identification and management.</p> <p>Interview with the Assistant MDS Coordinator on 08/03/15 at 12:40 PM revealed she had been the acting DON for approximately one (1) week. She stated when the ADON became the formal DON she resumed her duties related to the MDS system. Continued interview revealed she had worked with the ADON, taking care of issues as</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 55</p> <p>they arose. She further stated she had not been involved with skin assessments or wound management in any way, and was not aware of any tracking of wounds in the time since the former DON had left the facility's employment.</p> <p>Interview with the Administrator on 08/03/15 at 3:40 PM revealed the former DON was responsible for keeping notes for the weekly Skin Committee meetings. He stated every resident with identified skin concerns was discussed at the meetings and tracked by the facility's Quality Assurance process. He further stated since the prior DON had left the facility, he was still finding documents she left behind; however, he was unable to produce any notes related to the weekly Skin Committee meetings. Continued interview revealed when a new skin ulcer was identified the nurse should document and report to the UM who reported to the DON; therefore, all new ulcers would be presented for QA for investigation and discussion. The Administrator revealed during the State Agency survey, he was "finding out" the former DON had failed to share information with the management team, and the facility was just becoming aware of the problems related to wound assessment and tracking. The Administrator acknowledged if new ulcers were not identified and documented, or not reported, the Committee would not know about them. He stated the facility had identified the need for more education related to its wound management process, and training was in progress at the time of the interview.</p> <p>***The facility provided an acceptable Allegation of Compliance (AOC) on 08/06/15. The facility implemented the following actions to remove Immediate Jeopardy:</p>	F 314		F314 Sept 21 2015

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F 314	<p>Continued From page 56</p> <p>1) Resident #1 had a Pressure Ulcer Care plan developed which was in place and reflected interventions for protection of Skin and Skin Integrity, to promote healing, to prevent infection and development of further pressure ulcers; however, there was undocumented evidence that the resident's care plan was not followed and/or revised for any identified pressure ulcer.</p> <p>It was reported the clinical record of Resident #1 was incomplete. The count of the pressure ulcers noted on Resident #1 did not match the photographic evidence, and documentation needed to validate care and treatment was provided for these pressure ulcers was not provided and had to be considered as lost or nonexistent. There was no documented evidence of a Comprehensive Skin Assessment for Resident #1 prior to discharge.</p> <p>2) One hundred percent of the resident census (71) had head to toe skin assessments completed by 08/04/15 by the Director of Nursing, Unit Managers, Staff Development RN, and Wound Nurse. No additional unidentified pressure ulcers were identified.</p> <p>3) The Weekly Skin Assessment Sheet (exhibit A) was reviewed and approved by the QA Committee on 07/30/15; the QA Committee consists of the Administrator, Director of Nursing, MDS, Social Services, Unit Managers, Rehabilitation Therapy Director, Staff Development RN, and the Medical Director. It is to be used weekly by the Charge Nurse, Wound Care Nurse, and/or Unit Manager for each in-house resident to identify any newly developed and/or existing pressure ulcers. Any new</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 57</p> <p>pressure ulcers identified will be communicated to the physician for potential treatment orders and to the Director of Nursing and to the Interdisciplinary Team (IDT) to implement interventions and update the comprehensive plan of care. The IDT consists of the Director of Nursing, Unit Managers, Dietary Manager, Rehabilitation Therapy Manager, and Social Services. The results of the Weekly Skin Assessment sheets will be reviewed a minimum of five (5) times per week by the Director of Nursing and/or the Assistant Director of Nursing and the Administrator. Any newly developed pressure ulcers will be reported immediately to the Director of Nursing and the Administrator. Staff responsible for the use of the Weekly Skin Assessment Sheet includes but is not limited to the Charge Nurse, Unit Manager, Weekend Manager, and the Director of Nursing. The Administrator will be responsible for oversight and to report to the QA Committee at least monthly or as outlined in this plan.</p> <p>4) Licensed Nursing Staff have been in-serviced by the DON, Unit Managers, and Staff Development RN with a completion date of 08/04/15 on how to identify risk factors for developing pressure ulcers and how to develop a comprehensive care plan to address: prevention for breakdown or further breakdown, interventions to promote healing and prevent infection, and interventions to include assessment, monitoring, and updating the comprehensive care plan with changes in residents' condition that may indicate a comprehensive review to update interventions as indicated and healing or decline of pressure ulcers, which is included in the Facility Skin System. The Braden Scale tool and the resident's</p>	F 314		F314 Sept 21 2015	

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F 314	Continued From page 58 medical history will be reviewed with the licensed nurses to assist in developing a comprehensive plan of care for pressure ulcers upon admission, readmission, and/or changes in the resident's condition. In addition, the Director of Nursing, Unit Managers, and or RN Staff Development Coordinator provided re-education for the Certified Nursing Assistants on skin reporting utilizing the Stop and Watch Form during bathing and ADL care by 08/04/15.  5) All residents have been assessed for the potential of skin breakdown using the Skin Assessment Worksheet (exhibit A), the Braden Tool, and the Stop and Watch tool (exhibit B), and current medical history with review and update of their comprehensive care plans to ensure risks have been identified and interventions were implemented to promote healing and prevent further breakdown, infection, and any unidentified pressure ulcers. This was completed on 08/04/15 by the DON, Unit Managers, Staff Development RN, and/or RN Supervisor. Information from the evaluation will determine if additional assessment and interventions would be necessary for each resident in the facility. Appropriate interventions were implemented and Care Plans updated initially by the DON and Staff Development RN, and thereafter by the RN Unit Managers and Charge Nurse by 08/04/15. Skin assessments were completed on the total in-house census of 71 residents and no unidentified pressure ulcers were found.  6) The Regional Quality Manager for Preferred Care Partners Management Group provided education regarding the Weekly Skin Management Guidelines on or before 08/04/15 for the Interdisciplinary Team (IDT) which	F 314		F 314 Sept 21 2015	

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F 314	Continued From page 59 consisted of the DON, Unit Managers, Wound Nurse, Dietary Manager, Therapy Manager, and Social Services Director.  7) Initial education for the Director of Nursing, Staff Development, and Unit Managers was provided by the Preferred Care Partners Management Group, Regional Quality Manager by 08/04/15 regarding use of the Care Plan as a communication tool to direct resident care and to follow the comprehensive plan of care related to pressure ulcers, and consistently following the skin care protocol which included the following: accurate weekly skin assessments, reporting of new or existing identified pressure ulcers, accurate pressure wound assessments to identify detection of decline or healing process, to identify risk issues to prevent breakdown and to promote healing and to effectively implement a comprehensive care plan and interventions, to accurately document pressures regarding healing or decline to include measurement and description, and to obtain Physician's Orders for treatments to assist in healing and infection, and to prevent further wound decline.  8) The remaining Licensed Facility Nursing Staff education was educated by the DON, Unit Managers, and Staff Development RN with a completion date of 08/04/15 with a post-test given. As of 08/04/15, a total of 15 of 20 licensed nurses have received this education and as of 08/04/15, a total of 22 of 34 nurse aides received the education by the Staff Development RN, DON, Unit Managers, or Wound Nurse. All nursing staff received the required wound education prior to working their next shift by the Staff Development RN, Unit Managers, Wound Nurse, or DON. All new nursing hires have been	F 314			

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F 314	<p>Continued From page 60</p> <p>educated during general orientation, with a post-test given by the Staff Development RN prior to their working on a unit regarding following the comprehensive care plan interventions, reporting skin breakdown to licensed nurses and the Stop and Watch Tool, communication with the physician in developing a plan of care, including treatment if indicated, to promote healing, prevent infection, and prevent further breakdown. Education also included how to perform an accurate wound assessment and identification of causal factors of breakdown in order to implement effective interventions.</p> <p>9) The Quality Assurance Committee members (Administrator, Director of Nursing, MDS, Unit Managers, and Staff Development RN) reviewed and approved the education material on 08/04/15. Records of the in-service on the educational materials included signatures of attendance, signature of in-services received, and copies of testing for efficacy of the training. Nursing in-service education on the subjects noted was completed by 08/04/15.</p> <p>10) Members of the QA Committee developed a tool on 07/31/15 to validate assessments and Care Plans were being utilized per policy protocol. This was implemented on 07/31/15 and is ongoing.</p> <p>In addition, the DON, Unit Managers, Staff Development RN, or Wound Nurse are responsible to reassess 5 resident skin assessments per week to ensure accuracy of licensed nurses' skin assessment within 24 hours of the resident's scheduled 7-day assessment. This will be updated to the QA Committee approved pressure ulcer tracking tool as</p>	F 314		F314 sept 21 2015

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F 314	<p>Continued From page 61</p> <p>completed by the DON, Staff Development RN, Unit Managers, and Wound Nurse. Any concerns identified with accuracy of the skin assessment will have re-education provided by the Director of Nursing, Unit Managers, Staff Development RN, or Wound Nurse to the licensed nurse weekly for 3 months until 10/30/15. The Director of Nursing will discuss the results of accuracy and if any education should be provided regarding the reassessments during the next scheduled QA Meeting.</p> <p>11) Monitoring will be done by the Administrator, DON, Staff Development RN, RN Unit Managers, and Wound Nurse. Any issues identified will be corrected immediately and taken to the next scheduled QA meeting for review and a revised plan of action if warranted. The Administrator will provide oversight on a weekly basis and this practice will become effective on 07/31/15.</p> <p>12) QA Meetings will be held with two or more team members in attendance daily 5 days a week and on weekends if necessary for review of data to ensure compliance: completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. Any findings of newly developed or existing pressure ulcers and the interventions implemented will be reviewed for effectiveness or need for additional interventions until the situation is controlled.</p> <p>QA Committee members will review minimally 5 days a week for 30 days or additionally as necessary until 09/01/15; then one time weekly until 09/30/15 or as needed; then monthly thereafter or as needed sooner.</p>	F 314		F314 Sept 21 2015

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F 314	<p>Continued From page 62</p> <p>***The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1) Resident #1 was no longer in the facility.</p> <p>2) Review of the facility's documentation dated 07/30-08/04/15, and interviews with Unit Manager (UM) #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>3) Review of the facility's 100% skin assessment sheets revealed facility staff utilized the Weekly Skin Assessment Sheet approved by the QA committee on 07/30/15. Interviews with UM #1 on 08/08/15 at 1:20 PM, UM #2 on 08/08/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the DON on 08/06/15 at 4:40 PM, Licensed Practical Nurse (LPN) #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, and LPN #3 on 08/06/15 at 3:25 PM, revealed the Weekly Skin Assessment Sheet was being utilized to conduct weekly skin assessments and to conduct skin assessments for new or readmitted residents to the facility.</p> <p>Per interview with LPN #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, LPN #3 on 08/06/15 at 3:25 PM, UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM, revealed any concerns identified with a newly developed</p>	F 314			

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F 314	<p>Continued From page 63</p> <p>pressure ulcer and/or existing pressure ulcers would be reported to the physician, to the DON, and to the IDT to implement interventions and to update the resident's comprehensive plan of care. According to staff interviews, no new pressure ulcers have been identified since 07/29/15.</p> <p>Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/06/15 at 3:00 PM, revealed he provided oversight to ensure the skin assessments were done correctly in accordance with the facility's protocols and training.</p> <p>4) Review of the In-service Training related to risk factors for the development of pressure ulcers and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the residents' comprehensive care plan. Interview conducted on 08/06/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3:25 PM with LPN #3, 08/06/15 at 1:20 PM with UM #1, and 08/08/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure</p>	F 314			

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F 314	<p>Continued From page 64</p> <p>ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15, at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility's skin care protocols during orientation when hired by the facility.</p> <p>Further review of the In-service Training dated 08/03-05/15, revealed the Staff Development RN provided education for the Certified Nurse Aides (CNAs) regarding skin reporting utilizing the "Stop and Watch" form during bathing and ADL care. Interviews conducted on 08/06/15 with CNA #16 at 1:21 PM, CNA #20 at 1:28 PM, CNA #1 at 1:41 PM, CNA #5 at 1:47 PM, CNA #15 at 1:55 PM, CNA #7 at 2:00 PM, CNA #22, at 2:05 PM, CNA #23 at 2:07 PM, CNA #18 at 2:20 PM, and CNA #24 at 3:40 PM verified each staff member had attended the training and was knowledgeable about the use of the "Stop and Watch" form and reporting any changes in a resident's skin condition.</p> <p>5) Review of the facility's documentation dated 07/30-08/04/15, and interviews with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>6) Review of In-service Training dated 08/03/15, revealed the Preferred Care Partners Management Group provided training regarding the Weekly Skin Management Guidelines for the Interdisciplinary Team (IDT) which consisted of the DON, Unit Managers, Wound Nurse, Dietary</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 65</p> <p>Manager, Therapy Manager, and Social Services Director. Interviews conducted with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM revealed each of the IDT members attended the training and had knowledge of the Weekly Skin Management Guidelines.</p> <p>7) Review of In-service Training dated 08/03/15, revealed the Regional Quality Manager provided training for the DON, Staff Development Nurse, and Unit Managers related to use of the care plan as a communication tool and following the comprehensive care plan and to consistently follow the facility skin care protocols. Interviews on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM, confirmed each of the staff members attended the in-service training and had knowledge of the care plan process and the facility skin care protocols. In addition, a post-test was provided.</p> <p>8) Review of the In-service Training related to risk factors for the development of pressure ulcers and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the resident's comprehensive care plan. Interview conducted on 08/08/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3:25 PM with LPN #3, 08/06/15 at</p>	F 314		F314 Sept 21 2015	

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F 314	<p>Continued From page 66</p> <p>1:20 PM with UM #1, and 08/06/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15 at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility skin care protocols during orientation when hired by the facility.</p> <p>9) Review of the Daily QA Meeting Sign-In Sheets revealed the QA Committee met on 08/04/15 and review of the in-service records revealed the educational materials included signatures of attendance, signature of in-services received, and copies of efficacy of the training.</p> <p>10) The Pressure Ulcer tool was reviewed on 08/06/15 and verified the tool was being utilized to validate skin assessments and care planning for residents with pressure ulcers. The QA Committee members were reviewing the tool daily. Interviews conducted on 08/06/15 with the Administrator at 3:00 PM, UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, the MDS Nurse at 3:35 PM, and the DON at 4:40 PM confirmed the tool was being used to validate skin assessments were conducted and documented correctly and care plans were being updated and followed for residents with pressure</p>	F 314		F314 Sept 21 2015	

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F 314	Continued From page 67 ulcers.  Interviews conducted on 08/06/15 with LPN #1 at 1:25 PM, with RN #1 at 2:55 PM, and with LPN #3 at 3:25 PM, revealed licensed nurses were responsible to complete a head to toe skin assessment for residents weekly as assigned on the skin assessment schedule. LPN #1, RN #1, and LPN #3 stated the skin assessment was documented on the Skin Assessment Sheet with the "man" figure on it. Interviews conducted on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM revealed they were responsible to reassess 5 resident skin assessments weekly to ensure the skin assessments had been completed accurately by the licensed nurse who was assigned to complete the scheduled skin assessment. The reassessment had been done within 24 hours of the resident's scheduled 7-day assessment. The UMs, Staff Development RN, and DON stated no problems had been identified with the reassessments they had completed.  11) Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/06/15, at 3:00 PM, revealed he provided oversight to ensure the skin assessments were done correctly in accordance with the facility's protocols and training.  12) Review of the facility's documentation dated 08/04-06/15 revealed daily QA meetings were conducted to review the completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. No newly developed pressure ulcers have been identified since 07/29/15. Interviews conducted	F 314			

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F 314	Continued From page 68 on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Therapy Manager at 2:30 PM, the Staff Development RN at 2:45 PM, the Administrator at 3:00 PM, the Social Services Director at 3:15 PM, and the DON at 4:40 PM, confirmed daily QA meetings were held to review the completion and accuracy of skin assessments and comprehensive care plans for any new and/or existing pressure ulcers.	F 314		F314 Sept 21 2015	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible. Observation of a medical supply room, one (1) utility closet, one (1) housekeeping closet, and one (1) nursing supply closet revealed the areas were unlocked, unsupervised by staff, and accessible to residents. Additionally, observation of a medication/treatment cart was unlocked, unsupervised by staff, and accessible to residents. Review of documentation provided by the facility revealed twelve (12) of the facility's sixty-nine (69) residents were cognitively impaired, yet independently mobile	F 323	F323  What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  No resident were found to have been affected by the deficient practice. The medical supply room door, the utility closet, the housekeeping closet and nursing supply closet were locked immediately upon notification. All med carts were assessed and locked per the licensed nursing staff upon notification.  How you will identify other residents/patients having the potential to be affected by the same deficient practice?	F323 Sept 2015	

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10/09/2015 10:42

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10-14-13 a.m. 10-09-2015 76 From: Stanton Nursing and Rehab.

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F 323	<p>Continued From page 69</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Proper Storage of Chemical Supplies," undated, revealed chemicals were to be stored behind a locked door with Personal Protective Equipment readily available for anyone who may be utilizing the chemical.</p> <p>Review of the facility's policy titled "Storage of Medication," dated 09/10, revealed the medication supply should only be accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Further review revealed medication rooms, cabinets, and medication supplies should remain locked when not in use or attended by persons with authorized access.</p> <p>Review of the facility's policy titled "Syringe and Needle Inventory Storage," undated, revealed the syringes were stored in the locked Central Supply storage room with limited access. Further review revealed syringes requested for resident use were stored in the medication room and/or medication cart, which were to remain locked at all times.</p> <p>Review of a list of residents provided by the facility revealed the facility had twelve (12) residents that were confused and independently mobile.</p> <p>1. Observation on 07/21/15 at 2:48 PM revealed the medication/treatment cart on the South Hall to be unlocked and accessible to residents. Further observation revealed the cart contained topical medications as well as scissors, six bottles</p>	F 323	<p>All cognitively impaired, mobile residents would have the potential to be impacted by the deficient practice. All doors were checked for appropriate locking by the Administrator and Maintenance Director on July 29, 2015, as well as all medication and treatment carts assess for proper locking by the licensed nursing staff at this time.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The facility will continue to ensure that the resident environment is free of accident hazards as is possible and each resident will receive adequate supervision and assistance to prevent accidents. The utility closet, housekeeping closet, medical supply storage and nursing supply closet have been locked with signs placed on the door stating "Door must be locked." All staff received</p>	<p>F 323 Sept 21 2015</p>	

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F 323	<p>Continued From page 70</p> <p>(237-milliliter bottles) of hydrogen peroxide, one bottle (473 milliliters) of alcohol, and one canister of Super Sani-Cloth Germicidal Wipes.</p> <p>Interview with Registered Nurse (RN) #6 on 07/22/15 at 4:26 PM revealed the medication/treatment cart should be locked at all times when not in use or not supervised by staff to ensure resident safety. Further interview revealed the treatment cart did have supplies that would be harmful to residents. Continued interview revealed she was unsure if the supply closets should be locked; however, she did report that items found in the closets could be hazardous to the residents.</p> <p>2. Observation on 07/21/15 at 2:12 PM of a medical supply closet revealed the closet was unlocked and accessible to residents. Continued observation revealed a sign posted on the door that read "Door Should Be Locked At All Times." Further observation revealed the closet contained intravenous needles and syringes, seven boxes of 50-count per box needles and twelve suture removal kits.</p> <p>3. Observation on 07/24/15 at 11:10 AM revealed a nursing supply closet door unlocked and accessible to residents. Further observation revealed the closet contained disposable razors, one 8-ounce bottle of Thera-gel Therapeutic Shampoo, two 8-ounce bottles of hydrogen peroxide, 88 alcohol swab sticks, 88 Betadine swab sticks, and nail polish removal swabs.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/24/15 at 11:15 AM revealed the nursing supply closet usually stayed unlocked. Further interview revealed the door did have a lock;</p>	F 323	<p>education by the Administrator and/or Nurse Educator beginning 9/11, 9/12, 9/14, 9/15, 9/16, 9/17, 9/19 and 9/20/2015 in regards to the proper procedure for maintaining locked doors. Licensed nursing staff were educated by the Director of Nursing and/or the Quality Assurance Nurse in regards to keeping medication and treatment carts locked at all times when not in use. This education was completed by September 20, 2015.</p> <p><b>How will the facility monitor its performance to ensure that solutions are sustained?</b></p> <p>The Administrator and/or Maintenance Supervisor will make rounds five times per week for four weeks to ensure compliance for locked doors, starting on September 14, 2015. The Director of Nursing and/or Unit Manager will audit the medication and treatment carts 5 days per week for four weeks for proper locking, starting on</p>	F323 Sept 21 2015

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F 323	<p>Continued From page 71</p> <p>however, the lock was not functional. Continued interview revealed the items in the closet could be dangerous for some residents.</p> <p>4. Observation on 07/21/15 at 2:57 PM revealed the utility room was unlocked and accessible to residents. Further observation revealed the room contained a large gas hot water heater, large floor cleaning equipment, and one bottle of Sani-Cloth Wipes with Bleach.</p> <p>Interview with Housekeeping Staff Member #4 on 07/22/15 at 8:54 AM revealed the utility closet should be locked at all times for resident safety.</p> <p>5. Observation on 07/24/15 at 11:20 AM revealed a housekeeping supply closet to be unlocked and accessible to residents. Further observation revealed the closet contained two 1-quart containers of Orange Power Citrus Degreaser Cleaner and one bottle of diluted Clorox Bleach.</p> <p>Interview with Housekeeping Staff Member #25 on 07/24/15 at 11:01 AM revealed the housekeeping storage closet should be locked at all times. Continued interview revealed the doors should be locked for resident safety.</p> <p>Interview with the South Hall Unit Manager on 07/21/15 at 3:25 PM revealed she was unsure if the supply closets should be locked. However, she pointed to a sign on the door to the medical supply closet that read "Door Should Be Locked At All Times." Continued interview revealed the needles, syringes, scissors, razors, and chemicals should be locked and secured at all times. The Unit Manager further stated the medication treatment cart should be locked at all times when not in use. Further interview revealed</p>	F 323	<p>September 14, 2015. The results of the audits will be provided to the Quality Assurance Committee to review if further interventions are warranted.</p> <p>Compliance Date: September 21, 2015</p>		

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F 323	<p>Continued From page 72</p> <p>the facility did have residents that were confused and mobile. Per interview, the items would be hazardous to some of the facility's residents.</p> <p>Interview with the Environmental Services Director on 07/24/15 at 11:04 AM, revealed the storage closets should be kept locked and not accessible to residents. Further interview revealed this could be hazardous to the facility's residents.</p> <p>Interview with the Director of Maintenance on 07/22/15 at 3:07 PM revealed the facility's procedure was for Nursing to monitor the doors and locks to ensure the doors were secure and if issues were identified, to report the issue to him. Further interview revealed he had received no reports of any door locks malfunctioning.</p> <p>Interview with the Director of Nursing on 07/24/15 at 11:26 AM revealed she was not sure if the facility had a system in place to ensure locks were functioning appropriately and the doors remained locked. Further interview revealed the facility did have confused residents that were mobile and access to medications, sharp items, and dangerous chemicals was potentially hazardous to these residents.</p> <p>Interview with the Administrator on 07/22/15 at 2:39 PM revealed the facility's procedure to ensure locks were functioning appropriately and doors remained locked was for all staff to monitor and to report any issues. The Administrator stated the facility did not have a system failure; the facility had a personnel failure. Continued interview revealed chemicals, medications, and sharp items would be a potential hazard if left unlocked and unsecured.</p>	F 323		F323 Sept 21 2015	

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F 441 SS=D	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident, and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><b>F441</b></p> <p><b>What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?</b></p> <p>Resident #4 did not have a negative outcome as a result of the deficient practice. C.N.A. #10 was re-educated on correct peri-care procedures by the Nurse Educator on August 31, 2015.</p> <p><b>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</b></p> <p>All residents receiving staff assistance with personal care would have the potential to be affected by the deficient practice.</p> <p><b>What measures will be put into place or what systemic changes you will</b></p>		

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F 441	Continued From page 74  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's practice reference for hand hygiene, it was determined the facility failed to ensure perineal care was provided in a manner to help prevent the development and transmission of disease and infection for one (1) of twenty-four (24) sampled residents (Resident #4). Staff was observed to clean Resident #4 after an episode of urinary incontinence. The Certified Nursing Assistant (CNA) failed to remove her gloves or wash her hands after cleaning the resident and before adjusting the resident's clothing and linens and bed controls.  The findings include:  Review of the facility's practice reference for hand hygiene revealed recommendations were taken from the Centers for Disease Control and Prevention's "Guidelines for Hand Hygiene in Health-Care Settings," dated 10/25/02. Continued review revealed when used together, good hand hygiene practices and gloves substantially reduce the risk of cross-contamination and the spread of infection between patients and between patients and health care personnel. Further review revealed hand hygiene and decontamination should occur whenever the health care worker moved their hands from a contaminated body site to a clean body site during the provision of care.  Observation on 07/21/15 at 2:15 PM revealed CNA #10, who was assisted by Licensed Practical Nurse (LPN) #3, performed perineal care for	F 441	make to ensure that the deficient practice does not recur?  The facility maintains and will continue an infection control program that provides for a safe and sanitary environment to prevent the development and transmission of disease and infection. All licensed staff and nursing assistants were re-educated on proper technique for perineal care to prevent the spread of disease and infection. This education was completed by the Director of Nursing and/or Nurse Educator by September 20, 2015.  How will the facility monitor its performance to ensure that solutions are sustained?  Perineal care will be observed and audited on five patients weekly for	

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F 441	<p>Continued From page 75</p> <p>Resident #4. Continued observation revealed CNA #10 applied gloves prior to beginning the procedure. While LPN #3 assisted with positioning Resident #4 for the procedure, CNA #10 removed the resident's pants and brief, both of which were saturated with urine. The CNA cleaned the resident's perineal area and proceeded to adjust his/her shirt, repositioned the resident in bed, lowered the bed using the remote control device, and attached the call bell to the sheet, all prior to removing the soiled gloves or washing her hands.</p> <p>Interview with CNA #10 on 07/21/15 at 2:35 PM revealed she should have removed her gloves and washed her hands after cleaning Resident #4, and before completing his/her care. She stated she was nervous while being observed.</p> <p>Interview with LPN #3 on 07/21/15 at 2:40 PM revealed she witnessed CNA #10 using improper hand hygiene during the provision of care for Resident #4, but by the time she realized what happened it was too late to stop the CNA. She acknowledged the CNA did handle clean items with soiled gloves, and stated she should have removed her gloves and washed her hands after completing the perineal care and before resuming other tasks.</p> <p>Interview with the Education Nurse on 07/22/15 at 12:50 PM revealed hand hygiene was a topic of education for new hire orientation, and covered during annual mandatory in-services. Review of education records revealed CNA #10 did attend the hand hygiene in-service on 07/08/15 (before exit of this survey). The Education Nurse stated the CNA should have removed her gloves and washed her hands after completing perineal care</p>	F 441	<p>4 weeks by the Director of Nursing and/or Nurse Educator. Any identified concerns with technique will be addressed immediately.</p> <p>This audit began on 9/17/15.</p> <p>The audit results will be forwarded to the QA Committee for review and appropriate response.</p> <p>Compliance Date: September 21, 2015</p>	F441 Sept 21 2015	

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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380		
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F 441	Continued From page 76 and before continuing to provide "clean care." Continued interview revealed a failure to practice good hand hygiene was an infection control concern.  Interview with the Assistant Director of Nursing (ADON) on 07/23/15 at 9:06 AM revealed it was the facility's expectation that staff practiced good hand hygiene while providing care to residents. She stated CNA #10 should have removed her gloves and washed her hands after cleaning the resident and before proceeding to other tasks, e.g., when moving from a contaminated area to a clean area.	F 441		F 441 Sept 21 2015	
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's pest control policy it was determined the facility failed to maintain an effective pest control program to ensure the facility was free of pests. Flies were observed in various areas of the facility on 08/04/15 in contact with residents' skin and food.  The findings include:  Review of the facility's pest control policy titled "Pest Control and Flies Protocol," undated,	F 469	F469  What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  No residents were identified to have been affected by the deficient practice.  How you will identify other residents/patients having the potential to be affected by the same deficient practice?  All residents would have the potential to be affected by the deficient practice.	F 469 Sept 21 2015	

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F 469	<p>Continued From page 77</p> <p>revealed the facility contracts with a certified pest control company to control insects including flies. According to the policy, services are provided on a monthly and as needed basis. The Maintenance Supervisor monitors the services' effectiveness and additional services were requested as needed to maintain the environment pest free.</p> <p>Observations conducted during the initial tour on 08/04/15 at 11:58 AM revealed four (4) flies near the windowsill and on the bedside table in resident room 200.</p> <p>Observation on 08/04/15 at 12:20 PM revealed three (3) flies around the doorway in resident room 205.</p> <p>Observation on 08/04/15 at 4:20 PM revealed four (4) flies in resident room 107.</p> <p>Observation on 08/04/15 at 5:45 PM revealed a fly near the North Hall Nurses' Station.</p> <p>Flies were observed on the South Hall on 08/04/15 at 3:55 PM, in the front hall dining room on 08/04/15 at 4:25 PM, and at the South Hall Nurses' Station on 08/04/15 at 6:15 PM.</p> <p>Observation of the back dining room during the evening meal service on 08/04/15 at 6:30 PM revealed six (6) flies flying in the dining room. The flies were observed to land on Resident #4's skin near his/her mouth and eyes and land on Resident #4's and Resident #18's food. In addition, flies landed on the tables where residents were eating.</p> <p>Observation of the "Air Curtain Blower" above the</p>	F 469	<p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p> <p>The facility will continue to maintain an effective pest control program.</p> <p>The Administrator and Maintenance Director met with the contracted pest control service on 9/11/15 and requested a complete review of the fly issue with a subsequent plan to correct. The pest control service representative indicated that more treatment times during fly season would curtail the problem.</p> <p>The pest control company will service for insects every other week commencing immediately until the pest season is over or until October 30, 2015. Air curtains were ordered on 9/15/15 to replace three currently in use based</p>	<p>7469 sept 21 2015</p>	

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F 469	Continued From page 78 doorway in the back dining room and the doorway going from the North Hall exit to the laundry building revealed the air curtain blower did not emit enough air to prevent flies from entering the building.  During a group interview with thirteen (13) alert and oriented residents conducted on 08/05/15 at 3:45 PM, the residents stated that the facility had a problem with flies.  Review of the facility's pest control agreement dated 07/06/07, revealed the facility had a contract for a fly control program for the months of May-October.  Review of pest control invoices revealed the pest control company had treated the facility for flies on 05/28/15, 06/29/15, 07/09/15, and 08/05/15.  Interview with the Maintenance Director on 08/06/15 at 11:10 AM revealed the Maintenance Director had not contacted the pest control company for any additional fly treatments and had not considered that the air curtain blowers were not emitting enough air to prevent flies from entering the building when the doors were open.	F 469	upon the recommendation of the pest control company. They will be installed upon arrival.  How will the facility monitor its performance to ensure that solutions are sustained?  The Administrator and Maintenance Director will monitor for any potential issue with flies five days a week to evaluate if improvement of the issue has been achieved. The results of the audits will be forwarded to the QA Committee for review and appropriate response.  Compliance Date: September 21, 2015	7469 sept 21 2015	
F 514 SS=J	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient	F 514	F514  What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  Resident #1 was discharged from the facility on 4/15/15.  Resident #8 was discharged to home on 7/21/15.	F514 sept 21 2015	

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F 514	<p>Continued From page 79</p> <p>information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the medical record was complete and accurate for two (2) of twenty-four (24) sampled residents (Resident #1 and Resident #8). Resident #1's medical record was not complete and accurate as it related to pressure sores when staff did not follow the facility's policies and procedures for documentation of wounds. Furthermore, according to the "Assessment Date," all Body Map Assessments provided by the facility for the period of time between 02/25/15 and 04/15/15 appeared to have been completed on 07/28/15, the day they were requested by the State Survey Agency. (Refer to F280 and F314.)</p> <p>In addition, the facility failed to ensure Resident #8's medical record included documentation to reflect the resident's refusal of scheduled wound care.</p> <p>Furthermore, the facility failed to ensure the narcotic count sheets for one (1) of two (2) medication carts on the North Hall were complete with nurses' signatures.</p> <p>The facility's failure to ensure the medical record</p>	F 514	<p><b>How you will identify other residents/patients having the potential to be affected by the same deficient practice?</b></p> <p>Residents have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered. The facility does and will continue to provide services for individual needs and preferences. A review of all treatment time for wound care patients will be conducted by September 20, 2015 to determine the level of satisfaction for each patient, and including documentation review to determine any potential missing documentation or evidence of resident refusal. The review will be conducted by interviewing each wound patient and review of the medical</p>		

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F 514	<p>Continued From page 80</p> <p>for each resident having pressure sores was complete and accurate was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/29/15, and was determined to exist on 02/23/15. The facility was notified of the Immediate Jeopardy on 07/29/15.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/06/15, alleging removal of the Immediate Jeopardy on 08/05/15. The State Survey Agency determined the Immediate Jeopardy was removed on 08/05/15 as alleged, which lowered the scope and severity to "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's Quick Reference Guide titled "Pressure Ulcer Assessment," undated, revealed the results of all wound assessments were to be documented in the medical record. Continued review revealed the nurse should document the physical characteristics of each pressure ulcer, including location, category/stage, size, tissue type, color, condition of the surrounding skin, wound edges, drainage, odor, and a description of any sinus tracts, undermining or tunneling (characteristics observed with highly staged or complex ulcers).</li> </ol> <p>Review of the facility's policy titled "Skin System Policy and Procedure," revised 08/14, revealed the intent of the policy was to promote the prevention of pressure ulcer development and promote healing of pressure ulcers that were</p>	F 514	<p>treatment record to determine if any patient dissatisfaction or opportunities exists. The reviews will be conducted by the Director of Nursing, Nurse Educator, Wound Nurse, or Social Worker. Any identified documentation issues will be addressed immediately by the licensed nurse.</p> <p>All residents are at risk for developing pressure ulcers due to physical dependency, decreased cognition, decreased mobility and age-related comorbidities. A 100% audit of the current resident census (71 residents) was completed on August 4, 2015 by the Director of Nursing, Unit Managers, Nurse Educator, and Wound Nurse with no additional unidentified pressure ulcers found. All residents were assessed using the skin assessment worksheet, Braden tool, Stop and Watch Tool, and review of current medical history to ensure that risks had been identified and interventions implemented</p>	<p>F514 Sept 21 2015</p>	

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F 514	Continued From page 81 present. Continued review revealed an interdisciplinary approach would be used to assist in the appropriate documentation of wound classification and/or pressure ulcer staging. According to the policy, a skin assessment would be completed upon admission and weekly thereafter.  Interview with the Assistant Director of Nursing (ADON) on 07/24/15 at 5:00 PM, revealed the facility did not have a policy related to maintaining complete and accurate medical records. She explained the facility practice for skin assessments and related documentation as follows: each resident was to have a head-to-toe skin assessment each week; the nurse performing the assessment was to initial the Treatment Administration Record (TAR) to indicate the assessment was done as scheduled; the nurse was to complete documentation in the computer; the nurse was to indicate whether the skin was intact or not, and if any areas that were identified were new or existing; if there was any non-intact skin, the nurse was to document on the Body Map, which provides a visual diagram of exactly where each area is located, and allows the nurse to label each area according to the type of each wound; the nurse was responsible for documenting all problem areas on the Wound Assessment Report, where a detailed description of any non-intact areas was entered. The ADON stated every area was to be measured by the nurse and entered on the report. Continued interview revealed if the nurse followed the protocol correctly, all wounds would be identified and when the nurse logged into the computer system, he/she could tell if a particular wound was new or previously identified. She further stated any new wound was to be reported to the	F 514	to promote healing and prevent further breakdown of skin on the resident plan of care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Licensed nursing staff will be educated by the Director of Nursing and/or Nurse Educator beginning on September 11, 2015 and completed by September 20, 2015 in regards to documentation of any resident refusals of treatment, including the reason given for refusal and that the licensed nurse shall contact the physician to make reasonable changes to treatment hours per resident request. The Director of Nursing, Unit Manager or MDS Nurse will update the plan of care to communicate the resident requests for change in treatment times. This education also includes discussion of accommodation of needs by providing wound treatment in compliance with the		

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F 514	<p>Continued From page 82</p> <p>Physician for treatment orders, which were to be entered on the TAR; the nurse completing the skin assessment should be able to tell at a glance if a specific wound had been identified previously by looking at the TAR.</p> <p>Review of the closed clinical record revealed the facility admitted Resident #1 on 10/02/13 with diagnoses which included Dementia, Depression, Hypertension, Chronic Pain, and Delusional Disorder.</p> <p>Review of the Wound Assessment Report, dated 10/19/14, revealed Resident #1 was assessed to have a new area of denuded skin on the left inner buttock. The wound was assessed to be 0.3 centimeters (cm) by 0.2 cm. Continued review of the Wound Assessment Reports provided by the facility revealed the next report was dated 12/02/14. The report indicated an area of "irritation/excoriation" on the coccyx was newly identified, measured 2.8 cm by 2.0 cm, and was described as "denuded skin." Although the area was classified as newly identified, the status was documented as "deteriorated." No other areas, including the left inner buttock identified on 10/19/14, were mentioned. No other Wound Assessment Reports for the period between 10/19/14 and 02/23/15 were provided.</p> <p>Review of the Body Map Assessments dated 12/23/14, 01/23/15, and 02/23/15 revealed Resident #1 was assessed to have excoriation to the left buttock area, which was "non-pressure." No other Body Map Assessments for the period of time between 10/19/14 and 02/23/15 were provided.</p> <p>Review of the Nurse's Notes for October 2014</p>	F 514	<p>corresponding physician orders, updating care plans to reflect preferences for treatment including providing care in respect to normal sleeping hours of the residents and notifying the resident physician in the event the resident continues to refuse treatment after reasonable accommodations have been made.</p> <p>Licensed nursing staff received in-service education by the Director of Nursing, Unit Manager and/or Nurse Educator beginning on 8/3/15 with a completion date of 8/4/15 on how to identify risk factors for developing pressure ulcers and how to develop a comprehensive care plan that addresses: prevention for skin breakdown or further skin breakdown, interventions to promote healing and prevent infection, assessment monitoring and updating the comprehensive care plan with changes in residents condition that may indicate an improvement or</p>		

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F 514	<p>Continued From page 83 through February 2015 revealed Resident #1 was documented to have "denuded skin" to the buttocks beginning on 10/19/15. Continued review of the Nurse's Notes, and review of the comprehensive Care Plan, the TAR, the Skin Inspection Report, the Wound Assessment Reports, and the Body Map Assessments for the same period of time revealed no documented evidence of any other skin concerns or any pressure ulcers.</p> <p>However, review of hospital records revealed Resident #1 was transported to the Emergency Department (ED) on 02/23/15, and was admitted by the hospital. Review of the Physician's Note made in the ED, and review of photographs taken when the resident was admitted, revealed the presence of multiple abrasions, Stage I and Stage II pressure areas on the buttocks, and areas of necrotic tissue on both heels.</p> <p>Review of the facility's Nurse's Notes revealed Resident #1 went out to the hospital on 02/23/15, and was readmitted by the facility on 02/25/15 with multiple areas of skin breakdown. The facility documented the pressure areas present when the resident returned, and identified new areas on the coccyx and the left hip, on 03/05/15 and 03/16/15, respectively. However, there was no documented evidence the facility ever identified any additional pressure ulcers, particularly on the feet, ankles, or toes.</p> <p>Review of Wound Assessment Reports for the period between 02/25/15 and 04/15/15 revealed the following significant findings: on 03/05/15, the assessment did not address the pressure ulcers on the left and right buttocks, but did describe an 8.0 cm x 2.5 cm area of excoriation on the</p>	F 514	<p>potential change in treatment interventions. This education included use of the Braden scale tool and the residents' relevant medical history to develop a comprehensive plan of care for pressure ulcers upon admission, readmission or changes in condition. A post-test was provided to validate comprehension of content. As of end of day on 8/4/15, a total of 15 out of 20 licensed nurses had received the education and completed the post test. At that time, none of the additional 5 nurses or any new hires began their shift without first receiving this education. 100% of all current licensed nurses had received this education by September 20, 2015</p> <p>How will the facility monitor its performance to ensure that solutions are sustained? The Social Worker, Wound Nurse or Director of Nursing will conduct five interviews weekly for four weeks, beginning on</p>	
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F 514	Continued From page 84 coccyx; on 03/10/15, the assessment only referred to the SDTI on the right great toe; on 03/11/15, the assessment addressed the ulcers on the heels but no other areas; on 03/16/15, two (2) new wounds to the left hip were identified as a 2.0 cm x 1.5 cm Stage II pressure ulcer, and a 13 cm x 9.2 cm Stage I pressure ulcer - no other wounds were documented on this date; on 03/17/15, twelve (12) days after the coccyx area was described on 03/05/15, the area was reassessed to have deteriorated to a 10.75 cm x 7.0 cm pressure ulcer which was unstageable due to the presence of slough and eschar; on 03/25/15, the facility assessed and documented the coccyx and heel ulcers but the left hip ulcer was not assessed again until 03/31/15, fifteen (15) days after it was identified on 03/16/15, when the two (2) original ulcers had merged into one Stage II ulcer at 5.5 cm x 1.5 cm. The last Wound Assessment Report completed by the facility on 04/13/15, addressed four (4) areas, the coccyx, the left hip, and the left and right heels.  On 07/28/15, the State Survey Agency requested a copy of all Body Map Assessments completed between 02/23/15 and 04/15/15. The facility provided a reprint of all Wound Assessment Reports during the time period. The Wound Assessment Reports themselves were identical to those previously provided by the facility; however, they had been reprinted and now included a Body Map Assessment printed on the back of each Wound Report. Review of the Reports revealed each Wound Assessment Report included the specific date the assessment was completed and the date it was printed (07/28/15); however, review of the Body Map Assessments on the back of each Wound Report revealed all were identical, and each included an	F 514	September 13, 2015, to determine resident satisfaction with current treatment times.  Any identified issue will be addressed with the physician by the licensed nurse. Results of the interviews will be forwarded to the QA Committee for review and appropriate response. The Quality Assurance Committee is comprised of the Administrator, Director of Nursing, Unit Managers, Social Services, MDS Nurse, Medical Director, Therapy Director, Dietary Manager, and Activities Director. Documentation of wound care treatment will be reviewed by the QA Committee twice weekly for four weeks and then weekly for four weeks. Findings will be summarized and appropriate response taken by the QA Committee to assure compliance. The Quality Assurance Committee developed a tool on 7/31/15 to validate that skin assessments are being completed and subsequent care plans being developed and utilized per policy. This		

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F 514	<p>Continued From page 85</p> <p>"Assessment Date" of 07/28/15, in addition to the print date of 07/28/15.</p> <p>The same four (4) pressure areas, including the left hip, left buttock, and the bilateral heels, were pinpointed on each Body Map Assessment and printed on the Wound Assessments Reports beginning 02/26/15 through 04/13/15; however, according to the Wound Reports, the left hip ulcer was not identified until 03/16/15. In addition, each Body Map reflected an area on the left buttock, the same area documented as excoriation/denuded skin prior to 02/23/15, although the color-coded symbol was changed from green to red, which indicated the wound progressed from a non-pressure area to a pressure ulcer. Furthermore, there was no documented evidence on the Body Map Assessments to reflect the merging of multiple pressure areas on the buttocks into one large pressure ulcer over the coccyx.</p> <p>Review of hospital records revealed Resident #1 was hospitalized again on 04/15/15. Review of photographs taken at the hospital, and review of wound assessment notes, revealed the resident had five pressure areas not previously identified by the facility, located on the bilateral ankles, left great toe, right foot, and right fifth toe.</p> <p>Review of the April 2015 TAR for Resident #1 revealed treatments were in place for the left hip, coccyx, and both heels prior to the resident being discharged to the hospital. Continued review revealed no documented evidence of treatments in place for any other areas.</p> <p>Subsequent interview with the ADON on 08/03/15 at 12:40 PM, revealed she became the formal</p>	F 514	<p>tool is reviewed a minimum of 5 times per week by QA Committee. This was implemented on 7/31/15 and remains on-going. In addition, the Director of Nursing, Unit Managers, Nurse Educator and/or Wound Nurse will reassess 5 residents per week to ensure that skin has been accurately assessed and that the resident care plan accurately reflects risk factors, interventions, and status update. This began on August 4, 2015 and will continue weekly for 3 months until 10/30/15. Any issues identified shall be corrected immediately and reviewed at the next scheduled QA Meeting for review and revised plan of action if warranted. The Quality Assurance Committee is comprised of the Administrator, Director of Nursing, Unit Managers, Social Services, MDS Nurse, Medical Director, Therapy Director, Dietary, by Manager, and Activities Director. Documentation of wound care treatment will be reviewed by the</p>		

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F 514	Continued From page 86 DON on 07/31/15. Continued interview revealed there was discussion about Resident #1 in Skin Committee meetings, but she was unable to locate or provide any notes from the meetings. The DON recalled the resident's coccyx, left hip, and heel wounds, but did not remember anything about any other wounds on the resident's feet or ankles. Review of the TAR for April 2015 with the DON revealed no treatment orders were in place for any wounds other than the coccyx, left hip, and heels. The DON acknowledged the additional wounds present when Resident #1 arrived at the hospital on 04/15/15 were not documented in facility records. The DON could think of no reason for how the wounds were missed other than the nurses assumed they were existing, and they failed to follow the facility's policies related to assessing, measuring, and documenting newly identified sores. She further acknowledged the wounds on the resident's right foot, left toe, and bilateral ankles were new at some point; however, with the lack of documentation it was impossible to know when they developed.  2. Review of the facility's policy titled "Refusal of Treatment," revised November 2010, revealed if a resident refused treatment, the Unit Manager, Charge Nurse, or Director of Nursing Services would interview the resident to determine what and why the resident was refusing in order to try to address the resident's concerns and explain the consequences. Continued review revealed if the resident refused to accept treatment, detailed information relating to the refusal should be entered into the resident's medical record to include at least the following: the date and time staff attempted to give a medication or treatment, the medication or treatment refused, the	F 514	QA Committee twice weekly for four weeks, beginning on September 15, 2015, and then weekly for four weeks. Findings will be summarized and appropriate response taken by the QA Committee to assure compliance.  Compliance Date: September 21, 2015	F514 Sept 21 2015	

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F 514	<p>Continued From page 87</p> <p>resident's response and reason for the refusal, the name of person attempting to administer the treatment, that the resident was informed of the purpose of the treatment and the consequences of not receiving the medication/treatment, the resident's condition and any adverse effects due to such refusal, the date and time the physician was notified as well as the physician's response, all other pertinent observations, and the signature and title of the person recording the data.</p> <p>Review of the clinical record revealed the facility admitted Resident #8 on 07/14/15 with diagnoses including severe Hidradenitis Suppurativa of Bilateral Axillary and underneath Pannus region with Cellulitis and small abscesses, Anxiety, Depression, Possible Urinary Tract Infection, and Anemia. Review of the Nursing Admission Assessment, dated 07/14/15, revealed Resident #8 was alert and oriented with no memory problems.</p> <p>Review of Resident #8's Physician's Orders, dated 07/14/15, revealed an order for wound care to cleanse the left axilla and right groin with Normal Saline, pack with Aquacel AG, and cover areas with Mepilex AG BID (twice each day). Review of Resident #8's Treatment Administration Record (TAR), dated July 2015, revealed the resident to have an order for wound care to be performed BID (twice each day). Continued review revealed the wound care was scheduled on the TAR to be performed once during the 7:00 AM shift and once during the 7:00 PM shift. Further review revealed wound care was refused on 07/15/15 during the 7:00 AM shift, and not performed on 07/14/15, 07/15/15, 07/16/15, 07/17/15, or 07/20/15 on the 7:00 PM shift; however, there was no documented evidence to</p>	F 514		F514 Sept 21 2015	

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F 514	<p>Continued From page 88</p> <p>indicate why the care was refused or not performed.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 07/24/15 at 6:56 AM, revealed she was Resident #8's primary nurse on the 7:00 PM shift. Further interview revealed she would normally perform wound care between 10:30 PM and 7:30 AM. Continued interview revealed Resident #8 had refused his/her wound care, reporting to LPN #4 that he/she was already tired, sleepy, and it was too late; however, there is no documented evidence the resident had refused care. LPN #4 reported she should have documented each refusal of care or treatment with detailed documentation; however, she got busy and forgot.</p> <p>Interview with the Director of Nursing (DON), on 08/03/15 at 6:25 PM, revealed if a resident refused care, her expectation was for staff to document in the medical record to reflect the refusal.</p> <p>***The facility provided an acceptable Allegation of Compliance (AOC) on 08/06/15. The facility implemented the following actions to remove Immediate Jeopardy:</p> <p>1) Resident #1 had a Pressure Ulcer Care plan developed which was in place and reflected interventions for protection of Skin and Skin Integrity, to promote healing, to prevent infection and development of further pressure ulcers; however, there was undocumented evidence that the resident's care plan was not followed and/or revised for any identified pressure ulcer.</p> <p>It was reported the clinical record of Resident #1</p>	F 514		

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F 514	<p>Continued From page 89</p> <p>was incomplete. The count of the pressure ulcers noted on Resident #1 did not match the photographic evidence, and documentation needed to validate care and treatment was provided for these pressure ulcers was not provided and had to be considered as lost or nonexistent. There was no documented evidence of a Comprehensive Skin Assessment for Resident #1 prior to discharge.</p> <p>2) One hundred percent of the resident census (71) had head to toe skin assessments completed by 08/04/15 by the Director of Nursing, Unit Managers, Staff Development RN, and Wound Nurse. No additional unidentified pressure ulcers were identified.</p> <p>3) The Weekly Skin Assessment Sheet (exhibit A) was reviewed and approved by the QA Committee on 07/30/15; the QA Committee consists of the Administrator, Director of Nursing, MDS, Social Services, Unit Managers, Rehabilitation Therapy Director, Staff Development RN, and the Medical Director. It is to be used weekly by the Charge Nurse, Wound Care Nurse, and/or Unit Manager for each in-house resident to identify any newly developed and/or existing pressure ulcers. Any new pressure ulcers identified will be communicated to the physician for potential treatment orders and to the Director of Nursing and to the Interdisciplinary Team (IDT) to implement interventions and update the comprehensive plan of care. The IDT consists of the Director of Nursing, Unit Managers, Dietary Manager, Rehabilitation Therapy Manager, and Social Services. The results of the Weekly Skin Assessment sheets will be reviewed a minimum of five (5) times per week by the Director of</p>	F 514		F514 Sept 21 2015	

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F 514	Continued From page 90 Nursing and/or the Assistant Director of Nursing and the Administrator. Any newly developed pressure ulcers will be reported immediately to the Director of Nursing and the Administrator. Staff responsible for the use of the Weekly Skin Assessment Sheet includes but is not limited to the Charge Nurse, Unit Manager, Weekend Manager, and the Director of Nursing. The Administrator will be responsible for oversight and to report to the QA Committee at least monthly or as outlined in this plan.  4) Licensed Nursing Staff have been in-serviced by the DON, Unit Managers, and Staff Development RN with a completion date of 08/04/15 on how to identify risk factors for developing pressure ulcers and how to develop a comprehensive care plan to address: prevention for breakdown or further breakdown, interventions to promote healing and prevent infection, and interventions to include assessment, monitoring, and updating the comprehensive care plan with changes in residents' condition that may indicate a comprehensive review to update interventions as indicated and healing or decline of pressure ulcers, which is included in the Facility Skin System. The Braden Scale tool and the resident's medical history will be reviewed with the licensed nurses to assist in developing a comprehensive plan of care for pressure ulcers upon admission, readmission, and/or changes in the resident's condition. In addition, the Director of Nursing, Unit Managers, and or RN Staff Development Coordinator provided re-education for the Certified Nursing Assistants on skin reporting utilizing the Stop and Watch Form during bathing and ADL care by 08/04/15.	F 514		

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F 514	<p>Continued From page 91</p> <p>5) All residents have been assessed for the potential of skin breakdown using the Skin Assessment Worksheet (exhibit A), the Braden Tool, and the Stop and Watch tool (exhibit B), and current medical history with review and update of their comprehensive care plans to ensure risks have been identified and interventions were implemented to promote healing and prevent further breakdown, infection, and any unidentified pressure ulcers. This was completed on 08/04/15 by the DON, Unit Managers, Staff Development RN, and/or RN Supervisor. Information from the evaluation will determine if additional assessment and interventions would be necessary for each resident in the facility. Appropriate interventions were implemented and Care Plans updated initially by the DON and Staff Development RN, and thereafter by the RN Unit Managers and Charge Nurse by 08/04/15. Skin assessments were completed on the total in-house census of 71 residents and no unidentified pressure ulcers were found.</p> <p>6) The Regional Quality Manager for Preferred Care Partners Management Group provided education regarding the Weekly Skin Management Guidelines on or before 08/04/15 for the Interdisciplinary Team (IDT) which consisted of the DON, Unit Managers, Wound Nurse, Dietary Manager, Therapy Manager, and Social Services Director.</p> <p>7) Initial education for the Director of Nursing, Staff Development, and Unit Managers was provided by the Preferred Care Partners Management Group, Regional Quality Manager by 08/04/15 regarding use of the Care Plan as a communication tool to direct resident care and to follow the comprehensive plan of care related to</p>	F 514		F514 Sept 21 2015	

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F 514	Continued From page 92 pressure ulcers, and consistently following the skin care protocol which included the following: accurate weekly skin assessments, reporting of new or existing identified pressure ulcers, accurate pressure wound assessments to identify detection of decline or healing process, to identify risk issues to prevent breakdown and to promote healing and to effectively implement a comprehensive care plan and interventions, to accurately document pressures regarding healing or decline to include measurement and description, and to obtain Physician's Orders for treatments to assist in healing and infection, and to prevent further wound decline.  8) The remaining Licensed Facility Nursing Staff education was educated by the DON, Unit Managers, and Staff Development RN with a completion date of 08/04/15 with a post-test given. As of 08/04/15, a total of 15 of 20 licensed nurses have received this education and as of 08/04/15, a total of 22 of 34 nurse aides received the education by the Staff Development RN, DON, Unit Managers, or Wound Nurse. All nursing staff received the required wound education prior to working their next shift by the Staff Development RN, Unit Managers, Wound Nurse, or DON. All new nursing hires have been educated during general orientation, with a post-test given by the Staff Development RN prior to their working on a unit regarding following the comprehensive care plan interventions, reporting skin breakdown to licensed nurses and the Stop and Watch Tool, communication with the physician in developing a plan of care, including treatment if indicated, to promote healing, prevent infection, and prevent further breakdown. Education also included how to perform an accurate wound assessment and identification of	F 514		F514 Sept 21 2015	

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F 514	<p>Continued From page 93</p> <p>causal factors of breakdown in order to implement effective interventions.</p> <p>9) The Quality Assurance Committee members (Administrator, Director of Nursing, MDS, Unit Managers, and Staff Development RN) reviewed and approved the education material on 08/04/15. Records of the in-service on the educational materials included signatures of attendance, signature of in-services received, and copies of testing for efficacy of the training. Nursing in-service education on the subjects noted was completed by 08/04/15.</p> <p>10) Members of the QA Committee developed a tool on 07/31/15 to validate assessments and Care Plans were being utilized per policy protocol. This was implemented on 07/31/15 and is ongoing.</p> <p>In addition, the DON, Unit Managers, Staff Development RN, or Wound Nurse are responsible to reassess 5 resident skin assessments per week to ensure accuracy of licensed nurses' skin assessment within 24 hours of the resident's scheduled 7-day assessment. This will be updated to the QA Committee approved pressure ulcer tracking tool as completed by the DON, Staff Development RN, Unit Managers, and Wound Nurse. Any concerns identified with accuracy of the skin assessment will have re-education provided by the Director of Nursing, Unit Managers, Staff Development RN, or Wound Nurse to the licensed nurse weekly for 3 months until 10/30/15. The Director of Nursing will discuss the results of accuracy and if any education should be provided regarding the reassessments during the next scheduled QA Meeting.</p>	F 514		F014 sept 21 2015
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F 514	Continued From page 94  11) Monitoring will be done by the Administrator, DON, Staff Development RN, RN Unit Managers, and Wound Nurse. Any issues identified will be corrected immediately and taken to the next scheduled QA meeting for review and a revised plan of action if warranted. The Administrator will provide oversight on a weekly basis and this practice will become effective on 07/31/15.  12) QA Meetings will be held with two or more team members in attendance daily 5 days a week and on weekends if necessary for review of data to ensure compliance: completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. Any findings of newly developed or existing pressure ulcers and the interventions implemented will be reviewed for effectiveness or need for additional interventions until the situation is controlled.  QA Committee members will review minimally 5 days a week for 30 days or additionally as necessary until 09/01/15; then one time weekly until 09/30/15 or as needed; then monthly thereafter or as needed sooner.  ***The State Survey Agency validated the Immediate Jeopardy was removed as follows:  1) Resident #1 was no longer in the facility.  2) Review of the facility's documentation dated 07/30-08/04/15, and interviews with Unit Manager (UM) #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment	F 514		F514 Sept 21 2015	

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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 514	<p>Continued From page 95</p> <p>was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>3) Review of the facility's 100% skin assessment sheets revealed facility staff utilized the Weekly Skin Assessment Sheet approved by the QA committee on 07/30/15. Interviews with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/08/15 at 2:45 PM, the DON on 08/06/15 at 4:40 PM, Licensed Practical Nurse (LPN) #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, and LPN #3 on 08/06/15 at 3:25 PM, revealed the Weekly Skin Assessment Sheet was being utilized to conduct weekly skin assessments and to conduct skin assessments for new or readmitted residents to the facility.</p> <p>Per interview with LPN #1 on 08/06/15 at 1:25 PM, RN #1 on 08/06/15 at 2:55 PM, LPN #3 on 08/06/15 at 3:25 PM, UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM, revealed any concerns identified with a newly developed pressure ulcer and/or existing pressure ulcers would be reported to the physician, to the DON, and to the IDT to implement interventions and to update the resident's comprehensive plan of care. According to staff interviews, no new pressure ulcers have been identified since 07/29/15.</p> <p>Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/08/15 at 3:00 PM, revealed he provided oversight to</p>	F 514		F514 sept 21 2015	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/06/2015
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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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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 514	<p>Continued From page 96</p> <p>ensure the skin assessments were done correctly in accordance with the facility's protocols and training.</p> <p>4) Review of the In-service Training related to risk factors for the development of pressure ulcers and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the residents' comprehensive care plan. Interview conducted on 08/06/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3.25 PM with LPN #3, 08/06/15 at 1:20 PM with UM #1, and 08/06/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15, at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility's skin care protocols during orientation when hired by the facility.</p> <p>Further review of the In-service Training dated 08/03-05/15, revealed the Staff Development RN provided education for the Certified Nurse Aides</p>	F 514		<p>F514 Sept 21 2015</p>
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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(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 514	<p>Continued From page 97</p> <p>(CNAs) regarding skin reporting utilizing the "Stop and Watch" form during bathing and ADL care. Interviews conducted on 08/06/15 with CNA #16 at 1:21 PM, CNA #20 at 1:28 PM, CNA #1 at 1:41 PM, CNA #5 at 1:47 PM, CNA #15 at 1:55 PM, CNA #7 at 2:00 PM, CNA #22, at 2:05 PM, CNA #23 at 2:07 PM, CNA #18 at 2:20 PM, and CNA #24 at 3:40 PM verified each staff member had attended the training and was knowledgeable about the use of the "Stop and Watch" form and reporting any changes in a resident's skin condition.</p> <p>5) Review of the facility's documentation dated 07/30-08/04/15, and interviews with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Staff Development RN on 08/06/15 at 2:45 PM, and the DON on 08/06/15 at 4:40 PM, revealed a skin assessment was conducted for each resident in the facility and no additional unidentified pressure ulcers were identified.</p> <p>6) Review of In-service Training dated 08/03/15, revealed the Preferred Care Partners Management Group provided training regarding the Weekly Skin Management Guidelines for the Interdisciplinary Team (IDT) which consisted of the DON, Unit Managers, Wound Nurse, Dietary Manager, Therapy Manager, and Social Services Director. Interviews conducted with UM #1 on 08/06/15 at 1:20 PM, UM #2 on 08/06/15 at 2:05 PM, the Therapy Manager on 08/06/15 at 2:30 PM, the Staff Development RN on 08/06/15 at 2:45 PM, the Social Services Director on 08/06/15 at 3:15 PM, and the DON on 08/06/15 at 4:40 PM revealed each of the IDT members attended the training and had knowledge of the Weekly Skin Management Guidelines.</p>	F 514		F514 Sept 21 2015

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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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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 514	<p>Continued From page 98</p> <p>7) Review of In-service Training dated 08/03/15, revealed the Regional Quality Manager provided training for the DON, Staff Development Nurse, and Unit Managers related to use of the care plan as a communication tool and following the comprehensive care plan and to consistently follow the facility skin care protocols. Interviews on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM, confirmed each of the staff members attended the in-service training and had knowledge of the care plan process and the facility skin care protocols. In addition, a post-test was provided.</p> <p>8) Review of the In-service Training related to risk factors for the development of pressure ulcers and the development of a comprehensive care plan revealed education had been conducted for the Licensed Staff by the Staff Development RN on 08/03/15 and 08/04/15, which included the prevention of skin breakdown, interventions to promote healing and to prevent infection, skin/wound assessment, and monitoring and updating the resident's comprehensive care plan. Interview conducted on 08/06/15 at 1:25 PM with LPN #1, 08/06/15 at 2:55 PM with RN #1, 08/06/15 at 3:25 PM with LPN #3, 08/06/15 at 1:20 PM with UM #1, and 08/06/15 at 2:05 PM with UM #2 revealed all the staff interviewed had attended the training and was knowledgeable related to risk factors related to the development of pressure ulcers and the development of the comprehensive care plan for residents with pressure ulcers to include prevention, healing, wound assessment, and monitoring for infection. Staff was also able to verbally relate the purpose of the Stop and Watch Form and to state how to communicate issues/concerns with pressure</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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F 514	<p>Continued From page 99</p> <p>ulcers with other staff. Staff also completed a post-test. Per interview with the Administrator on 08/06/15 at 3:00 PM, the facility had not hired any new employees since 07/29/15; however, all new employees would receive training on the facility skin care protocols during orientation when hired by the facility.</p> <p>9) Review of the Daily QA Meeting Sign-In Sheets revealed the QA Committee met on 08/04/15 and review of the in-service records revealed the educational materials included signatures of attendance, signature of in-services received, and copies of efficacy of the training.</p> <p>10) The Pressure Ulcer tool was reviewed on 08/06/15 and verified the tool was being utilized to validate skin assessments and care planning for residents with pressure ulcers. The QA Committee members were reviewing the tool daily. Interviews conducted on 08/06/15 with the Administrator at 3:00 PM, UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, the MDS Nurse at 3:35 PM, and the DON at 4:40 PM confirmed the tool was being used to validate skin assessments were conducted and documented correctly and care plans were being updated and followed for residents with pressure ulcers.</p> <p>Interviews conducted on 08/06/15 with LPN #1 at 1:25 PM, with RN #1 at 2:55 PM, and with LPN #3 at 3:25 PM, revealed licensed nurses were responsible to complete a head to toe skin assessment for residents weekly as assigned on the skin assessment schedule. LPN #1, RN #1, and LPN #3 stated the skin assessment was documented on the Skin Assessment Sheet with the "man" figure on it. Interviews conducted on</p>	F 514		<p>F514 Sept 21 2015</p>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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F 514	<p>Continued From page 100</p> <p>08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Staff Development RN at 2:45 PM, and the DON at 4:40 PM revealed they were responsible to reassess 5 resident skin assessments weekly to ensure the skin assessments had been completed accurately by the licensed nurse who was assigned to complete the scheduled skin assessment. The reassessment had been done within 24 hours of the resident's scheduled 7-day assessment. The UMs, Staff Development RN, and DON stated no problems had been identified with the reassessments they had completed.</p> <p>11) Review of the documentation dated 08/03-05/15, and interview with the Administrator on 08/06/15, at 3:00 PM, revealed he provided oversight to ensure the skin assessments were done correctly in accordance with the facility's protocols and training.</p> <p>12) Review of the facility's documentation dated 08/04-06/15 revealed daily QA meetings were conducted to review the completion and accuracy of skin assessments and comprehensive care plan for any new and/or existing pressure ulcers. No newly developed pressure ulcers have been identified since 07/29/15. Interviews conducted on 08/06/15 with UM #1 at 1:20 PM, UM #2 at 2:05 PM, the Therapy Manager at 2:30 PM, the Staff Development RN at 2:45 PM, the Administrator at 3:00 PM, the Social Services Director at 3:15 PM, and the DON at 4:40 PM, confirmed daily QA meetings were held to review the completion and accuracy of skin assessments and comprehensive care plans for any new and/or existing pressure ulcers.</p>	F 514		
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**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185352	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 10/16/2015
<b>Name of Facility</b> STANTON NURSING AND REHABILITATION CENTER		<b>Street Address, City, State, Zip Code</b> 31 DERICKSON LANE STANTON, KY 40380

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0246</u> Reg. # <u>483.15(e)(1)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0253</u> Reg. # <u>483.15(h)(2)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0280</u> Reg. # <u>483.20(d)(3), 483.10(k)(2)</u> LSC _____	Correction Completed 09/21/2015
ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0314</u> Reg. # <u>483.25(c)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed 09/21/2015
ID Prefix <u>F0441</u> Reg. # <u>483.65</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0469</u> Reg. # <u>483.70(h)(4)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>F0514</u> Reg. # <u>483.75(l)(1)</u> LSC _____	Correction Completed 09/21/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/>	Reviewed By <u>DB</u>	Date: <u>10/30/15</u>	Signature of Surveyor: <u>Donetta Ball</u>	Date: <u>10/30/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/6/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

**State Form: Revisit Report**

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 100445	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 10/16/2015
<b>Name of Facility</b> STANTON NURSING AND REHABILITATION CENTER		<b>Street Address, City, State, Zip Code</b> 31 DERICKSON LANE STANTON, KY 40380

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>N0123</u> Reg. # <u>902 KAR 20:300-6(4)(a)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>N0134</u> Reg. # <u>902 KAR 20:300-6(7)(a)2.</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>N0144</u> Reg. # <u>902 KAR 20:300-6(7)(b)2.a.</u> LSC _____	Correction Completed 09/21/2015
ID Prefix <u>N0192</u> Reg. # <u>902 KAR 20:300-7(4)(b)3.</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>N0199</u> Reg. # <u>902 KAR 20:300-8</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>N0211</u> Reg. # <u>902 KAR 20:300-8(3)(b)</u> LSC _____	Correction Completed 09/21/2015
ID Prefix <u>N0219</u> Reg. # <u>902 KAR 20:300-8(7)(a)</u> LSC _____	Correction Completed 09/21/2015	ID Prefix <u>N0354</u> Reg. # <u>902 KAR 20:300-15(10)(a)2</u> LSC _____	Correction Completed 09/21/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/>	Reviewed By <u>BB</u>	Date: <u>10/30/15</u>	Signature of Surveyor: <u>Donetta Ball</u>	Date: <u>10/30/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/6/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		

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

PRINTED: 09/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING 23 2015	(X3) DATE SURVEY COMPLETED  08/05/2015
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NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380
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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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K 000	<p>INITIAL COMMENTS</p> <p>FACILITY TYPE: SNF/NF</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Six smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II generator. Fuel source is LP gas.</p> <p>A Life Safety Code survey was initiated and concluded on 08/05/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation with Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest</p>	K 000		Sept 20 2015
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE N/A	(X8) DATE 9-23-15
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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.

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

PRINTED: 09/18/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/05/2015
NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(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
K 000	Continued From page 1 deficiency identified at a scope and severity of "E."	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations in the smoke barrier wall in the attic area were properly sealed. This deficient practice affected two (2) of six (6) smoke compartments, staff, and approximately fifty-one (51) residents. The facility has the capacity for 81 beds with a census of 71 on the day of the survey.  The findings include:  During the Life Safety Code survey on 08/05/15, at 12:00 PM with the Director of Maintenance (DOM), observations revealed unsealed penetrations around electrical conduit and wiring in the fire/smoke barrier wall in the attic area in	K 025	All areas around electrical conduit and wing in the fire/smoke barrier wall in the attic will be inspected by the maintenance director and repaired and sealed in accordance with NFPA 101 Life Safety Code standard by September 20, 2015.  In the future any contracted company working in the facility will be serviced concerning NFPA 101 Life Safety Code. Work done by contractors will be completed within the Life Safety Code. A protocol was established on September 17, 2015, that at the time work is being performed by contractors, the Maintenance Director will review the work being performed is up to code. After completion of work being performed by the contractor, Maintenance director will establish and approve the work before the contractor leaves the facility.	

K 025  
9/20/15

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185352	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/05/2015
NAME OF PROVIDER OR SUPPLIER  STANTON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 31 DERICKSON LANE STANTON, KY 40380	
(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
K 025	<p>Continued From page 2</p> <p>the North Wing corridor. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility.</p> <p>An interview on 08/05/15 at 12:00 PM with the DOM revealed contractors had been working at the facility approximately two months ago and did not properly seal the fire/smoke barrier walls when the work was completed.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for</li> </ol>	K 025		K025 Sept 20 2015

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K 025	Continued From page 3 the specific purpose.	K 025		K025 Sept 30 2015	