STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345026	A. BUILDING ______ B. WING ______	C 08/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY NURSING AND REHAB CTR OF MECKLENBURG CTY	3700 SHAMROCK DR CHARLOTTE, NC 28215

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F 157 SS=G

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

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

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

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and medical record review, the facility failed to notify the physician of a change in skin condition for 1 of 3 (Resident

F 157

The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.

To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F157

§ 483.10(B)(11) Notifications of Changes

F157

CORRECTIVE ACTION:

Resident # 61 is being followed by the Wound MD weekly as of June 28, 2013. Primary Physician and Family have been updated on wound and progress on June 21, 2013. The wound on Resident # 61 has increased due to debridement of necrotic tissue. The plan per the MD is to continue debridement weekly. Treatment with Santyl/Bactroban ointment is ongoing for chemical debridement. The wound is cleaner. The Wound Care MD, Dr. Ralph Stegemoller, did conservative sharp debridement to remove necrotic tissue causing the wound to be larger. He plans to weekly assess the need for further debridement due to the extent of the necrotic tissue.

DHSR NH L & C Black Mountain WRO
Received
SEP 03 2013
by: MMH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 8-30-13

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.

Original signature 8-23-13 nh

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F 157 Continued From page 1

#61) sampled residents reviewed for pressure ulcers.

The findings include:

A facility policy entitled "General Treatment Guidelines" revision date 03/2010 indicated to notify the physician (MD) of all wounds and any time a wound shows no evidence of healing, worsening or signs of infection in 2 weeks.

Resident #61 was admitted to the facility on 10/16/06. Diagnoses included dementia and diabetes. An annual Minimum Data Set (MDS) dated 05/22/13 indicated Resident #61 had cognitive impairment, required total-extensive assistance with activities of daily living (ADL) and was at risk for pressure ulcer development. The MDS did not indicate the presence of any pressure ulcers. A plan of care dated 05/22/13 documented a risk for skin breakdown and indicated an intervention of skin audit weekly and report changes.

Review of Resident #61's weekly skin assessment risk factors sheet dated 04/17/13 indicated heels were red and to keep elevated on pillows.

Review of Resident # 61's physician (MD) orders revealed a 04/23/13 order for skin prep to heels twice daily (bid) to maintain skin integrity.

Review a weekly skin assessment dated 04/24/13 indicated to keep the heels elevated on pillows

A nurse's note dated 04/30/13 indicated Resident 61's left heel was reddish black, soft to touch and the wound nurse was notified. The note indicated

F 157 POTENTIAL EFFECT:

All residents have the potential to be effected by this alleged practice. On August 7, 2013 skin checks were performed on all current residents by the wound nurse and 11-7 charge nurse. For any resident with a newly identified wound the medical record was checked to ensure physician and family were notified, treatment orders appropriate, support surfaces were in place (cushion in w/c, mattress, heels floated, etc.), a Dietary consult was obtained if needed, nutritional supplements ordered as appropriate, and the care plan is updated and current. The last Minimum Data Set (MDS) was reviewed on any resident with a current wound to ensure proper documentation of the wound was recorded. All risk assessments are current and the wound section updated to reflect the recent wound checks. The results of this audit revealed there were 5 new areas identified. The MD was notified, Dietary notified and RP/family notified of these findings. The wound nurse and Nurse #1 were counseled on notification of MD and Responsible Party (RP) or Family.

SYSTEMIC CHANGES:

On August 20 through 22, 2013 the Nurses and Nurse Aides both full and part time were in serviced on Wound Prevention and Wound Documentation Policies by the DON and MDS Coordinator. Topics included risk assessments, skin assessments on admission and weekly, general care (incontinence care, turning and repositioning, offloading of the area involved, etc.), nutrition, support surfaces, and care planning. Wound Care topics included; documentation, Weekly UDA, review of wound types, notifications of MD and.

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F 157

Continued From page 2

the wound nurse ordered to clean heels with skin prep and elevate on pillow.

A weekly skin assessment dated 05/08/13 indicated the left heel area was red and purple and to continue with skin prep to bilateral heels as well as elevating the heels off the bed.

A nurse's note dated 05/19/13 indicated Resident #61's left heel with moderate amount of brown colored drainage. The note indicated while applying skin prep the top layer which was a dark colored area sloughed off with pink colored skin noted below and an email was sent to the wound nurse.

A review of the June 2013 weekly skin assessment sheet revealed no documentation of changes in Resident #61's skin integrity to the left heel.

A review of Resident #61's nurse's notes from 04/09/13 to 06/14/13 made no mention of the physician being notified of a change in skin integrity.

A physician progress note dated 06/21/13 indicated the left heel with necrosis; to follow up with the wound physician for questionable debridement and start med pass (nutritional supplement) three times a day.

A wound consultant report dated 06/28/13 indicated a pressure area to the left heel measuring 4.3x3.2 with an estimated depth of 0.4 centimeters (cm). The left heel was documented with excessive necrotic tissue black in color and mild serous drainage. The report indicated the clinical stage was unstageable. The report

F 157

Family/Responsible party and treatment orders. Stop and Watch Early Warning Tool (Interact II) was reviewed with emphasis on use on any shift with any change of condition when identified by Nurse Aid. The updated standing orders for wounds were approved by the MD and Wound MD with the understanding that the MD may order an appropriate treatment not on the standing orders. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required annual in-service. On admission, readmission and quarterly a risk assessment will be completed and care developed to include risk on any areas present. A complete skin assessment will be done on admission, readmission and weekly by a nurse. Any identified wound will have a Wound UDA completed at that time and weekly until healed. MD will be notified and orders for treatment and nutritional supplements as appropriate obtained. Family or Responsible party will be notified. Any new wound identified, the nurse on the floor is responsible to complete the first Weekly Wound UDA, notify MD for orders and notify the family or Responsible party. The nurse will document this change of condition on the Nurses Daily Report. Monday through Friday The Daily Clinical Meeting will review the nursing daily report, new Wound UDAs, and new physician orders for treatments. The Daily Clinical Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed. Any resident with a newly identified wound or a worsening wound, the Team will ensure that MD was notified, appropriate action taken by reviewing documentation. The Unit Manager will review the Treatment Administration Record for treatment orders, Medication Administration Record for nutritional supplements as appropriate. A Dietary consult will be obtained

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F 157	Continued From page 3 indicated the eschar was loosening and starting to drain with need for consent for debridement. Review of the weekly skin assessment sheet for July revealed an assessment dated 07/03/13which indicated an open area to the left heel. Review of the physician communication log from April to July revealed no communication regarding a change in Resident #61's skin integrity. During an interview with the treatment nurse on 07/31/13 at 11:36AM, the treatment nurse explained as part of her duties she would monitor wounds weekly for improvement or worsening and report that in a weekly quality report. The treatment nurse also explained all wounds were placed on that report regardless of stage. The treatment nurse added when the staff notified her of any new areas she would notify the physician, order consultation as needed, inform the dietician for supplementation and enter it on the weekly wound report. During a follow -up interview with the treatment nurse on 07/31/13 at 5:47PM, the treatment nurse stated she did not recall if the left heel area was blanchable on the 17th of April and was not aware if it was ever communicated to the physician. The treatment nurse also stated she could not recall when the area became a blister but thought it was in May. The treatment nurse also stated it was her mistake but Resident #61's left heel wound was never measured or added to the weekly wound monitoring report. During an interview with Nurse #3 on 08/01/13 at	F 157	and support surfaces reviewed for appropriate implementation. The care plan will be updated by the MDS coordinator to reflect current wound. Any issues will be reported to the Administrator and the Medical Director for appropriate action. The wound nurse will continue the documentation on the weekly wound UDA and update the physician and RP/Family weekly. During the Weekly QA Meeting the wound nurse will present all wounds for review with emphasis on wounds not showing signs of healing or showing signs of infection, recommendation of wound Physician or changes in treatments to ensure proper monitoring of wounds. Any identified issues will be reported to the Administrator and the Medical Director. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. MONITORING: To ensure compliance the Supervisor/Unit Manager will conduct a review using the Wound QA Survey Tool observing four residents with wounds. The items reviewed will include medical record, weekly wound documentation for notification of MD and Family/ RP, observation of the resident for support surfaced and repositioning, review of the TAR for documentation of treatment provided and MAR for documentation of supplements per physician order. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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F 157	Continued From page 4 8:36 AM, who functioned in a supervisory role, Nurse #3 explained the nurses and/or the nurse aides brought it to her attention on 06/21/13 that Resident #61's left heel wound looked worse and the Nurse Practitioner (NP) was notified. Nurse #3 added the NP observed the wound and based on the characteristics the NP ordered to consult the wound physician. The Nurse also mentioned that prior to the 21st of June she was aware the nurses had been applying skin prep to Resident #61's heels but was unaware what the area looked like. An interview was conducted on 08/01/13 at 11:03AM with the Nurse Practitioner (NP). The NP explained she was unaware of any pressure area to the left heel prior to 06/21/13. The NP added when she observed the left heel on 06/21/13 it was necrotic and dry and warranted consultation from the wound physician due to the necrosis. The NP added she would have expected to be notified when the wound was originally noted to assess the area and review the treatment protocol. The NP also added re-notification was expected when the area started to worsen so the area could have been reassessed, labs ordered, wound physician consulted and a nutritional review conducted. During an interview with Nurse #1 on 08/02/13 at 11:39AM, Nurse #1 explained the MD and DON probably should have been notified. Nurse #1 added the treatment nurse was contacted and she was the first line of defense, she was the most knowledgeable person. Finally the Nurse stated she did not usually contact the MD with changes in skin condition but contacted the treatment nurse.	F 157	Date of Compliance: August 30, 2013	

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F157	Continued From page 5 Interview with the Director of Nursing (DON) on 08/02/13 at 3:22 PM revealed the nurses were expected to notify the physician via the MD communication book with all changes in condition. The DON added that the wound nurse should be notified but the physician should have also been notified.	F 157		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	F250 **§ 483.15(g)(1)** Provision of Medically Related Social Service F250 CORRECTIVE ACTION:	
	This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and medical record review, the facility failed to assist a resident with transportation to a neurology appointment for 1 of 3 sampled residents reviewed for social services. (Resident #102) The findings are: Resident #102 was admitted to the facility 12/20/12. Diagnoses included multiple sclerosis with left hemiplegia, neurogenic bladder, fitting urinary devices, chronic pain and paranoid schizophrenia. Review of the medical record for Resident #102 revealed the nurse practitioner (NP) made a	F 250	Resident #102 has an appointment rescheduled for September 3, 2013 transportation has been scheduled, Physician and RP/Family aware. POTENTIAL EFFECTS: All residents with appointments outside the facility have the potential to be effected by this practice. An audit of all residents' medical record was completed on August 12, 2013 by Unit Managers/ Support Nurses. Medical record was reviewed for MD orders for appointments, Hospital Discharge Summaries, and consult reports for follow up appointments. Any appointment identified was compared to the appointment calendar to ensure appointment was recorded and transportation was arranged.	

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F 250

psychology referral dated 02/18/13 due to increased behaviors, personality disorder and manipulation disorder.

Further review revealed a physician's order dated 05/3/13 for a neurology evaluation.

A psychology consult dated 05/6/13 documented that Resident #102 expressed fears regarding discrimination of his past and continued health problems which resulted in increased isolation, worsening mood and increased irritation, despondency and demanding behavior. The psychologist recommended a neurology consult.

Review of a quarterly minimum data set dated 06/13/13 assessed Resident #102 with intact cognition.

A second psychology consult dated 06/17/13 documented that Resident #102 expressed he was looking forward to the upcoming neurology consult.

The medical record of Resident #102 included documentation from a doctor's office for a neurology appointment scheduled for 06/26/13.

Review of the facility's appointment book revealed no appointment was documented for Resident #102 for 06/26/13.

During an interview on 07/29/13 at 11:50 AM Resident #102 expressed that he was upset regarding a missed neurology appointment scheduled in June 2013. Resident #102 stated he did not know why the appointment was missed. He further stated that the physician spoke to him about the missed appointment and expressed

F 250

The audit revealed only two residents with appointments in the future (2014) that had not been recorded in the calendar. All other appointments were appropriately booked and transportation scheduled.

SYSTEMIC CHANGES:

The Charge Nurse on the floor is responsible for reviewing residents discharge paperwork on admission or readmission, Consult reports with follow up appointments, MD orders requiring appointments. The nurse will ensure a physician order is written, placed on the appointment calendar, transportation form completed, and documented on the Medication Administration Record (MAR). 11-7 Nurse will review all discharge summaries, consult reports, MD orders for the prior day verifying appointment has been processed. Monday through Friday The Daily Clinical Meeting will review the nursing daily report, Hospital discharge records on readmissions/admissions, consultant reports, Physician orders for appointments. The team will ensure appointments are scheduled on the calendar and confirm with the transportation scheduler that the appointment has been recorded. The notification of both the family/RP and physician is documented. The Daily Clinical Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed.

In-service for all Nurses part time and full time was provided on August 20 through 22nd, 2013 by DON and MDS Coordinator. The topics included: procedure for recording and scheduling appointments, completion of the transportation form, and notification of resident, family and MD. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed.

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F 250	Continued from page 7 that the neurology consult was rescheduled for October 2013, but that efforts were being made to get an earlier appointment. Resident #102 expressed that he did not think he could wait and that he felt he was "getting worse". An interview with the social worker (SW) on 07/31/13 at 2:51 PM revealed that in June 2013 Resident #102 informed her that he thought he missed a doctor's appointment he had that day. The SW spoke to the treatment nurse who checked the appointment book, but no appointment was documented. An interview on 07/31/13 at 4:05 PM with the treatment nurse revealed she assisted residents with arranging transportation for appointments. She stated that sometime towards the end of June 2013 the SW stated to her that Resident #102 thought he had missed a doctor's appointment that day. The treatment nurse spoke to Resident #102 and he reported the same concern. The treatment nurse checked the appointment book, but there was no appointment noted. The treatment nurse stated she checked his medical record and saw documentation from the doctor's office regarding a neurology appointment for 06/26/13. The treatment nurse stated she was aware that a physician's order dated 05/03/13 was written for Resident #102 to see a neurologist because she faxed the request for the appointment to the doctor's office. The treatment nurse further stated that she could not explain how the Resident's appointment confirmation for 06/26/13 got into his medical record or why transpiration had not been arranged.	F 250	MONITORING: To ensure compliance the Supervisor/Unit Manager will conduct a review using the QA Survey Tool reviewing four residents with consults, hospital discharge paperwork, and MD orders for appointments outside the facility. Ensuring appointment recorded on calendar and transportation arranged. MD and Family/RP are aware. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Compliance: August 30, 2013	

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F 250	During a follow-up interview with Resident #102 on 07/31/13 at 4:30 PM he stated that he received a letter from the neurologist confirming his June 2013 appointment and he gave the letter to the treatment nurse. An interview on 08/01/13 at 10:29 AM with the NP revealed that she referred Resident #102 to the neurologist due to his request, worsening mood and increased behaviors. The NP stated she remembered seeing documentation regarding the appointment in his medical record in early June 2013. The NP stated she did not know why the appointment was missed, but that the appointment should have been kept.	F 250		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record review, the facility failed to assess, monitor and implement appropriate treatment for a Stage 2 pressure ulcer to the left heel for 1 of 3 (Resident #61) sampled residents reviewed for pressure ulcers.	F314	F 314 **§ 483.15(g)(1)** Treatment/Services to prevent/heal Pressure Sores F314 <u>CORRECTIVE ACTION</u>: Resident # 61 is being followed by the Wound MD weekly as of June 28, 2013. Primary Physician and Family have been updated on wound and progress on June 21, 2013. The wound on Resident # 61 has increased due to debridement of necrotic tissue. The plan per the MD is to continue debridement weekly. Treatment with Santyl/Bactroban ointment is ongoing for chemical debridement. The Wound is cleaner. The Wound Care MD, Dr. Ralph	

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F 314	Continued from page 9	F 314		

Summary statement of deficiencies (F 314):

The findings include:

A facility policy entitled "General Treatment Guidelines" revision date 03/2010 indicated:
1. All pressure ulcers to be reviewed in the Quality of Life Committee initially and with any signs of non-healing/ worsening
2. Treatment of pressure ulcers will vary depending on the orders of the physician.
3. Notify the physician (MD) of all wounds and any time a wound shows no evidence of healing, worsening or signs of infection in 2 weeks.

Resident #61 was admitted to the facility on 10/16/06. Diagnoses included dementia and diabetes. An annual Minimum Data Set (MDS) dated 05/22/13 indicated Resident #61 had cognitive impairment, required total-extensive assistance with activities of daily living (ADL) and was at risk for pressure ulcer development. The MDS did not indicate the presence of any pressure ulcers. A plan of care dated 05/22/13 documented a risk for skin breakdown and indicated an intervention of skin audit weekly and report changes.

Review of Resident #61's weekly skin assessment risk factors sheet dated 04/17/13 indicated heels were red and to keep elevated on pillows.

Review of Resident # 61's physician (MD) orders revealed a 04/23/13 order for skin prep to heels twice daily (bid) to maintain skin integrity.

Review a weekly skin assessment dated 04/24/13 indicated to keep the heels elevated on pillows

Provider's plan of correction (F 314):

Stegemoller, did conservative sharp debridement to remove necrotic tissue causing the wound to be larger. He plans to weekly assess the need for further debridement due to the extent of the necrotic tissue.

POTENTIAL EFFECT:

All residents have the potential to be effected by this alleged practice. On August 7, 2013 skin checks were performed on all current residents by the wound nurse and 11-7 charge nurse. For any resident with a newly identified wound the medical record was checked to ensure physician and family were notified, treatment orders appropriate, support surfaces were in place (cushion in w/c, mattress, heels floated, etc.), a dietary consult was obtained if needed, nutritional supplements ordered as appropriate, and the care plan is updated and current. The last Minimum Data Set (MDS) was reviewed on any resident with a current wound to ensure proper documentation of the wound was recorded. All risk assessments are current and the wound section updated to reflect the recent wound checks. The results of this audit revealed there were 5 new areas identified. The MD was notified, Dietary notified and RP/family notified of these findings. The wound nurse and Nurse #1 were counseled on notification of MD and Responsible Party (RP) or Family.

SYSTEMIC CHANGES:

On August 20 through 22, 2013 the Nurses and Nurse Aides both full and part time were in serviced on Wound Prevention and Wound;

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F 314	Continued from page 10 A nurse's note dated 04/30/13 indicated Resident 61 ' s left heel was reddish black, soft to touch and the wound nurse was notified. The note indicated the wound nurse ordered to clean heels with skin prep and elevate on pillow. A weekly skin assessment dated 05/08/13 indicated the left heel area was red and purple and to continue with skin prep to bilateral heels as well as elevating the heels off the bed. A nurse's note dated 05/19/13 indicated Resident #61's left heel with moderate amount of brown colored drainage. The note indicated while applying skin prep the top layer which was a dark colored area sloughed off with pink colored skin noted below and an email was sent to the wound nurse. A review of the June 2013 weekly skin assessment sheet revealed no documentation of changes in Resident #61's skin integrity to the left heel. A physician progress note dated 06/21/13 indicated the left heel with necrosis; to follow up with the wound physician for questionable debridement and start med pass (nutritional supplement) three times a day. A wound consultant report dated 06/28/13 indicated a pressure area to the left heel measuring 4.3x3.2 with an estimated depth of 0.4 centimeters (cm). The left heel was documented with excessive necrotic tissue black in color and mild serous drainage. The report indicated the clinical stage was unstageable. The report indicated the eschar was loosening and starting to drain with need for consent for debridement.	F 314	Documentation Policies by the DON and MDS Coordinator. Topics included risk assessments, skin assessments on admission and weekly, general care (incontinence care, turning and repositioning, offloading of the area involved, etc.), nutrition, support surfaces, and care planning. Wound Care topics included documentation, Weekly UDA, review of wound types, notifications of MD and Family/Responsible party, and treatment orders. Stop and Watch Early Warning Tool (Interact II) was reviewed with emphasis on use on any shift with any change of condition when identified by Nurse Aid. The updated standing orders for wounds were approved by the MD and Wound MD with the understanding that the MD may order an appropriate treatment not on the standing orders. Any in-house staff who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required annual in-service. On admission, readmission and quarterly a risk assessment will be completed and care developed to include risk on any areas present. A complete skin assessment will be done on admission, readmission and weekly by a nurse. Any identified wound will have a Wound UDA completed at that time and weekly until healed. MD will be notified and orders for treatment and nutritional supplements as appropriate obtained. Family or Responsible party will be notified. Any new wound identified, the nurse on the floor is responsible to complete the first Weekly Wound UDA, notify MD for orders and notify the family or Responsible party.	

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F 314	Continued from page 11 Review of the weekly skin assessment sheet for July revealed an assessment dated 07/03/13which indicated an open area to the left heel. A 07/12/13 physician order indicated to discontinue current treatment and cleanse left heel wound then apply 50:50 mix of santyl (enzymatic agent used to remove necrotic tissue) and bactroban (antibiotic ointment) to left heel and then to cover the heel with gauze daily and as needed. A 07/26/13 wound consultation report indicated the left heel wound was less necrotic and likely developing undermining as the necrotic tissue had been removed. The report indicated a clinical Stage 4 with wound measurements of 4.9x 3.6x 0.6cm. A weekly wound review report dated 07/31/13 indicated no location or Stage for the pressure ulcer. The weekly report indicated under additional documentation a late entry note dated 06/21/13. The note indicated on 06/21/13 an order was received for evaluation of the left heel wound by the wound physician related to the status of the left heel. Heelz up (positioning device) was added on 06/19/13 to aide in offloading the heel. Prior necrosis was noted on the heel. Red heels were initially noted in late April and a blistered area to the left heel was noted in early May (stage 2). In mid May the top layer sloughed off revealing pink colored skin. Review of the Treatment Administration Record (TAR) for April 2013 to July 2013 revealed skin prep was applied to bilateral heels from April 23rd	F 314	. The nurse will document this change of condition on the Nurses Daily Report. Monday through Friday The Daily Clinical Meeting will review the nursing daily report, new wound UDAs, and new physician orders for treatments. The Daily Clinical Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed. Any resident with a newly identified wound or a worsening wound, the Team will ensure that MD was notified, appropriate action taken by reviewing documentation. The Unit Manager will review the Treatment Administration Record for treatment orders, Medication Administration Record for nutritional supplements as appropriate. A Dietary consult will be obtained and support surfaces reviewed for appropriate implementation. The care plan will be updated by the MDS coordinator to reflect current wound. Any issues will be reported to the Administrator and the Medical Director for appropriate action. The wound nurse will continue the documentation on the weekly wound UDA and update the physician and RP/Family weekly. During the Weekly QA Meeting the wound nurse will present all wounds for review with emphasis on wounds not showing signs of healing or showing signs of infection, recommendation of wound Physician, or changes in treatments to ensure proper monitoring of wounds. Any identified issues will be reported to the Administrator and the Medical Director. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manger and the Administrator.	

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Continued from page 12
until July 13th.

Review of the treatment standing orders revealed a Stage 1 pressure ulcers were to be treated with granulex as indicated; a Stage 2 pressure ulcer if shallow then apply a moisture barrier and if the wound had light drainage use hydrogel and a Stage 3 or 4 pressure ulcer if the area was necrotic then use an autolytic debriding agent.

An observation of Resident #61 's left heel wound was made on 07/31/13 at 11:25AM. The observation revealed the left heel ulcer approximately 5x4x 0.2 cm encompassing the entire heel, with necrotic edges and a beefy red colored center with yellowish slough. When the soiled dressing was removed it contained a moderated amount of blackish, red colored drainage with no odor noted.

Interview with nurse aide (NA) #1 on 07/31/13 at 9:52AM, NA #1 stated she reported redness to the left heel a couple of months ago and was told to continue to turn and reposition and elevate the heels on the pillow. The NA stated the left heel then became a grayish blister and was filled with fluid and mushy. The NA added when it started getting worse she reported it to the nurses and was told to continue elevating the feet but the nurse did not look at the area and stated they would have the wound nurse look at the heel.

During an interview with the treatment nurse on 07/31/13 at 11:36AM, the treatment nurse explained as part of her duties she would monitor wounds weekly for improvement or worsening and report that in a weekly quality report. The treatment nurse also explained all wounds were placed on that report regardless of stage. The

F 314

MONITORING

To ensure compliance the Supervisor/Unit Manager will conduct a review using the Wound QA Survey Tool observing four residents with wounds. The items reviewed will include medical record, weekly wound documentation for notification of MD and Family/RP, observation of the resident for support surfaced and repositioning, review of the TAR for documentation of treatment provided and MAR for documentation of supplements per physician order. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action.

Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.

Date of Compliance:

August 30, 2013

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treatment nurse added when the staff notified her of any new areas she would notify the physician, order consultation as needed, inform the dietician for supplementation and enter it on the weekly wound report.

Review of the weekly wound quality report from April 29th through July 1st. indicated Resident #61 was not listed on the report.

During a follow -up interview with the treatment nurse on 07/31/13 at 5:47PM, the treatment nurse stated she did not recall if the left heel area was blanchable on the 17th of April and was not aware if it was ever communicated to the physician. The treatment nurse also stated she could not recall when the area became a blister but thought it was in May. The treatment nurse also stated it was her mistake but Resident #61's left heel wound was never measured or added to the weekly wound monitoring report.

An interview with Nurse #4 on 07/31/13 at 6:22 PM, Nurse #4 explained when the skin prep was first started the area was not open but was a fluid filled area and the area was noted to change and went from a blister to an open area. The nurse added when the blister opened it was bleeding and pinkish. Nurse #4 added before the dressing was changed on 07/12/13 skin prep was being applied and the area was a little blackish. Nurse #4 further explained the treatment nurse was notified of the changes to the left heel.

During an interview with Nurse #1 on 08/01/13 at 10:33 AM, Nurse#1 explained the left heel was a blistered area that became dark and skin prep was being applied. Nurse #1 added the area finally opened sometime in May. The nurse

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explained a black layer of dark old blood came off and foul smelling dark blackish blood oozed out. Nurse # 1 stated she emailed the wound nurse because she felt the skin prep could no longer be used as the area was now open and applying skin prep would be painful.

An interview was conducted on 08/01/13 at 11:03AM with the Nurse Practitioner (NP). The NP explained she was unaware of any pressure area to the left heel prior to 06/21/13. The NP added when she observed the left heel on 06/21/13 it was necrotic and dry and warranted consultation from the wound physician due to the necrosis. The NP added she would have expected to be notified when the wound was originally noted to assess the area and review the treatment protocol. The NP also added re-notification was expected when the area started to worsen so the area could have been reassessed, labs ordered, wound physician consulted and a nutritional review conducted.

During an interview with the Director of Nursing (DON) on 08/01/13 at 12:07 PM, the DON explained he was unaware of the pressure area to Resident #61's left heel until yesterday. The DON further explained wounds were discussed daily in morning meeting and weekly in a quality meeting which the treatment nurse attended and had never mentioned Resident #61's wound. The DON added he would have expected the treatment nurse to have followed-up on the wound checking on it at least weekly and reporting on the worsening condition.

During an interview with the Wound Physician on 08/02/13 at 8:16 AM, the wound physician stated when he assessed the wound on the 28th of June

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F 314	Continued from page 15 it was an evolving necrosis and was not dry but hard and softening with some slight odor and drainage. The wound physician added he was unaware of the history of the wound. The wound physician did explain that skin prep should not be used once an area was open because it would be painful on a raw surface. He explained once a blister ruptured the treatment should be changed to something more gentle such as hydrogel or xeroform. During a telephone interview with the medical Director on 08/02/13 at 2:51 PM, the Medical Director stated he believed that Resident #61 was on a slow decline in December of 2012 and continued to be on a decline.	F 314		
F 323 SS=D	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, staff interviews and record review, the facility failed to implement a bed alarm for 1 of 3 sampled residents at risk for falls (Resident #171). The findings are: Resident #171 was admitted to the facility on	F 323	F323 **§ 483.25(h) Free of Accidents Hazards/Supervision/Devices** F323 CORRECTIVE ACTION: Resident #171 last fall was on July 18, 2013 and there was no injury. The Interdisciplinary team (Nursing, SS, Dietary, Activities and Therapy as applicable) reviewed the fall care plan to ensure interventions in place were appropriate interventions. The care plan has been updated to reflect the current fall interventions as a sensor pad alarm. Nurse #2 along with Nurse Aid #3 was counseled on checking placement and function for all fall intervention alarms. Nurse Aid #4 is no longer employed by the facility.	

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04/12/13 with diagnoses which included syncope and dementia.

Review of Resident #171's admission Minimum Data Set (MDS) dated 04/22/13 revealed severely impaired cognition with a history of falls prior to admission. The MDS indicated Resident #171's balance was not steady and could only stabilize with staff assistance.

Review of a nursing note and fall investigation report dated 05/09/13 revealed Resident #171 fell in his room without injury at 8:45 PM.

Review of a nursing note and fall investigation report dated 06/10/13 revealed Resident #171 fell in his room without injury and 3:50 AM. A bed alarm sounded to alert the staff.

Review of a nursing note and fall investigation report dated 06/30/13 revealed Resident #171 fell in his room at 10:00 AM. There was no injury and a bed alarm sounded.

Review of Resident #171's quarterly MDS dated 07/17/13 revealed severely impaired cognition with a history of falls since admission. The MDS indicated Resident #171's balance was not steady and could only stabilize with staff assistance.

Review of a nursing note and fall investigation report dated 07/18/13 revealed Resident #171 fell out of his wheelchair at 8:45 AM. The report indicated Resident #171 currently received antibiotics for a urinary tract infection and staff were to increase frequency of toileting.

Review of Resident #171's care plan dated

F 323

POTENTIAL EFFECT:

All residents with an order for fall alarms have the potential to be affected by this alleged deficient practice. The Unit Managers/Support Nurses conducted an audit on August 19, 2013 of all residents who have MD orders or care plans for alarms as falls interventions. There were 30 residents who used alarms for both or either bed and chair. These orders and fall care plans were reviewed by the Unit Managers to ensure that the alarms were still relevant for the patient's current condition. Orders were obtained to discontinue the alarms if warranted by the resident's condition. All alarms were assessed for placement and function at the time of the audit. MDS nurse reviewed fall and fall risk Care Plans to assure they were consistent with the interventions in place. The Unit Managers/support nurses reviewed NA assignment sheets to ensure alarms were listed. The results of the audit revealed that all NA assignment sheets matched the physician orders for alarms.

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F 323	7/24/13 revealed Resident #171 was at risk for falls related to an unsteady gait, poor safety awareness and use of psychotropic medication. Interventions to prevent falls included frequent reminders to use the call bell, non-slip shoes, and a personal alarm to the wheelchair and bed at all times. Review of the nurse aide assignment sheet for Resident #171 revealed direction of a pressure pad alarm to the bed and wheelchair. Observation on 07/31/13 at 9:46 AM revealed Resident #171 walked from the bathroom independently in bare feet. Resident #171's gait was unsteady. Resident #171 placed his left hand on the room wall and dropped a wet brief into the wastebasket in the room. Resident #171 walked to the bed and used the raised side rail to get into the bed. The bed alarm was disconnected. Observation on 07/31/13 at 2:52 PM revealed Resident #171 in bed watching television with the bed alarm disconnected. Observation on 07/31/13 at 5:30 PM revealed Resident #171 in bed and the bed alarm was connected. Observation on 08/01/13 at 8:30 AM revealed Resident #171 in bed with the bed alarm disconnected. Observation on 08/01/13 at 9:06 AM revealed Nurse Aide (NA) #3 delivered the breakfast meal to Resident #171. The bed alarm was disconnected.	F 323	SYSTEMIC CHANGES: All nursing staff, Nurses and Nurse Aides part time and full time was in-serviced by the DON and MDS Coordinator on August 20 through 22, 2013 on fall interventions, processing MD orders for alarms, transcribing order to the Treatment Administration Record (TAR), obtaining and placing correct alarms on residents from floor supply located in central supply. The NA assignment will also reflect the alarms in use for each resident and will be updated by the Unit Manager/ Support Nurse. The Nurse will document placement on the TAR and NA will reflect in the electronic medical record in the computer. Also nursing staff were in serviced on devices placement and checking functioning. This information has been integrated into the standard orientation training and required In-service refresher course for all staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. Monday through Friday the Daily Clinical QA meeting will review new falls for interventions including alarms. This falls review will include: Review of incident reports, Nurse Daily Report and Nurses notes to ensure an appropriate intervention is initiated to lessen risk of future falls with injury. If an alarm is being utilized for the resident, the team will check to ensure alarm is listed on the Treatment Administration Record with nurse signing off when alarm is checked for placement and functioning during the shift. Also the alarm is listed on the Nurse Aid assignment sheet with the Nurse Aid documenting in the Electronic Medical Record as to placement and function during their shift. The Daily Clinical	

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F 323	Continued from page 18 Observation on 08/01/13 at 9:32 AM revealed Resident #171 in bed with the bed alarm disconnected. Interview with NA #4 on 08/01/13 at 9:38 AM revealed she removed Resident #171's breakfast meal and did not notice the disconnected bed alarm. NA #4 explained Resident #171 was her assigned Resident and the alarm should be connected. NA #4 reported she checked Resident #171 earlier and should have checked the bed alarm. Observation on 08/01/13 at 9:39 AM revealed NA #4 entered Resident #171's room and attempted to connect the bed alarm. NA #4 reported the bed alarm cord would not stay in place and was broken. NA #4 explained she would need to obtain a new alarm. Interview with NA #3, who delivered Resident #171's breakfast meal, on 08/01/13 at 9:44 AM revealed she did not notice the disconnected bed alarm. NA #3 explained she should have checked the alarm connection but forgot. Interview with Nurse #2 on 08/01/13 at 9:52 AM revealed she did not check bed alarm connections during her initial rounds. Nurse #2 reported Resident #171 should have an alarm at all times. Interview with the Director of Nursing (DON) on 08/01/13 at 10:00 AM revealed he expected Resident #171's bed alarm to be connected. The DON explained he expected the nurse aides to check the bed alarms.	F 323	Meeting includes DON, Unit Managers, Support Nurse, Rehab Director, MDS, Wound Nurse, Dietary and other clinical staff as needed. MONITORING: To ensure compliance the Supervisor/Unit Manager will conduct a review using the QA Survey Tool observing four residents with alarms. The items reviewed will include review of the TAR for documenting, the electronic medical record for NA documentation of placement and function followed by observation of the resident to ensure alarm interventions has been implemented appropriately. This will be done five times a week for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. Date of Compliance: August 30, 2013	