

JUL 18 2013

PRINTED: 07/08/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/26/2013
NAME OF PROVIDER OR SUPPLIER RIDGEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1624 HIGHLAND DRIVE WASHINGTON, NC 27889	
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to develop a care plan for one of three sampled residents with comprehensive assessments that had pressure ulcers and surgical wounds. Residents #2.</p> <p>The findings included: Resident #2 was admitted to the facility on 5/29/13 with diagnoses including coronary artery disease, anemia, respiratory failure and diabetes.</p>	F 279	<p>(1) CAA's & care plan for resident #2 was completed on July 3, 2013.</p> <p>(2) The CAA's & care plan for residents admitted within the last 30 days have been reviewed to ensure completion.</p> <p>(3) Care plan team will be in-serviced on MDS 3.0 requirements for completion of CAA's and care plans.</p> <p>(4) Don/Designee will audit 10 care plans & CAA's as the MDS is completed q week x one month, then 5 care plans & CAA's q week x 1 month, then random audits will be done thereafter x one month. Admin./DON will trend findings and submit to QA committee.</p> <p>Completion date July 24, 2013.</p>	

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

TITLE

Administrator

(X6) DATE

7/15/13

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.

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F 279	Continued From page 1 Review of the Admission Minimum Data (MDS) Set dated 6/5/13 revealed Resident #2 had a Stage 4 pressure ulcer and surgical wounds that were present on admission to the facility. There were no Care Area Assessments (CAAs) for review in Resident #2 ' s electronic record. Review of the care plan in Resident #2 ' s electronic record revealed a care plan was not developed to address the resident ' s pressure ulcer. Interview with the MDS nurse on 6/26/13 at 1:42 PM revealed that a care plan to address Resident #2 ' s pressure ulcer was not developed. This nurse explained the CAAs would be completed with the 14 day MDS assessment and the resident ' s 14 day MDS was completed on 6/16/13. She was unable to find any CAAs for that assessment. The MDS nurse explained that Resident #2 currently had a stage four pressure sore on his sacrum that was present on admission and that staff should have developed a care plan for this pressure ulcer. Interview with the Director of Nursing (DON) on 6/26/13 at 4:45 PM revealed Resident #2 should have had a care plan for the pressure ulcer. She was not aware there was not a care plan. The DON explained that the nurse who was responsible for the care plan was not available for interview.	F 279			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	(1) Treatment orders for the surgical wound for resident #2 were obtained on 6/26/13.		

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F 309	<p>Continued From page 2</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, physician interview and record review the facility failed to assess a surgical wound for signs and symptoms of complication after a chest tube was removed, obtain clarification orders for the treatment to the chest wound and failed to complete physician ordered weekly skin assessments for one of one sampled residents with surgical wounds. Resident #2.</p> <p>Resident #2 was admitted to the facility on 5/29/13 with a chest tube to drainage. Admitting diagnoses included diabetes and respiratory failure.</p> <p>Review of an order dated 5/31/13 revealed daily dressing changes were to be completed at the chest tube site.</p> <p>Review of the current monthly re-cap orders for June 2013 included daily dressing change to chest tube site daily and weekly skin assessments to check for redness and skin breakdown every week. Follow protocol as needed. See nursing notes for any abnormalities. The skin assessments were to be done on Sunday PM.</p> <p>Review of the consult report dated 6/12/13 revealed the chest tube was removed at the</p>	F 309	<p>(2) Residents with surgical wounds have been assessed and the chart has been reviewed for appropriate treatment orders.</p> <p>(3) Licensed nurses will be in-serviced on: (a) Assessment of surgical wounds. (b) Obtaining appropriate orders for treatment of surgical wounds.</p> <p>(4) DON/Designee will monitor treatment records/nurses notes weekly x 1 mo., bi-weekly x 1 mo., and monthly x 2 months to ensure surgical wounds are assessed and treated as ordered. Findings will be trended and reported to QA. Completion date 7-24-13.</p>		

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F 309	<p>Continued From page 3</p> <p>pulmonary specialist ' s office on 6/12/13. The consult did not address the surgical chest wound for treatment or dressing changes.</p> <p>Review of the " Treatments - All Shifts " for documentation of the treatments revealed the treatment dated 5/31/13 for daily dressing changes to the chest tube was " DC ' d (discontinued) on 6/12/13 " on the electronic treatment record.</p> <p>A written order to discontinue the daily dressings changes and signed by a physician was not obtained.</p> <p>Weekly skin assessments completed for the month of June were located in the electronic chart. One assessment dated, 6/16/13 was completed. This skin assessment did not address the surgical wound on the chest.</p> <p>Review of the 3-11 shift nurses ' notes dated 6/12/13, documented a dressing was " dry and intact " to the old chest tube site. Nurses ' notes on 11-7 shift, dated 6/13/13 documented the dressing was " dry and intact " at the chest wound.</p> <p>Review of documentation on 6/18/13 (no time) assessed the surgical chest wound as slightly opened, pink tissue and small amount of drainage. A dry dressing was in place.</p> <p>The electronic record was silent as to the condition of the surgical chest wound from 6/19/13 to 6/22/13. On 6/22/13, the daily skilled assessment note by 7-3 shift documented the surgical chest wound was assessed as having a</p>	F 309			

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F 309	<p>Continued From page 4</p> <p>small amount of bloody drainage and was covered with a dry dressing.</p> <p>The nurse practioner had examined Resident #2 on 6/24/13 and ordered a culture and sensitivity to be obtained of the drainage at the surgical chest wound site.</p> <p>Review of the nurse practioner ' s note dated 6/26/13 revealed the chest tube site had " moderate amount of thick green yellow drainage notedWill address infection to left chest wall wound when culture available. "</p> <p>Observations on 6/26/13 at 9:25 AM revealed Resident #2 had no dressing in place at the wound site. The wound was a dime size open area on the left chest flank. The wound bed was red with a yellow center.</p> <p>Interview with nurse #1, who makes rounds with the doctors, was conducted on 6/26/13 at 2:23 PM. Nurse #1 explained a telephone order should be written when a treatment order was discontinued. The specialist who saw Resident #2 did not discontinue the previous order.</p> <p>Interview with nurse #2 on 6/26/13 at 2:30 PM revealed the nurse practioner saw Resident #2 on 6/24/13. A culture and sensitivity was ordered due to bloody drainage from the chest wound. The preliminary results of the culture were not back for review.</p> <p>Nurse #3 was interviewed on 6/26/13 at 2:40 PM. She had worked on 6/24/13 and took care of Resident #2. The treatments provided by nurse #3 to Resident #2 were to the sacral wound.</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>Continued interview revealed she did not remember if a dressing was on the surgical chest wound. She stated " I think in the last day or two, it had oozing and may have had a dressing on the site. Nurse #3 did not check or change a dressing to that area.</p> <p>Nurse #4 was interviewed on 6/26/13 at 2:55 PM. She explained Resident #2 had to be encouraged to let staff change dressings. Resident #2 had a dressing on the surgical chest wound. Treatments would be provided according to what was on the treatment record or medication record. The orders were on the computer on the medication cart.</p> <p>An interview was conducted on 6/26/13 at 3:10 PM with nurse #5. Nurse #5 was the charge nurse on duty on 6/12/13 when Resident #2 returned from the appointment with the specialist. She notified the primary doctor, notified the chest tube had been discontinued. Nurse #5 discontinued the previous orders for dressing changes to the surgical chest wound in the computer. She explained she did not write a telephone order to discontinue the treatment. The specialist who removed the chest tube was not called for clarification of the treatment orders. Nurse #5 explained she had not looked at the wound after Resident #2 returned from the specialist ' s appointment. Nurse #5 further explained any patient with a surgical wound would be monitored every shift. Nurse #5 stated " someone should have looked at the surgical wound. If nothing was documented, I would assume it was healed. "</p> <p>Interview conducted on 6/26/13 at 5:08 PM with</p>	F 309		

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F 309	Continued From page 6 the Director of Nursing revealed the nurses should have had direction from a physician for treatment of the surgical wound. She would expect the floor nurses to inspect a surgical wound daily. Further explanation revealed nurses usually have orders to change dressing every day. At the time of the dressing change, the wound would be assessed. Interview on 6/26/13 at 5:40 PM with the primary physician revealed typically a dressing would be used to cover the site. The chest tube drain was very small and the wound would be small. If the wound had any drainage, a dressing should have been applied. He had not been contacted for an order for a dressing to the surgical wound after removal of the chest tube drain.	F 309			
F 314 SS=D	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 record review the facility failed to provide treatment as ordered to a pressure wound and failed to provide preventative dressing to prior pressure ulcer site for one of three sampled	F 314	(1) The treatment orders for residents #3 have been reviewed and clarified. Necessary supplies have been obtained. (2) Residents' treatment orders have been reviewed and facility has ensured appropriate treatment supplies are available. (3) Nurses will be in-serviced on Apex Policy for clean dressing change.		

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F 314	Continued From page 7 residents with pressure ulcers. Resident #3. The findings included: Resident #3 was admitted to the facility on 6/16/95 with diagnoses of diabetes, paralysis of lower extremities, and neurogenic bladder. Review of the current Minimum Data Set (MDS) dated 5/6/13 revealed Resident #3 had a stage 3 pressure ulcer, required extensive assistance of two staff with bed mobility, total assistance with transfers and extensive assistance with personal hygiene. This MDS assessed Resident #3 as having an indwelling urinary catheter and incontinent of bowel. Review of the physician 's initial order dated 12/15/10, the sacrum was to be cleaned, and apply non adhesive foam daily. Review of the June monthly orders revealed a preventative treatment to the sacrum for cleaning with normal saline, and applying a non-adhesive foam dressing was to be provided daily. Review of the physician 's order that was not dated revealed the sole of the left foot was to be cleansed with normal saline, pat dry, apply Polysporin (antibiotic) to the wound bed, then apply nickel thickness of Santyl (removes dead tissue), then Calcium Alginate (absorbs drainage). Wrap with gauze and secure with tape every day. Review of the Treatment flowsheet for June revealed an order dated 6/5/13 for the left foot was entered as " Apply Polysporin Powder to wound bed." Documentation of the	F 314	(4) DON/Designee will observe five dressing changes a week x four weeks, three dressing changes a week x three weeks, two dressing changes a week x one month. Findings will be trended and reported to QA. Completion date 7-24-2013.		

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F 314	<p>Continued From page 8</p> <p>non-adhesive foam to the sacrum as a preventative measure had been done six times from June 1, 2013 to June 16, 2013.</p> <p>Observations of wound care to left foot were made on 6/26/13 at 10:50 AM. The treatment nurse cleansed the wound with normal saline (NS), applied Calcium Alginate, 4X4s and gauze wrap. After providing the treatment, the chart was reviewed for current treatment orders.</p> <p>Interview on 6/26/13 at 11:05 AM with the treatment nurse revealed the Polysporin had not been applied. She explained she knew the treatment, and must have gotten nervous with a surveyor watching her. The treatment nurse explained she usually is on a medication cart, and checks the orders on the computer. Today she was only doing treatments and measurements and did not have the med cart computer with the treatment orders to review before doing the treatment. A date of 6/10/13 was provided by the treatment nurse who explained she had written the order. When asked about the dressing to the sacrum area, she replied the nurse on the hall would do that treatment. The treatment nurse stated the sacral dressing was for protection since the skin was fragile due to a previous healed pressure ulcer.</p> <p>On 6/26/13 at 11:10 AM observations were made of the wound care after the orders were verified by the treatment nurse. The previous dressing was removed; the wound bed cleansed with NS, and Santyl was applied, but not the Polysporin. She stated the medicated ointment was not available and she would have to chart that it was not used. The left foot was redressed with 4X4</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>gauze and Gauze wrap. The treatment nurse placed the non-adhesive foam dressing between the folds of the buttocks. A pink scarred area was observed in the folds. The sacrum was not cleansed before the dressing was applied.</p> <p>Interview with aide #1 on 6/26/13 at 11:25 AM revealed Resident #3 did not have a foam dressing on the sacrum that morning when care was provided. He had a bed bath before the nurse did the treatment. Aide #1 had been assigned to Resident #3 on previous days and the foam dressing was not on the sacrum. When asked what he did if it was not in place, he stated " if the area was healed a cream was used. "</p> <p>Interview with the Director of Nursing on 6/26/13 at 12:21 PM reviewed the pharmacy delivery slip, and the Polysporin came in on 6/10/13. The treatment nurse would order it today and it would be in tonight. They will let the doctor know the Polysporin was not used today.</p> <p>Interview with nurse #6 that worked on 6/25/13 was conducted on 6/26/13 at 4:27 PM revealed she had used normal saline to cleanse the foot, applied a powder and Santyl. Nurse #6 could not remember what the powder was, but thought it was used to absorb drainage. " Resident #3 has all of the wound supplies in his room. " There was a small amount of the powder left. Nurse #6 was asked if there were any other dressings on Resident #3. She replied he had a prophylactic dressing on the sacrum, it was clean and she did not have to change it.</p> <p>The Director of Nursing was asked to look for any</p>	F 314			

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F 314	Continued From page 10 powder or ointment that might be in Resident #3's room with the wound supplies. The Director of Nursing did not find either type of Polysporin in the wound supplies.	F 314			