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

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING _____ B. WING _____ FEB 16 2012	C 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to develop a Care Plan for a resident with behavior problems, was at high risk for falls and at risk for pressure sores. (Resident #5). The findings included: 1a. Resident #5 was originally admitted to the facility on 12/15/11 with diagnoses including Hypertension, Hyperlipidemia, Diabetes Mellitus II, and Sleep Apnea.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F-279** **Corrective Action for Resident Affected** Resident # 5 had a care plan developed on 1/18/12 which included the problems of being at risk for falls, pressure ulcer and behaviors. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this alleged deficient practice. Residents were reviewed by Administrative Nurses by 2/10/12 to ensure that all residents have a care plan and residents that are at risk for falls, pressure ulcers and behaviors were addressed in their care plan. **Systemic Changes** An in-service was conducted on 2/8/12 by Nurse Consultant for the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Dietary Manager and Activities Director about the importance of each resident having a care plan and that after completing the MDS Assessment, it is important to work the Care Area Assessments and to proceed to care plan if indicated. The MDS Coordinator, DON or SDC is responsible for developing the care plan.In-services were conducted on 2/9/12 by the Administrator and SDC.	02/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy W Bullock RN/LNHA — TITLE — (X6) DATE: 2-16-12

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 facility's Assessment Risks for Falls dated 12/15/11 noted Resident #5's fall risk score was 9. According to the falls risk assessment a score from 7 to 18 a resident was considered a high risk for falls. Review of the Minimum Data Set Care Area Assessment dated 12/29/11 noted the Care Area Assessment triggered falls. The location and date of the Care Area Assessment Information, read, " New Care Plan started. " Resident assessment 12/29/11. Review of the Minimum Data Set Care Area Problem Area dated 12/29/11 for Falls, read, "Requires extensive assist with transfers and toileting using two or more persons for physical support. Contributing factors include history of falls, Diabetes Mellitus, Gout, Hypertension, Seizure Disorder and Peg Tube placement. He is continent of bowel and bladder. Risk factors include injuries related to falls, increased agitation, increased negative behaviors, etc." Under Care Plan Considerations: "He will be referred to therapy and restorative nursing. Will proceed to care plan and minimize his risks for falls and injuries." Review of an incident report dated 1/3/12, 9:30AM, read in part, Narrative of incident and description of injuries: "Resident very confused. Coming out of bed across siderail, CNA assisted to floor and lowered. No apparent injury." Immediate actions taken: "Fall mat in place." During observations the siderails were on Resident #5's bed, but the siderails were not up during the survey.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Those who attended all RNs, LPNs, and CNAs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included the importance of the care plan and how it can provide information about resident care specific for the resident. Also included were the inclusion of risk areas for the resident and interventions for the resident. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing or MDS Coordinator will monitor this issue using the "Survey QA Tool for Risk Areas Care Planned for Behaviors, PU and Falls". The monitoring will include verifying that all residents have a care plan and that all residents with behaviors or at risk for pressure ulcers or falls have a care plan problem for this area. 10% of residents will be reviewed each week. See attached monitoring tool. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 279	Continued From page 2 On 1/17/12 a review of Resident #5's record and the facility's Care Plan book revealed there was no care plan. During an interview on 1/18/12 at 4:30PM with the Minimum Data Set (MDS) Coordinator and the MDS Consultant revealed they could not find Resident #5's Care Plan. The MDS Consultant stated since they were not able to find Resident #5's care plan, they wrote the care plan again on that day. She stated they could not find the original care plan and signature sheet. During another interview on 1/18/12 at 5:15PM, the MDS Consultant stated the care plan must have fallen through the cracks. She stated an interim care plan was completed when Resident #5 was initially admitted to the facility. She stated she did not know why the care plan developed by the team was not in the computer system. During an interview on 1/18/12 at 12:05PM, 1st shift Nursing Assistant (NA) #1, revealed Resident #5 had a bed alarm to alert staff during falls. She revealed she did not know of any other fall interventions for Resident #5. She added that if she had just been employed with the facility and was not familiar with how to care for a resident, she would ask the head nurse. During an interview on 1/18/12 at 4:30PM, 2ndshift NA #2 revealed Resident #5's intervention for falls was a pressure alarm on his bed. She stated she did know about a fall mat for Resident #5. She stated she had not used one when she assisted him to bed. She revealed there was no information for staff to learn about how to care for a particular resident, she stated,	F 279		

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F 279	Continued From page 3 "you learn as you go." 1b. Resident #5 was originally admitted to the facility on 12/15/11 with diagnoses including Hypertension, Hyperlipidemia, Diabetes Mellitus II, and Sleep Apnea. Review of the facility's Assessment of Pressure Sore Potential dated 12/15/11 noted Resident #5's pressure sore risk potential score was 14. According to the pressure sore assessment a score of 7 to 39, it was recommended to follow pressure sore protocol. Review of the Minimum Data Set Care Area Assessment dated 12/29/11 noted the Care Area Assessment triggered pressure sores. The location and date of the Care Area Assessment Information, read, "New Care Plan started, Weekly wound review." Review of the Minimum Data Set Care Area Problem Area dated 12/29/11 for Pressure Ulcers, read, "He has a stage two pressure ulcer on his left buttock that he was admitted with. He is also incontinent of bowel and bladder and wears adult briefs. He requires extensive weight bearing assist with toileting using two or more person for physical support. He also has a surgical wound that is now healed. He remains at risk for further skin breakdown and other issues with alteration with skin integrity." Care Plan Considerations read, "He will be referred to the MD and wound clinic as needed. Will proceed to care plan and minimize his risk for further skin break down." On 1/17/12 a review of Resident #5's record and	F 279		

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F 279	Continued From page 4 the facility's Care Plan book revealed there was no care plan. During an interview on 1/18/12 at 4:30PM with the Minimum Data Set (MDS) Coordinator and the MDS Consultant revealed they could not find Resident #5's Care Plan. The MDS Consultant stated since they were not able to find Resident #5's care plan, they wrote the care plan again on that day. She stated they could not find the original care plan and signature sheet. During another interview on 1/18/12 at 5:15PM, the MDS Consultant stated the care plan must have fallen through the cracks. She stated an interim care plan was completed when Resident #5 was initially admitted to the facility. She stated she did not know why the care plan developed by the team was not in the computer system. 1c. Resident #5 was originally admitted to the facility on 12/15/11 with diagnoses including Hypertension, Hyperlipidemia, Diabetes Mellitus II, and Sleep Apnea. Review of the Minimum Data Set Care Area Assessment dated 12/29/11 noted the Care Area Assessment triggered for Behavioral Symptoms. The location and date of the Care Area Assessment Information, read, " New Care Plan started. " On 1/17/12 a review of Resident #5 ' s record and the facility ' s Care Plan book revealed there was no care plan. During an interview on 1/18/12 at 4:10PM, NA#2 stated Resident #5 required total care. She	F 279		

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F 279	Continued From page 5 revealed he was very combative and did not like to be touched. Na#2 stated Resident #2 also had behaviors of trying to get out of bed and staff kept him near the nurse ' s station to watch him until he settled down. An interview on 1/18/12 at 4:30PM with the Minimum Data Set (MDS) Coordinator and the MDS Consultant revealed they could not find Resident #5 ' s Care Plan. The MDS Consultant stated since they were not able to find Resident #5 ' s care plan, they wrote the care plan again on that day. She stated they could not find the original care plan and signature sheet. During another interview on 1/18/12 at 5:15PM, the MDS Consultant stated the care plan must have fallen through the cracks. She stated an interim care plan was completed when Resident #5 was initially admitted to the facility. She stated she did not know why the care plan developed by the team was not in the computer system.	F 279		
F 280 SS=D	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 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,	F 280		

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F 280	Continued From page 8 transfers. The MDS showed that the resident was admitted to the facility with one unstageable pressure ulcer. A review of the Physician ' s Telephone Orders dated 12/21/11 revealed an order for an indwelling urinary catheter to be placed. The Nurse ' s Notes showed that an indwelling urinary catheter was inserted on 12/21/11 at 6:03 PM. The resident was observed to receive catheter care on 01/19/12 at 3:41 PM. The resident ' s Care Plan dated 12/03/11 contained no information about the resident ' s indwelling urinary catheter. The Administrator stated in an interview on 01/19/12 at 2:15 PM that the previous Director of Nursing (DON) was also the MDS Nurse. The Administrator stated that the DON would take the Care Plan book to their daily meetings where they discussed changes in resident ' s conditions and reviewed new orders. The Administrator stated that the Care Plans were updated at this time. The Administrator stated that the previous DON left around the first of December, 2011 and a new MDS Nurse was hired that left after 2 weeks. The Administrator stated that the facility ' s Nurse Consultants came in to make sure that all of the Care Plans were up to date. The Administrator stated that a new MDS Nurse was currently being trained and was supposed to be reviewing new orders daily and updating all resident ' s Care Plans. The Administrator did not explain why this resident ' s Care Plan had not been updated.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 280	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: 1a. Resident #6 was admitted to the facility on 12/03/11 and had diagnoses including Aftercare Joint Replacement (Hip Fracture), Congestive Heart Failure, Cardiomyopathy, Chronic Obstructive Heart disease, Hypertension, Atrial Fibrillation, Pacemaker and Osteoporosis. The resident ' s Care Plan dated 12/03/11 listed pressure ulcers as a problem with approaches that included monitoring of nutritional status, weekly skin assessments, chair cushion while in wheelchair and turning and repositioning. The Admission Minimum Data Set (MDS) Assessment dated 12/09/11 showed that the resident was cognitively intact and required extensive assistance for bed mobility and transfers. The MDS showed that the resident was admitted to the facility with one unstageable pressure ulcer. The Care Area Assessment (CAA) for pressure ulcers dated 12/16/11 showed that the resident was admitted to the facility with a pressure ulcer on the sacral area and required staff assistance to move sufficiently to relieve pressure.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F280** **Corrective Action for Resident Affected** Resident # 6's care plan was updated with the problems of heel protectors and infomation concerning the resident's urinary catheter. **Corrective Action for Resident Potentially Affected** All residents with heel protectors and urinary catheters have the potential to be affected by this alleged deficient practice. Residents were reviewed by Administrative Nurses by 2/10/12 to ensure that every resident that had heel protectors or a urinary catheter were addressed in their care plans. **Systemic Changes** An in-service was conducted on 2/8/12 by Nurse Consultant for the Administrator, DON, SDC, MDS Coordinator, Social Services Director, Dietary Manager and Activities Director about the importance of updating the care plan. Any of the Interdisciplinary Care Plan Team or support staff mentioned above who did not receive in-service training will not be allowed to work until training has been completed. The MDS Coordinator, DON and or SDC will be responsible for bringing the care plan books to our morning stand-up Monday through Friday and so that care plans are updated as needed	02/13/12

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F 280	Continued From page 7 A review of the Physician ' s Telephone Orders showed an order dated 12/20/11 that read: Heel protectors to heels to relieve pressure. " There was no information on the resident ' s Care Plan to include the use of heel protectors. The Administrator stated in an interview on 01/19/12 at 2:15 PM that the previous Director of Nursing (DON) was also the MDS Nurse. The Administrator stated that the DON would take the Care Plan book to their daily meetings where they discussed changes in resident ' s conditions and reviewed new orders for the residents. The Administrator stated that the Care Plans were updated at this time. The Administrator stated that the previous DON left around the first of December, 2011 and a new MDS Nurse was hired that left after 2 weeks. The Administrator stated that the facility ' s Nurse Consultants came in to make sure that all of the Care Plans were up to date. The Administrator stated that a new MDS Nurse was currently being trained and was supposed to be reviewing new orders daily and updating all resident ' s Care Plans. The Administrator did not explain why the resident ' s Care Plan had not been updated. 1b. Resident #6 was admitted to the facility on 12/03/11 and had diagnoses including Aftercare Joint Replacement (Hip Fracture), Congestive Heart Failure, Cardiomyopathy, Chronic Obstructive Heart disease, Hypertension, Atrial Fibrillation, Pacemaker and Osteoporosis. The Admission Minimum Data Set (MDS) Assessment dated 12/09/11 showed that the resident was cognitively intact and required extensive assistance for bed mobility and	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The in-service topics included that the care plans for heel protectors and urinary catheters should be updated and revised to include planning the care of the resident and treatment or changes in care and treatment of the resident. Also reviewed was the importance of reviewing orders and the identification of problems that need to be included in the care plan. This information has been integrated into the orientation training of any new Interdisciplinary Care Plan Team Members and in the required in-service refresher courses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing or MDS Coordinator will monitor this issue using the "Survey QA Tool for Updating Care Plans for Heel Protectors and Urinary Catheters". The monitoring will include verifying that care plans are updated with heel protectors and urinary catheters and revised to include planning the care of the resident as indicated. See attached monitoring tool. 10% of residents will be reviewed with each audit. This will be done weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 314	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to apply a barrier cream to a resident ' s buttocks and failed to float the resident ' s heels for 1 of 4 residents reviewed for pressure ulcers (Resident #5). The facility also failed to apply heel protectors for 1 of 4 residents reviewed for pressure ulcers (Resident #6). The findings include: 1a. Resident #5 was admitted to the facility on 12/15/11 and had diagnoses including Intracranial Hemorrhage with severe aphasia, Seizures, Hypertension, Diabetes Mellitus and Arthritis. The Admission Minimum Data Set (MDS) Assessment dated 12/22/11 showed that the resident had short and long term memory loss, poor decision making skills requiring cues and supervision and had physical behaviors directed at others such as hitting, kicking and grabbing. The MDS showed that the resident required extensive assistance with bed mobility, transfers and toileting and required total assistance with hygiene and bathing. The MDS showed that the	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **F – 314** **Corrective Action for Resident Affected** Resident #5's treatment for his pressure area was changed to a hydrocolloid dressing on 1/20/12 and heels were floated to provide pressure relief to heels on 1/20/12. . Resident #5 heels are to be floated while in bed or in geri-chair. A reminder was sent to the Certified Nursing Assistant's Smart Charting for providing floating heels to Resident #5 on 2/9/12 A reminder was sent to the Certified Nursing Assistant's Smart Charting for providing floating heels to Resident #5 on 2/9/12. For Resident #6 heel protectors were applied on 1/19/12. A reminder was sent to the Certified Nursing Assistant's Smart Charting for providing heel protectors to Resident #6 on 2/9/12. **Corrective Action for Resident Potentially Affected** All residents with potential to be affected by this alleged deficient practice were reviewed by Administrative Nurses by 2/9/12 to identify every resident that had an order for heel protectors and those residents who needed their heels floated were identified. All residents who need their heels floated were ensured that floating of heels where on their care plan and reminders were sent to Smart Charting for Certified Nursing Assistants by 2/9/12. All residents with orders for heel protectors were identified and ensured that heel protectors were updated on their care plan and reminders were sent to Smart Charting for Certified Nursing Assistants by 2/9/12.	02/13/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346309	A. BUILDING _____ B. WING _____	C 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 10 resident was frequently incontinent of bowel and bladder. The MDS showed that the resident was at risk for developing a pressure ulcer and had an unhealed stage II pressure ulcer that was present on admission. A review of the Physician ' s Telephone Orders showed an order dated 12/23/11 that read: " D/C (discontinue) wet dressing to sacrum and apply Calmaseptine barrier cream to inner top buttock area Q (every) shift. " Calmoseptine provides a physical moisture barrier keeping feces and urine from intact and injured skin. The CAA for Pressure Ulcer dated 12/29/11 showed that the resident was admitted with a stage II pressure ulcer on the left buttock and was at risk for further skin breakdown. The CAA read: " Will proceed to care plan and minimize his risk for further skin break down. " There was not a care plan for pressure ulcers for Resident #5. A Weekly Wound Review sheet dated 01/10/12 showed a stage II pressure ulcer on the left buttocks that measured 4 cm (centimeters) long and 3.8 cm wide. A note under Additional description or documentation read: " Instructed staff about how to use camolseptine ointment as a barrier cream. " A Weekly Wound Review sheet dated 01/18/12 at 9:40 AM showed that the resident had a Stage II Pressure wound on the left buttocks measuring 3 cm (centimeters) in length and 2 cm in width. Incontinence management with barrier ointments was listed as one of the interventions for healing.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* All residents with treatments were identified and information sheets printed off for each type of treatment being performed for residents. These information sheets were placed in a notebook on the treatment cart on 2/9/12. **Systemic Changes** An in-service was conducted on 2/10/12 by the Staff Development Coordinator and Administrator. Those who attended all RNs, LPNs, and CNAs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included the requirement to follow guidelines for treatments as set forth by the manufacturer and the initiation of a Treatment Information Notebook that will be kept on the treatment cart, that all residents who are at risk for heel breakdown will have their heels floated and that if heel protectors must be applied as ordered. This information has been integrated into the orientation training of any new Interdisciplinary Care Plan Team Members and in the required in-service refresher courses and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing or SDC will monitor this issue using the "Survey QA Tool for Floating Heels/Use of Heel Protectors" and "Survey QA Tool for Treatment Accuracy".	

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OMB NO. 0938-0391

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

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	345309	A. BUILDING _____ B. WING _____	C 01/19/2012

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F 314	Continued From page 11 The Treatment Administration Record for January 2012 had an entry that read: "May apply Calmaseptine barrier cream to inner top buttocks q (every) shift." There were 8 shifts on the MAR that were not initialled as being done including the 7AM to 3PM shift on 01/18/12. Nursing Assistant (NA) #1 and NA #3 was observed to check Resident #5 for incontinence on 01/18/12 at 11:37 AM. The resident was dry and did not require incontinence care. There was an open area on the resident ' s left upper buttocks that was red and inflamed, without drainage. There was no cream observed on the wound. The NAs reapplied the incontinent brief on the resident and did not apply a barrier cream. During the observation, the resident was observed to be cooperative without behaviors. On 01/18/12 at 11:54 AM, the Nurse (Nurse #4) assigned to Resident #5 stated in an interview that the resident did not currently have any skin breakdown. NA #4 stated in an interview on 01/18/12 at 12:05 PM that the resident had a spot on his bottom that was healing and they were putting a thick barrier cream on it. On 01/18/12 at 2:35 PM the Staff Development Coordinator stated in an interview that she had instructed the NAs to keep a thick layer of the calmoseptine cream over the pressure area and to not completely wipe it off during incontinent care and to reapply a thick layer of the cream over the area after each incontinent episode.	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The monitoring will include verifying that heels are floated for those identified, heel protectors used as ordered and that treatments are applied as ordered. See attached monitoring tools. This will be done on 5 residents 5 times a week for two weeks and then 5 residents weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.	

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OMB NO. 0938-0391

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

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F 314	Continued From page 12 On 01/18/12 at 2:40 PM the Director of Nursing (DON) stated in an interview that the resident had an open area on his sacrum that they were putting calmoseptine barrier cream on after each incontinent episode. The DON stated that the NAs had been instructed to keep a thick layer of cream over the area and to not completely wash it off during incontinent care. The DON stated that when the NAs checked for incontinence at 11:37 that morning they should have applied the calmoseptine cream. On 01/18/12 at 3:05 PM, NA #1 who was assigned to the resident stated in an interview that she does not apply the Calmoseptine barrier cream that the nurses did that. The NA stated that the nurse changed the resident first thing this morning. On 01/18/12 at 3:15 PM Nurse #4 stated in an interview that she changed the resident ' s incontinent brief that morning but did not apply calmoseptine barrier cream because the resident was combative. On 01/19/12 at 8:48 AM, NA #5 stated in an interview that after each incontinent episode she applied a thick barrier cream over the open area on the resident ' s bottom. On 01/19/12 at 2:30 PM an interview was conducted with the Administrator and the DON. The DON stated that there was no barrier cream over the resident ' s pressure area when she looked at it yesterday. The Administrator stated that they have a computerized system that gives the NAs an Assigned Task List that tells them how to care for a resident. .	F 314		

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

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

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F 314	Continued From page 13 On 01/19/12 at 2:37 PM the Administrator and the DON was observed to review an Assigned Tasks List for Resident #5. There was no information on the tasks list to instruct the NAs to apply Calmoseptine barrier cream to the resident ' s pressure ulcer on his bottom after each incontinent episode. The Administrator stated that some of the information on the Tasks List comes from the Care Plan b. Resident #5 was admitted to the facility on 12/15/11 and had diagnoses including Intracranial Hemorrhage with severe aphasia, Seizures, Hypertension, Diabetes Mellitus and Arthritis. The Admission Minimum Data Set (MDS) Assessment dated 12/22/11 showed that the resident had short and long term memory loss, poor decision making skills requiring cues and supervision and had physical behaviors directed at others such as hitting, kicking and grabbing. The MDS showed that the resident required extensive assistance for bed mobility. The CAA for Pressure Ulcer dated 12/29/11 showed that the resident was admitted with a stage II pressure ulcer on the left buttock and was at risk for further skin breakdown. The CAA read: " Will proceed to care plan and minimize his risk for further skin break down. " There was not a care plan for pressure ulcers for Resident #5. A review of the Physician ' s Telephone Orders showed an order dated 12/24/11 that read: " Right heel clean fluid filled blister float heels on	F 314		

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

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 14 pillows to keep pressure off. " A Weekly Wound Review dated 01/10/12 showed that the resident had a stage II pressure area on the right heel that measured 4 cm long and 3.8 cm wide. A section on the Weekly Wound Review sheet titled Interventions for healing listed multiple possible interventions. The intervention " Float heels " was not marked as an intervention for healing the heel pressure area. A section on the Weekly Wound Review sheet titled Document conditions that would affect wound healing showed that the resident refused repositioning. The Additional description or documentation read: " Heel blister from friction and shear by repetitive scrubbing heel on the bed and chair. Blister dry and intact. " On 01/17/12 at 11:00 AM, Resident #5 was observed sitting in a geri-chair near the nurses ' station. The resident was calm and resting with his eyes closed. The resident was reclined in the geri-chair, had on white socks and both heels were resting on the foot rest of the geri-chair. There were no pillows under the resident ' s heels. On 01/17/12 at 4:15 PM the resident was observed to be reclined in a geri-chair in his room. The resident was calm and a family member was talking with the resident. The resident was observed to have on socks and both heels were resting on the foot rest of the chair. A Weekly Wound Review sheet dated 01/18/12 at 9:53 AM showed that the resident had a non-stageable pressure ulcer on the right heel that measured 4cm long and 3.8 cm wide. The	F 314		

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

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 15	F 314		

interventions for healing on the review sheet did not include floating of the resident ' s heels. Additional description or documentation read: " Really question if this is eschar or skin that will peel off. Will continue to monitor. "

NA #1 and NA #3 were observed to transfer the resident from the bed to a geri-chair on 01/18/12 at 11:40 AM. NA #3 stated that the staff would float the resident ' s heels on pillows when the resident would allow them to. NA #3 removed the resident ' s socks and the right heel was observed with a dried circular area. The top half of the area was clear and the bottom half was dark underneath the skin. The area was intact. The NA reapplied the resident ' s socks and the resident was left reclining in the geri-chair with both heels resting on the foot rest without pillows under the heels of the feet. During the observation, the resident was calm, was not combative and did not resist care.

In a separate interview on 01/18/12 at 12:05 PM, NA #1 stated that Resident #5 was up in his geri-chair most of the time. The NA stated that she would use a pillow every now and then to prop up the resident ' s feet because of his pressure sore.

On 01/18/12 at 12:14 PM, Nurse #5 stated in an interview that the resident had an area on the right heel and they were floating the resident ' s heels to keep the pressure off.

On 01/18/12 at 2:30 PM, Resident #5 was observed reclined in the geri-chair. The resident had socks on his feet and his heels were resting on the foot rest. There was not a pillow under the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 16 resident ' s heels. A family member was visiting and the resident was resting quietly. On 01/19/12 at 8:48 AM Resident #5 was observed lying in bed asleep. The heels of both feet were resting on the mattress of the bed. The only pillow on the bed was the one under the resident ' s head. On 01/19/12 at 2:30 PM an interview was conducted with the Administrator and DON. The Administrator stated that the NAs have a computerized system that provides the NAs with an Assigned Task List that tells them how to care for the resident. On 01/19/12 at 2:37 PM the Administrator and the DON was observed to review an Assigned Tasks List for Resident #5. There was no information on the tasks list to instruct the NAs to float the resident ' s heels. The Administrator stated that some of this information comes from the resident ' s Care Plan. 2. Resident #6 was admitted to the facility on 12/03/11 and had diagnoses including Aftercare Joint Replacement (Hip Fracture), Congestive Heart Failure, Cardiomyopathy, Chronic Obstructive Heart disease, Hypertension, Atrial Fibrillation, Pacemaker and Osteoporosis. The resident ' s Care Plan dated 12/03/11 listed pressure ulcers as a problem with approaches that included monitoring of nutritional status, weekly skin assessments, chair cushion while in wheelchair and turning and repositioning. The Admission Minimum Data Set (MDS)	F 314		

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

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

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F 314	Continued From page 17 Assessment dated 12/09/11 showed that the resident was cognitively intact and required extensive assistance for bed mobility and transfers. The MDS showed that the resident was admitted to the facility with one unstageable pressure ulcer. The Care Area Assessment (CAA) for pressure ulcers dated 12/16/11 showed that the resident was admitted to the facility with a pressure ulcer on the sacral area and required staff assistance to move sufficiently to relieve pressure. A review of the Physician ' s Telephone Orders showed an order dated 12/20/11 that read: " Heel protectors to heels to relieve pressure. " On 01/18/12 at 10:10 AM the resident was observed to be lying in bed with no heel protectors on the resident ' s feet. On 01/19/12 at 9:40 AM Resident #6 was observed lying in bed with the heels of her feet resting on the mattress. There were no heel protectors on the resident ' s feet or pillows under the resident ' s heels. During the observation an interview was conducted with an individual in the room who stated that she was a sitter and sat with the resident 5 days a week from 8 AM until 2 PM. The Sitter stated that the staff usually put anti-embolism stockings on the resident but did not use heel protectors. During the interview Nurse #2 entered the room. The Nurse was asked about the heel protectors and was observed to pick up 2 heel protectors from the corner of the room. An observation of the resident ' s heels at this time showed no redness or open areas. Nurse #2 put the heel protectors on the	F 314		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 18 resident ' s feet. On 01/19/12 at 9:46 AM an interview was conducted with the nursing assistant (NA #6) assigned to the resident on the 7 AM to 3 PM shift. NA #6 stated that when the resident was in bed she usually floated the resident ' s heels on pillows. When asked if the resident used heel protectors, the NA stated: " Sometimes. " The NA stated that at the beginning of her shift she did not check to see if heel protectors were on the resident ' s feet. The NA stated that she had not applied the heel protectors to the resident ' s feet and had not removed heel protectors from the resident ' s feet since the beginning of her shift. The Administrator stated in an interview on 01/19/12 at 2:15 PM that when new interventions were put into place such as heel protectors, the nurses pass along the information to the nurse on the next shift and the nurses let the NAs know about the changes. An interview was conducted with the Administrator and the DON on 01/19/12 at 2:30 PM. The Administrator stated that the NAs have a computerized system that provides the NAs with an Assigned Task List that tells them how to care for the resident. On 01/19/12 at 2:37 PM the Administrator and the DON was observed to review an Assigned Tasks List for Resident #6. There was no information on the tasks list to instruct the NAs to apply heel protectors to the resident ' s feet. The Administrator stated that some of this information comes from the resident ' s Care Plan.	F 314		