

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

PRINTED: 01/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345499</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/10/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITCHFORD FALLS HEALTHCARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8200 LITCHFORD ROAD</b> <b>RALEIGH, NC 27615</b>		
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F 278 SS=B	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to accurately reflect skin conditions on the most recent quarterly assessments for 2 of 3 residents reviewed for minimum data set assessment accuracy, Resident #1 and Resident #3. Findings included:</p>	F 278	Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction.	12/22/14	

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

TITLE

(X6) DATE

Electronically Signed

12/19/2014

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 278	<p>Continued From page 1</p> <p>1. A review of Resident #1's quarterly minimum data set (MDS) assessment dated 10/30/2014 revealed that the resident had no pressure ulcers, no arterial or venous ulcers, and no other skin lesions, rashes, cuts, burns, skin tears, or moisture related skin damage. The same assessment indicated that the resident was always incontinent of bladder and bowel. In addition, the MDS assessments dated 08/05/2014 and 06/27/2014 revealed the resident had no pressure ulcers, no arterial wounds, and no other skin lesions, rashes, cuts, burns, skin tears, or moisture related skin damage, and that the resident was always incontinent of bladder and bowel.</p> <p>A review of the nursing care plan last updated on 10/30/2014 for the resident revealed there were goals and interventions in place for the potential for skin breakdown related to incontinence and immobility.</p> <p>On 12/10/2014 at 10:30 AM, an observation of incontinent care and bathing provided by two nursing assistants for Resident #3 was made. As the nursing assistants prepared to cleanse the perineal area of the resident, the Treatment Nurse removed a dressing from the right inner thigh. A large area of excoriation was noted on the right inner aspect of the thigh. The Treatment Nurse stated that the area of redness and excoriation on the inner right thigh was a chronic condition. The Treatment Nurse left the resident's room as the nursing assistants bathed the resident's perineal area, the gluteal fold, and the buttocks. During this part of the bath, the resident complained of itching on her right inner</p>	F 278	<p>1. Resident #1 and #3 skin was re-assessed by facility treatment nurse and Medical Director. Medical Director diagnosed Resident #1 and #3 with Erythema Intertrigo. Minimum Data Set was modified and transmitted to show skin status on resident #1 and #3.</p> <p>2. Treatment nurse and RN supervisor did skin assessment audit of current residents in the facility on 12/17/2014 &amp; 12/18/2014 to identify any residents with skin issues related to F278. The results from these audits were documented in resident medical record which included update to MDS, Care plan and Treatment Administration Record. Any residents with skin issues related to F278 were reviewed by Medical Director and provided appropriate diagnosis/treatment.</p> <p>3. On 12/19/2014, licensed nursing staff was re-trained on weekly skin assessment which included how to complete weekly skin assessments, documentation for residents <input type="checkbox"/> skin intact, skin not intact, existing area skin not intact, new area and required documentation for those areas by Director of Nursing. MDS nurse was re-trained on 12/19/2014 by Regional MDS nurse consultant on Section M of MDS which included skin conditions including Moisture Associated Skin Damage.</p> <p>Licensed nursing staff will be conducting weekly skin assessment forms on current residents. New admission residents will</p>		

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F 278	<p>Continued From page 2</p> <p>thigh. As the perineal area was washed, some bleeding was noted on both the right and left inner thighs. When the resident was turned to the left side, the Treatment Nurse re-entered the room and cleansed the right posterior thigh with normal saline, pat dry, and placed a Comfeel dressing over the area. The Treatment Nurse then cleansed the left thigh with normal saline and placed a Comfeel dressing over it. The Treatment Nurse also applied Calmoseptine to the buttocks and the sacral area, and front inner thighs bilaterally.</p> <p>A review of the Skin Inspection Report for Resident #3 revealed the resident's skin status to be, "Skin Not Intact - Existing," for the weeks of 07/31/2014, 08/07/2014, 08/14/2014, 08/21/2014, 08/21/2014, 09/04/2014, 09/10/2014, 09/18/2014, 10/02/2014, 10/09/2014, 10/23/2014, 10/30/2014, and 12/04/2014.</p> <p>A review of the Treatment Administration Record for December 2014 revealed some of the treatments for the resident were as follows:</p> <ol style="list-style-type: none"> <li>1. Cleanse right buttock with normal saline, pat dry, and place Comfeel to open area.</li> <li>2. Left groin inner aspect, cleanse with normal saline, pat dry, and place Comfeel to open areas, change every third day and as needed.</li> <li>3. Clean barrier cream between thighs and buttocks twice per day.</li> <li>4. Cleanse right groin (inner aspect) with normal saline, pat dry and place Comfeel to open area, change every third day.</li> </ol> <p>The right buttock treatment had been initiated on 08/04/2014. The left groin treatment had been</p>	F 278	<p>receive a skin assessment within 24 hours of admission. If there any skin conditions, the licensed nurse will contact the attending physician to confirm treatment to be started. During the weekly standards of care meeting, residents with any skin conditions will be reviewed.</p> <ol style="list-style-type: none"> <li>4. Resident skin assessments will be audited by Director of Nursing and/or administrative nursing staff for accuracy and completeness weekly X3 months then monthly X2 months. MDS audits for accuracy of section M will be completed during standards of care meeting weekly X3 months then monthly X2 months by Director of Nursing/MDS nurse.</li> <li>5. DON will complete a summary of all monitoring results and present at the monthly QAPI meetings.</li> </ol>		

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F 278	<p>Continued From page 3</p> <p>initiated on 05/13/2014, and the barrier cream treatment had been initiated on 01/31/2013. The right groin treatment had been initiated on 03/27/2014. Each of these four treatments were initialed as completed as ordered for the month of December.</p> <p>In an interview with the Treatment Nurse on 12/10/2014 at 3:15 PM, she stated that Resident #1's excoriation on the left groin, the right groin, and the buttocks was a chronic condition in part due to her obesity and her incontinence of bladder and bowel. Also, the treatment nurse stated she completed Wound Assessment Reports for all stage 2 and above pressure ulcers and for surgical wounds, not for excoriations, rashes, or other skin conditions. She stated there was no other assessment form for skin conditions except for the weekly skin inspections.</p> <p>In an interview with the Minimum Data Set (MDS) Nurse on 12/10/2014 at 4:26 PM, she stated that she receives information about the skin conditions for residents for the quarterly assessments through daily clinical meetings, by using significant changes in residents' conditions, and by reviewing 24-Hour reports. In addition, the MDS Nurse stated she met regularly with the Treatment Nurse to obtain information regarding skin conditions and wounds. She added that care area assessments were used as a guide as to whether a resident should be care planned for specific problems.</p> <p>In an interview with the Director of Nursing and the Administrator on 12/10/2014 at 4:53 PM, both stated they would expect to have to accurate assessments for skin wounds and so nursing care plans could be updated with for actual</p>	F 278			

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F 278	<p>Continued From page 4 wounds or skin conditions.</p> <p>2. A review of Resident #3's quarterly minimum data set (MDS) assessment dated 11/10/2014 revealed that the resident had no pressure ulcers, no arterial or venous ulcers, and no other skin lesions, rashes, cuts, burns, skin tears, or moisture related skin damage. The same assessment indicated that the resident was always incontinent of bladder and bowel. In addition, the quarterly minimum data set assessment dated 09/18/2014 and 06/19/2014 reflected that the resident the resident had no pressure ulcers, no arterial or venous ulcers, and no other skin lesions, rashes, cuts, burns, skin tears, or moisture related skin damage, and that the resident was always incontinent of bladder and bowel.</p> <p>A review of the nursing care plan for the resident last updated on 11/10/2014 revealed there were goals and interventions in place for the potential for skin breakdown related to incontinence and immobility.</p> <p>On 12/10/2014 at 9:30 AM, an observation of incontinent care and bathing provided by two nursing assistants for Resident #3 was made. As the resident was turned during the care, a large area of redness and excoriation was noted on the left posterior thigh and the buttocks. In addition there was reddened skin noted underneath the abdominal fold noted when the resident was turned again during the care. After the bathing to the perineal area, the buttocks, and the abdomen was completed, the treatment nurse applied a Nystatin ointment to the abdominal fold, and</p>	F 278			

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F 278	<p>Continued From page 5</p> <p>applied non-sting skin prep to the left posterior thigh, and then a comfort dressing to the area. In addition, the treatment nurse applied Calmoseptine ointment over the rest of the left and right buttocks and gluteal fold.</p> <p>A review of the physician's orders revealed there had been an order in place since 03/05/2014 to apply Nystatin ointment to the groin and to the abdominal fold.</p> <p>A review of the Treatment Administration Record (TAR) revealed the following treatments were in place for Resident #3 for the months of October 2014, November 2014, and December 2014:</p> <ol style="list-style-type: none"> <li>1. Calmoseptine cream to peri area twice per day and as needed.</li> <li>2. Apply Nystatin ointment to abdominal fold twice per day until resolved for yeast.</li> <li>3. Left ischium cleanse with normal saline and apply Comfeel dressing every three days and as needed for protection and wound healing. The Calmoseptine and Nystatin treatments were initialed to indicate the treatments were applied daily as ordered. The treatments for the left ischium were initialed as completed starting on 10/01/2014, and continuing for 13 days in October 2014, 7 days in November 2014, and 2 days in December 2014.</li> </ol> <p>A review of the TAR revealed the following additional treatment was in place for Resident #3 for the months of November 2014 and December 2014: Left posterior thigh cleanse with normal saline, apply non-stick skin prep, apply Calmoseptine to excoriations.</p> <p>In an interview with the Treatment Nurse on 12/10/2014 at 3:15 PM, she stated that Resident</p>	F 278			

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F 278	<p>Continued From page 6</p> <p>#3's skin in the abdominal fold and groin was chronic and had exacerbated when the Nystatin ointment was not applied, so it was necessary to continue the application regularly, twice per day. She stated the skin condition was probably yeast related. The Treatment Nurse also stated that the resident's excoriations on the left posterior thigh and the buttocks was chronically present due to his urinary incontinence, and that the skin problems were moisture related skin damage. She explained that this issue had been present for a very long time. Also, the treatment nurse stated she completed Wound Assessment Reports for all stage 2 and above pressure ulcers and for surgical wounds. She stated there were no wound reports for other skin issues such as excoriations, moisture related skin damage, or rashes.</p> <p>In an interview with the Minimum Data Set (MDS) Nurse on 12/10/2014 at 4:26 PM, she stated that she receives information about the skin conditions for residents for the quarterly assessments through daily clinical meetings, by using significant changes in residents' conditions, and by reviewing 24-Hour reports. In addition, the MDS Nurse stated she met regularly with the Treatment Nurse to obtain information regarding skin conditions and wounds. She added that care area assessments were used as a guide as to whether a resident should be care planned for specific problems.</p> <p>In an interview with the Director of Nursing and the Administrator on 12/10/2014 at 4:53 PM, both stated they would expect to have to accurate assessments for skin wounds and so nursing care plans could be updated with for actual</p>	F 278			

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