

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

PRINTED: 03/25/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345431</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUR COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>921 JUNIOR HIGH SCHOOL ROAD</b> <b>SCOTLAND NECK, NC 27874</b>		
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F 000	INITIAL COMMENTS	F 000			
F 157 SS=D	<p>On-site complaint investigation was conducted from 2/18/15 through 2/20/15. The exit date was changed to 2/23/15 due to an interview required and completed on 2/23/15 for the tags cited during the investigation.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's</p>	F 157		3/12/15	

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

TITLE

(X6) DATE

Electronically Signed

03/12/2015

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 157	<p>Continued From page 1 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to notify the Responsible Party (RP) of a pressure ulcer for 1 of 3 sampled residents (Resident #30) reviewed for pressure ulcers.</p> <p>Findings included:</p> <p>Resident # 30 was admitted on 9/4/14 with diagnoses that included acute bronchitis, diabetes, Alzheimer ' s disease and hypertension.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated 12/15/14, indicated the resident was cognitively impaired. Resident #30 had no pressure ulcers at the time of assessment.</p> <p>Nurse ' s notes, dated 1/19/15 at 10:03 AM, revealed the Treatment Nurse was called to Resident #30 ' s room by the nursing assistant (NA). While providing care, the NA had discovered open areas on the resident ' s backside. The Treatment Nurse documented Resident #30 had two small Stage II pressure ulcers to the sacrum. The Treatment Nurse documented one of the pressure ulcers measured 0.5 centimeters (cm) by 0.5 cm. The second pressure ulcer measured 0.5 cm by 0.9 cm. The nurse described the wound bed as pink with a scant amount of drainage. Lantiseptic (a moisture barrier cream) was applied. There was no documentation the RP was notified.</p> <p>Review of nurse ' s notes for 1/27/15, identified as a late entry for 1/26/15, indicated Resident #30</p>	F 157	<p>A. Resident number 30 is no longer in facility having been discharged on 1/31/15.</p> <p>B. How corrective action will be accomplished to prevent practice from affecting other residents: 1. Mandatory nursing staff meeting to review 2567 of 2/18/15 addressing failure to notify responsible party. (3/11/15, 3/12/15) DON, Administrator 2. Review of "Notification of Changes" Policy during manadatory nursing staff meeting. Policy includes when to notify resident, family, responsible party, what to report during notification. Policy also includes a procedure which clearly outlines the notification/reporting process. Notification will be made to the responsible party for improvement or deterioation in pressure ulcers and also for any treatment changes. 3/11/15, 3/12/15 (DON,Adm) 3. Review of Skin and Wound Care Treatment policy and procedures reviewed at nursing staff meeting. 3/11/15,3/12/15 (DON,Adm)</p> <p>C. Measures put into place to prevent practice from reoccurring: 1. The treatment nurse does wound/skin assessments each week, if during that time a new pressure ulcer is discovered, she/he will inform the resident, consult</p>		

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F 157	<p>Continued From page 2</p> <p>had a Stage II pressure ulcer measuring 3.4 cm by 0.8 cm. The Treatment Nurse documented the treatment was changed to Duoderm (a type of adhesive dressing used for pressure ulcers) every 3 days and as needed. There was no documentation the RP was notified about the decline of the pressure ulcer or the change in treatment.</p> <p>An interview was held with the Treatment Nurse on 2/19/15 at 4:43 PM. She stated the RP and the physician were to be notified on the day a pressure ulcer was discovered. The Treatment Nurse reviewed notes and stated she had not called Resident #30 's RP because the pressure ulcers were reoccurring. She acknowledged she did not call the family member on 1/26/15 when the 2 small pressure ulcers merged into one larger pressure ulcer and the treatment was changed. The Treatment Nurse stated she was so use to working in the emergency room and not used to calling family members over everything.</p> <p>The Director of Nursing (DON) was interviewed on 2/20/15 at 2:02 PM. The DON stated nurses were expected to notify family members for the development of pressure ulcers or changes in pressure ulcers. The DON reviewed the nurse 's notes for 1/19/15 and 1/26/15 and stated there was no documentation the family member had been notified of the pressure ulcer or the pressure ulcer worsening. She added even if the pressure ulcer reoccurred the treatment nurse should have notified the RP. The DON stated the RP should have been notified when the pressure ulcers merged into one ulcer and the treatment was changed.</p> <p>The RP was interviewed via telephone on 2/23/15</p>	F 157	<p>with the physician, and will notify the family/responsible party (RP). The charge nurse for that resident will be informed as well as the Minimum Data Set Coordinator (MDSC) for update or initiation of new care plan. Documentation will occur in the resident's Electronic Medical Record (EMR) to reflect observations, assessment, notification and to whom. Any nurse who discovers a pressure ulcer will be responsible for notification to responsible party. 3/11/15, 3/12/15</p> <p>2. Treatment will be initiated immediately using the protocols from the Skin and Wound Care Management policy.</p> <p>3. Documentation will be done weekly in the EMR by the treatment nurse.</p> <p>4. Treatments will be documented on the resident's individual Treatment Administration Record (TAR. Frequency of documentation determined by frequency of dressing change/treatment orders.)</p> <p>D. The treatment nurse will report on wound status weekly at Risk Management meeting to include when notification was made, if new pressure ulcer and to whom. The DON or ADON will audit EMR nursing notes and wound notes for appropriate notification and compliance with "Notification of Changes" policy. Threshold for compliance for notification is 100%. DON or ADON will report to QA the results of EMR audits for assurance that notification is being done appropriately. Information will be obtained from the weekly wound report which includes check-box for notification of RP.</p>		

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F 157	Continued From page 3 at 1:15 PM. She stated no one from the facility had notified her of the pressure ulcers developing on 1/19/15. The RP added she had not been notified of the two ulcers merging into one ulcer and the change in treatment for Resident # 30.	F 157	(DON, ADON		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		3/12/15	

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F 225	<p>Continued From page 4 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #30).</p> <p>Findings included:</p> <p>On 1/30/15, an Incident/Accident Report was submitted by Nurse #6 on behalf of Resident #30. The nurse documented the incident was reported to have occurred on 1/27/15 while the resident resided in the long term care unit. The nurse described Resident #30 as having a 5 to 7 day old bruise found on the resident 's right side in various stages of healing. The bruise was described as involving 30% of the right axilla, 20% right lateral pectoral area, 10% right lateral edge of the clavicle and 40% of the right lateral superior rib area involving ribs #1-3. The color was listed as 30% yellow, 40% green to dark purple and 30% with normal color. The nurse did note the resident received Warfarin (a medication that thins blood) daily. The report also documented the nursing assistant (not named) reported the incident to Nurse #3 on 1/27/15.</p> <p>Review of the 24 hour initial report revealed it was submitted to HCPR on 1/30/15.</p> <p>On 1/30/15 the 5 day working report was</p>	F 225	<p>A. Resident number 30 is no longer in the facility having been discharged 1/31/15. B.(1) The requirement will be met as evidenced by through investigations of alleged violations involving mistreatments, neglect, abuse, misappropriation of resident property and injury of unknown origin in accordance with state law including the state survey and certification agency with in 5 working days of the incident(s) and as per facility policy. B. (2)All residents have been assessed for unexplained bruising or injuries of unknown origin per body check. No bruises or injuries of unknown origin have been reported or noted. All residents have been assessed for any brusing, injuries, or any abnormalities in skin condition/integrity using the skin assessment form which checks for skin temperature, color,jaundice,rash, bruising, edema, skin tears, blisters, decubitus ulcers, comments and documentation in electronic medical record (EMR) as needed for abnormalities. Body check/assessments were done by the treatment nurse on 100% of the residents. (3/10/15)</p> <p>B.(3) Corrective Action:</p>	

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F 225	<p>Continued From page 5</p> <p>submitted. The report documented Nurse #6 had reported a large bruise under the right axilla area from an unknown origin. Under description, the area was described as a large bruise under the right axilla, extending under the right upper arm and right side of the chest under the breast area. The investigation was summarized as on 1/29/15 at 3:30 PM, (Nurse #6 's name), reported a large bruised area in the resident 's right axilla, extending to the underside of right upper arm and side of right chest under breast area. The bruise was described as purple in color. No other areas of bruising or any other injuries were found. The investigation indicated Resident #30 was discharged from facility on 1/31/15. It was noted the resident was on warfarin and her PT/INR (prothrombin time/international ration-a blood test to monitor the therapeutic level of the blood thinner) was extremely high, which may account for the bruised area. The investigation was signed by the Assistant Director of Nursing (ADON).</p> <p>A telephone interview was held with Nurse #3 on 2/19/15 at 3:27 PM. She stated prior to the resident 's transfer to acute care, she had not been made aware of the bruise on Resident #30. The nurse added on 1/30/15, she and an un-named nursing assistant went to the acute care side to see the resident 's bruise. Nurse #3 stated the bruising on Resident #30 extended from under her arm, to her breast to mid back.</p> <p>An interview was held with Nursing Assistant (NA) #9 on 2/19/15 at 3:35 PM. The NA stated she was familiar with Resident #30 and had worked with her 2 to 4 times per week on the 3 to 11 shift. The NA stated she had worked with the resident on 1/28/15. On 1/28/15, when she worked with</p>	F 225	<p>A mandatory staff meeting was conducted at which time the policy for abuse prevention, reporting, and investigation was reviewed. The policy was explained in detail to staff members in attendance with an explanation of why an injury of unknow origin requires a thorough investigation. 3/11/15, 3/12/15 (DON,Adm)</p> <p>C. All allegation of abuse, neglect, mistreatment, injury of unknown origin and misappropriation of property will be reported to the facility administrator and to the DON. The DON will begin a complete investigation which includes interviews with staff having any knowledge of the incident or who has had contact with the resident over the past 3 days. Statements are obtained from employees, witnesses, family, and from resident if able to do so. 3/11/15 (DON,Adm)</p> <p>Any incident involving injury of unknown origin will be presented to the weekly Risk Management meeting at the time of occurrence with review of findings, allegation/complain and outcome. The DON will review all 5 day allegations and all investigative reports to ensure accuracy and compliance with regulations and facility policy. (DON) 3/11/15</p> <p>D. A detailed report will be presented to the Quality Assurance (QA) Committe for all allegations or injuries of unknown origin with focus on the allegation/complaint and the outcome and trends. Reports will be brought to QA monthly. (DON)</p>		

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F 225	<p>Continued From page 6</p> <p>Resident #30 she had seen the bruise on her side, but thought it was an old bruise so she did not report the bruise to anyone. She added NA #2 had worked with her that night and told her she had previously reported the bruise. NA #9 stated NA #2 again reported the bruise to Nurse #4 that worked that night. The NA stated the bruise was approximately 2 to 3 inches wide by approximately 6 inches long.</p> <p>Nurse #4 was interviewed on 2/20/15 at 9:00 AM. She stated she had worked with Resident #30 on the 7:00 PM to 7:00 AM shift on 1/28/15. She stated she had not received a report about a bruise on Resident #30.</p> <p>On 2/20/15 at 3:40 PM, NA #2 was interviewed. She stated she had worked with NA #9 on 1/28/15 during the 3 to 11 shift. During that time, she stated she and NA #9 had seen the bruise on Resident #30 ' s right side. Prior to 1/28/15, NA #2 stated she had reported the bruise, but she was unable to remember the name of the nurse. On 1/28/15, NA #2 stated she again reported the bruise, this time to Nurse # 4. The NA stated the bruise was about the size of a dinner plate and extended under the resident ' s arm, to her breast and on her chest below her breast. She added there was no way staff could not have seen the bruise if Resident #30 had been changed or bathed.</p> <p>The ADON was interviewed on 2/20/15 at 4:04 PM. She stated the paragraph included on the 5 day working report was her entire investigation concerning Resident #30 ' s bruise. The ADON stated she had obtained no witness statements from any staff that had worked with Resident #30.</p>	F 225			

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F 225	Continued From page 7	F 225			
F 226 SS=D	<p>The Administrator was interviewed on 2/20/15 at 4:32 PM. He reviewed the investigation for Resident #30 ' s bruise and stated the investigation was not thorough and complete. He added this was not how the facility typically investigated injuries of unknown origin.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to thoroughly investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #30).</p> <p>Findings included:</p> <p>The facility Abuse Prevention Policy, with a revision date of 7/2/07, indicated all injuries of unknown sources, shall be thoroughly and completely investigated. On Page 1 of Guidelines for Investigation of Abuse, Neglect and Misappropriation of Resident Property, Paragraph 4, Bullet 1, is included the requirement to provide interviews or statements gathered to include a list of persons working who could have reasonable knowledge of the incident.</p> <p>On 1/30/15, an Incident/Accident Report was</p>	F 226	<p>A. The requirement will be met as evidenced by compliance with facility policy and regulations, which states that all injuries of unknown origin will be thoroughly investigated. Resident number 30 is no longer in the facility having been discharged on 1/31/15. There have been no other injuries of unknown origin discovered or reported.</p> <p>B.To ensure that other resident are not affected by this practice, the abuse policy, including preventing, reporting, and investigating was in-serviced and reviewed with staff on 3/11/15 and 3/12/15 (DON, Adm) The policy details the requirements for reporting and the responsibility of the</p>	3/12/15	

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F 226	<p>Continued From page 8</p> <p>submitted by Nurse #6 on behalf of Resident #30. The nurse documented the incident was reported to have occurred on 1/27/15 while the resident resided in the long term care unit. The nurse described Resident #30 as having a 5 to 7 day old bruise found on the resident ' s right side in various stages of healing. The bruise was described as involving 30% of the right axilla, 20% right lateral pectoral area, 10% right lateral edge of the clavicle and 40% of the right lateral superior rib area involving ribs #1-3. The color was listed as 30% yellow, 40% green to dark purple and 30% with normal color. The nurse did note the resident received warfarin (a medication that thins blood) daily. The report also documented the nursing assistant (not named) reported the incident to Nurse #3 on 1/27/15.</p> <p>On 1/30/15 the 5 day working report was submitted. The report documented Nurse #6 had reported a large bruise under the right axilla area from an unknown origin. Under description, the area was described as a large bruise under the right axilla, extending under the right upper arm and right side of the chest under the breast area. The investigation was summarized as on 1/29/15 at 3:30 PM, (Nurse #6 ' s name), reported a large bruised area in the resident ' s right axilla, extending to the underside of right upper arm and side of right chest under breast area. The bruise was described as purple in color. No other areas of bruising or any other injuries were found. The investigation indicated Resident #30 was discharged from facility on 1/31/15. It was noted the resident was on warfarin and her PT/INR (prothrombin time/international ration-a blood test to monitor the therapeutic level of the blood thinner) was extremely high, which may account for the bruised area. The investigation was</p>	F 226	<p>facility for investigating each allegation or injury of unknown origin. Through this in-service staff were explained the procedures involved during an investigation and the importance of reporting any abnormal observations or findings immediately.</p> <p>C. For report of injury of unknown origin or for any reportable incident or allegation the process of investigation will begin by:</p> <ol style="list-style-type: none"> <li>1. DON and Administrator will be made aware immediately</li> <li>2. DON will begin an investigation</li> <li>3. Report will be sent to Nurse Aide Registry or other licensing authorities. This will be done within 24 hours oof discovery (DON,ADON)</li> <li>4. The 5 day report will be submitted to the Nurse Aide Registry and to the state agency. (DON,Adm,ADON) A detailed report will accompany the 5 day report summarizing all findings of the investigation including any statements from staff, resident, family.</li> <li>5. If the investigation is assigned to someone other than the DON, she/he will review the final report for accuracy.</li> </ol> <p>D. A report will be submitted to the QA Committee monthly for any incidents or allegation which have been reported during the month. The report will include what the incident was, who investigated, any trends, and the outcome of the investigation. (DON)</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345431</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/23/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>OUR COMMUNITY HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>921 JUNIOR HIGH SCHOOL ROAD</b> <b>SCOTLAND NECK, NC 27874</b>		
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F 226	Continued From page 9 signed by the Assistant Director of Nursing (ADON).  The ADON was interviewed on 2/20/15 at 4:04 PM. She stated the paragraph included on the 5 day working report was her entire investigation concerning Resident #30 ' s bruise. The ADON stated she had obtained no witness statements from any staff that had worked with Resident #30.  The Administrator was interviewed on 2/20/15 at 4:32 PM. He reviewed the investigation for Resident #30 ' s bruise and stated the investigation was not thorough and complete. He added this was not how the facility typically investigated injuries of unknown origin.	F 226			
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 staff interviews, physician interview and record review the facility failed to provide pressure ulcer treatment per protocols for 1 of 3 sampled residents (Resident #30) and failed to document treatment for 7 days after the development of the pressure ulcer for 1 of 3	F 314	A. Resident number 30 is no longer in the facility having been discharged on 1/31/15. The treatment for all residents with pressure ulcers was reviewed and found to be appropriate per wound policy. Any	3/12/15	

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F 314	<p>Continued From page 10 residents (Resident #30) who were reviewed for pressure ulcers.</p> <p>Findings included:</p> <p>The facility ' s Skin and Wound Care Management policy, undated, indicated all residents of LTC (long term care) would be provided with services needed for the prevention of pressure ulcers or skin breakdown. In the event a pressure ulcer developed, the following procedures would be implemented. Under Staging Pressure Ulcers, Section B, a Stage II Pressure ulcer was described as a partial thickness skin loss that involved the epidermis, dermis or both. The ulcer presented clinically as an abrasion, blister or a shallow crater.</p> <p>The facility ' s undated Skin Care Protocols indicated under Stage II, that treatments included cleaning the ulcer with normal saline, drying and choosing a dressing dependent upon the amount of drainage. For non-draining wounds or lightly draining wounds the following were listed:</p> <ul style="list-style-type: none"> <li>· No drainage- apply transparent dressing and change every 3 days and as needed until resolved</li> <li>· Moderate drainage-apply hydrocolloid dressing and change every 3 to 5 days and as needed</li> <li>· May apply wound gel and dry dressings to wounds and change daily as an alternative.</li> </ul> <p>Resident #30 was admitted on 9/4/14 with diagnoses that included diabetes, Alzheimer ' s disease, hypertension, coronary artery disease, congestive heart failure and osteoarthritis.</p>	F 314	<p>treatment which was different from the policy had a specific order written by the attending physician. (3/9/15)</p> <p>B. To ensure that other residents are not affected by the ssame practice the policy on "Skin and Wound Care Management" has been reviewed with all licensed nursing staff. The policy states the procedures for wound management with description for staging pressure ulcers. The policy clearly outlines the treatments for Stage I through Stage IV pressure ulcers as well as for different types of wounds including, surgical, infected, skin tears, abrasio and any denuded skin. Mandatory staff meeting conducted on 3/11/15 and 3/12/15 (DON, Adm) The current wound care policy was reviewed by facility medical director with no changes in current treatment protocols or procedures. (3/10/15) DON Policy treatment will be initiated as soon as discovery of new pressure ulcer. Treatment will be initiated either by the treatment nurse or for the charge nurse for a specific resident.</p> <p>C. An addendum was added to the Skin and Wound Care Management to include when to initiate treatment, when and how to document in Electronic Medical Record (EMR). Adherence to the policy will be monitored by the DON or the ADON through weekly review of physician orders for wound care and review of treatment nurse documentation.DON or ADON will continue to review care plans to ensure</p>		

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F 314	<p>Continued From page 11</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated 12/15/14, indicated the resident was cognitively impaired. Resident #30 had no pressure ulcers at the time of assessment. The resident was coded as requiring extensive to total assistance with bed mobility, transfer and personal hygiene.</p> <p>The care plan with a revision date of 1/16/15 indicated the resident had no pressure ulcers.</p> <p>Nurse ' s notes dated 1/19/15 at 10:03 AM indicated the treatment nurse was called to the resident ' s room by the Nursing Assistant (NA). During care, the NA had noticed open areas on the resident ' s sacrum. The treatment nurse documented the open areas as 2 small Stage II pressure ulcers. The first measured 0.5 centimeters (cm) by 0.5 cm. The nurse documented the second pressure ulcer measured 0.5 cm x 0.9 cm. Documentation revealed the wound bed was pink with a scant amount of drainage. The treatment nurse documented Lantiseptic (a moisture barrier) was applied.</p> <p>Review of the January 2015 Treatment Administration Record (TAR) revealed Lantiseptic had been placed on the TAR to be applied to the sacrum after each incontinent episode and labeled as a " for your information " entry. There was no entry identifying 2 Stage II pressure ulcers.</p> <p>On 1/26/15, an entry to the TAR indicated to clean the pressure area to the sacrum with normal saline and apply Duoderm every 3 days and as needed until healed. The entry had been signed daily by the Treatment Nurse.</p>	F 314	<p>that any changes in treatment are reflected in the care plan.</p> <p>The treatment nurse will report all pressure ulcers weekly during the Risk Management Meeting to include the number of residents with pressure ulcers, site, size/depth, wound protocol followed, current treatment, supplement, care plan initiated and responsible party notified. (Treatment Nurse)3/10/15</p> <p>D. A detailed report will be present to the QA committee wwith a summary of all wounds. DON will report on compliance with policy, treatment initiated immediately, responsible party notified. Threshold for compliance 100%. DON will review 100% of the documentation for residents with wounds, wound notes, weekly wound reports. Report will be submitted to QA monthly with an analysis of findings and trends. (DON)2/27/15</p>		

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F 314	<p>Continued From page 12</p> <p>An interview with Resident #30 's Primary Care Physician (PCP) on 2/19/15 at 1:59 PM. He stated he could not remember if Resident #30 had pressure ulcers. He added the resident 's nutritional status impacted the development and healing of the pressure ulcers intermittently. On 2/19/15 at 3:35 PM an interview was held with Nursing Assistant (NA) #9. NA #9 worked with Resident #30 on the 3:00 PM to the 11:00 PM shift. She stated for pressure ulcer prevention she used barrier cream on reddened skin, but did not provide pressure ulcer treatments.</p> <p>NA #7 was interviewed on 2/19/15 at 3:51 PM. The NA stated she knew Resident #30 and worked with her on the 7:00 AM to the 3:00 PM shift. The NA stated she used barrier cream on the resident 's bottom after incontinent episodes to help prevent skin breakdown. She stated she did not do any pressure ulcer treatments.</p> <p>An interview was held with Treatment Nurse on 2/19/15 at 4:43 PM. The Treatment stated she followed facility pressure ulcer protocols when treating pressure ulcers. Physician telephone orders were written when a protocol for pressure ulcer treatment was used. The nurse stated the protocols were used unless the physician ordered a specific treatment. The nurse added if the pressure ulcer protocols were used or a treatment order was received from the physician, an entry for the pressure ulcer treatment was entered on the Treatment Administration Record (TAR) to be initialed when she completed the treatment. The Treatment Nurse added she measured and documented the progress of wounds weekly in the progress notes. The nurse added prior to Resident #30 's discharge to the hospital, her 2 Stage II wounds merged into</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>one larger Stage II wound. At that point, on 1/27/15, the treatment was changed from Lantiseptic to Duoderm. The treatment nurse reviewed the physician ' s orders and the treatment sheet for January 2015 and stated she forgot to write the order for the pressure ulcer protocol used and failed to place the order on the treatment sheet. The Treatment Nurse added she typically placed the Lantiseptic on the treatment sheet when a pressure ulcer was present. The Treatment Nurse stated between 1/19/15 and 1/26/15 she did not provide pressure ulcer treatment for Resident #30. She stated that while the nursing assistants were assigned to apply the Lantiseptic, she had no way of knowing for sure if the treatment was completed.</p> <p>The 7:00 PM to 7:00 AM nurse was interviewed on 2/20/15 at 9:00 AM. Nurse #4 stated she was unaware Resident #30 had pressure ulcers or treatments.</p> <p>An interview was held with the Assistant Director of Nursing (ADON) on 2/20/15 at 11:44 AM. The ADON added the Treatment Nurse was expected to follow the pressure ulcer protocols unless the PCP ordered a different treatment. She added an order was to be written for the protocol used and a telephone order was to be written if a different treatment order was received from the PCP. Any treatment orders were to be added to the TAR and signed as the treatment was completed. The ADON reviewed the 1/19/15 at 10:03 AM nurse ' s note and stated Stage II meant Resident #30 had open skin. She then reviewed the pressure ulcer protocol for a Stage II pressure ulcer and acknowledged Lantiseptic was not an approved treatment. The ADON reviewed the telephone orders and stated there were no</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>pressure ulcer treatment orders found. She reviewed the TAR and stated there was no documentation Resident #30 ' s 2, Stage II pressure ulcers had received treatment between 1/19/15 and 1/26/15.</p> <p>On 2/20/15 at 12:32 PM, the Treatment Nurse was interviewed again. She reaffirmed the areas on Resident #30 ' s sacrum were Stage II pressure ulcers. The Treatment Nurse reviewed the facility protocol for the treatment of Stage II pressure ulcers and acknowledged Lantiseptic was not an approved treatment. She stated she chose Lantiseptic because Duoderm had previously damaged intact skin for Resident #30. The Treatment Nurse added when the wound got larger, she changed the treatment to Duoderm. The nurse added there were other options for treating Stage II pressure ulcers included on the protocol other than Lantiseptic or Duoderm.</p> <p>The Director of Nursing (DON) was interviewed on 2/20/15 at 2:02 PM. The DON stated pressure ulcer protocols were used for the treatment of pressure ulcers. She added the only time the pressure ulcer protocols were not used were if the physician preferred a different treatment. The DON stated nurses were expected to write physician ' s orders for protocols if used and expected to write telephone orders for any treatment ordered by the physician. All pressure ulcer treatments were expected to be placed on the TAR for the Treatment Nurse to sign when the treatment was completed. The DON reviewed the pressure ulcer protocols and acknowledged Lantiseptic was not an approved treatment for Stage II pressure ulcers. She reviewed the TAR and acknowledged there was</p>	F 314			

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F 314	Continued From page 15 no documentation of pressure ulcer treatment from 1/19/15 to 1/26/15. The DON stated she expected the Treatment Nurse to complete treatments on all pressure ulcers.	F 314			