

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 18, 2013

Mr. Neil Gruber, Administrator
Helen Porter Healthcare & Rehab
30 Porter Drive
Middlebury, VT 05753-8422

Provider #: 475017

Dear Mr. Gruber:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 12, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2012
NAME OF PROVIDER OR SUPPLIER HELEN PORTER HEALTHCARE & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 30 PORTER DRIVE MIDDLEBURY, VT 05753	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection from 12/10/2012 through 12/12/2012. The following regulatory deficiencies were identified during the survey:	F 000	<u>Corrective Action for Individual Residents</u> Resident #62 – care plan has been revised to reflect one area of impaired skin integrity, including location of impaired skin integrity and appropriate interventions for nursing staff. The area on the “back of the left upper thigh” is healed.	12/12/12
F 280 SS=E	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, 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: Based on interview and medical record review the facility failed to revise care plans to reflect the current needs of 3 of 23 residents (Resident #49, #62, and #32) reviewed in Stage 2. Findings include:	F 280	Resident #49 – care plan has been revised to reflect non-pharmacological interventions to use prior to administering Ativan. Examples of interventions include massage, watch TV, go to an activity or day room. Resident #32 – care plan has been revised to reflect the impaired skin integrity on third left toe. Upon request a copy of the revised care plans can be provided. <u>Identifying other Residents</u> A query was made of all residents that currently have impaired skin integrity or who are receiving pm psychotropic medications and the care plan has been revised as needed. <u>Systematic Changes</u> The EHR has been customized in such a way that when a pressure ulcer or other impaired skin integrity is documented the EHR will automatically open the resident's care plan for revision. Before the nurse will be able to close the care plan folder, he/she will need to provide a signature attesting to the following statement “I have reviewed the care plan and can verify it is current or have made appropriate changes to ensure it is current”.	12/28/12 12/12/12 1/4/13 1/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ASSISTANT ADMINISTRATOR (X6) DATE 1/7/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PML

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F 280	<p>Continued From page 1.</p> <p>1) Per record review, Nursing Notes for Resident #62 starting on 11/13/12 report an "open lesion present to area between rectum and coccyx 0.5 centimeters [cm] center with split coming off side 1 cm long, approx. 0.3 cm wide." Nursing Notes from 11/14/12 through 11/25/12 repeat the assessment "open area crease in buttocks".</p> <p>On 11/27/12 the Nursing Note reads "open area on coccyx looking improved and smaller from 11/25". The next Nursing Note on 12/3/12 reports Resident #62's pressure ulcer "on coccyx appears larger in size...Open area to coccyx 2.5 cm x 1.5 cm". [Original size of the open area was 1 cm long x 0.3 cm wide]. Additionally, Resident #62 now has 2 openings in h/her skin "to back of left upper thigh. First is 1.5 cm x 0.5 cm, one below is 1 cm x 0.5 cm." Nursing Notes on 12/4/12 through 12/11/12 record Resident #62 "continues with areas on left upper thigh and coccyx".</p> <p>Per interview on 12/12/12 at 1:40 P.M. Resident #62's Unit Manager stated that if a treatment is not working or a condition worsened, the resident's Care Plan would be reviewed and updated, and revisions would be reflected on both the Care Plan and the Treatment Record.</p> <p>During the interview on 12/12/12 the Unit Manager confirmed the condition of the area on Resident #62's coccyx had worsened since the discovery on 11/13/12 in addition to new open areas on the left upper thigh. The Unit Manager confirmed that despite the documented worsening of Resident #62's skin condition, there was no revision to the resident's Care Plan and</p>	F 280	<p><u>Monitoring</u></p> <p>A QA tool will be completed weekly by the charge nurse and reviewed by the Unit Manager to ensure compliance is established for all residents who have impaired skin integrity or who have prn psychotropic medications ordered to ensure the applicable care plan is current and reflects appropriate interventions. Immediate corrective action will be taken by the Unit Manager for any deficient practice noted. On-going monitoring will continue on a weekly basis until 100% compliance has been achieved for 6 consecutive weeks at which time monitoring will be reduced to a monthly basis for 3 months and then quarterly thereafter. (see attachment #1 & 2).</p> <p><i>F280 POC accepted 1/16/13 M Higgins RN/PMC</i></p>	1/12/13
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F 280	Continued From page 3 very aware of his/her medication regime and often asks specifically for a medication, not allowing staff to try alternatives. This also is not reflected on the care plan and is confirmed by the Unit Manager. 3). Per record review on 12/11/2012 for Resident #32, documentation dated 12/04/2012 indicated that the resident had scabbed, reddened areas present on top of third left toe and moisture barrier was applied. Further documentation on 12/08/2012 indicated that the red areas were still present and that Bacitracin Ointment and a band-aid were applied. The skin integrity care plan did not have a revision to indicate the presence of open red areas, goals, or approaches for the areas on resident's third left toe. Per interview with the Unit charge nurse on 12/12/2012, s/he confirmed that there was no care plan involving the open, red areas of the resident's 3rd left toe. On 12/12/2012, per interview with the Director of Nursing (DON), s/he verified that a care plan should indicate the location, stage, goal and approach to wounds, skin tears, or pressure ulcers. The DON also verified that it should be the practice to have a care plan for the areas in place or updated within 24 hours of discovery. During observation of the resident's 3rd left toe with the charge nurse on 12/12/2012, the area	F 280		

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F 280	Continued From page 4 was covered with a band-aid. When the wound was observed there was no open area apparent. Per interview on 12/12/2012 with the Nurse Practitioner, immediately after her/his assessment of the area, s/he stated that the area was closed and healed and that there had been recurrences of the area due to the resident's extremely poor circulation in her lower extremities.	F 280		
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to assure that services provided by the facility met professional standards of quality regarding following physician's orders, for 2 of 23 residents (Resident #62 and #187) reviewed in Stage 2. Findings include: 1) Per record review on 12/10/12 at 3:44 P.M., the Care Plan for Resident #62, who has a history of pressure ulcers developing on h/her coccyx and buttocks, included interventions under "Impairment of Skin Integrity". Interventions listed include for Nursing: "treat as ordered...Update MD as needed." For Nurse Assistants, the interventions include "reposition [the resident] every two hours with nurse present, or get a nurse to verify position has been changed".	F 281	<u>Corrective Action for Individual Residents</u> Resident #62 – 1. The order for Dermagran has been changed from prn to BID on the MAR and has been applied appropriately since 12/12/12. 2. The Nurse Practitioner was aware of the resident's skin condition although this was not reflected in the resident's chart at the time of the Survey. The NP has since written a late entry note indicating her knowledge of the resident's skin condition. 3. The EHR has been implemented to allow for documentation of turning and repositioning by the LNA so that verification of this intervention being done can be made. Resident #187 – The treatment per physician order was reapplied by RN on 12/12/12 in the presence of a Surveyor. On Skin Rounds the following day the wound was assessed and found to be completely resolved so treatment was d/c'd on 12/13/12. (Clarification – wound is not a pressure ulcer but was caused as a result of trauma while having foot measured at shoe store).	12/12/12 12/26/12 12/13/12 12/12/12

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F 281	Continued From page 5 Per record review, a Physician's Order for Resident #62, dated 8/22/12, states Dermagran ointment and spray [medications used for treatment of pressure ulcers and preventative skin care] to be applied twice daily as needed [for treatment of Resident #62's pressure ulcers], may change to use as needed when resolved. Per record review, Nursing Notes for Resident #62 starting on 11/13/12 report an "open lesion present to area between rectum and coccyx 0.5 centimeters [cm] center with split coming off side 1 cm long, approx. 0.3 cm wide." On the next day, 11/14/12, Nursing Notes record "Dermagran spray/ointment to open area coccyx as ordered." Nursing Notes from 11/14/12 through 11/25/12 repeat the assessment "open area crease in buttocks" and repeat that Dermagran was applied. On 11/27/12 the Nursing Note reads "open area on coccyx looking improved and smaller from 11/25". The next Nursing Note on 12/3/12 reports Resident #62's pressure ulcer "on coccyx appears larger in size. Dermagran (applied). Open area to coccyx 2.5 cm x 1.5 cm". [Original size of the open area was 1 cm long x 0.3 cm wide] Additionally, Resident #62 now has 2 openings in h/her skin "to back of left upper thigh. First is 1.5 cm x 0.5 cm, one below is 1 cm x 0.5 cm. Dermagran" (applied). Nursing Notes on 12/4/12 through 12/11/12 record Resident #62 "continues with areas on left upper thigh and coccyx" with both Dermagran ointment and spray being used for treatment. Per interview on 12/12/12 at 1:40 P.M. Resident #62's Unit Manager stated that if a resident's skin	F 281	<u>Identifying Other Residents</u> A query was made of all residents that currently have impaired skin integrity and who are receiving treatment to ensure the appropriate treatment is on the MAR. An additional query was made of all residents who are on a turning/repositioning schedule to ensure the EHR has been revised to allow for LNA documentation of this intervention. <u>Systemic Changes</u> All residents who have impaired skin integrity other than surgical wounds or rash will be rounded weekly by the Skin Care Team. During Rounds the resident's care plan and treatment plan will be reviewed using the table PC. Because the NP is part of the Skin Care Team this will also ensure proper notification of the Provider for any wound that is worsening. This was first implemented on 1/3/13. This organization's Skin Care Guidelines was made into a web-based learning module and deployed to all nursing staff. A quiz was utilized to ensure understanding of the Guidelines and to verify competence relative to current standards A department communication was sent to all LNA staff informing them of the new documentation requirement for turning/repositioning (see attachment #3). <u>Monitoring</u> A QA tool will be completed weekly by the charge nurse and reviewed by the Unit Manager to ensure compliance is established for all residents that are on a turning/repositioning schedule in which the EHR is reviewed for verification that the intervention is being implemented consistently and documented. Immediate corrective action will be taken by the Unit Manager for any deficient practice noted. On-going monitoring will continue on a weekly basis until 100% compliance has been achieved for 6 consecutive weeks at which time monitoring will be reduced to monthly for 3 months and then quarterly thereafter.	1/4/13 1/4/13 1/3/13 1/2/13 1/2/13 1/12/13

F281 POC accepted 1/16/13
M Higgins RN / Pmc

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F 281	<p>Continued From page 6</p> <p>condition worsened the Nurse Practitioner would be notified or nursing staff would let the resident's Physician know about the change. The Unit Manager stated that if a treatment is not working or a condition worsened, the resident's Care Plan would be reviewed and updated, and revisions would be reflected on both the Care Plan and the Treatment Record.</p> <p>During the interview on 12/12/12 the Unit Manager confirmed the condition of the area on Resident #62's coccyx had worsened since the discovery on 11/13/12 in addition to new open areas on the left upper thigh. The Unit Manager confirmed that despite the documented worsening of Resident #62's skin condition, there was no revision to the resident's Care Plan and no change in treatment recorded on the Treatment Record. The resident's Unit Manager also confirmed that Resident #62's Medication Administration Record (MAR) lists the Physician's Order for Dermagran ointment and spray to be applied twice daily as needed, and the Care Plan calls for Nursing to "treat as ordered...Update MD as needed".</p> <p>The Unit Manager stated that the Dermagran applications should be documented on the MAR twice a day after completion per facility policy. Per record review, and confirmed by the Unit Manager on 12/12/12 at 1:40 P.M., Resident #62's MAR records only a single application of the Dermagran treatment over the 30 days since the initial pressure ulcer was discovered. The Unit Manager also reported there was no documentation on Resident #62's written or electronic record that the Nurse Practitioner or the resident's Physician had seen or was notified</p>	F 281		

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FORM APPROVED
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F 281	<p>Continued From page 7 after the resident's pressure ulcer had worsened.</p> <p>Additionally, the Unit Manager confirmed that although Resident #62's Care Plan for Impairment of Skin contained the intervention for Nurse Assistants to "reposition [Resident #62] every two hours with nurse present, or get a nurse to verify position has been changed" there was no documentation in Resident #62's record of the repositioning ever being done or of nurse verification.</p> <p>Per record review, the facility's Skin Care Guidelines state the "protocols have been organized to correspond with the pertinent aspects of the current standards in skin care according to the American Medical Directors Association". Under 'Prevention/Treatment' in the Skin Care Guidelines, interventions include "Recognize and communicate ulcer complications - monitor the patient for possible complications and notify practitioner", "Decide whether to change the approaches to managing the ulcer - reassess current treatments to ensure they are being properly implemented", and "Utilize prevention measures: create a turning and repositioning schedule based on the individual risk factors (e.g. every two hours)".</p> <p>2. Per medical record review on 12/12/12, the record indicated that Resident #187 was admitted to the facility on 11/16/12 with diagnoses that included; chronic foot ulcer.</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>Per direct observation on 12/12/12 at 0910 AM, Resident #187 was observed to be sitting up in bed with both feet in socks. Per direct observation on 12/12/12 at 0910 AM with the Registered Nurse (RN), the RN removed the socks from Resident #187's feet and it was noted that there was no dressing covering the left heel of Resident #187. The area on the left heel was noted to be a healing Stage 3 area circular in shape that was crusty in appearance, pink and looked slightly open on the right side of the wound.</p> <p>Per interview with the RN on 12/12/12 at 0910 am, he/she indicated he/she did not know why there was no dressing/treatment on Resident #187's left heel per physicians order and that no changes to the order or Resident condition was communicated to him/her in the verbal report provided by the out-going night nurse on 12/12/12.</p> <p>Per review of the physicians orders dated 12/6/12 indicated that the staff is to "apply elta silver gel to open left heel wound and cover with mepilex in the AM two times per week on Monday and Thursday." Per review of the treatment record the last time the treatment had been performed and signed for by the nurse was 12/10/12 on the AM shift. Review of the nurses notes dated 12/12/12 at 04:33 AM, the nurse indicates that "mepilex dressing intact to left heel."</p> <p>Per interview with the Registered Nurse assigned to Resident #187 on 12/12/12, he/she confirmed that the expectation is that Resident #187 was, per physician order, to have elta silver gel applied to open left heel wound and covered with mepilex and that the dressing should have been intact</p>	F 281			

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F 281	Continued From page 9 when observed on 12/12/12 at 0910 AM, or communicated to the nurse in report it was not intact. The RN also indicated that if it comes off it is to be replaced. The RN confirmed she had not seen the left heel since his/her shift began on 12/12/12 and was not aware as to why there was no dressing on the left heel when observed at 0910 AM on 12/12/12. Reference: Lippincott Nursing Manual, Williams and Wilkins, 8th Edition.	F 281		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services in accordance with the written plan of care for 2 of 23 residents (Residents #62 and #187) in the sample group. Findings include: 1) Per record review on 12/10/12 at 3:44 P.M., the Care Plan for Resident #62, who has a history of pressure ulcers developing on h/her coccyx and buttocks, included interventions under "Impairment of Skin Integrity". Interventions listed include for Nursing: "treat as ordered... Update MD as needed." For Nurse Assistants, the interventions include "reposition	F 282	<u>Corrective Action for Individual Residents</u> Resident #62 1. The order for Dermagran has been changed from prn to BID on the MAR and is being applied appropriately since 12/12/12. 2. The Nurse Practitioner was aware of the resident's skin condition although this was not reflected in the resident's chart at the time of the Survey. The NP has since written a late entry note indicating her knowledge of the resident's skin condition. 3. The EHR has been implemented to allow for documentation of turning and repositioning by the LNA so that verification of this intervention being done can be made. Resident #187 - Once staff recognized resident's heels were not floated they placed a pillow under her heels so that they did not have direct contact with the mattress.	12/12/12 12/26/12 12/13/12 12/12/12

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F 282	<p>Continued From page 10 [the resident] every two hours with nurse present, or get a nurse to verify position has been changed".</p> <p>Per record review, a Physician's Order for Resident #62, dated 8/22/12, states Dermagran ointment and spray [medications used for treatment of pressure ulcers and preventative skin care] to be applied twice daily as needed [for treatment of Resident #62's pressure ulcers], may change to use as needed when resolved.</p> <p>Per record review, Nursing Notes for Resident #62 starting on 11/13/12 report an "open lesion present to area between rectum and coccyx 0.5 centimeters [cm] center with split coming off side 1 cm long, approx. 0.3 cm wide." On the next day, 11/14/12, Nursing Notes record "Dermagran spray/ointment to open area coccyx as ordered." Nursing Notes from 11/14/12 through 11/25/12 repeat the assessment "open area crease in buttocks" and repeat that Dermagran was applied.</p> <p>On 11/27/12 the Nursing Note reads "open area on coccyx looking improved and smaller from 11/25". The next Nursing Note on 12/3/12 reports Resident #62's pressure ulcer "on coccyx appears larger in size. Dermagran (applied). Open area to coccyx 2.5 cm x 1.5 cm". [Original size of the open area was 1 cm long x 0.3 cm wide] Additionally, Resident #62 now has 2 openings in h/her skin "to back of left upper thigh. First is 1.5 cm x 0.5 cm, one below is 1 cm x 0.5 cm. Dermagran" (applied). Nursing Notes on 12/4/12 through 12/11/12 record Resident #62 "continues with areas on left upper thigh and coccyx" with both Dermagran ointment and spray</p>	F 282	<p><u>Identifying Other Residents</u></p> <p>A query has been made of all residents that:</p> <ol style="list-style-type: none"> 1. Currently have impaired skin integrity and who are receiving treatment to ensure the appropriate treatment is on the MAR. 2. Are on a turning/repositioning schedule to ensure the EHR has been revised to allow for LNA documentation of this intervention. 3. Have "float heels" as an intervention on the care plan to ensure the EHR has been revised to allow for LNA documentation of this intervention. <p><u>Systemic Changes</u></p> <p>The EHR has been implemented in such a way that will allow documentation of "heels floated" by the LNA so that verification of this intervention being done can be made.</p> <p>A web-based training program has been deployed for all LNA staff regarding skin breakdown prevention measures.</p> <p>A department communication was sent to all LNA staff informing them of the new documentation requirement for "floating heels". (see attachment #3)</p>	1/4/13	1/4/13 1/2/13 1/2/13

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F 282	<p>Continued From page 11 being used for treatment.</p> <p>Per interview on 12/12/12 at 1:40 P.M. Resident #62's Unit Manager stated that if a resident's skin condition worsened the Nurse Practitioner would be notified or nursing staff would let the resident's Physician know about the change. The Unit Manager stated that if a treatment is not working or a condition worsened, the resident's Care Plan would be reviewed and updated, and revisions would be reflected on both the Care Plan and the Treatment Record.</p> <p>During the interview on 12/12/12 the Unit Manager confirmed the condition of the area on Resident #62's coccyx had worsened since the discovery on 11/13/12 in addition to new open areas on the left upper thigh. The Unit Manager confirmed that despite the documented worsening of Resident #62's skin condition, there was no revision to the resident's Care Plan and no change in treatment recorded on the Treatment Record. The resident's Unit Manager also confirmed that Resident #62's Medication Administration Record (MAR) lists the Physician's Order for Dermagran ointment and spray to be applied twice daily as needed, and the Care Plan calls for Nursing to "treat as ordered...Update MD as needed".</p> <p>The Unit Manager stated that the Dermagran applications should be documented on the MAR twice a day after completion per facility policy. Per record review, and confirmed by the Unit Manager on 12/12/12 at 1:40 P.M., Resident #62's MAR records only a single application of the Dermagran treatment over the 30 days since the initial pressure ulcer was discovered. The Unit</p>	F 282	<p><u>Monitoring</u></p> <p>A QA tool will be completed weekly by the Charge Nurse and reviewed by the Unit Manager to ensure compliance is established for all of the following indicators:</p> <ol style="list-style-type: none"> 1. Turning/repositioning schedule in which the EHR is reviewed for verification that the intervention is being implemented consistently and documented. 2. Heels floated in which the EHR is reviewed for verification that the intervention is being implemented consistently and documented. <p>On-going monitoring will continue on a weekly basis until 100% compliance has been achieved for 6 consecutive weeks at which time monitoring will be reduced to a monthly basis for 3 months and quarterly thereafter. (see attachment #1)</p> <p><i>F88a POC accepted 11/16/13 mHiggins RN/PMC</i></p>	1/12/13

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F 282	<p>Continued From page 12</p> <p>Manager also reported there was no documentation on Resident #62's written or electronic record that the Nurse Practitioner or the resident's Physician had seen or was notified after the resident's pressure ulcer had worsened.</p> <p>Additionally, the Unit Manager confirmed that although Resident #62's Care Plan for Impairment of Skin contained the intervention for Nurse Assistants to "reposition [Resident #62] every two hours with nurse present, or get a nurse to verify position has been changed" there was no documentation in Resident #62's record of the repositioning ever being done or of nurse verification.</p> <p>2. Per medical record review on 12/12/12, the record indicated that Resident #187 was admitted to the facility on 11/16/12 with diagnoses that included; chronic foot ulcer.</p> <p>Per review of the Nurses Notes, Resident #187 was admitted to the facility with a Stage 3 open area located on the left heel. Per review of the nursing orders dated 11/16/12 indicated that the staff is to "float patient's heels at all times while in bed daily, nights, days and evenings."</p> <p>Per review of the Braden Skin Assessment dated 11/16/12 indicates Resident #187 is at risk for skin integrity issues. Per review of the Comprehensive Assessment (MDS) dated 11/28/12, Resident #187 is at risk for skin integrity issues and currently has a Stage 3 area. Per review of the comprehensive care plan titled 'Impaired physical mobility' and 'Impairment of skin integrity' both initiated on 11/16/12, they indicated that the staff is to "float heels while in</p>	F 282			

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F 282	<p>Continued From page 13 bed."</p> <p>Per direct observation on 12/12/12 at 0813 AM, Resident #187 was observed to be sitting up in bed with both heels touching directly on the mattress surface. It was noted there was no pillow in place or other device keeping the heels/feet off the mattress surface. Per continuous observation, Resident #187 had his/her feet directly touching the mattress surface from 8:13 AM until 09:15 AM when staff recognized that Resident #187's feet were not being "floated".</p> <p>Per interview with Licensed Nursing Assistant #1 (LNA #1) on 12/12/12 at 8:31 AM, he/she indicated that the care plan for each resident is reviewed before care is provided each day and that the verbal report received at the change of shift from the nurses indicates any changes to a resident's care. LNA #1 indicated that on the post acute unit all aides work together as a team and provide care to all the residents as per there individual plans of care. LNA #1 indicated that he/she and another aide (LNA #2) were providing care to Resident #187 on 12/12/12. Per interview with LNA #2 on 12/12/12 at 8:50 AM, he/she indicated that he/she had reviewed the care plan of Resident #187 prior to providing care to the resident. Per interview with LNA #1 and LNA#2, both reviewed the care plan for Resident #187 that was initiated on 11/16/12 and confirmed that the care plans titled skin impairment and impaired mobility both indicated that Resident #187's heels are to be "floated when in bed".</p> <p>Per direct observation with LNA #1 and LNA #2, they confirmed that Resident #187 on 12/12/12 at 8:50 am, was in bed and Resident #187's feet</p>	F 282		
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F 282	Continued From page 14 had socks on them and that both heels were not floated and having direct contact with the mattress. LNA #1 and #2 confirmed that there was no pillow in place to provide floating to Resident #187's heels per the care plan. Per review of the facility policy and procedure titled "Skin Care Guidelines" with an effective date of 11/15/2010, the policy indicates that in Step 2 to "manage pressure, patients who have or are at risk of developing ulcers will require offloading or pressure redistribution devices (e.g. heel boot, heel elevator, heel lift, suspension boot, or a device that "floats" the heel) to relieve the pressure on the heels and prevent skin breakdown." Per interview with the Registered Nurse assigned to Resident #187 on 12/12/12, he/she confirmed that Resident #187 was in bed at 8:50 AM and that his/her socked feet were making direct contact with the bed mattress and not floated as per Resident #187's care plan. The RN confirmed that the expectation is that the LNA's follow the resident's care plan when providing care and that Resident #187 should have had his/her heels floated off of bed.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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F 314	Continued From page 15 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide necessary treatment and services to promote healing of pressure sores and prevent new sores from developing for 1 of 4 residents (Resident #62) in the sample group. Findings include: Per record review on 12/10/12 at 3:44 P.M., the Care Plan for Resident #62, who has a history of pressure ulcers developing on h/her coccyx and buttocks, included interventions under "Impairment of Skin Integrity". Interventions listed include for Nursing: "treat as ordered... Update MD as needed." For Nurse Assistants, the interventions include "reposition [the resident] every two hours with nurse present, or get a nurse to verify position has been changed". Per record review, a Physician's Order for Resident #62, dated 8/22/12, states Dermagran ointment and spray [medications used for treatment of pressure ulcers and preventative skin care] to be applied twice daily as needed [for treatment of Resident #62's pressure ulcers], may change to use as needed when resolved. Per record review, Nursing Notes for Resident #62 starting on 11/13/12 report an "open lesion present to area between rectum and coccyx 0.5 centimeters [cm] center with split coming off side 1 cm long, approx. 0.3 cm wide." On the next day, 11/14/12, Nursing Notes record "Dermagran	F 314	<u>Corrective Action for Individual Residents</u> Resident #62 1. The order for Dermagran has been changed from prn to BID on the MAR and has been applied appropriately since 12/12/12. 2. The Nurse Practitioner was aware of the resident's skin condition although this was not reflected in the resident's chart at the time of the Survey. The NP has since written a late entry note indicating her knowledge of the resident's skin condition. 3. The EHR has been implemented to allow for documentation of turning and repositioning by the LNA so that verification of this intervention being done can be made. This resident is well known to the staff to frequently refuse care to prevent skin breakdown such as visual inspection of the area, turning and repositioning, etc. thereby increasing the likelihood that this pressure ulcer was unavoidable. The care plan will be revised to reflect her right to refuse medical care. <u>Identifying Other Residents</u> A query was made of all residents that currently have impaired skin integrity and who are receiving treatment to ensure the appropriate treatment is on the MAR and that all dressings/treatment are present on the patient/resident. An additional query was made of all residents who are on a turning/repositioning schedule to ensure the EHR has been revised to allow for LNA documentation of this intervention.	12/12/12 12/26/12 12/13/12 1/12/13 1/4/13 1/4/13	

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F 314	<p>Continued From page 16</p> <p>spray/ointment to open area coccyx as ordered." Nursing Notes from 11/14/12 through 11/25/12 repeat the assessment "open area crease in buttocks" and repeat that Dermagran was applied.</p> <p>On 11/27/12 the Nursing Note reads "open area on coccyx looking improved and smaller from 11/25". The next Nursing Note on 12/3/12 reports Resident #62's pressure ulcer "on coccyx appears larger in size. Dermagran (applied). Open area to coccyx 2.5 cm x 1.5 cm". [Original size of the open area was 1 cm long x 0.3 cm wide] Additionally, Resident #62 now has 2 openings in h/her skin "to back of left upper thigh. First is 1.5 cm x 0.5 cm, one below is 1 cm x 0.5 cm. Dermagran" (applied). Nursing Notes on 12/4/12 through 12/11/12 record Resident #62 "continues with areas on left upper thigh and coccyx" with both Dermagran ointment and spray being used for treatment.</p> <p>Per interview on 12/12/12 at 1:40 P.M. Resident #62's Unit Manager stated that if a resident's skin condition worsened the Nurse Practitioner would be notified or nursing staff would let the resident's Physician know about the change. The Unit Manager stated that if a treatment is not working or a condition worsened, the resident's Care Plan would be reviewed and updated, and revisions would be reflected on both the Care Plan and the Treatment Record.</p> <p>During the interview on 12/12/12 the Unit Manager confirmed the condition of the area on Resident #62's coccyx had worsened since the discovery on 11/13/12 in addition to new open areas on the left upper thigh. The Unit Manager</p>	F 314	<p><u>Sytemic Changes</u></p> <p>All residents who have impaired skin integrity other than surgical wounds or rash will be rounded weekly by the Skin Care Team. During Rounds the resident's care plan and treatment plan will be reviewed using the tablet PC. Because the NP is part of the Skin Care Team this will also ensure proper notification of the Provider for any wound that is worsening. This was first implemented on 1/3/13.</p> <p>A care plan folder relative to the right to refuse medical treatment will be created in the EHR to ensure resident rights and preferences are honored.</p> <p><u>Monitoring</u></p> <p>A QA tool has been developed and will be completed weekly by the Charge Nurse and reviewed by the Unit Manager to ensure compliance is established for all residents that are on a turning/repositioning schedule in which the EHR is reviewed for verification that the intervention is being implemented consistently and documented. Immediate corrective action will be taken by the Unit Manager if deficient practice is noted. On-going monitoring will continue weekly until 100% compliance is achieved for 6 consecutive weeks at which time monitoring will be reduced to a monthly basis for 3 months and then quarterly thereafter. (see attachment #1)</p>	1/3/13 1/12/13 1/12/13

F314 POC accepted 1/16/13
M Higgins RN / Pmc

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F 314	<p>Continued From page 17</p> <p>confirmed that despite the documented worsening of Resident #62's skin condition, there was no revision to the resident's Care Plan and no change in treatment recorded on the Treatment Record. The resident's Unit Manager also confirmed that Resident #62's Medication Administration Record (MAR) lists the Physician's Order for Dermagran ointment and spray to be applied twice daily as needed, and the Care Plan calls for Nursing to "treat as ordered...Update MD as needed".</p> <p>The Unit Manager stated that the Dermagran applications should be documented on the MAR twice a day after completion per facility policy. Per record review, and confirmed by the Unit Manager on 12/12/12 at 1:40 P.M., Resident #62's MAR records only a single application of the Dermagran treatment over the 30 days since the initial pressure ulcer was discovered. The Unit Manager also reported there was no documentation on Resident #62's written or electronic record that the Nurse Practitioner or the resident's Physician had seen or was notified after the resident's pressure ulcer had worsened.</p> <p>Additionally, the Unit Manager confirmed that although Resident #62's Care Plan for Impairment of Skin contained the intervention for Nurse Assistants to "reposition [Resident #62] every two hours with nurse present, or get a nurse to verify position has been changed" there was no documentation in Resident #62's record of the repositioning ever being done or of nurse verification.</p>	F 314	<p>This plan of correction constitutes our written allegation of compliance effective 1/12/13 for the deficiencies cited. However submission of this plan of correction is not an admission that any deficiencies exist or were cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.</p> 	