

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

May 14, 2012

Mr. J. Michael Rivers, Administrator  
Pine Heights At Brattleboro Center For Nursing & Rehab  
187 Oak Grove Avenue  
Brattleboro, VT 05301

Provider #: 475023

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **April 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, MS  
Licensing Chief

PC:ne

Enclosure



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

MAY 11 2012

PRINTED: 04/30/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>475023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/12/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE HEIGHTS AT BRATTLEBORO CENTER FOR NURSING &amp; R</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>187 OAK GROVE AVENUE BRATTLEBORO, VT 05301</b>	
(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	F 000		
F 157 SS=D	<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</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> <li>1. Resident #4 has discharged from the facility.</li> <li>2. All residents with new pressure ulcers may be affected by this alleged deficient practice.</li> <li>3. Audits to be performed on residents with pressure areas to ensure physician and responsible party notification is documented.</li> <li>4. Staff re-education on physician and responsible party notification in regards to pressure ulcers.</li> <li>5. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance.</li> <li>6. Results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance.</li> <li>7. Complete by May 12, 2012.</li> </ol> <p><i>F157 POC accepted 5/11/12 Thynner RN, Pincot RN</i></p>	

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

TITLE

(X6) DATE

*Mike Rivers*

*Administrator*

*5/11/12*

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.

*Pme*

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure the physician and responsible party were notified of the development of an additional pressure ulcer until three days after it was first documented. This affected one (Resident #4) of four sampled resident records reviewed. Findings include:</p> <p>Per clinical record review on 03/21/12, Resident #4 was admitted on 03/02/12 with one open area noted to the right buttocks measuring 0.5 centimeters in diameter. The Nursing Admission Assessment dated 03/02/12 also indicated the left buttock was reddened and intact. The Nurse's Notes dated 03/05/12, and timed 7:00 A.M. to 7:00 P.M., indicated the dressing was changed to the right buttocks open area. The note did not include a description of the area at that time. The Nurse's Notes dated 03/06/12 at 2:00 P.M., indicated Resident #4 had two open areas on buttocks. The coccyx measured 0.4 centimeters in diameter and the left gluteal fold measured 0.3 centimeters in diameter. The Weekly Pressure Ulcer Flow Sheet indicated that the initial assessment of the pressure ulcers by the Wound Nurse was completed on 03/06/12 and two pressure ulcers were present in close proximity on the right buttock at that time.</p> <p>A Nurse's Note dated 03/09/12, 7:00 A.M. to 7:00 P.M., indicated that the dressing was changed secondary to loose stools and the open areas</p>	F 157			

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F 157	Continued From page 2 were not described. On 03/09/12 at 1:30 P.M., an entry indicated the responsible party was notified of a new pressure ulcer noted by the wound care nurse on 03/09/12 and at 1:45 P.M. the Nurse's Note indicated the physician was notified of the development of a new stage II (partial thickness) ulcer located in close proximity to the stage II ulcer noted on admission. Orders for treatment were noted at that time. The Nurse's Notes revealed no indication that the physician or responsible party was notified of the development of additional skin breakdown between 03/06/12 and 03/09/12. Interview of the Director of Nursing Services and the Minimum Data Set Registered Nurse on 03/21/12 at 3:45 P.M. verified that the Nurse's Notes did not indicate the physician or responsible party had been notified until 03/09/12.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  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	F 278	F 278 1. Resident #4 has discharged from the facility. 2. All new admissions into the facility may be at risk from this alleged deficient practice. 3. Audits to be performed on new admission assessments to ensure accuracy and completeness. 4. Staff re-education on New Admission Assessment. 5. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance. 7. Complete by May 12, 2012.	

F278 POC accepted 5/11/12  
Thynhiter RN / P. Mcota RN

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F 278	<p>Continued From page 3</p> <p>\$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 clinical record review and interview, the facility failed to ensure that an accurate assessment of pressure ulcer risk was conducted for one Resident (Resident #4) admitted with a pressure ulcer. This affected one of four applicable resident records reviewed. Findings include:</p> <p>Per clinical record review on 03/21/12, Resident #4 was admitted on 03/02/12 with an open area to the right buttock measuring 0.5 centimeters in diameter. The Braden (pressure risk assessment) score was noted to be 17 (low risk for those over 75 years old). The assessment indicated no impairment of sensory perception, occasional moisture to skin, walks occasionally for activity, slightly limited mobility with frequent position changes, adequate nutrition, and potential friction and shear problem. No individualized interventions were noted to be implemented based on a risk for pressure ulcers. The Braden assessment was completed again on 03/09/12, and indicated a score of 15 (indicating mild risk). The sensory perception box had the date of 03/09/12 in it and indicated no score. The</p>	F 278		

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F 278	Continued From page 4 assessment indicated the skin was rarely moist, activity walks occasionally, mobility slightly limited with frequent position changes, nutrition adequate, and potential sheer and friction problem.  Review of the nurse's notes from 03/02/12 through 03/09/12 indicated that Resident #4 was noted on admission to be incontinent at times. The notes indicated that Resident #4 developed loose, watery stools on 03/03/12 and was incontinent of urine and stool daily. Review of the Nurse Aid flow sheet revealed that Resident #4 was incontinent of urine from one to six times daily and incontinent of stool one to four times daily with the exception of 03/08/12 and 03/10/12. Review of intake and output records for the period indicated that Resident #4 was not meeting hydration goals due to the frequent loose stools and daily hydration monitoring continued. Dietary notes dated 03/07/12 indicated Resident #4 had poor oral intake secondary to acute illness, antibiotic therapy and resulting diarrhea for several days.  Interview of the Director of Nursing Services on 03/21/12 at 3:45 P.M. confirmed that the Braden pressure risk assessment dated 03/09/12 did not accurately reflect Resident #4's risk for developing pressure areas. It included no score for sensory perception. It did not accurately reflect the status of Resident #4 on 03/09/12, for moisture to the skin, considering the documented incontinence of urine and stool and the nutritional status of the Resident #4 who presented with poor oral intake and diarrhea.	F 278			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 5</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to implement a physician's order to insert a Foley catheter to promote wound healing until the following day and failed to provide documentation of collaboration with the wound care clinic that was ordered on two occasions to promote wound healing and prevent the development of additional skin breakdown. This affected one (#3) of four applicable Resident records reviewed. Findings include:</p> <p>Per clinical record review on 03/21/12, Resident #3 was admitted to the facility for a three week respite stay with diagnosis of left cerebral hemorrhage on 02/09/12. The Admission Nursing Assessment indicated that Resident #3 had a Stage II (partial thickness) open area on the coccyx, had a Foley catheter, required the assistance of two staff to reposition in bed and the assistance of two staff and a standing lift to transfer. The Admission physical exam completed on 02/09/12 by the Nurse Practitioner acknowledged the three week respite stay. The note indicated a wound was present on the gluteal fold and indicates it was not observed because the Resident was dressed. It went on to state: get the wound care plan from the wound center. The notes acknowledged the use of the Foley catheter for wound healing and indicated to begin bladder retraining to remove the Foley catheter. These orders were written on the</p>	F 281	<p>F 281</p> <ol style="list-style-type: none"> <li>1. Resident #3 has discharged from the facility.</li> <li>2. All residents with pressure ulcers who have physician orders for Foley placement may be affected by this alleged deficient practice.</li> <li>3. All residents with pressure ulcers who have physician orders for wound clinic consultation may be affected by this alleged deficient practice.</li> <li>4. Audits to be performed on residents with pressure ulcers to ensure implementation of physician orders regarding Foley catheters and wound clinic collaboration.</li> <li>5. Staff re-education on implementation of physician orders and documentation.</li> <li>6. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance.</li> <li>7. Results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance.</li> <li>8. Complete by May 12, 2012.</li> </ol> <p><i>F281 POC accepted 5/11/12 Tmyhner RN / SMCotARN</i></p>	

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F 281	<p>Continued From page 6</p> <p>physician's order sheet. After a three day clamping schedule was completed, the Foley catheter was removed at 6:00 A.M. on 02/13/12 and incontinence was noted twice on that night shift.</p> <p>Review of the Nurse Aid Activities of Daily Living Flow Sheet for February 2012, revealed that Resident #3 was incontinent of urine from four to seven times daily after the catheter was removed and no continent episodes were documented. On 02/17/12 an untimed order was noted to place a Foley catheter due to the sacral wound and to refer Resident #3 to the wound care clinic. No evidence of collaboration with the wound care clinic was located in the record from the 02/09/12 order or the 02/17/12 order. The Nurse's Notes dated 02/17/12 do not indicate a Foley catheter was inserted on that date. The note on 02/18/12 at 5:00 A.M. indicated a Foley catheter was inserted with immediate urine flow.</p> <p>Interview of the Director of Nursing Services (DNS) on 03/21/12 at 3:00 P.M. confirmed that the order to insert the Foley catheter was untimed and the catheter had not been inserted until the next day. The DNS stated that the order was written by the Nurse Practitioner and was not a verbal order written by the evening nurse. S/he speculated it was written late afternoon or early evening. S/he was unable to state why it was not placed when the order was received to prevent additional incontinence and moisture to the wound. S/he confirmed that no documentation of collaboration with the wound clinic was located in the clinical record despite orders on 02/09/12 and 02/17/12 to get the wound plan of care from the wound center and to refer Resident #3 for wound</p>	F 281			

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F 281	Continued From page 7 care. S/he stated that the wound clinic recommended the reinsertion of the Foley catheter and the Nurse Practitioner wrote the order. No documentation of any wound specialists recommendations were provided.	F 281			
F 314 SS=G	<b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  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 clinical record review and interview, the facility failed to provide services to prevent two residents admitted with pressure ulcers from developing additional pressure ulcers while in the facility. This affected two (#4, #3) of four applicable resident records reviewed. Findings include:  1. Per clinical record review on 03/21/12, Resident #4 was admitted on 03/02/12 with one open area noted to the right buttocks measuring 0.5 centimeters (cm). The Nursing Admission Assessment dated 03/02/12 also indicated the left buttock was reddened and intact. The admission Braden (pressure risk) assessment indicated a score of 17 indicating low risk. The Nurse's Notes dated 03/05/12, and timed 7:00 A.M. to	F 314	<b>F 314</b> 1. Residents #3 & 4 have discharged from the facility. 2. All residents admitted with pressure areas may be affected by this alleged deficient practice. 3. Audits to be performed on residents admitted with pressure ulcers to ensure proper interventions and preventative measures are in place. 4. Staff re-education on pressure ulcer prevention. 5. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance. 7. Complete by May 12, 2012.  <i>F314 POC accepted 5/11/12 Tmynhier RN/ Director RN</i>		

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F 314	<p>Continued From page 8</p> <p>7:00 P.M., indicated the dressing was changed to the right buttocks open area. The note did not include a description of the area at that time. The Nurse's Notes dated 03/06/12 at 2:00 P.M., indicated Resident #4 had two open areas on the buttocks and coccyx measuring 0.4 cm in diameter and to the left gluteal fold measuring 0.3 cm in diameter. The note indicated the areas were present on admission and no new intervention was implemented.</p> <p>The dietary notes dated 03/07/12 indicated poor intake and recommended diet liberalization and the addition of supplements twice daily. This was implemented on 03/08/12. The Weekly Pressure Ulcer Flow Sheet indicated that the initial assessment of the pressure ulcers by the wound nurse was completed on 03/06/12, and two ulcers were present in close proximity on the right buttock at that time. This was the only assessment documented by the wound nurse and indicated area #1, located to the superior right buttock, measured 0.4 cm by 0.8 cm and was superficial in depth, and area #2 measured 0.3 cm by 0.5 cm and was superficial in depth. Both flow sheets indicated the ulcers were present on admission and were acquired outside of the facility. The Braden (pressure risk) assessment dated 03/09/12 indicated a score of 15 (mild risk). The nurses notes on 03/09/12 at 1:30 P.M. indicated that the next of kin was notified of a new pressure ulcer noted by the wound nurse on that date.</p> <p>The plan of care for Pressure Ulcers, dated 03/03/12 indicated the presence of actual breakdown acquired prior to admission and urine and fecal incontinence as risk factors. It</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>indicated a Stage II (partial thickness) wound was located on the right ischium. The interventions included: update MD as needed, pressure reducing mattress, turn and reposition every 2 hours, incontinence care every two hours and as needed and treatment as ordered of Mepilex (an occlusive dressing) changed three times a week. A multivitamin was requested by the dietician on 03/07/12. No individualized interventions specific to the Resident #4's hydration, positioning or device needs was noted. The plan of care for a second Pressure Ulcer with a date discovered of 03/06/12, was initiated on 03/09/12. It was identical to the initial plan of care and stated under treatment cleanse and cover with Mepilex used for the other Stage II ulcer.</p> <p>Review of the policy and procedure for pressure ulcers, the National Health Care Association Pressure Ulcer Prevention Management and Treatment Program, revised 10-2007, revealed on page 18, Stage II protocol, intervention number 5, the use of preventative pressure relief non powered devices on the bed and chair. Note: multiple stage II areas on the trunk require a low air loss mattress. The clinical record did not indicate a low air loss mattress or a cushion to the chair was implemented per this protocol.</p> <p>Interview of the Wound Nurse on 03/21/12 at 3:00 P.M., confirmed that there had been one weekly assessment documented on 03/06/12, noting two pressure ulcers. The Wound Nurse stated that it was not unusual for the initial assessment to be completed several days (up to one week) after admission, depending on the timing of the admission, because the wound assessments were completed on Tuesdays.</p>	F 314		

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F 314	<p>Continued From page 10</p> <p>Wound treatments were completed throughout the week and skin was assessed on admission by the various charge nurses. The Wound Nurse verified that the Nursing Admission assessment completed 03/02/12 indicated one open area to the right buttocks and was consistent with the admission paperwork received from the hospital. The wound nurse verified the weekly pressure ulcer flow sheet s/he completed 03/06/12 indicated two pressure ulcers were present on the right buttocks on admission but verified that the wound was not assessed on admission by him/her.</p> <p>No explanation was provided for the discrepancy in the number and location of the wounds or where or when they had developed. This information was confirmed by the Director of Nursing Services (DNS) and the Minimum Data Set assessment Registered Nurse on 03/21/12 at 3:45 P.M. who stated after reviewing the documentation that the Admission assessment indicated a stage II (partial thickness) pressure ulcer to the right buttock and a stage I (red area) ulcer on the left buttock. The stage I ulcer resolved and a new stage II ulcer was documented on 03/06/12. The DNS stated that a low air loss mattress is used when there are multiple stage II pressure ulcers and did not indicate why it was not implemented on 03/06/12 when the second ulcer was documented. The DNS verified that the Braden pressure risk assessment completed 03/09/12 did not accurately reflect the nutritional status, the exposure of skin to moisture or the sensory perception of Resident #4. S/he could not state specific or individualized intervention that had been implemented for Resident #4 as a result of</p>	F 314		
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F 314	<p>Continued From page 11</p> <p>having a pressure ulcer on admission, and risk factors of moisture to the skin, incontinence, and poor nutritional intake to prevent the development of a Stage II pressure ulcer in the facility on 03/06/12.</p> <p>2. Per clinical record review on 03/21/12, Resident #3 was admitted on 02/09/12, for a three week respite stay and discharged on 02/29/12. A diagnosis of left cerebral hemmorage was noted. The Nurse Practitioner documented on 02/09/12, that Resident #3 had a wound to the gluteal fold that was not observed because the Resident was dressed. The history and physical exam also indicated a Foley catheter was in place for wound healing. The Nurse Practitioner requested 02/09/12 that the facility get the wound care plan from the wound center. Orders for bladder retraining to discontinue the catheter were noted. The Foley catheter was discontinued on 02/13/12 at 6:00 A.M. and Resident #3 was incontinent of urine four to seven times daily until it was replaced on 02/18/12 at 5:00 A.M., with no documented continent episodes. The Nurse Practitioner wrote orders on 02/17/12, to refer Resident #3 to the wound clinic.</p> <p>Review of the Weekly Pressure Ulcers Flow Sheet indicated Resident #3 was admitted with a pressure ulcer to the top proximal gluteal cleft on 02/09/12. No measurements were noted. No treatment orders were noted. On 02/14/12 the first wound assessment documented, indicated the area measured 2.5 centimeters (cm) length by 1.5 cm width by 0.3 cm depth. The wound bed was described as beefy red and moist with wound edges pink and intact. The Weekly assessment</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>form did not indicate treatment orders. The Nurse's notes on 2/15/12, day shift, indicated the wound was beefy red with a dark shadow center. It indicated the Wound Nurse and the Nurse Practitioner would assess the wound the next day. No evidence of an assessment was noted on 02/16/12.</p> <p>On 02/17/12, no assessment is documented but a treatment is ordered to include: cleanse the wound to the coccyx, apply Melgisorb AG (a debriding dressing containing silver), to the wound bed (cut to fit), and cover with Mepilex border (an occlusive dressing). It was to be changed three times a week and as needed until the area resolved. The note dated 02/19/12, night shift, indicated the dressing was changed and the wound appeared beefy red with yellow slough. The second Weekly Pressure Ulcer Assessment was documented on 02/21/12, and indicated the measurements were 2.3 cm length by 1.0 cm width. The assessor was unable to determine a depth and the wound bed was described as covered 100 percent with yellow slough. No changes were noted to be made to the treatment or devices used by the Resident.</p> <p>No collaboration was documented between facility staff and the wound care clinic as requested on 02/09/12 and 02/17/12. The Braden scale (pressure risk assessment) completed 02/16/12 and 02/22/12 indicated a score of 12 (10-12 indicates high risk). No individualized interventions were noted to be in place as a result of the identification of high risk for pressure ulcers. The plan of care for Skin at Risk indicated a goal of no further breakdown during the next 12 weeks. The interventions</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>included a pressure reducing mattress, observe skin integrity during care, protective barrier, turn and reposition ever two hours, toilet or change every two hours and as needed and transfer with lifter to prevent friction. On 02/17/12, the plan of care indicated the addition of a multivitamin and protein shakes three times daily for wound healing. The plan of care for Pressure Ulcers was developed on 02/14/12 and included the pressure reducing mattress, update the MD as needed, turn and reposition every two hours, toilet or incontinence care every two hours and treatment as ordered.</p> <p>Review of the policy and procedure for pressure ulcers, the National Health Care Association Pressure Ulcer Prevention Management and Treatment Program, revised 10-2007, revealed on page 18, Stage II protocol, intervention number 1 states to cleanse the area with cleansing solution (normal saline) and intervention number 5 directs the use of preventative pressure relief non powered devices on the bed and chair. Note: multiple stage II areas on the trunk require a low air loss mattress.</p> <p>On 02/28/12 the wound measurements were 3.0 cm length by 1.5 cm width by 0.6 cm depth with 90 percent of the wound covered with yellow slough, 10 percent beefy red wound bed and reddened wound edges. On 02/28/12 three additional areas were noted to the left buttock measuring #1) 0.2 cm length by 0.2 cm width, #2) 0.3 cm length by 0.5 cm width and #3) 0.4 cm length by 0.7 cm width. All three were described as superficial and beefy red in appearance with bloody drainage. A Mepilex dressing was ordered to cover all three, as they</p>	F 314		

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F 314	<p>Continued From page 14</p> <p>were located in close proximity on the left, lower and inner buttock.</p> <p>Interview of the Wound Nurse on 03/21/12 at 10:45 A.M., before observation of wound care to another Resident, revealed that the facility uses a wound cleanser to clean wounds prior to dressing applications. Interview of the therapy manager on 03/21/12 at 1:15 P.M., revealed that Resident #3 was seen by occupational therapy during her stay to promote upright positioning in a personal customized wheelchair for improved self feeding. The short term goal of two hours and long term goal of four hours had been identified. When questioned about the affect of the wheelchair positioning on the pressure ulcer, the therapy manager indicated no awareness, stating that nursing would be monitoring the Resident's skin. An Occupational Therapy Daily Encounter noted dated 02/22/12, indicated that a waffle cushion was acquired and labeled as Resident #3's personal property because a personal cushion brought to the facility and used by the Resident in the custom chair at home was missing. The therapy manager could not state how long the cushion had been missing.</p> <p>During interview on 03/21/12 at 3:00 P.M., the Director of Nursing Services and the Minimum Data Set Registered Nurse indicated that the measurements of the wound declined from 02/14/12 to 02/28/12, but stated the initial measurement on 02/09/12 was 1.2 cm by 4.5 cm, indicating it had initially improved, and declined due to the debriding treatment in place. They stated the facility standard mattress, used for all residents without special orders, is pressure relieving and a low air loss mattress is</p>	F 314			

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F 314	Continued From page 15 used when multiple stage II areas are noted. They confirmed that the Foley catheter was discontinued and that Resident #3 had been incontinent for five days when it was replaced, that nutritional supplements were ordered on 02/10/12 and increased on 02/17/12, but no changes had been made to the turn and reposition schedule, the devices used by the Resident in the bed or chair to redistribute pressure, or limitations made to the amount of time Resident #3 spent sitting up on the wound as it declined. They verified that three additional Stage II pressure areas developed the day prior to Resident #3's discharge home.	F 314		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, the facility failed to ensure that one clinical record contained documentation of collaboration with a wound specialist. This affected one (#3) of four	F 514	F 514 1. Resident #3 has discharged from the facility. 2. All residents seeing wound consultant may be affected by this alleged deficient practice. 3. Audits to be performed on residents admitted with pressure ulcers to ensure proper documentation regarding wound specialist collaboration. 4. Staff re-education on documentation regarding collaboration with the wound specialist. 5. Audits will be performed by DNS or designee weekly x4 then monthly x2 to ensure continued compliance. 6. Results to be reported at CQI monthly x3 at which time committee will decide process for further surveillance. 7. Complete by May 12, 2012.	

*F514 PDC accepted 5/11/12  
TMynhier RN / SMcota RN*

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F 514	<p>Continued From page 16 applicable Resident records reviewed. Findings include:</p> <p>Per clinical record review on 03/21/12, Resident #3 was admitted to the facility for a three week respite stay with diagnosis of left cerebral hemorrhage in 02/2012. The Admission Nursing Assessment indicated that Resident #3 had a Stage II (partial thickness) open area on the coccyx. The Admission physical exam completed on 02/09/12, by the Nurse Practitioner acknowledged the three week respite stay. The note indicated a wound was present on the gluteal fold and indicated it was not observed because the Resident was dressed. It went on to state: get the wound care plan from the wound center. This order was written on the physician's order sheet. On 02/17/12 an untimed order was noted to refer Resident #3 to the wound care clinic. No evidence of collaboration with the wound care clinic was located in the record.</p> <p>Interview of the Director of Nursing Services (DNS) on 03/21/12 at 3:00 P.M. confirmed that there were orders to get the wound plan of care from the wound center on 02/09/12 and to refer Resident #3 to the wound center on 02/17/12. S/he confirmed that no documentation of collaboration with the wound clinic was located in the clinical record despite orders on 02/09/12 and 02/17/12 to get the wound plan of care from the wound center and to refer Resident #3 for wound care. S/he stated that someone spoke with the wound specialist and the Foley catheter was reinserted because of their recommendation. S/he stated that an appointment was made for follow up at the clinic on 02/29/12 (the day of discharge). S/he was unable to state who spoke</p>	F 514		

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F 514	Continued From page 17 with the clinic or when, and could locate no documentation in the record.	F 514		