

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

ORIGINAL

PRINTED: 07/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/10/2014
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NAME OF PROVIDER OR SUPPLIER  AVERA MARYHOUSE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 717 EAST DAKOTA PIERRE, SD 57501
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F 000	INITIAL COMMENTS  Surveyor: 30170 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/9/14 through 7/10/14. Areas surveyed included: Quality of Care/Treatment for Pressure Ulcers, Resident Assessments for Pressure Ulcers, and Infection Control Practices in Nursing Services. Avera MaryHouse Long Term Care was found not in compliance with the following requirements: F280, F314, and F514.	F 000	Addendums noted with an asterisk per 8/11/14 telephone to facility DON. S4SDDOH/MF	
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	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mark Schmitt* TITLE: *Executive Director* (X6) DATE: *8/1/14*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting, provided 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 280	<p>Continued From page 1</p> <p>by: Surveyor: 30170</p> <p>Based on observation, record review, interview, and policy review, the provider failed to ensure three of four sampled residents (1, 2, and 3) who had a history of or had a current pressure ulcer had the care plan reviewed and revised to reflect the current status and the most recent interventions that were in place to assist with the healing or prevention of those skin issues. Findings include:</p> <p>1. Review of resident 2's complete medical record revealed: *He had been admitted on 6/20/14 from the hospital. *His diagnoses had included: -Congestive heart failure (the heart does not pump efficiently and fluid builds up in the lungs and in the lower extremities [legs]). -Weakness. -Dependent gait and mobility (required the assistance of staff for walking and moving). -Renal (kidney) failure. -Edema (swelling in the lower extremities). -Peripheral vascular disease (poor circulation). *On 6/20/14 the nursing skin assessment on admission revealed he had a stage 2 pressure ulcer on his medial left buttock (in the mid area of his left buttock cheek region). The measurement was 1 centimeter (cm) by 2 cm with scant (small) drainage. *The treatments to the left medial buttock area were as follows: -6/22/14 Aquacel and CombiDERM dressing. -6/29/14 Eucerin lotion. -7/2/14 Wipe the area with SurePrep (alcohol based cleanser). *On 7/6/14 he had an abrasion that was 0.5 cm</p>	F 280	<p><i>A temporary short term paper care plan was developed that will be used to enhance resident care until the comprehensive Plan of care is created, (within 7 days of completing a resident's Comprehensive MDS assessment).</i></p> <p><i>Policy 6312.09: Comprehensive Plan of Care was reviewed and revised to ensure staff identify resident strengths and weaknesses when addressing identified problems, create realistic goals with specific and realistic interventions, and ensure the resident care plans are updated to reflect changes in status. The facility will be using a combination of paper and electronic record (bubble text interventions) for care plans.</i></p>	8/29/14
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F 280	<p>Continued From page 2 by 1 cm and was left open to air.</p> <p>Review of resident 2's 7/4/14 Minimum Data Set (MDS) fourteen day assessment revealed he was: *An extensive assist of two staff for transfers. *Non-ambulatory. *An extensive assist of two persons for bed mobility.</p> <p>Review of resident 2's undated Activity of Daily Living care plan revealed: *He was independent with assistance of one staff person. *He was an assistance of one or two staff with transfers. *He used a wheeled walker. *He was dependent with all personal hygiene. *No further information had been provided regarding his current skin issues.</p> <p>Review of resident 2's undated Personal Evaluation Sheet revealed: *He was forgetful and needed to be cued (prompted). *He had a wheel chair and a chair cushion. *There was no information provided regarding his skin issues.</p> <p>Review of comprehensive care plan for his skin issues dated 7/8/14 revealed: **Monitor skin with all opportunities and notify charge nurse for any new s/s (signs and symptoms) of break down. *Weekly head to toe skin observation by licensed nurse. *PRESSURE REDISTRIBUTION: Pressure redistributing mattress for bed and cushion for chair. Encourage frequent positioning.</p>	F 280	<p><del>addendum 07/14/14 RAISE SKIN CARE</del></p> <p>All staff responsible for direct resident care received education on care planning including identification of resident strengths and weaknesses, creating realistic goals and approaches, and how to document these items, as well as changes in the electronic system.</p> <p>Compliance with care plan development, review and revision will be monitored by designated Rts and LPNs (12 monthly).</p> <p>Results will be reported to Quality Improvement Committee (QIC) quarterly by the Director of Nursing (DON) until the QIC advises discontinuation.</p> <p>Resident 2 is no longer in the facility, as of July 15, 2014. Unable to accomplish corrective action.</p>	
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F 280	<p>Continued From page 3</p> <p>*Assist to toilet at regular intervals to help promote bowel continence. Provide protective undergarment as needed and meticulous skin care after any incontinent episode.</p> <p>*Refer to EMR (electronic medical records) for the most updated information on medication and cares."</p> <p>*There was no information in the above care plans that would indicate he was totally dependent on staff for transferring and repositioning.</p> <p>Observation and interview on 7/10/14 at 8:55 a.m. with certified nursing assistants (CNA) C and D during personal care for resident 2 revealed:</p> <p>*The CNAs were assisting him from his wheelchair to his recliner.</p> <p>*The resident's buttocks area was visualized during the transfer after partial removal of his disposable brief.</p> <p>*There were several open areas noted on the left and the right buttock areas.</p> <p>*The CNAs stated SurePrep (alcohol solution) was placed on the wounds and then SensiCare cream was applied during their shift, but there was no regularity to the application of the solution or the cream.</p> <p>*The CNAs transferred the resident with a stand aide (a mechanical lift that assisted in the transferring of the resident) to his recliner. He needed total assistance from the two CNAs present during the transfer. It was noted there was no cushion in his recliner, and the cushion was in his wheelchair. When asked about the cushion in his recliner the CNAs agreed the cushion should have been placed in his recliner prior to his transfer. They both stated they had not toileted him regularly, because he had a Foley</p>	F 280	<p><i>Staff responsible for direct resident care includes RNs, LPNs, CNAs, Nurse Aides, and Med Aides. The education was provided by our MDS nurses on July 29th, 30th and 31st of 2014. The DON and ADON will be responsible for overseeing the RNs and LPNs who monitor the residents' care plans.</i></p> <p><i>A pressure ulcer risk assessment (Braden Scale) will be completed on admission and interventions will be added to the care plan based on the residents' Braden Scale scores.</i></p> <ul style="list-style-type: none"> <li><i>• At Risk 15-18 Weekly head-to-toe skin inspection by nurses</i></li> <li><i>• Moderate Risk 13-14 Pressure redistributing mattress and seat cushion if applicable in addition to intervention listed above.</i></li> <li><i>• High Risk 10-12 Turning/repositioning program in addition to interventions listed above.</i></li> <li><i>• Very high Risk 9 or below Consult Wound Care Team for further preventative measures in addition to interventions listed above.</i></li> </ul> <p><i>Residents whose Braden Scores do not indicate risk will be advanced to the At Risk 15-18</i></p>	
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F 280	<p>Continued From page 4</p> <p>catheter (a tube placed in the bladder to drain urine into a bag). So they were unsure as to how many times a day they would apply the SurePrep and the SensiCare cream.</p> <p>Interview on 7/10/14 at 9:15 a.m. with MDS coordinator B regarding resident 2's pressure ulcer revealed:                  *The charge nurses were responsible for measuring the areas weekly.                  *The measurements would have been documented weekly in the electronic medical record.                  *The direct care staff would be notified of changes in regards to the treatments during a shift change report.</p> <p>Observation and interview on 7/10/14 at 11:30 a.m. with registered nurse (RN) E and MDS coordinator B during resident 2's transfer and the inspection of his buttock area revealed:                  *The open area on his left buttock was 4 cm by 3 cm.                  *There were two new open areas observed below the above pressure ulcer that measured: 1 cm by 2 cm and 2 cm by 1 cm.                  *The right buttock pressure ulcer was 1 cm by 2 cm.                  *The RN agreed the 4 cm by 3 cm area on his left buttock was much larger than previously documented in the nursing assessments, and the right medial (middle region) area was larger than previously documented on 7/6/14.</p> <p>3. Review of resident 3's complete electronic medical records revealed:                  *On 6/13/14 she had been admitted from the hospital.                  *Her diagnoses included:</p>	F 280	<p><i>Level interventions by the charge nurse if they have a history of pressure ulcers. Residents who currently have a pressure ulcer and newly discovered pressure ulcers on residents will have this process followed: The charge nurse on duty will open the applicable worst list intervention in Meditech, and list the following items within the bubble text: location and date wound was discovered, discovering nurse's initials, goal of wound resolution and specific type and frequency of monitoring and/or treatment. Interventions are put into a completed status by charge nurse when healed. This info flows automatically to the process plans (electronic portion of Meditech care plan) and can be reviewed or printed at any time.</i></p> <p><i>Resident 3 was discharged from the facility on July 15, 2014. Unable to accomplish corrective action for this patient.</i></p>	
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F 280	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-Diabetes.</li> <li>-Obesity.</li> <li>-Right heel ulcer with surgical debridement on 6/10/14.</li> <li>-Cellulites (redness and swelling) of the lower extremities (legs).</li> <li>-Heart failure.</li> <li>-Peripheral neuropathy (numbness and tingling on the skin).</li> <li>-Chronic venous stasis.</li> </ul> <p>*Her Braden Score assessments had been:</p> <ul style="list-style-type: none"> <li>-On 6/13/14 her score was 12 (high risk).</li> <li>-On 6/21/14 her score was 13 (moderate risk).</li> </ul> <p>*On 6/29/14 there was documentation there was an open area in the crease of her buttocks. There was no documentation the physician had been notified, no current interventions had been put in place, and no communication had been provided to other staff.</p> <p>*There was no documentation in the nursing assessment for consistent repositioning of the resident multiple times from 6/13/14 through 7/4/14.</p> <p>Review of resident 3's 6/27/14 fourteen day MDS assessment revealed she was:</p> <ul style="list-style-type: none"> <li>*Completely dependent on the staff for all transfers.</li> <li>*Non-ambulatory.</li> <li>*An extensive assistance of two staff persons for bed mobility.</li> <li>*An extensive assistance of one staff person for all personal hygiene.</li> <li>*She was at risk for the development of pressure ulcers.</li> </ul> <p>Review of resident 3's 6/13/14 care plan revealed:</p> <ul style="list-style-type: none"> <li>*"Monitor skin with all opportunities and report</li> </ul>	F 280	<p><i>The charge nurse on duty is responsible for making all applicable updates to the care plan as they occur via the intervention bubble text to ensure communication between staff responsible for the care of those residents who are at risk for, have history of, or who currently have a pressure ulcer.</i></p>	

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F 280	<p>Continued From page 6</p> <p>any abnormal bruising/bleeding or new areas of concern to the charge nurse.</p> <p>*Weekly head-to-toe skin observations by the nurse.</p> <p>*PRESSURE REDISTRIBUTION: Pressure redistributing mattress for bed and cushion for her chair. Heel protectors and floating of the heels to avoid pressure, friction, or shearing."</p> <p>*There was no documentation regarding the frequency of repositioning or her history of circulatory problems, numbness, and tingling.</p> <p>Interview on 7/10/14 at 1:00 p.m. with the director of nursing regarding resident 2 and 3 who had current pressure ulcers revealed the current care plans were not specific for the current pressure ulcer status, the current interventions, and the current treatments.</p> <p>Surveyor: 23059</p> <p>2. Review of resident 1's closed medical record revealed she had been admitted on 5/1/14 and discharged to the hospital on 5/14/14. Review of her nurses notes during that stay revealed she had been incontinent of bowel movement on multiple occasions. Review of her 5/2/14 skin assessment indicated she had been given a pressure relieving cushion for her wheelchair. A specialized pressure relieving mattress had been applied to her bed. She had been having "slight bleeding and peeling with wiping between buttocks." Barrier cream had been applied to that area.</p> <p>Review of her undated short term care plan revealed: *She was continent of bowels. *She was not using a special mattress or wheelchair cushion.</p>	F 280		

*Resident 1 was discharged from this facility May 14, 2014. Unable to accomplish corrective action for this patient.*

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F 280	<p>Continued From page 7</p> <p>*There was no mention of using a barrier cream when providing perineal (bottom) care.</p> <p>Interview on 7/10/14 at 10:30 a.m. with the assistant director of nursing revealed the short term care plan should have reflected the care provided to the resident. It could have been updated at any time by any of the nurses who had provided care. A comprehensive care plan had not yet been developed. That was because resident 1 was still within the twenty-one day window after admission allowed for completion of that form at the time of her discharge.</p> <p>Review of the provider's 1/16/14 Comprehensive Plan of Care policy revealed: *Until the comprehensive care plan was completed a bedside care plan was used along with the orders and work list interventions. *Short-term problems, goals, and approaches would have been addressed and managed through the intervention list. Those would not have been routinely duplicated on the comprehensive care plan unless the information and inclusion was deemed essential by the interdisciplinary team. *The purpose was to ensure the most current information regarding mobility and activities of daily living preferences was updated and effectively communicated at _____ (name of the provider), staff would give shift-to-shift report and refer to work list interventions. *Comprehensive care plans would have been revised as necessary to reflect change in the patient/resident and the care they were receiving. Revision to the comprehensive care plan would have taken place on the paper copy in between MDS assessments.</p>	F 280		

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F 314 F 314 SS=G	Continued From page 8 483.25(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: Surveyor: 23059 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate and ongoing assessments, monitoring, physician notification, and documentation was maintained for three of four sampled residents (1, 2, and 3) with pressure ulcers. Findings include:  1. Review of resident 1's closed medical record revealed she had been admitted on 5/1/14 following knee replacement surgery. She had been discharged on 5/14/14 to the hospital for debridement (removal of damaged tissues) of a pressure ulcer.  Review of her 5/1/14 physician's admission history and physical (H&P) revealed she had been admitted for: *Physical therapy following a total knee replacement. *Diabetes. *Anticoagulation (decreasing the time it takes	F 314 F 314	<i>The DON, Medical Director and the interdisciplinary team reviewed and revised policy 6312.29 Pressure Ulcer Prevention and Wound Treatment to ensure staff systematically assess and document skin risk factors; implement skin protection components of care and provide appropriate treatment when indicated.  A paper document which includes body diagrams was updated for staff to use during their head-to-toe skin assessments and wound identification. Title: Head-to-toe Skin Documentation Sheet.  All staff responsible for direct resident care received education on prevention and treatment of pressure ulcers and</i>	<i>8/29/14</i>

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F 314	<p>Continued From page 9 blood to clot) management. *Pain management. There was no mention in that H&amp;P of any concerns regarding skin integrity issues.</p> <p>Review of her 5/1/14 admission basic skin assessment revealed: *Her skin was warm and dry. *Her skin color was normal for her race. *Her skin turgor (tension) was adequate. *She had a skin irregularity with an incision to the right knee. -That incision was not observable due to a dressing. -There was no drainage or odor noted. *There was no documentation of any other skin irregularities found.</p> <p>Review of resident 1's next basic skin assessment on 5/4/14 revealed the same information as above.</p> <p>Review of her 5/5/14 nurse's note revealed "Incontinent of stool. When peri care (wiping the bottom) was provided a lesion on her coccyx (tail bone) measuring 6 cm (centimeters) by 2.5 cm was noted. The lesion could not be staged (method of identifying the severity of skin ulcer) because it is dark blue to black. PIN (physician inter-departmental notification) will be sent and nursing administration notified."</p> <p>Review of the above faxed PIN to the physician revealed the physician responded with treatment for the incontinent stools. The physician did not respond to the report of the lesion on the coccyx.</p> <p>Review of her next basic skin assessment on 5/7/14 revealed:</p>	F 314	<p><i>wounds to ensure that residents are receiving accurate and comprehensive skin assessments, and that staff understand appropriate interventions for pressure ulcer wound prevention as well as the importance of monitoring treatment of wounds and modification of treatment interventions as necessary to promote the fastest pathway to wound resolution.</i></p> <p><i>Regular ongoing training and education regarding skin assessment and wounds will be provided for staff no later than September, 2014.</i></p> <p><i>Resident 1 was discharged May 14, 2014. Unable to accomplish corrective action for this resident.</i></p>	

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NAME OF PROVIDER OR SUPPLIER  <b>avera maryhouse long term care</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>
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F 314	<p><i>*Addendums 5/14/14 RAISO</i></p> <p>Continued From page 10</p> <p>*A wound to the coccyx that was "red with black spot." *That wound was open with scant drainage and measured 7.0 cm in length and 3.0 cm in width. *There was no odor noted.</p> <p>Review of her next basic skin assessment on 5/9/14 revealed: *A wound to the coccyx that was "red with black spot." *That wound was purple and black/brown in color. *The wound was intact (no open areas) and measured 4.0 cm in length and 3.0 cm in width. *There was no drainage and no odor.</p> <p>Review of a 5/9/14 nurse's note revealed the nurse had "described the eschar (dead tissue) central between the buttocks over the coccyx to the physician. Agrees she was sleeping in a seated position at home and that moisture is a huge factor along with leaking bm. Already seen by _____, PT (physical therapist) and no other treatment can be identified at this time. Will continue with barrier creams and no dressing as would be contaminated nearly constantly." There was no indication the physician viewed the lesion on the coccyx at that time.</p> <p>Review of a 5/12/14 nurse's note revealed the "eschar area is firm/non-yielding to the touch, hardened, flat on both sides of inner buttocks; dark brown/black. Intact, non-moveable, not open, no drainage, no odor. Surrounding skin is fragile, moisture is affecting is as she is incontinent of urine and the odor of the urine is quite foul." There was no indication the physician had been notified of the above finding.</p> <p>Review of her next basic skin assessment on</p>	F 314	<p><i>Staff responsible for direct resident care who received education on prevention and treatment of pressure ulcers included RNs, LPNs, CNAs, nurse aides and Med Aides. RNs and LPNs were educated on proper documentation, notification and treatment of pressure ulcers. The education was provided for these staff members by our MDS nurses on July 29th, July 30th and July 31st, 2014. The ADON and DON will be responsible for overseeing the RNs and LPNs who are designated to monitor assessments, documentation and physician notifications. The charge nurse on duty is responsible for ensuring the appropriate pressure ulcer care is provided to residents who are at risk of developing pressure ulcers, have a history of pressure ulcer development, or who have a current pressure ulcer.</i></p>	
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F 314	<p>Continued From page 11 5/13/14 revealed: *A wound to the coccyx that was "red with black spot." *The edges of the wound had separated, and the area was open. *That wound was red and dark red/purple in color. *The wound was hard and measured 9.0 cm in length and 4.0 cm in width. *There was some drainage, and a foul odor noted. The physician had been notified regarding that wound.</p> <p>Review of resident 1's 5/14/14 at 7:15 a.m. nurse's note revealed: *There was a moderate amount of brown bloody drainage from the wound. *There was black eschar with sloughing (release of dead tissue). *The area surrounding the eschar was red, inflamed, and hard.</p> <p>Review of an 8:05 a.m. nurse's note on the same day revealed: *The wound was looking worse and draining. It had an increasingly foul odor. *A request was made for a consultation by the wound team.</p> <p>Review of the 12:45 p.m. physical therapist note on that same day revealed: *The resident's buttocks had needed to be spread in order to complete a thorough assessment. *The visible area was hardened and red. *The area between the buttocks was dark purple. *There was an odor noted, and a dressing was applied to absorb the drainage and assist with the odor.</p>	F 314	<p><i>The ongoing training and education of staff regarding skin assessments and wounds will take place on September 29th and 30th, 2014 and annually thereafter.</i></p>		

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F 314	<p>Continued From page 12</p> <p>*Nursing planned to notify the physician.</p> <p>Review of the 2:05 p.m. nurse's note on that same day revealed the physician's assistant was there to assess the wound. There was a moderate amount of brown, bloody, foul drainage noted from the wound.</p> <p>Review of the 2:40 p.m. nurses' note on that same day revealed the physician was there to check on resident 1. The wound was measured as a 7.2 cm by 8.2 cm black eschar with sloughing and brown drainage noted. She was pale, sweaty, and somewhat slow to respond. Some shaking was noted. Orders were received to admit the resident to the hospital for wound management.</p> <p>Review of information provided to the South Dakota Department of Health by the receiving hospital revealed the wound was measured at 12 cm in length, 11 cm in width, and 6 cm in depth after surgical removal of the dead tissue. She was subsequently transferred to a higher level of care for wound management and antibiotic therapy.</p> <p>Interview on 7/10/14 at 3:00 p.m. with the assistant director of nursing revealed she confirmed a thorough skin assessment at the time of resident 1's admission on 5/1/14 was not documented. She stated a proper skin assessment was difficult to complete due to the resident's extreme obesity. She stated it would have been necessary to have two people present in order to do a complete assessment: one to spread the buttocks "cheeks" apart, and another to complete a measurement. She was unsure how often that took place. She confirmed the</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>area was not assessed accurately and in a timely manner to prevent further breakdown. She confirmed there was no consistency in the nurses assessing that area to ensure accuracy in measurement or assessment criteria.</p> <p>Interview on 7/10/14 at 8:50 a.m. with MDS (Minimum Data Set) coordinator B revealed the electronic medical record (EMR) basic skin assessment did not lend itself to extensive documentation of a full body assessment. She stated she felt confident a full body assessment had been completed on resident 1 at the time of admission. She confirmed the documentation did not indicate that had been completed. She stated she was the nurse that visited with the physician on 5/9/14 regarding the wound. She confirmed the physician did not visually assess the wound at that time. She did not recall if she had suggested he should look at it.</p> <p>Review of the provider's February 2014 admission checklist revealed a detailed head to toe skin assessment was to have been completed at the time of admission.</p> <p>Surveyor: 30170 2. Review of resident 2's EMR revealed: *He had been admitted on 6/20/14 from the hospital. *His diagnoses had included: -Congestive heart failure (the heart does not pump efficiently and fluid builds up in the lungs and in the lower extremities [legs]). -Weakness. -Dependent gait and mobility (required the assistance of staff for walking and moving). -Renal (kidney) failure. -Edema (swelling in the lower extremities).</p>	F 314			

*Resident 2 was no longer in facility as of July 15, 2014. Unable to accomplish corrective action for this resident.*

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F 314	<p>Continued From page 14</p> <p>-Peripheral vascular disease (poor circulation). *On 6/20/14 the nursing skin assessment on admission revealed he had a stage 2 pressure ulcer on his medial left buttock (in the mid area of his left buttock region). The measurement was 1 centimeter (cm) by 2 cm with scant drainage. *The treatments to the left medial buttock area were as follows: -6/22/14 Aquacel and CombiDERM dressing. -6/29/14 Eucerin lotion. -7/2/14 Wipe the area with SurePrep. *On 7/6/14 he had an abrasion to his midline buttocks area that was 0.5 cm by 1 cm and was left open to air. There was no documentation the physician had been notified. There was no treatment specified for the area.</p> <p>Review of resident 2's 7/4/14 Minimum Data Set (MDS) fourteen day assessment revealed he was: *An extensive assistance of two staff for transfers. *Non-ambulatory. *An extensive assistance of two staff for bed mobility.</p> <p>Review of resident 2's undated Activity of Daily Living care plan revealed: *He was independent with assistance of one staff person. *He was an assistance of one or two staff with transfers. *He used a wheeled walker. *He was dependent (needed help) with all personal hygiene. *No further information had been provided regarding his current skin issues.</p> <p>Review of resident 2's undated Personal</p>	F 314		

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F 314	<p>Continued From page 15 Evaluation Sheet revealed: *He was forgetful and needed to be cued (prompted). *He had a wheelchair and a chair cushion. *There was no information provided regarding his skin issues.</p> <p>Review of the comprehensive care plan for his skin issues dated 7/8/14 revealed: **Monitor skin with all opportunities and notify charge nurse for any new s/s (signs and symptoms) of break down. *Weekly head to toe skin observation by licensed nurse. *PRESSURE REDISTRIBUTION: Pressure redistributing mattress for bed and cushion for chair. Encourage frequent positioning. *Assist to toilet at regular intervals to help promote bowel continence. Provide protective undergarment as needed and meticulous skin care after any incontinent episode. *Refer to eMAR (electronic medical records) for the most updated information on medication and cares." *There was no information in the above care plans that would indicate he was totally dependent on staff for transferring and repositioning.</p> <p>Observation and interview on 7/10/14 at 8:55 a.m. with certified nursing assistants (CNA) C and D during personal care for resident 2 revealed: *The CNAs were assisting him from his wheelchair to his recliner. *The resident's buttocks area was visualized during the transfer after partial removal of his disposable brief. *There were several open areas noted on the left</p>	F 314			

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F 314	<p>Continued From page 16 and the right buttock area.</p> <p>*The CNAs stated SurePrep (alcohol solution) was placed on the wounds, then SensiCare cream was applied during their shift, but there was no regularity to the application of the solution or the cream.</p> <p>*The CNAs transferred the resident with a stand aide (a mechanical lift that assisted in the transferring of the resident) to his recliner. It was noted there was no cushion in his recliner, and the cushion was in his wheelchair. When asked about the cushion in his recliner the CNAs agreed the cushion should have been placed in his recliner prior to his transfer. They both stated they had not toileted him regularly, because he had a Foley catheter (a tube placed in the bladder to drain urine into a bag). So they were unsure as to how many times a day they would apply the SurePrep and the SensiCare cream.</p> <p>Review of resident 2's Braden scale assessments (an assessment performed to predict pressure ulcer risk) revealed: *On 6/20/14 his score was seventeen (mild risk). *On 6/27/14 his score was fifteen (moderate risk). *On 7/4/14 his score was fifteen (moderate risk).</p> <p>Review of resident 2's twice daily nursing assessments on the EMR regarding positioning revealed: *There was documentation he was independent with positioning from 6/20/14 through 6/26/14. *On 6/27/14 there was documentation he was repositioned every two hours. *There was no nursing documentation as the reason he had become dependent on repositioning and/or required staff assistance. *There was no documentation in the nursing assessments he had been repositioned for the</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>following dates and times: -6/29/14 at 9:14 p.m. -7/4/14 at 10:32 p.m. -7/5/14 at 8:00 p.m. -7/6/14 at 8:00 p.m.</p> <p>The following treatments and observations were documented in the nursing assessments: -6/20/14 Aquacel/CombiDERM dressing to left medial buttock. -6/22/14 Aquacel/CombiDERM dressing to left medial buttock. -6/29/14 Wipe area with SurePrep and leave open to air. -7/2/14 Wipe area with SurePrep and leave open to air. -7/6/14 No dressing, open to air, wet, red, and scaly.</p> <p>3. Review of resident 3's complete electronic medical records revealed: *On 6/13/14 she had been admitted from the hospital. *Her diagnoses included: -Diabetes. -Obesity. -Right heel ulcer with surgical debridement (removal of dead tissue so new tissue can grow) on 6/10/14. -Cellulites (redness and swelling) of the lower extremities (legs). -Heart failure. -Peripheral neuropathy (numbness and tingling on the skin). -Chronic venous stasis (poor circulation that could cause open area). *Her Braden Score assessments had been: -On 6/13/14 her score was 12 (high risk) for pressure ulcers.</p>	F 314	<p><i>Resident 3 was discharged from this facility on July 15, 2014. Unable to accomplish corrective action for this resident.</i></p>	
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F 314	<p>Continued From page 18</p> <p>-On 6/21/14 her score was 13 (moderate risk). *On 6/29/14 there was documentation there was a new open area in the crease of her buttocks. There was no documentation the physician had been notified, no current interventions had been put in place to prevent skin breakdown, and no communication regarding the newly observed area to other staff. *There was no consistent documentation in the nursing assessment that the repositioning of the resident had occurred multiple times from 6/13/14 through 7/4/14.</p> <p>Review of resident 3's 6/27/14 fourteen day MDS assessment revealed she was: *Completely dependent on the staff for all transfers. *Non-ambulatory. *An extensive assistance of two staff persons for bed mobility. *An extensive assistance of one staff person for all personal hygiene. *At risk for the development of pressure ulcers.</p> <p>Review of resident 3's 6/13/14 care plan revealed: **Monitor skin with all opportunities and report any abnormal bruising/bleeding or new areas of concern to the charge nurse. *Weekly head-to-toe skin observations by the nurse. *PRESSURE REDISTRIBUTION: Pressure redistributing mattress for bed and cushion for her chair. Heel protectors and floating of the heels (keep the heels off the bed) to avoid pressure, friction, or shearing." *There was no documentation regarding the frequency of repositioning or her history of circulatory problems, numbness, and tingling.</p>	F 314		

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F 314	Continued From page 19  4. Interview on 7/9/14 at 3:30 p.m. with MDS coordinator B regarding Braden scale assessments for all residents revealed: *The assessment was done on all residents. *The residents were scored, and the risk of developing a pressure ulcer was identified. *There were no interventions put in place for those residents at risk of developing a pressure ulcer. *The MDS nurse would assess the fourteen day assessment information after admission. She then would make a determination for any interventions that might have been needed.  Interview on 7/10/14 at 10:00 a.m. with the ADON regarding pressure ulcers revealed: *Pressure ulcers were not staged, because every nurse might interpret the ulcer differently. *The nurses would document the description and the treatment of the pressure ulcer in the EMR assessment area. *She agreed the consistency of the treatments and the description of those pressure ulcers were minimal. *The staff would have used the Patricia A. Potter and Anne Griffin Perry, Pocket Guide to Nursing Skill and Procedures, 7 th Ed., 2007, for reference to nursing standards of practice.  Interview on 7/10/14 at 9:15 a.m. with MDS coordinator B regarding resident 2's pressure ulcer revealed: *The charge nurses were responsible for measuring the areas weekly. *The direct care staff would be notified of changes in regards to the treatments during a shift change report. *The measurements would have been	F 314			

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F 314	<p>Continued From page 20</p> <p>documented weekly in the nursing assessments electronic medical records.</p> <p>Interview on 7/10/14 at 9:30 a.m. with registered dietician A regarding supplements for residents with pressure ulcers revealed: *Nutritional assessments were completed on admission and weekly for residents with skin issues. *Resident 2 had refused to take his supplements. *There had been no request for a multivitamin, because she stated "Physicians were not ordering the multivitamins anymore." *She could not provide documentation in the EMR that resident 2 had refused his supplements. *Resident 2 was not eating well, the dietary department would provide a selective menu and would allow him to eat what he wanted to eat, so he could have received protein in his diet.</p> <p>Observation and interview on 7/10/14 at 11:30 a.m. with registered nurse (RN) E and MDS coordinator B during resident 2's transfer and inspection of his buttock area revealed: *The area was on his left buttock was 4 cm by 3 cm. *There were two new areas observed below the above pressure ulcer that measured 1 cm X 2 cm and 2 cm X 1 cm. *The right buttock pressure ulcer was 1 cm X 2 cm. *The RN agreed the 4 cm X 3 cm area on his left buttock was much larger than previously documented in the nursing assessments, and the right medial area was larger then previously documented on 7/6/14.</p> <p>Interview on 7/10/14 at 1:00 p.m. with the DON</p>	F 314	<p><i>The dietician was interviewed and reported she is aware of the importance of offering supplements to residents with wounds. She will implement a process of documenting when a resident refuses wound nutritional supplements. This information will be noted in the bubble text of the Nutrition Intervention, so that information flows over to the electronic care plan. 12 Monitoring tools will be completed by the dietician monthly. The dietician will</i></p>	
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA MARYHOUSE LONG TERM CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>717 EAST DAKOTA PIERRE, SD 57501</b>	
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F 314	<p>Continued From page 21 regarding residents with pressure ulcers revealed:</p> <p>*The documentation system that was currently in place was not able to provide consistent and accurate assessments.</p> <p>*The Braden scale assessments were performed on admission, but there was no specific interventions for at risk residents.</p> <p>*The resident's individualized care plans were not specific for the current status and interventions in place for skin issues.</p> <p>*The physician notifications regarding identified skin concerns were not always completed.</p> <p>*The current reviewed 7/10/12 Pressure Ulcer policy had minimal information and would not have provided necessary information to the nursing staff.</p> <p>Review of the provider's revised 5/17/14 Pressure Ulcer Prevention policy revealed:</p> <p>*The purpose of the policy was to have improved patient/resident safety by identifying inpatient/residents at risk for healthcare-acquired pressure ulcers, to systematically assess and document skin risk factors; and to have implemented the skin-protection components of care.</p> <p>*Interventions: Implement interventions based on Braden Scale score: -At risk: Braden Score 15 to 18. -Moderate risk: Braden Scale Score 13 to 14. -High: Braden Scale Score 10 to 12. -Very High Risk: Braden Scale Score 9 or below.</p> <p>*There was no indication in the policy of the interventions that were to have been put in place from the above scores.</p> <p>*Communication: A mechanism must have been in place for CNA to RN/LPN (licensed practical nurse) to MD (medical doctor) communication</p>	F 314	<p><i>report these monitors to the QIC quarterly and continue to do so until the QIC advises discontinuation.</i></p> <p><i>A new process for documenting head-to-toe skin assessments was developed using a combination of paper and the electronic record as outlined in the SKIN ALGORITHM. Furthermore, residents with wounds (other than rashes and skin tears) have been assigned to one nurse for weekly documentation for the purpose of consistency and accuracy.</i></p> <p><i>Policy 6312.29: Pressure Ulcer Prevention and Wound Treatment was revised to include specific interventions that staff will be</i></p>	

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F 314	<p>Continued From page 22 regarding the discovery of pressure ulcers.</p> <p>*Documentation: Documentation must have been in the patient/resident record: -Risk Assessment-Braden Scale with timing/frequency as listed. -Malnutrition Screening Tool. -Skin Assessment. -Pressure Ulcer Assessment. -Plan of Care - Interventions documented according to the intervention schedule. -Notification of physician if the pressure ulcer was present on admission or thereafter. *There was no further information in the policy in regards to interventions for those at risk, or for those that had a current pressure ulcer.</p> <p>Review of the provider's June 25 and June 26, 2014 agenda for skills stations education revealed there was a skin assessment skills station provided to the entire nursing staff.</p> <p>Review of the provider's 7/25/13 reviewed and revised Nursing Documentation policy revealed: *The purpose of the policy was to establish a uniform and timely system of documentation for all patients/residents. *To have incorporated as many hand written documents as possible into the paperless system. *Nurses would document by exception. Other staff would document care provided. *Document pertinent, factual, objective data and correct any errors in documentation. *Skin assessment and documentation should have been completed upon return from any hospital/ER visit regardless of the cause or duration.</p> <p>Review of the provider's November 2013 revised</p>	F 314	<p><i>expected to implement based upon a resident's Braden Score. The policy was also updated to reflect that physician notification must occur whenever a pressure ulcer or wound is discovered or appears to be worsening. The newly revised Head-to-Toe Skin Documentation sheet was also updated to include a cue to the nurse to notify the physician for all identified wounds or worsening wounds.</i></p> <p><i>All staff responsible for direct resident care received education that CNAs are to report any newly discovered pressure ulcers or wounds to the charge nurse on duty who will take responsibility for notifying the physician and other applicable individuals. Compliance</i></p>	

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F 314	Continued From page 23 Nutrition Documentation policy revealed: *Documentation of the resident's nutritional care was the responsibility of the dietary professional. *The registered dietitian would document whenever there was a change in patient/resident's food texture, and addition or elimination of nutritional supplements.  Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8 th Ed., 2009, p. 1184, revealed: **A major aspect of nursing care is the maintenance of skin integrity. Consistent, planned skin care interventions are critical to ensuring high-quality care. Nurses constantly observe their patients' skin for breaks or impaired skin integrity. Impaired skin integrity occurs from prolonged pressure, irritation of the skin, and /or immobility, leading to the development of pressure ulcers. *Several instruments are available for assessing patients who are at risk for developing a pressure ulcer. By identifying at-risk patients, you are able to put interventions into place for the at-risk patient and spare patients with little risk for pressure ulcer development the unnecessary and sometimes costly preventive treatment. Prevention and treatment of pressure ulcers are major nursing priorities. *Preventing pressure ulcers is a priority in caring for patients and is not limited to patients with restriction in mobility; impaired skin integrity is not usually a problem in healthy, immobilized individuals but is a serious and potentially devastating problem in ill or debilitated patients."  483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 314	<i>With ongoing assessments, monitoring, physician notification and documentation will be monitored by designated RNs and LPNs (12 monthly). Results will be reported by the DON to the QIC quarterly. These will continue until the QIC advises discontinuation.  The dietician's plan of correction does not involve Residents 1, 2, 3, or 4 as none of them are currently residing in the facility. One resident was discharged in May. Two residents were discharged on July 15, 2014 and one resident had a closed record at the time of the survey.</i>		
F 514 SS=D		F 514			

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F 514	<p>Continued From page 24</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, and policy review, the provider failed to ensure complete and accurate documentation was maintained for three of four sampled residents (1, 2, and 3) related to skin assessments and nutritional interventions. Findings include:</p> <p>1. Review of resident 1's basic skin assessments revealed there was no mention of a wound to the coccyx (tail bone area on the lower back) until the assessment on 5/7/14. Review of a nurse's note on 5/5/14 indicated a 6 cm (centimeter) by 2.5 cm lesion (wound) was noted on the coccyx. Refer to F314, finding 1.</p> <p>2. Review of resident 1's electronic medical record (EMR) interventions documentation revealed moisture barriers were applied at least daily from 5/1/14 through 5/14/14. The statement box related to that intervention indicated "Use sensicare [skin barrier cream] to skin between buttocks and over lesion with all peri [bottom]</p>	F 514	<p><i>A document entitled: Skin Algorithm was created to help guide staff on the new documentation process for skin assessments and wounds when they are present. The new documentation process will involve documentation on paper as well as in the electronic record to help ensure accuracy, accessibility and organization. Compliance with complete, accurate, readily accessible and systematically organized clinical records will be monitored by designated RNs and LPNs (12 monthly). Results will be reported to the DON who will report it to the QIC quarterly until advised by the QIC for</i></p>	8/29/14
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F 514	<p>Continued From page 25 care." There was no further documentation as to what was observed in that area when the cream was applied.</p> <p>Review of the resident's EMR interventions documentation revealed an intervention to view the wound care/dressing. The statement box related to that intervention revealed "Coccyx area: 6 cm by 2.5 cm lesion, black, non-blanchable. Apply house protective ointment. Position off coccyx area." That intervention was documented as being done at least daily from 5/5/14 through 5/14/14. There was no further documentation on a daily basis as to what was observed during the wound care.</p> <p>Review of the resident's EMR interventions documentation revealed an intervention for skin integrity check. The statement box related to that intervention revealed it applied to monitoring the right knee incision. There was no indication the skin integrity of the coccyx area was being monitored.</p> <p>Interview on 7/10/14 at 8:50 a.m. with registered nurse B revealed the EMR basic skin assessment did not lend itself to extensive documentation of a full body assessment. She stated she felt confident a full body assessment had been completed on resident 1 at the time of admission. She confirmed the documentation did not indicate that had been completed. She confirmed the interventions above were documented as being done, but there was no specific documentation to indicate assessments at those times.</p> <p>Surveyor: 30170 3. Review of resident 2's and 3's complete EMR revealed there was lack of consistent and</p>	F 514	<p><i>discontinuation.</i></p> <p><i>Resident 1 was discharged May 14, 2014. Unable to accomplish corrective action for this resident.</i></p> <p><i>Resident 2 was no longer in facility as of July 15, 2014. Unable to accomplish corrective action on this resident.</i></p> <p><i>Resident 3 was discharged from the facility on July 15, 2014. Unable to accomplish corrective action for this resident.</i></p>	

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F 514	Continued From page 26 accurate documentation regarding current pressure ulcers, treatments, and interventions, and refusal of offered nutritional supplements. Refer to F314, findings 2 and 3.	F 514			