



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2125 5921

December 3, 2014

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

FILE COPY

Provider #: 135130

Dear Mr. Frasure:

On **November 18, 2014**, a Complaint Investigation survey was conducted at Aspen Transitional Rehabilitation by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be **ISOLATED** and to constitute immediate jeopardy to residents' health and safety. You were informed of the immediate jeopardy situations in writing on **November 17, 2014**.

On **November 18, 2014**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction. The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is isolated in scope, as evidenced by the Form CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that

each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 16, 2014**. Failure to submit an acceptable PoC by **December 16, 2014**, may result in the imposition of additional civil monetary penalties by **January 5, 2015**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Based on the immediate jeopardy cited during this survey;

F314 -- S/S: J -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores

Joseph Frasure, Administrator
December 3, 2014
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We are recommending to the Centers for Medicare & Medicaid Services (CMS) Regional Office that the following remedies be imposed:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

A 'per instance' civil money penalty of \$10,000.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 18, 2015**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F314 -- S/S: J -- 42 CFR §483.25(c) -- Treatment/Services to Prevent/Heal Pressure Sores

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents #4 as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

STATE ACTIONS effective with the date of this letter (**December 3, 2014**): none

If you believe the deficiencies have been corrected, you may contact Lorene Kayser, L.S.W.,

Joseph Frasure, Administrator
December 3, 2014
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Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **December 16, 2014**. If your request for informal dispute resolution is received after **December 16, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2014
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation of your facility on November 12, 2014 through November 18, 2014. An Immediate Jeopardy (IJ) was identified at F 314. The facility was notified of the IJ verbally and in writing on 11/17/14 at 2:30 p.m., and an acceptable abatement plan was presented to the survey team on 11/18/14 at 4:00 p.m.</p> <p>The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator, Linda Hukill-Neal, RN, and Arnold Rosling RN, BSN, QMRP.</p> <p>Survey Definitions: BIMS = Brief Interview for Mental Status DON = Director of Nursing IDT = Interdisciplinary Team LN = Licensed Nurse LTC = Long Term Care MD = Medical Doctor MDS = Minimum Data Set assessment NP = Nurse Practitioner PRN = As needed Q = Every</p>	F 000	<p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>	
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</p>	F 157	<p>A root cause analysis has been performed as to the cause of these deficiencies and the following plan of correction has been developed.</p> <p style="text-align: right;">ACCEPTED JAN - 2 2015 FACILITY STANDARDS</p>	

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

TITLE

(X6) DATE

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.

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

PRINTED: 12/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F 157	<p>Continued From page 1</p> <p>status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to notify the physician when three Stage II pressure ulcers were present on admission then deteriorated to unstageable for 1 of 5 residents (#4) reviewed for pressure ulcers. The failure created the potential for harm when the resident's physician was not given the opportunity to make medical decisions based on the resident's needs. Findings included:</p> <p>Resident #4 was admitted to the facility on 10/6/14 with diagnoses that included multiple myeloma (metastatic cancer); post operative vertebrectomy of the 2nd thoracic vertebrae (T2)</p>	F 157	<p>F 157</p> <p>Patient Specific:</p> <p>Patient number 4 has been discharged.</p> <p>Other Patients:</p> <p>All patients with pressure sores on admit, who develop pressures sores and/or with deterioration of pressure sores have been audited and their physician has been notified and said notification has been documented.</p> <p>Systemic Changes:</p> <p>Licensed staff have been inserviced in regards to notification of the physician if the patient admits with a pressure sore, if the patient develops a pressure sore and/or if a patient's pressure sore deteriorates.</p>	

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F 157	<p>Continued From page 2</p> <p>with tumor resection and implantation of an expandable cage at T1-3; laminectomy and fusion at T1-5; paraplegia; bacteremia due to tooth abscess; hypertension (high blood pressure); and, neurogenic bladder and bowel.</p> <p>The resident was transferred to a second LTC facility on 10/27/14 and less than 24 hours later he was diagnosed with septic shock and a necrotizing gangrenous sacral wound in a hospital emergency department.</p> <p>The resident's 10/5/14 Transfer Orders to Subacute Care and Physician Order Report for 10/6/14-11/6/14 did not contain any orders for PU/open wound care or treatment.</p> <p>The resident's 10/6/14 Admission Assessment documented 3 Stage II pressure ulcers (PUs) on the coccyx and left and right buttocks were present on admission.</p> <p>Resident Progress Notes (RPNs) for 10/6/14-10/27/14 contained documentation that deep tissue injury developed on or near the aforementioned Stage II PUs and they deteriorated to unstageable with weeping PUs after an emergency room visit on 10/11/14. Please refer to F314 for details regarding the deterioration of the PUs.</p> <p>There was no documented evidence in the clinical record that the facility notified the physician about the PUs when the resident was admitted to the facility; when he was seen by the physician on 10/9/14; when staff noted the deep tissue injury, then eschar and weeping; or when a NP visited the resident on 10/13/14, 10/20/14, and 10/27/14.</p>	F 157	<p>Monitors:</p> <p>The Director of Nursing or her designee will review all patients with pressure sores weekly times 26 to ensure that the physician has been notified of patients who have been admitted with a pressure sore, develops a pressure sore or the pressure sore deteriorates and that documentation of said notification is in place.</p> <p>She will report her findings at the Q.A. meetings and make changes to the above plan of correction as needed.</p> <p>Date of Compliance: 12/8/2014</p>	

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F 157	Continued From page 3	F 157			
F 314 SS=J	<p>On 11/14/14 at 3:07 a.m., the DON and Nurse Manager (NM) were asked if orders for PU care and treatment were in place when the resident was admitted. The DON stated, "[Name of hospital] did not send any orders." When asked if the physician was notified of the PUs and asked for orders upon the resident's admission, the NM indicated no. When asked for documentation that the physician or NP was notified about the PUs, the DON stated, "No documentation."</p> <p>The facility did not provide any other information which resolved the notification issue.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff and a Nurse Practitioner (NP), record review, policy review, and complaint from the general public, it was determined the facility failed to notify the physician and seek treatment when existing stage II pressure ulcers (PUs) deteriorated to unstageable for 1 of 5 residents (#4) reviewed for pressure ulcers (PUs). The facility failed to</p>	F 314	<p>F 314</p> <p>Patient Specific:</p> <p>Patient numbers 1,2,3,4 and 5 have been discharged</p> <p>Other Patients:</p> <p>All current patients with pressure sores (if any) have:</p> <ol style="list-style-type: none"> 1. Physician orders in place for pressure ulcer care and treatment, including orders from the pressure ulcer risk 		

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F 314	<p>Continued From page 4</p> <p>ensure Resident #4's PUs were appropriately assessed by the physician, NP or facility nursing staff; appropriate devices were utilized to prevent pressure; physician orders for PU care/treatment were in place upon admission; and, Standing Orders for treatment of open wounds were implemented. In addition, topical medication and dressings were applied to the resident's buttocks/PUs without physician orders. The resident was hospitalized with septic shock attributed to a large necrotizing gangrenous sacral wound. The resident received IV (intravenous) fluids and an IV medication "for resuscitation." Two broad spectrum IV antibiotics were started in the emergency department (ED), and the wound was promptly surgically debrided. These failures resulted in immediate jeopardy for Resident #4's health and safety.</p> <p>The facility also failed to conduct thorough initial and at least weekly PU wound assessments for the other 4 residents (#s 1, 2, 3 and 5), which created the potential for more than minimal harm should the residents' existing PUs worsen or new PUs develop.</p> <p>On 11/17/14, the facility's Administrator was informed verbally and in writing of the IJ. The Administrator was provided with details regarding the failures related to Resident #4's worsened and unstageable PUs and the overall lack of appropriate care and treatment of the PUs.</p> <p>On 11/18/14 at 4:00 p.m., the facility's Administrator provided the survey team with an acceptable abatement plan and the immediate jeopardy was abated.</p> <p>The abatement plan noted Resident #4 had been</p>	F 314	<p>protocol and care plan form.</p> <ol style="list-style-type: none"> 2. Medicated ointments and dressings are only applied to pressure sores after obtaining a physician's order. 3. Skin integrity is accurately and consistently assessed after admission and at least weekly and include PU characteristics such as depth; condition of the wound bed, wound edges and surrounding skin; and whether or not there was drainage, odor, or associated pain. 4. Physicians are notified of changes in the patients' pressure ulcers. 5. Appropriate interventions, care and treatment are provided to existing pressure ulcers to promote healing. 6. Donuts are not utilized in the facility. 	

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F 314	<p>Continued From page 5</p> <p>discharged and included review and head to toe skin checks for all current residents with PUs, licensed staff in-services regarding PU care and treatment, and weekly visual review of residents with PUs. The date of compliance was November 17, 2014.</p> <p>Findings included:</p> <p>During the complaint investigation, the facility's PU policies and procedures (P&P) were reviewed. They included: PU Prevention; Assessment and Intervention; Treatment of PU; Documentation of Wounds; and Weekly Skin Report.</p> <p>The facility did not follow these P&Ps for the identified residents. Physician's orders were not always in place or obtained when residents were admitted with PUs, when PUs deteriorated, or when new PUs developed. Standing Orders for treatment of open wounds were not enacted and specific orders requested; conversely, some treatments were performed without physician orders. There was no documented evidence that residents' physicians were always notified about negative PU changes. Residents' clinical records lacked documentation of thorough initial and at least weekly PU assessments for tracking and monitoring. The facility did not consistently provide the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>1. Resident #4 was admitted to the facility on 10/6/14 with diagnoses that included multiple myeloma (metastatic cancer); post operative vertebrectomy of the 2nd thoracic vertebrae (T2); laminectomy and fusion at T1-5; paraplegia;</p>	F 314	<p>Systemic Changes:</p> <p>All current patients have had a head to toe skin check performed by a licensed nurse. Anyone with a pressure sore has been reviewed to ensure that items one through six (see above) are in compliance by the clinical nurse manager or their designee. Written inservicing has been provided to licensed staff in regards to the above six items. This information was also reviewed at the staff meeting.</p> <p>The root cause identified was that the wound was of such a complex</p>		

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F 314	<p>Continued From page 6</p> <p>bacteremia due to tooth abscess; hypertension (high blood pressure); and, neurogenic bladder and bowel.</p> <p>The resident's 10/5/14 Transfer Orders to Subacute Care and his Physician Order Report for 10/6/14-11/6/14 did not contain any orders for PU/open wound care or treatment.</p> <p>The resident's 10/6/14 Admission Assessment documented 3 Stage II PUs. They were: coccyx - 2 x (by) 0.5 cm; left (L) buttock - 1.5 x 1.5 cm; and right (R) buttock - 4 x 1.5 cm. Dry and flaky areas were also noted: L buttock - 1.5 x 1.5 cm and R buttock - 2.5 x 2.5 cm. "Granulation tissue" was documented.</p> <p>The Admission Assessment did not include other PU characteristics, such as depth; condition of the wound bed, wound edges and surrounding skin; and, whether or not there was drainage, odor, or associated pain.</p> <p>A 10/6/14 Braden Risk Assessment Scale documented the resident's risk for PUs was 13, or moderate risk.</p> <p>The goal for the resident's 10/6/14 interim PU Risk Protocol/Care Plan was, "...decreased risk of developing pressure ulcers with appropriate interventions..." The interventions included: * Minimal Risk - "Pressure Reducing Mattress, Standard Wheelchair Cushion, Weekly Skin Assessment by LN [licensed nurse], PT/OT [physical and occupational therapy] Eval[uation] & [and] Treatment, Patient Education." * Low Risk - Assist/prompt Turn Q [every] 2 hours [and] Barrier Ointment." * Moderate Risk - "...Air Mattress."</p>	F 314	<p>nature that outside resources should have been utilized for additional expertise and monitoring.</p> <p>All patients with pressure sores are assessed by the patient's physician or physician extender.</p> <p>All patients with pressure sores (excluding Stage 1 pressure sores) are being referred to the wound clinic for additional expertise and monitoring.</p> <p>Any patients that have pressure sores are discussed and reviewed at each morning meeting to ensure that all of the above six items have been addressed.</p> <p>Additional training materials were obtained from outside resources that include pressure sore assessment, treatment, classification, prevention, change in condition, documentation, and terminology. Training was also provided on acceptable pressure sore prevention/treatment devices and on proper notification of physicians .</p>	

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F 314	Continued From page 7 A 10/9/14 Short Physician Order documented, "Criticaid [sic] cream to be applied to buttocks Q shift and PRN." A 10/13/14 admission MDS assessment documented the resident had intact cognition with a BIMS score of 15; extensive assistance was needed for bed mobility, transfers, and toileting; he was unsteady moving from a seated to standing position and surface-to-surface transfers without staff assistance; limited range of motion in both upper and lower extremities; indwelling urinary catheter was in place; and 3 Stage II PUs present on admission. The resident's undated initial care plan included: * Problem: "Risk for impaired skin integrity. Approaches: "Pressure reducing mattress, Cushion to wheelchair, Encourage and/or assist to reposition at least every 2 hours...Monitor skin daily during cares and report changes to LN/MD [licensed nurse/physician]...Barrier ointment QS [every shift] PRN [as needed]." * Problem: "Actual Impaired Skin Integrity related to: Site 1: 2 unstageable wounds to (R) & (L) buttock, Site 2: 2 stage II pressure wounds to (R) & (L) upper buttock, Site 3: Stage II to coccyx [and] Spinal incision" Approaches: "Treatment per current MD orders, Monitor for increased redness, change in skin temp[ature], or abnormal exudates, Measure wound area(s) at least weekly to monitor response to treatment, Keep affected areas clean, dry and minimize irritation and pressure, Request supplements and increased protein to promote healing per RD [registered dietitian] and MD order, Air Mattress to bed, Pressure Displacement Cushion to w/c [wheelchair]...Barrier Ointment QS [every shift]"	F 314	Monitors: At each morning meeting anyone with a pressure sore will have their chart reviewed to ensure that the above six items have been addressed and are in place. For the next 26 weeks. The Administrator or his designee will oversee the review. If any issues are identified the Director of Nursing will ensure and document further education and/or appropriate disciplinary action. Date of Compliance: 12/8/2014		

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F 314	<p>Continued From page 8 and PRN [and] Encourage and assist patient to reposition at least every 2 hours."</p> <p>Resident Progress Notes (RPNs) documentation, dated 10/6/14 - 10/27/14, included: * 10/6 at 1:46 p.m., 5:58 p.m., 8:47 p.m. and 11:45 p.m. - PUs were not mentioned. * 10/7 at 10:53 a.m. - "...Miller's Mix applied to buttocks..." * 10/8 at 11:35 a.m. - "...Open areas to buttocks cleansed and Miller's mix applied as per MD order..." Note: Miller's Mix was not included in any physician's orders. * 10/9 at 8:28 a.m. - Physician saw resident. * 10/11 at 11:51 a.m. - sent to an ED, returned to the facility at 5:00 p.m., the buttocks and coccyx were, "...dark red, and has dry peeling flaking skin. (R) Buttock has 5.5 x 3.5 cm open areas [with] deep purple tissue 9 x 6 cm surrounding open areas. Left buttock has a 3.5 x 1.5 cm open area surrounded by dark red to purple area 9 x 5 cm..." * 10/12 at 2:39 p.m. - "...Buttocks open areas and deep tissue areas were cleaned..." * 10/12 at 10:24 p.m. - "...Buttocks skin is excoriated and dark red to purple in color..." * 10/13/14 at 1:40 a.m. - "...Buttocks excoriated bilat[eral], darken areas unstageable..." * 10/13/14 at 7:51 a.m. - NP saw resident. * 10/14/14 at 6:23 p.m. - "...Bedsore on the bottom was cleaned, protective skin lotion applied with a silver cloth. Ulcers is [sic] partially covered with black color Escher [sic], open area is red and seeping. Note: Silver cloth was not included in any physician's orders. * 10/20/14 at 9:12 a.m. - NP saw resident. * 10/21/14 at 9:25 a.m. - "...right buttock with</p>	F 314		
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F 314	Continued From page 9 black area measuring 6 x 4 cm and with open area measuring 6 x 5.5 cm...left buttock has black/deep tissue injury measuring 6 x 5 cm and open area measuring 4 x 4.5 cm. The open areas are surrounding the black/deep tissue injury parts, and they have new tissue and active bleeding...." * 10/21/14 at 10:56 p.m. - "...On an air cushion at the buttocks and on a [sic] air mattress..." * 10/24/14 at 11:01 p.m. - "...Buttocks wound cleansed as ordered...Left buttock with large area of eschar and the right buttock has improved with pink tissue that readily bleeds with cleansing..." * 10/26/14 at 9:13 p.m. - "...Buttocks wound cleansed and silver cloth applied. Pt is on air mattress and a donut..." * 10/27/14 at 7:22 a.m. - NP saw resident and "Discharging to [name of other LTC facility] today...They are aware of his wound on his buttocks/coccyx and will continue to treat..." * 10/27/ at 11:50 a.m. - "...change in his wound this am r/t [related to] noted drainage in his attends [with] foul odor. Measurements...(L) Buttock unstageable area 10 x 4 cm...Black/Brown Eschar full thickness, (R) buttock unstageable area 6 x 7 cm full thickness Black/brown eschar. (R) buttock outer edge of eschar 1.8 x 5.5 @ [at] end of buttock...active bleeding [with] dressing change [with] pink tissue, (L) buttock outer edge of eschar @ the bottom 2.5 x 1.7 cm...active bleeding noted [with] dressing change. Sacral area note [sic] to have new area [with] redness, warm to touch, blanchable...Notified...NP...who seen [sic] him earlier this am...update to [name of other facility] that he would need to see skin specialist for possible debridement of wound. Notified patient of wound change...spoke [with] [name of other facility staff]...gave report..."	F 314			

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F 314	<p>Continued From page 10</p> <p>On 11/13/14 at 3:30 p.m., the Nurse Manager (NM) was interviewed about the resident's PUs. The NM stated, "I may go in to peek at residents' skin when the med [medication] nurses are doing skin checks but I do not actually do the assessments." The NM said the nurses gave her PU wound assessment information and she entered it on the Weekly Skin Report-PU (WSR-PU). She added, "The med nurses don't usually stage pressure ulcers." The NM provided 4 WSR-PU forms dated 10/10/14, 10/16/14, 10/24/14, and 10/31/14 with information regarding Resident #4 and other residents (the other residents' names and information were redacted). The reports included areas to note where PUs were acquired, location, actual stage, size, "visual stage," drainage/amount, description, current treatment orders, frequency of treatment, drainage type, other interventions, and date resolved.</p> <p>The WSR-PU reports noted the following for Resident #4: * 10/10/14 - Four Stage II PUs: 2 on (L) buttock, 1 on (R) buttock, and 1 on coccyx, all with scant drainage. Treatment was normal saline (NS)/Critic-aid gel. * 10/16/14 - Two Unstageable and 2 Stage II PUs at (L) and (R) buttocks and 1 Stage II PU at coccyx. (L) Unstageable: "10 x 5 dark color skin non blanchable from ER [emergency room] visit" and (R) Unstageable: "93.5 cm dark color skin nonblanchable from ER visit." "Barrier cream" 3 times/day and PRN" was the treatment for the Unstageable PUs; 3 Stage II PUs: "L top buttock area open, raw, S.T. with dry flaky skin[:]; R inner buttock, open, raw, with dry flaky skin[:]; Coccyx open redness." Scant drainage noted for all and</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>the treatment was NS/Critic-aid 3 times/day and PRN. All were noted as "worsened."</p> <p>* 10/24/14 - Two Unstageable and 2 Stage II PUs at the (L) & (R) buttocks. "Barrier cream, Silver cloth" was the treatment. The Stage II PUs had scant serosanguinous drainage. Protective devices included a "donut." The coccyx PU was not mentioned.</p> <p>NOTE: The Hartford Institute for Geriatric Nursing (HIGN) and Wound, Ostomy, and Continence Nurses Society (WOCN) are in "agreement that donut-type devices should not be used for pressure redistribution ... The use of a pressure-reducing device (not a donut), is recommended by both groups for chair-bound clients." [http://www.guideline.gov].</p> <p>* 10/31/14 - Essentially the same documentation as the 10/24/14 WSR-PU.</p> <p>The interview with the NM continued. The NM reviewed the resident's RPNs then acknowledged that staging and other PU characteristics were not consistently documented in the RPNs. The NM stated, "It should be in there." The NM said she put the stages and other PU characteristics on the WSR-PU reports herself "because I did see the resident's pressure ulcers but I did not make an entry of my observations except on 10/27/14." When asked about the donut, the NM stated, "There's no order for the donut." When asked when the donut was implemented, the NM stated, "I honestly don't know where it came from." When asked for wound care orders, the NM stated, "There are none. I know it's not there." When asked if silver cloth should be used without an order, the NM stated, "No." When asked for documentation that Critic-aid was applied to the</p>	F 314			

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F 314	<p>Continued From page 12 buttocks/PUs, the NM reviewed the Treatment Record (TR) and stated, "It's not here."</p> <p>There was no documented evidence in the clinical record that the facility notified the physician about the PUs when the resident was admitted, when the physician saw the resident on 10/9/14, or when the NP saw him on 10/13/14, 10/20/14, and 10/27/14; nor, when the staff noted deep tissue injury, then eschar and weeping. In addition, there was no evidence that the facility conducted a thorough PU assessment when the resident was admitted and at least weekly thereafter.</p> <p>Note: Please refer to F157 for details about the lack of physician notification.</p> <p>On 11/13/14 at 12:30 p.m., the DON was asked for the order for Miller's Mix. The DON stated, "I didn't see one. I wonder if they got the Miller's Mix mixed up with the Critic-aid." When asked if there was any place, other than Resident Progress Notes, to document about PUs, the DON stated, "No." All physician orders and information about Miller's Mix was requested.</p> <p>On 11/13/14 at 2:30 p.m., the DON provided Standing Orders signed by the resident's physician on 10/9/14. It included the order, "Open wounds: Select per...Wound Dressing Selection Guide protocol." The DON also provided the Compound Template for Miller's Mix which listed Triamcinolone 0.1% cream, Calmoseptine ointment, and Lubri-skin lotion as the ingredients. She was asked to provide the wound care protocol.</p> <p>On 11/14/14 at 10:30 a.m., the DON was again</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>interviewed. When asked about the WSR-PU reports and the lack of PU information in the resident's clinical record, the DON said the WSR-PU reports were not part of the resident's clinical record, but rather they were a tool for the NM to monitor PUs. She stated, "It's important for the measurements." When asked if PU measurements/information was documented in any other place, the DON stated, "It's supposed to be in the nurses' notes. I hope."</p> <p>On 11/14/14 at 11:25 a.m., LN #1 was interviewed. The LN said she did the resident's admission assessment and that all 3 of the Stage II PUs were superficial.</p> <p>On 11/14/14 at 12:40 p.m., LN #2 was interviewed. The LN said she was on duty when the resident returned from the ED on 10/11/14 and she assessed him after dinner. The LN stated, "He had some darkness, darker areas, it seemed like, since the last time I took care of him. There were open areas on it and dry flaking areas around the open areas. It looked darker red. The overall size didn't seem bigger, it just seemed deeper, redder." The LN said the resident told her he had been on a gurney the entire time while in the ED. When asked what deeper and redder meant to her, the LN stated, "It would be a cause for concern." When asked if she reported the change, the LN stated, "I can't remember." The LN was asked what the process was for reporting a problem. She stated, "You would alleviate the pressure and monitor. Unfortunately for him it got worse." When asked about the use of Critic-aid, the LN reviewed the TR and stated, "I'm not seeing it. I know we cleaned him every night after bowel care with wound cleanser. There was not a dressing per</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>se, just a silver cloth." When asked if silver cloth was documented, the LN reviewed the TR again and said, "I don't see it on there. It's not on there." The LN stated, "It seemed to me it was darker in color the next day." When asked if she notified the resident's physician then or at any time regarding the changes in the resident's PUs, the LN stated, "I did not call the physician. I believe I just talked to my nurse manager about his skin."</p> <p>On 11/14/14 at 3:07 p.m., the DON and NM were interviewed together. The DON provided a document, which she labeled as "Wound Care protocol." It listed a variety of products for use according to wound color (black, yellow, red, red-pink, and pink), description, exudate, and depth. The DON said, however, there were no specific orders for the resident's PUs. When asked if they had PU care/treatment orders when the resident was admitted to the facility, the NM stated, "Maybe we didn't have orders but we were treating him." Regarding the PUs, the NM stated, "It merged when it became the bad one when he came back from the hospital." When asked if the resident's physician or NP were informed, the NM stated, "No, that was a weekend." When asked if the on-call physician was notified, the NM stated, "There's always someone on call." Regarding the use of a donut, the NM stated, "Nursing thought it was [Physicial] Therapy. Therapy does not have anything." They were again asked if the physician or NP was notified at any time. The NM stated, "Not that it's documented." When asked who oversaw the skin program, the NM stated, "I guess it would be me." When asked if the Wound Care Protocol was followed, the DON stated, "No."</p> <p>The physician's 10/9/14 visit note and the NPs</p>	F 314		

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F 314	<p>Continued From page 15</p> <p>visit notes for 10/13/14, 10/20/14, and 10/27/14 did not contain any documented evidence that either of them [physician or NP] assessed the PUs during the resident's stay in the facility. Note: Refer to F386 for details regarding physician visits.</p> <p>On 11/17/14 at 12:10 p.m. the NP was interviewed per telephone. The NP recalled the resident and said she had assessed him in the facility. When asked if she had assessed the resident's PUs, the NP said that if she did "it would be documented in the physical assessment and I would have included characteristics, like size, etc." The NP said if it was not documented in the physical assessment or assessment/plan, "I wouldn't have physically seen it then." The NP added, "I knew about the issues on his backside. They were communicating with me. I want to say he was improving." When asked if "improving" was based on communication with the staff, the NP stated, "Right. Yeah, I don't think I physically saw it."</p> <p>On 11/18/14 at 2:15 p.m., the Administrator indicated the facility was not responsible for the worsened condition of the resident's PU because the resident came back to the facility with unstageable PUs after a hospital visit. When asked if the facility notified the resident's physician of the worsened condition of the PU's, the Administrator stated, "We don't have that." The Administrator said the first time the facility realized there was a problem was when the resident "was going out the door when he was discharged."</p> <p>The resident was transferred to another LTC facility (Facility #2) on 10/27/14.</p>	F 314		

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F 314	<p>Continued From page 16</p> <p>Clinical records from the receiving facility, Facility #2, documented: * 10/27/14 Initial Data Collection Tool/Nursing Service - large area of eschar and redness over most of the buttocks. * 10/27/14 at 6:24 p.m. Progress Notes (PNs) - "...wound to coccyx, which is eschar in color, redness noted around the edges, with some bleeding noted..." * 10/28/14 at 2:18 a.m. PN - "Coccyx is eschar in color with red around the edges. Some bleeding was noted..." * 10/28/14 at 9:31 a.m. PN - "...admitted yesterday with a very large, complex, unstageable pressure wound to entire sacrum and down buttocks...buttocks is black eschar, soft and unstable with some openings that weep foul seropurulent and small amt [amount] of sanguineous drainage...Unable to dress area d/t [due to] size and location, I have contacted wound MD for tx [treatment] options. [Wound physician's name] feels that betadine paints BID [twice/day]...to try and dry out eschar...was in the process of asking PCP [primary care physician] for these order, but staff noted resident to be quickly declining with poor color, temp, very low b/p [blood pressure] and [increased] pain...sent out to ER [emergency room]..."</p> <p>The 10/28/14 ED/ER records documented, "History of Present Illness: ...has had a decubitus ulcer on his sacral area...fever to 103 and blood pressure of 60/40. He is awake and alert...he does have sacral pain... Physical Examination: Back: ...does have pain at the sacral region and a large necrotic appearing pressure ulcer...approximately 10 cm x 12 cm...black with crepitation to palpation... Emergency Department</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>Course and Medical Decision Making: ...evidence for acute sepsis with fever, hypotension and tachycardia...sacral wound shows evidence for crepittance and subcu air...CT shows diffuse soft tissue air and stranding consistent with necrotizing gangreous wound...infused 2 liter of normal saline...and covered broadly with antibiotics of vancomycin and Zosyn. The CT was obtained emergently...The patient was termed a code sepsis and [physician's name] from the Intensive Care Unit evaluated the patient... After the findings on the CT scan, [physician's name] from General Surgery was consulted...and took him promptly to the Operating Room [OR] for a wound debridement. Diagnostic Impression: 1. Septic shock. 2. Necrotizing gangrenous sacral wound.</p> <p>The 10/28/14 Hospital History and Physical documented, "Objective: ...Backside: ...large eschar roughly 8 cm x 8 cm with warm erythematous-skin surrounding...also exhibits some crepitus. It is severely foul smelling... Assessment and Plan: ...found to be in severe septic shock with extensive necrotizing soft tissue infection. 1. Sacral pressure ulcer with secondary necrotizing soft tissue infection... Assessment and Plan by System: ... Skin: ...severe necrotizing skin infection. Surgery was consulted in the Emergency Room...and decided to take him directly to the OR for debridement...placed on Vancomycin, Zosyn, and clindamycin...will continue antibiotic therapy once admitted to the ICU. He likely will need serial operations to debride this extensive injury, possibly involving reconstructive surgery..."</p> <p>Resident #4 was harmed when the facility failed to notify the physician when deep tissue injury,</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>then eschar and weeping occurred, used a donut at the resident's buttocks, did not obtain PU care/treatment orders upon admission or obtain specific orders when Standing Orders were signed 3 days after admission, applied medications/dressing to the buttocks/PU without orders, did not conduct thorough PU assessments upon admission and at least weekly thereafter, and did not ensure the physician or NP assessed the resident's PUs.</p> <p>2. Resident #1 was admitted to the facility on 10/13/14 with diagnoses that included acute renal failure and altered mental state likely due to acute respiratory failure and possible infection.</p> <p>The resident's 10/13/14 Admission Assessment documented 2 Stage II PUs as follows (L) buttock - 1 x 2 cm "open area" and (R) buttock - 1 x 0.5 cm "open area" with "surrounding dryness bilat[erally]. However, no other PU characteristics, such as depth; condition of the wound bed, edges and surrounding skin; and whether or not there was drainage, odor, or pain were documented.</p> <p>A 10/13/14 Braden Risk Assessment Scale documented the resident's risk for PUs was 20, or low risk.</p> <p>A 10/13/14 interim PU Risk Protocol/Care Plan documented the resident was at risk to develop PUs related to impaired mobility. The goal was, "...decreased risk of developing pressure ulcers with appropriate interventions..." Minimal and Low risk interventions were both marked, they included: * Minimal Risk - "Pressure Reducing Mattress, Standard Wheelchair Cushion, Weekly Skin</p>	F 314			

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F 314	<p>Continued From page 19</p> <p>Assessment by LN [licensed nurse], PT/OT. [physical and occupational therapy] Eval[uation] & [and] Treatment, Patient Education." * Low Risk - Assist/prompt Turn Q [every] 2 hours [and] Barrier Ointment."</p> <p>The resident's undated initial care plan included: * Problem: "Risk for Impaired Skin Integrity related to: decreased Mobility." Goals: "...will not develop additional pressure ulcers..." Approaches: Monitor skin daily during cares and report changes to LN/MD." * Problem: "Actual Impaired Skin Integrity related to: Site 1: admitted [with] 2 Stage II pressure ulcers to (R) [and] (L) buttocks." The problem was crossed out with a single line and noted as "healed 10/27/14."</p> <p>The resident's Physician Order Report for 10/13/14 - 11/13/14 documentation included: * 10/13/14 - Weekly skin assessments on Mondays, document "[positive] results" in nursing notes; and, * 10/14/14 - "Millers Mix to open/dry areas to buttocks" every shift.</p> <p>The resident's 10/20/14 admission MDS assessment documented intact cognition with a BIMS score of 15; extensive assistance needed for bed mobility, transfers, and toileting; unsteady moving from a seated to standing position, moving on and off a toilet, and surface-to-surface transfers without staff assistance; limited range of motion in both lower extremities; and 2 Stage II PUs were present on admission.</p> <p>The resident's Treatment Administration History (TRH) dated 10/13/14 - 11/12/14 documented weekly skin assessments were done every</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>Monday during that time frame with the comments, "butoff [sic] has healed" noted on 10/27 and "bottom is healed, no open soars [sic]" noted on 11/3/14. It also documented that Miller's Mix was administered 3 times/day (every shift) from 10/14/14 through 11/12/14.</p> <p>Per the surveyor's request, on 11/13/14 at 2:30 p.m., the DON provided a Compound Template for Miller's Mix which listed Triamcinolone 0.1% cream, Calmoseptine ointment, and Lubri-skin lotion as the ingredients.</p> <p>RPNs dated 10/13/14 - 11/13/14 documented the Stage II PUs decreased to 0.5 x 0.5 cm on the (L) and 0.2 x 0.2 cm on the (R) by the next day, 10/14/14. No other PU characteristics were documented that day and no PU assessments were documented after 10/14/14. Thirteen days later, on 10/27/14, the PUs were noted as "healed" and "Zero redness and zero open areas."</p> <p>On 11/13/14 at 10:00 a.m., with the resident's permission, the surveyor observed while LN #4 assessed her skin. The resident's buttocks, sacrum, and coccyx were intact without redness or dry skin.</p> <p>On 11/14/14 at 1:50 p.m., the DON and NM were interviewed. When asked if the resident's PUs were thoroughly assessments on admission and thereafter, the NM stated, "No. It's not documented." The DON nodded her head "yes" in agreement.</p> <p>3. Resident #5 was admitted to the facility on 8/12/14 with diagnoses for rehabilitation and aftercare related to a heel trauma fracture. The</p>	F 314			

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F 314	<p>Continued From page 21 resident discharged from the facility on 9/25/14.</p> <p>The resident's 8/12/14 Admission Assessment documented one Stage II PU with epithelial tissue was present on the resident's right heel. It was noted as a blister that measured 2 x 2.3 cm. No other PU characteristics, such as depth; condition of the surrounding skin; and whether or not there was drainage, odor, or pain were documented. One healed Stage II PU was also documented but there was no indication where the healed PU was.</p> <p>An 8/12/14 Braden Risk Assessment Scale documented the resident's risk for PUs was 18, or low risk.</p> <p>An 8/12/14 PU Risk Protocol/Care Plan documented the resident had current PUs related to impaired mobility. The goal was, "...decreased risk of developing pressure ulcers with appropriate interventions...[and] ...current pressure ulcer(s)...will heal...within 30 days..." Interventions included: "Low Risk" with "Assist/Prompt Turn Q [ever] 2 Hours [and] Barrier Ointment." Minimal Risk and Moderate Risk were not marked themselves; however, all interventions under minimal risk were checked, "Pressure Reducing Mattress, Standard Wheelchair Cushion, Weekly Skin Assessment by LN [licensed nurse], PT/OT [physical and occupational therapy] Eval[uation] & [and] Treatment, Patient Education" and "Heelz Up" under moderate risk was checked.</p> <p>The resident's initial care plan included: * Problem: "Risk for Impaired Skin Integrity related to: decreased Mobility." Goals: "...will not develop pressure ulcers..." Approaches: "Monitor</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>skin daily during cares and report changes to LN/MD."</p> <p>* Problem: "Actual Impaired Skin Integrity related to: Site 1: Admitted [with] 2 Stage II (R) heel de-roofed blister. Goals: "Area(s) of concern will heal...within 30 days." Approaches: "Treatment per current MD orders[,] Multi-Podus Boot: (R)."</p> <p>The approach, "Measure wound area(s) at least weekly to monitor response to treatment" was not checked.</p> <p>The resident's Physician Order Report for 9/22/14 - 10/22/14 included:</p> <p>* 8/12/14 "Right heel-cleanse with NS, change Allevyn drsg Q3d & PRN [right heel-cleanse with normal saline, change Allevyn dressing every 3 days and as needed]" and</p> <p>* 8/12/14 "Weekly Skin Assessment" on Mondays with instructions to document "(+) [positive] results" in nursing notes.</p> <p>The resident's Treatment Administration History for 8/12/14-9/11/14 and 9/12/14-9/25/14 documented:</p> <p>* Skin assessments were done every Monday with negative results except on 9/25/14 when "heels boggy, heel lift applied" was noted. Note: The resident was discharged 9/25/14.</p> <p>* Right heel cleanse with NS and change Allevyn drsg was done every 3 days.</p> <p>RPNs for 8/12/14-9/25/14 contained documentation that subsequent right heel Stage II PU assessments were incomplete and inconsistent through 8/25/14. In addition, the right heel PU was not mentioned after 8/25/14 even though skin assessments and wound care/dressing changes were documented through 9/23/14.</p>	F 314		

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F 314	<p>Continued From page 23</p> <p>On 11/14/14 at 2:20 p.m., the DON and NM were asked if there actually was a dressing on the resident's heel after 8/25/14. The DON pointed to the TRH and stated, "According to this there was [a dressing] after 8/25/14. When asked if either of them assessed the PU, the NM stated, "At some point I did." When asked if she documented the assessment, the NM stated, "No, not unless I did it myself. I go in with my nurses usually and the nurse usually does the documentation." The DON and NM reviewed the resident's RPNs and confirmed there were no PU assessments documented after 8/25/14. The also acknowledged that PU assessments before 8/25/14 were not thorough.</p> <p>4. Resident #2 was recently admitted to the facility on 11/5/14 with diagnoses for rehabilitation after a right hip internal fixation surgery.</p> <p>The resident's 11/5/14 Braden Risk Assessment Scale documented the risk for PUs as a 17 or moderate risk.</p> <p>The resident's 11/5/14 Admission Assessment documented areas of concern: Red and blanchable coccyx, 2 dressings on the right hip, 3 sections on the right hip with staples, and a left foot with discoloration and faint pedal pulse.</p> <p>Resident #2's PU Risk Protocol/Care Plan documented the resident at risk for developing pressure ulcers related to impaired mobility. The goal was, "...decreased risk of developing pressure ulcers with appropriate interventions..." Interventions included: "Minimal Risk" with "Pressure Reducing Mattress, Standard Wheelchair Cushion, Weekly Skin Assessment</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>by LN [licensed nurse], PT/OT [physical and occupational therapy] Eval[uation] & [and] Treatment"; "Low Risk" with interventions "Assist/Prompt Turn Q [every] 2 Hours [and] Barrier Ointment."; and "Moderate Risk" with interventions "Heelz Up and air mattress."</p> <p>The resident's interim Care Plan dated 11/5/14 documented: * Problem: "Risk of or Actual Alteration in Skin Integrity." Goals: "...will have decreased risk of developing [additional] areas of altered skin integrity. Approaches: Preventative devices: Wheelchair Pad, Mattress,... Air Bed, other heelz. Treatments: "Dressing per MD order..., Assess and report [changes] during cares and treatments. Wound type: Surgical..., open area to coccyx follow MD Rx [prescription] and dsg [dressing]. Wound site: R [right] hip."</p> <p>The resident's Physician Order report documented: 11/5/14 - Open Ended: "Weekly Skin Assessment once a day on Tue [Tuesday]" 11/6/14 - 11/8/14 Discontinued (DC) date - "Millers mix to buttocks q [every] shift and after each incontinent episode." 11/7/14 - Open Ended: "CriticAid cream. Apply CriticAid to coccyx QS [at bedtime] and PRN [as needed] after incontinent episodes." 11/10/14 - Open Ended: "Coccyx wound-Cleanse with NS [normal saline], skin prep peri wound, apply silver wound gel and cover with Allevyn once a day."</p> <p>Resident #2's TAR documented: Weekly skin assessment was completed on 11/11/14 with documentation of positive results but no comment in notes.</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>Coccyx wound cleansed with NS, skin prep peri wound, apply silver wound gel and cover with Allevyn was completed on 11/11/14 and 11/12/14.</p> <p>RPNs for Resident #2 documented: 11/5/14 - "...Red area to coccyx that is blanchable..." 11/6/14 - "...New order also received for Millers mix to buttocks r/t [related to] red/blanchable buttocks..." 11/7/14 - "...1 x [by] 1 open area to coccyx. Blanchable edges...New order for CriticAid to be applied to coccyx..." 11/9/14 - "...Received order from MD to place dressing on coccyx. Cleansed with NS, skin prep peri-wound, Silver gel applied and Allevyn dressing applied as ordered..." 11/10/14 - "...Open area to coccyx measures 0.4 x 0.4 cm with blanchable edges. Old dressing with zero drainage and zero s/sx [signs/symptoms] of infection. Wound cleansed with NS, sprayed with skin prep, Silver gel applied, and new Allevyn dressing applied." 11/11/14 - "...Dressing to the coccyx is clean, dry, and intact..." 11/12/14 - "...Sore to coccyx is healing well. Dressing changed as ordered..."</p> <p>Resident #2's 11/10/14 Weekly Skin Report-PU documented: *Date acquired: 11/7/14; Acquired: In house; Ulcer Location: Coccyx; Stage 2; Measurements: 0.4 cm x 0.4 cm; Description: Coccyx, open, superficial, surrounding tissue pink; Current Tx order: Wound cleanser, skin prep peri wound, Allevyn dressing; Change every 3rd day and PRN.</p> <p>On 11/14/14 at 2:45 pm, the Nurse Manager (NM)</p>	F 314		

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F 314	<p>Continued From page 26</p> <p>was interviewed regarding the Weekly Skin Report-PU. The NM said the Weekly Skin Reports are a tool only and the reports are not a permanent part of the resident's clinical record. The NM acknowledged Resident #2's clinical record did not reflect staging and other characteristics of the PU. The NM and the DON said the nurses are to document in the progress notes the same information they relay to her for the Weekly Skin Reports, but most nurses have not been trained in staging PUs.</p> <p>5. Resident #3 was admitted to the facility on 9/23/14 with diagnoses of rehabilitation after oral and digestive system surgery. The resident was discharged home on 10/17/14.</p> <p>The resident's 9/23/14 Braden Risk Assessment Scale documented the risk for PUs as a 17 or moderate risk.</p> <p>The resident's 9/23/14 Admission Assessment documented areas of concern: 1 Stage II 5 x 3 cm on left coccyx, 1 Stage II 7 x 4 cm on right coccyx, bilateral heels intact, dry and blanchable, surgical dressing on right abdomen, scrotal swelling, and a 0.5 x 0.5 cm deroofed blister on right calf. The Admission Assessment did not include other PU characteristics, such as depth, condition of the wound bed, wound edges and surrounding skin; and, whether or not there was drainage, odor, or associated pain.</p> <p>Resident #3's PU Risk Protocol/Care Plan documented the resident with current pressure ulcers related to impaired mobility. The goal was, "...current pressure ulcer(s) as identified above will heal without s/s [signs/symptoms] of infection within 30 days..." Interventions included: "Minimal</p>	F 314			

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F 314	<p>Continued From page 27</p> <p>Risk" with "Pressure Reducing Mattress, Standard Wheelchair Cushion, Weekly Skin Assessment by LN, PT/OT Eval & Treatment"; "Low Risk" with interventions "Assist/Prompt Turn Q 2 Hours [and] Barrier Ointment."; "Moderate Risk" with interventions "Heelz Up and air mattress."; and, "Actual Wound" with interventions "Air Mattress, Speciality Wheelchair Cushion, and Supplements."</p> <p>The resident's 10/6/14 Care Plan documented: * Problem: "Actual Impaired Skin Integrity related to Right and Left Buttocks Stage II on admit..." Goals: "...Area(s) of concern will heal without s/s of infection within 30 days. Area(s) of concern will heal without s/s of infection within 60 days." Approaches: Treatment per current MD orders. Monitor for increased redness, change in skin temperature, or abnormal exudates. Keep affected areas clean, dry and minimize irritation and pressure. Air mattress to bed. Barrier ointment QS and PRN, Silver cloths per MD Rx, Encourage and assist patient to reposition at least every 2 hours.</p> <p>The resident's Physician Order report documented: 9/23/14 - 10/17/14 DC date (discontinued date): "Bi-lat[eral] buttock wounds-cleanse with Microklenz, apply no sting barrier to bi-lat wounds, cover with Mepilex or Tegaderm Foam. Change q 3 days and PRN." 9/23/14 - 10/17/14 DC date: "FYI- If unable to get drsg [dressing] to buttocks to stay in place greater than 48 hours, DC and apply Criticiad QID [four times a day] and PRN." 9/23/14 - 10/17/14 DC date: "Weekly skin assessment once a day on Tuesday."</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>Resident #3's TAR documented: Weekly skin assessments were completed weekly on Tuesdays on 9/23, 9/30, 10/7 and 10/14/14 and recorded as a positive but no comments in notes.</p> <p>Bilateral buttock wounds-cleanse with microkienz, apply no sting barrier to bilateral wounds, cover with Mepilex or Tegaderm foam, change every 3 days and PRN was recorded to have been completed on 9/23, 9/26, 9/29, 10/2, 10/5, 10/8, 10/11 and 10/14/14.</p> <p>RPNs for Resident #3 documented: 9/23/14 - "...admitted for inpt [inpatient] rehab d/t [due to] s/p [status post] inguinal repair and bi-lat buttock wounds..." 9/24/14 - "...Bilateral buttock with dry peeling skin, 2 superficial open areas noted to bilat buttock. Left measures 8x5, right measures 7x5. Area cleansed and powder applied. 9/25/14 - "...Has areas on each buttock healing stage 2's..." 9/29/14 - "...Powder applied to the inner buttocks to keep skin dry, and area is drying out and appears less reddened." 10/1,2,3,7,8 &- 9/14 - Powder applied to buttocks, area healing well, resolving. 10/10/14 - "...Corticaid cream applied to buttocks..." 10/11/14 - "...New cream applied to buttock as per MD order..." 10/14/14 - "...Skin assessment: Bottom with dry skin and zero redness and zero open areas..." The RPNs made no mention of dressing changes and treatment was documented 7 times as being powder.</p> <p>Resident #3's Weekly Skin Report-PU documented:</p>	F 314			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2014
NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642	
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F 314	Continued From page 29 *9/26/14 - L (left) buttocks; Stage 2; 8.00 x 5.00 cm and R (right) buttocks; Stage 2; 7.00 x 5.00 cm; Description: both open, superficial, dry flaky areas; No drainage; Current tx (treatment) order-NS (normal saline) and baby powder; frequency of tx-TID (three times a day). *10/3/14 - L buttocks; Stage 2; 5.00 x 4.00 cm and R buttocks; Stage 2; 4.00 x 3.00 cm. Description: both sides have scattered healing areas, hard to measure and same description, treatment and frequency of tx as on 9/26. *10/10/14 - L buttocks; Stage 2; 5.00 x 4.00 cm and R buttocks; Stage 2; 4.00 x 3.00 cm. Same description, treatment and frequency of tx as on 9/26. These Weekly Skin Reports are not retained as a part of the resident's clinical record and were being maintained by the NM, from information obtained from her licensed staff. On 11/13/14 at 3:00 pm, the NM was asked about the treatment for Resident #3's Stage 2 PUs. The NM stated, "Cleaned with NS and apply baby powder because it was superficial." The NM and the DON were asked about the physician's orders for dressing changes, TAR documentation reflecting the nurses were performing the treatment as ordered and the RPNs contradicting what was ordered. The NM said the nurses are not taking credit for what they do by failing to document.	F 314		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress	F 386	F 386 Patient Specific: Patient number 4 has been discharged.	

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F 386	<p>Continued From page 30</p> <p>notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and an NP and record review, it was determined the facility failed to ensure a physician took an active role in supervising the care and evaluating the condition of 1 of 5 residents (#4) reviewed for physician's visits. The failure created the potential for more than minimal harm when the resident did not receive thorough assessments from his primary care provider. Findings included:</p> <p>Resident #4 was admitted to the facility on 10/6/14 with diagnoses that included multiple myeloma (metastatic cancer); post operative vertebrectomy of the 2nd thoracic vertebrae (T2) with tumor resection and implantation of an expandable cage at T1-3; laminectomy and fusion at T1-5; paraplegia; bacteremia due to tooth abscess; hypertension (high blood pressure); and, neurogenic bladder and bowel.</p> <p>The resident was transferred to a second LTC facility on 10/27/14 and less than 24 hours later he was diagnosed with septic shock and a necrotizing gangrenous sacral wound in a hospital emergency department.</p> <p>The resident's 10/6/14 Admission Assessment documented 3 Stage II pressure ulcers (PUs) at the coccyx and left and right buttocks were present on admission. Please refer to F314 for</p>	F 386	<p>Other Patients:</p> <p>All patients with pressure ulcers (if any) have had their ulcers assessed by the physician or the physician extender and such assessments are documented.</p> <p>Systemic Changes:</p> <p>Nurse Management staff have been inserviced as to the need for the physician or the physicians extender to assess and document said assessment on all patients with pressure ulcers.</p> <p>Monitors:</p> <p>The Director of Nursing or her designee will perform weekly chart audits on all patients with pressure ulcers times 26 weeks to ensure that the physician or his extender has seen and documented on said pressure ulcers.</p> <p>Date of Compliance: 12/8/2014</p>		

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F 386	<p>Continued From page 31 details about the deterioration of the PUs.</p> <p>Physician and NP visit notes documentation included: * 10/9/14 MD note - "Skin- Warm, dry, good turgor." * 10/13/14 NP note - "Subjective-...bed sore on his backside, it sounds like he came to us...with these. They don't seem to be making much improvement and after his trip to the hospital..." The PUs were not addressed in the Physical Examination section of the note and in the Assessment/Plan section was, "Pressure ulcer. Nursing staff are taking care of this, very poor prognosis as he has no feeling and he has very limited ability to change position even with assistance..." * 10/20/14 - "Subjective-...he thinks that being up in the chair and getting out of bed a little bit more easily is helping heal his pressure ulcer. He says that he still can't feel it. Nursing staff are continuing to monitor it, it's healing very very slowly..." The PUs were not mentioned in the Physical Examination or Assessment/Plan-sections of the note. * 10/27/14 - "Interim history and physical-...We are continuing to monitor the sore on his backside. He says that he's doing everything that he can, changing his position every couple of hours. He will have wound management at [name of other LTC facility]." The PUs were not mentioned in the Physical Examination or Assessment/Plan sections of the note.</p> <p>The NP was interviewed by telephone on 11/17/14 at 12:10 p.m. The NP recalled the resident and said she had assessed him in the facility. When asked if she had assessed the resident's PUs, the NP said if she had, "it would</p>	F 386			

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F 386	<p>Continued From page 32</p> <p>be documented in the physical assessment and I would have included characteristics, like size, etc." The NP said if it was not documented in the physical assessment or assessment/plan, "I wouldn't have physically seen it then." The NP added, "I knew about the issues on his backside. They [facility staff] were communicating with me. I want to say he was improving." When asked if "improving" was based on communication with the staff, the NP stated, "Right. Yeah, I don't think I physically saw it."</p> <p>On 11/18/14 at 4:00 p.m., the Administrator was asked for assistance to contact the resident's physician for an interview.</p> <p>On 11/18/14 at 4:15 p.m., the Administrator said the physician was unavailable because he was seeing patients. The Administrator then stated, "I know he doesn't do head to toe assessments and he only treats what he knows about."</p> <p>On 11/18/14 at 4:20 p.m., the Administrator said the same statement to the survey team. When asked who the facility's medical director was, the Administrator said the resident's physician was the medical director.</p> <p>The facility did not provide any other information regarding the issue.</p>	F 386			

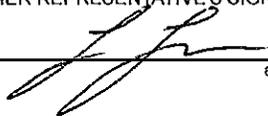
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001505	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2014
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NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642
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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the State Licensure complaint survey in your facility. The survey team entered the facility on 11/12/14 and exited the facility on 11/18/14. The surveyors who conducted the survey were: Linda Kelly, RN, Team Coordinator; Linda Hukill-Neal, RN, and Arnold Rosling RN, BSN, QMRP.	C 000		
C 173	02.100,12,d Immediate Notification of Physician of Injury d. The physician shall be immediately notified regarding any patient/resident injury or accident when there are significant changes requiring intervention or assessment. This Rule is not met as evidenced by: Refer to F157 about the lack of physician notification regarding pressure ulcers.	C 173	C173 Please refer to Plan of Correction for F157 Date of Compliance: 12/8/2014	
C 732	02.154,02,a Physician Supervision 02. Physician Supervision. a. Each patient/resident shall be under the direct and continuing supervision of a physician of his own choice licensed by the Idaho Board of Medicine. This Rule is not met as evidenced by: Refer to F386 as it related to the physician's active role in supervising resident care.	C 732	C732 Please refer to Plan of Correction for F386 Date of Compliance: 12/8/2014	
C 789	02.200,03,b,v Prevention of Decubitus v. Prevention of decubitus ulcers	C 789		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X8) DATE

12-8-14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001505	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2014
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C 789	Continued From page 1 or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it related to the development of deep tissue injury and deterioration of existing Stage II pressure ulcers to unstageable.	C 789	C789 Please refer to Plan of Correction for F314 Date of Compliance: 12/8/2014	
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RICHARD M. ARMSTRONG -- Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

February 3, 2015

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **November 18, 2014**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #6737

ALLEGATION:

Residents are not provided with appropriate skin and wound care resulting in medical complications associated with pressure ulcers.

FINDINGS:

During the investigation, facility's policies and residents' records were reviewed and staff interviews were conducted with the following results:

The facility's policies for pressure ulcer prevention, assessment and intervention, treatment of pressure ulcers, documentation of wounds and weekly skin reports were reviewed. The medical records of five residents, who had pressure ulcers, were also reviewed. The records did not demonstrate that facility's policies had been consistently implemented to ensure residents received appropriate treatment and services to promote healing, prevent infection and prevent new sores from developing.

Five of the five medical records reviewed did not include documentation that thorough initial and at least weekly pressure ulcer wound assessments were completed, per facility's policy. Additionally, one of the five records documented deteriorating pressure ulcers without appropriate treatment, which resulted in the resident experiencing a large necrotizing gangrenous sacral wound.

Joseph Frasure, Administrator
February 3, 2015
Page 2 of 2

The resident's record documented he was admitted to the facility on October 6, 2014, with three Stage II pressure ulcers. The resident's record did not include evidence that a thorough pressure ulcer assessment had been completed when the resident was admitted or that the physician had been notified about the pressure ulcers. There was no evidence that the facility conducted a thorough pressure ulcer assessment at least weekly after his admission. The physician's October 9, 2014, visit note and the nurse practitioner's visit notes for October 13, 2014, October 20, 2014 and October 27, 2014, did not contain any documented evidence that either of them, the physician or the nurse practitioner assessed the pressure ulcers during the resident's stay in the facility. The resident's record did not include physician's orders for pressure ulcer care and treatment or evidence that standing orders for open wounds were implemented. The facility applied topical medication and dressings to the resident's pressure ulcers without physician's orders, and appropriate devices to prevent pressure ulcers were not utilized. Further, the resident's record did not include documentation the physician had been notified when the staff noted deep tissue injury, then eschar and weeping of the wound sites.

On November 13, 2014, at 3:30 p.m., the nurse manager was interviewed about the resident's pressure ulcers. The nurse manager acknowledged that staging and other pressure ulcer characteristics were not consistently documented. When asked for wound care orders, the nurse manager stated, "There are none. I know it's not there."

Residents are not provided with appropriate skin and wound care. Therefore, the allegation was substantiated and deficient practices were identified and cited.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORENE KAYSER, L.S.W., Q.I.D.P., Supervisor
Long Term Care

LKK/dmj