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

PRINTED: 06/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING _____ B. WING _____	06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 06/12/13 through 06/14/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "G".	F 000	**Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.**	
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). 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. The facility must record and periodically update	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 7/8/13

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

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to immediately consult with the resident's physician a need to alter treatment for one resident (#1) in the sample of fourteen (14) residents (Resident #1). The facility failed to notify the physician of unrelieved pain during treatments. During a dressing change, on 06/12/13 at 1:15 PM, and on 06/13/13 at 10:00 AM, Resident #1 exhibited verbal/non-verbal signs of pain; however, the nurse continued the treatment without further intervention. On 06/12/13 at 1:15 PM, Resident #1 winced with pain while tears rolled down his/her face as the nurse attempted to remove an old dressing to the right leg. Additionally, on 06/13/13 at 10:15 AM, Resident #1 began complaining of left heel pain. The nurse assessed the resident as having a "red, mushy" area to the left heel with a darkened scabbed area to the left second toe; however, the nurse failed to notify the physician of the pain to the left heel, or the new areas identified. The findings include: Review of the Notification of Resident Change in Condition policy/procedure, undated, revealed clinicians would immediately consult with the resident's physician when there was a significant	F 157	F157 – Notify of Changes 1. The physician was notified of the unrelieved pain for resident #1 by the Director of Nursing on 7/5/13 with new orders noted. The physician was notified of the identified wound to resident #1's left heel on 6/13/13 by the Assistant Director of Nursing with treatment orders noted. 2. A complete skin assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Any identified skin impairments will be reviewed to assure that the MD has been notified and an appropriate treatment, if needed, is in place. Any identified skin impairments that have not had MD notification or that does not have an appropriate treatment in place, the facility will contact the physician for notification and/or treatment. A comprehensive pain assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Results of the comprehensive pain assessment will be reviewed by the Director of Nursing, Assistant Director of Nursing or Unit Manager to determine if the resident's level of pain exceeds the resident's goals for pain. Any identified as not meeting the resident's goal for level of pain will be reviewed with the physician for further intervention and a follow up pain assessment completed.	7/28/13

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F 157	Continued From page 2 change in the resident's physical, mental, or psychosocial status. Review of the Pain Management Process, dated 03/11, revealed the physician and family would be notified when pain levels were outside normal levels for each individual resident and could not be relieved or interfered with the resident's goal or functional ability. Review of the Skin System policy/procedure, revised 08/08, revealed the physician and family would be notified of any changes of skin condition. Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the significant change Minimum Data Set, dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired. Review of the Pressure Ulcer Risk Assessment, dated 03/20/13, revealed the facility identified the resident at high risk for pressure ulcers. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" (four) on the pain scale of 0-10. Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to report unrelieved or unacceptable levels of pain to the	F 157	3. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on completion of comprehensive pain assessment, physician notification of unrelieved pain outside the resident's goal for pain levels or pain at unacceptable levels. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on identification of skin impairments, notification of the physician and appropriate treatment. Both of these re-education will be completed by 7/28/13 with no Licensed Staff working after 7/28/13 without having received these trainings. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review five (5) resident records per week for twelve (12) weeks to identify any unacceptable levels of pain to assure that the physician has been notified. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressings per week for twelve (12) weeks to assure that the resident does not experience pain levels during treatment at unacceptable levels and if the resident does, the nurse will notify the physician of unacceptable pain levels. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for	

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F 157	Continued From page 3 physician as needed. Observation of a dressing change, on 06/12/13 at 1:15 PM, with Registered Nurse #1 (RN) revealed a moderate amount of yellow/bloody drainage to the right leg wound dressing. During the removal of the dressing, the resident was observed wincing in pain with facial grimacing. The dressing appeared to be stuck to the resident's leg and difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued the dressing removal without any other intervention. Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Resident #1 continuously stated "Oh" during the treatment, dressing change of the wounds. Further observation revealed the resident with facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Observation revealed dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?" Observation, on 06/13/13 at 10:15 AM, revealed Resident #1 continuously complained of pain to the left heel. RN #1 observed the heel to be red and "mushy." She stated "We need to prop that	F 157	twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments and notified the physician of any new skin impairments. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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F 157	Continued From page 4 heel up." RN #1 additionally observed a darkened scabbed area to the left second toe. Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed the pain medications were not effective during treatments. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" eight out of "10" (ten). The resident indicated that was "pretty bad" pain. Observation of Resident #1, on 06/14/13 at 10:45 AM, revealed a red, non-blanchable area to the left heel per assessment of the Assistant Director of Nursing (ADON). She indicated the area was "boggy" underneath. At approximately 10:55 AM, a blister had ruptured on the left heel with serous drainage noted. Additionally, an unstageable area to the left second toe measured 1 x 1.4 centimeters (cm). Record review, on 06/14/13, revealed no documentation related to the left heel/left second toe. Further review revealed no documented evidence new orders were initiated. Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not notified the resident's physician of unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident feared the treatment before it even started. RN #1 stated the resident had anxiety disorder, which was "a lot of the problem." When a resident complained of pain before touching them, it had to be determined anxiety. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical."	F 157		

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F 157	Continued From page 5 Continued interview with RN #1, on 06/14/13 at 10:10 AM, revealed she had not noticed the red, "mushy" area to the resident's left heel prior to the assessment, on 06/13/13. She did not report the resident's pain to the left heel as she did not feel it was significant. She revealed the ADON was notified of the area; however, interview with the ADON, on 06/14/13 at 3:50 PM, revealed she had no knowledge of the area prior to observation with the state surveyor. Further interview with RN #1 revealed she did not report the area to the left second toe; however, she should have made the ADON aware. She stated it was "up in the air" whose responsibility it was to notify the physician of the new areas. She revealed it was "probably" her responsibility since she found the new areas. Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed she expected staff to try other measures for relief during treatments and call the physician if pain continued. An attempted interview with Resident #1's primary physician, on 06/14/13 at 10:35 AM, revealed he was not available for interview. Interview with the ADON, on 06/14/13 at 10:45 AM, revealed if a new wound was discovered, it would be the nurse's responsibility to notify the physician. Interview with the DON, on 06/14/13 at 4:45 PM, revealed she expected the nurse to assess, document, and notify the physician of any new areas identified. Interview with the Medical Director, on 06/14/13	F 157		

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F 157	Continued From page 6 at 2:00 PM, revealed he would expect staff to notify the physician of any new areas identified on a resident. Continued interview with the Medical Director, revealed he would expect staff to notify the physician if pain medication was not effective during a treatment.	F 157		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review and facility policy; it was determined the facility failed to ensure the residents' environment was comfortable and homelike related to the absence of window coverings in five (5) of thirty-four (34) residents' rooms. The findings include: Observations on 06/12/13 at 6:30 AM and on 06/14/13 at 3:45 PM, revealed five residents' rooms (rooms 1, 2, 11 and 34) revealed the windows had no window coverings such as blinds, shades, and/or curtains. Interview with Assistant Director of Nursing (ADON), on 06/14/13 at 3:45 PM, revealed the window coverings were a housekeeping and/or maintenance issue. The ADON stated she was not aware there were resident rooms without window coverings for the outside wall windows.	F 252	F252 – Safe/Clean/Comfortable/ Homelike Environment 1. The identified resident rooms # 1,2,11 and 34 will have window blinds installed by the Maintenance director by 7/12/13. 2. The Administrator and Housekeeping supervisor will complete an audit of all resident rooms to assure that they have window coverings and present a comfortable home like environment by 7/28/13. Any identified as not being homelike and comfortable or without window coverings will be made comfortable and homelike or have window coverings installed by 7/28/13. 3. The Administrator will re-educate the Housekeeping Supervisor by 7/28/13 on the requirement of a comfortable home like environment and window coverings. 4. The Administrator and Housekeeping Supervisor will complete weekly audits of all resident rooms for twelve (12) weeks to assure that all rooms have window coverings and present as comfortable and homelike. The results of these audits will be	7/28/13

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F 252	Continued From page 7 The ADON revealed the absence of window coverings put resident's privacy at risk. Interview with Director of Nursing (DON), on 06/14/13 at 4:15 PM, revealed she did not know who was responsible for ensuring the residents' rooms had window coverings, but each window should have something. Interview with the Housekeeping Supervisor in the presence of the Environmental Services District Manager, on 06/14/13 at 4:50 PM; revealed he/she was not aware there were resident rooms without blinds, curtains, or shades. The Housekeeping Supervisor stated the resident rooms should be homelike and have curtains or blinds covering an outside window to ensure privacy for the resident.	F 252	reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of fourteen (14)sampled residents (Resident #1). The facility failed to follow physician's orders related to a daily dressing change to the resident's right leg. The findings include: The facility had no specific policy related to	F 281	F281 – Services Provided Meet Professional Standards 1. The dressings for resident # 1 were noted to be changed per physician order by the Director of Nursing on 7/8/13. 2. A review of all current residents' physician orders for the past 30 days will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all physician orders have been followed or the physician has been notified if unable to follow the order. Any identified as not being followed without physician notification will have physician notification for further direction. An observation of all wound dressings will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure treatment were completed per physician orders. Any identified as not	7/28/13

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F 281	Continued From page 8 following physician's orders. Observation, on 06/13/13 at 5:30 PM, revealed a dressing intact to the resident's right leg, dated 06/12/13. There was a large amount of brownish/pink tinged drainage observed on the outside of the dressing, as well as a towel laying under the resident's leg. Interview with the Resident #1's husband, on 06/13/13 at 5:30 PM, revealed the nurse said she was going to change the dressing; however she did not. Observation, on 06/14/13 at 8:10 AM, revealed a dressing intact to the resident's right leg, dated 06/14/13. Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Peripheral Vascular Disease and Chronic Ulcer of the Leg. Review of the Significant Change Minimum Data Set (MDS), dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired and required extensive assistance with bed mobility and transfer. Review of the Physician's Orders, dated 05/30/13, and the Treatment Administration Record (TAR), dated June 2013, revealed an order for Solosite Hydrogel Wound (wet-to-dry) dressing topically, daily to the right calf. A copy of the TAR was received by the surveyor, on 06/13/13 at 5:45 PM. The TAR revealed an order to complete the treatment on dayshift (6:00 AM-2:00 PM); however, it was not initialed as being completed on 06/13/13.	F 281	will have MD notification for further direction. 3. All Licensed Nurses will be re-educated on following physician orders and notification of the physician if unable to follow the physician orders. This re-education will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager and will be completed by 7/28/13 with no licensed nurse working past 7/28/13 without having received this re-education. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) resident's medical records weekly for twelve (12) weeks to assure physician orders have been followed or the physician was notified if unable to follow. In addition, the Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) wound treatments per week for twelve (12) weeks to assure the treatment was completed per physician order. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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F 281	Continued From page 9 Interview with Resident #1, on 06/14/13 at 9:25 AM, revealed staff did not change the dressing on 06/13/13. It was changed after his/her bath, on 06/14/13. Interview with the Assistant Director of Nursing (ADON), on 06/14/13 at 3:50 PM, revealed the treatment to the resident's right leg was completed by her, on 06/14/13 at approximately 6:45 AM. She indicated the dressing had been removed prior to the treatment; therefore, she was unsure of the date on the old dressing. Interview with Registered Nurse (RN) #1, on 06/14/13 at 10:10 AM, verified she did not complete the treatment for Resident #1, on 06/13/13. RN #1 revealed it was reported to the Dayshift Charge Nurse, Licensed Practical Nurse (LPN) #1, who indicated she would change the dressing. Interview with LPN #1, on 06/14/13 at 2:40 PM, revealed she was the Dayshift Charge Nurse on 06/13/13. She further stated the Charge Nurse typically completed treatments; however, she thought RN #1 completed the dressing change for Resident #1. Interview with LPN #2, on 06/14/13 at 9:45 AM, revealed she was the nurse on evening shift for Resident #1, on 06/13/13. She stated she did not complete the treatment to the resident's right leg on 06/13/13. Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed she expected staff to complete treatments, per the physician's	F 281		

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F 281	Continued From page 10 orders.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one (1) of fourteen (14) sampled residents (Resident #1). The findings include: Review of the guidelines for the Resident Comprehensive Care Plan, dated 09/08, revealed the resident's Comprehensive Care Plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the Significant Change Minimum Data Set (MDS), dated 05/20/13, revealed the facility	F 282	F282 – Services by Qualified Persons/Per Care Plan 1. The Assistant Director of Nursing observed on 7/5/13 that resident # 1's care plan interventions were being followed; that staff had documented pain location; rate of pain prior to and after intervention and the dressing change was completed without exceeding the resident's stated pain goal. 2. A complete audit of all resident's records will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure all care plan interventions are in place. Any intervention not in place will be implemented. 3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing or Unit Manager on the requirement to follow the resident's plan of care to include rating pain before and after treatment including location of pain, report unrelieved pain or unacceptable pain levels to the physician and stop treatment if unacceptable pain implement further intervention before resuming treatment. This re-education will be completed by 7/28/13. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit five (5) resident's pain flow	7/28/13

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	185224	A. BUILDING _____ B. WING _____	06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOWLING GREEN NURSING AND REHABILITATION CENTER	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 282	Continued From page 11 identified the resident as moderately cognitively impaired. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" (four) on the pain scale of 0-10 (zero to ten). Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to identify the location and rate of pain prior to and after any interventions. Report unrelieved or unacceptable levels of pain to the physician as needed. Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed Registered Nurse (RN) #1 administered Dilaudid (pain medication) 4 milligram (mg) to Resident #1 at 7:05 AM. Review of the Medication Administration Record (MAR), dated 06/12/13 at 7:05 AM, revealed the Dilaudid was administered for generalized pain; however, there was no rate of pain documented. Further review of the MAR revealed the resident's pain had decreased at 8:00 AM, but no rate of pain was noted. Observation, on 06/12/13 at 10:00 AM, revealed Resident #1 was sitting up in his/her room, after completing physical therapy. The resident complained of his/her "bottom" hurting and appeared uncomfortable. Observation, on 06/12/13 at 10:15 AM, revealed a staff member reported the resident's pain to Registered Nurse (RN) #1 with the state surveyor	F 282	sheets per week for twelve (12) weeks to assure pain rate before and after intervention and location of pain are documented, that the physician was notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressing changes per week to assure that the pain is relieved or at acceptable levels or the nurse stops treatment for further intervention. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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F 282	Continued From page 12 present. At 10:30 AM, the resident remained in the wheelchair with facial grimacing. Further observation, on 06/12/13 at 11:50 AM, revealed Resident #1 remained up in his/her room. The resident revealed his/her "bottom" was still hurting "pretty bad." Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed RN #1 administered Dilaudid 4 mg at 12:40 PM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 12:40 PM. Interview with RN #1, on 06/14/13 at 10:10 PM and 3:00 PM, revealed she "tried" to look at the care plans as she charted on residents. She was aware documentation of pain medication included the location, rate of pain, and a re-evaluation; however, she was unsure of the reason it was not documented on 06/12/13. She did not give the resident pain medication when asked, on 06/12/13 at 10:15 AM, as it was not time for a dose. She revealed the physician was not notified of unrelieved pain, per the care plan. Review of the Impaired Skin Integrity Care Plan, dated 05/20/13, revealed if there was complaints of pain during a treatment, stop the treatment, leave the resident safe, and seek pain relief. Return to complete the treatment when the pain was reported as acceptable. Observation of a dressing change, on 06/12/13 at 1:15 PM, revealed a moderate amount of yellow/bloody drainage to the right leg wound	F 282		

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F 282	Continued From page 13 dressing. During the removal of the dressing, the resident was wincing in pain with facial grimacing. Further observation revealed the dressing appeared to be stuck to the resident's leg and was difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued removing the dressing without implementing any other intervention. Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Further observation revealed Resident #1 continuously stated "Oh" during the treatment/dressing of the wounds. Observation revealed facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?" Interview with RN #1, on 06/14/13 at 10:00 AM and 3:00 PM, revealed Resident #1 always had pain during treatments. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical." Interview with the Director of Nursing (DON), on	F 282		

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F 282	Continued From page 14 06/14/13 at 4:45 PM, revealed she felt the interventions on Resident #1's care plan were generic and should have been more individualized; however, she still expected staff to follow the interventions.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the plan of care for one (1) of fourteen (14) sampled residents (Resident #1). On 06/12/13, Resident #1 complained of unrelieved pain three (3) hours after pain medication was given; however, he/she did not receive any further intervention until the next "as needed" dose of medication could be given. During a wound treatment, on 06/12/13 at 1:15 PM, Resident #1 was observed wincing in pain with tears rolling down his/her face; however,	F 309	F309 – Provide Care/Services for Highest Well Being 1. A comprehensive pain assessment was completed on Resident # 1 on 7/5/13 by the Director of Nursing that indicated her new pain regimen was effective. The Assistant Director of Nursing noted on 7/5/13 during a wound treatment that the resident did not exhibit any signs or symptoms of pain greater than the stated pain goal. The Director of Nursing noted on 7/8/13 that staff documented pain before and after as needed pain medication was given on 7/8/13. 2. A comprehensive pain assessment will be completed on all current residents by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that all residents pain interventions are effective for their goals. Any identified as not being effective will have physician notification with further interventions and reassessment. An observation of all current residents with wound treatment dressing orders will be completed by 7/28/13 by the Director of Nursing, Assistant Director of Nursing	7/28/13

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F 309	Continued From page 15 the nurse continued the treatment with no further intervention. Resident #1 exhibited non-verbal and verbal signs of pain during a wound treatment, on 06/13/13 at 10:00 AM; however, the nurse continued the treatment without further intervention. Additionally, the facility failed to assess and document the resident's pain before and after pain medication was administered. The findings include: Review of the Pain Management Process policy/procedure, dated 03/11, revealed the facility would react to the resident's pain control needs based on the resident's goals for pain relief and the resident's goals for functional ability. The facility's goal was to ensure all residents received appropriate pain relief measures to assure that the residents' pain did not affect their ability to function within their designated goals for functional ability. Documentation of pain intensity would be recorded along with the intervention for pain reduction using appropriate facility forms. A post intensity evaluation would be assessed and documented in a timely manner. Upon follow-up, if the intervention was ineffective, the process should be repeated until the resident indicated adequate relieve and/or functional goals were met. Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Anxiety Disorder, Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the Significant Change Minimum Data Set, dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired	F 309	or Unit Manager to ensure that all residents with wound treatment interventions are effective. Any noted to have pain during treatment not relieved by interventions will have physician notification with further interventions and follow up assessment completed. An audit of all current residents who receive as needed pain medications will be reviewed by the Director of Nursing, Assistant Director of Nursing or Unit Manager by 7/28/13 to assure that pain is assessed before and after as needed pain medications are administered. Any identified as not having pain rated before and after pain medication administrated will have a pain assessment completed with follow up with the physician for pain levels unrelieved or unacceptable for further intervention and follow up assessment completed. These audits will be completed by 7/28/13. 3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant related to pain assessments, pain goals and physician notification related to unacceptable pain levels: stopping treatment with unacceptable levels of pain with further intervention before resuming treatment as well as documentation of pain levels before and after administration of as needed pain medication. This re-education will be completed by 7/28/13. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager	

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F 309	Continued From page 16 and required extensive assistance with bed mobility and transfer. Review of the Comprehensive Pain Assessment Form, dated 05/20/13, revealed the resident indicated having frequent pain, making it hard to sleep at night and limiting day-to-day activities. The pain assessment indicated the resident's medication/treatments moderately relieved his/her pain. The resident's pain intensity goal was a "4" on the pain scale of 0-10. Review of the Physician's Orders, dated 06/01/13 through 06/30/13, revealed an order for the following pain medications: 1. Fentanyl (controlled pain medication) 100 microgram (mcg)/hour patch, one patch topically every seventy-two (72) hours 2. Hydromorphone (Dilaudid, controlled pain medication) 4 milligram (mg) tablet every six (6) hours, as needed, and 3. Acetaminophen (pain medication) 325 mg tablet every four (4) hours, as needed Review of the Risk for Alteration in Comfort Care Plan, dated 05/20/13, revealed to identify the location and rate of pain prior to and after any interventions. Report unrelieved or unacceptable levels of pain to the physician as needed. Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed Registered Nurse (RN) #1 administered Dilaudid 4 mg to Resident #1 at 7:05 AM. Review of the Medication Administration Record (MAR), dated 06/12/13 at 7:05 AM, revealed the Dilaudid was administered for generalized pain; however, there was no rate of pain documented. Further review of the MAR revealed the resident's pain had	F 309	will audit five (5) resident's pain flow sheets per week for twelve (12) weeks to assure pain rate before and after intervention and location of pain are documented, that the physician was notified of any unrelieved or unacceptable levels of pain to the physician. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe five (5) wound dressing changes per week to assure that the pain is relieved or at acceptable levels or the nurse stops treatment for further intervention. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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F 309	Continued From page 17 decreased at 8:00 AM, but no rate of pain was noted. Observation, on 06/12/13 at 10:00 AM, revealed Resident #1 was sitting up in his/her room, after completing physical therapy. The resident complained of his/her "bottom" hurting and appeared uncomfortable. Observation, on 06/12/13 at 10:15 AM, revealed a staff member reported the resident's pain to Registered Nurse (RN) #1 with the state surveyor present. At 10:30 AM, the resident remained in the wheelchair with facial grimacing. Further observation, on 06/12/13 at 11:50 AM, revealed Resident #1 remained up in his/her room. The resident revealed his/her "bottom" was still hurting "pretty bad." Review of the Controlled Substance Proof of Use sheet, dated 06/12/13, revealed RN #1 administered Dilaudid 4 mg at 12:40 PM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 12:40 PM. Review of the Impaired Skin Integrity Care Plan, dated 05/20/13, revealed if there was complaints of pain during a treatment, stop the treatment, leave the resident safe, and seek pain relief. Return to complete the treatment when the pain was reported as acceptable. Observation of a dressing change, on 06/12/13 at 1:15 PM, revealed a moderate amount of yellow/bloody drainage to the right leg wound	F 309		

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F 309	Continued From page 18 dressing. During the removal of the dressing, the resident was wincing in pain with facial grimacing. Further observation revealed the dressing appeared to be stuck to the resident's leg and was difficult to remove. The resident began to cry, with visible tears rolling down the resident's face, as RN #1 continued to remove the dressing. RN #1 indicated the resident had been "pre-medicated" and continued removing the dressing without implementing any other intervention. Review of the Controlled Substance Proof of Use sheet, dated 06/13/13, revealed RN #1 administered Dilaudid 4 mg at 8:00 AM. Review of the MAR, dated June 2013, revealed no documentation of the location, rate of pain, or effectiveness of the medication given at 8:00 AM. Observation of a dressing change, on 06/13/13 at 10:00 AM, revealed old dressings were removed from four (4) wounds on the resident's right side. Further observation revealed Resident #1 continuously stated "Oh" during the treatment/dressing of the wounds. Observation revealed facial grimacing and complaints of pain during the treatment. The resident was rolled to the other side while continuously stating "Oh God, please." Dressings were removed from three (3) wounds on the resident's left side. During treatment of these wounds, facial grimacing was observed with the resident stating "Oh, please." Throughout the treatment of the wounds, RN #1 stated "Is the pain pill not helping?" and "We are almost done. It's hard on you, isn't it?" Interview with Resident #1, on 06/13/13 at 5:30 PM, revealed pain medications were not effective	F 309		

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F 309	Continued From page 19 during treatments. The resident stated it may be better if staff give him/her pain medications before the pain was so bad. He/she revealed the rate of pain during the treatment on 06/13/13 was an "8" out of "10." The resident indicated that was "pretty bad" pain. Interview with Resident #1's husband, on 06/13/13 at 5:30 PM, revealed the pain had actually improved as the resident used to "squawl out" during treatments. He indicated the resident sometimes had to ask three (3) times before getting pain medications. Interview with RN #1, on 06/14/13 at 10:00 AM and 3:00 PM, revealed pain medication was not given when asked on 06/12/13 as it was not time for the medication. She revealed the resident was assessed and informed that it was not time for pain medication. Further interview with RN#1 revealed she had not notified the resident's physician of the resident's unrelieved pain. She indicated Resident #1 always had pain during treatments. She stated the resident feared the treatment before it even starts. She stated the resident had anxiety disorder, which was "a lot of the problem." She stated when a resident complained of pain before touching them, then it had to be due to the resident's anxiety. She revealed documentation of pain medications included the location of the pain pain, rate of pain, and effectiveness; however, she was unsure of the reason it was not documented on 06/12/13 or 06/13/13. She revealed the resident's pain management was effective for him/her as the resident's behavior during treatments on 06/12/13 and 06/13/13 was "typical."	F 309		

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F 309	Continued From page 20 Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed documentation of pain included the rate of pain. The DON stated she expected staff to reassess and document within the hour after a pain medication was given. She felt the interventions on Resident #1's care plan were generic and should have been more individualized; however, she still expected staff to follow the interventions. She stated staff should try non-pharmalogical interventions if it was not time for pain medication but if a resident continued to complain of pain, the physician should be notified. She expected staff to try other measures for relief during treatments and call the physician if pain continued. An attempt to interview Resident #1's primary physician, on 06/14/13 at 10:35 AM, revealed he was not available for interview. Interview with the Medical Director, on 06/14/13 at 2:00 PM, revealed he would expect staff to notify the physician if the pain medication was not effective during a treatment.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 – Treatment/Svcs to Prevent/Heal Pressure Sores 1. The physician was notified of resident # 1's pressure ulcer on 6/13/13 by the Assistant Director of Nursing with an appropriate treatment put in place. 2. A complete skin assessment will be completed on all current residents by 7/28/13 by the Director of Nursing, Assistant Director of Nursing or Unit Manager. Any identified skin impairments will be reviewed to assure that the MD has been notified, documentation complete and an appropriate treatment if needed are in place. Any identified skin impairments that have not had MD notification or	7/28/13

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F 314	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received necessary treatment and services to promote healing for one (1) of fourteen (14) sampled residents (Resident #1). A skin assessment for Resident #1 revealed the nurse identified a "red, mushy" area on the resident's left heel, and a darkened scabbed area to the left second toe; however, the nurse did not assess, document, or notify the physician of the new areas to ensure an appropriate treatment was in place to promote healing. The findings include: Review of the Skin System policy/procedure, revised 08/08, revealed on admission and when observed skin was compromised, the nurse finding the problem would initiate a treatment using a formulary product, if possible and physician approval. Physician and family would be notified at the time of discovery and notification would be documented in the medical record. Record review revealed the facility admitted Resident #1 on 03/20/13, with diagnoses which included Peripheral Vascular Disease, Chronic Ulcer of the Leg, Rheumatoid Arthritis, Pain in Joint, and Muscle Weakness. Review of the significant change Minimum Data Set (MDS), dated 05/20/13, revealed the facility identified the resident as moderately cognitively impaired. Review of the Pressure Ulcer Risk Assessment,	F 314	that does not have an appropriate treatment in place, the facility will contact the physician for notification and or treatment. 3. All Licensed Nurses will be re-educated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Regional Nurse Consultant on assessing, documentation, physician notification and appropriate treatment for pressure ulcers. This re-education will be completed by 7/28/13 with no Licensed Nurse working after 7/28/13 without having receiving this training. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments documented the skin impairment and notified the physician of any new skin impairments for appropriate treatment if needed. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social	

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	185224	A. BUILDING _____ B. WING _____	06/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 22 dated 03/20/13, revealed the facility identified the resident at high risk for pressure ulcers. Observation, on 06/13/13 at 10:15 AM, revealed Resident #1 complained of pain to the left heel. Upon observation by Registered Nurse (RN) #1, the left heel was described as "red, mushy." RN #1 made the statement the heel needed to be "propped up." Additionally, RN #1 identified a darkened scabbed area on the resident's left second toe. Record review, on 06/14/13 at 9:00 AM, revealed no documentation of the area identified to the resident's left heel or left second toe. There were no new treatments initiated. Observation with the Assistant Director of Nursing (ADON), on 06/14/13 at 10:45 AM, revealed the resident's left heel was red and non-blanchable. The ADON revealed it was "boggy" underneath. The ADON left the room to obtain supplies to assess the wound. Approximately ten (10) minutes later, yellow drainage was noted to the bed as the "blister" had ruptured. The ADON assessed the area as a "Stage 2" measuring 1.2 centimeters (cm) in length by 1.1 cm width. She assessed the darkened scabbed area to the left second toe as "unstageable" measuring 1.0 cm in length by 1.4 cm width (possibly an arterial or venous ulcer). Interview with RN #1, on 06/14/13 at 10:10 AM, revealed she identified the area to the resident's left heel, on 06/13/13. She revealed the ADON was made aware and would be responsible to notify the physician for a treatment plan. She revealed the increased pain to the left heel was	F 314	Services Director with the Medical Director attending at least quarterly.	

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F 314	Continued From page 23 not addressed as she did not feel it was significant. RN #1 revealed the darkened scabbed area to the left second toe was identified on 06/13/13; however, she did not address the findings. She revealed the ADON should have been made aware. She indicated it was "probably" her responsibility to notify the physician of both areas, since she was the identifying nurse. Interview with the ADON, on 06/14/13 at 10:45 AM, revealed she was not aware of the newly identified areas on 06/13/13. She revealed RN #1 should have assessed, measured, and documented the wounds, as well as notified the physician for a treatment plan. Interview with the Director of Nursing (DON), on 06/14/13 at 4:45 PM, revealed the ADON assessed and measured wounds weekly; however, if new areas were identified, it would be that nurse's responsibility to assess, document, and notify the physician for treatment.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	F323 – Free of Accident Hazards/ Supervision/Devices 1. The knife for resident # 12 was removed by a CNA on 6/12/13. 2. A facility wide audit was completed by the Administrator and Maintenance Director on 7/17/13 to identify any environmental hazards including knives. No other identified environmental hazards were identified. 3. All facility staff will be re-educated by the Administrator, Director of Nursing, Assistant Director of Nursing of Unit Manager related to promoting a safe environment including residents using sharp objects to include knives and scissors. This education will be completed by 7/28/13 with no staff	7/28/13

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F 323	Continued From page 24 by: Based on observation and interview it was determined the facility failed to ensure the resident environment remained as free of accident hazards as is possible related to sharp knives observed being kept unsecured in a resident's room. The findings include: Review of the facility's Admission Agreement, dated 07/01/12, revealed under the responsibilities Section #9: "The resident agrees that if the presence of any of his or her personal possessions violates local, State, Federal laws, rules, or regulations, or policies of the Center, the Center has the right to require the resident to remove them or to seek assistance from appropriate authorities to assist in the removal of such possessions". A record review revealed Resident #12 was admitted to the facility on 03/11/13 with diagnoses to include Diabetes Mellitus and Congestive Heart Failure. A review of the admission Minimum Data Set assessment, dated 03/18/13 revealed the facility assessed the resident as cognitively intact. There was no evidence an assessment was completed to determine if it was safe for the resident to store knifes in his/her room. Observation on 06/12/13 at 6:30 AM, during the initial tour, revealed Resident #12 was in his/her room. Interview with the resident at this time revealed the resident was confused. Observation on 06/12/13 at 12:00 PM, revealed the lunch meal being served to Resident #12 in	F 323	working after 7/28/13 without having received this education. 4. The Administrator, Director of Nursing, Assistant Director of Nursing or Unit Manager will complete weekly audits for twelve (12) weeks of the facility to assure that no unsafe objects are unsecured. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete a look behind skin assessment five (5) times per week for twelve (12) weeks. A look behind skin assessment is a skin assessment completed after the direct care nurse has completed a skin assessment to assure that the nurse has identified any new skin impairments and notified the physician of any new skin impairments. The results of these audits will be reviewed with the Quality Assurance Committee Monthly for at least three (3) months to assure ongoing compliance. If at any time concerns are identified, a Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director with the Medical Director attending at least quarterly.	

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F 323	Continued From page 25 his/her room. Resident #12 did not want what was being served and requested the Certified Nurse Aide (CNA) #1 to obtain ring bologna from the resident's personal refrigerator located in the room and a knife to cut the bologna. The CNA obtained the bologna from the refrigerator and then got a sharp knife from the bed side night stand top drawer. Observation, at the time revealed two (2) sharp knives, unsecured, in the top drawer of the Resident #12's bed side night stand. Interview with CNA #1, on 06/12/13 at 12:50 PM, revealed sharp objects were never to be unsecured in residents' rooms and she did not know how long Resident #12 had the sharp knives. The CNA reported the sharp knives she had observed to her supervisor after serving Resident #12's lunch. Interview on 06/12 13 at 3:45 PM, with the Assistant Director of Nursing (ADON), revealed residents were not permitted to keep sharp knives in a drawer unsecured because there was a potential for injury as multiple residents who were confused and wandered. Interview with the Director of Nursing (DON), on 06/12/13 at 3:50 PM, revealed no resident was to have any sharp object in their room that was not secured. It was the responsibility of everyone to observe and ensure sharp objects were not left unsecured.	F 323		