STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **365277**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF BRADFORD PLACE	**1302 MILLVILLE AVENUE** **HAMILTON, OH 45013**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview and review of a facility drug reference manual, the facility failed to develop a comprehensive care plan regarding the use of psychoactive medications. This affected one (#7) of five residents reviewed for unnecessary medications. The facility identified 56 residents who receive psychoactive medications. Facility census was 72. Findings include: Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #7's medical record revealed an admission comprehensive assessment dated [DATE] which revealed the resident receives antipsychotic and antidepressant medications. The admission assessment documented that Resident #7 triggered for [MEDICAL CONDITION] drug use and that a comprehensive care plan would be developed. Review of Resident #7's comprehensive care plans revealed there was no care plan to address Resident #7's [MEDICAL CONDITION] drug use. Review of Resident #7's admission physician orders [REDACTED]. On 02/12/14 at 10:33 A.M., Registered Nurse (RN) #9 confirmed that Resident #7 receives the several [MEDICAL CONDITION] medications: [REDACTED]. RN #9 confirmed this care plan should have been completed several weeks ago; however, she has been busy and just did not get to the care plan.
F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, resident and staff interview, facility policy review and review of documentation from the National Pressure Ulcer Advisory Panel (NPUAP), the facility failed to implement interventions to prevent avoidable in-house acquired pressure ulcers and failed to identify multiple avoidable pressure ulcers until they were either Stage III or unstageable (blackened in color with necrotic tissue). This resulted in Immediate Jeopardy for five (#103, #2, #81, #133, #143) of eight residents reviewed for pressure ulcers. The facility identified seven residents with in-house acquired pressure ulcers. This had the potential to affect all residents in the facility. The facility census was 72. On 02/13/14 at 11:21 A.M., Regional Vice President #3, Director of Clinical Operations #5 and the Director of Nursing (DON) were notified Immediate Jeopardy began on 09/08/13, when Resident #103 was found with an avoidable, unstageable blackened pressure ulcer to the left heel. In addition, Resident #2 was found with an avoidable, unstageable pressure ulcer to the right heel on 01/02/14; Resident #81 was found with avoidable, unstageable pressure ulcers to the right and left heel on 02/03/14; Resident #133 was found with an avoidable Stage III pressure ulcer to the left ischium on 02/05/14; and Resident #143 was found with an avoidable, unstageable pressure ulcer to the left heel on 02/05/14. There were no documented measures to prevent skin breakdown implemented for any of the five residents prior to the facility's discovery of either Stage III or unstageable pressure ulcers. Immediate Jeopardy was removed on 02/18/14 when the facility implemented the following corrective actions: ? On 02/13/14, Certified Nurse Specialist (CNS) #112 completed a full assessment of all current residents identified with pressure areas and any resident identified at risk for the development of pressure ulcers. ? On 02/13/14, the Director of Nursing or designee assessed all residents identified at risk for pressure ulcers and ensured interventions to prevent skin breakdown were implemented and in place. ? On 02/13/14, the facility implemented a new skin policy and wound protocol. The new skin care policy and wound protocol was to provide a system for evaluation of skin at risk, identify individual interventions to address risk and process for care of changes/disruption in skin integrity. The process stated all residents admitted will be observed for baseline skin condition and evaluated for risk of skin breakdown within 24 hours of admission and will be documented in the electronic record; weekly review of the patient's skin will be completed by the nurse and documented; residents will be observed by the State tested Nursing Assistant (STNA) daily for reddened/open areas changes will be reported to the licensed nurse; pressure relieving cushions for any resident who utilized a wheelchair; and initiate redistribution schedule as necessary for residents who have skin integrity issues. The policy also instructed staff to do an updated Braden score and new risk assessment so they can identify when the plan of care needs to be changed or updated. Pictures of skin alterations were included in training packet so STNA's and nurses could identify and correctly assess the skin issue they were seeing so correct treatment could be implemented. ? On 02/13/14 through 02/18/14, the facility provided in-service training to staff nurses and State tested Nursing Assistants (STNA) on the new skin policies that included interventions for residents identified with skin concerns, residents at risk for pressure and on the new wound protocol. ? On 02/16/14, the DON or designee completed a compliance audit of skin protocol including Braden scales and ensured appropriate interventions to prevent pressure ulcers and/or promote healing of pressure ulcers were in place. ? On 02/18/14, STNA's #14, #25, #32, #33, #64, #77, #88 and #42 and Licensed Practical Nurse (LPN) #13 and #4 were able to correctly articulate the new protocols and verified they were in-serviced on resident's skin and potential issues. ? During observations on 02/18/14 and 02/19/14, the survey team verified interventions to prevent pressure ulcers and/or promote healing of pressure ulcers were in place for identified residents. Although the Immediate Jeopardy was removed on 02/18/14, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) because enough time had not elapsed for the facility to audit the compliance of their new skin protocol and audit that the appropriate preventative interventions were in place. Findings Include: 1. Review of Resident #103's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #103's Admission assessment dated [DATE] documented no skin breakdown related to pressure ulcers was present upon admission. According to Resident #103's Braden Scale for Predicting Pressure Sore Risk dated 06/07/13, the resident scored 15, placing the resident at low risk for the development of pressure ulcers. Review of Resident #103's comprehensive assessment dated [DATE] revealed the resident required extensive assistance of two staff with bed mobility, total dependence of two staff for transfers and does not ambulate. The assessment revealed the resident was at risk for pressure ulcer development, however, there were no pressure ulcers present. The assessment revealed a pressure ulcer care area assessment (CAA) had been completed and a care plan was put into place. Review of the Braden Scale to predict skin risk dated 07/07/13 revealed Resident #103 scored 14, indicating the resident was at moderate risk for pressure ulcers. The Braden Scale documented Resident #103's risk factors including slight sensory impairment, occasional moisture issues, chair-fast, very limited mobility, nutrition was probably inadequate and the resident had potential friction/shearing issues. Review of Resident #103's skin grid dated 09/08/13 documented Resident #103 was found with a 5 centimeter (cm) by 4 cm black/red area on the left distal heel. According to nursing focus notes dated 09/08/13, the resident was found with a dry blood blister on left heel. The skin grid dated 09/11/13 documented

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.

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) the left distal heel ulcer had progressed to a dark purple deep tissue injury that was unstageable. Review of a physician order [REDACTED]. Review of a skin grid dated 10/16/13 revealed the presence of a black area on the left lateral ankle measuring 0.7 cm by 0.4 cm. Review of a nursing focus note dated 10/16/13 revealed the wound nurse found the area on Resident #103's left lateral ankle. The area was described as unstageable. Review of a skin grid dated 10/30/13 revealed the onset of a purple deep tissue injury measuring 0.8 cm by 1.8 cm on the left proximal heel. According to a nursing focus note dated 10/30/13, the facility found the new area on the left proximal heel as a deep tissue injury and suspension boots were ordered. An air mattress was put in place on 11/27/13. Review of a skin grid dated 12/19/13 revealed the onset of a deep tissue injury on the left buttock measuring 10 cm by 3.0 cm by a depth of 0.1 cm, which was described as dark purple. Resident #103 was experiencing pain, scoring the pain a five on a one to ten scale, with ten being excruciating pain. Review of nursing notes dated 12/19/13 revealed the area on the left buttock was found during wound rounds with the wound care nurse. On 12/26/13, the wound was documented as a Stage III pressure ulcer and measured 6 cm by 2.5 cm by 0.1 cm. The area had a moderate amount of serous drainage, there was 80 percent (%) slough present and 20% granulation tissue. Resident #103 had an ultrasound to the bilateral lower extremities on 11/14/13. The ultrasound report showed no significant left-sided [MEDICAL CONDITION] and minimal to mild diffuse right-sided [MEDICAL CONDITION]. Review of a multilevel lower extremity evaluation/ arterial physiologic evaluation dated 02/06/14 revealed the right lower extremity with no hemodynamic stenosis with calcified vessels and left lower extremity is non-compressible, heavily calcified, no ankle-brachial index (ABI) was detected and the test indicated it was non-diagnostic. Review of the wound assessment report dated 02/07/14 revealed the presence of a new pressure ulcer on the right heel measuring 4 cm by 3.5 cm by a depth of 0.1 cm. The right heel was covered with 50% slough, 50% eschar and had moderate serous drainage from the wound. The resident rated the pain a nine on a one to ten scale. Nursing notes dated 02/07/14 documented the resident returned from the wound clinic with new orders related to the right heel pressure ulcer and to obtain heel lift suspension boots for both feet. On 02/11/14 at 12:39 P.M., Resident #103 was observed lying in bed on an air mattress, positioned on his back, favoring his left side. His left foot was observed in a cloth covered padded boot. The resident had his foot pulled upward and the left heel was digging into the boot and his left heel was touching the mattress through the boot. The resident would get spastic and pull his leg upward, and in the process he would externally rotate the leg. The left lateral ankle externally rotated with the lateral ankle on the bed. Resident #103's right leg was elevated on a pillow. On 02/11/14 at 1:13 P.M., Resident #103 remained in his bed, on his back, favoring his left side. Resident #103's heel remained touching the mattress in the cloth covered padded boot. On 02/11/14 at 4:45 P.M., Resident #103 was lying in bed, on his back, favoring the left side. The resident was asked at that time about the dressing on his feet. He stated he had sores on both of his feet. He stated he was comfortable at this time, but the sores hurt when they change the dressings. During the observation there was a moderate amount of drainage on the pillow located under Resident #103's right lower leg. On 02/11/14 at 5:02 P.M., Resident #103 was assisted up to his wheelchair for supper by two STNAs. Resident #103 had his left boot in place in the wheelchair; however, the right foot rested on the foot pedal without suspending the right heel. Resident #103 was seated on a cushion but was favoring his left side in the wheelchair. STNA #64 was interviewed at the time of the observation about the presence of the drainage on the pillow and she stated this was from the drainage from the right heel area. STNA #64 stated the resident squirms around a lot in the bed and moves his right leg. She stated staff put a padded boot on the left foot, but no boot is used on the right foot. She stated it was difficult to suspend the right heel on a pillow as the resident squirms and is uncooperative with keeping his foot on a pillow. On 02/12/14 at 8:42 A.M., Resident #103 was observed lying in bed on his back favoring the left side. The resident's left foot was in a boot; the left lateral ankle was externally rotated and toward the bed; and the left leg was drawn upward toward the resident's body. A sign was on the wall above the resident's bed indicating the resident should wear yellow foam boots in bed and while in the wheelchair, wear a yellow boot on the left foot and shoe on right foot. The only boot observed in the room at that time was a blue cloth boot, which was on the left foot. On 02/12/14 at 10:29 A.M., Resident #103 was lying in bed on his back, favoring his left side. His right heel was resting directly on the mattress and his left foot was in a boot, however the left leg was drawn upward and his outer ankle was resting on the mattress. Two pillows were stacked at the right edge of the bed on the mattress, not under the resident's right foot. LPN #3 was interviewed at that time and confirmed the resident's right heel was resting on the bed. LPN #3 confirmed the blue cloth boot would effectively suspend the heel for a cooperative resident however; it is not a true suspension boot. LPN #3 was interviewed on 02/12/14 at 2:40 P.M. and stated skin inspections are completed on shower/bathing days. LPN #3 stated the only documented skin inspections prior to the development of the unstageable pressure ulcer on the right heel were dated 12/26/13, 01/02/14 and 01/09/14. LPN #3 confirmed the last skin inspection completed prior to the discovery of the unstageable pressure ulcer on the right heel on 02/07/13 was done a month prior, on 01/09/14. On 02/12/14 at 3:54 P.M., Registered Nurse (RN) #19 was interviewed and stated Resident #103 went to the wound clinic on 02/07/14 and the wound clinic staff discovered an unstageable pressure ulcer on the resident's right heel. RN #19 confirmed the area on the right heel was blackened, the area was having moderate drainage and the resident was experiencing pain to the area. RN #19 stated the facility no longer uses the yellow boots. The yellow boot was a foam boot that was used by the company that previously owned the facility. When the new company purchased the facility, they began using a blue boot, which would have been in either October or November 2013. RN #19 stated she was unsure of the nursing note dated 10/30/13 that indicated suspension boots were ordered, as the first time true suspension boots were actually ordered was on 02/07/14 when the wound clinic ordered them. RN #19 stated the sign on the resident's wall was confusing for staff as it instructed the staff that a shoe was acceptable for the right foot, which at this time shoes are contraindicated to the right heel pressure ulcer. RN #19 stated Resident #103 would benefit from a more effective suspension boot that would be fitted to his needs, which is why the wound clinic ordered the suspension boot. RN #19 confirmed Resident #103 has some muscle tone issues related to a prior stroke which places him at increased risk of skin breakdown to the bilateral heels and left lateral ankle. The resident digs his heels into the bed and he pulls his left leg up toward his body causing friction/shearing issues to the left outer ankle region. Resident #103's family member was interviewed on 02/12/14 at 5:05 P.M. and stated the resident has had some restlessness since a stroke that occurred in May 2013 and he has been at the facility since June 2013. The resident entered the facility with no skin breakdown and currently has multiple bed sores. Resident #103's family member stated due to the stroke, the resident moves/ digs his legs into the bed. The family member and the resident confirmed the resident could feel sensation of the lower extremities and toes. Clinical Nurse Specialist (CNS) #112, RN #19 and the Director of Nursing (DON) were observed on 02/13/14 at 2:09 P.M. changing the resident's pressure ulcer dressings and measuring the pressure ulcers. CNS #112 and RN #19 measured Resident #103's pressure ulcers. The left buttocks measured 1.2 cm by 0.3 cm by 0.1 cm depth, identified as Stage III, 100% granulation tissue present; the left proximal heel over the bony prominence measured 4 cm x 3.6 cm and the area was circular; the left distal heel over the bony prominence, circular in appearance, measured 0.8 cm x 0.6 cm and contained eschar (necrotic, dead tissue); the left lateral ankle over the outer ankle bony prominence measured 3.8 cm x 3.4 cm x 0.3 cm depth, had a moderate amount of bright red bleeding, was circular in appearance and had eschar covering the wound; the right heel over the bony prominence measured 3.8 cm by 4.8 cm by 0.3 cm and had a moderate amount of serous drainage with eschar in the wound bed. The resident complained of pain, rating it a nine out of ten on a one to ten scale. CNS #112 stated Resident #103 recently had bone and tendon exposed in the left lateral ankle; however, this has now been covered with granulation (healthy) tissue. CNS #112 and the DON stated at the time of the observation they could not answer why preventative measures were not implemented prior to the development of the pressure ulcers. On 02/18/14 at 10:29 A.M., interview with LPN #7 revealed she began working on the floor in January 2014 and all of the resident's pressure ulcers were present, except the right heel area. LPN #7 stated she was on duty on 02/07/14 when the wound clinic found the presence of an unstageable pressure ulcer on the right heel. LPN #7 confirmed the STNA's did not make her aware of any area on the right heel and she did not find the area either. LPN #7 confirmed the right heel area was found at an advanced stage as it was blackened, draining a moderate amount and the resident was experiencing pain, at a nine out of ten on a one to ten scale. LPN #7 stated the suspension boots have been fitted, ordered and put into place following the appointment at the wound clinic on 02/07/14. The Medical Director was interviewed on 02/18/14 at 12:30 P.M. and stated Resident #103 is at very high risk for skin breakdown as he is immobile due to a stroke and the resident has compromised circulation to the lower extremities. The Medical Director stated the development of eschar can take days to weeks, varying on the resident. The Medical Director stated she feels Resident #103's eschar could have formed over a period of days, as the resident has compromised circulation. The Medical Director confirmed if a pressure ulcer is found with eschar covering the wound or if the wound is a deep tissue injury, the wound would be considered to be at an advanced stage of the process. The Medical Director further confirmed that pressure ulcer

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) prevention is the key; however, if a pressure ulcer develops early identification and treatment is also important. 2. Review of Resident #2's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Resident #2's comprehensive admission assessment dated [DATE] documented the history of bilateral heel pressure ulcers; however, these areas had healed following admission. According to Resident #2's significant change assessment dated [DATE], the resident required extensive assist of two staff for bed mobility, extensive assist of one staff for transfers, walking occurred once or twice and the resident was at high risk for pressure ulcer development. Review of Resident #2's Braden Scale for Predicting Pressure Sore Risk dated 12/12/13 documented the resident's overall risk factor was mild risk; however, Resident #2 was slightly limited with mobility, was chair-fast and had potential problems with friction/shearing. According to nursing notes dated 01/02/14, Resident #2's hospice aide informed the nurse of a change of status to the heels. The note documented the staff would begin a new treatment, the staff would encourage Resident #2 to wear boots while in bed and to elevate the heels as much as possible and a cradle would be applied to the resident's bed. A physician order [REDACTED]. Review of a wound assessment report dated 01/02/14 documented Resident #2 was found with a 2.5 cm by 4 cm Stage II pressure ulcer on the left heel that was facility acquired and was found with an unstageable pressure ulcer on the right heel measuring 1 cm by 1 cm that was 100% eschar covered. There was no other wound documentation prior to 01/02/14. Review of a comprehensive care plan dated 02/07/14, entitled I have an unstageable pressure ulcer and Stage II pressure ulcer, revealed the facility did not implement specific interventions regarding prevention of a heel pressure ulcer until after the development of the heel pressure ulcers. On 02/18/14 at 10:24 A.M., Resident #2 was observed lying in his bed with suspension boots on both feet. The heels were covered with dressings, no drainage was noted and the heels were appropriately suspended within the boots. The DON was interviewed on 02/18/14 at 2:05 P.M. and stated the resident was admitted with right and left pressure ulcers in May 2013, however these areas healed. She stated the resident was at high risk for pressure ulcer development on the heels despite the low score on his Braden scale dated 12/18/13. The DON confirmed the hospice aide found the right heel pressure ulcer at an advanced stage as it was a blackened area when it was discovered. The DON confirmed no preventative measures were implemented until after the pressure ulcers were discovered on 01/02/14. 3. Resident #81 was readmitted to the facility 01/07/14 after a one week hospital stay. The resident had [DIAGNOSES REDACTED]. The Initial Plan of Care dated 01/07/14 entitled potential for impaired skin integrity related to immobility, sensory loss and fragile skin. The interventions included to turn and reposition every one to two hours and as needed while in bed, encourage mobility as tolerated, keep heels up off of surfaces as tolerated, notify dietitian of skin issues, minimize sheer/friction, nursing staff to monitor skin daily with care, notify the skin nurse of new areas and stand every three to five minutes when up. The admission nursing assessment dated [DATE] revealed the resident had no pressure ulcer history, no wounds on the feet and the skin was warm and intact with pedal pulses present in both feet. The physician orders [REDACTED]. The Medication Administration Records (MAR) dated January 2014 and February 2014 documented the placement and the removal of the compression bandage wraps to both legs and feet daily. The comprehensive assessment dated [DATE] revealed the resident was alert and oriented, was not at risk for pressure ulcers and had no Stage I or higher pressure ulcers. The resident required the extensive assistance of one staff for bed mobility and transfers. The most current skin inspection report, dated 01/15/14, documented the skin was intact. Nursing notes dated 02/01/14 documented a skin tear on the left coccyx that measured 1 cm by 0.4 cm. The wound was documented very small and the wound clinic nurse was to evaluate, however, treatment was put in place for a skin tear. The nursing note dated 02/03/14 documented the resident had complained to the Physical Therapist about right heel pain. The right heel was black with an open area in the center. The area measured 5.5 cm by 3 cm by 0.1 cm with macerated edges and an open area that was pink in color. No drainage was present. A physician order [REDACTED]. The wound assessment report dated 02/03/14 documented only a Stage II pressure ulcer to the right heel, however, the report stated the wound was covered with eschar and was referred to the facility wound treatment nurse. The wound management assessment note dated 02/06/14 documented an unstageable pressure area to the right heel with eschar and slough, with a wound status of deteriorated. The treatment order dated 02/06/14 was to cleanse the right heel with wound wash, apply skin preparation, apply zinc oxide based hydrophyllic wound paste, then cover with dry dressing and wrap daily. The wound management note dated 02/06/14 documented the wound to the left coccyx was not a skin tear, but a Stage II pressure area that measured 0.5 cm by 0.3 cm by 0.1 cm; the edges were not well approximated and there were missing, torn skin flaps. On 02/10/14 at 3:09 P.M., Resident #81 was observed sitting up in wheelchair with the right and left heels touching the foot rests. She was only wearing the ordered wraps to her legs. The blue pressure relieving boots were observed sitting on the window ledge. On 02/11/14 at 1:14 P.M., Resident #81 was observed sitting up in the wheelchair with the right and left heels resting against the foot rests, wearing only the ordered wraps to her legs. The blue pressure relieving boots remained on the window ledge. At 3:15 P.M., she was still sitting in the wheelchair with both feet and heels resting upon the foot rest. On 02/12/14 at 6:25 A.M., the resident was in bed lying on her back. Her heels were resting directly on the bed and the blue pressure relieving boots remained on the window ledge. On 02/12/14 at 11:10 A.M., Resident #81 was observed in the therapy room working with the speech therapist. She was wearing sandals. On 02/12/14 at 2:30 P.M., LPN #4 confirmed the most current skin inspection report was dated 01/15/14 and further reported the State tested Nursing Assistant (STNA) lets the nursing staff know if there are any new areas. The wound management assessment note dated 02/13/14 documented the left coccyx area was a pressure area and a new Stage II pressure ulcer was identified on the right coccyx measuring 2 cm by 1 cm by 0.1 cm. The note stated the right coccyx wound was found that day during the wound rounds. A new treatment order was initiated on 02/13/14 for a low air loss mattress to the bed at all times. On 02/13/14 at 9:39 A.M., the Occupational Therapist (OT) said she had been working with Resident #81 and she complained of foot pain. She examined her foot and found the area. She stated she reported to the nurse immediately. She stated she only saw Resident #81 come to therapy wearing the blue pressure relieving boots maybe two times. She stated she thought a nurse told her the resident did not need to wear the boots. On 02/13/14 at 11:10 A.M., treatments to the resident's wounds were observed. The resident complained of pain in her buttocks from her bed sore. When the old dressing was removed, the buttocks were red and excoriated. The wound to the left coccyx measured 1.2 cm by 0.6 cm and the right coccyx measured 2 cm by 1 cm by 0.1 cm. The right heel was a large circular area covered in eschar on the back of the heel over the bony prominence and measured 2.7 cm by 5 cm with 100% eschar. CNS #112 stated the cause of the resident's pressure ulcers was from contact with a surface, probably the bed. According to the facility wound care procedure and protocol, revised 11/07/06, the nurse was to identify and stage pressure ulcers so then they could select the appropriate protocol for the condition identified. 4. Medical record review revealed Resident #133 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission clinical health status form, dated 01/20/14, documented Resident #133 was alert and oriented, required the physical assistance of two staff for bed mobility and transfer, used a wheelchair for locomotion and had a history of [REDACTED]. The documentation stated the resident's skin was warm and did not have any open areas. Pedal pulses were present in both feet. The initial plan of care entitled I am at risk for pressure ulcers with a goal of I will not experience any complications related to skin with interventions, dated 01/20/14, included interventions to reposition (no frequency documented), reduce friction and shearing, daily observation of skin with routine care and a full skin evaluation with weekly bath/shower. The daily skilled nursing note dated 01/25/14 documented a pressure area to the coccyx. There was no other documentation indicating further assessment or a treatment initiated at this time. The nursing note dated 02/06/14 documented the nurse was alerted by STNA's of an open area to the perineum. The resident was assessed and an excoriated area near her vulva was discovered measuring 3 cm by 2 cm by 0.1 cm. A Braden Risk Assessment was also completed at this time, scoring 16, indicating mild risk for skin breakdown; however, Resident #133 is paraplegic, has sensory loss in lower extremities and has limited mobility. The wound assessment report dated 02/06/14 documented wound nurse discovered the left ischium had a Stage III pressure area measuring 1.5 cm by 3.5 cm by 0.10 cm covered in 50% slough and 50% granulation tissue; the left sacrum was identified as a Stage II pressure ulcer measuring 1.2 cm by 0.50 cm by 0.10 cm with 100% granulation tissue; and the right labia had a Stage II pressure ulcer that measured 2.5 cm by 1 cm by 0.10 cm with 10% eschar and 90% granulation tissue. The physician order [REDACTED]. The skin inspection report dated 02/06/14 was the only skin inspection documented in the record and reported the skin was not intact. On 02/11/14 at 2:47 P.M., resident was observed sitting in the wheelchair with a pressure relieving cushion in place. At 4:05 P.M., the resident was observed sitting in her room in the wheelchair. The [MEDICATION NAME] bag was full of urine. The wafer was not intact around the stoma and urine was leaking around the stoma. On 02/12/14 at 9:29 A.M., care was observed. STNA #32 removed the resident's incontinent brief and a large amount of stool was observed on Resident #133's skin. STNA #32 began to clean the stool and as she wiped, some of the stool was dried on the resident's skin. STNA #32 stated the stool dries fast and she was last in her room about two hours ago. When STNA #32 went to remove the soiled incontinent brief, she began to tug the brief out

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F 0314 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) from underneath the resident. She stopped herself, then rolled and tucked the brief up underneath the resident and rolled her over to remove the brief. The resident's perineal area was red and the left ischium had no dressing intact. STNA #32 said she had not ever observed a dressing in place to the ischium and her perineal area was always red. On 02/13/14 at 10:02 A.M., Resident #133 had her call light on and upon entering the room, it smelled of feces. Resident #133 stated she put the light on to alert staff she needed some help. She stated I put it on because it could take a long time before someone comes. Resident #133 was lying on her back slightly turned toward the right side and her heels were resting on the bed. At that time, two STNA's approached the room to attend to the resident. On 02/13/14 at 10:10 P.M., morning care was observed with STNA #33 and STNA #77. The incontinent brief contained a large amount of stool and the stool was on the resident's skin. STNA #33 pulled the old brief out from underneath the resident. The brief rubbed against the resident's skin and got stuck at times. STNA #33 reported she should not have pulled on it like this as it was not good for the resident. She then went to get some of the ointments in the top drawer and grabbed the wrong one and was told by the resident which ointment was the correct one for each area. STNA #33 said she really did not know what barrier cream to use and she said she would have to ask the nurse, but she continued to put on the ointment the resident said was correct. Both confirmed the resident's heels were resting against the bed and they were not off loaded. While the STNA's were applying the resident's antiembolism stockings (stockings to prevent blot clots) a large red circular area was observed on the outer aspect of the right heel where it had been lying against the bed. STNA #7
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure a resident who was at risk for falls had care planned interventinos in place. This affected one (Resident #103) of six residents reviewed for falls. The facility census was 72. Findings include: Resident #10's assessment dated [DATE] identified the resident as at risk for falls due to impaired balance, the use of antipsychotic and antidepressant medications, incontinence, [DIAGNOSES REDACTED]/hemiparesis, [DIAGNOSES REDACTED]. Review of his care plans revealed he had a plan of care for falls with an onset date of 06/07/13. Review of the plan of care for falls revealed Resident #103 was identified as at risk for falls related to having a history of falls, generalized weakness, co-morbidities and medication used daily. The interventions included the use of a wheelchair to transport; to evaluate effectiveness and side effects of medications; the use of a low bed low; to keep the room free of clutter; to keep needed items in reach; and to keep a fall matt on the floor to the open side of the bed. Review of his plan of care for transfers revealed he required a hoyer lift and two staff for all transfers. Review of nursing notes revealed on 01/17/14 at 3:50 P.M. the nurse was notified by housekeeping that the resident was laying on the floor. According to the note upon entering the room, she observed the resident was laying on the floor next to the bed on his side. The resident told the nurse that he tried to scoot over and slid out of the bed. An interdisciplinary note dated 01/20/14 stated that that the intervention of fall mat to the open side of the bed was added as result of this fall. On 02/12/14 at 10:25 A.M., the resident was laying in his bed. At that time the bed was not low and the mat was not on the floor next to the bed. The mat was folded up and sitting next to the dresser. Staff were not present in the room or in the corridor outside of the resident's room. LPN #3 verified the resident had been left in the room alone with the bed in the high position and without the fall mat next to his bed.
F 0325 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to reassess and intervene after a resident suffered a significant weight loss and failed to ensure a resident was weighed in accordance with the plan of care. This affected two (Resident #12 and Resident #7) of four residents reviewed for nutritional status. Findings include: 1. Review of Resident #12's medical record revealed he was admitted on [DATE] and weighed 223 pounds. He had [DIAGNOSES REDACTED]. Review of the resident's plan of care with an initiation date of 12/12/13 revealed the resident had a tube feeding that was only being flushed and was no longer used as his primary means of receiving nutrition and hydration. According to the plan of care he had a history of [REDACTED]. The goal on the dietary plan of care was for the resident to remain between 175 and 195 pounds and to maintain an intake of 50 to 75 percent for most meals. The goal date was 03/30/14. The interventions were for the staff to encourage the resident to eat in the dining room with other residents and to monitor intakes, weights, labs, and skin condition. Review of the resident's weight record revealed he weighed 206 pounds on 06/01/13; 206.2 pounds on 07/11/13; 204 pounds on 10/02/13; 198 pounds on 11/01/13; 196.6 pounds on 12/09/13; and 184.2 pounds on 01/15/14. Review of these notes revealed this represented a 6.3 percent weight loss from 12/09/13 to 01/15/14 and a 10.6 percent weight loss from 07/11/13 to 01/15/14 (a six month period). Review of progress notes revealed the weight loss of 12.4 pounds was not addressed in the progress notes and no additional interventions were put into place to prevent further weight loss. Review of the record revealed the last dietary note was a 01/29/14 care conference note written by the dietitian. The note stated the resident was having a slow consistent weight loss and the goal was to have a consistent intake without rapid weight change. The notes did not address the resident's significant weight loss between December 2013 and January 2014. On 02/12/14 the resident was weighed at the request of the surveyor and he weighed 174.6 pounds, representing an additional 5.2 percent weight loss. The Dietitian was interviewed on 02/12/14 at 9:30 A.M. she verified the resident had lost a significant amount of weight and verified she had not placed any additional interventions in place to prevent any further weight loss. 2. Review of Resident #7's medical record revealed the resident was originally admitted to the facility on [DATE] and more recently readmitted from a hospital stay on 12/21/13. [DIAGNOSES REDACTED]. Review of Resident #7's admission physician orders [REDACTED]. According to Resident #7's nutritional assessment dated [DATE] and dietary progress note dated 11/29/13, the resident was at nutritional risk. His current meal intakes were 50-60 percent overall. The resident feels that his appetite is decreased, and the facility plan to monitor his meal intake, fluid intake and weights as available. Review of a situation, background, assessment, recommendation (SBAR) form dated 12/24/13 revealed Resident #7 was experiencing increased [MEDICAL CONDITION] and the physician ordered to monitor daily weights. Resident #7's comprehensive nutritional care plan dated 01/03/14 was reviewed. The nutritional care plan documented a [DIAGNOSES REDACTED]. The care plan documented to monitor weights. Review of the resident's record revealed on 11/23/13 the resident weighed 151.8 pounds (lbs); 12/22/13,169.4 lbs; 12/26/13, 164 lbs; 12/27/13, 158 lbs; 12/28/13,155.8 lbs; 12/29/13, 155.2; 12/30/13, 146.6; 01/01/14, 140 lbs; 01/03/14, 137.9; 01/04/14, 134.8 lbs; 01/14/14, 155 lbs; 02/03/14, 150.4 lbs and 02/11/14, 141 lbs. There was a lack of documentation to support admission weights were taken every day for three days, then weekly times four weeks and a lack of documentation that multiple daily weights were not monitored following the order dated 12/24/13. On 02/12/14 at 8:55 A.M. the Director of Nursing (DON) was interviewed and confirmed the facility's protocol is to weigh residents every day for three days following admission and then weekly time four weeks; however, the DON confirmed this was not done for Resident #7. The DON confirmed Resident #7 received an order for [REDACTED].#7 had nutritional risk due to the [DIAGNOSES REDACTED]. The DON confirmed Resident #7 experience some significant weight fluctuations regarding gains and losses, which supports the need to monitor the weights as recommended by the dietician and ordered by the physician. The DON stated she feels some of the missing weights maybe related to the new electronic medical record the facility implemented within the past several months.
F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **365277**	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED **02/19/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF BRADFORD PLACE	**1302 MILLVILLE AVENUE HAMILTON, OH 45013**

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F 0329 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) Based on medical record review and staff interview, the facility failed to have an adequate indication for use for an antipsychotic medication. This affected one (#7) of five residents reviewed for unnecessary medication review. The facility identified nine residents who receive psychoactive medications. Facility census was 72. Findings include: Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. Review of Resident #7's admission physician orders [REDACTED]. Review of the comprehensive admission assessment 01/16/14 revealed the resident receives an antipsychotic medication, however, no psychotic [DIAGNOSES REDACTED].#7's medical record revealed a lack of an appropriate [DIAGNOSES REDACTED]. The Director of Nursing (DON) stated during interview on 02/12/14 at 8:51 A.M. Resident #7 has taken [MEDICATION NAME] daily since admission. Since this drug is an antipsychotic, this would require some type of psychiatric diagnosis. The DON confirmed a lack of an appropriate [DIAGNOSES REDACTED].#7.
F 0431 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and facility policy, the facility failed to keep all medications secured at all times on the 300 south hall cart. This affected one of five medication carts reviewed for medication storage. This had the potential to affect all residents who resided on the 300 floor. The facility census was 72. Findings include: On 02/10/14 at 12:04 P.M., Licensed Practical Nurse (LPN) #13 was observed taking medications into Residents in room [ROOM NUMBER]. As LPN #13 walked away from the cart and left the cart unlocked. There were no residents in the vicinity at this time. When LPN #13 came out of the room she verified she left her cart unlocked and verified the cart should be locked at all times. On 02/10/14 at 3:15 P.M., a bottle of Vitamin B was observed sitting on top of the 300 south hall medication cart. The cart was locked and no staff or residents were in the area. LPN #13 was then observed coming out of a room and reported she did not leave this medication here. It was a brand new stock medication and had the safety seal still attached. She further reported it must had just been dropped off, but could not confirm when it had been placed on her cart. On 02/12/14 at 6:27 A.M., nine pharmacy packaged medications were observed sitting in the hallway on top of the 300 south hall medication cart. The medications included Celexa 20 tablets, fluticasone nasal spray, Odanestron 40, Promethazine, Coumadin, Prilosec 20 mg, vitamin D, Dontazil 5 mg and Exelon patches. All packages were sealed and intact, however no staff were around. At 6:35 A.M., LPN #26 was observed coming from the nurses station. She verified the medication were unsecured on top of the cart and began to put them away and reported she should had locked them up when she first checked them in. Review of the facility policy titled Storage and Expiration of Medications revised 01/01/13 the facility should keep all medications secured in accordance with applicable laws.
F 0463 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's room or bathroom and bathing area.** Based on observations, resident interview and staff interview, the facility failed to ensure a residents call light was properly functioning. This affected one (#139) of 19 residents in the stage two survey sample. Facility census was 72. Findings include: On 02/10/14 at 12:00 P.M., observations of Resident #139's call light revealed the residents call light was connected to the call light system in the resident room with a Y connector to allow a pressure pad bed alarm to be linked into the call light system. Resident #139 attempted to activate the call light and the call light did not activate. During the observations Resident #139 pulled on the call light which caused it to slightly disconnect from the Y connection and the call light activated. The surveyor was unable to cancel the call light and Registered Nurse (RN) #9 came to the room. RN #9 had difficulties canceling the call light and was unable to get it to reactivate. RN #9 stated she would ensure the call light was fixed by maintenance. On 02/11/14 at 9:41 A.M., Resident #139 was observed in her bed. Resident #139 had moved rooms. Resident #139's call light was observed and it appeared to be the same call light with the Y connector to allow the pressure pad alarm to be connecting into the call light system. Resident #139's call light would not activate during the observations. On 02/11/14 at 9:42 A.M., Licensed Practical Nurse (LPN) #12 confirmed that Resident #139 had moved to a different room since the previous day. LPN #12 confirmed that Resident #139's call light has a Y connector to allow her to use the call light and to allow a pressure pad bed alarm to be linked into the call light system. LPN #12 confirmed that Resident #139's call light would not activate and she contacted maintenance by phone during the interview. Maintenance Staff #11 was interviewed on 02/11/14 at 1:21 P.M. regarding Resident #139's call light. Maintenance staff #11 stated the Y connector on the call light system had a short and this has been replaced and the call light now works. Maintenance Staff #11 stated this morning was the first he was made aware of Resident #139's call light not functioning properly.
F 0501 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Choose a doctor to serve as the medical director to create resident care policies and coordinate medical care in the facility.** Based on record review and staff interview, the facility failed to involve the Medical Director, in collaboration with the facility, in his roles and functions related to coordination of medical care and the implementation of resident care policies resulting in a substandard quality of care deficiency related to pressure ulcers. Additionally, the facility and Medical Director were unable to provide any documented evidence of Medical Director input or reports of oversight from October 2012 through December 2013. This affected all 72 residents who reside in the facility. Findings include: The facility failed to obtain the Medical Director's input to assure that residents were provided with the necessary care, assessments and services to prevent actual harm to residents when five (Residents #2, #81, #103, #133 and #143) of eight residents reviewed for pressure ulcers were found with avoidable multiple advanced staged pressure ulcers which resulted in substandard quality of care under CFR 483.25 (c), Quality of Care (refer to Data Tag F314). The facility administration failed to ensure the Quality Assessment and Assurance Committee developed and implemented a plan of action, monitored the effectiveness of the plan, and revised the plan as needed (refer to Data Tag F520). As a result, the facility was not assessing residents, monitoring care processes in relation to development of pressure ulcers. Review of the Medical Director reports dated from October 2012 through December 2013 revealed there were no documented concerns relating to pressure areas or skin issues. On 02/18/14 at 12:30 P.M., the Medical Director confirmed if a pressure ulcer is found with eschar covering the wound or if the wound is a deep tissue injury the wound would be considered to be at an advanced stage of the process. The Medical Director confirmed that pressure ulcer prevention is the key; however, if a pressure ulcer develops early identification and treatment is also important.
F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on observation, interview and record review, the facility failed to implement an action plan when they identified pressure ulcers as an area of quality concern, resulting in a substandard quality of care deficiency. Failure to implement an action plan directly affected five (Residents #2, #81, #103, #133 and #143) of eight residents reviewed for pressure ulcers who were found with avoidable multiple advanced staged pressure ulcers and had the potential to affect all residents in the facility. The facility census was 72. Findings Included: During the survey process concerns were identified through observations, medical record review, staff interview, policy review, physician interview, medical director interview, and review of medical director reports in the area of pressure ulcers. Actual harm, substandard care was identified at 483.25 (c) pressure ulcers. (See Data Tag F314). Interview with the Medical Director on 02/16/14 at 12:30 P.M. revealed the facility had identified concerns with pressure ulcers prior to the survey, about two to three weeks ago. The Medical Director stated they did not change their policy or procedure or implement an action plan at that time. Interview on 02/18/14 at 2:23 P.M. and 4:30 P.M. with the Director of Nursing (DON) revealed the facility identified concerns related to

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F 0520 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) pressure ulcers during their Quality Assurance meeting on 01/24/14, but had not fully implemented their action plan.