STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **115467**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **02/05/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY NURSING & REHAB CTR	**180 EPPS BRIDGE RD ATHENS, GA 30606**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility staff interview, resident interview, Wound Care Specialist Evaluation review, and Employee Statement of Events form review, the facility failed to provide care in a manner which prohibited neglect, related to warm moist compress application and resident monitoring after compress application, for one (1) resident (A) from a survey sample of thirteen (13) residents. This failure resulted in neglect for Resident A, when a warm moist compress was applied to the resident's left knee without nursing staff checking the compress temperature to ensure safety, and without nursing staff frequently monitoring the resident after application, per facility Procedure. Resident A sustained left knee blisters in an area approximately six (6) centimeters (cms) by ten (10) cms in size which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. in size. This resulted in a situation in which the facility's non-compliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator, Director of Nursing (DON), and Risk Manager were informed of the immediate jeopardy on February 3, 2014, at 11:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 17, 2013 (the date a moist heat compress which had been heated in a microwave oven was applied to the left knee of Resident A without staff determining the temperature of the moist heat compress or frequently monitoring the resident's skin under the compress, per facility Procedure, resulting in the resident sustaining second [MEDICAL CONDITION] blistering to the left knee and thigh), continued through February 3, 2014, and was removed on February 4, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 3, 2014. During a 01/15/2014, 3:30 p.m. interview, the Administrator and Director of Nursing (DON) acknowledged that after the application of the warm moist compress to Resident A's knee on 12/17/2013, the nurse should have monitored Resident A more frequently, as specified by the facility's Procedure regarding warm moist compress application. An allegation of jeopardy removal was received on February 3, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 3, 2014, and the facility remained out of compliance at a lower scope and severity of D while the facility completed a process which involved the retraining, via staff in-service, of nursing staff related to a new Policy and Procedure regarding warm moist compress use to ensure the safe use of warm moist compresses. All available nursing staff had received this in-service training, however, the training process continued as staff who were initially unavailable received this in-service training as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the use and application of warm moist compresses, and observations were made to assess staffs' performance of care. Findings include: Record review for Resident A revealed a 12/10/2013 Minimum Data Set in which Section C - Cognitive Patterns documented that the resident was cognitively intact, having a Brief Interview for Mental Status score of fifteen. Section I - Active [DIAGNOSES REDACTED]. A 12/16/2013 Physician's Telephone Orders form for Resident A specified application of warm moist heat to the left knee every shift for three (3) days for pain and swelling, and a 12/17/2013, 9:09 a.m. Progress Notes (PN) entry documented the 1:00 a.m., 12/17/2013 application of warm moist heat to the top the left knee using a towel in a plastic bag, wrapped in a pillowcase. Neither this PN, nor any additional medical record documentation, reflected any evidence to indicate that nursing staff determined the actual temperature of the warm moist compress prior to its placement on Resident A's knee. A 12/17/2013, 9:30 a.m. PN for Resident A documented that at around 3:15 a.m. that morning, it was reported to Licensed Practical Nurse (LPN) BB that the resident had blisters on the left knee, which were confirmed on assessment. A 12/17/2013, 2:30 p.m. PN more specifically documented that Resident A had intact, fluid-filled left knee blisters of various sizes in an area of approximately six (6) cms by ten (10) cms, and left thigh blisters approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. in size. Further record review for Resident A, however, revealed no evidence to indicate that nursing staff observed Resident A, or monitored the resident's status, after the 1:00 a.m. warm moist compress application, as documented in the 12/17/2013, 9:09 a.m. PN above, until approximately 3:15 a.m., as indicted in the 12/17/2013, 9:30 a.m. PN above. Following this two-plus hour period during which nursing staff failed to monitor Resident A, the resident was found to have the burned, blistered areas to both the left knee and left thigh. A 12/30/2013 Wound Care Specialist Evaluation (WCSE) which documented a wound care physician's treatment of [REDACTED]. This WCSE also documented a left thigh burn wound having a total surface area of 8 cms, requiring blister roof removal. A 12/20/2013 Employee Statement of Events (ESE) written by LPN BB indicated that on 12/17/2013 at 1:00 a.m., she and Certified Nursing Assistant (CNA) CC had gone to Resident A's room to apply a warm moist compress, per the resident's request. LPN BB indicated that once in the room, Resident A held the warm compress in the hand and stated it was too hot, but that at the resident's request, the warm compress was placed on the resident's knee. At 4:30 a.m., LPN BB went to Resident A's room, after the resident called for assistance, and observed blistering. In a 12/20/2013 ESE statement, CNA CC indicated that on 12/17/2013 after Resident A requested the warm moist compress, and after the CNA heated the compress in a microwave oven for three (3) minutes, she informed LPN BB of heating the compress via the microwave, and she and LPN BB then went to the resident's room. However, CNA CC indicated that even though Resident A stated the compress was too hot, LPN BB touched the heated compress, stated that the compress was fine, and allowed placement of the compress on the resident's knee. During a 12/23/2013, 12:30 p.m. interview, Resident A acknowledged that on 12/17/2013, he/she had informed LPN BB that the heated compress was too hot, but that the compress was placed on the knee anyway, and caused the burns. During a later interview conducted on 02/03/2014 at 12:45 p.m., Resident A also confirmed that after the warm moist compress had been applied to his/her knee on 12/17/2013, no staff, either licensed nursing staff or CNA staff, had come to check on his/her status for two to three hours. During a 02/03/2014, 10:30 a.m. interview, the Administrator and DON acknowledged that LPN BB and CNA CC had not provided care to Resident A in conformance with facility policy, related to the process used for heating the warm moist compress and to monitoring the resident once the compress was applied to the knee. During an interview conducted on 02/04/2014 at 11:20 a.m. in the presence of the Administrator, DON, and Risk Manager, the DON and Risk Manager further stated that, per the facility's General Guidelines for Clean - Warm Compress Procedure, the water temperature for a warm compress was not supposed to exceed 100 degrees Fahrenheit (F), and that the nurse was supposed to frequently monitor a resident when a compress was applied. Based on the above, even though facility Procedure specified that water utilized for a warm moist compress was not to exceed 100 degrees F, and even though Procedure specified that the nurse was to check a resident frequently after the application of a heated compress, facility nursing staff neglected Resident A during the application of a warm moist compress. LPN BB allowed the application of the warm moist compress to Resident A's knee after having been informed by CNA CC that the compress had been heated for three (3) minutes in a microwave oven, and after having been informed by Resident A that the heated compress was too hot to the

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 0224

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
touch. There was no evidence to indicate that the actual temperature of the heated compress was checked to ensure that it did not exceed 100 degrees F, as specified by facility Procedure, prior to application of the compress to Resident A's knee. There was also no evidence to indicate that nursing staff monitored Resident A, once the compress was applied, for a period of over two (2) hours, even though facility Procedure specified frequent monitoring. This failure by facility staff resulted in Resident A sustaining areas of left knee blistering approximately six (6) cms by ten (10) cms, requiring debridement, and left thigh blistering measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. Cross refer to F323 for more information regarding Resident A. The immediate jeopardy was determined to have been removed on February 4, 2014, at which time the facility had presented and implemented an allegation of jeopardy removal which included the following corrective actions: 1.On December 17, 2013, treatment for [REDACTED]. 2.On December 17, 2013, the facility evaluated the Procedure being utilized by the facility for the use of warm moist compresses, and implemented a new Policy and Procedure, the Hot Packs/Moist Heat Standard of Practice Policy and Procedure, related to warm moist compress use. 3.On December 17, 2013, the DON, Assistant Director of Nursing (ADON), and Unit Manager reviewed residents for physicians' orders related to warm moist compresses. 4.On December 20, 2013, the LPN involved in the burn incident of Resident A was terminated, as the facility's investigation for neglect was substantiated. 5.On January 7, 2014, the facility modified protocol to require that the application of warm moist compresses would be accomplished through the facility's Therapy Department. 6.On January 7, 2014, the facility's Performance Improvement (PI) Committee evaluated and approved the new protocol involving the application of warm moist compresses through the Therapy Department. 7.On January 7, 2014, the facility modified facility protocol to require the Maintenance Director to check the [MEDICATION NAME] monthly regarding its operation and temperatures to ensure operation per manufacturer's specifications. This monitoring was to be documented utilizing the [MEDICATION NAME] Temperature Log Form, which will be audited monthly by the Administrator to ensure compliance. The results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 8.On January 15, 2014, the facility modified protocol to include the Restorative Nursing staff, under the supervision of the Therapy Department, in the provision of care regarding warm moist compress application. 9.On January 15, 2014, the PI Committee reviewed the modified protocol which included Restorative Nursing staff, under the supervision of the Therapy Department, in the application of warm moist compresses to be heated via the [MEDICATION NAME]. 10.On January 15, 2014, the facility initiated a procedure by which the DON, Risk Manager, ADON, Unit Manager, or Restorative Nurse would audit the Restorative Care Flow Record bimonthly to monitor compliance with warm moist compress application and documentation, and the results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 11.On February 3, 2014, the facility modified the Restorative Care Flow Record form to allow for the documentation of warm moist compresses which, as indicated above, had on January 15, 2014 been assigned to the Restorative Nursing staff, under the supervision of the Therapy Department. Warm compress application would be documented on the Restorative Care Flow Record, and would include the documentation of skin checks every five minutes and a twenty-minute maximum time of application. 12.On February 3, 2014, the PI Committee met and approved the Restorative Care Flow Record as the monitoring tool to be utilized during warm moist compress application. 13.On February 3, 2014, the facility continued the process of providing staff in-service training to nursing staff regarding the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, and the procedural modification of allowing only Restorative Nursing staff, under the direction of the Therapy Department, to apply warm moist compresses to residents. As of that date, the one (1) Restorative LPN, and all seven (7) Restorative Aides, had received this in-service training. A total of forty-one (41) of forty-six (46) facility CNAs (89%) had received in-service training, and thirty-four (34) of forty-two (42) licensed nursing staff (81%), both Registered Nurses and LPNs, had received this in-service training. The remaining eight (8) licensed nursing staff and five (5) CNAs were to receive this in-service training as they returned to work, and prior to providing direct resident care, to ensure compliance. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 4, 2013. However, at the time of survey exit, the effectiveness of these corrective action plans could not be fully assessed to ensure ongoing application and completion. On December 17, 2013, the facility implemented the new the Hot Packs/Moist Heat Standard of Practice Policy and Procedure. On January 7, 2014, the facility modified its protocol to require monthly [MEDICATION NAME] temperature checks by the Maintenance Director via the [MEDICATION NAME] Temperature Log Form, which was to be audited monthly by the Administrator
and the audit results to be submitted to the PI Committee. On January 15, 2014, the facility specified that Restorative Nursing staff, under the supervision of the Therapy Department, would provide warm moist compress application, and the DON/Risk Manager/ADON/Unit Manager would audit the Restorative Care Flow Record bimonthly to monitor compliance and report
the audit results to the PI Committee monthly. As of February 3, 2014, all eight (8) Restorative Nursing staff had received in-service training on the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, the procedural modification specifying that only Restorative Nursing staff provide warm moist compress therapy, and the use of the [MEDICATION NAME] Temperature Log. Additionally, forty-one (41) of forty-six (46) facility CNAs, and thirty-four (34) of forty-two (42) licensed nursing staff had received this in-service training, regarding the new Policy and Procedure as referenced above, as of that date. However, eight (8) licensed nursing staff and five (5) CNAs had not yet received this in-service training, due to their having been unavailable, and would therefore be required to receive this training as they returned to work to ensure competency. Therefore, the training of these remaining nursing staff members could not be evaluated at the time of survey completion and will need to be evaluated at a future time. In addition, the facility had implemented routine auditing by administrative staff of nursing staffs' conformance related to the new Policy and Procedure, utilizing the [MEDICATION NAME] Temperature Log and the Restorative Care Flow Record, with the results of these audits to be submitted to the PI Committee for their review and development of any needed corrective actions. The PI Committee had met on January 7, 2014 and February 3, 2014 to review and approve the newly-implemented Policy and Procedure changes as referenced above, but the PI Committee's ongoing oversight, via reports of administrative staff audits, of facility nursing staffs' compliance with these new procedural changes will need to be evaluated after subsequent monthly PI Committee meetings, and thus could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.

F 0280

Level of harm - Immediate jeopardy

Residents Affected - Few

Allow the resident the right to participate in the planning or revision of the resident's care plan.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review, facility staff interview, facility General Guidelines For Clean-Warm Compress Procedure review, and Employee Statement of Events form review, the facility failed to review and revise the Care Plan of one (1) resident (A), related to an order specifying the application of a warm moist compress, from a survey sample of thirteen (13) residents.
For Resident A, the resident's Care Plan was not revised, as specified by facility Procedure, to reflect the receipt of a physician's orders [REDACTED]. This failure resulted in a certified nursing assistant, rather than a licensed nurse as specified by facility Procedure, applying a warm moist compress to the left knee of Resident A, and nursing staff then failing to monitor Resident A's skin after application of the compress for over two (2) hours. Resident A was found to have left knee blisters in an area approximately six (6) centimeters (cms) by ten (10) cms, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. This resulted in a situation in which the facility's non-compliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator, Director of Nursing (DON), and Risk Manager were informed of the immediate jeopardy on February 3, 2014, at 11:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 17, 2013 (the date a moist heat compress which had been heated in a microwave oven was applied to the left knee of Resident A, without staff checking the temperature of the moist heat compress or frequently monitoring the resident's skin under the compress, per Procedure, resulting second [MEDICAL CONDITION] blistering to the left knee and thigh), continued through February 3, 2014, and was removed on February 4, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 3, 2014. During a 01/15/2014, 3:30 p.m. interview, the Administrator and Director of Nursing (DON) acknowledged the incident of 12/17/2013 during which ResidentA [MEDICAL CONDITION] application of a warm moist compress by Certified Nursing Assistant (CNA) CC. During an interview with
the Administrator, DON, and Risk Manager conducted on 02/03/2014 at 11:30 a.m., the DON stated that staff were expected to follow facility policy regarding warm moist compress application, including compress temperature and monitoring. However,

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) during a later interview conducted on 02/04/2014 at 11:20 a.m. with the Administrator, DON, and Risk Manager, the DON and the Risk Manager acknowledged that facility Procedure did not give clear instructions regarding heating and monitoring warm moist compresses, and thus failed to instruct staff as to the method by which to use compresses. An allegation of jeopardy removal was received on February 3, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 3, 2014, and the facility remained out of compliance at a lower scope and severity of D while the facility completed a process which involved the retraining, via staff in-service, of nursing staff related to a new Policy and Procedure regarding warm moist compress use to ensure the safe use of warm moist compresses. All available nursing staff had received this in-service training, however, the training process continued as staff who were initially unavailable received this in-service training as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the use and application of warm moist compresses, and observations were made to assess staffs' performance of care. Findings include: The facility's General Guidelines for Clean-Warm Compress Procedure specified, in the Care Plan Documentation Guideline section, that when a warm compress was to be used, the use of the compress would be listed as an Approach (Intervention) under the appropriate Care Plan Problem (Focus area). This Guideline section also specified that the Care Plan Approaches should list instructions for the application of the compress which were unique to each resident, and should include the discipline responsible for application. This Procedure also specified that only licensed nurses were to apply warm moist compresses. Record review for Resident A revealed a Minimum Data Set of 12/10/2013 which documented in Section C - Cognitive Patterns a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact, and documented in Section I - Active [DIAGNOSES REDACTED]. A 12/16/2013 Physician's Telephone Orders form for Resident A specified the application of warm moist heat to the left knee every shift for three (3) days for pain and swelling. Resident A's current Care Plan referenced a Focus area, originally dated 10/28/2011 and dated as last reviewed on 12/10/2013, which indicated that the resident had chronic pain related to a chronic physical disability, and listed multiple Interventions to address this identified problem. However, even though the Physician's Telephone Orders form of 12/16/2013 referenced above specified the application of warm moist heat to Resident A's left knee every shift for three days for pain and swelling, and even though the facility's General Guidelines for Clean - Warm Compress Procedure specified that the warm compress and instructions for its use would be listed on the Care Plan, further review of Resident A's Care Plan revealed no evidence to indicate that the Care Plan had been reviewed and revised to reflect the use of the warm moist compress and the instructions for its use. A 12/17/2013, 9:09 a.m. Progress Notes (PN) entry for Resident A documented that at 1:00 a.m. on that date, warm moist heat had been applied by a CNA (instead of a licensed nurse, per facility Procedure) to the resident's left knee. A 12/17/2013, 9:30 a.m. PN then documented that at around 3:15 a.m. on that date, staff reported that Resident A had blisters to the left knee, requiring physician notification, and a 12/17/2013, 2:30 p.m. PN documented fluid-filled blisters to the left knee in an area measuring approximately six (6) cms by ten (10) cms, and thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. In a 12/20/2013 Employee Statement of Events, Licence Practical Nurse (LPN) BB indicated that on 12/17/2013 at 1:00 a.m., CNA CC informed her that Resident A requested the application of a warm compress to the left knee. LPN BB indicated that she had gone to Resident A's room and the warm compress was placed on the resident's knee. LPN BB indicated that at 4:30 a.m., Resident A called and CNA CC first responded, then LPN BB went to Resident As room to observe left knee blisters. In a 12/20/13 Employee Statement of Events, CNA CC indicated that on 12/17/13 at 1:00 a.m., when Resident A requested a warm compress, she had asked another CNA how to heat the compress because she had not performed that procedure before for this resident. CNA CC indicated that she was told by the other CNA to heat the compress in the microwave oven for three (3) minutes, which she had done before the compress was placed on the resident's knee. CNA CC indicated that she next checked Resident A at 4:00 a.m. and found blistering on the resident's knee. During a 01/15/2014, 3:30 p.m. interview with the Administrator and DON, these staff members acknowledged that Resident A had not received care, as per facility policy, related to the application of the warm moist compress, further stating that CNA CC should not have been involved in the application of the knee compress. Based on the above, the facility failed to include in the Care Plan of Resident A, per facility Procedure, the use of a warm moist compress to the left knee, the instructions for the preparation and use of the warm moist compress, and the discipline responsible for application of the warm moist compress, to ensure that nursing staff had instructions for the safe use of warm moist compresses. A moist compress was then heated in a microwave by CNA CC, after she consulted another CNA about the procedure for heating the compress due to CNA CC's stated lack of knowledge, and lack of instructions for preparation and use, regarding the process. CNA CC then applied the heated warm moist compress to the knee of Resident A, against facility Procedure, and nursing staff then failed to monitor the resident for a period which exceeded two (2) hours. Resident A was later found to have left knee fluid-filled blisters in an area approximately six (6) cms by ten (10) cms, which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. Cross refer to F323 for more information regarding Resident A. The immediate jeopardy was determined to have been removed on February 4, 2014, at which time the facility had presented and implemented an allegation of jeopardy removal which included the following corrective actions: 1. On December 17, 2013, treatment for [REDACTED]. 2. On December 17, 2013, the facility evaluated the Procedure being utilized by the facility for the use of warm moist compresses, and implemented a new Policy and Procedure, the Hot Packs/Moist Heat Standard of Practice Policy and Procedure, related to warm moist compress use. 3. On December 17, 2013, the DON, Assistant Director of Nursing (ADON), and Unit Manager reviewed residents for physicians' orders related to warm moist compresses. 4. On December 20, 2013, the LPN involved in the burn incident of Resident A was terminated, as the facility's investigation for neglect was substantiated. 5. On January 7, 2014, the facility modified facility protocol to indicate that the application of warm moist compresses would be accomplished through the facility's Therapy Department. 6. On January 7, 2014, the facility's Performance Improvement (PI) Committee evaluated and approved the new protocol involving the application of warm moist compresses through the Therapy Department. 7. On January 7, 2014, the facility modified facility protocol to require the Maintenance Director to check the [MEDICATION NAME] monthly regarding its operation and temperatures to ensure operation per manufacturer's specifications. This monitoring was to be documented utilizing the [MEDICATION NAME] Temperature Log Form, which will be audited monthly by the Administrator to ensure compliance. The results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 8. On January 15, 2014, the facility modified protocol to include the Restorative Nursing staff, under the supervision of the Therapy Department, in the provision of care regarding warm moist compress application. 9. On January 15, 2014, the PI Committee reviewed the modified protocol which included Restorative Nursing staff, under the supervision of the Therapy Department, in the application of warm moist compresses to be heated via the [MEDICATION NAME]. 10. On January 15, 2014, the facility initiated a procedure by which the DON, Risk Manager, ADON, Unit Manager, or Restorative Nurse would audit the Restorative Care Flow Record bimonthly to monitor compliance with warm moist compress application and documentation, and the results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 11. On February 3, 2014, the facility modified the Restorative Care Flow Record form to allow for the documentation of warm moist compresses which, as indicated above, had on January 15, 2014 been assigned to the Restorative Nursing staff, under the supervision of the Therapy Department. Warm compress application would be documented on the Restorative Care Flow Record, and would include the documentation of skin checks every five minutes and a twenty-minute maximum time of application. 12. On February 3, 2014, the PI Committee met and approved the Restorative Care Flow Record as the monitoring tool to be utilized during warm moist compress application. 13. On February 3, 2014, the facility continued the process of providing staff in-service training to nursing staff regarding the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, and the procedural modification of allowing only Restorative Nursing staff, under the direction of the Therapy Department, to apply warm moist compresses to residents. As of that date, the one (1) Restorative LPN, and all seven (7) Restorative Aides, had received this in-service training. A total of forty-one (41) of forty-six (46) facility CNAs (89%) had received in-service training, and thirty-four (34) of forty-two (42) licensed nursing staff (81%), both Registered Nurses and LPNs, had received this in-service training. The remaining eight (8) licensed nursing staff and five (5) CNAs were to receive this in-service training as they returned to work, and prior to providing direct resident care, to ensure compliance. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 4, 2013. However, at the time of survey exit, the effectiveness of these corrective action plans could not be fully assessed to ensure ongoing application and completion. On December 17, 2013, the facility implemented the new the Hot Packs/Moist Heat Standard of Practice Policy and Procedure. On January 7, 2014, the facility modified is protocol to require monthly

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F 0280

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)
[MEDICATION NAME] temperature checks by the Maintenance Director via the [MEDICATION NAME] Temperature Log Form, which was
to be audited monthly by the Administrator and the audit results to be submitted to the PI Committee. On January 15, 2014, the facility specified that Restorative Nursing staff, under the supervision of the Therapy Department, would provide warm moist compress application, and the DON/Risk Manager/ADON/Unit Manager would audit the Restorative Care Flow Record bimonthly to monitor compliance and report the audit results to the PI Committee monthly. As of February 3, 2014, all eight (8) Restorative Nursing staff had received in-service training on the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, the procedural modification specifying that only Restorative Nursing staff provide warm moist compress therapy, and the use of the [MEDICATION NAME] Temperature Log. Additionally, forty-one (41) of forty-six (46) facility CNAs, and thirty-four (34) of forty-two (42) licensed nursing staff had received this in-service training, regarding the new Policy and Procedure as referenced above, as of that date. However, eight (8) licensed nursing staff and five (5) CNAs had not yet received this in-service training, due to their having been unavailable, and would therefore be required to receive this training as they returned to work to ensure competency. Therefore, the training of these remaining nursing staff members could not be evaluated at the time of survey completion and will need to be evaluated at a future time. In addition, the facility had implemented routine auditing by administrative staff of nursing staffs' conformance related to the new Policy and Procedure, utilizing the [MEDICATION NAME] Temperature Log and the Restorative Care Flow Record, with the results of these audits to be submitted to the PI Committee for their review and development of any needed corrective actions. The PI Committee had met on January 7, 2014 and February 3, 2014 to review and approve the newly-implemented Policy and Procedure changes as referenced above, but the PI Committee's ongoing oversight, via reports of administrative staff audits, of facility nursing staffs' compliance with these new procedural changes will need to be evaluated after subsequent monthly PI Committee meetings, and thus could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.

F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review, facility staff interview, National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules review, facility General Guidelines for Clean-Warm Compress Procedure review, and Employee Statement of Events form review, the facility failed to ensure that services were provided in accordance with professional standards of quality, related to the monitoring of a warm moist compress for one (1) resident (A) from a survey sample of thirteen (13) residents. This failure to provide services in accordance with professional quality standards resulted in nursing staff failing to monitor Resident A for over two (2) hours after the application of a warm moist compress to the resident's left knee. Resident A was then found to have a cluster of left knee blisters in an area approximately six (6) centimeters (cms) by ten (10) cms, which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. This resulted in a situation in which the facility's non-compliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator, Director of Nursing (DON), and Risk Manager were informed of the immediate jeopardy on February 3, 2014, at 11:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 17, 2013 (the date a warm moist compress which had been heated in a microwave oven was applied to the left knee of Resident A, without staff determining the actual temperature of the moist heat compress or frequently monitoring the resident's skin under the compress, per facility Procedure and in accordance with Nursing Standards of Practice, resulting in the resident sustaining second [MEDICAL CONDITION] blistering to the left knee and thigh), continued through February 3, 2014, and was removed on February 4, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 3, 2014. During a 01/15/2014, 3:30 p.m. interview, the Administrator and Director of Nursing (DON) acknowledged the 12/17/2013 incident which resulted in ResidentA sustaining from the application of a warm moist compress by Certified Nursing Assistant (CNA) CC. The Administrator and DON acknowledged that the facility's Procedure required that Licensed Practical Nurse (LPN) BB, who should have applied the warm moist compress, to provide more frequent monitoring of Resident A once the compress was applied. An allegation of jeopardy removal was received on February 3, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 3, 2014, and the facility remained out of compliance at a lower scope and severity of D while the facility completed a process which involved the retraining, via staff in-service, of nursing staff related to a new Policy and Procedure regarding warm moist compress use to ensure the safe use of warm moist compresses. All available nursing staff had received this in-service training, however, the training process continued as staff who were initially unavailable received this in-service training as they reported to work.
In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the use and application of warm moist compresses, and observations were made to assess staffs' performance of care.
Findings include: Review of the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules revealed that Chapter 2 - Standards of Nursing Practice, Section 2.3.2, Standards Related to Licensed Practical Nurse (LPN/VN) Responsibilities for Nursing Practice Implementation, requires in Section 2.3.2(c) that the nurse demonstrates attentiveness and provides client surveillance and monitoring. Review of Resident A's clinical record revealed that Section C - Cognitive Patterns of the 12/10/2013 Minimum Data Set documented a Brief Interview for Mental Status score of 15, indicating that the resident was cognitively intact, and Section I - Active [DIAGNOSES REDACTED]. A 12/16/2013 Physician's Telephone Orders form specified the application of warm moist heat to Resident A's left knee every shift for three (3) days. A 12/17/2013, 9:09 a.m. Progress Notes (PN) entry documented that at 1:00 a.m. on that date, LPN BB had been informed of the application of warm moist heat by a CNA to Resident A's left knee. However, additional record review revealed no evidence to indicate that LPN BB, or any licensed nursing staff, provided frequent monitoring of Resident A on 12/17/2013 after the 1:00 a.m. application of the warm moist heat pack to the resident's left knee, even though the facility's General Guidelines for Clean-Warm Compress Procedure specified that nursing staff check the resident's skin beneath a compress frequently, and even though the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules required that the nurse provide attentiveness and monitoring to the resident.
Instead, a 12/17/2013, 9:30 a.m. PN documented that at around 3:15 a.m. (over two hours after application of the most heat pack), it was reported to the nurse that Resident A had left knee blisters. A subsequent 12/17/2013, 2:30 p.m. PN documented that Resident A had sustained fluid-filled blisters on the left knee in a clustered area approximately six (6) centimeters (cms) by ten (10) cms, and thigh blisters approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. In a 12/20/2013 Employee Statement of Events written statement, LPN BB (the licensed nurse referenced in the 12/17/2013, 9:09 a.m. and 9:30 a.m. PNs above) indicated that on 12/17/2013 at 1:00 a.m., she had been told by CNA CC that Resident A requested a warm compress to the left knee, and went to the resident's room to observe the resident holding the warm pad in his/her hand.
LPN BB indicated that Resident A told her that the warm compress was too hot, but further indicated that because the resident requested for the warm compress be placed on the knee, it was placed on the knee. Nowhere in this written statement did LPN BB indicate that she provided frequent monitoring, or any monitoring, of Resident A (as specified by facility Procedure, and by the Standards of Nursing Practice referenced above) after the warm compress was put into place on 12/17/2013 at approximately 1:00 a.m. In fact, instead of providing frequent monitoring of Resident A upon application of the warm moist compress, LPN BB indicated in this written statement that she instructed the resident to call when the warm moist compress got cool. LPN BB further indicated that at 4:30 a.m., Resident A did call, and at that time, the LPN went to Resident As room and observed the blisters. In a 12/20/2013 Employee Statement of Events statement, CNA CC indicated that on 12/17/2013 at 1:00 a.m., she told LPN BB that she had warmed Resident A's warm moist compress in the microwave. CNA CC further indicated that once she and LPN BB had gone to Resident A's room, Resident A had told LPN BB that the heated compress was too hot as the resident held the compress in his/her hand, but that LPN BB felt of the heated compress and stated that the compress was fine, the hotter the better, and the heated warm compress was then placed on Resident A's knee. During an interview conducted on 12/23/2013 at 1:30 p.m., the Administrator acknowledged that on the evening when Resident A [MEDICAL CONDITION] the heated compress, LPN BB had allowed the placement of the warm moist compress even after Resident A had told LPN BB that the compress was too hot when touched with his/her hand. During a subsequent interview with the Administrator and Director of Nursing conducted on 02/03/2014 at 10:30 a.m., these staff

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY NURSING & REHAB CTR	**180 EPPS BRIDGE RD ATHENS, GA 30606**

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 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) members stated that LPN BB should have checked the status of Resident A's warm compress immediately upon application to the knee, then every ten (10) minutes thereafter, allowing the compress to stay on for a maximum of twenty (20) minutes. Based on the above, even though professional standards of practice specified that a nurse demonstrate attentiveness and provide client surveillance and monitoring, and even though facility Procedure specified frequent monitoring upon the application of a moist heat pack to a resident, a warm moist compress was applied to Resident A's knee even though the resident stated it was too hot, and then LPN BB failed to monitor the resident for a period exceeding two (2) hours. Thus, facility licensed nursing staff failed to demonstrate attentiveness and provide monitoring to Resident A, in accordance with the Standards of Nursing Practice referenced above. As a result, Resident A was found to have left knee fluid-filled blisters in a clustered area approximately six (6) cms by ten (10) cms, which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. Cross refer to F323 for more information regarding Resident A. The immediate jeopardy was determined to have been removed on February 4, 2014, at which time the facility had presented and implemented an allegation of jeopardy removal which included the following corrective actions: 1. On December 17, 2013, treatment for [REDACTED]. 2. On December 17, 2013, the facility evaluated the Procedure being utilized by the facility for the use of warm moist compresses, and implemented a new Policy and Procedure, the Hot Packs/Moist Heat Standard of Practice Policy and Procedure, related to warm moist compress use. 3. On December 17, 2013, the DON, Assistant Director of Nursing (ADON), and Unit Manager reviewed residents for physicians' orders related to warm moist compresses. 4. On December 20, 2013, the LPN involved in the burn incident of Resident A was terminated, as the facility's investigation for neglect was substantiated. 5. On January 7, 2014, the facility modified facility protocol to indicate that the application of warm moist compresses would be accomplished through the facility's Therapy Department. 6. On January 7, 2014, the facility's Performance Improvement (PI) Committee evaluated and approved the new protocol involving the application of warm moist compresses through the Therapy Department. 7. On January 7, 2014, the facility modified facility protocol to require the Maintenance Director to check the [MEDICATION NAME] monthly regarding its operation and temperatures to ensure operation per manufacturer's specifications. This monitoring was to be documented utilizing the [MEDICATION NAME] Temperature Log Form, which will be audited monthly by the Administrator to ensure compliance. The results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 8. On January 15, 2014, the facility modified protocol to include the Restorative Nursing staff, under the supervision of the Therapy Department, in the provision of care regarding warm moist compress application. 9. On January 15, 2014, the PI Committee reviewed the modified protocol which included Restorative Nursing staff, under the supervision of the Therapy Department, in the application of warm moist compresses to be heated via the [MEDICATION NAME]. 10. On January 15, 2014, the facility initiated a procedure by which the DON, Risk Manager, ADON, Unit Manager, or Restorative Nurse would audit the Restorative Care Flow Record bimonthly to monitor compliance with warm moist compress application and documentation, and the results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 11. On February 3, 2014, the facility modified the Restorative Care Flow Record form to allow for the documentation of warm moist compresses which, as indicated above, had on January 15, 2014 been assigned to the Restorative Nursing staff, under the supervision of the Therapy Department. Warm compress application would be documented on the Restorative Care Flow Record, and would include the documentation of skin checks every five minutes and a twenty-minute maximum time of application. 12. On February 3, 2014, the PI Committee met and approved the Restorative Care Flow Record as the monitoring tool to be utilized during warm moist compress application. 13. On February 3, 2014, the facility continued the process of providing staff in-service training to nursing staff regarding the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, and the procedural modification of allowing only Restorative Nursing staff, under the direction of the Therapy Department, to apply warm moist compresses to residents. As of that date, the one (1) Restorative LPN, and all seven (7) Restorative Aides, had received this in-service training. A total of forty-one (41) of forty-six (46) facility CNAs (89%) had received in-service training, and thirty-four (34) of forty-two (42) licensed nursing staff (81%), both Registered Nurses and LPNs, had received this in-service training. The remaining eight (8) licensed nursing staff and five (5) CNAs were to receive this in-service training as they returned to work, and prior to providing direct resident care, to ensure compliance. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 4, 2013. However, at the time of survey exit, the effectiveness of these corrective action plans could not be fully assessed to ensure ongoing application and completion. On December 17, 2013, the facility implemented the new the Hot Packs/Moist Heat Standard of Practice Policy and Procedure. On January 7, 2014, the facility modified is protocol to require monthly [MEDICATION NAME] temperature checks by the Maintenance Director via the [MEDICATION NAME] Temperature Log Form, which was to be audited monthly by the Administrator and the audit results to be submitted to the PI Committee. On January 15, 2014, the facility specified that Restorative Nursing staff, under the supervision of the Therapy Department, would provide warm moist compress application, and the DON/Risk Manager/ADON/Unit Manager would audit the Restorative Care Flow Record bimonthly to monitor compliance and report the audit results to the PI Committee monthly. As of February 3, 2014, all eight (8) Restorative Nursing staff had received in-service training on the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, the procedural modification specifying that only Restorative Nursing staff provide warm moist compress therapy, and the use of the [MEDICATION NAME] Temperature Log. Additionally, forty-one (41) of forty-six (46) facility CNAs, and thirty-four (34) of forty-two (42) licensed nursing staff had received this in-service training, regarding the new Policy and Procedure as referenced above, as of that date. However, eight (8) licensed nursing staff and five (5) CNAs had not yet received this in-service training, due to their having been unavailable, and would therefore be required to receive this training as they returned to work to ensure competency. Therefore, the training of these remaining nursing staff members could not be evaluated at the time of survey completion and will need to be evaluated at a future time. In addition, the facility had implemented routine auditing by administrative staff of nursing staffs' conformance related to the new Policy and Procedure, utilizing the [MEDICATION NAME] Temperature Log and the Restorative Care Flow Record, with the results of these audits to be submitted to the PI Committee for their review and development of any needed corrective actions. The PI Committee had met on January 7, 2014 and February 3, 2014 to review and approve the newly-implemented Policy and Procedure changes as referenced above, but the PI Committee's ongoing oversight, via reports of administrative staff audits, of facility nursing staffs' compliance with these new procedural changes will need to be evaluated after subsequent monthly PI Committee meetings, and thus could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.
F 0323 **Level of harm -** Immediate jeopardy **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, record review, facility staff interview, resident interview, Wound Care Physician interview, facility General Guidelines For Clean-Warm Compress Procedure review, Wound Care Specialist Evaluation review, and Employee Statement of Events form review, the facility failed to ensure the application of a warm moist compress by licensed nursing staff, per facility Procedure, failed to check the temperature of the heated warm moist compress prior to application, per facility Procedure, and failed to ensure frequent monitoring after the application of the warm moist compress, per facility Procedure, for one (1) resident (A) from a survey sample of thirteen (13) residents. This failure resulted in a certified nursing assistant applying a warm moist compress to the left knee of Resident A, with staff then failing to assess the condition of the resident's skin after the application of the compress for over two (2) hours. Resident A was then found to have sustained left knee blisters in a clustered area measuring approximately six (6) centimeters (cms) by ten (10) cms which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. This resulted in a situation in which the facility's non-compliance with the requirements of participation caused, or had the likelihood to cause, serious harm, injury, impairment or death to residents. The facility's Administrator, Director of Nursing (DON), and Risk Manager were informed of the immediate jeopardy on February 3, 2014, at 11:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on December 17, 2013 (the date a moist heat compress which had been heated in a microwave oven was applied to the left knee of Resident A, without staff ascertaining the temperature of the moist heat compress or frequently monitoring the resident's skin under the compress, per facility Procedure, resulting in the resident sustaining second degree burns and blistering to the left knee and thigh), continued

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) through February 3, 2014, and was removed on February 4, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 3, 2014. During a 01/15/2014, 3:30 p.m. interview, the Administrator and Director of Nursing (DON) acknowledged the incident of 12/17/2013 during which ResidentA sustained burns after application of a warm moist compress by Certified Nursing Assistant (CNA) CC after the CNA had heated the compress in a microwave oven. The Administrator and DON stated that, per facility Procedure, a licensed nurse, not a CNA, should have applied the compress, and that nursing staff should have monitored Resident A more frequently after the application of the heated compress, per facility Protocol, and that facility Procedure related to Resident A's warm moist compress application had not been followed. An allegation of jeopardy removal was received on February 3, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 3, 2014, and the facility remained out of compliance at a lower scope and severity of D while the facility completed a process which involved the retraining, via staff in-service, of nursing staff related to a new Policy and Procedure regarding warm moist compress use to ensure the safe use of warm moist compresses. All available nursing staff had received this in-service training, however, the training process continued as staff who were initially unavailable received this in-service training as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the use and application of warm moist compresses, and observations were made to assess staffs' performance of care. Findings include: The facility's General Guidelines for Clean-Warm Compress Procedure specified that a licensed nurse was responsible for the application of a warm moist compress. This Procedure specified that the temperature of the water or prescribed solution utilized for a warm compress was not to exceed 100 degrees Fahrenheit (F). The Procedure also specified that nursing staff were to check a resident's skin beneath the compress frequently for tenderness, pain, and extreme redness, and that treatment was to be discontinued if these complications occurred. Record review for Resident A revealed that the Quarterly Minimum Data Set (MDS) assessment having an Assessment Reference Date of 12/10/2013 documented in Section C - Cognitive Patterns that the resident had a Brief Interview for Mental Status score of 15, indicating that the resident was cognitively intact. Section I - Active [DIAGNOSES REDACTED]. Section G - Functional Status documented that Resident A required supervision/oversight with eating, but was totally dependent on staff for all other Activities of Daily Living. Review of Resident A's clinical record revealed a Physician's Telephone Orders form of 12/16/2013 which specified the application of warm moist heat to the resident's left knee every shift for three (3) days for pain and swelling. A Progress Notes (PN) entry dated 12/17/2013, timed at 9:09 a.m. and labeled as a Status Note, documented that at 1:00 a.m. on 12/17/2013, a CNA had applied warm moist heat to the top of Resident A's left knee, per the resident's request. This PN documented that a towel placed inside a plastic bag, and then wrapped in a pillowcase cover, had been applied to the resident's left knee, and that the resident had been instructed to call for staff when the heat pack got cool. However, the application of the warm moist compress to Resident A's knee by a CNA, as documented in the 12/17/2013 9:09 a.m. PN referenced above, was in violation of the facility's General Guidelines for Clean-Warm Compress Procedure, as referenced above, which specified that the compress was to be applied by a licensed nurse. Additionally, review of Resident A's clinical record, to include review of this PN, revealed no evidence to indicate that nursing staff checked the temperature of the warm moist compress, before application of the compress, to ensure that the temperature did not exceed 100 degrees F, as specified by the General Guidelines for Clean-Warm Compress Procedure. A later PN entry of 12/17/2013, timed at 9:30 a.m. and labeled as a Skin/Wound Note, for Resident A documented that earlier on 12/17/2013 at around 3:15 a.m., staff had reported to the nurse that Resident A had blisters from the heat which had been applied to the left knee. This PN documented that assessment at that time revealed blisters and redness on the resident's left knee, and that the physician, when contacted, had ordered the application of antibiotic ointment to the blisters. A 12/17/2013 Physician's Telephone Orders form for Resident A specified that Triple Antibiotic Ointment be applied to the blisters, and another 12/17/2013 Physician's Telephone Order's form specified a skin preparation to the intact blisters on Resident A's left knee, then the application of Silvadene (silver sulfadiazine) Ointment twice daily to the left knee blisters when opened until healed. A PN entry of 12/17/2013, timed at 2:30 p.m. and labeled as a Skin/Wound Note, for Resident A documented that assessment of the resident had revealed intact, fluid-filled blisters of various sizes on the left knee, in a total clustered area measuring approximately six (6) cms by ten (10) cms. This PN also documented intact blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm, with a red area surrounding the blisters approximately 5 cms in size, to the resident's left thigh above the knee. However, despite the facility's General Guidelines for Clean-Warm Compress Procedure referenced above which specified that the nurse was to check a resident's skin beneath a warm compress frequently after application for tenderness/pain/extreme redness, further record review for Resident A revealed no evidence to indicate that a nurse, or any staff member, checked the status of the warm moist compress after application to Resident A's left knee on 12/17/2013 at 1:00 a.m. (as documented in the 12/17/2013, 9:09 a.m. PN referenced above) until approximately 3:15 a.m. on 12/17/2013 (as documented in the 12/17/2013, 9:30 a.m. PN referenced above). This represented a period in excess of two (2) hours after moist heat pack application to Resident A's knee during which facility nursing staff failed to monitor the status of the moist heat pack and the resident's skin. When facility staff finally checked Resident A over two (2) hours after moist heat pack application, blistering to the resident's left knee and thigh was discovered. A Wound Care Specialist Evaluation (WCSE) report of 12/30/2013 for Resident A documented, in the History of Present Illness section, a Chief Complaint indicating wound care physician consultation for a left knee wound. This WCSE documented, in the Burn Wound of the Left Knee section, that the left knee burn wound measured 7.5 cms. in length, 10 cms. in width, and 0.1 cm. in depth, for a total surface area of 75 cms, and that the knee wound had thick adherent devitalized necrotic tissue of 70 percent. This WCSE documented, in the Procedure section, that Resident A's left knee burn wound was debrided via surgical excision, with removal of necrotic tissue and subcutaneous tissue, with a post-debridement depth of two (2) centimeters. In addition, this 12/30/2013 WCSE for Resident A documented, in the Burn Wound to the Left, Distal Thigh section, that the left thigh burn wound measured 4 cms. in length, 2 cms in width, and was of an unmeasurable depth, for a total survey area of 8 cms. This WCSE documented that the roof of the thigh wound blisters was removed. This WCSE specified that both Resident A's left knee and left thigh burn wounds were to be treated with silver sulfadiazine and a dry protective dressing once daily. A WCSE report of 01/08/2014 documented the Wound Care Physician's evaluation and treatment of [REDACTED]. This WCSE documented that at that time, the resident's left knee burn wound measured 6.6 cms by 9.5 cms by 0.1 cm, with sixty (60) percent devitalized necrotic tissue, and that the thigh burn wound measured 2.7 cms by 1.7 cms by 0.1 cms. This WCPE also documented debridement of the left knee burn wound, with removal of necrotic tissue. This WCSE continued to specify the application of silver sulfadiazine ointment with a dry protective dressing once daily to both burn wounds. During an interview with the Wound Care Physician conducted on 01/15/2014 at 11:30 a.m., the physician stated, in reference to Resident A's burn wounds, that the wounds would be categorized as second degree burns. In a 12/20/2013 Employee Statement of Events written statement of Licensed Practical Nurse (LPN) BB obtained by the facility during the facility's investigation into the burn wounds of Resident A, LPN BB indicated that on 12/17/2013 at 1:00 a.m., CNA CC informed her that Resident A had requested that the CNA put a warm compress on the left knee. LPN BB indicated that Resident A had asked the CNA to warm a towel, place it inside a plastic bag, and put it into a pillow case. LPN BB indicated that she then went to Resident A's room and initially observed the resident holding the warm compress in the palm of the hand, at which time the resident stated that the warm moist pad was too hot for his/her hand, but requested that the warm pad be placed on the knee. LPN BB further documented that she then pulled Resident A's gown over the resident's left knee, and the warm pad was placed on the resident's knee and the resident was instructed to call when the warm pad got cool. LPN BB indicated that at 4:30 a.m., when Resident A called via the call light, CNA CC answered and then came to inform the LPN that the resident said he/she had blisters on the left knee. LPN BB indicated that she then went to Resident As room, observed the blisters, and placed a telephone call to the nurse practitioner. In a 12/20/2013 written Employee Statement of Events statement of CNA CC obtained by the facility during its investigation into Resident As burns, CNA CC indicated that on 12/17/2013 at 1:00 a.m., Resident A requested that the CNA warm a towel inside of a plastic bag, which were both inside of a pillow case, to help with knee pain. CNA CC indicated that she had not utilized a warm compress for Resident A before, and so she had asked another CNA how to heat the warm compress and had been told to place the compress in a microwave oven for three (3) minutes for heating. CNA CC indicated that after she had warmed the compress in the microwave, she had informed LPN BB of the resident's request regarding the warm compress and of how she had been told to heat the warm compress. CNA CC indicated that she and LPN BB then went to Resident A's room and the CNA placed the warm compress in the resident's hand, and the resident stated that the warm compress was too hot. CNA CC indicated that LPN BB felt of the heated warm compress and stated that the compress was fine.

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F 0323

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 6)
CNACC indicated that the heated warm compress was then placed on Resident A's knee. CNA CC indicated that she went back at 4:00 a.m. to check Resident A, noted the towel compress to still be on the resident's knee, and removed the compress to find the resident's knee blistered. During an interview with Resident A conducted on 12/23/2013 at 12:30 p.m., Resident A was asked about the burn incident involving the application of the warm compress to the knee on 12/17/2013. Resident A stated that on 12/17/2013, before application of the compress heated in the microwave to his/her knee, he/she had informed LPN BB that the compress was too hot, but that the compress had been placed on the knee and had caused the burn. Resident A further stated that he/she had experienced some pain. During an observation of Resident A's knee on 12/23/2013 at 12:30 p.m., conducted at the time of the resident interview referenced above, an area of scattered, intact fluid-filled blisters measuring approximately six (6) cms by ten (10) cms was observed to the knee. During interview with the Administrator and Director of Nursing (DON) conducted on 01/15/2014 at 3:30 p.m., these staff members acknowledged that ResidentA's burn had occurred after the warm moist compress had been heated in the microwave oven, and that facility protocol did not indicate the compress was to be heated in the microwave. They stated that CNA CC had heated and been involved in applying the warm moist compress, which was not considered within the duties of a CNA. It was also stated once the heated warm moist compress had been applied to Resident As knee, staff should have checked the status of the compress approximately five (5) minutes after application. The Administrator and DON acknowledged that facility policy had not been followed. During a later interview conducted on 02/03/2014 at 10:30 a.m. with the Administrator and DON, these staff members again stated (as in the 01/15/2014, 3:30 p.m. interview referenced above) that CNA CC, who had applied the warm moist compress to Resident A's knee on 12/17/2013, should not have been involved in this procedure. These staff stated that only a licensed nurse should have applied the resident's warm moist compress, per facility Procedure. These staff members also again stated (as in the 01/15/2014, 3:30 p.m. interview above) that the water utilized for a warm moist compress should not have been heated in the microwave, further stating that warm water from the tap was to be used in the preparation of a compress. During a subsequent interview conducted on 02/04/2014 at 11:20 a.m. with the Administrator, DON, and Risk Manager, the facility's General Guidelines for Clean-Warm Compress Procedure (the Procedure in place on 12/17/2013 when Resident A sustained the burn wounds to the left knee and thigh) referenced above was reviewed. During this interview and Procedure review with these staff, the DON and Risk Manager acknowledged that, while the Procedure had specified that the temperature of water or prescribed solution utilized for a warm compress was not to exceed 100 degrees F., the Procedure had failed to specify that staff were to utilize only faucet tap water for a warm moist compress, and thus did not instruct staff on how to heat water when preparing a warm moist compress. The DON and Risk Manager further acknowledged that, while this Procedure had specified that nursing staff were to check a resident's skin beneath a compress frequently, the Procedure did not specify the actual frequency that nursing staff were to check, and therefore failed to instruct staff how often to monitor a resident once a warm moist compress had been applied. Based on the above, even though facility Procedure specified that only licensed nursing staff were to apply warm moist compresses, even though the Procedure specified that water or solution utilized in the preparation of warm moist compresses was not to exceed 100 degrees F, and even though the Procedure specified that nursing staff were to check a resident's skin beneath a compress frequently for tenderness/pain/extreme redness after compress application, CNA CC, instead of a licensed nurse, heated a warm moist compress for Resident A for three (3) minutes utilizing a microwave oven and applied the warm moist compress to the resident's knee, without nursing staff ascertaining the temperature of the compress and even though the resident stated that the warm moist compress was too hot. Then, nursing staff failed to frequently check Resident A after the application of the warm moist compress for a period exceeding two (2) hours. Resident A was found to have left knee fluid-filled blisters in a clustered area approximately six (6) cms by ten (10) cms, which required debridement, and left thigh blisters measuring approximately 0.5 cm by 0.8 cm, and 0.5 cm by 1.0 cm. The immediate jeopardy was determined to have been removed on February 4, 2014, at which time the facility had presented and implemented an allegation of jeopardy removal which included the following corrective actions: 1. On December 17, 2013, treatment for [REDACTED]. 2. On December 17, 2013, the facility evaluated the Procedure being utilized by the facility for the use of warm moist compresses, and implemented a new Policy and Procedure, the Hot Packs/Moist Heat Standard of Practice Policy and Procedure, related to warm moist compress use. 3. On December 17, 2013, the DON, Assistant Director of Nursing (ADON), and Unit Manager reviewed residents for physicians' orders related to warm moist compresses. 4. On December 20, 2013, the LPN involved in the burn incident of Resident A was terminated, as the facility's investigation for neglect was substantiated. 5. On January 7, 2014, the facility modified facility protocol to indicate that the application of warm moist compresses would be accomplished through the facility's Therapy Department. 6. On January 7, 2014, the facility's Performance Improvement (PI) Committee evaluated and approved the new protocol involving the application of warm moist compresses through the Therapy Department. 7. On January 7, 2014, the facility modified facility protocol to require the Maintenance Director to check the hydrocollator monthly regarding its operation and temperatures to ensure operation per manufacturer's specifications. This monitoring was to be documented utilizing the Hydrocollator Temperature Log Form, which will be audited monthly by the Administrator to ensure compliance. The results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 8. On January 15, 2014, the facility modified protocol to include the Restorative Nursing staff, under the supervision of the Therapy Department, in the provision of care regarding warm moist compress application. 9. On January 15, 2014, the PI Committee reviewed the modified protocol which included Restorative Nursing staff, under the supervision of the Therapy Department, in the application of warm moist compresses to be heated via the hydrocollator. 10. On January 15, 2014, the facility initiated a procedure by which the DON, Risk Manager, ADON, Unit Manager, or Restorative Nurse would audit the Restorative Care Flow Record bimonthly to monitor compliance with warm moist compress application and documentation, and the results of these audits will be presented to the PI Committee monthly for review and any necessary corrective action. 11. On February 3, 2014, the facility modified the Restorative Care Flow Record form to allow for the documentation of warm moist compresses which, as indicated above, had on January 15, 2014 been assigned to the Restorative Nursing staff, under the supervision of the Therapy Department. Warm compress application would be documented on the Restorative Care Flow Record, and would include the documentation of skin checks every five minutes and a twenty-minute maximum time of application. 12. On February 3, 2014, the PI Committee met and approved the Restorative Care Flow Record as the monitoring tool to be utilized during warm moist compress application. 13. On February 3, 2014, the facility continued the process of providing staff in-service training to nursing staff regarding the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, and the procedural modification of allowing only Restorative Nursing staff, under the direction of the Therapy Department, to apply warm moist compresses to residents. As of that date, the one (1) Restorative LPN, and all seven (7) Restorative Aides, had received this in-service training. A total of forty-one (41) of forty-six (46) facility CNAs (89%) had received in-service training, and thirty-four (34) of forty-two (42) licensed nursing staff (81%), both Registered Nurses and LPNs, had received this in-service training. The remaining eight (8) licensed nursing staff and five (5) CNAs were to receive this in-service training as they returned to work, and prior to providing direct resident care, to ensure compliance. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 4, 2013. However, at the time of survey exit, the effectiveness of these corrective action plans could not be fully assessed to ensure ongoing application and completion. On December 17, 2013, the facility implemented the new the Hot Packs/Moist Heat Standard of Practice Policy and Procedure. On January 7, 2014, the facility modified is protocol to require monthly hydrocollator temperature checks by the Maintenance Director via the Hydrocollator Temperature Log Form, which was to be audited monthly by the Administrator and the audit results to be submitted to the PI Committee. On January 15, 2014, the facility specified that Restorative Nursing staff, under the supervision of the Therapy Department, would provide warm moist compress application, and the DON/Risk Manager/ADON/Unit Manager would audit the Restorative Care Flow Record bimonthly to monitor compliance and report the audit results to the PI Committee monthly. As of February 3, 2014, all eight (8) Restorative Nursing staff had received in-service training on the new Hot Packs/Moist Heat Standard of Practice Policy and Procedure, the procedural modification specifying that only Restorative Nursing staff provide warm moist compress therapy, and the use of the Hydrocollator Temperature Log. Additionally, forty-one (41) of forty-six (46) facility CNAs, and thirty-four (34) of forty-two (42) licensed nursing staff had received this in-service training, regarding the new Policy and Procedure as referenced above, as of that date. However, eight (8) licensed nursing staff and five (5) CNAs had not yet received this in-service training, due to their having been unavailable, and would therefore be required to receive this training as they returned to work to ensure competency. Therefore, the training of these remaining nursing staff members could not be evaluated at the time of survey completion and will need to be evaluated at a future time. In addition, the facility had implemented routine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115467	A. BUILDING ______ B. WING _____	**02/05/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY NURSING & REHAB CTR	**180 EPPS BRIDGE RD ATHENS, GA 30606**

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) auditing by administrative staff of nursing staffs' conformance related to the new Policy and Procedure, utilizing the Hydrocollator Temperature Log and the Restorative Care Flow Record, with the results of these audits to be submitted to the PI Committee for their review and development of any needed corrective actions. The PI Committee had met on January 7, 2014 and February 3, 2014 to review and approve the newly-implemented Policy and Procedure changes as referenced above, but the PI Committee's ongoing oversight, via reports of administrative staff audits, of facility nursing staffs' compliance with these new procedural changes will need to be evaluated after subsequent monthly PI Committee meetings, and thus could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.