F 000
INITIAL COMMENTS

Investigation of C/O #26358, #26462, #26399 and #26709 was conducted September 27, 2010-November 3, 2010, at Golden Livingcenter-Mountain View. Deficient practice was cited for C/O #26358 and #26399. Deficient practices were cited at F157, F279 and F281 related to C/O #26709, and at F314 related to C/O #26462 and #26709.

F 157
483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

F157
Resident

Resident #8 Physician has been notified and
Order for treatment obtained by charge nurse on
9/22/10.

Affected Residents

New admissions to facility with wounds have the potential to be affected by this alleged deficient practice. Current residents admitted since Sept 27, 2010 have been assessed for any skin issues by ADNS/Wound nurse/charge nurses on 11/21/10.
Continued From page 1

The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review, observation and interview, the facility failed to notify the physician of a Pressure Ulcer and failed to obtain orders for treatment of the Pressure Ulcer for one (#8) of fifteen residents with Pressure Ulcers reviewed.

The findings included:

Resident #8 was admitted to the facility on September 9, 2010, with diagnoses including Anxiety, Urinary Tract Infection, Diabetes Mellitus, Lung Cancer and Hypertension. Medical record review of the "Clinical Health Status" (initial nursing assessment) dated September 9, 2010, revealed the resident had one Stage 3 Pressure Ulcer on the right buttock which measured "1 ½" inches and was covered with a foam dressing and had an "unstageable" wound to the left heel. Medical record review of the Minimum Data Set dated September 16, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making skills; required extensive assistance with bed mobility, transfers, and activities of daily living; was incontinent of bowel and had an indwelling urinary catheter; had moderate pain daily; and had three stage 3 Pressure Ulcers.

Medical record review of the physician's admission orders dated September 9, 2010, revealed no orders were obtained for wound...
Continued From page 2

care/dressing changes on admission. Continued review of the admission physician's orders revealed, "...May use low loss air mattress d/t (due to) Pressure Ulcer to coccyx ..." Medical record review of physicians' orders dated September 9-22, 2010, revealed orders for wound care were not obtained by the facility until September 22, 2010. Medical record review of a physician's order dated September 22, 2010, revealed, "clean open areas to rt (right) buttocks with wound cleanser; apply tender wet cover with combiderm; change qd (every day) and pm (as needed) until healed." Medical record review of a physician's order dated September 22, 2010, revealed, "cleanse red areas to lt (left) buttock with wound cleanser and apply Duoderm change q (every) 3 days and pm until healed."

Review of the facility's policy for "Skin Care Management" revealed, "...Pressure Ulcer Flow Diagram ... Pressure Ulcer identified from admission skin assessment/weekly skin assessment observation ... Notify physician and document notification ... Input MD (Medical Doctor) order/treatment ... Print new treatment order and place on Treatment Administration Record (TAR)."

Medical record review of nurse's notes revealed a Duoderm dressing was applied to the buttock on September 21, 2010, and with no physician's order for the Duoderm.

Observation on September 27, 2010, at 4:30 p.m., with the Director of Nursing (DON) and Licensed Practical Nurse #1 revealed the resident had three wounds on the right buttocks which were measured by the DON as follows: one stage 3 measured 3.0 cm (centimeters) x (times) 2.0
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GOLDEN LIVINGCENTER - MOUNTAIN VIEW

STREET ADDRESS, CITY, STATE, ZIP CODE
1300 BYPASS ROAD
WINCHESTER, TN 37398

(11/03/2010)

F 157 Continued From page 3

- one stage 2 measured 1.0 cm x 1.5 cm, both described with "yellow slough," and one stage 2, measured 0.3 cm x 0.3 cm.
- Continued observation with the DON and LPN #1 revealed an unstageable wound to the left heel which was measured by the DON as 2.5 cm x 3.0 cm and a "new" unstageable wound at the base of the right "little toe" which measured 0.3 cm x 0.3 cm.

Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with the Treatment Nurse (RN #2), who was providing wound care in the facility in the month of September 2010, revealed the Treatment Nurse "never knew about ...wounds" and confirmed the Treatment Nurse did not notify the physician to obtain treatment orders for the Pressure Ulcers which were present on admission or which developed after admission to the facility.

Medical record review and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed the only dressing change which was documented from the date of admission until September 21, 2010, was Duoderm which was applied on September 21, 2010. Continued medical record review and interview with the DON on October 6, 2010, at 8:40 a.m., confirmed the resident had one stage 3 pressure ulcer on admission on September 9, 2010, and on September 21, 2010, the resident had a stage 3 and two stage 2 Pressure Ulcers to the right buttock. Continued interview with the DON confirmed the facility failed to notify the physician of the wounds which were present on admission and failed to secure orders for treatment to the wounds from September 9, 2010, until September 22, 2010.
GOLDEN LIVINGCENTER - MOUNTAIN VIEW

F 279
SS=E

483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.20; and any services that would otherwise be required under §483.20 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review, observation and interview, the facility failed to update the care plan to include wounds and interventions to promote healing of the wounds for four (#3, #9, #13, #14) of sixteen residents reviewed.

The findings included:

Resident #3 was admitted to the facility on May 14, 1999, with diagnoses including Hypertension, Peripheral Vascular Disease, Delusion, Psychosis, Diabetes Mellitus and Depressive...
**F 279** Continued From page 5

Disorder. Medical record review of the Minimum Data Set (MDS) dated June 18, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills and was totally dependent of staff for all activities of daily living.

Medical record review of a physician's order dated June 27, 2010, revealed, "Two times a day apply skin prep to right toes until resolved two times per day." Medical record review of a physician's order dated September 17, 2010, revealed, "Clean it (right) heel with ns (normal saline) and apply skin prep daily bid."

Medical record review of the current care plan revealed the care plan included the resident's "...risk for Pressure Ulcers and altered skin integrity..." with the goal of "...will have no loss of skin integrity..." Continued review of the current care plan revealed the care plan had not been updated to reflect the unstable wound to the right heel and the intervention to "float" the heel from the bed to relieve pressure on the heel.

Observation and interview on September 27, 2010, at 3:45 p.m., with the Director of Nursing (DON) revealed the resident's right leg was lying on a pillow with the right heel lying on the bed. Observation revealed black necrosis to the right heel measured by the DON as 4.0 cm (centimeters) x (by) 5.0 cm and described by the DON as unstageable. Continued observation with the DON revealed a wound to the right great toe which was measured by the DON as 4.0 cm x 4.0 cm. Interview with the DON at the time of the observation confirmed the right heel was resting on the bed and was not "floated" to relieve pressure on the heel.

**Monitoring**

DNS/ADNS will audit 5 residents with wound care plans weekly x 4 and monthly x 2 to verify appropriate updates.

Results of audits will be discussed in QA&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly.

**F 279**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<tbody>
<tr>
<td>F 279</td>
<td>Monitoring</td>
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</table>

**Street Address, City, State, Zip Code**

1380 BYPASS ROAD
WINCHESTER, TN 37398
Medical record review and interview on October 5, 2010, at 7:25 a.m., with the MDS Coordinator confirmed the current care plan addressed prevention of loss of skin integrity and had not been updated to include the untreatable wound to the right heel and the intervention to "float" the heel from the bed to relieve pressure on the heel.

Resident #9 was admitted to the facility on June 29, 2010, with diagnoses including Paraplegia, Alzheimer's Disease, Chronic Kidney Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Degenerative Disk Disease and Decubitus Ulcer. Review of the "Clinical Health Status" (initial nursing assessment) dated June 29, 2010, revealed the resident had a Pressure Ulcer on the coccyx which measured 11.0 cm x 9.0 cm x 4.0 cm with tunneling of 8.0 cm.

Medical record review of the care plan dated June 30, 2010, revealed the care plan did not address the stage 4 Pressure Ulcer to the coccyx and did not include interventions related to treatment of the Pressure Ulcer.

Telephone interview and review of the care plan on October 21, 2010, with the MDS Coordinator confirmed the care plan did not address the stage 4 Pressure Ulcer to the coccyx and did not include interventions related to treatment of the Pressure Ulcer.

Resident #13 was readmitted to the facility on September 10, 2010, with diagnoses including Pressure Ulcer, Urinary Obstruction, Epilepsy and Recurrent Seizures, Congestive Heart Failure, Diabetes Mellitus, Anemia, Paranoid Schizophrenia and Hypertension. Medical record
Continued From page 7
review of the MDS dated September 17, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills; was totally dependent on staff for activities of daily living; and had one stage 2 Pressure Ulcer.

Medical record review of the current care plan revealed the care plan included the resident's "potential for altered skin integrity" with the goal of "...will have no loss of skin integrity ..." Continued review of the current care plan revealed no interventions were included related to the stage 2 Pressure Ulcer.

Medical record review of the facility's skin care management policy revealed, "...The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of Pressure Ulcers and/or skin integrity concerns identified ...Determine care plans consistently ...revised based on the needs of the resident ...."

Medical record review and interview on October 5, 2010, at 7:20 a.m., with the MDS Coordinator confirmed the current care plan addressed prevention of loss of skin integrity and had not been updated to include the stage 2 Pressure Ulcer and interventions to promote healing.

Resident #14 was admitted to the facility on November 13, 2008, with diagnoses including Alzheimer's Disease, Dementia with Behavioral Disturbances, Dehydration, Psychosis, Seizures and Benign Prostatic Hypertrophy. Medical record review of the Minimum Data Set dated July 3, 2010, revealed the resident had short and long-term memory problems and severely
 Continued From page 8
impaired decision-making skills; was totally dependent on staff for all activities of daily living; and had no pressure ulcers. Medical record review of the "Clinical Health Status" dated October 5, 2010, revealed the resident had no wounds except to the left ankle.

Medical record review of a nurse's note dated October 25, 2010, revealed, "Open area note to ear which was note bloody drainage noted; resident grimaces when area is touched. Tx (treatment) nurse aware of NS (normal saline), bacitracin (Bacitracin) ointment applied, gauze in place to keep tubing off area..." Review of the facility's weekly Pressure Ulcer report dated October 28, 2010, revealed the resident had a Stage 2 Pressure Ulcer to the right posterior ear which measured 1.6 cm x 0.2 cm.

Medical record review of a nurse's note by RN #4/Treatment Nurse revealed, "raw area to rt (right) ear 1.6 (cm) x 0.2 (cm), cleaned with normal saline and applied oxy ears (foam padding around oxygen tubing) to O2 (oxygen) for preventive measures."

Medical record review of the "Wound Evaluation Flow Sheet" dated October 26, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear measured 1.6 cm x 0.2 cm.

Medical record review and interview, in the conference room, on November 2, 2010, at 12:00 p.m., with the RN/Treatment Nurse #4 confirmed the care plan had not been updated to include the Stage 2 Pressure Ulcer and interventions to reduce the risk of the development of a Pressure Ulcer from the pressure of oxygen tubing on the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

445145

**X2 MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**X3 DATE SURVEY COMPLETED**

C

11/03/2010

**NAME OF PROVIDER OR SUPPLIER**

GOLDEN LIVINGCENTER - MOUNTAIN VIEW

**X4 ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<tbody>
<tr>
<td>F 279</td>
<td>Continued From page 9 years.</td>
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<tr>
<td>C/O #26709</td>
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<tr>
<td>F 281</td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</td>
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<tr>
<td>SS-D</td>
<td>The services provided or arranged by the facility must meet professional standards of quality.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, observation and interview, the facility failed to assess the surgical wounds and injuries for one (#2) and failed to implement the care plan for one (#3) of sixteen residents reviewed.</td>
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<td>The findings included:</td>
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|               | Resident #2 who was involved in a high-speed motorcycle crash, was admitted to the facility on June 10, 2010, with diagnoses including Fracture of the Left Arm and Shoulder with Open Reduction Internal Fixation, Fracture of the Left Wrist, Left Knee, Left Tibia and Fibula, MRSA (methicillin-resistant Staphylococcus aureus), Psychosis and Bipolar Disorder. Medical record review of the Minimum Data Set dated June 18, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making; had no behavioral symptoms or indicators of Depression, Anxiety or sad mood; required limited assistance with bed mobility, transfers, dressing, toileting and hygiene and was continent of bladder and bowel. Medical record review of a physician's order dated July 5, 2010, revealed, "Cleanse surgical
Continued From page 10

wound left lower leg with wound cleanser and 4x(by)4's, apply Triple Antibiotic Ointment to wound, cover with gauze, secure with Kerlex and tape...every shift...

Medical record review of the "Clinical Health Status" (initial nursing assessment) dated June 11, 2010, revealed no assessment of the resident's skin condition.

Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with Registered Nurse (RN #2)/Treatment Nurse confirmed the resident had surgical and trauma wounds on admission and confirmed the initial nursing assessment dated June 11, 2010, did not include any skin assessment or assessment of the resident's wounds.

Resident #3 was admitted to the facility on May 14, 1999, with diagnoses including Hypertension, Peripheral Vascular Disease, Delusion, Psychosis, Diabetes Mellitus and Depressive Disorder. Medical record review of the Minimum Data Set dated June 18, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills and was totally dependent of staff for all activities of daily living.

Medical record review of the current care plan revealed, "...Resident to use a heel boot to right heel." Review of the facility's policy for "Skin Care Management" revealed, "...Determine care plans consistently implemented ...based on the needs of the resident ..."

Observation and interview on September 27, 2010, at 3:45 p.m., with the Director of Nursing...
<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 11 (DON) revealed the resident's right leg was lying on a pillow with the right heel lying on the bed. Continued observation revealed a heel protector was not in place to the right heel. Observation revealed black necrosis to the right heel measured by the DON as 4.0 cm (centimeters) x (by) 5.0 cm and described by the DON as unstageable. Continued observation with the DON revealed a wound to the right great toe which was measured by the DON as 4.0 cm x 4.0 cm. Interview with the DON at the time of the observation confirmed a heel boot was not in place on the right heel. C/O #28709</td>
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<tr>
<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policies, observation and interview, the facility failed to accurately assess and provide dressing change as ordered by the physician for one (#7); failed to obtain physician's orders for treatment and failed to assess Pressure Ulcers for one (#8); and failed to pad oxygen tubing to prevent a Pressure Ulcer for one (#14) of fifteen residents with Pressure Ulcers reviewed.

<table>
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<tr>
<th>ID PREFIX TAG</th>
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<td>F 281</td>
<td>Monitoring</td>
<td>11-24-10</td>
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Results of audits will be discussed in Q&A.
X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly.

<table>
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<tr>
<th>F 314</th>
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<tbody>
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<td>Resident</td>
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Resident #7 has been discharged from facility.
Resident #8: Physician was notified and Order for treatment obtained by charge nurse on 9/22/10.
Res 8 no longer resides in facility.
Resident #14 has appropriate padding for O2 tubing.

Affected residents

Residents at risk to develop wounds have potential to be affected by this alleged deficient practice. Skin audits were conducted by charge nurses on 11/21/10 on residents currently residing in facility and reviewed by DNS/ADNS and identified skin concerns were addressed according to protocol.
The findings included:

Resident #7 was admitted to the facility on July 8, 2010, for a five-day hospice respite stay, with diagnoses including Alzheimer's Disease, Failure to Thrive and Pressure Ulcer. Medical record review of the physician's recaptulation orders dated July 9-31, 2010, revealed, "...Change hydrocolloid dressing every 3 days or if soiled cleanse with saline, pat dry with gauze sponges then apply dressing..." Medical record review of a nurse's note dated July 8, 2010, at 7:07 a.m., revealed, "...Resident came with orders for wound care: Change hydrocolloid dressing to right lower sacral areas every 3 days and prn..."

Medical record review of the Treatment Record dated July 8-31, 2010, revealed no documentation wound care was provided July 8-13, 2010, (date of discharge).

Review of the facility's "Skin Care Management" policy and "Pressure Ulcer Flow Diagram" revealed, "...Implement resident specific interventions immediately: Treatment as ordered...

Interview on September 29, 2010, at 9:05 a.m., in the conference room, with Registered Nurse (RN) #1, (assigned to the unit where the resident resided) revealed the RN was "unaware" the resident had a dressing and stated, "No one told me (resident) had a place that needed attention." Interview with the RN confirmed the Duoderm dressing was not changed during the resident's stay in the facility from July 8-13, 2010, as ordered by the physician.

System changes
Weekly skin inspections conducted
By charge nurses will be brought to morning meeting and reviewed by IDT
This is ongoing.
The IDT consist of DNS, ADNS, SSD, DCE, Dietary Manager and periodically by Executive Director.

Morning meeting is conducted Mon through Fri.

DNS/ADNS/Supervisor will do second skin evaluation on new Admissions within 24 hours of admission.
This will be ongoing.

DNS/ADNS are conducting weekly wound Rounds on current residents with current Pressure, arterial, stasis or surgical wounds to verify treatments, evaluations and intervention in place. These rounds will be ongoing.

ED/DNS redistributed and clarified the wound care and charge nurse duties in identifying, treatment and monitoring of skin care. When wound is identified charge nurse on duty is responsible to notify Dr. and get treatment started. Wound nurse will assist with treatments related to pressure wounds, arterial, stasis, and surgical and measurements. Other treatments are responsibility of charge nurses.

The 24-72 hour new admission/Readmission Chart reviews will be reviewed in morning meeting Mon through Fri by IDT to verify completion of skin evaluation on admission and review clinical health assessment to verify resident identified at risk will have appropriate interventions in place.

The IDT consist of DNS, ADNS, SSD, DCE, Dietary Manager and periodically by Executive Director.
F 314 Continued From page 13

Interview on September 29, 2010, at 12:20 p.m., in the conference room, with the Director of Nursing (DON) confirmed the dressing to the Pressure Ulcer was not changed during the resident's five-day stay in the facility from July 8-13, 2010.

Medical record review of the "Clinical Health Status" dated July 8, 2010, revealed no documentation the Pressure Ulcer on the sacrum was assessed for location, size, stage, drainage, surrounding tissue nature of the wound. Medical record review revealed no documentation the Pressure Ulcer was assessed during the resident's five-day stay in the facility from July 8-13, 2010.

Review of the facility's "Skin Care Management" and "Risk Identification/Prevention" policy revealed, "... All residents will be assessed/observed for risk of skin breakdown within 24 hours of admission... Pressure Ulcer identified from admission skin assessment... document initial assessment of pressure area including: Location and staging; (1) Size; (2) Exudate (drainage); if present: type, color, odor, and approximate amount; (3) Pain if present: nature and frequency; (4) Wound bed: color & (and) type of tissue/character including evidence of healing (granulation) or necrosis (slough and exudate); (5) Description of (wound) edges and surrounding tissue ...".

Medical record review and interview on October 5, 2010, at 10:25 a.m., in the conference room, with the DON confirmed the facility's policy was not followed, and the Pressure Ulcer was not assessed on admission or at any time during the

Education to licensed nursing staff by DCEO/DOS/ADNS/Administrative Nurses on 11/10, 11/11, and 11/22/10 on skin care management guideline which includes identification of skin concerns and interventions. Weekly skin inspection and documentation requirements were included in the education. This was validated by current roster. This education has been added to new hire education packet.

Monitoring

Results of audits will be discussed in Q&A X 3 months. The meeting is attended by Executive Director, Director of Nursing (DNS), Assistant Director of Nursing (ADNS), Medical Director, Social Service, Activities, Dietary, Resident Assessment Coordinator and Maintenance Director and is held monthly,
F 314

Continued From page 14

Resident #8 was admitted to the facility on September 9, 2010, with diagnoses including Anxiety, Urinary Tract Infection, Diabetes Mellitus, Lung Cancer and Hypertension. Medical record review of the Minimum Data Set (MDS) dated September 16, 2010, revealed the resident had no short or long-term memory problems and was independent in decision-making skills; required extensive assistance with bed mobility, transfers, activities of daily living; was incontinent of bowel and had an indwelling urinary catheter; and had three stage 3 Pressure Ulcers.

Medical record review of the "Clinical Health Status" (initial nursing assessment) dated September 9, 2010, revealed the resident was at moderate risk for Pressure Ulcers; had a Stage 3 Pressure Ulcer on the left buttock which measured "1 ½" inches (one inch equals 2.5 centimeters) and was covered with a foam dressing; and had an "unstageable" wound to the left heel (no measurements documented). Continued review revealed no documentation of the size or nature of the unstageable wound on the left heel.

Review of the weekly skin report for Pressure Ulcers revealed the wounds were not assessed again until September 21, 2010 (twelve days later). Medical record review of the weekly Pressure Ulcer report dated September 21, 2010, revealed the resident had a Stage 2 Pressure Ulcer on the right buttock measuring 1.0 cm (centimeters) x (by) 1.5 cm, a Stage 2 Pressure Ulcer on the right buttock measuring 0.5 cm x 1.3 cm, a Stage 3 pressure on the right buttock.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F314</td>
<td>Continued From page 15</td>
<td>measuring 3.0 cm x 2.0 cm and a Stage 1 Pressure Ulcer to the left buttock (no measurement documented). Medical record review of a &quot;Wound Evaluation Flow Sheet&quot; dated September 22, 2010, revealed the resident had an unstageable Pressure Ulcer to the left heel measuring 3.0 cm x 3.0 cm. Review of the facility's &quot;Skin Care Management&quot; policy revealed, &quot;Purpose: to provide a systematic approach and monitoring process for skin ...All residents will be assessed/observed for risk of skin breakdown within 24 hours of admission ... (facility) develops a routine to review residents with wounds or at risk on a weekly basis ...Wound status is monitored on a weekly basis ...Documentation of Weekly Skin Assessments/Observations: Licensed nurse will be responsible for performing this skin assessment/observation ...Licensed nurse to document weekly on all wounds using the &quot;Wound Evaluation Flow Sheet ...document ...Location and staging ...Size (length x width/depth) presence and location of undermining and tunneling ...Exudate/if present: nature and frequency ...Wound bed: color &amp; (and) type of tissue/character including evidence of healing (granulation) or necrosis (slough and eschar) ...Description of (wound) edges and surrounding tissue...&quot;</td>
<td>F314</td>
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Medical record review, review of the weekly skin reports for Pressure Ulcers and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed the Pressure Ulcers had not been assessed between September 9, 2010, and September 21, 2010. Continued interview confirmed on September 9, 2010, the resident had one stage 3 Pressure
F 314 Continued From page 16

Ulcer on the left buttock, and on September 21, 2010, the resident had two stage 2 and one stage 3 on the right buttock and a stage 1 Pressure Ulcer on the left buttock. Continued interview confirmed the pressure ulcers were not assessed the week of September 13, 2010, and confirmed the facility's policy to perform weekly Pressure Ulcer assessments had not been followed.

Medical record review of the physician's admission orders dated September 9, 2010, revealed no orders were obtained for wound care/dressing changes on admission. Continued review of the admission physician's orders revealed, "...May use low loss air mattress d/t (due to) Pressure Ulcer to coccyx ..." Continued review of physicians' orders dated September 9-21, 2010, revealed no orders for wound care were obtained by the facility. Medical record review of a physician's order dated September 22, 2010, revealed, "clean open areas to rt (right) buttock with wound cleanser(,) apply tenderwet cover with combiderm(,) change qd (every day) and prn (as needed) until healed." Medical record review of another physician's order dated September 22, 2010, revealed, "cleanse red areas to lt (left) buttock with wound cleanser and apply Duoderm(,) change q (every) 3 days and prn until healed."

Medical record review of the Treatment Record dated September 2010, and nursing notes dated September 9-22, 2010, revealed wound care was not provided from September 9-21, 2010. Medical record review of nurses' notes dated September 9-22, 2010, revealed no documentation wound care had been provided from September 9-20, 2010, and revealed a Duoderm dressing was applied to the buttock on
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September 21, 2010 (twelve days after admission).

Observation and interview on September 27, 2010, at 4:30 p.m., with the DON and the Licensed Practical Nurse (LPN) #1 revealed the resident lying in bed on a low air-loss mattress. Continued observation with the DON and LPN #1 revealed the resident had Pressure Ulcers on the right buttocks, described by the DON as: one stage 3, 3.0 cm x 2.0 cm and one stage 2, 1.0 cm x 1.5 cm, both with "yellow slough" and one stage 2, 0.3 cm x 0.3 cm. The DON described an unstageable wound to the left heel, 2.5 cm x 3.0 cm with the margins intact and a "new" unstageable wound to the base of the right "little toe" which measured 0.3 cm x 0.3 cm.

Medical record review and interview on October 5, 2010, at 1:00 p.m., in the conference room, with RN #2/Treatment Nurse, who was providing wound care in the facility, in the month of September 2010, confirmed the Treatment Nurse had no knowledge of the resident's wounds; did not provide wound care for the resident; and did not notify the physician to obtain treatment orders for the Pressure Ulcers.

Medical record review and interview on October 6, 2010, at 8:40 a.m., in the conference room, with the DON confirmed wound care was not provided from September 9-20, 2010, and confirmed the facility failed to obtain physician's orders for treatment to the wounds from September 9, 2010, until September 22, 2010.

Resident #14 was admitted to the facility on November 13, 2008, with diagnoses including Alzheimer's Disease, Dementia with Behavioral
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Disturbances, Dehydration, Psychosis, Seizures and Benign Prostatic Hypertrophy. Medical record review of the Minimum Data Set dated July 3, 2010, revealed the resident had short and long-term memory problems and severely impaired decision-making skills; was totally dependent on staff for all activities of daily living; and had no pressure ulcers. Medical record review of the "Clinical Health Status" dated October 5, 2010, revealed the resident had no Pressure Ulcers.

Medical record review of the physician's orders dated November 1, 2010, revealed, "...O2 (Oxygen) at 2 lpm (liters per minute) to maintain O2 sats (saturation level) above 90 % (percent)..." 

Medical record review of a nurse's note dated October 25, 2010, at 2:57 p.m., revealed, "Open area noted to be retracted with bloody drainage noted; resident grimaces when area is touched. Tx (treatment) nurse aware & (and) area cleaned with NS (normal saline), bacitracin (Bacitracin) ointment applied, gauze in place to keep tubing off area..." Medical record review of a nurse's note dated October 25, 2010, at 3:45 p.m., revealed, "...CNA noted an open area behind residents ear while shaving...Area appears to be caused from O2 tubing..." Review of the facility's weekly Pressure Ulcer report dated October 26, 2010, revealed the resident had a Stage 2 Pressure Ulcer to the right posterior ear which measured 1.6 cm x 0.2 cm.

Medical record review of a nurse's note by RN #4/Treatment Nurse dated October 26, 2010, revealed, "raw area to rt (right) ear 1.6 (cm) x 0.2 (cm), cleaned with normal saline and applied Oxy..."
### Statement of Deficiencies and Plan of correction

**Provider/Supplier/CLA Identification Number:**
445145

**Multiple Construction**

- **Building:**
- **Wing:**

#### Golden Livingcenter - Mountain View

**Street Address, City, State, Zip Code**
1360 Bypass Road
WINCHESTER, TN 37398

**Id Prefix Tag**

- **F 314**

#### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

**Id Prefix Tag**

- **F 314**

#### Provider's Plan of Correction

(Each corrective action should be cross-referenced to the appropriate deficiency)

**Completion Date**

- **11/03/2010**

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Ears (foam padding around O2 tubing) to O2 tubing for preventive measures.*

Medical record review of the “Wound Evaluation Flow Sheet” dated October 26, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear measured 1.6 cm x 0.2 cm. Medical record review of the “Wound Evaluation Flow Sheet” dated October 29, 2010, revealed the Stage 2 Pressure Ulcer to the right posterior ear had healed.

Interview on November 2, 2010, at 11:30 a.m., in the conference room, with the RN/Treatment Nurse #4 confirmed the resident had a painful Stage 2 Pressure Ulcer “caused by oxygen tubing.” Continued interview with RN#4/Treatment Nurse revealed Oxy Ears (foam padding around oxygen tubing) were placed on the oxygen tubing over both ears to promote healing. Continued interview with RN #4/Treatment Nurse revealed the Pressure Ulcer to the right posterior ear was healed as of October 29, 2010.

Observation and interview on November 2, 2010, at 11:40 a.m., with RN #4/Treatment Nurse revealed the resident was lying in bed with oxygen tubing in place around both ears, and Oxy Ears were not in place. Continued observation and interview with RN #4/Treatment Nurse confirmed the Oxy Ears were not in place and confirmed the resident had a new Stage 2 Pressure Ulcer to the right posterior ear which was red and moist but with no drainage and measured by the Treatment Nurse as 0.5 cm x 0.5 cm. Continued interview with the Treatment Nurse confirmed the Treatment Nurse would reapply Oxy Ears to the O2 tubing.
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<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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