Printed: 03/22/2006 1:56:42PM
Due Date: 11/24/2005
Priority: Non-IJ High
Referral-Other

Intake ID: KY00005479
Facility ID: 100959 / HOSP-ACU
Provider Number: 180132

ACTS Complaint/Incident Investigation Report

PROVIDER INFORMATION

Name: LAKE CUMBERLAND REGIONAL HOSPITAL
Address: 305 LANGDON ST, PO BOX 620
City/State/Zip/County: SOMERSET, KY, 42502, PULASKI
Telephone: (606) 679-7441

License #: 100959
Type: HOSP-ACU
Medicaid #:
Administrator: THOMAS WEISS

INTAKE INFORMATION

Taken by - Staff: MONHOLLEN, PHYLLIS A.
Location Received: REGION C COMMUNITY HEALTH
Intake Type: Complaint
Intake Subtype: Federal COPs, CFCs, RFPs, EMTALA
External Control #:
SA Contact:
RO Contact: HOLLINGSWORTH, JOEANN
Responsible Team: REGION C COMMUNITY HEALTH
Source: Other

Received Start: 11/09/2005 At 11:57
Received End: 11/09/2005 At 11:57
Received by: Telephone
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Home Phone	Work Phone	Link ID
				05J507

RESIDENTS

Name	Admitted	Location	Room	Discharged	Link ID
					1456254

INTAKE DETAIL

Date of Alleged Event: Time: Shift:

Standard Notes: The investigation of the allegation was initiated on November 16, 2005, and concluded on November 17, 2005, by Kimberly Burton, a representative of the Division of Health Care Facilities and Services.

During the course of the investigation, the following individuals were interviewed:

Mandy Lynch, Wound Care Nurse
Sheryl Glasscock, Chief Nursing Officer

--Patient Roster:

, Patient #9

Extended RO Notes:

ALLEGATIONS

Category: Quality of Care/Treatment
Subcategory:
Seriousness:
Findings: Substantiated:Federal deficiencies related to alleg are cited

Tags:		S/S:
	A0199-NURSING SERVICES(482.23)	NOT SPECIFIED
	A0204-RN SUPERVISION OF NURSING CARE(482.23(b)(3))	NOT SPECIFIED

Details: The facility failed to provide the necessary care and treatment to patient(s); i.e., During October 2005 (exact dates unknown), patient , was admitted to the hospital from another health care facility. The patient developed a Stage II pressure sore to the left heel while in the hospital due to the failure of staff to utilize any interventions to prevent skin breakdown for this patient, such as heel protectors.

Findings Text:

This allegation investigation was conducted in conjunction with a follow-up visit related to ARO #KY5257.

A closed record review was conducted on November 16, and 17, 2005, for patient #9.

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Patient #9 presented to the hospital Emergency Room on , with a fractured left hip, and subsequently underwent an open reduction and internal fixation of the left hip on June 22, 2005. A review of patient #9's admission assessment revealed that the patient was profoundly mentally retarded, and had diagnoses including Sanfilippo's Syndrome, Cholecystitis, Cholelithiasis, and Osteoporosis.

Patient #9 was admitted to the hospital on 11:42 a.m., and arrived on the surgical floor on June 21, 2005, at 1:23 p.m. The admission assessment for patient #9 revealed that the patient's skin was intact, the patient had no decubitus ulcers, and no skin issues were identified. Patient #9 was assessed to have a Braden Scale Assessment score of 16. Additional record review revealed that patient #9 was transferred to the hospital's Telemetry Unit on June 22, 2005, during the evening hours after experiencing a drop in his heart rate and blood pressure status post left hip surgery.

A review was conducted of patient #9's skin documentation record, which revealed an entry on June 23, 2005, at 11:00 a.m., by a registered nurse documenting patient #9 to have intact 5-centimeter (cm) by 5-cm blisters to both right and left heels, with the surrounding skin clean, dry, and intact. Patient #9's Braden Scale Assessment score remained unchanged at 16. An assessment was conducted by the hospital's wound care nurse (WCN) on June 23, 2005, at 11:30 a.m. The WCN's assessment revealed that patient #9 had fluid-filled blisters to both heels, and that both heels were red, warm, and soggy-feeling. The assessment went on to reveal that the blister to the left heel covered the entire heel and had purple discoloration. The WCN made recommendations for an air mattress, heel bootie protectors to be utilized for patient #9, and for patient #9 to have his legs elevated on pillows. Further record review revealed that no treatment protocols regarding skin breakdown were implemented by the staff for patient #9. Subsequent nursing skin assessments made on patient #9 through June 24, 2005, at 3:00 a.m., consistently documented Stage II blisters to the patient's right and left heels, 5 cm by 5 cm, with the surrounding skin clean, dry, and intact. Patient #9's Braden Scale Assessment score remained unchanged at 16. An entry made in patient #9's skin documentation record by a registered nurse on June 25, 2005, at 7:00 a.m., indicated that patient #9 had a Stage I pressure sore to the right heel that was assessed to be clean and dry, and that patient #9 had large fluid-filled blisters to both heels. At this time, patient #9's Braden Scale Assessment score was 15. On June 25, 2005, at 6:30 p.m., an entry by the registered nurse revealed that approximately 60 cubic centimeters (cc) of clear yellow bile-like fluid was drained from a blister on patient #9's left heel after the blister had been punctured. The entry further stated that patient #9 tolerated the procedure well, and that a dressing was placed on patient #9's left heel. However, no documentation could be found in patient #9's medical record regarding physician's orders to treat the left heel after the blister was punctured, or evidence that hospital protocols had been implemented for patient #9 for treatment after the left heel was punctured and drained. Patient #9's Braden Scale Assessment score remained at 15. No further documentation was made in the skin documentation record for patient #9 regarding assessment of his heels until 3:00 p.m. on June 26, 2005, at which time an entry by a registered nurse stated that the dressing to the left foot was removed, that a large blister was forming on the left heel, and that a blister was present to the right heel. Patient #9's Braden Scale Assessment score remained at 15. Further entries on June 26, 2005, at 7:00 p.m., and on June 27, 2005, at 3:00 a.m., stated that the dressing to patient #9's left foot was intact. On June 26, 2005, at 7:00 a.m., an assessment was made by a registered nurse that reflected that patient #9's right heel Stage I area was clean, dry, and measured 5 cm by 5 cm. The entry further stated that the Stage I area to patient #9's left foot had a large copious amount of yellow drainage, and measured 15 cm by 7 cm, further indicating that the outer portion of patient #9's left foot was red/purple. Patient #9's Braden Scale Assessment score was 12. Record review revealed that on June 26, 2005, at 11:00 a.m., patient #9 was transferred from the hospital's Telemetry Unit to the surgical floor. Upon initial assessment by a registered nurse on the surgical floor, patient #9 was assessed to have blisters to the back of both feet, draining a moderate amount of amber drainage, and surrounding skin was noted to be red. Patient #9's Braden Scale Assessment score was 15. Subsequent entries made in patient #9's skin documentation record consistently revealed that patient #9 had blisters without drainage to the backs of both feet, and that surrounding skin was inflamed in appearance. Patient #9's Braden Scale Assessment score was 15. Further review of the skin documentation record revealed that patient #9's Braden Scale Assessment score was 13 on June 30, 2005, at 7:00 a.m.; however, no assessment of patient #9's heels was made.

A review of the hospital's policy/procedure regarding skin care pressure ulcer/wound management revealed that a patient would be classified as high risk if the Braden Assessment score was 15 or less. Further review of the policy revealed that patients with the following risk factors would be classified as high risk for skin breakdown: (a) bedfast/chair bound, (b) immobility, (c) incontinence, (d) nutritionally compromised, (e) decreased level of consciousness, and (f) co-existing systemic medical conditions. Further review of the policy revealed that patients assessed to be at high risk for skin breakdown would have the intervention of a pressure-relief support surface, and if the patient was incontinent, a skin agent would be provided. The appropriate protocol would be recorded with the date and time of implementation and placed in the patient's medical record with the physician's progress notes. Furthermore, the policy stated that referrals of high-risk patients would be made to the wound care nurse and Dietary.

A review of patient #9's medical record revealed a nutrition consultation dated June 23, 2005. The hospital's

registered dietician noted that patient #9 had Stage II pressure ulcers present to both left and right heels, and factored the estimated caloric and protein intake needed for healing. A dietary recommendation was made to include a health shake with each meal for patient #9. No nutritional consultation prior to the development of patient #9's pressure areas, or follow-up consultation to assess effectiveness of the intervention, caloric and protein intake, or healing status was present in patient #9's medical record.

A review of patient #9's physician's orders dated June 23, 2005, revealed a verbal order for an air mattress for wound prevention which had been signed by the physician, and a telephone order signed by the physician dated June 25, 2005, to puncture the blister to patient #9's heel. However, no further physician's orders regarding pressure areas were present in patient 9's medical record. Further review revealed that no hospital protocols were present in patient #9's medical record regarding prevention/treatment of pressure areas.

An interview was conducted on November 17, 2005, at 4:20 p.m., with the hospital's WCN. During the interview, the wound care nurse stated that a patient was considered high risk if the Braden Assessment score was 15 or below. The wound care nurse went on to say that patient #9 should have been classified as high risk for skin breakdown upon admission to the hospital, due to patient #9 having all the risk factors listed in the hospital's protocol, despite the Braden Assessment score of 16. The wound care nurse went on to say that patient #9 should have had the high risk protocol implemented and a copy of the protocol placed in the physician progress notes of his medical record. The wound care nurse stated that no preventative measures for skin breakdown were implemented for patient #9 upon admission to the hospital. When questioned further regarding the hospital's Braden Assessment tool, the wound care nurse stated that patient #9's Braden Assessment score remained at 16 after development of the pressure areas. The wound care nurse stated that due to the questions asked on the Braden Assessment tool, the score remained above 15, even after development of actual skin breakdown. The wound care nurse went on to say that, subsequently, a wound care referral, dietary referral, and treatment protocol implementation could be omitted for a patient with active skin breakdown if the patient's Braden Assessment score remained above 15. When questioned regarding treatment of patient #9's pressure areas, the wound care nurse stated that she made the initial assessment of the areas on June 23, 2005, and made recommendations for the air mattress and elevation of the patient's feet; however, she made no further follow-up assessments, even though the pressure sore to the left heel had significant decline. Furthermore, the wound care nurse stated that after the initial referral was made there was no formal tracking system to monitor the progress or decline of a wound. The wound care nurse stated that she would not know if a wound declined or that further assessment was needed unless she was notified by the direct care nurses. However, the wound care nurse stated that the facility had no system in place to prompt the direct care nurses to notify the WCN of a decline in wound status. The wound care nurse stated that she did not conduct follow-up assessments of all wound/pressure sores. During the interview, the wound care nurse stated that no treatment had been provided for patient #9's wounds. The wound care nurse also stated that no physician's orders had been obtained for treatment and no hospital protocols for the treatment of pressure areas had been implemented for patient #9. On June 30, 2005, patient #9 was discharged to the hospital's special care unit with a large open draining blister to the left heel, and an intact blister to the right heel.

An interview was conducted on November 17, 2005, at 11:25 a.m., with the hospital's chief nursing officer (CNO). The CNO stated that the hospital had relied on the Braden Scale Assessment tool for wound identification, referral, and treatment; however, the CNO stated, "It is just a screening tool."

--Conclusion:

The Division of Health Care Facilities and Services found that the allegation was substantiated. Based on the above information, it was determined that the facility failed to implement a preventative plan for pressure ulcer development for patient #9, when he was assessed to have all the risk factors listed in the facility's High Risk for Pressure Ulcer Development Protocol. Furthermore, the facility failed to provide treatment to patient #9 when he developed pressure ulcers to both heels, and further failed to intervene and reassess the pressure areas when their status declined. The facility was found to be out of compliance with the Condition of Participation for Nursing Services. Deficiencies were cited at A199 and A204 related to patient #9. These deficiencies were included in the statement of deficiencies for ARO #KY5757. 90-day termination was recommended.

--Follow-Up:

An acceptable plan of correction was received on December 22, 2005. A follow-up visit was conducted on January 30-31, 2006. All deficiencies were found to be corrected. It is recommended that the 90-day termination be rescinded.

Kim Burton Brock, Nurse Consultant/Inspector

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SURVEY INFORMATION

Event ID	Start Date	Exit Date	Team Members	Staff ID
JRTZ11	10/19/05	11/17/05	Bentley, Shirley	13025
			Roark, Ora M.	14701
			Mullins, Nancy	16116
			Gilbert, Gail	18682
			Dills, Mary	20594
			Burton, Kimberly S.	20595

Intakes Investigated: KY00005257(Received: 10/10/2005); KY00005479(Received: 11/09/2005); KY00005480(Received: 11/09/2005)

SUMMARY OF CITATIONS:

Event ID	Exit Date	Tag	S/S
JRTZ11	11/17/2005		
		Federal - Link to This Intake	
		A0199-NURSING SERVICES	NOT SPECIFIED
		A0204-RN SUPERVISION OF NURSING CARE	
		Federal - Link to another Intake of this Survey	
		A0210-WRITTEN MEDICAL ORDERS FOR DRUGS	NOT SPECIFIED
JRTZ12	01/31/2006		
		Federal - Link to This Intake	
		A0199-NURSING SERVICES	NOT SPECIFIED
		A0204-RN SUPERVISION OF NURSING CARE	
		Federal - Link to another Intake of this Survey	
		A0210-WRITTEN MEDICAL ORDERS FOR DRUGS	NOT SPECIFIED

ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	10/19/2005	10/19/2005	11/17/2005	MULLINS, NANCY GILBERT, GAIL DILLS, MARY BURTON, KIMBERLY S. BENTLEY, SHIRLEY ROARK, ORA M.

INVESTIGATIVE NOTES

AGENCY REFERRAL

Agency	Contact Name	Date Referred	Due Date	Agency Visit	Report Received	RO or SA
DCBS	Angela Thompson	11/09/2005				S

NOTICES

Letters:

Created	Description

Notification:

Date	Type	Party	Method

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PROPOSED ACTIONS

Proposed Action	Proposed Date	Imposed Date	Type
Involuntary Termination - Non-IJ	12/07/2005		Federal
Plan of Correction	12/07/2005		Federal

END OF COMPLAINT INVESTIGATION INFORMATION