Printed: 03/22/2006 1:04:07PM
Due Date: 10/24/2005
Priority: Non-IJ High
Referral-Other

Intake ID: KY00005257
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:

Received Start: 10/10/2005 At 09:55
Received End: 10/10/2005 At 09:55
Received by: Written
State Complaint ID:
CIS Number:

COMPLAINANTS

Name	Address	Home Phone	Work Phone	Link ID
				05ZKJD

INTAKE DETAIL

Date of Alleged Event: Time: Shift:

Standard Notes: The investigation of the allegation that the facility failed to provide the necessary care and services to patient(s) was initiated on October 19, 2005, and concluded on November 17, 2005, by Nancy Mullins, Gail Gilbert, Kim Burton, and Mary Dills, representatives of the Division of Health Care Facilities and Services.

Individuals interviewed during the course of the investigation:

, Chief Nursing Officer (CNO)
Nurse Manager
tical Nurse (LPN #1)
Nurse (LPN #2)
(LPN #3)
Registered Nurse (RN #1)
Registered Nurse (RN #2)
Unit Manager #1
Certified Nurse Aide (CNA #1)
(CNA #2)
(CNA #3)
, Wound Care Nurse (WCN)
, Quality Assurance (QA) Coordinator
Physician #1
Physician #2
, Physician #3
Robin Carlton, Pulaski County Department for Community Based Services

--Patient Roster:

, Patient #1
Patient #2
, Patient #3
Patient #4
Patient #5
Patient #6
, Patient #7

ACTS Complaint/Incident Investigation Report

, Patient #8
Patient #9

Extended RO Notes.

ALLEGATIONS

Category: Quality of Care/Treatment
Subcategory:
Seriousness:

Findings: Substantiated:Federal deficiencies related to alleg are cited, State deficiencies related to the alleg are cited

Tags: A0199-NURSING SERVICES(482.23)	S/S: NOT SPECIFIED
A0204-RN SUPERVISION OF NURSING CARE(482.23(b)(3))	S/S: NOT SPECIFIED
A0210-WRITTEN MEDICAL ORDERS FOR DRUGS(482.23(c)(2))	S/S: NOT SPECIFIED

Details: The facility failed to provide the necessary care and services for patient(s); i.e., Patients who are from area nursing homes have had an increase in progression of pressure sores and/or increase in development of new pressure sores after admission to the hospital due to the staff's failure to utilize appropriate interventions to prevent this increase in pressure sore development and failure to appropriately treat existing pressure sores.

Findings Text:

A telephone interview was conducted with Robin Carlton from the Pulaski County Department for Community Based Services (DCBS) on October 17, 2005. Robin Carlton stated that an investigation was not done on this allegation by DCBS due to no specific patient names being given.

On October 19, 2005, the Nurse Manager who was covering for the facility Chief Nursing Officer (CNO) was informed of the reason for the investigation. The Nurse Manager stated that Administration was attending an off-site meeting away from the hospital. The Nurse Manager provided the surveyor with a list of the most recent nursing home patients who had received wound care for pressure ulcers. A sample of medical records was selected from the list for review.

A tour of the Intensive Care Unit (ICU) was conducted on October 19, 2005. The ICU had a census of 18 patients with eight Registered Nurses and two monitoring technicians working in the unit providing care to patients. During the tour, patient #1 in room was noted to have a pressure ulcer, covering the entire left heel, which was black in color. Staff had elevated patient #1's heel on a pillow; however, the heel was hanging off the edge of the pillow and resting on the bed.

Medical record review revealed that patient #1 was admitted to the facility on . , with a diagnosis that included Acute/Chronic Respiratory Failure precipitated by an exacerbation of the patient's underlying chronic obstructive pulmonary disease. Patient #1 was also diagnosed with Diabetes/Severe Obesity and had been intubated and sedated for acute/chronic respiratory failure. At the time of the tour, patient #1 was observed to be lying supine (on back) at 10:15 a.m., and was observed to be in the same position at 12:15 p.m. Staff admitted that patient #1 had not been turned and stated that there was no need to turn the patient since the patient was on a bariatric bed. Further review of the medical record revealed that on October 18, 2005, a Stage I pressure ulcer had been noted on both of patient #1's heels. There was no documented treatment of the pressure ulcers and no evidence that the physician had been notified of the pressure ulcers. The Director of the Critical Care Unit admitted during interview on October 19, 2005, that staff had failed to consult the wound care nurse per facility policy regarding patient #1's low Braden Score (score to determine those patients who had or were at risk of having pressure ulcers).

A tour of the third floor medical surgical unit was conducted on October 19, 2005. During the tour at 11:20 a.m., patient #2 was observed to be lying supine and was unable to turn herself in bed. There was no evidence that patient #2 had been turned by staff at 12:50 p.m., and no evidence that patient #2 had been turned at 1:56 p.m. Interview with CNA #1 who was providing care to patient #2 on October 19, 2005, at 1:56 p.m., confirmed that patient #2 required staff assistance with turns/repositioning. CNA #1 stated that the charge nurse gave report on the patients who needed turning at the beginning of each shift. CNA #1 went on to say that turn sheets were normally kept on the bathroom door for staff to document each time that the patient was turned. CNA #1 admitted that staff had failed to document turns for patient #2.

The Nurse Manager stated in interview on October 19, 2005, that staff had recently been instructed to document when patients were turned/repositioned in the computer. The nurse manager stated that staff had not documented when patients were turned/repositioned in the computer or on the turn sheets.

An interview was conducted at the facility on October 19, 2005, with the wound care nurse who stated that she had been working at the facility as a wound care nurse since June 10, 2005, and was presently working four days per week. The wound care nurse confirmed that staff was required by facility policy to consult the wound care

nurse when a patient had a Braden Score of 15 or less. The wound care nurse stated that the facility had protocols in place for wound care/pressure sores and that the treatment plans had been approved by the medical staff.

Review of the facility's policy for Skin Care/Pressure Ulcer/Wound Management revealed that each patient was to be assessed by an RN upon admission and once every 24 hours for risk of skin impairment/presence of impaired skin integrity. A consent for a photograph was to be obtained and the pressure ulcers were required to be photographed every six days and again upon discharge. Documentation of the measurement of these wounds including length, width, depth, and tunneling was to be recorded every six days. Referrals to the wound care nurse and Dietary were also required to be made on each patient with a Braden score of 15 or less (with or without an existing pressure ulcer). Infection control guidelines/standard precautions were to be followed for wound care on those patients who had a Braden score of less than 15 and a plan of care was required to be implemented.

A second visit was made to the facility on October 26, 2005. The CNO was informed of the reason for the continued investigation. The CNO provided the surveyors with a list of those patients receiving treatment for pressure ulcers. Surveyors conducted a tour of the medical surgical floors and reviewed medical records of those patients with pressure ulcers. Observation during the tour revealed that four more patients (patients #2, #3, #5, and #6) were observed to have pressure ulcers that had not been included on the facility's list of patients receiving treatment for pressure ulcers.

Observation during the tour on the third floor medical unit on October 26, 2005, revealed that the unit had 22 patients and three of the 22 patients required staff assistance with turning/repositioning. Patient #3 was noted to have multiple and chronic decubiti. The patient's wife, who was at the bedside, told the surveyor that patient #3 developed the pressure ulcers during a previous stay in the hospital after being placed on a bariatric bed. The wife stated that the bariatric bed was supposed to turn the patients to prevent pressure ulcers from developing; however, "the bariatric bed did not work." When asked if staff had been turning patient #3 during this hospital stay, the wife replied, "Sometimes." Observation during the tour revealed that patient #3 was resting supine at 11:45 a.m., and revealed that patient #3 was still resting supine at 1:45 p.m. Patient #3 told the surveyor that staff had not made any attempts to turn him since he had returned from surgery earlier that morning.

Medical record review revealed that patient #3 was a quadriplegic with a longstanding history of chronic obstructive pulmonary disease and respiratory disease. Patient #3's admitting diagnoses included Multiple and Chronic Decubiti. Review of patient #3's care plan revealed that skin integrity had been identified as a care need for this patient; however, there was no documented evidence that patient #3 had been turned/repositioned every two hours per facility protocol.

The nurse manager stated in interview that patient #3 would sometimes refuse to be turned; however, there was no documentation in the medical record to show that patient #3 ever refused to be turned. A skin assessment was requested by the surveyor but the nurse stated that patient #3 refused to give permission for the skin assessment.

At the time of the tour, patient #4 was observed to be sitting in a chair at the bedside and the family was feeding the patient. Family stated that patient #4 was unable to provide care for herself and added that patient #4 had recently fractured her shoulder when the patient attempted to get out of the hospital bed without requesting assistance from the nursing staff.

Medical record review revealed that patient #4 had recently been diagnosed with Pancreatic Cancer. Patient #4 was admitted on with no skin breakdown noted at the time of admission. Further review of the medical record revealed that on October 23, 2005, patient #4 was noted to have a Stage II pressure ulcer on the coccyx area; however, there was no evidence that patient #4 had received treatment for the pressure ulcer, that the wound care nurse or dietitian had been consulted, or that measurements or photographs of the Stage II pressure ulcer had been obtained. A skin assessment conducted on October 26, 2005, of patient #4 revealed that this patient had a Stage II pressure ulcer to the coccyx area. The pressure ulcer measured 1.5 centimeters (cm) in size with no evidence that the pressure ulcer had been treated.

During the tour patient #5 was observed to be resting supine in bed and unable to turn herself. A turn sheet was noted on the bathroom door which revealed that staff had been turning the patient every two hours. The surveyor asked LPN #1, who was providing care to patient #5, if the patient had any pressure ulcers. LPN #1 stated that it was never mentioned in report that patient #5 had pressure ulcers and that patient #5 had not received treatment for pressure ulcers. LPN #1 stated in interview that when a pressure ulcer was found, a consent form was signed for a photograph and wound protocols for each stage of wound care were required to be followed. LPN #1 went on to say that a consultation was also required to be made to the dietitian and wound care nurse for all patients who have or are at risk of having pressure ulcers. LPN #1 stated that patients were also placed on an air mattress if the patient was at risk of developing a pressure ulcer. When asked how staff

ensured that the physician was made aware of the pressure ulcers, LPN #1 stated that the protocol sheet was placed under the physician's orders on the chart. However, LPN #1 stated that there was no system in place to ensure that the physician read the protocol and added that the physician was not required to sign the protocol. A skin assessment of patient #5 was conducted and LPN #1 stated that she was "shocked" when she observed four small draining pressure ulcers to patient #5's coccyx during the skin assessment. LPN #1 did not measure the pressure ulcers during the assessment.

An interview was conducted with RN #1 on October 26, 2005. RN #1 stated that she had worked at the facility for the past 19 months. RN #1 stated that a full body assessment should be conducted on each patient at the time of admission and those patients who were susceptible to pressure ulcers were required to be referred to the dietitian and wound care nurse. RN #1 went on to say that the staff had placed a protocol sheet on the medical record under the physician's orders. RN #1 confirmed that wound care/treatment was required to be documented on the medication administration record. RN #1 stated that dressings were required to be changed every three days. RN #1 stated that those patients who were at risk for skin breakdown should be turned every two hours and the staff was required to document when a patient was turned/repositioned on the turn sheet. RN #1 assisted the surveyor in further review of the medical records of patients #1, #2, and #3, and stated that staff had failed to follow facility protocols for the care of pressure ulcers for patients #1, #2, and #3.

Medical record review revealed that patient #5 was a diabetic and was admitted to the ICU on [redacted] with no skin breakdown. Further review of the medical record revealed that on October 19, 2005, patient #5 was noted to have a Stage II pressure ulcer to the coccyx. Patient #5 was placed on a rotating sports bed and nursing notes dated October 20, 2005, revealed that Nursing had applied Sensicare creme to the Stage II pressure ulcer; however, the pressure ulcer treatment was not noted on the medication administration record. Patient #5 was transferred from ICU to the third floor medical unit on October 20, 2005. There was no evidence that the treatment protocol for patient #5's Stage II pressure ulcer was followed, no measurement or photograph of the pressure ulcer had been obtained, and there was no evidence that staff had followed the facility guidelines for wound care management.

Patient #6 was admitted to the fourth floor medical unit on [redacted], with the following diagnoses: Diabetes Mellitus, Dementia, Multifactorial Anemia, Osteoporosis, Gastroesophageal Reflux Disease, Hyperlipidemia, Status Post Previous Cerebrovascular Accident, Chronic Obstructive Pulmonary Disease, and Status Post Left Shoulder/Right Hand Fractures. Patient #6 was assessed upon admission on [redacted] to have a one-centimeter bruised area to the right heel. The patient care notes dated October 22, 2005, revealed that the bruised area to patient #6's right heel was non-staged and had increased in size (3 cm by 3 cm). Documentation on October 22, 2005, also revealed that patient #6 had a non-staged pressure ulcer to the left heel, measuring 4 cm by 3 cm. A review of the nursing care plan revealed that patient #6 had potential/actual skin problems identified related to disease process, poor hygiene, trauma, medication, impaired ability to perform activities of daily living and poor nutrition. However, this care plan was not individualized and did not identify the pressure ulcers to patient #6's right and left heels. The goal on patient #6's care plan was vague, stating that the skin integrity would be monitored and treated appropriately. In addition, no interventions were included on the care plan in response to the specific care needs and treatment of the pressure ulcers.

According to the facility's policy and procedure for pressure ulcer/wound management, the appropriate treatment for non-staged pressure ulcers revealed that the wound would be cleansed with Normal Saline, Santyl ointment would be applied to eschar daily, and the wound would be covered with a dry dressing. The policy required that the dressing be changed daily and that the Santyl would be discontinued when the eschar was debrided. The appropriate protocol for the staged wound after debridement would then be followed. An interview with the charge nurse caring for patient #6 and the nurse manager on October 26, 2005, revealed that a copy of the non-staged pressure ulcer protocol was in patient #6's medical record; however, patient #6 had not received treatment to the pressure ulcers as required by the facility's policy and procedure. Interview with the charge nurse at 5:05 p.m. on October 26, 2005, revealed that patient #6 had not received treatment to the non-staged pressure ulcers because she was told by the wound care nurse that it would be best to leave patient #6's heels elevated and administer no other treatment.

A review of the facility's guidelines for skin care included turning/repositioning of the patient every two hours and as needed. A review of the nursing care plan for patient #6 revealed that turning the patient every two hours was not included as a nursing care plan intervention. Interview with CNA #2 on October 26, 2005, at 3:30 p.m., revealed that patient #6 was turned by the staff every two hours. A review of the nursing assistant's "Preventive Care Record" revealed that on October 26, 2005, patient #6 was positioned on the right side from 11:00 a.m. to 1:00 p.m., on the back from 1:00 p.m. to 3:00 p.m., and on the left side at 3:00 p.m. Observation of patient #6 on October 26, 2005, revealed that patient #6 was positioned on the back at 12:20 p.m., 12:45 p.m., and 1:20 p.m., and continued to be positioned on the back at 3:15 p.m. On October 26, 2005, an interview was conducted at 3:30 p.m., with CNA #2, who was assigned to turn patient #6. CNA #2 stated that she had turned patient #6 at 2:00 p.m.

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A review of the facility's policy and procedure on October 26, 2005, for Pressure Ulcer/Wound Management revealed that the appropriate protocol sheet would be placed with the physician progress notes. The policy did not require that the appropriate protocol be signed by the practitioner responsible for the care of the patient. The protocol for the treatment of pressure ulcers and skin tears included Normal Saline, Santyl ointment, DuoDerm and Aquacel, depending on the stage of the ulcer.

Interview with the CNO on October 26, 2005, revealed that the protocol used for the treatment of pressure ulcers was placed on the patient's medical record but was not signed by the practitioner responsible for the care of the patient.

A review of the medical record for patient #6 on October 26, 2005, revealed that a copy of the protocol for treatment of the non-staged pressure ulcer had been completed and included in the medical record. The protocol indicated that it was to be implemented on October 21, 2005, at 7:00 p.m.; however, the protocol had not been signed by the practitioner responsible for the care of patient #6.

A telephone interview was conducted with physician #1 on November 3, 2005. Physician #1 stated that a physician committee helped set the protocols that were in place for pressure ulcers and that the protocols had been approved by the medical staff. Physician #1 stated that the nurse was to assess each patient upon admission and routinely for pressure ulcers, and when an area of redness or ulcer was found the nurse made the recommendation by placing a protocol sheet on the medical record under the physician's orders. Physician #1 stated that she had worked at the facility for the past ten years and added that even though staff may not always follow the protocols for pressure ulcers it was still better today than before.

On November 16, 2005, following supervisory review, it was determined that more information was needed regarding condition level deficiencies. A third visit was conducted at the facility to assure that treatment and services were being provided to those patients with or at risk of developing pressure sores. Upon arrival, the CNO was asked to provide another list of those patients with pressure sores and a tour of the medical units was conducted by surveyors. In addition, another allegation (#KY5479) related to pressure sores was conducted in conjunction with the third on-site visit.

A tour of the ICU was conducted on November 16, 2005. Nurse #2, who was providing care to patient #7, stated in interview that patient #7 was scheduled for surgery to have a pressure ulcer debrided and was not to have anything by mouth until after the surgery. It should be noted that patient #7 did not go to surgery until the afternoon of November 17, 2005. The nurse stated that patient #7's surgery was postponed due to an emergency surgery which took priority. When asked what type of treatment patient #7 was receiving for the pressure sore to the coccyx which measured 18 by 21 centimeters, the nurse stated that wet to dry dressings were being applied every twelve hours along with antibiotics. Observation during the dressing change revealed that patient #7 had a pressure sore which covered the entire buttock. The pressure sore was unable to be staged due to necrosis. The area around the pressure sore was red and draining yellow foul-smelling drainage and there was bowel movement noted on the pressure sore. Further observation revealed that patient #7 required assistance with turns/repositioning due to amputation of both legs below the knee. Patient #7 was resting on his back/buttock at the time of the tour and, even though an air mattress had been ordered on the day of admission, the patient still had not been placed on an air mattress as of November 16, 2005, at 3:30 p.m. (nearly 32 hours later).

Medical record review revealed that patient #7 was a diabetic admitted to the ICU on [redacted], with a pressure sore to the coccyx measuring 18 by 21 centimeters. Review of the nursing notes dated November 15-16, 2005, revealed that nursing staff had been applying wet to dry dressings to this area every twelve hours. Review of the physician's orders dated November 15-16, 2005, did not show an order for the wet to dry dressing changes. Review of patient #7's medication administration record did not show any documentation of the wet to dry dressing changes. According to the medical record, a consultation with the wound care nurse had been made on November 15, 2005, at 6:40 a.m. There was no evidence that the wound care nurse had assessed patient #7 as of November 16, 2005, at 3:15 p.m. There were no protocols in place per hospital policy regarding patient #7's pressure sore. The nurse providing care to patient #7 at the time of the tour confirmed that Nursing had failed to implement the protocols for patient #7's pressure sore. There was no evidence that staff had followed the facility guidelines for wound care management.

A phone interview was conducted on November 16, 2005, with physician #2, who stated that he was consulted regarding patient #7's fever and pressure sore but did not know that Nursing was applying wet to dry dressings to patient #7's pressure sore and added that patient #7 was scheduled for surgery and did not need the wet to dry dressings. Physician #2 was not aware of the protocol sheets regarding pressure ulcers and physician #2 stated, "I've never see a protocol sheet for pressure sores."

A phone interview was conducted on November 16, 2005, with physician #3, who stated that he was not aware that the nursing staff was providing wet to dry dressing changes for patient #7. Physician #3 stated that a

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consultation was requested with the wound care nurse, antibiotics had been ordered, and patient #7 was scheduled for surgery to have the pressure sore debrided. Physician #3 was not aware that the hospital had pressure sore protocols in place and stated that he had "never seen a protocol sheet for pressure sores."

The wound care nurse (WCN) confirmed in interview on November 17, 2005, that she had received a consultation by fax dated November 15, 2005, for patient #7. When asked why it took so long for her to conduct the assessment for patient #7, the wound care nurse stated that she had been off work at the time of the consultation and there was nobody else available to provide coverage. The wound care nurse stated that she had plans to implement a wound care team but the team was not in place at the time of the investigation.

Patient #8 was admitted to the third floor medical surgical unit on . . . . , . at 5:46 p.m., with diagnoses of Congestive Heart Failure, Alzheimer's Disease, Chronic Aspiration, and History of a Right Hip Fracture. A review of the admission nursing assessment revealed that patient #8 was admitted with a Stage I decubitus to the coccyx. A Braden Scale Risk assessment completed on November 13, 2005, identified patient #8 with a total score of 15. Laboratory tests done on November 13, 2005, revealed that patient #8 had a total protein level of 5.9 mg/dl (range is 6.3 to 8.2 mg/dl) and albumin level of 2.8 mg/dl (range is 3.5 to 5.0 mg/dl). A review of the medication orders revealed that patient #8 was receiving ProMod two scoops three times a day, Therapeutic M vitamin daily, and Osmolite at 65 cc per hour via pump per gastrostomy tube. Documentation on the "daily interventions" dated November 13, 2005, at 9:35 p.m., described patient #8 to have skin alterations as "bottom red with open area; heels mushy." The notation stated that patient #8 had a Stage II decubitus of the buttocks and a total Braden score of 15. The notation also indicated that a referral was sent to the wound care nurse on November 13, 2005. Further documentation on the daily interventions records revealed that the staging of the skin breakdown for patient #8 continued to be inconsistent. A review of the care plan for patient #8 revealed that a skin problem related to skin integrity was addressed. However, the care plan failed to identify the patient's specific skin problems/breakdown and did not include individualized interventions or goals for patient #8.

Patient #8 was observed on November 16, 2005, at 12:20 p.m., to be in bed facing the door with a pillow placed behind his back. Patient #8 was observed to have heel protectors to both feet and a Foley catheter drainage bag connected to the bedside. Patient #8 was observed on November 16, 2005, at 2:05 p.m., to be lying on his back and at 5:10 p.m., to be positioned toward the window. A skin assessment of patient #8 conducted with facility staff on November 17, 2005, at 1:40 p.m., revealed a reddened non-blanchable area measuring approximately seven centimeters to the coccyx area. In addition, a reddish/purple unopened area measuring approximately one centimeter was observed on the right lower buttock area. Both heels were observed to be intact, with no redness noted. The nurse aide was then observed to apply Sensi-care cream to these areas.

An interview with certified nurse aide #3 on November 17, 2005, at 1:50 p.m., revealed that the nurse aides had been directed by the nurses to apply Sensi-care cream to patients having any red, irritated area. CNA #3 stated that the physician informed staff when a special mattress was required and that the nurses informed the nurse aide when to apply heel protectors to the patients. CNA #3 stated that patients were to be turned every two hours. CNA #3 stated that she received a list of patient names when she came on duty; however, there were no patient care needs identified on the assignment sheet. CNA #3 stated that walking rounds were made with the offgoing nurse aide. CNA #3 stated that the offgoing nurse aide related patient care needs such as turning, feeding, etc., during these rounds.

Category: Other
Subcategory:
Seriousness:
Findings: Substantiated:Federal deficiencies related to alleg are cited, State deficiencies related to the 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
	A0210-WRITTEN MEDICAL ORDERS FOR DRUGS(482.23(c)(2))	NOT SPECIFIED

Details: Continuation of allegation findings.
Findings Text:

An interview with LPN #3 on November 18, 2005, at 2:50 p.m., revealed that a DuoDerm dressing had been utilized for patient #8. LPN #3 stated that the staff had started using the Sensi-care cream today because the area no longer required a DuoDerm dressing. LPN #3 stated that a protocol sheet was to be placed in the chart and the treatment was to be documented on the treatment chart. However, further record review failed to provide evidence that the protocol sheet had been placed on patient #8's chart and there was no evidence that a treatment record had been initiated for patient #8.

A review of the facility's protocol for a Stage I pressure area revealed that the following measures were to be

implemented: preventative measures, open to air, and position off area until resolved.

An interview with the WCN on November 17, 2005, at 4:15 p.m., revealed that she believed that a referral had been done for patient #8. The WCN stated that she had not completed an assessment on patient #8 because she had not had time. The WCN stated that the current protocol using the Braden scale of 15 or less required a large number of consultations to be done. When informed of the treatment currently being administered for patient #8, the WCN stated that the staff should have contacted the physician and obtained orders to apply Xanaderm ointment rather than the Sensi-care.

An interview conducted with the Quality Assurance/Director of Risk Management on November 16, 2005, at 3:20 p.m., revealed that each Department Manager was responsible to do QA tracking, collection of data, and to report this information to the coordinator/director. The QA Coordinator stated that the QA committee meets on a monthly and quarterly basis to review the data. The QA Coordinator stated that an occurrence report was to be completed whenever a facility-acquired pressure sore was discovered; however, she stated that she had not received any data related to pressure sores in 2005. The QA Coordinator stated that the facility had formed a skin team approximately one month ago to address QA monitoring tools for pressure sores, but that none of these tools had been implemented. The QA Coordinator stated that she was not aware of any QA monitors that had been conducted during 2005 to address skin/pressure sores. The QA Coordinator stated that a comparison study had been completed by the Hill-Rom company in 2004 that indicated that the hospital percentage of pressure sores was low in comparison with other hospitals. The QA Coordinator stated that she felt that skin would be an important issue to monitor, but did not know why that it had not been done.

An interview conducted with Unit Manager #1 on November 16 and 17, 2005, revealed that the nurses were responsible for completing an occurrence report when a patient developed a pressure sore after being admitted to the facility. Unit Manager #1 stated that she then conducted an investigation into the occurrence and added the findings to the report. Unit Manager #1 stated that the QA Coordinator also received a copy of the occurrence report. Unit Manager #1 stated that she had not received a report regarding the two patients identified with having facility-acquired pressure sores; however, she stated that she did not know why. Unit Manager #1 stated that she monitored patient care through chart reviews, patient rounds, and talking to patients regarding their care. Unit Manager #1 stated that she had noted problems with "mis-staging" pressure sores. Unit Manager #1 stated that after the Hill-Rom comparison study had been done in 2004, no QA monitors had been conducted. The Unit Manager stated that "it kind of fell by the wayside."

An interview with the wound care nurse (WCN) on November 16 and 17, 2005, revealed that she had been employed in this position at the facility since June 2005. The WCN stated that her role at the facility was to educate staff, assess wounds, and make recommendations to the physicians for treatment. The WCN stated that the facility protocol directed that a Braden Scale risk assessment be completed for each patient upon admission to the facility and once per shift thereafter. The WCN stated that if the Braden Scale score was 15 or less, the nurse was responsible to implement the measures as directed by the protocol, to place and sign the appropriate protocol sheet on the patient's chart, and to complete a treatment record if indicated. The WCN stated that the nurse was also responsible to send a referral to her and the dietician by computer. The WCN stated that a problem with the computer program had been recently identified with the automatic computer-generated referrals and as a result, she had only started receiving computer-generated referrals last week. The WCN stated that the facility had not identified what QA monitors to do and that a skin care team had been formulated approximately one month ago to develop QA monitors related to skin/pressure sores; however, none has been implemented at this time. The WCN stated that when a new product was introduced for treatment she did an in-service with the nurse aide on duty. The WCN stated that she was not sure how this information was communicated to the next shift. The WCN stated that the protocol did not identify measures to follow when a wound worsened. In addition, the WCN stated that the problem was systemic because facility staff had not followed the established protocol for prevention, identifying, and treatment of pressure sores.

Refer to ARO #KY5479 for information related to patient #9.

--Conclusion:

The Department for Community Based Services did not conduct an investigation into this allegation.

The Division of Health Care Facilities and Services found the allegation to be substantiated. Interview, record review, and observation revealed that the facility failed to follow its own policy/protocol for treatment of patients who had or were at risk for developing pressure ulcers. Nine of nine medical records reviewed revealed that staff failed to follow their own policy and protocols for providing pressure ulcer/wound management. Four of six medical records reviewed had not been identified on the facility's list of patients identified to have pressure ulcers. Interview, record review, and observation revealed that the facility failed to follow its own policy for turning patients who had pressure ulcers or were at risk of having pressure ulcers. The facility was found to be out of compliance with the Condition of Participation for Nursing Services. A statement of deficiencies was

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issued with a recommendation that the facility be placed on a 90-day termination.

A telephone call was made to the complainant on October 27, 2005. The complainant was advised of the findings. The complainant requested that a copy of the findings be sent to Mr. Birdwhistell in Frankfort. The complainant was informed that the findings of the allegation investigation were public record and could be requested through this agency ' s Central Office in Frankfort. The complainant stated that he was gathering more information regarding a complaint against the Emergency Room. The complainant was given the name and phone number of our Complaints Coordinator and encouraged to call regarding any patient care concerns.

An acceptable credible allegation of compliance was received on December 22, 2005.

--Follow-Up:

A follow up visit was initiated on January 30, 2006 and completed on January 31, 2006. The condition level deficiencies were found to be corrected. It is recommended that the 90-day termination be rescinded.

Nancy Mullins, Nurse Consultant/Inspector

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	
		A0210-WRITTEN MEDICAL ORDERS FOR DRUGS	
JRTZ12	01/31/2006		
		Federal - Link to This Intake	
		A0199-NURSING SERVICES	NOT SPECIFIED
		A0204-RN SUPERVISION OF NURSING CARE	
		A0210-WRITTEN MEDICAL ORDERS FOR DRUGS	

ACTIVITIES

Type	Assigned	Due	Completed	Responsible Staff Member
Schedule Onsite Visit	10/19/2005	10/19/2005	10/26/2005	MULLINS, NANCY GILBERT, GAIL DILLS, MARY BURTON, KIMBERLY S. BENTLEY, SHIRLEY ROARK, ORA M.

INVESTIGATIVE NOTES

Printed: 03/22/2006 1:04:12PM
Due Date: 10/24/2005
Priority: Non-IJ High
Referral-Other

Intake ID: KY00005257
Facility ID: 100959 / HOSP-ACU
Provider Number: 180132

ACTS Complaint/Incident Investigation Report

AGENCY REFERRAL

Agency	Contact Name	Date Referred	Due Date	Agency Visit	Report Received	RO or SA
DCBS	Robin Carlton	10/10/2005				S

NOTICES

Letters:

Created	Description

Notification:

Date	Type	Party	Method

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