STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. BUILDING _____ B. WING _____	C 10/26/2017

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CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/24/17 through 10/26/17. Seven complaints were investigated during the survey Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 114 certified bed facility was 111 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through #20, #26 and #27), and 5 closed record reviews (Residents #21 through #25).	F 000		
F 153 SS=D	RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS CFR(s): 483.10(g)(2)(3) (g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when	F 153		12/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/10/2017

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F 153	Continued From page 1 such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. (3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to allow the Power of Attorney access to records in a timely manner for 1 Resident (Resident #1) of 27 Residents in the Survey sample. The findings included: Resident #1 was admitted to the facility on 10/18/16 with a readmission on 5/4/17. Diagnoses for Resident #1 included but are not limited to Deafness, Non-Alzheimer's Dementia, Schizophrenia, and Cerebral Vascular Incident.	F 153	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The Power of Attorney for Resident #1 was provided a copy of the requested record. 2. Medical Records Custodian completed	

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F 153	Continued From page 2 Resident #1's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) (of 7/20/17 coded Resident #1 with a BIMS (brief interview for mental status score) of 4 indicating a severe cognitive impairment. In addition, the Quarterly MDS scored Resident #1 as requiring total dependence with one staff person assistance for Bathing and Hygiene needs. In addition the Quarterly MDS scored Resident #1 as always incontinent of bowel functions and frequently incontinent of urine functions. Resident #1's Clinical Record had a Durable General Power of Attorney scanned into Resident #1's computer chart in October 2016. This document named Resident #1's three siblings as Durable Power of Attorney. Resident #1's Sister and Durable Power of Attorney requested copies of Medical records after Resident #1 went to the Emergency Room on 3/20/17 with Chief Complaint of Difficulty Swallowing. A letter sent to Resident #1's sister on 4/5/17 documented the her request for medical records were denied because it was determined that it was not HIPAA (Health Insurance Portability and Accountability) compliant. A letter dated 5/4/17 sent via email to the Medical Records Coordinator (Other #1) documented that request for medical records for Resident #1's sister is HIPAA compliant. In addition, the email documented "please release a copy of the requested records direct to (Resident #1's Registered Nurse Sister).	F 153	a quality review of requests for medical records. Findings showed requests for medical records have been completed. 3. The Medical Records Custodian to be re-educated on the need to provide requested Medical Records by resident or resident's legal representative who is HIPAA compliant in a timely manner. 4. Administrator/designee to complete quality monitoring of Medical Records requests for 8 weeks then monthly times 3 then quarterly to ensure timely provision of requested medical records. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 153	Continued From page 3	F 153		

A phone interview with Resident #1's Registered Nurse Sister and Power of Attorney on 10/24/17 at approximately 11:00 a.m. was conducted. Resident #1's sister stated that she had requested medical records after an Emergency Room Evaluation as she wanted to know the reason for the visit. Resident #1's sister stated that she had not been informed of the Emergency Room visit and that she was denied medical records even though she was the POA (Power of Attorney) The sister stated that a copy of the POA was scanned into the Medical Record at Admission to the facility. She stated that the Facility told her they did not have a copy of the Durable Power of Attorney.

An interview with the Facility's Medical Records Coordinator (Other #1) on 10/26/17 at approximately 10:30 a.m. was conducted. The Medical Records Coordinator stated that she forgot to send the document: "Durable Medical Power of Attorney" with the initial request for medical records by Resident #1's POA sister. The Facility Director of Nursing agreed on 10/26/17 at approximately 10:30 a.m., that the delay of the Durable Medical Power of Attorney being sent to the Facility Attorney delayed the POA's receiving medial records as the Durable Power of Attorney was scanned into the Electronic Medical Record in October 2016. The delay from the first documented letter of 4/5/17 to the letter authorizing release of medical records on 5/4/17 was approximately one month.

The Facility Policy and Procedure titled, "Request for Medical Records/Release of Information" with a revision date of 3/1/15 documented the following:
Processing a Request

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F 153	Continued From page 4 1. The Center should direct all requests (oral and written) for medical records immediately upon receipt to the Center's Medical Records Custodian. 2. If a current resident, former resident or legal representative comes into the Center to request medical records a Consist for Obtaining Medical Information form should be filled out to document the request. 4. The Center's Medical Records Custodian should stamp or write the date of receipt of the Request for Medical Records. 5. a. Requests by current residents or current resident's legal representatives (who should also be granted access to view their own records within 23 hours of the request). Following such access, copies should be reviewed by Medical Records Custodian for HIPAA compliance and then provided no more than 2 working days following Resident's designation of which records he or she would like copied.... 5. b. Requests by a legal representative of a resident (pursuant to the same guidelines above) ONLY if the resident has capacity and can independently, refer to legal pursuant to section II to ensure representative has proper legal authority. Legal with respond according to the timelines specified in 5 a. The facility administration was informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m.. The facility did not present any further information about the findings.	F 153		
F 157 SS=D	Complaint Deficiency NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14)	F 157		12/5/17

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F 157	Continued From page 5 (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		

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F 157	Continued From page 6 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to notify the Responsible Party of Resident #1 being sent for a Fiberoptic Endoscopic Evaluation of Swallow test for 1 of 27 Residents in the Survey sample. The findings included: Resident #1 was admitted to the facility on 10/18/16 with a readmission on 5/4/17. Diagnoses for Resident #1 included but are not limited to Deafness, Non-Alzheimer's Dementia, Schizophrenia, and Cerebral Vascular Incident. Resident #1's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/20/17 coded Resident #1 with a BIMS (brief interview for mental status score) of 4 indicating a severe cognitive impairment. In addition, the Quarterly MDS scored Resident #1 as requiring total dependence with one staff person assistance for Bathing and Hygiene needs. In addition the Quarterly MDS scored Resident #1 as always incontinent of bowel functions and frequently incontinent of urine functions.	F 157	1. Resident #1 had FEES test on date 3/28/17 . Responsible party was notified of results after completion of the test. A review of residents residing in the facility with an order to have FEES performed in the last 30 days revealed zero residents. Current responsible parties to be notified by Speech Therapist prior to FEES testing. 2. Upon recommendation by Speech Therapist that FEES testing is indicated the information is to be discussed in Clinical Morning Meeting. Nursing to be responsible for obtaining physician order. Once physician order obtained Responsible party to be notified of ordered FEES test. 3. Speech Therapy and nursing staff educated on new process. 4. DCS/designee to conduct quality monitoring on current residents recommended for FEES test to ensure: a)RP has been notified with informed verbal/written consent b)Physician order has been obtained	

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F 157	Continued From page 7 Resident #1's Care Plan documented the following problem: 10/26/16 Imbalanced nutrition related to diagnosis dementia, depression, stroke, on a mechanically altered diet related to diagnosis dysphagia, (Resident #1) to remain on honey thick liquid, pureed diet. Resident #1's Clinical Record documented a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Test completed on 3/28/17 that designated Resident #1 as an aspiration risk. Interventions included but were not limited to the following: Monitor and report to Medical Doctor as needed signs symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals Resident #1's Clinical Record documented an Emergency Department visit from 3/29/17 22:28 (10:28 p.m.) for evaluation of difficulty swallowing. Resident #1 had been reportedly been unable to swallow for several days. Patient sent to Emergency Room for further evaluation and recommendations for feeding. Patient is deaf and is able to communicate with writing or sign language. The Facility Policy and Procedure titled, "Notification of Change in Condition" with a revision date of 9/21/17 documented the following: "The nurse to notify the attending physician and Resident Representative when there is a(n)	F 157	before procedure is scheduled. DCS/designee to complete quality review weekly times 4 then monthly to ensure RP has been notified of FEES test. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 157	Continued From page 8 accident significant change in the patient/resident's physical, mental, or psychosocial status Need to alter treatment significantly New treatment Discontinuation of a current treatment due to but not limited to: adverse consequences Acute condition Exacerbation of a chronic condition A transfer or discharge of the Patient/Resident from the Center Patient/Resident consecutively refuses medication and/or treatment" .... An interview with the Director of Nursing on 10/26/17 at approximately 10:30 a.m. was conducted. The Director of Nursing stated that responsible party was notified of the FEES results, but no family Responsible Parties were notified the test was to be done. The facility administration was informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m.. The facility did not present any further information about the findings.	F 157		
F 164 SS=D	Complaint deficiency PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this	F 164		12/5/17

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F 164	Continued From page 9 does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical	F 164	1. Residents #3 and #16 verbalized no	

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F 164	Continued From page 10 record review and facility document review the facility staff failed to provide privacy to prevent unnecessary exposure of body parts during the provision of personal care for 2 of 27 residents in the survey sample, Resident #3 and #16. During the provision of PEG (1) tube site care for Resident #3 and Resident #16 on 10/24/17 the LPN #1 (Licensed Practical) failed to pull the privacy curtain or close the door. The findings included: 1. Resident #3 was admitted to the facility on 4/23/15 with diagnoses to include, but not limited to cerebrovascular disease and PEG tube. The current MDS, a quarterly with an assessment reference date of 8/12/17, coded the resident as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. The resident was dependent on staff for all ADL's (Activities of Daily Living). The resident was coded as receiving greater than 51% of daily calorie requirements via an artificial route (tube feeding). The physician orders dated 9/2/17 instructed the staff to apply bacitracin ointment 500 unit/gram to the PEG site topically every shift for PEG site care. Cleanse PEG site with normal saline, apply bacitracin and dry dressing every day. On 10/24/17 at 5:55 a.m., LPN #1 was observed providing PEG tube site care after administering the resident medications via the PEG tube. Dressing supplies to provide the care were already at the bedside prior to entering the room. The resident's roommate was awake at this time.	F 164	complaints or adverse reactions. Residents #3 and #16 have care provided while maintaining privacy. 2. All residents have the potential to be affected. DCS/designee completed walking rounds randomly for 3 days on all shifts for personal care being provided while maintaining privacy. Follow up based on findings. 3. Nurse # 1 received individualized re-education regarding the importance of providing privacy for all residents while providing care. Licensed nurses re-educated by DCS/designee on the importance of providing privacy to maintain dignity. 4. Unit managers/designee to complete random Quality monitoring weekly times 4 weeks then monthly.	

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The privacy curtain between both beds, and the room door where not closed to provide privacy. Resident #3's gown was pulled up exposing the resident's abdomen. While providing the care, two staff where observed walking by in the hallway. The PEG tube site was cleansed with wound flush, the treatment of bacitracin and a dressing was applied.

After the treatment the nurse was interviewed outside the resident's room in the hallway. The observation of the failure to provide for privacy by drawing the privacy curtain and closing the door was shared. She stated, "I guess we should do that".

The Assistant Director of Nursing was interviewed on 10/25/17 at 5:20 p.m. The above observation was shared. She stated, "She should have pulled to curtains and shut the door".

The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

The facility Policy and Procedures subject: "Medication-Administration Via Enteral Tube," revised 9/1/17 read, in part: "Pull the curtains to maintain privacy."

2. Resident #16 was admitted to the facility on 9/9/09 with a readmission date of 4/1/16 with diagnoses to include, but not limited to personal history of traumatic brain injury and PEG tube.

The current MDS a quarterly with an assessment

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reference date of 7/8/17 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was dependent on staff for all ADL's (Activities of Daily Living). The resident was coded as receiving greater than 51% of daily calorie requirements via an artificial route (tube feeding).

On 10/24/17 at 5:55 a.m., LPN #1 was observed providing PEG tube site care after administering the resident medications via the PEG tube. Dressing supplies to provide the care were already at the bedside prior to entering the room. The resident's roommate was awake at this time. The privacy curtain between both beds, and the room door where not closed to provide privacy. Resident #16's gown was pulled up exposing the resident's abdomen. The PEG tube site was observed to have erythema (redness) surrounding the site approximately the size of a 50 cent piece. The PEG tube site was cleansed with wound flush and the treatment of bacitracin to the PEG site was applied.

After the treatment the nurse was interviewed outside the resident's room in the hallway. The observation of the failure to provide for privacy by drawing the privacy curtain and closing the door was shared. She stated, "I guess we should do that".

The Assistant Director of Nursing (ADON) was interviewed on 10/25/17 at 5:20 p.m. The above observation was shared. She stated, "She should have pulled to curtains and shut the door". At this time the ADON stated that the treatment had been discontinued; the nurse did not have an order for the application of the bacitracin. The

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F 164	Continued From page 13 discontinue order dated 9/29/17 was created by the unit manager who was no longer employed at the facility. The reason to discontinue stated, "Upset". The ADON stated LPN #1 had been applying the treatment prior to it being discontinued and apparently did not look at the Treatment Administration Record (TAR). The presentation of the PEG tube site with erythema was shared with the ADON. The physician discontinue order dated 9/29/17 instructed the staff to discontinue the application of bacitracin zinc ointment 500 unit/gram to the PEG site topically every night shift for PEG site care. The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17. The facility Policy and Procedures subject: "Medication-Administration Via Enteral Tube," revised 9/1/17 read, in part: "Pull the curtains to maintain privacy." 1. PEG tube-A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. (www.medlineplus.gov)	F 164		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 241		12/5/17

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F 241	Continued From page 14 her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to promote dignity for 3 of 27 residents (Resident #20, 26 and 27) in the survey sample in a manner to enhance and maintain their dignity. The facility staff failed to provide dignity during dining services by wearing gloves while feeding or assisting with feeding. The findings included: During dining observation in the Recreation room on 10/24/17 at approximately 11:45 a.m., there were 4 staff members in the dining area assisting residents with their meals while 3 staff members wearing gloves. The Certified Nursing Assistant (CNA) #2 was feeding Resident #20, the Occupational Therapist (OT) was assisting Resident #26 and the Speech Therapist (ST) was assisting Resident #27 and during the entire dining observation all 3 staff members wore gloves. On the same day at approximately 11:55 a.m., the Regional Director of Clinical Services came into the recreation room to assist with meals. During the time the Regional Director was assisting with meals, gloves were not worn. 1. Resident #20 was originally admitted to the nursing facility on 7/22/11. The diagnoses for Resident #20 included but are not limited to Alzheimer's (1).	F 241	1. Residents receive dignified care as gloves are nor worn by facility staff while feeding or assisting with feeding. 2. Administrator/DCS designee completed quality review of dining services for 3 meals for facility staff wearing gloves while feeding or assisting with feeding. Follow up based on findings. 3. Nursing and Therapy staff re-educated on maintaining resident dignity during dining service by not wearing gloves. 4. Quality monitoring of dining service to be conducted by the DCS/designee weekly X 8 weeks then monthly as indicated to observe maintenance of resident dignity during meal service. Findings to be reported at QAPI and updated as indicated. Quality monitoring schedule modified based on findings.	

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Resident #20 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/2017 coded Resident #20 for short-term and long-term memory problem with severely impaired for making decisions. In addition, the MDS coded Resident #4 requiring total dependence of two with transfers, total dependence of one with dressing, eating, toilet use, personal hygiene and bathing of Activities of Daily Living care.

An interview was conducted with CNA #2 on 10/24/17 at approximately 1:45 p.m., who stated, "I know wasn't not appropriate to wear gloves when feeding; I guess it just a habit but it won't happen again."

2. Resident #26 was originally admitted to the nursing facility on 09/10/2009 and readmitted on 07/30/10. The diagnoses for Resident #26 included but are not limited to Cerebrovascular Disease (2) with hemiplegia (3).

Resident #26 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/03/2017 coded Resident #26 for short-term and long-term memory problem with moderately impaired - decisions poor; cues/supervision required. In addition, the MDS coded Resident #26 requiring extensive assistance of two with bed mobility, transfers and toilet use, extensive assistance of one with dressing and personal hygiene and limited assistance of one with eating.

An interview was conducted with OT on 10/24/17 at approximately 1:45 p.m., who stated, "I have feed residents in the past wearing gloves but I know now it's not appropriate."

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3. Resident #27 was admitted to the nursing facility on 06/21/16. The diagnoses for Resident #27 included but are not limited to Dementia (4) with behavioral disturbances.

Resident #27 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/31/2017 coded Resident #27 coded a 04 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), severe cognitive impairment. In addition, the MDS coded Resident #27 requiring total dependence of one with toilet use, dressing, personal hygiene and bathing, extensive assistance of one with bed mobility and transfers and supervision with set up help only.

On 10/24/17 at approximately 1:45 p.m., an interview was conducted with ST who stated, "The Director of Rehab had informed her that wearing gloves while feeding was not an acceptable practice but moving forward I know now not to wear gloves when assisting or feeding residents."

On 10/24/17 at approximately 2:30 p.m., an interview was conducted with the Director of Nursing (DON) who stated, "Staff are not supposed to wear gloves when feeding or assisting residents with their meals; this does not give a homelike environment plus it's a dignity issue.

An interview was conducted with Regional Director of Clinical Services on 10/26/17 at approximately 10:20 a.m., who stated, "No one should be assisting or feeding residents while wearing gloves, we don't wear them at home so we shouldn't be wearing them here." She

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proceeded to say, you may not have noticed but when I came in to assist with feeding, I didn't wear gloves. The surveyor asked if therapy should be wearing gloves with assisting or feeding residents, she replied "No, absolutely not, I did an in-service on 10/24/17, informing staff that gloves are not to be worn with assisting or feeding resident with meals which also included the therapy department.

The facility administration was informed of the findings during a briefing on 10/26/17 at 4:00 p.m. The facility did not present any further information about the findings.

Definitions:

1). Alzheimer's is the common form of dementia. A progressive disease beginning with mild memory loss possibly leading to loss of the ability to carry on a conversation and respond to the environment (Source: http://www.cdc.gov/aging/aginginfo/alzheimers.htm).

2) Cerebrovascular Disease is a medical emergency. Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die (https://medlineplus.gov/stroke.html).

3). Hemiplegia is the loss of muscle function on one side of the body (https://medlineplus.gov/druginfo/meds/a682514.html).

4). Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia

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F 241	Continued From page 18 (https://www.ncbi.nlm.nih.gov/pubmed/22644311) .	F 241		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		12/5/17

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F 279	Continued From page 19 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to care plan a triggered CAA (Care Assessment Area) for Communication for 1 of 27 residents in the survey sample, Resident #13.. The findings included: Resident #13 was admitted to the facility on 7/22/16. Diagnosis for Resident #13 included but are not limited to Alzheimer's Disease. Resident #13's Significant Change Minimum Data Set	F 279	1. Resident # 13 Care Plan was reviewed and updated on 10/25/17 for current data of the resident□s condition and plan of care and to include the triggered CAA for communication. 2. Current residents who have had a comprehensive assessment completed within the last 6 months had a quality review completed for accurate transcription of CAA to care plan to ensure that each triggered area is reflected in the residents plan of care and	

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F 279	Continued From page 20 (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 4/21/17 coded Resident #13 with a BIMS (Brief Interview for Mental Status) of 99 indicating a severe impairment in cognition. The MDS coded Resident #13 with short term and long term memory problems with cognitive skills severely impaired. Resident #13's Significant Change MDS triggered Communication as a problem for Resident #13. Review of Resident #13's Current Care Plan on 10/24/17 at approximately 5:00 p.m. had no documented problem area for Communication as indicated on the Significant Change MDS Care Assessment Area. Resident #13's Updated 10/25/17 Care Plan documented a Problem of impaired cognition and or impaired thought processes related to diagnosis of Dementia has communication deficit as she is usually understood and she usually understands. Interventions included but are not limited to the following created on 10/25/17. Ask yes/no questions in order to determine resident's needs Assist as needed with decision making Break tasks into one step at a time Introduce self frequently, add validation, visual cues and gestures. Speak slowly and distincly, maintain calm relaxed manner, observe body language for comminicating needs. Assist with placing hearing aides if applicable, allow response time, provide paper and pen... Present just one thought, idea, question or command at a time. Use simple, direct commands The MDS Coordinator stated on 10/25/17 at	F 279	reflects the residents current status. 3. MDS coordinators were in-serviced on 10/26/17 by Regional MDSC on completion of care plans in correspondence to triggered CAA□s per RAI manual and to ensure the plan of care addresses the resident□s plan of care accurately. 4. MDSC to review care plans weekly X 4 weeks, bi weekly X 1 month, monthly X 1 month and quarterly thereafter to ensure that the plan of care addresses all needs triggered in the CAA on completion of each comprehensive assessment. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 279	Continued From page 21 approximately 2:30 p.m,, "I thought I had Communication on the Care Plan. I must have overlooked it. I will have it corrected." The Facility Policy titled, "Plans of care", with a revision date of 9/25/17, the following: Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being. The facility administration was informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m.. The facility did not present any further information about the findings.	F 279		
F 287 SS=D	ENCODING/TRANSMITTING RESIDENT ASSESSMENT CFR(s): 483.20(f)(1)-(4) (f) Automated Data Processing Requirement (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer,	F 287		12/5/17

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reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

(2) Transmitting Data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:

(i) Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

(4) Data Format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:

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F 287	Continued From page 23 §483.20(f) Automated data processing requirement- (1) Encoding data. Within 7 days after a facility completes a resident ' s assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii)Significant change in status assessments. (iv)Quarterly review assessments. (v) A subset of items upon a resident ' s transfer, reentry, discharge, and death. (vi)Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident ' s assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident ' s assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident ' s transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission ofMDS data on resident	F 287	1. 8 of the 10 OBRA assessments on the Missing Assessment Report were re-submitted to QIES and accepted into the data base clearing it off the Missing assessment Report. A modification was made to one other and re-submitted to QIES and accepted in the data base clearing it off the Missing Assessment Report. The last assessment is being reviewed by a higher level. 2. Validation report will be reviewed by MDSC in facility after each transmission for error clarification. 3. MDS coordinators were in-serviced on 10-25-17 by Regional MDSC on reviewing missing OBRA assessment report, addressing any errors or trends and report findings to ED and DCS. 4. MDS Coordinators will pull their Missing OBRA Assessment Report weekly x 4 weeks, bi weekly X 1 month and monthly thereafter addressing any errors. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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that does not have an admission assessment.
(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved byCMS.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure that minimum data set (MDS) assessments were encoded and transmitted within 14 days of completion.

The findings included:

Based on record review and interview the facility failed to ensure that minimum data set (MDS) assessments were encoded and transmitted within 14 days of completion.

A review of the OBRA Missing Assessment report from CASPER dated 10/25/17 showed 10 residents as having missing OBRA assessments.

The Regional MDS Consultant was interviewed on 10/26/17 at 10:30AM regarding the OBRA Missing Assessment report. She stated that the computer records for these residents showed that discharges had been submitted and accepted for all the residents on the report. When asked for Final Validation reports to prove this, she was unable to produce them as the facility had no CMS Final Validation Reports that showed these assessments as accepted.
On review the facility MDS software showed submitted and accepted assessments for 8 of the 10 residents listed on the OBRA Missing Assessment Report. One resident showed a discharge that had not been submitted. Review of

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the Resident Level Facility QM report showed one of the 10 residents was listed twice, with two different Resident Internal IDs. One of these duplicate residents had timely submitted assessments, and one did not. The Regional MDS Consultant stated she would have facility staff re-submit the missing assessments. Note that if an MDS which has already been accepted by QIES is re-submitted that the Final Validation Report shows the MDS as 'rejected due to duplicate assessment'. The provider submitted two files to QIES (Submission IDs 13671249 and 13671732) for the 9 residents in question, and 8 of these assessments were accepted into the QIES database as new records. One resident's assessment was rejected as a duplicate.
A review of the provider's Policy and Procedure for MDS (document name N-1025, Dated 9/25/2017) showed no requirement for MDS submission as required by regulation. When asked for a policy for MDS transmission, the Regional MDS Consultant stated that the provider was to follow the current RAI Manual.
Record review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.15, dated October 2017, showed:

o 5.2 Timeliness Criteria
In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:
Transmitting Data: Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their

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F 287	Continued From page 26 State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted. - Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days). - Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records). On 10/26/17 a pre-exist interview was conducted with the Facility Administrator, Director of Nursing, and the Clinical Corporate nurse where the above information was shared. The facility staff had no other documentation to produce.	F 287		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care	F 309		12/5/17

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F 309	Continued From page 27 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interviews, the facility staff failed to ensure 2 of 27 residents received the necessary care to maintain the highest practicable physical, well-being (Residents #16 and #2), in the survey sample. 1. The facility staff failed to assess a dialysis access for bruit for Resident #16. 2. The facility staff failed to follow Physician order for TED stockings for Resident #2.	F 309	1. Resident # 17 AV fistula is functioning properly with positive bruit and thrill. Resident # 17 is the only dialysis resident residing in the facility. Nurses continue to document this assessment on the treatment administration record. Facility□s staff are following physician□s orders related to TED stockings for resident # 2. 2. Nurse # 7 received individualized re-education regarding the policy for assessing the AV fistula for bruit and thrill with return demonstration provided.	

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F 309	Continued From page 28 The findings included: 1. Resident #16 was admitted to the facility on 4/23/15 with a readmission on 12/9/15. Diagnoses for Resident #16 included but are not limited to End Stage Renal Disease (1). Resident #16's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 9/15/17 coded Resident #16 with a BIMS (Brief Interview for Mental Status) of 12 of 15 indicating moderate cognitive impairment. Review of Resident #16's Clinical Record Physician orders documented the following: 9/22/17 Order: Check AV (2) shunt each shift assess for bruit (3) and thrill (4). On 10/25/17 at approximately 4:05 p.m., Licensee Practical Nurse (LPN) #7 was asked to show surveyor how she assesses Resident #16's dialysis access. LPN #7 demonstrated checking for thrill on Resident #16's Left AV shunt and stated she would assess for signs of infection. The LPN placed her hand on Resident #16's dialysis access site and stated: "I am feeling for a buzzing sound or feel." When asked if checking for thrill and infection were all she checks, LPN #7 stated, yes. The Facility Policy and Procedure titled, "Coordination of Hemodialysis Services" with a revision date of 8/24/17, documented the following: "Policy: Residents requiring an outside ESRD (End Stage Renal Disease) facility will have	F 309	3. Licensed nurses re-educated by DCS/designee regarding policy on assessing AV fistulas for bruit and thrill. Nurse #3 received individualized re-education regarding donning TED stockings. Nurse # 3 received individualized re-education regarding verifying that delegated procedures are completed. Unit Managers were provided with a list of residents for each unit who received hemodialysis. Nursing staff received re-education on the importance of assessing the dialysis access for bruit and thrill. Unit Managers were provided with a list of residents who have orders for TED stockings. Nursing staff received re-education regarding applying TED stockings as ordered by physician. 4. Unit Managers were provided with a list of the current resident who is receiving hemodialysis. Unit Managers to conduct quality monitoring five times per week times 4 weeks then weekly and submitted to DCS. Unit Managers/designee to conduct quality monitoring of the TARs for current residents who have physician orders for TED hose daily. Unit Managers/designee to randomly observe residents who have physician orders for TED hose via walking/observational rounds weekly times 4 weeks then monthly. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule	

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services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/Arrangement if there are any residents requiring Dialysis Services. The agreement shall include how the residents care is to be managed."

The web site:
https://www.pittsburgh.va.gov/Dialysis/Dialysis_fistula_care.asp documented the following standard of care:
"Thrill" is a rhythmic vibration that can be felt over your fistula, whereas "bruit" - pronounced "brew-ee" is a sound that is heard when listening to your fistula with a stethoscope. Ask the doctor or nurse to allow you to hear the bruit and show you where to best feel the thrill. Check the thrill and bruit daily.

The facility administration was informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m.. The facility did not present any further information about the findings.

Definitions:

1. End Stage Renal Failure: Medline Plus documented the following: End-stage kidney disease is the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs.
End-stage kidney disease is also called end-stage renal disease (ESRD).

2. AV: National Institute of Health documented the following: AV: Arteriovenous
An AV fistula is a connection, made by a vascular surgeon, of an artery to a vein. Arteries carry

modified based on findings.

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blood from the heart to the body, while veins carry blood from the body back to the heart. Vascular surgeons specialize in blood vessel surgery. The surgeon usually places an AV fistula in the forearm or upper arm. An AV fistula causes extra pressure and extra blood to flow into the vein, making it grow large and strong. The larger vein provides easy, reliable access to blood vessels. Without this kind of access, regular Hemodialysis sessions would not be possible.

3. Bruit: Medline Plus documented the following: The sound blood makes when it rushes in a rough or turbulent manner through an artery.

4. Thrill: https://www.pittsburgh.va.gov/Dialysis/Dialysis_fistula_care.asp documented: Thrill is a rhythmic vibration that can be felt over your fistula.

2. The facility staff failed to follow the physician orders for the application of TED compression stockings for Resident #2. (TED-thromboembolic disease stockings.)

Resident #2 was admitted to the facility on 4/12/16 with diagnoses to include, but not limited to: diabetes, heart failure, phlebitis (1) and thrombophlebitis (2) of unspecified deep vessels of the lower extremity.

The current MDS (Minimum Data Set) a significant change with an assessment reference date of 10/2/17 coded the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident was dependent on staff for all Activities of Daily Living (ADL's).

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The Comprehensive Person Centered Care Plan last reviewed 8/31/17 included the following:
1. ADL self care performance deficit relate to diagnoses of dementia and decreased mobility. Goal- Resident will receive appropriate staff support with ADL's.
Intervention included-TED stockings on AM and off PM.
2. Potential for skin integrity related to incontinence, decreased mobility. Intervention included-TED stockings ordered.

The physician plan of care included the following order dated 5/9/17-Apply TED hose on in am and remove per schedule related to type 2 diabetes, heart failure, phlebitis and thrombophlebitis of unspecified lower extremity.

On 10/24/17 at 7:30 a.m., 9:15 a.m., 10:35 a.m., and 11:35 a.m., the resident was observed asleep in bed. The resident did not have TED stockings on.

On 10/25/17 at 10:45 a.m., 11:10 a.m., and 1:25 p.m., and at 3:30 p.m., the resident was observed asleep in bed. The resident did not have TED stockings on.

On 10/25/17 at 3:30 p.m., the nurse assigned to the resident was interviewed. She was asked about the TED stockings and stated she did not do treatments today stating the desk nurse did. The desk nurse Licensed Practical Nurse #3 was asked if the resident had the TED stockings on as ordered and as initialed by her on the Treatment Administration Record (TAR) for today. She stated, "When they were getting her ready this morning I told them (CNA) to put them (TED

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F 309	Continued From page 32 stockings) on her". The nurse was asked if she had observed the stockings on the resident she stated, "No". The nurse was asked to escort this inspector into the resident's room to check for use of the TED stockings. The nurse removed the linens and exposed the resident's legs. There were no TED stockings on. The nurse was asked to search the resident's drawers and closet to locate the TED stockings. TED stockings were not found. LPN #3 instructed the CNA to obtain TED stockings from the supply closet and apply them to the resident. The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17. Definitions-Referenced from Taber's Cyclopedic Medical Dictionary 1. Phlebitis-Inflammation of a vein. 2. Thrombophlebitis-Inflammation of a vein in conjunction with the formation of a thrombus (a blood clot).	F 309		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 314		12/5/17

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F 314	Continued From page 33 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and family interview and facility documentation, the facility staff failed to ensure the necessary care and services were provided to prevent pressure ulcer development for 2 of 27 residents in the survey sample, Resident #24, which constitutes harm. 1. The facility staff failed to identify Resident #24 had developed a left lateral leg (stump area) pressure ulcer until it had advanced to unstageable and presented with 80% eschar (dead and black) tissue. 2. The facility staff failed to provide appropriate care and services to prevent pressure ulcer development and promote healing of pressure ulcers for Resident #2, to include failure to conduct weekly skin checks, failure to consistently conduct weekly pressure ulcer assessments, and failure to identify a change in skin integrity. The findings included: 1. Resident #24 was originally admitted to the	F 314	1. Resident # 24 no longer resides at the facility. Resident #2 pressure ulcer identified has healed. Resident #12 wound continues to heal and physician order maintained for heels up as tolerated while in bed. 2. Residents with prosthesis have been identified and Braden scales as well as weekly skin assessments have been conducted. A skin sweep of residents in the facility was performed to identify any skin integrity concerns. Residents with physician orders for heels up while in bed have been reviewed. Follow up based on findings. Residents in the facility including those identified as having pressure ulcers to have skin assessments by a licensed nurse and registered nurse to identify current skin conditions. The certified wound nurse with AMT has made visit 11-6-17 as well as prn to provide consultation services with identification,	

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F 314	Continued From page 34 facility 5/8/17 and was discharged to a local acute care hospital on 6/21/17 for altered mental status, acute kidney injury, acute kidney failure, dehydration and high potassium levels in the blood. The diagnoses in the nursing facility included; diabetes, high blood pressure, left below the knee amputation, and high cholesterol The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/12/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #24's cognitive abilities for daily decision making was intact. In section"G"(Physical functioning) the resident was coded as requiring supervision after set-up with eating, limited assistance of 1 with locomotion on the unit, extensive assistance of 1 person with bed mobility, transfers, walking, locomotion off unit, personal hygiene, dressing, and toileting, and total care of 1 person with full body baths. On 6/19/17 an unstageable pressure ulcer to the left lateral leg (stump area) was initially identified by the Power of Attorney (POA) of Resident #24 who informed the facility staff to assess the site. The left lateral leg (stump area) pressure ulcer was without drainage, measured 1.3 centimeters by 1.1 centimeters. The pressure ulcer bed presented with 80% eschar (dead and black) tissue that required treatment with a chemical debriding agent.	F 314	staging and treatment of wounds.1 3. Re-education conducted by nurse management team regarding prevention, monitoring and reporting pressure ulcers. Education regarding the ongoing process of quality monitoring conducted by nurse management team regarding prevention, monitoring and reporting pressure ulcers. 4. Nursing staff to conduct quality monitoring rounds for application of devices and or treatments to promote wound healing. DCS or designee to have the following areas reviewed: a)Braden assessment to be completed by licensed nurse on residents. b)Evaluate shower/bathing schedules by licensed nurse review and update care plans for interventions by MDS staff or designee. c)Treatment regime for residents with existing skin condition to be reviewed by the IDT daily in morning meeting. Education for CNA□s/ licensed nurses related to prevention and reporting to be conducted. Quality monitoring of weekly skin assessments, shower/bathing and use of barrier cream/incontinence care to be completed five times per week times 4 weeks then monthly. Quality monitoring tools of Braden scale schedule to be completed weekly time 4 weeks the monthly by MDS staff on new	

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F 314	Continued From page 35 Review of the clinical record revealed skin assessments as follows; 5/29/17 skin intact, 6/5/17 skin intact, 6/12/17 skin tact, 6/19/17 a rash to the groin, right buttock, left knee and right leg with treatment in progress to all sites. No skin assessments were offered for 5/12/19 and 5/19/17 but the admission MDS assessment with an ARD of 5/12/17 coded the resident as at risk for pressure ulcer developments but without one or more unhealed pressure ulcer. The current care plan dated 5/25/17 had a problem which read; (name of resident) has the potential for impaired skin integrity related to immobility and occasional urinary incontinence. The goal read; (name of resident) will be free from impaired skin integrity through next review 8/7/17. The interventions were; Assist resident with turning and repositioning frequently. Avoid scratching and keep hands and body parts from excessive moisture. Maintain trim short nails. Braden scale on admission and time 4 weeks. Encourage adequate nutrition and hydration in order to promote healthier skin. Encourage appropriate fluid intake. Float heels. Incontinence care post episodes. Keep skin clean and dry. Monitor for and report any new skin impairment noted during care. Nutritional evaluation quarterly and as needed. Nutritional evaluation quarterly and as needed. Weekly skin checks. The above care plan had not been updated to reflect Resident #24's newly identified pressure ulcers. Review of the local hospital history and physical	F 314	admissions. Quality Monitoring of turning/Positioning to be conducted seven times per week by charge nurses, supervisors, mock surveyors, and CSL Weekly times 4 weeks then monthly. Care plans of resident□s with new or worsening skin condition to be reviewed at the weekly wound meeting. New admission care plans will be reviewed by DCS or designee five times per week. DCS/designee during Morning Clinical Meeting to conduct quality monitoring: Skin assessments Braden scales Skin alert sheets Turning/positioning Care plan review of residents with wounds To conduct weekly x four then monthly, Findings to be reported at QAPI and updated as indicated. Quality monitoring schedule modified based on findings.	

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exam notes dated 6/21/17 read; the resident was admitted from "(name of facility). Since that time he was not eating well and now has multiple decubitus ulcers along with altered mental status. He was brought to the emergency department and found to have acute renal failure and hyperkalemia and now referred for admission and treatment".

On 10/26/17 at approximately 11:15 a.m., an interview was conducted with the Registered Nurse, Assistant Director of Clinical Services (RNADCS). The RNADCS was asked about the unstageable pressure ulcer to the left lateral leg. She stated all of the pressure ulcers were identified on 6/19/17, after she was asked by a staff member to assess the wounds to 3 body sites identified by Resident #24's POA. The RNADCS identified the sites as a blood blister to his partially amputated right great toe, a stage II pressure ulcer of the left buttock and an unstageable pressure ulcer of the left lateral leg. The RNADCS stated there were no prior reports of Resident #24 having any type of skin impairment prior to 6/19/17.

The Braden Scale for Predicting Pressure Ulcer Risk assessment dated 5/15/17 evidenced the resident scored 17. This indicated the resident was at low risk for pressure ulcer development. Another Braden Scale for Predicting Pressure Ulcer Risk assessment dated 5/22/17 evidenced a score of 19 indicating no risk.

The Director of Clinical Services (DCS) was asked if a root cause was identified relating to the

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unstageable left lateral leg pressure ulcer development and she answered no official documentation was used but the team felt use of the prosthesis was identified as the causative factor. The DCS stated Resident #24 donned and doffed the prosthesis to the left leg and didn't allow the staff to manipulate it yet she confirmed the resident required staff assistance with incontinence care, bathing and dressing and the first line of detecting skin impairment would have been from direct care observations during care and weekly skin checks and assessments. The DCS also stated the resident complied with weekly skin assessments.

An interview was conducted with the Director of Rehabilitation Services on 10/26/17 at approximately 1:30 p.m. The Director of Rehabilitation stated the resident had utilized the prosthesis since 1999 or 2000 therefore they didn't work with him on use of the prosthesis. The Director of Rehabilitation Services further stated often Resident #24 did not don the prosthesis because he didn't want to participate in rehabilitative services and as a result of him frequently missing rehab services he was discharged from Part B rehabilitation therapy.

A telephone interview was conducted with Resident #24's POA on 10/26/17 at approximately 1:50 p.m. The POA stated Resident #24 passed away 7/5/17 because he was unable to recover from the condition he was in when admitted to a local hospital on 6/21/17. She stated Resident #24 had been a resident of the nursing facility for almost 6 weeks when she discovered "something" on his left stump and right big toe.

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She further stated the resident had a urine infection, was dehydrated from not receiving sufficient food and fluid intake and his rear end was in a terrible condition. The POA stated she didn't think the resident would have received any care if she had not insisted the facility staff send him to the emergency room.

The above information was shared with the Administrator, Director of Nursing and Corporate Consultant on 10/26/17 at 3:45 p.m. The Director of Nursing stated the facility staff had identified the above information also and a Quality Assurance Performance Improvement (QAPI) plan was developed and on 6/27/17 and the allegation of compliance date was 6/28/17.

The facility policy titled "Clinical Guideline - Skin and Wound" dated 4/1/17 read; "To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. On admission/readmission the resident's skin will be evaluated for baseline condition and documented in the medical record. Braden Risk evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition. Licensed Nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record. CNA to complete skin observations and report changes to Licensed Nurse. Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved."

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The QAPI plan read as follows;

1." Facility failed to notify physician and POA of in-house acquired pressure ulcers for" Resident #24."

2. "Current residents in the facility to have skin assessments performed by a licensed nurse to identify current skin conditions completed 7/3/17. Physician and Responsible Party to be notified of any new areas of concern."

3. "DCS or designee to have the following areas reviewed; Current residents re-evaluated using the Braden Scale for risk for skin breakdown. New Braden scales to be completed by licensed nurse 7/27/17. Review and Update care plans for interventions by the MDS staff for residents with a Braden score below 10 by 7/28/17. Kardex updated as indicated. Treatment regime for residents with existing skin conditions to be reviewed by the interdisciplinary team (IDT) on 7/28/17 for necessary changes. Weekly At Risk meeting to be conducted 7/28/17 to review residents with wounds and or skin integrity issues. Skin Grids to be completed 6/28/18 on current residents with Wound and Skin Integrity issues. Residents with new Skin and Wound Issues to be placed on 24 Hour Report and reviewed in Daily Clinical Meeting. Nursing staff re-educated on the use of the Stop and Watch to report changes in skin integrity. Education for Certified Nursing Assistants (CNA) related to prevention and reporting to be completed 6/28/17. Licensed Nurses to be educated related to identification of wounds, prevention, reporting and monitoring residents at risk for skin

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breakdown by 6/28/17."

4. "DCS and or ADCS to Quality monitoring completion of weekly skin checks, and skin grids in Daily Morning meeting. Unit Managers to Quality monitor completion of Stop and Watch forms, Shower/bathing sheets, and use of barrier cream/incontinence care to be completed 5 times per week by DCS or designee. DCS and or ADCS to Quality monitor completion of Braden Scales schedule to be completed weekly by MDS staff on new admissions times 4 weeks. Quality monitoring for turning/positioning and use of off-loading devices to be conducted7 times per week by charge nurses, supervisor, mock survey and Corporate Support." Care plans of residents with new or worsening skin conditions to be reviewed at the weekly wound meeting to ensure appropriate interventions are in place. Findings of quality monitoring to be reviewed for recommendation by the QARI committee, Quality monitoring schedule to be modified based on findings."

5. "Compliance date 6/28/17."

The facility presented a plan of correction however another resident was identified with a pressure ulcer after their compliance date. COMPLAINT DEFICIENCY

Pressure Ulcer - A pressure ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue(s). National Pressure Ulcer Advisory Panel (NPUAP)

Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown

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Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/)

Debridement - Debridement is the removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process.

2. The facility staff failed to provide appropriate care and services to prevent pressure ulcer development and promote healing of pressure ulcers for Resident #2, to include failure to conduct weekly skin checks, failure to consistently conduct weekly pressure ulcer assessments, and failure to identify a change in skin integrity.

Resident #2 was admitted to the facility on 4/12/16 with diagnoses to include, but not limited to: diabetes and heart failure.

The current MDS (Minimum Data Set) a significant change with an assessment reference date of 8/26/17 coded the resident as scoring a 3 out of a 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had

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severely impaired daily decision making skills. The resident required extensive assistance for all Activities of Daily Living (ADL's) to include one staff for bed mobility and transfers. The resident was assessed as being incontinent of bladder and bowel. The resident was coded as having one stage III pressure ulcer (1).

The Comprehensive Person Centered Care Plan dated 10/20/15 identified the resident had the potential for impaired skin integrity related to incontinence and decreased mobility. Goal was the resident would continue to have interventions in place to prevent impaired skin integrity. Interventions included-Braden scale quarterly, notify nurse of any new areas of skin breakdown: redness, blisters, bruises, discoloration during bath or daily care, weekly skin checks.

The most current Braden Scale (a risk assessment tool used as an indicator for pressure ulcer development) found in the clinical record was dated 6/27/17. The staff scored the resident as a 15, indicating the resident was at low risk for pressure ulcer development. There was no quarterly Braden Scale found prior to this date or after this date.

According to the Weekly Pressure Ulcer Records a pressure ulcer to the sacrum was initially identified on 8/17/17 as a stage III. The pressure ulcer measured 1.8 cm x 2.3 cm x 0.2 cm (centimeters). The facility staff failed to assess this pressure ulcer the week of 8/24/17. The next assessment was on 8/31/17. The pressure ulcer measured 0.5 cm x 0.3 cm x 0.1 cm. The sacral stage III pressure ulcer was healed on 9/6/17 per the ADON, the treatment was discontinued on 9/12/17 per the TAR (Treatment Administration

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Record).

Review of the weekly skin sheets scheduled to be done every Tuesday by the night shift licensed nurse evidenced that on 8/15/17 the resident's skin was intact, this was later found to be inaccurate, according to the ADON the resident was identified with a stage III pressure ulcer on 8/15/17. The 8/22/17 weekly skin sheet was also inaccurate, it indicated the resident's skin was intact, instead of identifying the stage III sacral pressure ulcer.

Per the interview with the ADON on 10/25/17 at 4:05 p.m., she and the then unit manager were responsible for measuring pressure ulcer wounds on the Green unit every Tuesday. The ADON was asked what was the root cause of the stage III sacral pressure ulcer, she stated "It was first identified on 8/15/17, it was caused from the fold in her upper buttock, the brief would roll up under it causing pressure...the resident sat up in a chair most of the time". When asked why the pressure ulcer was not measured on Tuesday 8/24/17, she stated "Sometimes the unit manager got pulled to work the floor...I don't have any measurements for any wounds for the week of 8/24...". When asked why the wound was initially identified at an advanced stage and not sooner, she stated, "It should have been found before it was a stage II...she had three sets of eyes on her skin every day at a minimum".

The facility staff failed to perform weekly skin assessments for Resident #2 from 8/23/17 through current 10/25/17. During this time frame on 9/28/17 the Pressure Ulcer Record identified the resident had again developed an advanced stage III pressure ulcer and multiple stage II

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pressure ulcers as described below:
1. A stage II to the sacrum-measuring 1.5 cm x 2.0 cm x 0.2 cm. The wound bed had red granulation tissue and small amount of sero-sanguineous drainage. The peri-wound was intact.
2. A stage II to the left thigh measuring 1.2 cm x 6.3 cm x 0.2 cm. The wound bed had granulation tissue, the wound edges were firm and without redness, with moderate amount of sero-sanguineous drainage. The peri-wound was intact.
3. A stage III to the right thigh measuring 13.0 cm x 1.3 cm x 0.2 cm. The wound bed had red granulation tissue, the wound edges were firm and without redness, with moderate amount of sero-sanguineous drainage. The peri-wound was intact.

The Comprehensive Person Centered Care Plan was revised on 9/29/17. The care plan included the impaired skin integrity related to cognitive deficit and impaired mobility as evidenced by pressure areas to the left and right thigh and sacrum. The goal was the resident would not develop additional skin integrity problems or wounds through next review. Interventions included- Administer treatments as ordered and monitor for effectiveness, Braden scale quarterly, identify/document potential causative factors and eliminate/resolve where possible and monitor changes in skin status.

The facility staff failed to conduct a weekly pressure ulcer assessment on all three pressure ulcers the week of 10/8/17 through 10/14/17.

The Pressure Ulcer Record dated 10/16/17 documented the pressure ulcers as:

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1. Sacrum- 7.5 cm x 7.0 x 0.2 cm. The wound bed had red granulation tissue and small amount of sero-sanguineous drainage. The peri-wound was intact.
2. Left thigh-1.0 cm x 0.3 cm x 0.1 cm. The wound bed had granulation tissue, the wound edges were firm and without redness. The peri-wound was intact.
3. Right thigh- 3.5 cm x 0.8 cm x 0.1 cm. The wound bed had red granulation tissue, the wound edges were firm and without redness. The peri-wound was intact.

On 10/24/17 at 11:45 a.m., a dressing change observation of the three pressure ulcer sites was observed. The dressing change was conducted by Licensed Practical Nurse #3 and the ADON. The sacral pressure ulcer had two separate small open areas, the peri-wound was pink. The right and left thigh pressure areas involved both the anterior and posterior (front and back) of the upper thighs. The front pressure sore areas of both upper thighs were pink and wrapped around to the backside. The right back thigh pressure ulcer wound bed was pink, there was no dressing on this site as ordered. LPN #3 stated she was not informed by the CNA (certified nurse aide) that the dressing had come off.

On 10/25/17 at 4:05 p.m., the ADON was interviewed in her office. Resident #2's pressure ulcer development was reviewed. The ADON stated the nurses note on 9/26/17 identified open areas to both thighs. A Foley catheter was inserted on 9/27/17 to aide in healing (a tube placed into the bladder to drain urine into a bag). The ADON stated the second sacral pressure ulcer was not in the same area as the previous healed sacral ulcer that healed on 9/6/17. She

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was asked what the root cause of the second sacral pressure ulcer was, she stated, "I probably can't tell you". When asked what was the root cause of the pressure ulcers to both thighs, she stated, "The resident's briefs would bunch up...the resident was resistant to opening her legs so the CNAs were not able to properly place the briefs on her...it took three of us to open up her legs to assess (the thigh pressure ulcers). The ADON stated she staged the right thigh pressure ulcer as a stage III due to visualization of subcutaneous fat.

The ADON stated a no brief order was obtained and currently active (this order was not found on the Active Order Summary Report dated 10/24/17 or found on the care plan).

The Treatment Administration Record indicated the resident was being treated for a rash to the left gluteal cleft and thigh abrasions under pendulous (3) abdomen from 6/3/17 through 8/17/17 with soap and water and zinc oxide ointment treatment. When asked if this was the same area as the pressure ulcers of the thighs she stated, "No, different areas". She stated "I was horrified the first time I saw them (thigh pressure ulcers)".

The staff failed to identify a change in skin condition resulting in the resident acquiring an advanced stage III pressure ulcer to the right thigh and two stage II pressure ulcers, one to the left thigh and one to the sacrum.

The TAR for October 2017 evidenced physician treatment orders as follows:
1. 9/27/16-Clean left and right inner thigh with normal saline, apply hydrogel and cologen and

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cover with dry dressing every day shift.
2. 9/28/17-Clean sacrum with normal saline, apply hydrogel, and collagen, cover with dry dressing daily every shift.

The October 2017 TAR's entries for the above treatments evidenced no nursing initials to indicated the treatments were provided on the following days:
10/13, 10/14, 10/15, 10/17, 10/18, and 10/19.

The above findings of the blank entries was shared with the ADON on 10/25/17. She stated the electronic record system goes down at times. The ADON stated there is a back up if this happens, the TAR's can be printed and used during this time. The ADON was asked to provide evidence of printed TAR's for this time frame.

Prior to exit no additional information was provided to support that the treatments were provided on 10/13, 10/14, 10/15, 10/17, 10/18, and 10/19.

The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

The facility's Clinical Guideline-Skin & Wound dated 4/1/17 read, in part:
Overview-To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury.
Process:

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1. Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition.
2. Licensed Nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record.
3. CNA to complete skin observations and report changes to Licensed Nurse.
4. Licensed Nurse to document presence of skin impairment/ new skin impairment when observed and weekly until resolved.
5. Develop individualized goals and interventions and document on the care plan and the CNA kardex.
6. Monitor resident's response to treatment and modify treatment as indicated.

Definitions:
1. Stage III pressure ulcer- Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. (MDS-Section M.)
2. Stage II pressure ulcer- Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact fluid filled blister. (MDS-Section M.)
3. Pendulous abdomen-Swinging freely like a pendulum; hanging. (Referenced from Taber's Cyclopedic Medical Dictionary)

3. The facility staff failed to ensure interventions were implemented according to the resident's identified needs and Person Centered Care Plan to promote healing of a right heel suspected deep tissue injury for Resident # 12.

Resident #12 was admitted to the facility on

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10/4/14 and readmitted on 6/24/17 with diagnoses to include but not limited to, unspecified dementia and closed fracture of the right femur (leg).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 8/4/17 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident was dependent on 1 staff for bed mobility and 2 staff for transfers. The resident was coded as having a suspected deep tissue injury-SDTI (1).

The Comprehensive Person Centered Care Plan with a review date of 10/3/17 identified the resident had impaired skin integrity to the right heel related to mobility as evidenced by a pressure ulcer to the right heel. The goal was that the resident would not develop additional skin integrity or wounds and the pressure ulcer to the right heel would resolve without complications. Interventions to achieve and maintain the goals was to float the heels as indicated.

The resident was readmitted to the facility on 6/24/17 after a hospitalization for a fractured right femur following a fall. Four days after returning from the hospital the resident was identified with a suspected deep tissue injury to the right heel.

The Pressure Ulcer Record dated 6/28/17 documented the right heel pressure ulcer measured 3.0 cm x 4.5 cm (centimeters) and presented as a suspected deep tissue injury.

The physician orders dated 6/27/17 instructed the staff to apply skin prep to the right heel pressure

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ulcer four times a day.

The physician orders dated 9/9/17 instructed the staff to float the resident's heels while in bed.

The current Pressure Ulcer Record dated 10/16/17 assessed the right heel pressure ulcer as measuring 1.2 cm x 2.0 cm presented as a deep tissue injury.

On 10/24/17 at 7:20 a.m., 9:15 a.m., 10:30 a.m., and 11:30 a.m. the resident was observed in bed laying on her back. The resident's heels were directly on the mattress surface and not floated. The heels up cushion was observed on the floor next to the bed.

On 10/25/17 at 10:45 a.m., the resident was observed in bed awake on her back. The resident's heels were directly on the mattress surface and not floated. The heels up cushion was observed on the floor next to the bed.

On 10/25/17 at 5:20 p.m., the above observations was shared with the Assistant Director of Nursing (ADON). When asked what caused the right heel pressure ulcer she stated when the resident returned from the hospital for the fractured right leg an abductor pillow was used and as a result the resident developed the SDTI. When asked if the resident required her heels to be floated, she stated "Yes". The ADON was asked to define what "float the heels as indicated" meant per the care plan, she stated, "Per the doctor's orders, when in bed".

On 10/26/17 at 10:40 a.m., the ADON was asked to escort the inspector into Resident #12's room to inspect the right heel ulcer. The resident was

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F 314	Continued From page 51 observed sitting up in a wheelchair. The resident's right tennis shoe and sock was removed. The pressure ulcer to the right lateral heel was observed to be the size of a quarter, the wound bed was black and hard. The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17. Definitions: 1. Suspected Deep Tissue Injury- a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. (MDS-Section M.)	F 314		
F 315 SS=D	COMPLAINT DEFICIENCY NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 315		12/5/17

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F 315	Continued From page 52 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure an incontinent resident, Resident #12, in the survey sample of 27 was checked and changed in a timely manner. The findings included: Resident #12 was admitted to the facility on 10/4/14 and readmitted on 6/24/17 with diagnoses to include but not limited to, unspecified dementia.	F 315	1. Nursing staff showered resident # 12 and provided perineal/incontinent care including application of barrier cream. The nurse completed a skin assessment which revealed no alteration in skin integrity. 2. Unit Managers were provided with an updated 802 which identified those residents who are dependent on staff for incontinence care. Unit Managers completed quality monitoring through observation rounds for residents receiving	

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F 315	Continued From page 53 The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 8/4/17 coded the resident as scoring a 3 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had severely impaired cognition. The resident was coded as always incontinent of both bladder and bowel. The Comprehensive Person Centered Care Plan with a review date of 10/3/17 identified the resident had altered bladder elimination related to diagnosis of dementia as evidenced by incontinence. The goal was listed as the resident will remain free of skin breakdown and free of symptoms of urinary tract infection. Interventions listed included-Check frequently for incontinence and provide peri-care with each incontinent episode. On 10/25/17 at 10:45 a.m., in the hallway prior to entering Resident #12's room was a bad heavy odor of urine. Upon entering the resident's room the odor was stronger. The resident was observed in bed, with day clothes on consisting of pants and a shirt, and the top sheet was at the foot of the resident. A lift sheet was observed on the floor. The lift sheet was saturated with what smelled like urine. A housekeeper was attending to the roommate's side of the room. She was asked what the smell was and stated urine. At this time the inspector left the room to locate the assigned CNA (certified nurse aide #1) for Resident #12. After returning to the room, CNA#1 was asked why the wet linen was on the floor. She stated she did not put the linen on the floor and did not observe the linen on the floor when she initially	F 315	incontinent care as needed. 3. Nursing staff re-educated on policy and procedure regarding observation and provision of incontinent care of residents identified with diagnosis of urinary or bowel incontinence. 4. Unit Managers/charge nurses to conduct random quality monitoring through observations for repositioning/changing schedule Unit Managers/designee to conduct weekly x four then monthly. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 315	Continued From page 54 rounded on the resident at the beginning of the shift. She further stated she was pulled to work from the other unit. She stated the resident was already dressed by the night shift when she first encountered the resident earlier this morning. She stated at that time the resident was sitting on the edge of the bed. Further inspection for the cause of the odor showed that the flat sheet, the resident's pants and shirt were saturated with urine. The urine on the flat sheet encircled the resident from mid back down to just above the knees and had begun to dry around the edges, leaving a faint brown color. The CNA stated she had not noted the wet linen earlier as the resident had the linen pulled up around her while in the sitting position at the edge of the bed. The CNA stated she had not checked the resident for incontinence that morning. The Assistant Director of Nursing (ADON) was interviewed on 10/2517 at 5:20 p.m. The above findings was shared. The ADON stated all residents should be checked at least every 2 hours regardless if the resident is incontinent or continent. She further stated when Resident #12 was first admitted and before declining, had always dressed herself well, used to wear her high heels and appeared distinguished. The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.	F 315		
F 322 SS=D	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5)	F 322		12/5/17

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F 322	Continued From page 55 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and facility document review the facility staff failed to provide the appropriate treatment and services to prevent complications of a feeding tube for 2 of 27 residents in the survey sample, Resident #3 and #16. 1. The nurse (Licensed Practical Nurse #1) failed to administer a medication via the PEG tube in a manner to prevent complications and failed to use appropriate infection control practices for glove use and hand hygiene during the application of a treatment to the PEG site to prevent infection for Resident #16.	F 322	1. Residents # 16 and resident #3 did not have any adverse effects. Care is provided following appropriate infection control standards. Nurse # 1 received individualized re-education regarding standard precautions, hand hygiene, and donning gloves. Nurse # 1 received individualized re-education regarding the facility□s policy and procedures for administering medications, feeding, and checking for placement for PEG tubes. 2. DCS/designee completed quality monitoring of current licensed nurses	

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F 322	Continued From page 56 2. The nurse (Licensed Practical Nurse #1) failed to administer a medication via the PEG tube in a manner to prevent complications and failed to use appropriate infection control practices for glove use and hand hygiene during the application of a treatment to the PEG site to prevent infection for Resident #3. PEG tube-A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. (www.medlineplus.gov) The findings included: 1. Resident #16 was admitted to the facility on 9/9/09 with a readmission date of 4/1/16 with diagnoses to include, but not limited to personal history of traumatic brain injury and PEG tube. The current MDS a quarterly with an assessment reference date of 7/8/17 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact. The resident was dependent on staff for all ADL's (Activities of Daily Living). The resident was coded as receiving greater than 51% of daily calorie requirements via an artificial route (tube feeding). The physician orders for the PEG tube management scheduled for the night shift included the following: 1. Medication order for levothyroxine 50 mg (milligram) one tablet once a day (a medication for treatment of a thyroid disorder). 2. Water flush 200 milliters every 4 hours, scheduled for 2 am and 6 am.	F 322	during administration of medications via PEG Tube for following policy and procedures and infection control standards. 3. Licensed nurses received re-education regarding standard precautions, hand hygiene, and donning gloves. Nurse # 1 received individualized re-education regarding the facility□s policy and procedures for administering medications, feeding, and checking for placement of PEG tubes. 4. Unit Manager/designee to conduct random observations of licensed nurses administering medications/feeding via PEG tube for those residents identified. A competency sheet to be completed for each nurse observed for technique including checking for placement, proper hand hygiene and glove use. Unit Managers/designee to conduct weekly x four then monthly. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 322	Continued From page 57 On 10/24/17 at 5:45 a.m., LPN #1 was observed administering medication via the PEG tube and providing PEG tube site care. Dressing supplies to provide the care were already at the bedside prior to entering the room. Prior to entering the resident's room the nurse was at the medication cart outside the resident room, and was observed pouring medications for both Resident #16 and his roommate with gloves on. The nurse crushed the levothryoxine 5 mg tablet and placed it inside 210 ml cup of water. The nurse entered the resident's room and placed the 210 ml cup on the resident's small bedside drawer. The nurse then disconnected the feeding tube from the enteral tube using the same gloves that she poured both Resident #16's and the roommates medications, instead of removing the gloves, washing her hands and donning (putting on) clean gloves. The nurse did not check placement by either checking residual or instilling 20 cc of air to listen for a "swooshing" sound in the stomach. The nurse pushed approximately 60 ml of the water/medication mix into the tube using the syringe, then removed the plunger and administered the rest of the 210 ml mix of water and the medication via gravity. Afterwards the nurse capped off the PEG tube. Instead of removing the gloves and washing her hands, the nurse removed the soiled PEG dressing. With the same gloves, the nurse cleansed the PEG tube site with wound flush and 4 x 4 gauze cleaning around the site, the PEG site was red (erythema). The nurse then applied the bacitracin around the PEG site, placed a clean dressing on and then removed her gloves. The nurse did not wash her hands, instead she placed on clean gloves and then went to the roommate (Resident #3) and initiated assessment of PEG tube placement.	F 322		

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After the treatment the nurse was interviewed outside the resident's room in the hallway. When asked about not washing her hands between glove changes she replied, "To be honest, I wear gloves between all residents".When asked how often should you wash your hands or use hand sanitizer when using gloves? She stated, "I'm not sure".

The Assistant Director of Nursing (ADON) was interviewed on 10/25/17 at 5:20 p.m. The above observation was shared. At this time the ADON stated that the treatment had been discontinued; the nurse did not have an order for the application of the bacitracin. The discontinue order dated 9/29/17 was created by the unit manager who was no longer employed at the facility. The reason to discontinue stated, "Upset". The ADON stated LPN #1 had been applying the treatment prior to it being discontinued and apparently did not look at the Treatment Administration Record (TAR). The presentation of the PEG tube site with erythema was shared with the ADON. The observation of the nurse using the PEG tube 210 ml water flush to mix the medication in and the failure to assess for placement was shared. The ADON nodded her head.

The physician discontinue order dated 9/29/17 instructed the staff to discontinue the application of bacitracin zinc ointment 500 unit/gram to the PEG site topically every night shift for PEG site care.

On 10/26/17 at 11: 45 a.m. after assessing the PEG tube site, the ADON documented the following: "Upon assessment of PEG tube site, there is some erythema extending to the right if

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{sic} tube insertion point measuring around 3 cm (centimeters), there is a small amount of maceration tissue surrounding the opening of the insertion site. Resident denies pain or burning sensation at site. Call placed to MD for new order for bacitracin and increase dressing changes to BID (twice a day), await return call for orders."

The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

The facility Policy and Procedures subject: "Medication-Administration Via Enteral Tube," revised 9/1/17 read, in part:
"1. If not a liquid medication, and if able to be crushed, finely crush each medication with pill crusher or open capsule and pour powder into a medication cup with 5-15 cc of water and dissolve. If liquid, pour the correct amount per the physician order into a medication cup.
2. Perform hand hygiene.
3. Don (apply) non-sterile gloves.

Checking for placement of enteral tube-To confirm proper placement:
1. Attach a syringe to end of tube and place stethoscope over left upper quadrant of the resident's abdomen. Instill approximately 20 cc of air using the syringe while listening for a "swooshing" sound in the stomach
2. AND/OR aspirate by gently pulling back on plunger of syringe to check for stomach contents.
3. Pour at least 15 cc of clear liquid into syringe and allow to drain into tube prior to medication administration.

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4. Pour one, individual liquefied medication in the syringe, and allow gravity to drain medication into the stomach. Followed by at least 15 cc (or physician order if different) of water in between each medication.
5. When finished administering the medication, follow with at least 15 cc of clear liquid to flush the tube.
6. Insert catheter plug or catheter cap into enteral tube.
7. Perform hand hygiene."

The facility Policy and Procedure subject: "Hand Hygiene" revised 8/29/17 read, in part:

"Overview- The CDC (Centers for Disease Control) defines hand hygiene as cleaning your hands by using either hand washing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel).

Purpose-To reduce the spread of germs in the healthcare setting.

Process:
Hand hygiene should be performed:
After glove removal."

2. The nurse (Licensed Practical Nurse #1) failed to administer a medication via the PEG tube in a manner to prevent complications for Resident #3, and failed to use universal precautions and clean technique during the application of a treatment to the PEG site to prevent infection.

Resident #3 was admitted to the facility on 4/23/15 with diagnoses to include, but not limited

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to cerebrovascular disease, GERD (gastroesophageal reflux) and PEG tube.

The current MDS, a quarterly with an assessment reference date of 8/12/17, coded the resident as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident had severely impaired cognition. The resident was dependent on staff for all ADL's (Activities of Daily Living). The resident was coded as receiving greater than 51% of daily calorie requirements via an artificial route (tube feeding).

The physician orders for the PEG tube management scheduled for the night shift included the following:
1. Medication order for metoclopromide 5 mg /5 ml every morning, (a drug used to treat GERD).
2. Water flush 210 milliters scheduled for midnight and 4 a.m.
3. Order dated 9/2/17 instructed the staff to apply bacitracin ointment 500 unit/gram to the PEG site topically every shift for PEG site care. Cleanse PEG site with normal saline, apply bacitracin and dry dressing every day.

On 10/24/17 at 5:55 a.m., an observation of medication administration and PEG tube site care for Resident #3 was conducted. Prior to this observation the nurse (Licensed Practical Nurse #1) had just provided PEG tube care to the roommate (Resident #16). The nurse did not wash her hands between provision of care from Resident #16 to Resident #3, instead she put on clean gloves. The nurse then assessed for PEG placement. The nurse disconnected the tube feeding from the enteral tube. She then obtained the 60 ml syringe and pulled back to check for residual. After this she proceeded to administer

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the 210 ml water mixed with the metoclopramide via gravity, and then capped off the PEG tube. The nurse then removed the soiled dressing from the PEG tube site, without first removing the gloves, washing her hands and placing on clean gloves. She then sprayed the site with wound flush, and cleansed the area with 4 x 4 gauze dressing. Using the same gloves, instead of removing them and washing her hands, she placed the bacitracin ointment onto her right index gloved finger and then applied it to the PEG site. The PEG site was noted to be red with a small amount of brown drainage. After applying a dressing the nurse then removed her gloves and left the room.

After the treatment the nurse was interviewed outside the resident's room in the hallway. When asked about not washing her hands between glove changes she replied, "To be honest, I wear gloves between all residents". When asked how often should you wash your hands or use hand sanitizer when using gloves? She stated, "I'm not sure".

The Assistant Director of Nursing (ADON) was interviewed on 10/25/17 at 5:20 p.m. The above observation was shared of the nurse mixing the scheduled medications with the 210 cc water flushes was shared. When asked when should staff wash their hands when using gloves, she stated, "Before and after patient care...after removing gloves".

On 10/26/17 at 11: 57 a.m. after assessing the PEG tube site the ADON documented the following: "Upon assessment of PEG tube site, there is some erythema extending downward about 1.5 cm, some brown drainage noted form

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PEG site. Dressing was intact. Call placed to MD for N.O (new order) to increase dressing changes to BID (twice a day) for moisture control. Will await return call."

The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

The facility Policy and Procedures subject: "Medication-Administration Via Enteral Tube", revised 9/1/17 read, in part:
"1. If not a liquid medication, and if able to be crushed, finely crush each medication with pill crusher or open capsule and pour powder into a medication cup with 5-15 cc of water and dissolve. If liquid, pour the correct amount per the physician order into a medication cup.
2. Perform hand hygiene.
3. Don (apply) non-sterile gloves.

Checking for placement of enteral tube-To confirm proper placement:
1. Attach a syringe to end of tube and place stethoscope over left upper quadrant of the resident's abdomen. Instill approximately 20 cc of air using the syringe while listening for a "swooshing" sound in the stomach
2. AND/OR aspirate by gently pulling back on plunger of syringe to check for stomach contents.
3. Pour at least 15 cc of clear liquid into syringe and allow to drain into tube prior to medication administration.
4. Pour one, individual liquefied medication in the syringe, and allow gravity to drain medication into the stomach. Followed by at least 15 cc (or physician order if different) of water in between

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F 322	Continued From page 64 each medication. 5. When finished administering the medication, follow with at least 15 cc of clear liquid to flush the tube. 6. Insert catheter plug or catheter cap into enteral tube. 7. Perform hand hygiene." The facility Policy and Procedure subject: "Hand Hygiene" revised 8/29/17 read, in part: "Overview- The CDC (Centers for Disease Control) defines hand hygiene as cleaning your hands by using either hand washing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Purpose-To reduce the spread of germs in the healthcare setting. Process: Hand hygiene should be performed: After glove removal."	F 322		
F 328 SS=D	. TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive	F 328		12/5/17

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proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care,

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F 328	Continued From page 66 including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and facility document review the facility staff failed to ensure 1 of 27 residents in the survey sample received proper treatment and care to maintain good foot health, Resident #2. Resident #2 did not receive podiatry services to maintain good foot health. The findings included: Resident #2 was admitted to the facility on 4/12/16 with diagnoses to include, but not limited to: diabetes. The current MDS (Minimum Data Set) a significant change with an assessment reference date of 10/2/17 coded the resident as having long and short term memory deficits with severely impaired daily decision making skills. The resident was dependent on staff for all Activities of Daily Living (ADL's).	F 328	1. Resident # 2 was placed on the Podiatry list and was seen the next day 10/30/17 by the Podiatrist. Residents who are diagnosed with DM are placed on the Podiatrist list for routine visits. Weekly skin assessments are performed and any residents identified as needing Podiatry are added. 2. Social Services was given a list of Residents with DM and or requiring Podiatry visit. Social Services reviewed list of residents for being on list for Podiatrist appointment. 3. Nursing staff re-educated on foot care for diabetic residents and performing weekly skin assessments for all residents. Social Services and nursing staff have been educated on the new process. Social Services has been re-educated to ensure residents receive Podiatry care per regulation.	

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F 328	Continued From page 67 On 10/24/17 at 11:35 a.m., the resident was observed in bed. A dressing change observation of the pressure ulcers to the resident's thighs and sacrum was observed conducted by the Assistant Director of Nursing (ADON) and Licensed Practical Nurse #3. The resident's legs and toes were exposed; all of the toenails were long and curled up under each toe except the two large toe toenails. The two large toe nail beds were discolored, thick and long and in need of podiatry services. On 10/25/17 at 3:30 p.m., the resident was observed in bed. The resident's toe nails remained long and in need of podiatry services. LPN #3 was in the room with this inspector and the resident's toes were assessed. The LPN stated, "We requested podiatry services". When asked when, she stated, "Monday (10/23/17)". She further stated the podiatrist comes once a month to the facility. A review of the clinical record evidenced Resident#2's last podiatry services was provided on 3/16/17. The podiatrist documented that the resident's medical history included diabetes. The resident's toenails were long, painful and the two large toenails had onychomycosis (1). The treatment consisted of routine foot care to include trimming the long toenails, and debriding the painful dystrophic (2) toe nails and treatment of an ingrown toe nail to the left great toe. The podiatry plan was to continue with monitoring foot pathologies. There was no return visit checked off. On 10/26/17 at 12:00 p.m., the Business Development Coordinator (BDC) was interviewed. She stated that she had been	F 328	4. Unit Manager/designee to conduct quality monitoring of those residents identified to ensure the names are on the Podiatry list. Unit Managers/designee to conduct quality monitoring weekly x four weeks then monthly. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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responsible for placing residents on the podiatry list to be seen monthly, to include all diabetic residents. She stated she has been covering this role intermittently as needed the last several months as there had been breaks in maintaining a Social Worker at the building. The list did not include Resident #2. She stated she updates the list with additional residents whenever staff inform her of a resident's need for podiatry services. The BDC stated the podiatrist visits once a month. When asked why the resident was not on the routine visit list as she was a diabetic, her response was "She should be, she should have been seen in September". Later, the BDC informed this inspector that the podiatrist was called and stated, "He will be in this Saturday, just to see her (Resident #2)."

The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

The facility Policies and Procedures subject: "Podiatry" revised 8/24/17 read:
"Policy- Podiatry consults are available to residents in need of services other than routine care.
Procedure:
1. Podiatry services are provided via one of the following mechanisms.
*The Center maintains a list of local podiatrists who will accept referrals to their office.
*The Center maintains a contract with a podiatrist who agrees to see referrals at the Center.
*Any member of the team may ask the attending physician to request the podiatric consult.
*Once the consult order is written or transmitted

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F 328	Continued From page 69 verbally to the Licensed Nurse, the charge nurse will make the referral. *The consulting podiatrist will complete the physician consultation form and/ or Podiatry Assessment and return it to the charge nurse for filing in the medical record. Orders are written on the physician's order sheet." Definitions: 1. Onychomycosis-Disease of a nail due to a parasitic fungus. (Referenced from Taber's Cyclopedic Medical Dictionary). 2. Dystrophic toe nail- Damage to the nail as a result of trauma or disease results in nail dystrophy. The presence of a misshapen or partially destroyed nail plate. Soft yellow keratin often accumulates between the dystrophic nail plate, resulting in elevation of the plate. (Referenced from Taber's Cyclopedic Medical Dictionary).	F 328		
F 364 SS=D	NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP CFR(s): 483.60(d)(1)(2) (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observations, a group interview, and staff interview, the facility staff failed to serve food that was palatable and at a safe and appetizing	F 364	1. The facility serves food that is palatable and at a safe and appetizing temperature.	12/5/17

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F 364	Continued From page 70 temperature for one of three Units of the facility. The findings included: Observations made at 12:05 P.M. on 10/25/17 during the lunch meal indicated food was not served which was palatable and at a safe and appetizing temperature. During the Group Interview on 10/25/17 at 10:00 A.M. one resident stated food is not always served hot . At 12:05 P.M. on 10/25/17 a test tray was conducted on the Four Hundred Unit. The Four Hundred Unit food trays were placed on an open serving cart. Food was prepared in the main kitchen and carted to the units for serving. The lunch menu consisted of pork lion, spinach, sweet potatoes, rolls, fruit cups, tea, milk, and juice. The alternate menu was vegetable soup, noodles, corn, and beef patties. At 11:18 A.M. the initial temperatures were started for the tray line. The initial temperatures were as follows: pork lions 187.8 degrees, puree bread 175.5 degrees, spinach 197.3 degrees, puree sweet potatoes 199.2 degrees, vegetable soup 202.2 degrees, noodles 190.2 degrees, brown gravy 186.2 degrees, mechanical pork lions 183.4 degrees, puree pork lions 193.0 degrees, sweet potatoes 173.6 degrees, beef patties 176.2 degrees, milk 38.0 degrees, juice 38.0 degrees, fruit cup 37.6 degrees. The test tray left the kitchen at 12:03 P.M. and arrived on the Four Hundred Unit at 12:05 P.M. The last tray was served at 12:46 P.M. The pork lions were tempted at 129.3 degrees, the sweet potatoes were tempted at 126.4 degrees, the	F 364	2. Administrator/designee and IDT interviewed current residents for food concerns. Follow up based on findings. 3. Kitchen staff to be educated to check food temperatures on the steam table before starting tray line at each meal. Nursing and CNA staff to be educated on the importance and necessity to begin passing food trays to residents as soon as food carts arrive on the unit to maintain required temperatures of food. Residents re-educated during Resident Council on how to voice concerns related to food temperatures. 4. Quality monitoring of food temperatures will be performed weekly by the Dietary Manager/designee for 8 weeks then monthly as indicated by utilizing a test tray as last tray served on the nursing unit. Concerns related to Food temperatures to be quality monitored via Resident Council monthly. Findings to be reported at QAPI.	

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F 364	Continued From page 71 spinach were tempted at 126.7 degrees. The fruit cup were tempted at 49.0 degrees. Milk was tempted at 53.1 degrees. Juice was tempted at 57.3 degrees. During an interview at 12:56 P.M. on 10/25/17 with the Dietary Manager, she stated, "The food is too cold." A "Food: Quality and Palatability Policy" indicated: "It is the center policy, that food is prepared by methods that conserve nutritive value, flavor and appearance. Food is palatable, attractive and served at the proper temperature." During an interview on 10/25/17 at 1:05 P.M., with the Dietary Manager, she was asked, what were the expectations for serving hot meals? The Dietary Manager stated, she would expect the food to be served timely and hot. The facility staff failed to served food that was palpable and at a safe and appetizing temperature.	F 364		
F 387 SS=E	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2) (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced	F 387		12/5/17

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F 387	Continued From page 72 by: Based on observation, clinical record review, staff interview, and review of the facility's policy the facility staff failed to ensure 1 of 27 Residents (Resident #4) in the survey sample was seen by a physician or his designee at least once every 60 days for recertification. The facility staff failed to ensure Resident #4 was seen by a physician or his designee for her 60 day recertification for November 2016, January 2017, March 2017, May 2017 and July 2017. The Findings include: Resident #4 was originally admitted to the facility 03/04/16. Diagnoses included but not limited to: Type 2 Diabetes (1), Heart failure (2), closed fracture of sternum (3) and lymphedema (4). The current Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date (ARD) of 09/29/17 coded the resident with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The review of the clinical record revealed a 60-day recertification progress note for 09/14/16 and 09/20/17. An interview was conducted with Medical Records Personnel on 10/25/17 at approximately 3:10 p.m., who stated she was asked by the Director of Nursing (DON) for all the 60-day recertification after September 2016 but could locate 2 recertifications and that was for 09/14/16 and 09/20/17. The surveyor asked when are recertifications due, she replied, "After being	F 387	1. Resident #4's last recertification progress note was performed on 9/20/17 and is due for next 60 day recertification progress note on 11/19/17. Physician will complete this by the due date. 2. The Medical Records Custodian to review all records for physician visits and determine any that are overdue and/or dates of next required visit. The Executive Director to have Medical Director update any physician visits that are out of compliance. 3. The Medical Records Custodian to be educated on the required physician visits and timeliness thereof. Also, the Records Custodian will be educated on her responsibility to inform ED/DCS of upcoming due dates for physician visits. The Medical Records Custodian to maintain an ongoing record of physician visits and required next visit. A list of required physician visits for upcoming week to be given to physicians. Each week Medical Records Custodian to review with ED visits not kept on due date and ED/designee will direct Medical Director to visit and document before grace period expires. 4. Weekly quality monitoring of physician visits will be performed by Medical Records Custodian and reported to ED/DCS. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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admitted to the facility, the recerification is due within 30 days, then 60 days, then 90 days then every 60 days thereafter. The surveyor asked, "Who is responsible for informing the Physician or Physician Assistant (PA) when the residents recertification was due, she replied "I'm responsible for letting them know."

On the same day the surveyor asked what is your process for notifying the Physician or Physician Assistant (PA) for upcoming recertification's, she replied, "I will email a list with the resident's name to include what type of recertification that is due whether it's a 30 day, 60 days, or 90 days after admission or 60-day recertification." The Medical Records Personnel proceeded to say, "I don't know what happen; they Physician and PA were notified when the recerts were due; they are always in the building so I don't understand why the residents recertificaiton were not completed."

On 10/25/17 at approximately 4:00 p.m., an interview was conducted with Physician Assistant (PA) who stated that residents should have a recertification done every 60 days after their 90 days after admission. The PA proceeded to say she could do a better job with the recertification if she was reminded on a regular basis. The PA also stated for the last 2 months she has been receiving a fax from the facility of the residents that needed recertification but the facility has had a large turn over with staff; that may have been part of the problem.

The facility administration was informed of the findings during a briefing on 10/26/17 at 4:00 p.m. The facility did not present any further information about the findings.

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The facility's policy: "Medical Care/Standards of Practice" (Last Revision Date: 8/25/17).

"1). Physician visits are required according to resident needs and/or state and Federal guidelines.

-For long term care, a physician must see the resident at least once every 30 days for the first 90 days after admission. After 90 days, an alternative schedule of visits, not to exceed 60 days, may be set if the physician justifies in the record that the resident's condition does not necessitate visits at 30 day intervals; and if change in the resident's condition warrants, the attending physician is obliged to begin more frequent visits."

Definitions:

1). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

2). Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart (Mosby's Dictionary of Medicine, Nursing &Health Professions 7th Edition).

3). A closed fracture of the sternum is a break of the breastbone that occurs without an associated skin injury. The upper and middle thirds of the sternum are the portions most commonly

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F 387	Continued From page 75 fractured (www.mdguidelines.com). 4). Lymphedema is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs (https://medlineplus.gov/ency/article/007365.htm).	F 387		
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		12/5/17

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(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

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F 441	Continued From page 77 Based on observations, staff interviews and facility document review the facility staff failed to implement appropriate hand hygiene practices during a medication pass and pour. The findings included: On 10/24/17 from 5:15 a.m. through 5:55 a.m., a medication pass and pour was conducted with the Licensed Practical Nurse (LPN#1). The medication pass included 9 residents. Between each of the 9 residents the nurse would put on clean gloves, prepare their medications, administer the medications and then remove the gloves. Two of the nine residents had their blood sugar tested. The nurse did not wash her hands or use an alcohol-based sanitizer at any time between residents or after removing her gloves. A bottle of alcohol-based sanitizer was observed stored on the side of the medication cart. After the medication pass observation was completed the nurse was interviewed. The above observations were shared. LPN #1 stated, "To be honest, I wear gloves between all residents". When asked by this inspector, "How often should you wash your hands or use hand sanitizer when using gloves? She stated, "I'm not sure". The Assistant Director of Nursing (ADON) was interviewed on 10/25/17 at 5:20 p.m. The above observation was shared. When asked when should staff wash their hands when using gloves, she stated, "Before and after patient care...after removing gloves". The above findings was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services	F 441	1. There were no adverse effects for residents #16 and #3. Residents #16 and #3 are administered medications following infection control standards. Nurse # 1 received individualized re-education regarding standard precautions and infection control relating to medication administration. Nurse #1 provided return demonstration. 2. DCS and or Unit Managers/designee completed observational quality monitoring with each licensed nurse for proper infection control during PEG tube medication administration. Follow up based on findings. 3. Licensed nurses to be re-educated on medication administration via PEG tube, the proper use of gloves, the importance of hand hygiene, and the ongoing observation process. 4. Unit Manager/designee to conduct random observations of licensed nurses administering medications/feeding via PEG tube for those residents identified. A competency sheet to be completed for each nurse observed for technique including checking for placement, proper hand hygiene and glove use. Unit Managers/designee to conduct quality monitoring weekly x four then monthly. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 441	Continued From page 78 during the pre-exit meeting conducted on 10/26/17. The facility Policy and Procedure subject: "Hand Hygiene" revised 8/29/17 read, in part: "Overview- The CDC (Centers for Disease Control) defines hand hygiene as cleaning your hands by using either hand washing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Purpose-To reduce the spread of germs in the healthcare setting. Process: Hand hygiene should be performed: After glove removal."	F 441		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the	F 465	1. The orange leather chairs have been	12/5/17

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F 465	Continued From page 79 facility staff failed to maintain a safe, clean, comfortable and sanitary environment. The findings included: During the initial tour on 10/24/17 at approximately 3:15 a.m., located on the Peach unit were 2 burnt orange colored leather chairs with torn and ripped arms. On 10/25/17 at approximately 2:10 p.m., on the Peach unit remains the 2 burnt orange colored leather chairs with torn and ripped arms. During General Observation of the facility on 10/26/17 at 10:30 a.m., with the Maintenance Director located inside the outside storage shed were the following items sitting on the floor: a box of cups, bath tissues, 2 boxes of rollers for trash can bins, an unopened urinary catheter kit, an unopened incentive spirometer, and an old mattress that was underneath a shelf. The maintenance director stated boxes should not be sitting directly on the floor; this shed is being shared with housekeeping, dietary, central supply and the maintenance department and no one takes ownership. The floor of the shed was dirty with spider webs in the corners. On 10/26/17 at 10:55 a.m., there were 3 electric beds being stored on the back service hall. The surveyor asked if beds were always stored on the back service hall, he replied "Yes, there is no other place to put them because when a resident goes Hospice, they will get a bed from Hospice so we will take the bed out of the room and place it back service hall." Also located on the service hall behind the fire doors in the corner were spider webs. The surveyor asked if the resident	F 465	discarded. All items in the storage shed are on pallets or shelving and floor is kept clean. The back hallway will be free of excess beds and equipment and the spider web in back hall corner behind the fire door was cleaned. 2. Environmental rounds were performed to identify any other furniture, equipment, and space not in compliance. 3. An additional shed will be obtained to store excess beds and maintain the back hallway free of equipment. Central Supply Clerk, Housekeeping staff, Dietary staff, and Maintenance staff were educated on maintaining outside storage sheds in orderly manner with no items stored on floor. Oversight of outside sheds is assigned to Housekeeping supervisor. 4. Weekly quality monitoring of outside sheds will be performed by Housekeeping Supervisor/designee for 8 weeks then monthly and PRN as indicated. Findings to be reported at QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 465	Continued From page 80 had access to this area, he replied "Yes." During an interview with the Administrator on 10/26/17 at 12:40 p.m., he stated, "Unfortunately there is no place to put the electric beds but I guess we need to come up with something." The Administrator staff were informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 465		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 514		12/5/17

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F 514	Continued From page 81 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure an accurate medical record for 2 Residents (Resident #1 and Resident #2) of 27 Residents in the Survey sample. 1. The facility failed to accurately document medication administration on Resident #1's Medication Administration Record. Blank entries were noted without reasons for medications not being given: 2. The facility staff failed to ensure the documentation on the October 2017 Treatment Administration Record (TAR) for Resident #2 was accurate for the application and removal of TED stockings. The findings included: 1. Resident #1 was admitted to the facility on 10/18/16 with a readmission on 5/4/17. Diagnoses for Resident #1 included but are not limited to Deafness, Non-Alzheimer's Dementia	F 514	1. Resident # 1 had no documented adverse effects. Resident #1 has medications administered per physician orders and documented. Physician notified of missing documentation. 2. Unit Managers/designee completed a quality Review of October and November MARs and TARs for missing documentation. Follow up based on findings. 3. Quality review of the MAR/TAR conducted by the off going and oncoming nurse at change of shift to ensure documentation is complete. Licensed nurses re-educated by the Director of Nursing (DCS)/designee regarding physician order and documentation on the MAR/TAR. 4. DCS/Unit Manager/designee to complete Quality Review of MARs and TARS for completeness daily times 4 weeks then weekly times 4 weeks then monthly. Findings to be reported to QAPI	

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F 514	Continued From page 82 (1), Schizophrenia (2), and Cerebral Vascular Incident (3). Resident #1's Quarterly Minimum Data Set (MDS - an assessment protocol) with an Assessment Reference Date (ARD) of 7/20/17 coded Resident #1 with a BIMS (brief interview for mental status score) of 4 indicating a severe cognitive impairment. In addition, the Quarterly MDS scored Resident #1 as requiring total dependence with one staff person assistance for Bathing and Hygiene needs. In addition the Quarterly MDS scored Resident #1 as always incontinent of bowel functions and frequently incontinent of urine functions. Resident #1's Physician Orders documented the following: 10/20/16 Aspirin (4) Tablet 325 milligrams (mg) Give 1 tablet by mouth one time a day for Hypertension 10/20/16 Donepezil HCl (5) tablet 5 mg give 1 tablet by mouth one time a day for dementia 10/19/16 Risperidone (6) tablet 0.5 mg give 1 tablet by mouth two times a day related to major depressive disorder single episode 10/19/16 Vitamin D3 (7) 1000 unit give 1 tablet by mouth one time a day for supplement 10/20/16 Tricor (8) tablet 48 mg give 1 tablet by mouth one time a day related to hyperlipidemia 11/21/16 Risperidone tablet 1 mg give 1 tablet by mouth two times a day related to major depressive disorder, single episode Resident #1's current active Care Plan documented the following intervention for the problems listed:	F 514	committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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Intervention:
Administer medications as ordered

Problems:
Revised 10/18/17: imbalanced nutrition related to diagnosis dementia, depression, stroke, on a mechanically altered diet....
Revised 3/23/17: Psychoactive Medication Use Anti-Depressant medication for Diagnosis of Depression and insomnia and an antipsychotic for psychosis
Revision 9/18/17: Potential for decreased cardiac output related to diagnosis of hypertension and hyperlipidemia
Revised 9/18/17: Impaired cognition and or impaired thought processes related to diagnosis of dementia and schizophrenia.

Resident #1's Medication Administration Record for the following dates had blanks without reasons for medications not being given:

10/28/16 Aspirin
10/28/16 Donepezil
10/28/16 Risperidone
10/28/16 Vitamin D3

12/24/16 Tricor
12/24/16 Risperidone

1/12/17 Tricor
1/12/17 Risperidone

A hand written note from the Facility's Director of Nursing on 10/16/17 at approximately 11:30 a.m. documented the following answer to the question: "Can you explain why?" to the blanks for

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medication signature blanks:

"Unable to determine documentation of administration omitted."

The Director of Nursing stated on 10/26/17 at approximately 11:30 a.m., that it is the facilities policy to document medications given or a reason for the medications not being given.

The facility administration was informed of the findings during a briefing on 10/26/17 at approximately 4:00 p.m.. The facility did not present any further information about the findings.

Definitions:

1. Non Alzheimer's Dementia: Medline Plus documented: Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there.

2. Schizophrenia: Medline Plus documented: is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves.

3. Cerebral vascular Accident: Medline Plus documented: A stroke is a medical emergency. Strokes happen when blood flow to your brain

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stops. Within minutes, brain cells begin to die. There are two kinds of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. "Mini-strokes" or transient ischemic attacks (TIAs), occur when the blood supply to the brain is briefly interrupted.

4. Aspirin: Medline Plus documented: Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots.

5. Donepezil HCl: Medline Plus documented:

Donepezil is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) in people who have Alzheimer's disease (AD; a brain disease that slowly destroys the memory

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and the ability to think, learn, communicate and handle daily activities). Donepezil is in a class of medications called cholinesterase inhibitors. It improves mental function (such as memory, attention, the ability to interact with others, speak, think clearly, and perform regular daily activities) by increasing the amount of a certain naturally occurring substance in the brain. Donepezil may improve the ability to think and remember or slow the loss of these abilities in people who have AD. However, donepezil will not cure AD or prevent the loss of mental abilities at some time in the future.

6. Risperidone: Medline Plus documented: Risperidone is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to 16 years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain.

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7. Vitamin D3: Medline Plus documented: a vitamin good for bone health

8. Tricor: Medline Plus documented: Fenofibrate is used with a low-fat diet, exercise, and sometimes with other medications to reduce the amounts of fatty substances such as cholesterol and triglycerides in the blood and to increase the amount of HDL (high-density lipoprotein; a type of fatty substance that decreases the risk of heart disease) in the blood. Build-up of cholesterol and fats along the walls of the arteries (a process known as atherosclerosis) decreases the blood flow and, therefore, the oxygen supply to the heart, brain, and other parts of the body. This increases the risk of heart disease, angina (chest pain), strokes, and heart attacks. Although fenofibrate decreases the levels of fatty substances in the blood, it has not been shown to decrease the risk of heart attacks or strokes. Fenofibrate is in a class of medications called antilipemic agents. It works by speeding the natural processes that remove cholesterol from the body.
2. The facility staff failed to ensure the documentation on the October 2017 Treatment Administration Record (TAR) for Resident #2 was accurate for the application and removal of TED stockings.

Resident #2 was admitted to the facility on 4/12/16 with diagnoses to include, but not limited to: diabetes, heart failure, phlebitis (1) and thrombophlebitis (2) of unspecified deep vessels of the lower extremity.

The current MDS (Minimum Data Set) a significant change with an assessment reference date of 10/2/17 coded the resident as having long

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CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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and short term memory deficits with severely impaired daily decision making skills. The resident was dependent on staff for all Activities of Daily Living (ADL's).

The Comprehensive Person Centered Care Plan last reviewed 8/31/17 included the following:
1. ADL self care performance deficit relate to diagnoses of dementia and decreased mobility. Goal- Resident will receive appropriate staff support with ADL's.
Intervention included-TED stockings on AM and off PM.
2. Potential for skin integrity related to incontinence, decreased mobility. Intervention included-TED stockings ordered.

The physician plan of care included the following order dated 5/9/17-Apply TED hose on in am and remove per schedule related to type 2 diabetes, heart failure, phlebitis and thrombophlebitis of unspecified lower extremity.

On 10/24/17 at 7:30 a.m., 9:15 a.m., 10:35 a.m., and 11:35 a.m., the resident was observed asleep in bed. The resident did not have TED stockings on.

The TAR entry for the application and removal of the TED stockings for 10/24/17 was initialed by nursing staff as completed.

On 10/25/17 at 10:45 a.m., 11:10 a.m., and 1:25 p.m., and at 3:30 p.m., the resident was observed asleep in bed. The resident did not have TED stockings on.

The TAR entry for the application of the TED stockings for day shift on 10/25/17 was initialed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495347	A. BUILDING _____ B. WING _____	C 10/26/2017

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CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

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as applied.

On 10/25/17 at 3:30 p.m., the nurse assigned to the resident was interviewed. She was asked about the TED hose and stated she did not do treatments today stating the desk nurse did. The desk nurse Licensed Practical Nurse #3 was asked if the resident had the TED stockings on as ordered and as initialed by her on the Treatment Administration Record (TAR) for today. She stated, "When they were getting her ready this morning I told them (CNA) to put them (TED stockings) on her". The nurse was asked if she had observed the stockings on the resident she stated, "No". The nurse was asked to escort this inspector into the resident's room to check for use of the TED stockings. The nurse removed the linens and exposed the resident's legs. There were no TED stockings on. The nurse was asked to search the resident's drawers and closet to locate the TED stockings. TED stockings were not found. LPN #3 instructed the CNA to obtain TED stockings from the supply closet and apply them to the resident.

The above findings of the inaccurate TAR documentation was shared with the Administrator, the Director of Clinical Services and the Regional Director of Clinical Services during the pre-exit meeting conducted on 10/26/17.

Definitions-Referenced from Taber's Cyclopedic Medical Dictionary
1. Phlebitis-Inflammation of a vein.

2. Thrombophlebitis-Inflammation of a vein in conjunction with the formation of a thrombus (a blood clot).