STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 02/12/2018

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HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/6/18 through 2/12/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/6/18 through 2/12/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 6 closed record reviews	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550** **Corrective Action(s):** Resident #58 has been assessed by nursing for her ADL needs to include incontinence care and toileting needs at night. Resident #58 has had her comprehensive plan of care reviewed and revised to reflect appropriate interventions and approaches to meet her incontinent care and toileting needs during the night time hours. C.N.A. #2 has been inserviced on resident Rights and Dignity regarding the use of Clothing protectors during meal times. A facility Incident & Accident form has been completed for this incident.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Lawrence	Administrator	2/28/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1	F 550	**Identification of Deficient Practices & Corrective Actions(s):**	

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on dining room observation and staff interview, the facility failed to promote independence and dignity while dining.

1. Facility staff were placing clothing protectors on resident's without asking.

2. Facility staff failed to provide incontinence care to Resident #56 during the night.

The Findings Include:

All other residents dependent for toileting /Incontinent care and using clothing protectors at meal times may have been potentially been affected. The nursing staff will conduct a 100% audit of all residents dependent for toileting & incontinent care and resident using clothing protectors at meal times to identify residents at risk. Residents identified at risk will be assessed by nursing for toileting/incontinent care needs and whether a clothing protector is warranted or wanted by the resident during meals. All comprehensive plans of care will be revised to address specific interventions and approaches to address resident care needs to maintain dignity during incontinent care and at meal time.

Systemic Change(s):
Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services director will inservice the nursing staff on the facility policy & procedure regarding resident rights and dignity, to include maintaining dignity during toileting/incontinent care and while providing assistance during meal times.

Monitoring:
The DON is responsible for compliance. The DON, Unit Manager and/or designee will perform 3 random incontinent care and meal pass audits weekly to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of the weekly audits will be reported to the QA Committee for review, analysis, and recommendations of change in facility

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F 550	Continued From page 2	F 550	policy, procedure, or practice. **Completion Date:**	**3/29/2018**

1. During dining observations conducted on 2/6/18 at 12:21 PM, staff were observed placing clothing protectors on residents without asking. At the time of the observation, 39 residents where in the dining room and only 2 residents did not have a clothing protector on.

Also during the dining observation another surveyor observed a resident pulling a clothing protector off and throwing it on the floor, a certified nursing assistant replaced it with another clothing protector.

On 02/06/18 at 2:11 PM two certified nursing assistants (CNA's) (that were in the dining room) were interviewed. When asked about if they (CNA's) ask Residents, do they want a protector on, CNA #2 verbalized no, we put the protectors on, but if they get agitated and pull them off then we will not put them back on.

On 02/08/18 10:21 AM the above finding was brought to the attention of the administrator and DON (director of nursing) regarding dining observations, understanding noted.

No other information was provided prior to exit conference on 2/12/18.

2. Facility staff failed to provide incontinence care to Resident #56 during the night.

Resident #56 was most recently admitted to the facility on 01/23/2018. Her diagnoses included, but were not limited to, acute kidney failure, acute respiratory failure with hypoxia, strain of the left

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Achilles tendon and dysphagia.

A 5 day MDS (minimum data set) assessment, coded Resident #56 with a cognitive summary score of "12", indicating she was moderately impaired.

On 02/06/2018 at 4:25 p.m. Resident #56 was observed sitting up in a wheelchair in her room. Her daughter was in the room visiting. A family interview was conducted. Resident #56's daughter was asked about care at the facility. She stated, "Everything is pretty good except I don't think they are changing her during the night...she [Resident #56] doesn't put out a lot of urine because of her kidney failure...there have been a few mornings when I have come in and she has been soaked to the bed...that tells me it's been a while since they checked her."

Resident #56 was asked about incontinence care during the night. She stated, "They put me to bed around 8:30 or 9:00 and I am fine with that, but they don't come back a lot of nights until the next morning..." Resident #56 was asked if she called for help to go the bathroom at night or to be changed. She stated, "No, I just wake up like that." Resident #56 was asked if she had requested not to be changed or awakened during the night. She stated, "No."

The clinical record was reviewed. The comprehensive care plan for incontinence, included the following interventions, but not limited to: "Check with resident at least every 2 hours for need to toilet/incontinence care. Provide incontinence care as needed and ensure dignity is maintained at all times."

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The above was discussed with the DON (director of nursing) on 02/08/2018 at approximately 8:30 a.m. Evidence of every 2 hour toileting/incontinence care was requested. A copy of Resident #56's, "Bowel and Bladder Cont. [Continence] or Incont [Incontinence]" record was provided for the months of January and February. There were no days listed showing that incontinence care had been provided every two hours. The bottom of the sheet had the following statement: "Time of documentation not necessarily time care provided. Answers entered once per shift may apply to the entire shift." The DON was asked what the statement meant. She stated, "I just noticed that, I don't know." The DON was asked what the expectation was for incontinence care during the night. She stated, "They need to go in and check to see if the resident is wet or if they want to go to the bathroom and act accordingly."

The above information was discussed during an end of the day meeting with the DON (director of nursing) and the administrator on 02/08/2018.

No further information was obtained prior to the exit conference on 02/12/2018.

F 558 SS=D Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)

§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.
This REQUIREMENT is not met as evidenced by:

F 558

F558
Corrective Action(s)
Resident #8, #38 & #10 have had the soap dispenser and sink in their room inspected, modified, adjusted or replaced to allow them to reach the sink, faucet handles and the soap dispenser. A Facility Incident & Accident form was completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All other resident room soap dispensers

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F 558	Continued From page 5 Based on observation, resident interview, staff interview, and facility document review the facility failed to assess the accommodation of needs regarding the ability to access the faucet and soap dispenser for three residents in two separate rooms: Resident # 8, # 38, and # 10. Findings include: On 2/6/18 beginning at 9:30 the initial pool process was initiated in the facility. During the process, two female residents were observed in their room in their wheelchairs. One resident was at the sink attempting to wash her hands, and was having obvious difficulty reaching the handles of the faucet, and the soap. The resident was pulled up to the sink as far as her wheelchair would allow, and her arms were up at head height trying to reach the faucet and soap. A surveyor on the same hall as this surveyor asked the resident if she was having trouble at the sink. The resident, identified as Resident # 8 looked at the surveyor and exclaimed "I sure am!" Later in the morning Resident # 8's roommate, identified as Resident # 38 was observed by this surveyor at the sink having the same difficulty as Resident # 8. This surveyor asked Resident # 38 about the sink and her difficulty reaching the faucet and soap. Resident # 38 stated "Well, it's a hard thing to do; I can't reach the faucet handles very well and my arms end up almost over my head trying to reach that far back." On 2/6/18 at approximately 2:40 p.m. Resident # 10 was interviewed and asked if she was able to access the sink, including the faucet and handles. Resident # 10 stated "Yes; it's very hard to reach the sink from my wheelchair; I'm not really able to stand, and I can't get my wheelchair close	F 558	and sinks may be potentially affected. The facility Maintenance Director and Administrator conducted a 100% audit of resident room soap dispensers and sinks to identify any that need to be modified, adjusted, or replaced based on resident use and assessment. All resident soap dispensers and sinks identified during the resident assessment determined to be unaccommodating for use in a wheelchair have been modified, adjusted, or replaced to accommodate the resident to ensure all sink controls and soap dispensers can be used appropriately by the residents. **Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director will provide in-services to all staff on company policy and procedure for completing maintenance work orders as well as the proper notification system to use when repairs or resident maintenance requests are needed throughout the facility. The maintenance request logs will be reviewed by the administrator weekly for completion of repairs. **Monitoring:** The Maintenance Director is responsible for maintaining compliance. The results of the Administrator's weekly monitoring of maintenance request logs will be reviewed by the Risk Management Committee weekly. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date:**	3/29/18

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enough to reach all the way back to the handles on the faucet.....or the soap, for that matter!"

On 2/8/18 at 10:20 a.m. during a meeting with facility staff the administrator was made aware of the above observations and interview. The administrator stated "Well, those are new sinks; corporate installed them, and I was told they met ADA (American Disability Act) standards." This surveyor asked if there was any documentation about the sinks installed, and what the ADA measurements were. The administrator stated "I can see if I can find that; I know they replaced the original sinks because they were in bad shape; they put in pedestal sinks but those didn't work either so they took all those out and put the ones that are in the room now. All the rooms have the same sinks."

On 2/8/18 at 12:45 p.m. the administrator, maintenance director, and this surveyor went to Resident # 8 and # 38's room. Permission was given by the residents to come in and look at the sinks. The maintenance director had the sheet including a diagram and measurements for the sinks per ADA guidelines. The maintenance director measured all the parameters as set forth by the guidelines, and the measurements were correct per the guidelines. Resident # 38 was asked if she would come to the sink and "pretend" to wash her hands. Resident # 38 smiled and propelled her wheelchair to the sink, and demonstrated how she attempted to wash her hands. Resident # 38 also described difficulty in being able to see past the top of her head in the mirror, even though it was at the height recommended by the ADA guidelines. Resident # 38 looked at the administrator and stated "If I could stand up this wouldn't be a problem, but the

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last time I tried to stand up at the sink I went right back down! This is a very difficult task to try and reach those handles..." As she was talking, Resident # 8 propelled over and watched Resident # 38 demonstrate the difficulty with the sink, and affirmed she also had difficulty. The administrator and this surveyor noted both residents' wheelchairs were fairly low to allow them to self-propel. The maintenance director was then asked to measure the wheelchairs per the ADA diagram to ensure the wheelchair height was within guideline. The wheelchair measured 27 inches from bottom of the wheels to the armrest, meeting the specifications of the guideline. This surveyor noted that while the wheelchair from wheel to armrest was correct, the seat appeared low. The administrator stated "That would be up to physical therapy (PT) to adjust." The administrator was asked if the therapist could come to the room to see if any adjust was able to be done. The physical therapist came to the room, and after the situation was explained to him stated "[name of Resident # 38] was able to stand at the sink a couple of months ago; we worked with her on strength and how to lock the chair to stand. She has declined a little and just doesn't stand well. [name of Resident # 8] has never been able to stand at the sink due to having really bad knees; she's just not able to stand. As far as the seat itself in the wheelchair, the seat is up as high as it can be for both residents; if the seat(s) were any higher they would not be able to self-propel. I hate it for [name of maintenance director] but looks to me the only thing that can done is lower the sink..." The administrator, maintenance director, and this surveyor all agreed that even though the sinks were within the ADA guidelines, there was no individuality for those residents

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unable to access the sink properly from the wheelchair.

No further information was provided prior to the exit conference.

F 567 Protection/Management of Personal Funds
SS=D CFR(s): 483.10(f)(10(i)(ii)

§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.
(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.
(ii) Deposit of Funds.
(A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing

F 558

F 567 **F567**

Corrective Action(s):
The BOM and B.O. assistant have received inservice training on the requirement to have resident funds available seven days a week for all residents. Resident #23 has been made aware of the personal Fund policy and the availability of personal funds on the weekends and how to access them.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have been potentially affected. The BOM will meet with all residents and review the personal fund policy and the availability of resident funds seven days a week.

Systemic Change(s);
Facility policy and procedure was reviewed and no changes are warranted at this time. The BOM will review the Resident Personal Funds policy with all new residents admitted to the facility to ensure they are aware of when and how to access their personal funds. The Licensed Nurses will be inserviced by the BOM on the resident fund process and accessing resident funds on the weekend. The Administrator & Social Services Director will investigate & follow through on all concerns reported regarding resident funds.

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F 567	Continued From page 9	F 567	**Monitoring:** The Business Office Manager is responsible for maintaining compliance. The Business Office Manager will review resident council minutes monthly and the grievance log weekly to monitor for any resident fund concerns. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date:**	**3/29/2018**

account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and facility document review, the facility staff failed ensure one of 21 residents in the survey sample had personal funds available on weekends (Resident # 23).

The facility staff failed to ensure personal resident funds were available for withdrawal on the weekends, for Resident # 23.

Findings include:

On 02/07/18 09:04 AM, Resident # 23 was interviewed regarding resident funds and the availability of those funds. The resident stated that he can only get money from his account, five days a week, Monday through Friday. The resident was asked about the weekends, the resident stated that he was not able to get money out on the weekend, because there is no one in the office on the weekends. The resident stated that when he gets money out, Monday through Friday that they (business office) will give him a receipt when money is taken out.

The business office/receptionist area was observed and is located at the front of the building entrance/lobby area. Signage is posted in this area with banking hours and included

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information regarding weekend hours.

On 02/09/18 at approximately 1:00 p.m., the administrator was asked for a policy on resident funds and banking hours.

A policy titled, "Resident Personal Funds...Patient Fund Petty Cash Available on Weekends" was presented and reviewed and documented, "...Friday afternoon a specified amount of money is secured in a bank bag and given along with withdrawal book and Trial Balance report to assigned nursing personnel. Assigned nursing personnel and business office representative will count and verify amount of money in bag. Nursing will lock money...on a specific unit...on the unit the money is kept will be responsible for disbursing resident fund money. At shift change the money will be counted and the Weekend Resident Fund Cash Log will be completed by both nurses doing the narcotics count...Saturday/Sunday...money disbursed will have signed withdrawal slip with appropriate signatures...money will be kept in secure locked location at all times...Monday morning...all money, signed documentation and withdrawal book is returned to business office...money will be counted and verified by both nursing and business office personnel...withdrawals will be keyed into RFMS [Resident Fund Management System] and processed as usual..."

On 02/12/18 at 11:37 AM, the BOM (Business Office Manager) was interviewed regarding Resident # 23's personal funds. The BOM printed a statement for the last 6 months of the resident's personal funds, which displayed deposits, withdrawals, interest paid and account balances. The BOM was asked if money was

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available to this resident on the weekend, as indicated by the signage located in the lobby area and per the facility's policy. The BOM stated that she (herself) and the receptionist are able to give money to residents and write out receipts. As far as the weekend personal fund availability, the BOM stated that $30.00 in one dollar bills is put into a money bag and taken to the nursing unit on Friday afternoon. The BOM stated that if someone gets money out we will document, if not we just pick it up and count it on Monday morning.

The BOM was asked about record keeping and documentation regarding the facility's policy on required signatures and accounting of personal fund money on the weekends. The BOM stated, "There isn't a log or anything like that." The BOM stated that she did not have evidence that personal resident fund money was available on the weekends.

On 02/12/18 at approximately 4:30 p.m., the administrator and DON were made aware in a meeting with the survey team of the above information.

No further information and/or documentation was presented prior to the exit conference on 02/12/18 at 6:45 p.m., to evidence that residents were aware that personal fund money was available on the weekends or that personal fund money and/or accounting were provided on the weekends per the facility's policy.

F 567

F 568 SS=D Accounting and Records of Personal Funds
CFR(s): 483.10(f)(10)(iii)

§483.10(f)(10)(iii) Accounting and Records.

F 568

F568
Corrective Action(s):
The BOM and B.O. assistant have received inservice training on the requirement to provide Resident Fund

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	495321	A. BUILDING _____ B. WING _____	C 02/12/2018

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(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.
(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.
(C)The individual financial record must be available to the resident through quarterly statements and upon request.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and facility document review, the facility staff failed to ensure one of 21 residents in the survey sample were provided a quarterly personal fund statement.

The facility staff failed to ensure Resident # 23 was provided a personal fund banking statement, at least quarterly for accounting purposes.

Findings include:

On 02/07/18 09:04 AM, Resident # 23 was interviewed regarding resident funds and the availability of those funds. The resident stated that he can only get money from his account, five days a week, Monday through Friday. The resident was asked about receiving monthly or quarterly statements and the resident replied that he did not get anything like that. The resident stated that he will usually go up front and just ask them (business office) how much money he has and they will tell him. The resident stated that if he gets money out, the staff will write him out a receipt.

statements at least quarterly to the resident or the resident representative. Resident #23 and the resident representative have been made aware of the personal Fund policy and the most recent resident fund statement was reviewed with resident #23 by the BOM. .

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have been potentially affected. The BOM will meet with all residents and review the personal fund policy and their most recent Resident fund statement.

Systemic Change(s);
Facility policy and procedure was reviewed and no changes are warranted at this time. The BOM will review the Resident Personal Funds policy with all new residents admitted to the facility to ensure they are aware of when and how to access their personal funds and when the resident fund quarterly statement is posted.

Monitoring:
The Business Office Manager is responsible for maintaining compliance. The Business Office Manager will review resident council minutes monthly and the grievance log weekly to monitor for any resident fund concerns. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.
Completion Date: **3/29/2018**

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On 02/09/18 at approximately 1:00 p.m., the administrator was asked for a policy on resident funds and banking hours.

A policy titled, "Resident Personal Funds" was presented and reviewed and documented, "...The individual financial record must be available to the resident through quarterly statements and upon request..."

On 02/12/18 at 11:37 AM, the BOM (Business Office Manager) was interviewed regarding Resident # 23's personal funds. The BOM printed a statement for the last 6 months of the resident's personal funds, which displayed deposits, withdrawals, interest paid and account balances. The BOM was asked if the resident receives this type of print out or a statement on a monthly or quarterly basis. The BOM stated that she does not print or give out statements, but if a resident wanted one she could do that. The BOM stated in regards to Resident # 23 he usually just comes up here and asks how much money he has. The BOM stated that corporate sends out a quarterly statement to either the resident and/or the resident's representative.

The BOM was informed of an interview with the resident and the resident's daughter (POA) and both stated that they had not received any type of personal resident money fund statement.

On 02/12/18 at approximately 4:30 p.m., the administrator and DON were made aware in a meeting with the survey team of the above information.

No further information and/or documentation was

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presented prior to the exit conference on 02/12/18 at 6:45 p.m., to evidence that Resident # 23 and/or his representative was provided with a quarterly resident personal fund statement, as indicated in the facility's policy.

F 568

F 580 Notify of Changes (Injury/Decline/Room, etc.)
SS=D CFR(s): 483.10(g)(14)(i)-(iv)(15)

§483.10(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 as specified in §483.10(e)(6); or

F 580

F580
Corrective Action(s)
Resident #259 is no longer in the facility. Resident #259's attending physician has been notified that facility failed to notify the physician that a wound vac was unavailable when the resident was admitted to the facility. A Facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All new admissions requiring wound care may have potentially been affected. The DON, Unit Manager and/or QA Nurse will review the last 60 days of admissions to identify any residents that did not have physician ordered wound care performed because of equipment or treatment unavailability. All negative findings will be corrected at the time of discovery and the attending physician and RP's will be notified. A facility Incident & Accident form will be completed for each incident identified.
Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source document for communicating changes in condition, status, proper notification to the attending physicians and the responsible parties and revision/updates to the comprehensive

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F 580	Continued From page 15 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to notify the attending physician that a wound vac was not available for one of 21 residents, Resident #259. Resident #259 was admitted to the facility with orders for a wound vac to treat a Stage IV pressure ulcer. The wound vac was not put into place for two days. The facility staff did not notify the attending physician that the wound vac was unavailable. The findings include: Resident #259 was admitted to the facility on 06/14/2017 with the following diagnoses, but not limited to: Stage IV pressure ulcer of left ankle, Spinal stenosis, Chronic Ischemic Heart Disease, hypertension and SIADH (syndrome of	F 580	plan of care. The 24 Hour Report will be reviewed and initialed daily by the Administrator, DON and Unit Manager. The Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of the facility policy and procedure. The inservice will include staff education on Physician and RP notification for any change in resident status, medications, treatments or equipment issues to prevent a delay treatment for new admissions while promoting continuity of care. **Monitoring:** The DON and QA Nurse are responsible for maintaining compliance. All new admission and readmission residents will be reviewed by the QA nurse or Unit Manager the next business day to monitor for compliance with physician ordered treatment plan. All Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date:**	3/29/2018

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inappropriate antidiuretic hormone secretion). Resident #259 was discharged from the facility on 06/17/2017, no MDS (minimum data set) information was obtained.

The clinical record was reviewed beginning 02/07/2018.

Discharge instructions from the hospital were reviewed. Under the section "Wound Care", the following was documented: "Wound vac changed on Mon, Wed, Fri. Duoderm dressing changed on Mon and Fri."

The facility physician orders were reviewed. There were no orders on the clinical record for a wound vac. The care plan was reviewed. There were no interventions on the initial care plan regarding Resident #259's wound, wound vac or wound care.

Additional documentation regarding Resident #259 was requested from the local hospital and received on 02/08/2018. Included in information received was an email between the hospital discharge planner and the facility's admission director. Included in the email was the following information: "Hospital discharge planner: 'Also, [name of Resident #259] will still need her wound vac when she comes to you. Just a head's up' [smiley face symbol]. Facility admissions director: 'Perfect- she will be in room 38 A and [name of physician] will be her attending' [smiley face symbol]"

At approximately 1:50 a.m., the wound nurse was interviewed regarding Resident #259's wound vac. She stated, " We didn't know that she was coming with a wound vac...The hospital didn't

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send the wound vac with her...they rent them from a company and didn't know how to transfer the rental from the hospital to here...We got orders for a wet to dry dressing. We called [name of company] to get a wound vac here but they said we wouldn't get it until the 16th so [name of admissions person] went and got it. I looked there is no documentation in the record that we contacted the physician..we should have contacted the doctor on June 14th when she got her...I don't see that documented but we did get an order for the wet to dry dressing on June 15th."

A note from the attending physician was observed. The note written 06/16/2017 contained the following information: Jun 16, 2017 Fri 11:40 a.m. 89 year old WF admitted after acute hospitalization for encephalopathy, pressure ulcer with cellulitis, hyponatremia....had been receiving care for an anterior tibial ulcer with unna boots. Developed pressure area anterior ankle...was admitted [to the hospital] for IV antibiotics and wound care...she was treated with a wound vac. Had an appt with vascular 6/12 and planned debridement then wound vac for a few weeks again before graft. She has not had wound vac on since Wednesday [06/14/2017]. Facility not aware that she required one. MD at site [facility] changed dressings to wet to dry and wound vac ordered. At facility now. ...Will admit for wound care. Wound vac in place at this point. Elevate LE..."

On 02/12/2018 at approximately 3:30 p.m., the attending physician for Resident #259 was interviewed via telephone. She was asked about Resident #259's wound and the care provided at the facility. She stated, "I did the admission

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F 580	Continued From page 18 exam on June 16...I didn't know about the wound vac...I wasn't contacted that the wound vac wasn't there...the admission coordinator and the DON decide if a patient can come to the facility and they are accepted if we can provide the care needed." The attending physician was asked if she felt Resident #259 was provided the care needed and if she should have been accepted to the facility. She stated, "No, she should not have been admitted...when it was determined that there was no available wound vac she should have been sent back to the hospital...no one contacted me...they contacted [name of another physician] and he gave them patch through orders until the wound vac could arrive." No further information was received prior to the exit conference on 02/12/2018.	F 580		
F 620 SS=D	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.	F 620	F620 **Corrective Action(s)** Resident #259 is no longer in the facility. Resident #259's attending physician has been notified that facility failed to follow the admission process for admitting new residents and ensuring equipment was available as needed to provide treatment. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All new admissions may have potentially been affected. The DON, Unit Manager and/or QA Nurse will review the last 60 days of admissions to identify any residents that did not have physician ordered care performed because of equipment or treatment unavailability. All negative findings will be corrected at the time of discovery and the attending	

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§483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the

physician and RP's will be notified. A facility Incident & Accident form will be completed for each incident identified.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. The Hospital and preadmission Admission referral package serves as the source document for communicating information about new admissions and care and treatment needs for all new admissions. The Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Admission process and the need to verify and clarify special orders or equipment needs prior to new admission residents arriving at the facility. The inservice will include staff education on Physician and RP notification for any change in resident status, medications, treatments or equipment issues to prevent a delay treatment for new admissions while promoting continuity of care.

Monitoring:
The DON and QA Nurse are responsible for maintaining compliance. All new admission and readmission residents will be reviewed by the QA nurse or Unit Manager the next business day to monitor for compliance with physician ordered treatment plan. All Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice.

Completion Date: **3/29/2018**

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facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

§483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

§483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, facility staff failed to implement their admissions policy for one of 21 residents, Resident #259.

Facility staff were unable to provide treatments as ordered for a newly admitted resident, Resident #259. Resident #259 was admitted to the facility with orders for a wound vac to treat a Stage IV pressure ulcer. The wound vac was not available at the time of admission and was not put into place for two days.

Findings were:

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Resident #259 was admitted to the facility on 06/14/2017 with the following diagnoses, but not limited to: Stage IV pressure ulcer of left ankle, Spinal stenosis, Chronic Ischemic Heart Disease, hypertension and SIADH (syndrome of inappropriate antidiuretic hormone secretion). Resident #259 was discharged from the facility on 06/17/2017, no MDS (minimum data set) information was obtained.

The clinical record was reviewed beginning 02/07/2018.

Discharge instructions from the hospital were reviewed. Under the section "Wound Care", the following was documented: "Wound vac changed on Mon, Wed, Fri. Duoderm dressing changed on Mon and Fri."

The facility physician orders were reviewed. There were no orders on the clinical record for a wound vac. The care plan was reviewed. There were no interventions on the initial care plan regarding Resident #259's wound, wound vac or wound care.

Additional documentation regarding Resident #259 was requested from the local hospital and received on 02/08/2018. Included in information received was an email between the hospital discharge planner and the facility's admission director. Included in the email was the following information: "Hospital discharge planner: 'Also, [name of Resident #259] will still need her wound vac when she comes to you. Just a head's up' [smiley face symbol]. Facility admissions director: 'Perfect- she will be in room 38 A and [name of physician] will be her attending' [smiley face symbol]"

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On 02/09/2018 at approximately 11:30 a.m., LPN (Licensed Practical Nurse) #4 was interviewed regarding the admission note she wrote on 06/14/2017. She was asked specifically about the reference to "wound vac noted to L ankle ulcer" in her note. She stated, "I remember that because I got a corrective action for what I wrote...the wound vac wasn't here...the dressing was there and the tubing was in place at admission but there wasn't a wound vac and there wasn't one here...they didn't send one from the hospital with her...we called the doctor and he said it was Ok to place it [the wound vac] the next day...I documented the wound vac was there but it was really just the dressing..." LPN #4 reviewed the documentation in the clinical record. She stated, "We got an order to do a wet to dry dressing on June 15...I don't remember if she ever got the wound vac or not." LPN #4 was asked how she knew what a resident was going to need when they arrived at the facility. She stated, "We get information from admissions about who's coming, their name and room they are going to." LPN #4 was asked how the facility got admission orders. She stated, "We get them from the hospital discharge summary." LPN #4 was asked if anyone contacted the hospital to let them know that a wound vac was not on site. She stated, "I don't see anything about it in the documentation and I don't know who notified them that we didn't have a wound vac, but I'm pretty sure we contacted the hospital."

At approximately 1:50 a.m., the wound nurse was interviewed regarding Resident #259's wound vac. She stated, " We didn't know that she was coming with a wound vac...The hospital didn't send the wound vac with her...they rent them

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from a company and didn't know how to transfer the rental from the hospital to here...We got orders for a wet to dry dressing. We called [name of company] to get a wound vac here but they said we wouldn't get it until the 16th so [name of admissions person] went and got it. I looked there is no documentation in the record that we contacted the physician..we should have contacted the doctor on June 14th when she got her...I don't see that documented but we did get an order for the wet to dry dressing on June 15th."

LPN # 1 (MDS) was interviewed at 12:45 p.m. She stated, "I don't know who reviewed the admission information before she [Resident #259] got here. We didn't know she had a wound vac...the admitting nurse documented that there was a wound vac in place but it was really just the dressing...the hospital wouldn't give us their wound vac so [name of supply person] contacted whoever we get our equipment from...she got a wound vac through a company in Salem so [name of former admissions director] went and got it." LPN #1 was asked if she felt the facility should have sent the resident back to the hospital since they didn't have the proper equipment in house to care for her. She stated, "Yes, we should have." LPN #1 was asked about Resident #259's care plan. She stated, "She wasn't here for 14 days so the comprehensive care plan was not done...the initial care plan should have included the wound care and the wound vac."

A note from the attending physician was observed. The note written 06/16/2017 contained the following information: Jun 16, 2017 Fri 11:40 a.m. 89 year old WF admitted after acute hospitalization for encephalopathy, pressure ulcer

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with cellulitis, hyponatremia....had been receiving care for an anterior tibial ulcer with unna boots. Developed pressure area anterior ankle...was admitted [to the hospital] for IV antibiotics and wound care...she was treated with a wound vac. Had an appt with vascular 6/12 and planned debridement then wound vac for a few weeks again before graft. She has not had wound vac on since Wednesday [06/14/2017]. Facility not aware that she required one. MD at site [facility] changed dressings to wet to dry and wound vac ordered. At facility now. ...Will admit for wound care. Wound vac in place at this point. Elevate LE..."

On 02/12/2018 at approximately 3:30 p.m., the attending physician for Resident #259 was interviewed via telephone. She was asked about Resident #259's wound and the care provided at the facility. She stated, "I did the admission exam on June 16...I didn't know about the wound vac...I wasn't contacted that the wound vac wasn't there...the admission coordinator and the DON decide if a patient can come to the facility and they are accepted if we can provide the care needed." The attending physician was asked if she felt Resident #259 was provided the care needed and if she should have been accepted to the facility. She stated, "No, she should not have been admitted...when it was determined that there was no available wound vac she should have been sent back to the hospital...no one contacted me...they contacted [name of another physician] and he gave them patch through orders until the wound vac could arrive."

The facility policy on admissions was requested and received. The policy, "Admissions Criteria" was reviewed. Per the facility policy, "Residents

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F 620	Continued From page 25 will be admitted to this facility as long as their nursing and medical needs can be met adequately by the facility..." The administrator was asked if he felt the policy had been followed for Resident #259. He shook his head side to side. The above information was discussed during an end of the day meeting on 02/12/2018. No further information was received prior to the exit conference on 02/12/2018.	F 620		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655	**F655** **Corrective Action(s):** Resident #259 is no longer in the facility. Resident #259's attending physician was notified that the facility failed to develop a base line care plan for resident #259 with 48 hours of admission. A Facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents without a base line care plan within 48 hours of admission. All residents identified with base line care plans developed after 48 hours of admission will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs and the attending physician and RP will be notifed. A Facility Incident & Accident Form will be completed for each incident identified.	

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F 655	Continued From page 26	F 655	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development and implementation process of base line care plan within 48 hours of admission. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	**3/29/2018**

care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, facility staff failed to develop a baseline care plan for one of 21 residents, Resident #259.

Resident #259 was admitted to the facility on 06/14/2017 and discharged on 06/17/2017. A baseline care plan was not developed to address her wound care, wound vac or her 1000 cc fluid restrictions.

Findings were:

Resident #259 was admitted to the facility on 06/14/2017 with the following diagnoses, but not limited to: Stage IV pressure ulcer of left ankle, Spinal stenosis, Chronic Ischemic Heart Disease, hypertension and SIADH (syndrome of

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inappropriate antidiuretic hormone secretion). Resident #259 was discharged from the facility on 06/17/2017, no MDS (minimum data set) information was obtained.

The clinical record was reviewed beginning 02/07/2018.

Discharge instructions from the hospital were reviewed. Under the section "What To Do At Home", the following was listed: "Fluid Restrictions: 1 liter fluid restriction" and under "Wound Care", the following was documented: "Wound vac changed on Mon, Wed, Fri. Duoderm dressing changed on Mon and Fri."

The baseline care plan was reviewed. There were no interventions on the initial care plan regarding Resident #259's wound, wound vac, wound care, or fluid restrictions.

LPN # 1 (MDS) was interviewed at 12:45 p.m. LPN #1 was asked about Resident #259's care plan. She stated, "She wasn't here for 14 days so the comprehensive care plan was not done...the initial care plan should have included the wound care, the wound vac and the 1 liter fluid restrictions.."

The above information was discussed with the DON and the administrator during an end of the day meeting on 02/12/2018.

No further information was received prior to the exit conference on 02/12/2018.

F 656 SS=D Develop/Implement Comprehensive Care Plan
CFR(s): 483.21(b)(1)

F 656

F 656
Corrective Action(s):
Resident #23 comprehensive care plan has been reviewed and revised to reflect

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§483.21(b) Comprehensive Care Plans
§483.21(b)(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).
(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

F 656 appropriate goals. interventions and approaches to address the residents specific dementia needs. A Facility Incident & Accident Form was completed for this incident. Resident #15 no longer resides in the facility.

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, Unit Manager, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.

Monitoring:
The RCC and DON are responsible for

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requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to develop a CCP (comprehensive care plan) for two of 21 residents in the survey sample, Resident # 23 and Resident # 15 for dementia care.

1. The facility staff failed to develop a CCP (comprehensive care plan) for dementia for Resident # 23.

2. The facility staff failed to a CCP for Resident # 15 for dementia care and services.

Findings include:

1. The facility staff failed to develop a CCP (comprehensive care plan) for dementia for Resident # 23.

Resident # 23 was admitted to the facility on 07/23/16. Diagnoses included, but were not limited to: difficulty walking, muscle weakness, transient cerebral ischemic attack, atrial fibrillation, high blood pressure, aortic stenosis, CHF (congestive heart failure), and unspecified dementia.

The most recent MDS (minimum data set) was a quarterly assessment dated 12/19/17. This MDS assessed the resident as having a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also coded on this MDS as having dementia in Section I. Neurological I4800.

F 656 maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: 3/29/2018

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During clinical record review Resident # 23 was reviewed for dementia. The resident had a diagnoses of dementia and was being seen by psych services. The resident was prescribed and antipsychotic medication, which did evidence gradual dose reductions.

Resident # 23's CCP was reviewed and did not have any information/documentation regarding the resident's diagnoses of dementia. The resident's CCP did have information regarding 'mood/well being' and included interventions of, 'socialization, encourage resident to talk about feelings, encourage participation in activities, and to approach in a warm friendly manner.'

On 02/12/18 at approximately 10:00 a.m., the administrator and DON (director of nursing) were made aware of the above information and was asked for assistance in determining why the resident did not have a CCP for dementia.

No information and/or documentation was presented to explain why Resident # 23 did not have a CCP for the care of dementia.

2. The facility staff failed to develop a comprehensive care plan (CCP) to address dementia care for Resident # 15.

Findings include:

Resident # 15 was admitted to the facility 10/25/06 with a readmission date of 12/24/13. Diagnoses for Resident # 15 included, but were

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not limited to: unspecified dementia with behavioral disturbance, legal blindness, cognitive communication deficit, osteoarthritis, and anxiety.

The most recent MDS (minimum data set) was a quarterly review dated 12/5/17 and had Resident # 15 with moderate impairment in cognition with a total summary score of 8 out of 15.

The clinical record was reviewed 2/8/18 at 3:00 p.m. A review of the care plan for Resident # 15 did not include any identified area for dementia care to include goals/interventions. Nurses' notes were noted to document Resident # 15's dementia, and some behavior related yelling out at night. There were no interventions developed to address behaviors related to dementia, such as any non-pharmacological interventions to calm the resident, or redirect her behavior.

On 2/12/18 at 10:45 the DON (director of nursing) was asked about the care plan. It was noted the care plan addressed the resident's Mood/communication/cognitive status with regard to safety awareness, and also addressed the resident's fall precaution/vision/psychotropic medication use with interventions for "staff to orient resident as needed throughout the shift." The DON was asked what the intervention was specifically. The DON stated "I really don't know what that is, either. It really doesn't describe what that means to orient the resident with regard to her dementia, which is most likely why she is yelling out at night." The DON was in agreement the care plan should have included how staff were going to address dementia care for the resident.

No further information was provided prior to the

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F 656	Continued From page 32 exit conference. F 657 Care Plan Timing and Revision SS=D CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the the CCP (comprehensive care plan) for three of 21 residents in the survey sample, Resident # 23, Resident # 34 and Resident # 35.	F 656		
F 657	**F-657** **Corrective Action(s):** Resident #23's comprehensive cares plan has been reviewed and revised to reflect his current TED hose orders and use. A Care Plan conference was held with Resident #23 and Resident #23's Representative to review his comprehensive plan of care. A copy of the care plan was given to the resident representative. A Facility Incident & Accident Form was completed for this incident. Resident #34's comprehensive care plan has been reviewed and revised to reflect specific interventions and approaches for Suprapubic catheter care to be performed, proper catheter bag and catheter tubing placement. A Risk Management Incident & Accident Form was completed for this incident. Resident #35's comprehensive care plan has been reviewed and revised to reflect the resident's cognitive decline and their current cognitive status. A Risk Management Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk	

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F 657	Continued From page 33	F 657	Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	**3/29/2018**

1a. The facility staff failed to review and revise the CCP for Resident # 23 related to bilateral TED hose.

1b. The facility staff failed to ensure Resident # 23 and his daughter (POA) were invited to the resident's CCP meetings.

2. The facility staff failed to review and revise the CCP for Resident # 34 related to foley catheter care.

3. The facility staff failed to review and revise the CCP for Resident # 35 for a change in cognition.

Findings include:

1a. The facility staff failed to review and revise the CCP for Resident # 23 related to bilateral TED hose.

Resident # 23 was admitted to the facility on 07/23/16. Diagnoses included, but were not limited to: difficulty walking, muscle weakness, transient cerebral ischemic attack, atrial fibrillation, high blood pressure, aortic stenosis, and CHF (congestive heart failure).

The most recent MDS (minimum data set) was a quarterly assessment dated 12/19/17. This MDS assessed the resident as having a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance for most ADL's (activities of daily living) including dressing and hygiene.

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Resident #23 was observed and interviewed on 02/07/18 09:31 AM in his room. The resident was sitting in his w/c and had bilateral hand/arm protectors on. An area on resident's left, first knuckle (approximately the size of a quarter) was scabbed with redness around the area.

The resident's legs were observed and appeared swollen. The resident stated that they were and pulled up his left pant leg, exposing his lower left leg. The resident's leg was a dark ruddy color with edema noted. The resident then pulled up his right pant leg and stated, "This one's not as bad."

02/07/18 11:00 AM Resident # 23 physician's order included an order for TED hose on in am (morning) off at hs (bedtime). The resident was observed 02/06/18 through 02/09/18 on multiple occasions without the physician ordered TED hose on.

02/09/18 11:54 AM Resident #23 was interviewed regarding the TED hose and his leg swelling. The resident stated that he wanted to get back on his feet and wanted the swelling in his legs to go down and asked what he could do about it. The resident was asked if he had TED hose for his legs for the swelling. The resident stated, "No." The resident was informed that he had an order for TED hose for swelling. The resident was asked if he knew that he had them. The resident stated that he did not know that. The resident was asked if staff had been putting them on him or attempting to put them on him. The resident stated, "No." The resident was then asked if, staff had asked him or attempted to put on the TED hose and again the resident stated,

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no. The resident was asked if staff had offered to put the TED hose on him and he refused or told staff that he did not want them. The resident stated, no again and again verbalized that he wanted to get it 'worked on' and he would be willing to try them, but the TED hose had not been offered.

On 02/09/18 11:58 AM LPN (Licensed Practical Nurse) # 2 was interviewed and asked if Resident # 23 had an order for TED hose. The LPN looked in the computer and stated that the resident does have a current order for TED hose. The LPN was asked who the resident's CNA (certified nursing assistant) was this morning or who had got him up this morning. The LPN stated that the night shift get him up and she was not sure who that was. The LPN was then asked, where the documentation for the TED hose application would be. LPN # 2 asked LPN # 3 who was standing at the nurses station, 'would that be in the CNA documentation' and then asked, 'where is the documentation for that?' LPN # 3 stated, 'the nurses do it.' Both LPN's were then asked if that would on the MAR (medication administration record) or the TAR (treatment administration record). LPN # 3 stated that it is on the TAR. LPN # 2 was then asked for a copy of the TAR for February for the TED hose application for Resident # 23.

The resident has been observed through out the survey process from 02/06/18 up to present 02/09/18 12:06 PM without any TED hose on. The TAR documented (with staff initials) giving the indication that the TED hose had been applied and removed as ordered for each day of the month of February (1st through 9th). The resident did not had the TED hose applied during

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multiple observations throughout the survey process on 02/06/18 through 02/09/18.

Nursing notes were then reviewed for the month of February, no information and/or documentation was found regarding the resident's TED hose application, removal of and/or refusal. The CCP was reviewed and documented in several 'problem areas' that the resident is to have bilateral TED hose per physician's orders for edema. The resident's CCP had old information regarding TED hose, which included "...8/26 [17] No TED hose to RLE [right lower extremity] until wound resolved...TED hose per current order..." The resident's last update on the CCP for TED hose was dated on 08/26/17. The resident did not have any current wound on his legs.

1b. The facility staff failed to ensure Resident # 23 and his daughter (POA) were invited to the resident's CCP meetings.

Resident # 23 was interviewed on 02/07/18 at 09:10 a.m. regarding CCP meeting and was asked if he is invited to have input into his plan of care. The resident stated that his daughter helps him out with all of this and stated that he didn't go any meetings like that. The resident was asked if he had been invited to any of his CCP meeting and the resident stated that he hasn't been invited to any care plan meetings and wasn't sure if his daughter attended these meeting or not.

No information and/or documentation was found to evidence that the resident or the resident's daughter had been invited to the resident's CCP meetings.

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On 02/12/18 01:49 p.m. an interviewed was conducted with Resident # 23 and his daughter (the resident's POA), the daughter stated that she had received invitations in the past regarding her father's CCP meeting, when he was first admitted, but had not been getting invitations for quite some time, and further stated that she felt it may be due to her father being a long term care resident now.

The above information was shared with the DON (director of nursing) and the administrator in a meeting with the survey team on 02/12/18 at approximately 4:30 p.m.

No further information and/or documentation was presented prior to the exit conference on 02/12/18 at 6:45 p.m. to evidence that the resident and or resident's daughter had been invited to attend CCP meetings for Resident # 23.

2. Resident # 34 was admitted to the facility on 01/06/16. Diagnoses for Resident # 34 included, but were not limited to: heart disease, dementia, diabetes, peripheral vascular disease, contractures of the knees, myelodysplastic syndrome, bladder outlet obstruction with permanent supra pubic catheter placement.

The most recent MDS (minimum data set) was a quarterly assessment dated 01/08/17. This MDS assessed the resident with short and long term memory impairment daily decision making skills and as requiring extensive assistance from staff for all ADL's (activities of daily living).

Observations of Resident #34 showed the following:

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02/06/18 at 10:16 AM, Resident #34 was observed in laying in a low bed with bilateral 1/4 grab bars. Resident's bed against wall, with a fall mat down on other side of bed. A bed alarm attached to bed, foley catheter bag hanging on side of bed frame with privacy bag, resting on the fall mat. Clear urine seen in the bag. The resident is covered and eyes are closed.

02/06/18 at 11:53 AM Resident is up in wheelchair, socks on feet right. The resident's foley bag hanging just below bladder level, hanging from side of w/c with privacy bag in place.

02/08/18 at approximately 8:40 a.m., resident observed in low bed with foley catheter bag resting on the fall mat beside of bed.

02/12/18 at 08:10 a.m. the resident was observed in the low bed with the foley catheter bag hanging on the side of the bed on the 1/4 grab bar. The foley catheter was not on the floor and was not resting on the fall mat.

On 02/12/18 at 08:53 a.m., the facility's policy for foley catheter care was requested from the DON (director of nursing).

On 02/12/18 at 08:54 AM A policy was presented for review on foley catheter care. The policy stated, "...Be sure the catheter tubing and drainage bag are kept off the floor..."

Resident # 34's CCP was reviewed and documented, "...Change catheter drain bag per order...catheter care per facility policy [did not specify care]...assist resident with proper

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placement of catheter drainage bag below level of bladder...remind as needed..." The CCP did not mention to keep the resident's foley catheter bag off the floor, as listed in the facility's policy. The resident's last CCP update was listed as 10/09/2017.

The DON and administrator were made of the above information on 02/12/18 at approximately 10:00 a.m. regarding the observations of Resident # 34 and that the resident's CCP had not been reviewed and revised. Both administrator and DON were made aware that the resident's bed is practically on the floor and does not leave a lot of room for proper placement and drainage of the foley bag. The administrator and DON agreed.

No further information and/or documentation was presented prior to the exit conference on 02/12/18 at 6:45 p.m.

3. Resident (R 35) care plan was not revised to include a change in cognitive status.

R 35 was admitted to the facility on 6/30/16 with a readmission on 12/15/17 with diagnoses that included Dementia, and cognitive deficit.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/9/18. R 35 was assessed as having short and long-term memory problems and being severely cognitively impaired.

R 35's electronic record was reviewed on 2/12/18. According to a annual MDS with an ARD of 5/1/17, R 35 was assessed cognitively as being

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intact with a score of 13 of 15. Further review of R 35's MDS's, a 5 day MDS was reviewed with an ARD of 9/26/17, indicating that R 35 had a decline in cognitive status and was assessed as having short and long term memory problems and being severely cognitively impaired.

All other MDS's were reviewed after the 5 day MDS and evidenced the same findings in cognitive status, including the most recent assessment.

Review of R 35's care plan documented a cognitive care plan was initiated on 5/3/17 and had no revisions to the original care plan even though there was a significant decline in cognition.

On 02/12/18 at 08:36 AM the MDS coordinator was interviewed regarding the change in cognitive status. After reviewing R 35's information the MDS coordinator verbalized that the care plan should have been updated to reflect the change in cognitive status.

On 2/12/18, the above finding was brought to the attention of the director of nursing and administrator during a meeting.

No further information was presented prior to exit conference on 2/12/18.

F 684 Quality of Care
SS=G CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive

F 684

F684
Corrective Action(s):
Resident #108 is no longer at the facility. Resident 108's attending physician was notified that the facility failed to check meal consumption prior to administering nighttime insulin. A facility Medication Error form was completed for this incident.

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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.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and in the course of a complaint investigation, the facility failed to ensure one of 21 residents in the survey sample's meal intake was assessed prior to administration of insulin resulting in harm Resident # 108; and also failed to follow physician orders for two of 21 residents: Resident # 259 and # 23.

1. Resident # 108 was administered Lantus (a long-acting insulin) at 8:00 p.m. without assessment of meal intake resulting in a hypoglycemic extremely low blood sugar) event which resulted in hospitalization and harm.

2. Resident # 259's physician ordered fluid restriction was not monitored.

3. Resident # 23 did not have TED hose applied as ordered by the physician.

Findings include:

1. Resident # 108 was administered 27 units of Lantus, a long-acting insulin, without being assessed for meal intake which resulted in harm. Resident # 108 was sent to the emergency room (ER) with loss of consciousness after being found at 1:20 a.m. on 11/11/17 with a blood sugar reading of 33.

Resident #259 is no longer at the facility. Resident #259's attending physician was notified that the facility staff failed to assess and monitor resident #259's physician ordered 1000cc fluid restriction while at the facility. A facility Incident & Accident form was completed for this incident.

Residents #23's attending physician was notified that the facility failed to apply and remove physician ordered TED hose as ordered for resident#23. A facility Incident and Accident form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):
All other residents receiving Insulin at Night, On fluid restriction and/or have physician ordered TED hose may have been potentially affected. The DON, Unit Manager and/or QA nurse will conduct a 100% audit of all resident's current physician orders, MAR's, TAR's and Meal consumption records to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains

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Resident # 108 was admitted to the facility 12/3/13 with a readmission date of 11/7/17. It should be noted here Resident # 108 signed herself out AMA (against medical advice) 11/14/17.

There was no MDS (minimum data set) information available as Resident # 108 was in the facility less than 14 days for completion of an admission assessment. Resident # 108 was assessed by nursing staff as alert with some confusion but able to make needs known.

During review of the clinical record 2/8/18 at approximately 2:00 p.m. it was noted a nurses' note dated 11/11/17 at 4:52 a.m. " 1:20 a.m. resident found to be sweeting (sic) and unresponsive. Blood sugar 33. one unit dose of glucagon administered. 1:40 a.m. blood sugar 54, loc (level of consciousness) unchanged, breathing uneven and labored. vs (vital signs): 184/85 bp, 69 pulse, 12 respiration, 97.5 temp, 87% oxygen (O2) . Oxygen 2 lpm (liters per minute) administered via nasal cannula. 1:50 a.m. blood sugar 72, remains unresponsive. Covering physician (name of physician) telephone order to send to ER. Transported to hospital at 2:10 a.m. via ambulance. Resident was not appropriately responsive or alert when she left facility. ER staff informed of pending arrival and status. Daughter, second listed for RP, notified of having been sent to ER. 4 am informed by ER staff of pending return, having had administered box lunch and ensure. Attending physician recommends primary physician review insulin orders, with attention to administration when refusal to eat meal. Resident returned to facility with daughter via personal car. 5:20 am refused vitals. Blood sugar 329, O2 89% placed on 2 lpm

the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders and monitoring meal consumption. This includes assessing meal consumption prior to Insulin administration, Monitoring Fluid intake and the application of TED hose. The DON and/or Regional nurse consultant will inservice licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders as well as performing physician ordered monitoring and follow up per physician orders.
C.N.A. staff will be inserviced by the DON or regional Nurse consultant on the procedure for reviewing and recording meal consumption percentages for each

meal and the expectation to notify the charge nurses if any resident refuses their meal.

Monitoring:
The DON will be responsible for maintaining compliance. The DON, Unit Manager and/or QA nurses will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: **3/29/2018**

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concentrator O2 via nasal cannula. Resident alert and oriented to person and place, with appropriate response and interactions. will continue to observe."

The meal intake roster was then reviewed and revealed the resident was documented as having eaten 5% - 25% of breakfast and lunch 11/10/17, and had refused dinner. Documented out from the refusal to eat dinner was in large type "NOTIFY NURSE." Further review of the clinical record failed to reveal if the nurse was notified of the resident refusing dinner, or the nurse verifying with the resident the meal consumption, or documentation from the physician regarding the event, including any changes in insulin administration with regards to the resident refusing meals.

On 2/9/18 at approximately 10:45 a.m. the hospital records were reviewed for the ER visit 11/11/17. The attending physician documented the admitting diagnoses as "Hypoglycemia due to insulin..... Pt. from (name of facility), complaint of hypoglycemia, blood sugar 33, pt given glucagon, blood sugar up to 72. Pt. placed on O2 for pulse ox of 87% per nursing home staff. O2 98% on arrival Blood sugar 84 by accucheck. Pt. awake and moaning on arrival.....Pt. ate entire ensure, half sandwich and most of pineapple cup. States didn't have supper this past evening." Discharge documentation included "Have PMD (primary medical doctor) review dietary and insulin requirements. Do a point of care glucose meter prior to administration of insulin. (Do not administer insulin if patient is not eating)."

On 2/12/18 at 10:45 a.m. the DON (director of nursing) was made aware of the above findings.

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The DON reviewed the clinical record and stated "Yes, looks like that's exactly what happened." This surveyor asked the DON for the following information: did staff notify the nurse of resident refusing dinner 11/10/17, did the nurse verify meal status prior to administration of insulin, and did the physician review insulin orders. The DON stated she would see what she could find out and get back to me.

On 2/12/18 at 4:00 p.m. the DON told this surveyor "I cannot find any other information about the nurse being told the resident did not eat her dinner. I have paged the doctor but have not heard from her yet. It doesn't appear the nurse knew the resident didn't eat, and it doesn't appear the nurse asked the resident about her meal intake before giving the insulin; one staff is only here occasionally and unable to reach the other staff. I hate it, but it looks like it went exactly as you have found."

On 2/12/18 during a meeting with facility staff beginning at 4:30 p.m. the administrator and DON were informed of the above findings and the concern of resultant harm to the resident. The administrator and DON verbalized understanding.

No further information was provided prior to the exit conference.

2. Facility staff failed to assess and monitor a physician ordered 1000 cc fluid restriction for Resident #259.

Resident #259 was admitted to the facility on

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06/14/2017 with the following diagnoses, but not limited to: Stage IV pressure ulcer of left ankle, Spinal stenosis, Chronic Ischemic Heart Disease, hypertension and SIADH (syndrome of inappropriate antidiuretic hormone secretion). Resident #259 was discharged from the facility on 06/17/2017, no MDS (minimum data set) information was obtained.

The clinical record was reviewed beginning 02/07/2018.

Discharge instructions from the hospital were reviewed. Under the section "What To Do At Home", the following was listed: "Fluid Restrictions: 1 liter fluid restriction".

The baseline care plan was reviewed. There were no interventions on the initial care plan regarding fluid restrictions.

The physician order sheet for June 2017 contained the following order: "6/14/2017 1 liter [1000 cc] fluid restriction".

The TAR [treatment administration record] and the MAR [medication administration record] for June was reviewed. There were no entries on either regarding Resident #259's fluid restrictions.

On 02/12/2018 the DON (director of nursing) was asked how fluid restrictions were monitored at the facility. She stated that there was an intake and output flow sheet that the staff completed. She stated she would look to see what she could find for Resident #259.

The DON came to the conference room at approximately 9:00 a.m. and stated, "You're not

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gonna like what I have to say, but I can't find anything showing where her [Resident #259] fluid intake was tracked." The DON was asked what the expectation was for a Resident ordered a 1000 cc fluid restriction. She stated, "They need to write it down and track it."

The above information was discussed with the DON and the administrator during an end of the day meeting on 02/12/2018.

No further information was received prior to the exit conference on 02/12/2018.

3. The facility staff failed to ensure Resident # 23's physician ordered TED hose were applied to bilateral lower extremities.

Resident # 23 was admitted to the facility on 07/23/16. Diagnoses included, but were not limited to: difficulty walking, muscle weakness, transient cerebral ischemic attack, atrial fibrillation, high blood pressure, aortic stenosis, and CHF (congestive heart failure).

The most recent MDS (minimum data set) was a quarterly assessment dated 12/19/17. This MDS assessed the resident as having a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance for most ADL's (activities of daily living) including dressing and hygiene.

Resident #23 was observed and interviewed on

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02/07/18 09:31 AM in his room. The resident was sitting in his w/c and had bilateral hand/arm protectors on. The resident's legs were observed and appeared swollen. The resident stated that they were and pulled up his left pant leg, exposing his lower left leg. The resident's leg was a dark ruddy color with edema noted. The resident then pulled up his right pant leg and stated, "This one's not as bad."

02/07/18 11:00 AM Resident # 23 physician's order included an order for TED hose on in am (morning) off at hs (bedtime). The resident was observed 02/06/18 through 02/09/18 on multiple occasions without the physician ordered TED hose on.

02/09/18 11:54 AM Resident #23 was interviewed regarding the TED hose and his leg swelling. The resident stated that he wanted to get back on his feet and wanted the swelling in his legs to go down and asked what he could do about it. The resident was asked if he had TED hose for his legs for the swelling. The resident stated, "No." The resident was informed that he had an order for TED hose for swelling. The resident was asked if he knew that he had them. The resident stated that he did not know that. The resident was asked if staff had been putting them on him or attempting to put them on him. The resident stated, "No." The resident was then asked if, staff had asked him or attempted to put on the TED hose and again the resident stated, no. The resident was asked if staff had offered to put the TED hose on him and he refused or told staff that he did not want them. The resident stated, no again and again verbalized that he wanted to get it 'worked on' and he would be willing to try them, but the TED hose had not

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been offered.

On 02/09/18 11:58 AM LPN (Licensed Practical Nurse) # 2 was interviewed and asked if Resident # 23 had an order for TED hose. The LPN looked in the computer and stated that the resident does have a current order for TED hose. The LPN was asked who the resident's CNA (certified nursing assistant) was this morning or who had got him up this morning. The LPN stated that the night shift get him up and she was not sure who that was. The LPN was then asked, where the documentation for the TED hose application would be. LPN # 2 asked LPN # 3 who was standing at the nurses station, 'would that be in the CNA documentation' and then asked, 'where is the documentation for that?' LPN # 3 stated, 'the nurse's do it.' Both LPN's were then asked if that would on the MAR (medication administration record) or the TAR (treatment administration record). LPN # 3 stated that it is on the TAR. LPN # 2 was then asked for a copy of the TAR for February for the TED hose application for Resident # 23.

The resident has been observed through out the survey process from 02/06/18 up to present 02/09/18 12:06 PM without any TED hose on. The TAR documented (with staff initials) giving the indication that the TED hose had been applied and removed as ordered for each day of the month of February (1st through 9th). The resident did not had the TED hose applied during multiple observations throughout the survey process on 02/06/18 through 02/09/18.

Nursing notes were then reviewed for the month of February, no information and/or documentation was found regarding the resident's TED hose

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F 684	Continued From page 49 application, removal of and/or refusal. The CCP (comprehensive care plan) was reviewed and documented in several 'problem areas' that the resident is to have bilateral TED hose per physician's orders for edema. The resident's CCP had old information regarding TED hose, which included "...8/26 [17] No TED hose to RLE [right lower extremity] until wound resolved...TED hose per current order..." The resident's last update on the CCP for TED hose was dated on 08/26/17. The resident did not have a current wound on either leg. The above information was shared with the DON (director of nursing) and the administrator in a meeting with the survey team on 02/12/18 at approximately 4:30 p.m. No information and/or documentation was presented prior to the exit conference on 02/12/18 at 6:45 p.m.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 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	F 686	**F686** **Corrective Action(s):** Resident #258 is no longer at the facility. Resident #258's attending physician is aware that the facility failed to assess resident #258's pressure injury for 10 days. Resident #259 is no longer at the facility. Resident #259's attending physician is aware that the facility failed to assess her pressure injury at admission and failed to apply a physician ordered wound vac to a pressure injury for 2 days after admission. Resident #56's physician was notified that the physician ordered Geri sleeves and Heel protectors were not applied as	

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of two complaint investigations, the facility staff failed to accurately assess and provide treatment and services for the prevention and/or healing of pressure ulcers for three of 21 residents (Resident #258, Resident # 259 and Resident #56), with resulting harm for one (Resident #258). This is a complaint deficiency.

1. Facility staff did not assess Resident #258's sacral wound for ten days. From 06/30/2017 until 07/10/2017, the wound increased from 2.60 cm X 1.30 cm X .10 cm to an unstageable with measurements of 7.0 cm X 5.0 cm X .10 cm. Additionally, when the assessment was completed on 07/10/2017, an additional seven Stage I pressure ulcers were assessed and documented on the facility wound assessment report. Two of the identified Stage I pressure ulcers progressed to Stage II pressure ulcers when reassessed on 07/14/2017.

2. Resident #259 was admitted to the facility with orders for a wound vac to treat a Stage IV pressure ulcer. The wound vac was not put into place for two days. The pressure ulcer was never assessed by the facility, nor did the facility notify the attending physician that the wound vac was unavailable.

3. Resident #56 was not wearing physician ordered geri sleeves or heel protectors.

Findings were:

ordered by the physician. Resident #56 has been re-assessed by nursing for compromised skin integrity and her preventative skin care orders have been reviewed. The comprehensive care plans have been updated to reflect the current preventative skin care approaches and interventions to prevent pressure injuries.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents identified at risk for compromised skin integrity or with pressure injuries may have been potentially affected. A 100% review of all residents utilizing the Braden Scale was conducted to identify residents at risk for skin breakdown. Additionally, a visual body audit will be completed for all residents to identify any new and existing pressure injuries and/or skin integrity issues. All residents identified at risk for skin breakdown and/or had wound or skin integrity issues indentified will be documented accurately per wound care Policy and procedure and their attending physicians notified for preventive orders and treatment orders.

Systemic Change(s):
The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The licensed staff will be inserviced by the DON and/or regional nurse consultant on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. Training will include assessing risk for pressure ulcers, preventative measures, treatment orders per facility protocol, assessing pressure ulcer location, size,

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1. Facility staff did not assess Resident #258's sacral wound for ten days. From 06/30/2017 until 07/10/2017, the wound increased from 2.60 cm X 1.30 cm X .10 cm to an unstageable with measurements of 7.0 cm X 5.0 cm X .10 cm. Additionally, when the assessment was completed on 07/10/2017, an additional seven Stage I pressure ulcers were assessed and documented on the facility wound assessment report. Two of the identified Stage I pressure ulcers progressed to Stage II pressure ulcers when reassessed on 07/14/2017.

Resident #258 was originally admitted to the facility on 10/06/2009, she was most recently readmitted on 04/04/2017 and died in the facility on 11/15/2017. Her diagnoses included but were not limited to: Parkinson's disease, dysphagia, osteoporosis, dementia without behaviors, and orthostatic hypotension.

A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/07/2017, identified Resident #258 as having difficulty with both long and short term memory, as well as being severely impaired with daily decision making skills. Resident # 258 was being followed by Hospice.

A progress note from the nurse practitioner dated 07/10/2017 contained the following information: "Skin Breakdown S [subjective]: 93 year old Parkinson's hx [history] on Hospice with 5 new area of skin breakdown since last week. Area on sacrum was old and was felt to be improving several wks ago. Staff are not sure how new areas occurred. O [objective]:there is an old necrotic area on sacrum and new area to L [left]

(measurements, length, width, & depth), undermining, tunneling, exudate, necrotic tissue, and the presence or absence of granulation tissue and epithelialization, and the timely assessment and documentation of all wounds and treatments.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or designee will complete weekly audits of all resident Pressure Ulcer preventative orders to ensure they are being implemented per physician order. Any negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed. All residents identified with pressure ulcers will be reviewed weekly by the Risk Management Committee. The committee will review the Pressure Injury tracking log weekly and evaluate the progression of healing by reviewing the consistent, accurate assessments and measurements of the wounds. The weekly risk management minutes will be reviewed by the DON and provide results of these audits to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice

Completion Date: **3/29/2018**

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of this on L buttock. There is a reddened area R [right] hip with a small area of breakdown, there are new areas across tops of L toes and sides of feet bilaterally. Allevyn are knocked wounds and she is not wearing her heel guards. A [assessment]: Skin breakdown, multiple new areas P [plan]: Wt loss with poor nutrition and advanced Parkinson's are contributing. Will call Hospice RN and discuss."

The wound records were reviewed. A "Wound Assessment Report" dated 06/30/2017 was reviewed. The following information was observed: "Wound Type: Pressure Ulcer Wound Location: Sacrum Wound Status: Improved Stage: Unstageable due to slough/eschar Measurements: Length: 2.60 cm Width: 1.30 cm Depth: .10 cm Notes: Rsd with unstageable wound of sacrum. There is no exudate present. There is no indication of pain. Rsd is tolerant of tx [treatment] to area. Rsd is compliant with turning and repositioning q2h to offload pressure to area. RP [responsible party] and MD notified, no changes warranted."

The next "Wound Assessment Report" was dated 07/10/2017 and contained the following information: "Wound Type: Pressure Ulcer Wound Location: Sacrum Wound Status: Deteriorated Stage: Unstageable due to slough/eschar Measurements: Length: 7.00 cm Width: 5.00 cm Depth: .10 cm Notes: Rsd with unstageable wound of sacrum. There is a small amount of serosanguineous exudate present. There is a 3.5 x 3.0 cm area of black necrosis. Rsd is tolerant of tx to the area. RP and MD notified. No changes warranted to treatment. Rsd with order to be turned and repositioned q2h while in bed. Rsd with no complaints of pain at

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his time. Area has deteriorated. Rsd is Hospice patient healing is not expected in this setting. Palliative care is the goal for this resident."

Additionally the following new areas of pressure were identified and documented on "Wound Assessment Records" on 07/10/2017:
1. "Wound Type: Pressure Ulcer Wound Location: Right hip Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 5.0 cm Width: 3.5 cm Notes: Rsd with Stage I of R hip. Area is non blanchable. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to be turned and repositioned q2h while in bed to assist in offloading pressure to the area, RP and MD notified."

2. "Wound Type: Pressure Ulcer Wound Location: Left Buttock Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 3.50 cm Width: 6.50 cm Notes: Rsd with Stage I non blanchable area to L buttock. Area is area of preexisting wound. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to turn and position q2h while in bed to assist in offloading pressure to the area, RP and MD notified."

3. "Wound Type: Pressure Ulcer Wound Location: Right Lateral Malleolus Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 3.00 cm Width: 3.00 cm Notes: Rsd with Stage I non blanchable area to R ankle. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd is compliant with wearing prevalon boots. Rsd with order to turn and

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position q2h while in bed to assist in offloading pressure to the area, RP and MD notified."

4. "Wound Type: Pressure Ulcer Wound Location: Right 5th Toe, R lateral side of foot behind 5th digit Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 2.50 cm Width: 2.0 cm Notes: Rsd with Stage I non blanchable area to lateral side of R foot behind fifth digit. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to turn and position q2h to assist in offloading pressure to the area, RP and MD notified."

5. "Wound Type: Pressure Ulcer Wound Location: Right 5th Toe Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 1.00 cm Width: 0.50 cm Notes: Rsd with Stage I of R 5th metatarsal that is non blanchable. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to turn and position q2h while in bed to assist in offloading pressure to the area. Rsd is complaint with wearing prevalon boots. RP and MD notified."

6. "Wound Type: Pressure Ulcer Wound Location: Left Great Toe Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 3.00 cm Width: 3.00 cm Notes: Rsd with Stage I of L Great Toe. Area is nonblanchable. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to turn and position q2h while in bed to assist in offloading pressure to the area. Rsd is compliant with wearing prevalon boots. RP and MD notified."

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7. "Wound Type: Pressure Ulcer Wound Location: Right Great Toe Date Wound Identified: 7/10/2017 Assessment Occasion: New Wound Stage: I Measurements: Length: 2.50 cm Width: 3.00 cm Notes: Rsd with Stage I of R Great Toe. Area is non blanchable. There is no indication of pain at this time. Rsd is tolerant of tx to area. Rsd with order to turn and position q2h while in bed to assist in offloading pressure to the area. Rsd is complaint with prevalon boots. RP and MD notified."

On 07/14/2017 Wound Assessment Records were completed and contained the following:
1. "Wound Type: Pressure Ulcer Wound Location: Left Great Toe Date Wound Identified: 7/10/2017 Assessment Occasion: Weekly Update Stage: 2 Measurements: Length: 2.50 cm Width: 1.50 cm Depth: 0.10 Notes: Rsd seen by wound specialist for Stage 2 of L distal medial foot. There is no indication of pain. There is no exudate present. Rsd is tolerant of tx to area. Rsd is palliative care, healing/improvement is not expected in this setting. RP and MD notified."

2. "Wound Type: Pressure Ulcer Wound Location: Right Great Toe Date Wound Identified: 7/10/2017 Assessment Occasion: Weekly Update Stage: 2 Measurements: Length: 3.00 cm Width: 2.00 cm Depth: 0.10 Notes: Rsd seen by wound specialist for Stage 2 of R great toe.. There is no indication of pain. There is no exudate present. Rsd is tolerant of tx to area. RP and MD notified. Rsd is palliative care, healing/improvement is not expected in this setting."

3. "Wound Type: Pressure Ulcer Wound

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Location: Right 5th Toe, R distal lateral foot and 5th toe Date Wound Identified: 7/10/2017 Assessment Occasion: Weekly Update Stage: I Measurements: Length: 4.50 cm Width: 1.00 cm Notes: Rsd seen by wound specialist for right distal leateral [sic] foot and fifth digit Stage I. There is no exudate present. There is no indication of pain. There is no exudate present. Rsd is tolerant of tx to area. RP and MD notified."

The physician order section was reviewed. On 07/05/2017 the following orders were written: "[Change symbol] mattress to concave mattress on bed with air flow. Bed side fall mat." On 07/10/2017 the following orders were written: "Turn Q2h [every 2 hours] when in bed... Apply skin prep to Stage I R hip qd [every day] apply skin prep to stage I of L buttock qd, Apply skin prep to stage I of R side of R 5th metatarsal foot qd, apply skin prep to stag I of side of R great toe qd, apply skin prep to Stage I to side of L great toe qd...prevalon boots at all times, bed cradle at all times."

The above information was discussed with the DON (director of nursing) and the wound nurse. Concerns were voiced by this surveyor that a wound assessment had not been conducted for ten days and when it was completed on 07/10/2017 the sacral wound had deteriorated, increased in size and the resident had multiple new areas. The wound nurse stated, "I was off the week of July 4th...when I came back in on that Monday [7/10/2017] the new areas were there...while I was off that week she [Resident #258] fell...they took her off of her air mattress and put her on a concave mattress...we think that might be why she developed the areas." The DON was asked what the expectation was

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regarding the frequency of wound assessments. She stated,"Weekly...every seven days." The DON was asked if a span of ten days would be considered too long. She stated, "Yes." The wound nurse and the DON also directed this surveyor to an additional report in the clinical record regarding wound assessment.

Further review of the electronic clinical record was conducted. "Skin Inspection Reports" were observed. The following information was collected on skin inspection report: Assessment Date, Skin Status and Entered By. Entries on electronic record for this screen were: "6/30/17 Skin Not Intact-Existing; 7/07/2017 Skin Not Intact-Existing; 7/14/2017 Skin Not Intact-New." All entries were signed by the wound nurse. The DON came to the conference room to speak with this surveyor. She was asked how the wound nurse had completed a "Skin Inspection Report" on 07/07/2017 when she was on vacation. The DON left the conference room. When she returned she stated, "[Name of Wound Nurse] didn't do the skin inspection report on 0/07/2017, [name of former DON] did it, she gave the information to [name of the wound nurse] and she recorded it..." The DON was asked if that was acceptable practice. She stated, "No." The DON was asked if the information was accurate. She stated, "I don't know." The concave mattress order was also discussed. An order on the clinical record dated 07/05/2017 was: "[Change symbol] mattress to concave mattress on bed with air flow..." The DON was asked what a concave mattress with air flow was. She stated, "They don't exist...they took her off of the air mattress and put her on the concave mattress because of her falls...when the new areas were discovered, she was put back on the air

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mattress...I can't find an order for that..."

LPN (licensed practical nurse) #4 was interviewed on 02/12/2018 at approximately 2:00 p.m. regarding the concave mattress order that she had transcribed. She stated, "I thought that was the kind of mattress that hospice used." According to the TAR (treatment record) LPN #4 had performed dressing changes to Resident #258's sacral area during the time that the wound nurse had been off. She was asked if she had measured the area during any of the dressing changes. She stated, "No, Usually the wound nurse does rounds with the wound doctor and do measurements...I guess when she's off the nurse's could do it."

The Hospice nurse who cared for Resident #258 was interviewed via telephone on 02/12/2018 at approximately 2:45 p.m. She was asked about Resident #258's pressure areas in relation to her diagnoses of Parkinson's disease, her decreased nutritional status and her orders for hospice. The hospice nurse stated, "We looked into this after it happened...the pressure areas that developed were not the type of pressure ulcers that are considered to be nutritionally related like a Kennedy ulcer...these were definitely pressure related... the resident had fallen...the facility put her on a concave mattress and that may have been a contributing factor..it's like laying them in a gutter..."

The nurse practitioner who was seeing the resident was interviewed on 02/12/2018 at approximately 3:00 p.m. regarding her note written on 07/10/2017 regarding Resident #258's new pressure areas. She stated, "She was declining rapidly, she was bed ridden and

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immobile...when I was there she was always in the bed or the wheelchair...I was very surprised when they told me she was trying to get up and had fallen...I don't know how she was getting out of the bed." The nurse practitioner was asked if she thought the areas were unavoidable. She stated, "I don't know what to say to that....she had a lot going on that predisposed her but that was a lot of breakdown in a short amount of time...I really can't say if they were unavoidable or not."

The facility policy, "Wound Care" was obtained. According to the policy, "All assessment data (i.e. wound bed color, size, drainage, etc) will be obtained weekly and documented in the medical record."

During an end of the day meeting the above information was discussed with the DON and the administrator. Concerns were voiced that Resident #258's sacral wound had not been assessed for ten days and when the assessment was completed on 07/10/2017 the wound had deteriorated. Concerns were voiced that in spite of daily dressing changes to the sacral wound, there was no documentation in the clinical record describing the change in the appearance or increase in size of the wound. Concerns were also voiced that there was no evidence that Resident #258 had been assessed after the change in her mattress and when the wound nurse returned on 07/10/2017 there were multiple new pressure areas. The DON and the administrator were informed that the survey team had identified the deficient practice as possible harm.

No further information was obtained prior to the exit conference on 02/13/2018.

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This is a complaint deficiency.

2. Resident #259 was admitted to the facility with orders for a wound vac to treat a Stage IV pressure ulcer. The wound vac was not put into place for two days. The pressure ulcer was never assessed by the facility, nor did the facility notify the attending physician that the wound vac was unavailable. Resident #259 was added to the survey sample as a closed record due to a complaint received at the Office of Licensure and Certification, alleging that a wound vac was not implemented per physician's orders.

Resident #259 was admitted to the facility on 06/14/2017 with the following diagnoses, but not limited to: Stage IV pressure ulcer of left ankle, Spinal stenosis, Chronic Ischemic Heart Disease, hypertension and SIADH (syndrome of inappropriate antidiuretic hormone secretion). Resident #259 was discharged from the facility on 06/17/2017, no MDS (minimum data set) information was obtained.

The clinical record was reviewed beginning 02/07/2018.

The progress note section of the clinical record contained the following nursing documentation:

06/14/2017 2:29 p.m. Resident admitted to room 38 A from [name of local hospital]. Resident arrived to facility at 1335 [1:35 p.m.] via w/c [wheelchair] via [name of transportation company] with sister-in-law accompanying. Resident is an 89 year old female alert and oriented to person

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and place only with admitting diagnosis of wound care and PT [physical therapy] and OT [occupational therapy....HX [history] of diagnosis include chronic ulcer of L [left] ankle exposed tendons, hyponatremia, PVD [peripheral vascular disease] cellulitis, and chronic ulcer of leg with fat layer exposed...Dimes size scab with redness around it noted to R [right] pinky knuckle, pencil eraser size purple discoloration noted to pointer knuckle, fifty cent piece size skin tear noted to L wrist, dime size purple discoloration noted to LFA [left forearm], pencil eraser sized scattered scabs noted to R knee, wound vac noted to L ankle ulcer, multiple discolorations noted to R ABD [abdomen], quarter size redness noted to L back of shoulder/neck area, and redness noted to bottom...MD/RP aware of admission. Addendum 6/14/2017 3:19 p.m.....Correction: Pencil eraser size purple discoloration noted to R pointer knuckle, fifty cent piece size purple discoloration noted to LFA and L AC [antecubital].

6/15/2017 4:57 a.m. Rsd [resident] continues as skilled for wound care....Wound vac dressing to left ankle clean, dry and intact. Rsd continues on 1 liter fluid restriction...

6/15/2017 2:26 p.m. Resident is skilled for wound care to L ankle. ...

6/15/2017 6:40 p.m. Resident is skilled for wound care to L ankle...

6/16/2017 4:39 a.m. Rsd continues as skilled for wound care...wet to dry dressing to left ankle clean, dry, intact. Rsd continues on 1 liter fluid restriction...

6/16/2017 2:02 p.m. Resident is skilled for

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wound care to L ankle...

6/16/2017 MD in on rounds today. New admission evaluation completed with new orders...elevate LE BID [lower extremities two times per day]for one hour...

6/16/2017 7:06 p.m. Resident is skilled for wound care to L ankle...wound vac in place and working properly...

6/17/2017 2:19 p.m. Rsd skilled for left ankle ulcer...Rsd was transported to [name of local hospital] ED [emergency department] at 1400 [2:00 p.m.,] for cough, SOB [shortness of breath], difficulty breathing and 3-4+ LLL [left lower leg] pitting edema and redness...

6/17/2017 10:18 p.m. Resident was admitted to [name of local hospital] for suspected cellulitis, SOB and cough."

Discharge instructions from the hospital were reviewed. Under the section "Wound Care", the following was documented: "Wound vac changed on Mon, Wed, Fri. Duoderm dressing changed on Mon and Fri."

The facility physician orders were reviewed. There were no orders on the clinical record for a wound vac. The care plan was reviewed. There were no interventions on the initial care plan regarding Resident #259's wound, wound vac or wound care.

Additional documentation regarding Resident #259 was requested from the local hospital and received on 02/08/2018. Included in information received was an email between the hospital

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discharge planner and the facility's admission director. Included in the email was the following information: "Hospital discharge planner: 'Also, [name of Resident #259] will still need her wound vac when she comes to you. Just a head's up' [smiley face symbol]. Facility admissions director: 'Perfect- she will be in room 38 A and [name of physician] will be her attending' [smiley face symbol]"

On 02/09/2018 at approximately 11:30 a.m., LPN (Licensed Practical Nurse) #4 was interviewed regarding the admission note she wrote on 06/14/2017. She was asked specifically about the reference to "wound vac noted to L ankle ulcer" in her note. She stated, "I remember that because I got a corrective action for what I wrote...the wound vac wasn't here...the dressing was there and the tubing was in place at admission but there wasn't a wound vac and there wasn't one here...they didn't send one from the hospital with her...we called the doctor and he said it was Ok to place it [the wound vac] the next day...I documented the wound vac was there but it was really just the dressing..." LPN #4 reviewed the documentation in the clinical record. She stated, "We got an order to do a wet to dry dressing on June 15...I don't remember if she ever got the wound vac or not." LPN #4 was asked how she knew what a resident was going to need when they arrived at the facility. She stated, "We get information from admissions about who's coming, their name and room they are going to." LPN #4 was asked how the facility got admission orders. She stated, "We get them from the hospital discharge summary." LPN #4 was asked if anyone contacted the hospital to let them know that a wound vac was not on site. She stated, "I don't see anything about it in the

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documentation and I don't know who notified them that we didn't have a wound vac, but I'm pretty sure we contacted the hospital."

At approximately 1:50 a.m., the wound nurse was interviewed regarding Resident #259's wound vac. She stated, " We didn't know that she was coming with a wound vac...The hospital didn't send the wound vac with her...they rent them from a company and didn't know how to transfer the rental from the hospital to here...We got orders for a wet to dry dressing. We called [name of company] to get a wound vac here but they said we wouldn't get it until the 16th so [name of admissions person] went and got it. I looked there is no documentation in the record that we contacted the physician..we should have contacted the doctor on June 14th when she got her...I don't see that documented but we did get an order for the wet to dry dressing on June 15th."

LPN # 1 (MDS) was interviewed at 12:45 p.m. She stated, "I don't know who reviewed the admission information before she [Resident #259] got here. We didn't know she had a wound vac...the admitting nurse documented that there was a wound vac in place but it was really just the dressing...the hospital wouldn't give us their wound vac so [name of supply person] contacted whoever we get our equipment from...she got a wound vac through a company in Salem so [name of former admissions director] went and got it." LPN #1 was asked if she felt the facility should have sent the resident back to the hospital since they didn't have the proper equipment in house to care for her. She stated, "Yes, we should have." LPN #1 was asked about Resident #259's care plan. She stated, "She wasn't here

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for 14 days so the comprehensive care plan was not done...the initial care plan should have included the wound care and the wound vac."

At approximately 1:30 p.m., the person who gets supplies for the facility, OS [other staff] # 3 was interviewed. She stated, "We did have a wound vac here when the resident arrived...when they hooked it up, it didn't work. I called [name of company] and they said it would take 5-6 hours to get one here...we called another company and they could get it here quicker...they had a guy bring it here, it wasn't [name of admissions director]...we called the hospital before we did any of that and they wouldn't give us a wound vac because the one they had was under their rental agreement with the company."

The above interviews were discussed with the DON and the documentation from the hospital was shown to her regarding the fact that the admissions coordinator did know about the wound vac. She shook her head side to side.

Further review of the clinical record was conducted. There were no wound assessments located in the clinical record. The DON was asked if there were any additional areas where the wound documentation might be located. She reviewed the closed record and stated that she had also not located any assessments of the wound. She was asked what the expectation was regarding wound assessments. She stated, "The wound should have been assessed on admission or as soon as the dressing was removed."

A note from the attending physician was observed. The note written 06/16/2017 contained the following information: Jun 16, 2017 Fri 11:40

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a.m. 89 year old WF admitted after acute hospitalization for encephalopathy, pressure ulcer with cellulitis, hyponatremia....had been receiving care for an anterior tibial ulcer with unna boots. Developed pressure area anterior ankle...was admitted [to the hospital] for IV antibiotics and wound care...she was treated with a wound vac. Had an appt with vascular 6/12 and planned debridement then wound vac for a few weeks again before graft. She has not had wound vac on since Wednesday [06/14/2017]. Facility not aware that she required one. MD at site [facility] changed dressings to wet to dry and wound vac ordered. At facility now. ...Will admit for wound care. Wound vac in place at this point. Elevate LE..."

The facility policy, "Pressure Ulcer/Skin Breakdown-Clinical Protocol" contained the following: "The staff will examine the skin of a new admission for ulcerations or alterations in skin."

The emergency department note from 06/1/2017 was reviewed and contained the following information:
"...presents with chief complaint of a cough that preludes dyspnea, but states to be the same for 2 years. Nursing home staff report patient to be short of breath with low Os saturations in the 80's...(Daughter states cough is worse than usual)...Treatments and ED course: ...introduced self and discussed pan with family. They are currently upset with care received at [name of facility]. States patient has been sitting with legs down in front of nurse's desk and mess hall. Claim patient's wound vac was not in place for several days. Have called [name of facility] supervisors for complaints. Have made multiple

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requests for [name of attending] to call and discuss care with staff, but has been unable to reach physician...Final Impression: Acute combined systolic and diastolic heart failure..."

On 02/12/2018 at approximately 3:30 p.m., the attending physician for Resident #259 was interviewed via telephone. She was asked about Resident #259's wound and the care provided at the facility. She stated, "I did the admission exam on June 16...I didn't know about the wound vac...I wasn't contacted that the wound vac wasn't there...the admission coordinator and the DON decide if a patient can come to the facility and they are accepted if we can provide the care needed."

The attending physician was asked if she felt Resident #259 was provided the care needed and if she should have been accepted to the facility. She stated, "No, she should not have been admitted...when it was determined that there was no available wound vac she should have been sent back to the hospital...no one contacted me...they contacted [name of another physician] and he gave them patch through orders until the wound vac could arrive." The attending physician was asked if she felt that Resident #259 was readmitted to the hospital with cellulitis and heart failure had anything to do with the care received at the facility. She stated, "I can't comment on the cellulitis or the heart failure...I would need to review the hospital records...certainly her situation at the facility was not ideal."

The above information was discussed with the DON and the administrator during an end of the day meeting on 02/12/2018.

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No further information was received prior to the exit conference on 02/12/2018.

This is a complaint deficiency.

3. Resident #56 was not wearing physician ordered geri sleeves or heel protectors.

Resident #56 was most recently admitted to the facility on 01/23/2018. Her diagnoses included, but were not limited to, acute kidney failure, acute respiratory failure with hypoxis, strain of the left achilles tendon and dysphagia.

A 5 day MDS (minimum data set) assessment, coded Resident #56 with a cognitive summary score of "12", indicating she was moderately impaired.

On 02/06/2018 4:25 p.m. Resident #56 was observed sitting up in a wheelchair in her room. Her daughter was in the room visiting. A family interview was conducted. Resident #56 was observed wearing Bilateral Geri sleeves.

The clinical record was reviewed on 02/07/2018 at approximately 8:00 a.m. Observed on the POS (physician's order sheet) were the following orders: "1/25/18 Heel protectors while in bed as tolerated" and "1/20/18 Geri Sleeves at all times to upper extremities for protection".

On 02/07/18 08:53 AM Resident #56 was observed in bed. Her geri sleeves were not on. She was asked if she was wearing her heel protectors. She stated, "No." She was asked if she had requested not to wear them. She stated,

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HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

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"No, sometimes they put them on me and sometimes they don't. I don't mind wearing them." Resident #56 was asked about her geri sleeves. She stated, "They took them to wash."

02/08/2018 2:00 p.m. Resident #56 was observed in bed, her geri sleeves were in place. Resident #56 was asked if she was wearing her heel protectors. She stated, "No, they didn't put them on me today." This surveyor went to the nurse's station and spoke with CNA (certified nursing assistant) # 2, who took care of Resident #56 on dayshift. She was asked about Resident #56's heel protectors. She stated, "I didn't put them on her...they weren't on earlier when I came in and I just didn't think about it when I put her back to bed." CNA # 2 was asked how she knew what care to provide for residents. She stated that there was a Kardex care plan in each resident's closet. This surveyor and CNA #2 went to Resident #56's room and looked at the Kardex. Heel protectors were listed on the CNA's Kardex to be applied as tolerated. The heel protectors were observed in the closet, CNA #2 stated, "I will put them on her now."

The above information was discussed during an end of the day meeting with the DON (director of nursing) and the administrator on 02/08/2018.

No further information was obtained prior to the exit conference on 02/12/2018.

F 756 SS=D Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a

F 756

F756
Corrective Action(s):
Resident #15 is no longer at the facility.

Identification of Deficient Practices & Corrective Action(s):
All other residents receiving psychotropic

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licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to provide a clinical rationale for pharmacy recommendations for one medication may have been potentially been affected. The pharmacy consultant will conduct a 100% review of all current residents receiving psychotropic medications to identify residents in need of Gradual dose reductions or pharmacy recommendations, follow up, and review. Any/all negative findings will be reported to the attending physician for correction at time of discovery. A Risk Management Incident/Accident form will be completed for each incident identified.

Systemic Change(s):
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The consultant pharmacist will review all resident's medication regime monthly with a focus on psychotropic medications to address appropriate use, reduction, and elimination if needed. Licensed nursing staff will be inserviced by the DON on the importance of monitoring medication regimens for medication reduction and elimination as recommended by the Consulting Pharmacist. The Consulting Pharmacists has reviewed the GDR regulations and requirement with the attending physicians at the facility.

Monitoring:
The DON is responsible for maintaining compliance. The DON, and/or designee will perform monthly audits of the pharmacy recommendations to ensure that the recommendations are being reviewed, completed and followed up on timely. Any/all negative findings will be corrected at time of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for

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F 756	Continued From page 71	F 756	review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	**3/29/2018**

of 21 residents: Resident # 15. The physician did not provide a clinical contraindication to a gradual dose reduction (GDR) for the resident's continued use of Lorazepam and Seroquel.

Findings include:

Resident # 15 was admitted to the facility 10/25/06 with a readmission date of 12/24/13. Diagnoses for Resident # 15 included, but were not limited to: unspecified dementia with behavioral disturbance, legal blindness, cognitive communication deficit, osteoarthritis, and anxiety.

The most recent MDS (minimum data set) was a quarterly review dated 12/5/17 and had Resident # 15 with moderate impairment in cognition with a total summary score of 8 out of 15.

The clinical record was reviewed 2/8/18 at 3:00 p.m. Pharmacy recommendations were reviewed and revealed the following:

4/6/17- the pharmacy consultation report documented "[name of resident] has received Lorazepam 0.5 mg at bedtime. Please consider decreasing to Lorazepam 0.25 mg at bedtime....." The consultation report included a space for the physician to check a response, and provide a clinical rationale for declining the recommendation. The physician checked the space for "I decline the recommendation above because GDR is CLINICALLY CONTRAINDICATED (sic) for this resident as indicated below. (NOTE: Please check option # 1 or # 2 AND provide patient-specific rationale on the lines provided below)." The options # 1 or # 2 were not checked by the physician, and in the lines provided under "Please provide CMS

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REQUIRED patient-specific rationale why a GDR attempt is likely to impair function or cause psychiatric instability in this individual:" the physician documented "She will not do this."

6/2/17 - pharmacy recommendation regarding the resident's use of Seroquel 50 mg was then reviewed. The consultation form documented the new order for Seroquel and the need for appropriate diagnosis as related to psychosis other than dementia. The same instructions for a GDR were included on the report, and included further instructions for documentation of "1. a psychotic disorder such as delusions, schizophrenia, bipolar disorder, or other psychosis. 2. BPSD (behavioral or physiological symptoms of dementia). 3. Symptoms or behaviors MUST (sic) present a DANGER to the resident AND one or both of the following a) symptoms due to mania or psychosis (auditory, visual, hallucinations, delusions, paranoia....) OR b) care planned interventions have been attempted, except in an emergency." The physician documented, as a clinical rationale "Staff have attempted to redirect pt., but she has been waking at 2 a.m., combative and danger to herself." (It should be noted here a review of nurses' notes April 2017 to present did not document any behaviors by the resident with regard to being combative. There were sporadic notes regarding the resident yelling out at night, but did not describe or document if the yelling out was disruptive to other residents, or what attempts were made to redirect the resident's yelling out other than administer the PRN (as needed) Lorazepam).

9/4/17- pharmacy recommendation for a GDR with end goal of discontinuation of Seroquel 50

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mg at bedtime. The physician again declined the recommendation, and on the lines provided under "Please provide CMS REQUIRED (sic) patient-specific rationale...." the physician documented "Pt. has Sundowners."

12/4/17- A second pharmacy recommendation for discontinuation of the lorazepam 0.5 mg at bedtime due to the medication being a PRN (as needed) antipsychotic in use greater than fourteen days without a stop date. The physician declined the recommendation with the rationale "She is 101 and this is the med that best controls her anxiety."

On 2/12/18 at 10 :45 a.m. during an interview with the DON (director of nursing) the above findings were reviewed. The DON stated "I'm not sure why the physician documented that way on those recommendations, especially about her being a danger..... I've looked at the documentation also, and I don't see it. There were a couple of references to the resident being resistive to being put to bed, but not anything that suggests a continuous pattern of aggressive behavior."

No further information was provided prior to the exit conference.

F 757 SS=E Drug Regimen is Free from Unnecessary Drugs
CFR(s): 483.45(d)(1)-(6)

§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

F 757

F 757
Corrective Action(s):
Resident 15 is no longer in the facility.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents receiving antipsychotic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents

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F 757	Continued From page 74 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure one of 21 residents in the survey sample was free from unnecessary medications without indication for it's use: Resident # 15. An order for Seroquel (an antipsychotic medication) was in use for an extended period of time without an appropriate diagnosis for its use. Findings include: Resident # 15 was admitted to the facility 10/25/06 with a readmission date of 12/24/13. Diagnoses for Resident # 15 included, but were not limited to: unspecified dementia with behavioral disturbance, legal blindness, cognitive communication deficit, osteoarthritis, and anxiety. The most recent MDS (minimum data set) was a quarterly review dated 12/5/17 and had Resident # 15 with moderate impairment in cognition with a total summary score of 8 out of 15.	F 757	receiving antipsychotic medication to ensure that each resident has an appropriate diagnosis for the use of the antipsychotic medication and that GDR is being performed as required. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. Nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication to include having an appropriate diagnosis for the use of antipsychotic medications and that GDR is being performed as required. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	**3/29/2018**

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The clinical record was reviewed 2/8/18 at 3:00 p.m. The current POS for January 2018 was reviewed, and included an order carried forward from 6/2/17 for "Seroquel 50 mg 1 tab by mouth at bedtime." The reason for the medication was documented as "Anxiety disorder." Further review of the record revealed two pharmacy recommendations for the gradual dose reduction (GDR) of the Seroquel with the end goal of discontinuation. The physician declined both recommendations as follows:

6/2/17 - pharmacy recommendation regarding the resident's use of Seroquel 50 mg was then reviewed. The consultation form documented the new order for Seroquel and the need for appropriate diagnosis as related to psychosis other than dementia. The same instructions for a GDR were included on the report, and included further instructions for documentation of "1. a psychotic disorder such as delusions, schizophrenia, bipolar disorder, or other psychosis. 2. BPSD (behavioral or physiological symptoms of dementia). 3. Symptoms or behaviors MUST (sic) present a DANGER to the resident AND one or both of the following a) symptoms due to mania or psychosis (auditory, visual, hallucinations, delusions, paranoia....) OR b) care planned interventions have been attempted, except in an emergency." The physician documented, as a clinical rationale "Staff have attempted to redirect pt., but she has been waking at 2 a.m., combative and danger to herself." (It should be noted here a review of nurses' notes April 2017 to present did not document any behaviors by the resident with regard to being combative. There were sporadic notes regarding the resident yelling out at night,

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but did not describe or document if the yelling out was disruptive to other residents, or what attempts were made to redirect the resident's yelling out other than administer the PRN (as needed) Lorazepam).

9/4/17- pharmacy recommendation for a GDR with end goal of discontinuation of Seroquel 50 mg at bedtime. The physician again declined the recommendation, and on the lines provided under "Please provide CMS REQUIRED (sic) patient-specific rationale...." the physician documented "Pt. has Sundowners."

The nursing notes were reviewed from June 2017 to present. There was no documentation located in the notes of Resident # 15 having behaviors which made her a danger to herself; in that time frame of approximately eight months there were two notes which documented two altercations with staff. The altercations were a resistance to being put to bed on one occasion and the resident grabbed the arm of the CNA attempting to put her to bed and her fingernails "dug in" to the CNA's arm. Other notes documented Resident # 15 would occasionally wake up during the night and yell out. There was no documentation that when the resident awoke and yelled out that she was also combative or a danger to herself. There was also no documentation of what attempts were made by staff to redirect or calm the resident other than to administer the PRN (as needed) order for Lorazepam 0.5 mg. Nursing notes also included several documentations of "Resident is 100 year old female with primary diagnosis of dementia without behavior distubance. Alert and oriented x1." The documentation was included monthly of the review of nurses' notes performed.

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On 2/12/18 at 10:45 a.m. during an interview with the DON (director of nursing) the above findings were reviewed. The DON stated "I'm not sure why the physician documented that way on those recommendations, especially about her being a danger..... I've looked at the documentation also, and I don't see it. There were a couple of references to the resident being resistive to being put to bed, but not anything that suggests a continuous pattern of aggressive behavior. I don't see a diagnosis for the continued use of the Seroquel either."

The administrator and DON were informed of the above findings during a meeting with facility staff 2/12/18 beginning at 4:30 p.m.

No further information was provided prior to the exit conference.

F 758 SS=E Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used

F 758

F 758
Corrective Action(s):
Resident 54's attending physician has reviewed resident 54's Medication orders and PRN Haldol medication has been discontinued by the attending physician.

Resident 15 is no longer in the facility.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents receiving PRN antipsychotic medications may have been potentially affected. The DON, Unit Manager and/or Pharmacy consultant will review the medication orders of all residents receiving antipsychotic medication to ensure that no unnecessary medications have been ordered and that PRN Antipsychotic medication orders are

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psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to assess for the appropriateness of an anti-psychotic and a psychotropic medication for two of 21 residents, Resident #54 (R 54) and Resident #15.

F 758

not in place for longer than 14 days without a physician evaluation. Any [illegible] negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding.

Systemic Change(s):
The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. The DON has reviewed the regulatory requirement for PRN psychotropic medication usage and time limits with the facility attending physicians. Nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication to include the need for PRN psychotropic medication orders to be limited to 14 days without physician review.

Monitoring:
The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: **3/29/2018**

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1. R 54 was ordered Haldol (anti-psychotic) as a PRN (as needed) for over 14 days without an evaluation.

2. Resident #15 was ordered Ativan (hypnotic) as a PRN for over 14 days without an evaluation.

Findings include:

1. R 54 was admitted to the facility on 1/22/18 with diagnoses of Dementia and cognitively impaired.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 1/29/18. R 54 was assessed as having short and long term memory problems and severely cognitively impaired.

R 54's electronic record was reviewed on 2/9/18. A physician's order dated 1/23/18 documented "Haldol 1 MG [milligram] IM [intramuscularly]" every 6 hours as needed for severe agitation.

Review of R 54's medication administration record for January through the present day of review, evidenced that R 54 did not receive Haldol at any time since it had been ordered (for a total of 18 days).

Review of the pharmacy medication review evidenced that the pharmacy had reviewed R 54's medication's on 2/6/18 and according to physician orders, medications had been adjusted, but did not evidence assessment or evaluation of the PRN Haldol (the Haldol was not discontinued).

On 02/09/18 at 11:20 AM this surveyor informed

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the DON (director of nursing) of PRN Haldol not being discontinued or evaluated after 14 days. DON verbalized that the pharmacy and the physician was just in the facility and should have addressed it.

No other information was provided prior to exit conference on 2/12/18.

2. Resident #15 was ordered Ativan (hypnotic) as a PRN for over 14 days without an evaluation.

Resident # 15 was admitted to the facility 10/25/06 with a readmission date of 12/24/13. Diagnoses for Resident # 15 included, but were not limited to: unspecified dementia with behavioral disturbance, legal blindness, cognitive communication deficit, osteoarthritis, and anxiety.

The most recent MDS (minimum data set) was a quarterly review dated 12/5/17 and had Resident # 15 with moderate impairment in cognition with a total summary score of 8 out of 15.

The clinical record was reviewed 2/8/18 at 3:00 p.m. The current POS (physician order summary) for January 2018 was reviewed, and included an order carried forward from 10/11/17 for "Lorazepam (Ativan) 0.5 mg Give 1 tablet by mouth at bedtime as needed." Review of the pharmacy consults revealed requests for the reduction of the Ativan were declined by the physician. One pharmacy consult dated 12/4/17 included "Resident has a PRN (as needed) order for an anxiolytic (hypnotic), which has been in place greater than 14 days without a stop date: Lorazepam 0.5 mg. The recommendation was for the prescribe to discontinue the PRN

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	495321	A. BUILDING _____ B. WING _____	C 02/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

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medication. Further review of the clinical record failed to reveal monitoring or assessment of the medication.

On 2/12/18 at 10 :45 a.m. during an interview with the DON (director of nursing) the above findings were reviewed. The DON stated " I don't know why the doctor didn't respond to the request since now a PRN medication like that can't be used more than 14 days. I guess if the doctor feels she needs it he could change from PRN to scheduled...."

No further information was provided prior to the exit conference.

F 880 Infection Prevention & Control
SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(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:

§483.80(a)(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

F 758

F 880

F880
Corrective Action(s):
Resident #34's Bed has been replaced to accommodate the proper placement of a catheter bag and catheter tubing off the floor to prevent infection and injury. The resident's care plan has been revised to reflect accurate Foley catheter care to include anchoring tubing and proper placement of the drainage bag.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents with a Foley catheter may have been potentially affected. The DON, ADON and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed.

Systemic Change(s):
The facility Policy and Procedure for

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F 880	Continued From page 82 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(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; (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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880	Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter care to include the proper anchoring of Foley catheter tubing and proper placement of the drainage bag while in the bed and/or wheelchair to prevent infection and injury. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or Designee will make random audits of Foley Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	**3/29/2018**

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infection.

§483.80(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:
Based on observation, clinical record review, staff interview and facility document review, the facility staff failed to ensure infection control practices regarding a foley catheter for one of 21 residents in the survey sample, (Resident # 34).

The facility staff failed to ensure proper placement of a foley catheter bag for Resident # 34, the drainage bag was observed on the floor.

Findings include:

Resident # 34 was admitted to the facility on 01/06/16. Diagnoses for Resident # 34 included, but were not limited to: heart disease, dementia, diabetes, peripheral vascular disease, contractures of the knees, myelodysplastic syndrome, bladder outlet obstruction with permanent supra pubic catheter placement.

The most recent MDS (minimum data set) was a quarterly assessment dated 01/08/17. This MDS assessed the resident with short and long term memory impairment daily decision making skills and as requiring extensive assistance from staff for all ADL's (activities of daily living).

The following observations were made concerning Resident #34.

02/06/18 at 10:16 AM resident observed in laying in a low bed with bilateral 1/4 grab bars.

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Resident's bed against wall, with a fall mat down on other side of bed. A bed alarm attached to bed, foley catheter bag hanging on side of bed frame with privacy bag, resting on the fall mat. Clear urine seen in the bag. The resident is covered and eyes are closed.

02/06/18 at 11:53 AM Resident is up in wheelchair, socks on feet right. The resident's foley bag hanging just below bladder level, hanging from side of w/c with privacy bag in place.

02/08/18 at approximately 8:40 a.m., resident observed in low bed with foley catheter bag resting on the fall mat beside of bed.

On 02/12/18 at 08:10 a.m. the resident was observed in the low bed with the foley catheter bag hanging on the side of the bed on the 1/4 grab bar. The foley catheter was not on the floor and was not resting on the fall mat.

On 02/12/18 at 08:53 a.m., the facility's policy for foley catheter care was requested from the DON (director of nursing).

On 02/12/18 at 08:54 AM A policy was presented for review on foley catheter care. The policy stated, "...Be sure the catheter tubing and drainage bag are kept off the floor..."

Resident # 34's CCP was reviewed and documented, "...Change catheter drain bag per order...catheter care per facility policy [did not specify care]...assist resident with proper placement of catheter drainage bag below level of bladder...remind as needed..." The CCP did not mention to keep the resident's foley catheter bag

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F 880	Continued From page 85 off the floor, as listed in the facility's policy. The resident's last CCP update was listed as 10/09/2017. The DON and administrator were made of the above information on 02/12/18 at approximately 10:00 a.m. regarding the observations of Resident # 34 and that the resident's CCP had not been reviewed and revised. Both administrator and DON were made aware that the resident's bed is practically on the floor and does not leave a lot of room for proper placement and drainage of the foley bag. The administrator and DON agreed. No further information and/or documentation was presented prior to the exit conference on 02/12/18 at 6:45 p.m.	F 880		