STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	C 06/15/2016

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HIRAM W DAVIS MEDICAL CTR	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 6/14/16 through 6/15/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey The census in this 90 certified bed facility was 68 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3).	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. For Resident #1, as indicated in the investigative report of May 31, 2016, the attending physician was aware of the resident's fracture since May 19 but it was not reported to HWDMC Administration until May 23. On interview, the attending stated that due to the nature of the injury, Resident's fracture was incidental to her possible osteomyelytis. The attending was instructed that any injury needs to be reported to Risk Management and Administration regardless how clinically incidental the injury may appear to be. There are legal and regulatory reporting requirements, particularly for serious injuries such as fractures that have timely notification requirements. The Facility Director and Medical Director have discussed this issue to insure reporting compliance in future incidents. Additionally, front line staff in fact was interviewed during the investigation; however,	

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

Brenda L. Brendarida — Licensed Nursing Home Adm. — 6-29-2016

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.

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed to thoroughly investigate and report to the SA (state agency- Office of Licensure and Certification) injuries of unknown origin for two Residents (Residents' #1 and #2) in a survey sample of three Residents. 1. For Resident #1, an injury of unknown origin, a fractured hip, diagnosed 5/19/16 was not reported to the SA until 5/23/16. Additionally none of the front line staff were interviewed during the investigation; and 2. For Resident #2, an injury of unknown origin, a fractured finger, diagnosed 6/4/16 was not reported to the SA until 6/6/16. Additionally no front line staff were interviewed during the investigation. The findings included:	F 225	staffs with no facts or observations to offer pertinent to the investigation were not included in the final report. For Resident #2, as indicated in the investigative report of June 9, 2016, an IUO was reported to Risk Management on Saturday, June 4 and an investigation initiated; however documentation was not submitted until Monday, June 6. Additionally, front line staff in fact was interviewed during the investigation; however, staffs with no facts or observations to offer pertinent to the investigation were not included in the final report. The abuse/neglect/IUO reporting process has changed to insure immediate notification, as defined by regulation, of all required incidents. Nursing Supervision will be trained in the proper notification process and the necessary forms will be made available to all supervisors. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by incidents of unknown origin. The facility Risk Manager will review all incident reports, the Nursing 24 Hour Report, and oral reports at daily treatment team meetings to insure that all unexplained incidents are investigated and reported in accordance with regulations and professional standards. During weekends and holidays incident reports and the Nursing 24 Hour Report will be checked electronically via remote	

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F 225	Continued From page 2 1. For Resident #1, an injury of unknown origin, a fractured hip, diagnosed 5/19/16 was not reported to the SA until 5/23/16. Additionally none of the front line staff were interviewed during the investigation. Resident #1, a female, was initially admitted to the facility 6/16/14 and readmitted after a hospitalization 10/17/15. Her diagnoses included right femoral head fracture, chronic intermittent right knee pain, diabetes mellitus, chronic renal failure, schizo-affective disorder, Bipolar disorder, sacral and ischial pressure ulcers, constipation, hypertension, dysphagia, and iron deficiency anemia. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/28/16 was coded as a significant change assessment. Resident #1 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as requiring total assistance of one to two staff members for her activities of daily living, with the exception of eating. For eating, Resident #1 was coded as requiring limited assistance of one staff member. She was coded as having no falls in the look back period. During investigation of a complaint, a FRI (facility reported incident) was reviewed. It was noted that Resident #1 had been diagnosed by X-ray on 5/19/16 with having an "age-indeterminate fracture of the right femoral neck." Review of Resident #1's clinical record revealed as part of a work up to diagnose osteomyelitis (an infection of the bone), an X-ray of Resident #1's pelvis was ordered.	F 225	file access and potential incidents discussed with any principals by telephone. Any identified IUO will be reported to the SA immediately. Names of staff even with no facts or observations to offer pertinent to the investigation will be included in the final report. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The facility Risk Manager will review all incident reports, the Nursing 24 Hour Report, and oral reports at daily treatment team meetings to insure that all unexplained incidents are investigated and reported in accordance with regulations and professional standards. During weekends and holidays the Nurse Supervisor on call will call the units, every shift and get verbal reports from the Charge Nurses. Any identified IOU shall be reported to the Nurse Supervisor, who will report to the Facility Director. In addition incident reports and the Nursing 24 Hour Report will be checked electronically via remote file access and potential incidents discussed with any principals by telephone. Any identified IUO will be reported to the SA immediately. In addition, electronic incident reporting will continue to be encouraged to allow the notification system to the Risk Manager, Medical Staff, and Facility Director when an incident has occurred so that it can immediately reviewed and addressed as an incident of unknown origin if required. Names of staff even with no facts or observations to offer	

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F 225	Continued From page 3 The X-ray was obtained on 5/19/16 and the physician had initialed the report as having been reviewed on 5/19/16. Review of Resident #1's clinical record revealed she had no symptoms of a fractured hip including pain, swelling, etc. Additionally there were no falls in the period of time prior to diagnosis of the fractured hip. Review of the FRI and subsequent investigation revealed the administrator and risk manager were not informed of the fracture until 5/23/16 and the investigation began at that time. The investigation was concluded on 5/31/16. Review of the investigation revealed the only staff members that were interviewed were a radiology technician and Resident #1's physician. Included in the investigation was, "The attending physician was aware of (Resident #1's name) fracture since May 19 but it was not reported to the facility Administration until May 23. On interview, (physician's name) stated that due to the nature of the injury, (Resident #1's name) fracture was incidental to her possible osteomyelitis." When interviewed, ADM B, the risk manager, stated 6/15/16 at 10:25 a.m., the fracture was not reported to him or the administrator until 5/23/16. ADM B reported that the matter (the failure of the physician to report a fracture of unknown origin) would be dealt with on an administrative level. When interviewed regarding interviewing front line staff regarding Resident #1's fracture of unknown origin, ADM B stated he "typically" interviewed the staff. ADM B stated, "unless they have something pertinent to say, I don't write it down."	F 225	pertinent to the investigation will be included in the final report. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Quality Management will monitor all [100%] reported incidents to insure proper categorization and 100% of all suspected incidents of unknown origin will be reported to all appropriate organizations in accordance with regulations. The Director of Quality Management will review and compile all data and submit same to the Medical Executive Committee quarterly. 5. Include dates when the corrective action will be completed. June 24, 2016	

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F 225	Continued From page 4	F 225		

Review of the facility's policy entitled "Patient Abuse, Neglect, & Injuries of Unknown Origin; Prevention & Investigation of" included:

"C. Injuries of Unknown Origin

Injuries of Unknown or Unexplained Origin (IUO) are an indicator that patient abuse/neglect has occurred. A patient injury is considered to be a possible IUO if:

1. The injury's cause can not be reasonably determined.
2. When an incident report is received coding the reported event as "Unexplained."
3. When an incident report is received without a marked event category.

All unknown patient events must be explained if at all possible by:
1. The supervisor initially receiving the report.
2. The Risk Manager during the initial review of the report.
3. The interdisciplinary treatment team after discussion at daily meetings."

ADM B stated that any fracture should be reported to him and the administrator at the time it is diagnosed.

The policy further stated:

"All IUOs will be reported to:
1. The facility Director
2. The Facility Patient Advocate
3. The patient's Authorized Representative (RP)
4. The Virginia Department of Health (VDH)

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F 225	Continued From page 5	F 225		

Any investigation that leads to an allegation of patient abuse/neglect must be reported to the Facility Director immediately."

The administrator, interim DON (director of nursing), and risk manager (ADM B) were informed of the failure of the staff to conduct a thorough investigation in a timely manner of an IUO for Resident #1, 6/15/16 at 1 p.m.

2. For Resident #2, an injury of unknown origin, a fractured finger, diagnosed 6/4/16 was not reported to the SA until 6/6/16. Additionally no front line staff were interviewed during the investigation.

Resident #2, a female, was initially admitted to the facility 2/17/13 and readmitted after a hospitalization 5/17/13. Her diagnoses included osteoporosis, self injurious behavior, Vitamin D deficiency, psychosocial deficit, schizophrenia, hearing impairment, gastroesophageal reflux disease, left fifth metacarpal neck fracture, hypertension with intermittent atrial fibrillation, chronic kidney disease, constipation and weight loss.

Resident #2's most recent MDS with an ARD of 3/7/16 was coded as a quarterly assessment. Resident #2 was coded as having short and long term memory deficits and required moderate assistance with making daily life decisions. She was coded as needing total assistance of two staff members for her activities of daily living, with the exception of eating. For eating, Resident #2 was coded as requiring set up assistance only.

During the course of complaint investigation, a

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F 225	Continued From page 6 FRI was reviewed regarding Resident #2's fractured fifth metacarpal on her left hand. Review of the FRI revealed the fracture was diagnosed on 6/4/16 after Resident #2 began to have swelling and bruising of her hand. The physician was informed of the symptoms and ordered an X-ray to be obtained. The X-ray was obtained and revealed Resident #2 had "an acute left hand fifth digit neck fracture." The physician was informed and treatment was initiated, including ice, immobilization and pain medication as needed. Review of the FRI revealed while the fracture was diagnosed on 6/4/16, the SA was not notified until 6/6/16. Additionally the investigation only included a paper review of the clinical record and interviews of two LPNs (licensed practical nurse) and Resident #2's physician, No front line staff were interviewed. When interviewed, ADM B stated 6/15/16 at 9:32 a.m., "That one fell through the cracks...I received the phone call, reporting the fracture, and assumed the administrator had been notified." ADM B stated while he was notified, he thought the administrator had also been notified. ADM B indicated 6/4/16 was on a Saturday and he did follow up until Monday, 6/6/16, when the SA was notified. The administrator, interim DON, and ADM B were informed of the failure of the staff to conduct a thorough investigation into Resident #2's fracture and report the IUO to the SA in a timely manner, 6/15/16 at 1 p.m.	F 225		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=D	Continued From page 7 PREVENT/HEAL PRESSURE SORES	F 314		

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to perform pressure injury wound care in a manner to prevent the spread of infection for one Resident (Resident #3) in a survey sample of three Residents.

For Resident #3, LPN (licensed practical nurse) removed and donned gloves four times during wound care without performing hand hygiene once.

The findings included:'

Resident #3, a male, was initially admitted to the facility 4/2/03 and readmitted after a hospitalization 5/10/13. His diagnoses included stage II pressure injury to the elbow, colon cancer with resection, profound intellectual disability, seizure disorder, constipation, spastic cerebral palsy, aspiration syndrome, Crohn's disease, self injurious behavior, and Vitamin D deficiency.

Resident #3's most recent MDS (minimum data

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The resident had no negative impact as a result of this deficient practice. The hand hygiene policy focusing specifically on clean dressing change was reviewed by shift supervisor with this specific nurse at the time of discovery. The specific nurse with the performance deficiency will receive additional training from the RN clinical educator to ensure competence in providing pressure injury wound care in a manner that would prevent spread of infection.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents requiring wound care have the potential to be affected by this deficient practice.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The shift supervisors will review the Clean Dressing policy with all licensed nurses focusing on hand washing to preventing spread of infection. The shift supervisors or designee will conduct 100% audit in a month, of all residents with wound care to observe clean dressing technique performed by the nurses to ensure all nurses provide wound care in accordance with

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F 314	Continued From page 8 set) with an ARD (assessment reference date) of 5/12/16 was coded as a quarterly assessment. Resident #3 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. He was also coded as requiring total assistance of one to two staff members to perform his activities of daily living. Resident #3 was coded as being at risk for formation of pressure injury and had one stage II pressure injury. Definition of a stage II pressure injury by www.npuap.com: "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." Resident #3 was observed during observation of wound care 6/15/16 at 11:16 a.m. He was lying on his back with the head of the bed elevated. His heels were floated. LPN (licensed practical nurse) A prepared her supplies on a covering on the over bed table. LPN A donned a pair of gloves and removed the old dressing on Resident #3's left elbow. LPN A discarded the dressing,	F 314	facility Clean Dressing policy. Any deficient practice will be corrected immediately. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Completed audits will be reviewed and reported monthly to the Medical Executive Committee through the DON and Quality Management department until all nurses wound care performance have been observed and deemed to be competent in providing wound care in a manner that prevents spread of infection! 5. Include dates when the corrective action will be completed. June 24, 2016	

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F 314	Continued From page 9 removed her gloves and donned a new pair of gloves. LPN A cleaned the area with normal saline and 4 x 4s and dried the area with another 4 x 4. LPN A removed her gloves and donned a new pair of gloves. LPN A cleaned the area again with normal saline (a mild salt solution) and dried the area with a 4 x 4. LPN A removed her gloves and donned a new pair of gloves. LPN A applied Isosorb ointment with an applicator stick (Isosorb is an ointment containing iodine). She removed her gloves and donned another pair of gloves. LPN A applied a folded 4 x 4 to the area and taped it in place. LPN A removed her gloves, dated and initialed a piece of tape and the staff member assisting applied the tape to the area. During the entire process, LPN A failed to perform hand hygiene upon removing and prior to donning gloves. When interviewed, LPN A stated 6/15/16 at 11:25 a.m., she should have used hand sanitizer every time she changed her gloves. Review of the facility's policy entitled "Handwashing" included: "When to Use Alcohol-Based Hand Rub *Before donning gloves and after removing gloves after each resident." Additional guidance within the facility policy, "Clean Dressing Technique" "E. Wash hands or use hand sanitizer. Put on non-sterile gloves. F. Open prepared packages of forceps or any supplies needed. G. Position patient for comfort and wound visualization. H. Remove soiled dressing or packing, using gloves or forceps. Dispose soiled dressing in biohazard bag. I. Remove and discard gloves and/or used forceps.	F 314		

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F 314	Continued From page 10 J. Wash hands or use hand sanitizer. K. Open prepared packages of dressing, forceps or any supplies needed. I. Put on non-sterile gloves. M. Thoroughly assess wound, appearance, odor, drainage, granulation and signs of infection. N. Cleanse the wound with saline or other solutions. A gauze sponge may be used gently wipe the wound to remove any loose debris. O. Apply dressings or packing to adequately cover the wound size. P. Secure dressing. Q. Remove and discard gloves, forceps and any supplies used, in the biohazard bag. R. Wash hands or use hand sanitizer." Guidance was provided by CDC (Centers for Disease Control) in MMWR October 25, 2002 Guideline for Hand Hygiene in Health Care Setting, p. 27: "Indications for hand hygiene · Contact with a patient ' s intact skin (e.g., taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) (25,26,45,48,51,53) · Contact with environmental surfaces in the immediate vicinity of patients (46,51,53,54) · After glove removal (50,58,71" The administrator, interim DON (director of nursing), and ADM B were informed of the failure of LPN A to perform hand hygiene after removing used gloves and prior to donning new gloves during pressure injury wound care, 6/15/16 at 1 p.m.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 318	Continued From page 11 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement the use of a physician ordered palmar hand roll to prevent further decline in range of motion for one Resident (Resident #3) in a survey sample of three Residents. Resident #3 was observed 5/14/16 during initial tour and at 3:13 p.m., and 5/15/16 at 8:58 a.m. and 11:16 a.m. without a physician ordered palmar hand roll in his left hand. The findings included: Resident #3, a male, was initially admitted to the facility 4/2/03 and readmitted after a hospitalization 5/10/13. His diagnoses included stage II pressure injury to the elbow, colon cancer with resection, profound intellectual disability, seizure disorder, constipation, spastic cerebral palsy, aspiration syndrome, Crohn's disease, self injurious behavior, and Vitamin D deficiency. Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/12/16 was coded as a quarterly assessment. Resident #3 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. He was also coded as requiring total assistance of	F 318	Palm roll was immediately applied to resident number 3's left hand as ordered upon surveyor informing interim DON. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with orders to apply palm rolls or other device to prevent decline in range of motion have the potential to be affected by this deficient practice. Upon notification of the deficient practice by the surveyor, Nursing staff were instructed to make rounds on all residents (100%) with palm roll devices to ensure all devices were applied as ordered. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. LPNs will make rounds on all (100%) assigned residents, each shift and after the residents' shower and bathing, to monitor CNAs compliance with orders to have a palm roll or other devices to prevent decline in range of motion. Any noncompliance will be corrected immediately. The LPN will document on an audit form daily any noncompliance and turn into the shift supervisor for corrective action. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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	495113	A. BUILDING _____ B. WING _____	C 06/15/2016

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F 318	Continued From page 12 one to two staff members to perform his activities of daily living. Resident #3 was coded as being at risk for formation of pressure injury and had one stage II pressure injury. Resident #3 was coded as having limited range of motion in both upper extremities. Definition of a stage II pressure injury by www.npuap.com: "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." Resident #3 was observed 5/14/16 during initial tour and at 3:13 p.m., and 5/15/16 at 8:58 a.m. and 11:16 a.m. without a physician ordered palmar hand roll in his left hand. During all of the observations, Resident #3 was observed to have notable contractures of his left hand. His right hand was covered with a mitt to prevent self injurious behavior. A dressing was noted on his left thumb. His thumb was contracted against the palm of his left hand. Review of Resident #3's clinical record revealed a	F 318	The Shift Supervisors will review 100% of the audits performed by the LPNs to monitor compliance. Any performance concerns noted during monitoring will be addressed and actions documented when identified. All audits will be submitted monthly to the Medical Executive Committee via the DON and Quality Management department. 5. Include dates when the corrective action will be completed. June 24, 2016	

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F 318	Continued From page 13 signed physician's order that included: "Dermasaver palm roll left hand." The order was on the most recently signed "Physician's Orders" dated as signed 6/9/16. An accompanying entry was noted on the "Positioning, Splinting, and Related Rehab-Orders" form. RN (registered nurse) A stated 6/15/16 at 11:45 a.m., the form was utilized for CNAs (certified nursing assistants) to document care they provided. CNA initials were evident for day, evening, and night shifts on 6/14/16 and 6/15/16 indicating the staff had implemented the "Dermasavers palm roll in left hand." When interviewed CNA A, a staff member assisting Resident #3, stated 6/15/16 at 11:55 a.m., she was aware Resident #3 was to use a palmar hand roll but she did not know where his was. CNA A stated she would get a new one and apply it in his left hand. She indicated the hand roll could possibly have gotten soiled and was in the laundry. Review of the OT (occupational therapy) recommendations included, "His Dermasaver palm roll continues to fit in his left palm and has been effective in reducing poor skin integrity, so it is recommended that this continue to be used." After performing wound care, 6/15/16 at 11:16 a.m. LPN A stated the dressing on Resident #3's thumb was for "protection" as his thumb was contracted against his palm. Review of his clinical record did include a physician's order, "Aquacel AG Apply to left thumb after cleaning, and then cover with 2x2	F 318		

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F 318	Continued From page 14 and wrap daily." The skin assessments and physician's notes revealed no area was on Resident #3's left thumb, the treatment was preventative. The administrator, interim DON (director of nursing), and ADM B were informed of the failure of the staff to implement the use of palmar hand roll to prevent further decline in range of motion for Resident #3, 6/15/16 at 1 p.m.	F 318		
F 354 SS=E	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have a full time DON (director of nursing). The 11-7 nurse supervisor was also the interim DON. The findings included:	F 354	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Night Shift Supervisor was designated as the Interim Director of Nursing for the facility. She will fulfill the duties of the Director of Nursing on a full time basis. Her duties as the Night Supervisor were assigned to another Nursing Supervisor. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. No resident was affected or harmed by this deficiency. However a designated Interim Director of Nursing on a full time basis is necessary to oversee the nursing care delivery of the facility, to ensure the highest quality of care is rendered to the residents. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.	

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F 354	Continued From page 15 Upon entering the facility 6/14/16, at 11:45 a.m., the administrator stated the current DON was an interim DON. The administrator said the previous DON had left the facility sometime in February, 2016. The administrator stated the position was posted for rehire. The interim DON (ADM C) stated 12:10 p.m., during initial tour, that she was also the 11-7 nurse supervisor and while she had worked primarily days since becoming interim DON, she had also worked 11-7 shift and a few 3-11 shifts. Review of the job descriptions for DON (or Chief Nurse Executive) and Registered Nurse Coordinator (the position ADM C held) revealed the job descriptions were two entirely separate positions and while some of the duties were overlapping the positions were two separate positions. The administrator stated 6/15/16 at 8:20 a.m., ADM C worked 1 7-3 shift, 2 3-11 shifts, and 2 11-7 shifts during the average work week. The administrator stated ADM C had her previous duties as 11-7 nurse supervisor and assumed the duties of the DON since February, 2016. The census of the facility was 68 upon entry on 6/14/16 and was consistently over 60 since February, 2016. The administrator, interim DON, and ADM C were informed of the failure of the facility to have a full time DON, 6/15/16 at 1 p.m.	F 354	A full time Interim Director of Nursing with no other duties assigned was designated and announced to all staff. The Interim Director of Nursing will be in place until the Director of Nursing is hired. In addition, a staff Registered Nurse on night shift will be designated as the Charge Registered Nurse. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Facility Director will monitor to ensure specific Interim DON duties are identified and performed: the Interim DON will attend 100% of all MEC (Quality) & Infection Control meetings and will conduct and chair 100% of a nursing shift supervisor's meetings. She will monitor and audit approval 100% of nursing purchasing requests and audit ensure sufficient and appropriate staffing 100% of the time. The Facility Director will identify the Night Shift Supervisor duties and ensure they are carried out by the covering Night Shift Supervisor with Charge Registered Nurse on the night shift. 5. Include dates when the corrective action will be completed. June 15, 2016	