DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495123	A. BUILDING _____ B. WING _____	06/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL HEALTH CARE CENTER	905 COUSINS AVENUE HOPEWELL, VA 23860

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and complaint survey inspection was conducted 6/1/16 through 6/3/16 to 6/6/16 and 6/8/16. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance With all Federal and State regulations, the facility has taken or will take the action set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 225 SS=D	The census in this 130 certified bed facility was 103 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through Resident #18) and six closed records, (Resident #19 through Resident #24). 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	F 225	F225 New employees shall have appropriate license/certification checks as required prior to employment starting. Current residents were at risk by this alleged deficient practice. Current employees have background checks	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth R. Dowe — TITLE: ADMINISTRATOR — (X6) DATE: 6/30/16

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 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged 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 employee record review, staff interview, and facility documentation review the facility staff failed to verify that the employee had a valid certification with the Department of Health Professions (DHP) prior to hire for one certified employee (Emp. #2) in a federal survey sample of 4 certified/licensed employees, and one non-certified/licensed employee. The findings included: Emp. #2, a CNA (certified nursing assistant) was hired by the facility on 3-21-16. Review of the employee records revealed that the CNA certification, was not verified initially upon hire, for the above individual. A thorough review of the employee records revealed the certification was verified 3 days after the employee was hired, on 3-24-16.	F 225	Department Heads shall be in-serviced on pre-employment requirements by regional HR/designee. The Administrator/ Regional HR shall validate new hires have had their pre-employment certification/license checks completed by compleitng random audits of new hire files weekly for 4 weeks then monthly for 3 months. Concerns identified shall be taken to the facility QAPI for follow up and resolution. Date of Compliance 7-13-16	

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F 225	Continued From page 2 On 6-8-16 at 11:00 a.m. the "Payroll and benefits Coordinator" for the facility who was responsible for these employee records was interviewed. She stated that the verification was late. Review of the facility's "Abuse Policy" included guidance: "Screening: interview, RN (Registered Nurse), LPN (Licensed Practical Nurse), CNA check, license check & verification, application specifies conviction, OIG (Office Inspector General), exclusion, 2 references, criminal background check..." The administrator, DON (director of nursing), and corporate RN consultant, were advised of the failure of the staff to verify Employee licenses/certifications before hire on 6-8-16 at 3:30 p.m., no further information was available to be presented by the facility.	F 225		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and in the course of a complaint investigation, the facility staff failed to ensure a clean, comfortable and homelike environment.	F 252	F252 The specific concerns with in the 2567 have been addressed and remediated. Current residents have the potential to be at risk from this alleged deficient practice.	

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F 252	Continued From page 3 1. The facility was observed to have dirty hand rails, holes in the walls, rusty toilet tissue holders, a rusty bed side commode, a bathroom door that would not open completely and uncovered bedpans and urinals in resident bathrooms. 2. During all days of the survey (6/1/16 to 6/3/16 and 6/6/16 and 6/8/16), there were pervasive, persistent urine and bowel movement odors on the second floor, especially to the right of the conference room and the left hall. The findings included: 1. During general observations of the facility conducted over the days of the survey the following observations were noted: a. The top portion of the hand rails on the second floor of the facility were darkened and dirty in appearance. The wood support ledge located directly behind the handrails were heavily coated with thick layers of dust. b. Room 218 - Wall area behind the headboard of the bed beside the window had a damaged area measuring 3 feet by 1 3/4 feet, that was unpainted and with exposed dry wall. c. Room 219 - Bedside commode with rust visible on chair legs and front support bar. Top of the bathroom commode was covered in a dirty film. An uncovered bedpan was positioned upside down on the floor beside the commode. The toilet water in the commode was constantly running. d. Room 203- Two large square holes were	F 252	Maintenance staff, housekeeping staff and Administrator shall be in-serviced on the expectations of mainitaining the facility to current standards by the Regional Maintenance Director. The Administrator/designee shall make rounds of up to 10 resident rooms weeklyfor 4 weeks then monthly for 3 months for concerns with maintenance or housekeeping. Concerns shall be taken to facility QAPI for follow up and resolution. Date of compliance 7-13-16	

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located in the wall behind the headboard of the bed located beside the window. There was damage 3/4 of the way up the wall beside the entrance door where a wall hand sanitizer dispenser had been removed.

e. Room 205/207 bathroom, an uncovered, used urinal with no name or room identifier was positioned on the hand rail beside the toilet.

f. Room 121 bathroom floor with dark brown dried smears on the floor behind the toilet and an uncovered urinal was on the floor.

g. Room 105 bathroom wall facing the toilet had three thick dark brown linear smears located three quarters of the way up the wall next to the glove box.

h. Room 104 bathroom door could only partially be opened. There was a heightened area of the floor that blocked the complete opening of the bathroom door.

i. Chrome/Silver colored toilet paper holders in the residents' bathrooms were heavily covered in rust. This was observed in 15 out of the 17 bathrooms.on the first floor and in 15 of the 18 bathrooms on the second floor.

The areas of concerns were shown to the head of environmental services, Other G, on 6/8/16 at 11:00 a.m. Other G said that the expectation was for the resident rooms to be cleaned daily.

On 6/8/16 at 11:20 a.m., the second floor unit manager, RN A, was informed of the urinal and the bedpan that were located uncovered and she immediately discarded them.

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The maintenance areas of concerns were pointed out to the maintenance supervisor, Other F, on . 6/8/16 at 11:40 a.m. When interviewed, Other F said the areas of concern would be repaired.

The administrator was informed of the concerns on 6/8/16 at end of day meeting. The administrator said that there were plans for renovation that included replacement of the handrails on the second floor. A review of the facility's Renovation Plan regarding the replacement of the hand rails read, "Handrails to be scrubbed and board behind rail is bolted. Proposed time 2017."

The administrator and DON (director of nursing) were informed of the failure of the staff to maintain the building in a clean, comfortable, and homelike environment, 6/8/16 at 6:15 p.m. No additional information was provided.

During all days of the survey (6/1/16 to 6/3/16 and 6/6/16 and 6/8/16), there were pervasive, persistent urine and bowel movement odors on the second floor, especially to the right of the conference room and the left hall.

On 6/2/16 at at 12:00 PM, there was a persistent urine odor on the front hall.

On 6/2/16 at 4:20 PM, there was strong persistent urine odors on the hall.

On 6/3/16 at 10:50 AM, Upon entering the room of Resident #4, there was a strong bowel movement odor in the room. After observing the

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F 252	Continued From page 6 heel wound of Resident #4, the sheet was pulled back, and the resident had a large amount of dried bowel movement from the brief onto the sheet. The two surveyors present left the room to allow the resident to be changed. On 6/8/16 during environmental rounds, odors remain persistent on the right and left areas on the East unit. On 6/3/16 at 2:10 PM, the Administrator and DON (director of nursing) were notified of the pervasive odors. Both denied being aware of these odors.	F 252	F279 R#6's CP has been reviewed and updated as needed to meet current needs.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	Residents with actual skin alterations have been identified at risk from this alleged deficient practice. Nurse Managers and Licensed Nurses shall be in-serviced by CSC/desginee on proper Care Planning process related to actual skin alterations such as arterial wounds. The DNS/designee shall audit up to 10 resident CP's weekly for actual skin breakdown CPs as needed for 4 weeks then monthly for 2 months. Concerns identified shall be taken to the facility QAPI for follow up and resolution. Date of Compliance 7-13-16	

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to develop a comprehensive care plan for a foot wound for Resident #6.
1. The facility staff failed to develop a care plan for an arterial wound on the right great toe of Resident #6.
Findings included:
Resident #6, a 60 year old female, was admitted to the facility on 4/14/2014 and readmitted on 2/5/2016. Her diagnoses included traumatic brain injury, contractures, dysphagia, hypertension, reflux, and aphasia. Resident #6 was the victim of a motor vehicle accident in 3/2014 resulting in a skull fracture and subdural hematoma. Her hands and feet were contracted and she was nonverbal.
Resident #6's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) was coded as an annual assessment. She was totally dependent on one person for her activities of daily living and was always incontinent of bowel and bladder. Resident #6 had a peg (percutaneous endogastric-feeding tube inserted through the skin and into the stomach) tube for nutrition, and a tracheostomy (tube placed into the throat through the neck) to facilitate breathing.
Resident #6 was observed on 6/2/2016 at 11:00 AM in a reclining wheelchair in her room. CNA Certified Nursing Assistant) C had just finished dressing the Resident. Resident #6 's toes were contracted at the first joint and an open wound on the knuckle of the right great toe was seen. CNA C stated that she was unsure when or how this wound developed.
On 6/2/2016 at 1:20 PM Resident #6 was again observed with LPN D and the right toe wound

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F 279	Continued From page 8 was more closely examined. The wound was over the bony prominence of the first knuckle of the right great toe and measured 1.8 cm (centimeters) x 2.1 cm. The depth was not measureable. The wound bed contained moderate sero-sanguinous tissue with 100% granulation tissue. It was treated with calcium alginate and covered with a dry dressing daily. LPN-D did not know the origin of the wound or how long the condition existed. Resident #6's Care Plan was examined and two areas relating to skin integrity were noted: "Infection of wound/skin" "At risk for alteration of skin integrity related to normal disease progression" There was no mention of Resident #6's wound to the right great toe in the current Care Plan. Facility policy "Skin Integrity Program: Identification and Prevention" states the following: "Plan and Implement Care 5. A comprehensive, interdisciplinary, resident centered plan of care will be developed and implemented based on identified risks and individual needs, to avoid skin breakdown and treat impaired skin integrity and existing ulcers. The effectiveness of the interventions will be evaluated and the plan of care will be reviewed and revised as needed". Administration was informed of the findings on 6/8/2016 at 6:00 PM.	F 279		
F 280 SS=D	THIS IS A COMPLAINT DEFICIENCY 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		

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F 280	Continued From page 9 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to review and revise the comprehensive plan of care for two Residents (#22 and # 4) in a survey sample of 24 Residents. 1. For Resident #22, the care plan was not revised after Resident #22 experienced a significant weight loss and a fall; and 2. For Resident #4, the facility staff failed to review and revise the nutrition care plan. The findings included:	F 280	F280 R#4 comprehensive care plans have been reviewed and up dated to meet current needs. R#22 no longer resides in the center. Current residents have been identified at risk from this alleged deficient practice. Nurse Managers, MDS staff and Charge nurses shall be in-serviced on the expectations of updating care plans as needed to reflect the current status of the residents. The DNS/designee shall review up to 10 CPs weekly for 4 weeks then monthly for 3 months for accuracy related to current needs. Concerns identfied shall be taken to the facility QAPI committee for follow up and remediation. Date of Compliance 7-13-16	

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1. For Resident #22, the care plan was not revised after Resident #22 experienced a significant weight loss and a fall.

Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was coded as needing limited assistance. Resident #22's weight was coded as being 172 pounds.

Review of Resident #22's clinical record revealed her admission weight of 171.5 pounds. Over the course of her stay at the facility her weight decreased to 147.4 pounds (her last documented weight prior to discharge).

Review of her comprehensive care plan revealed the only care plan developed to address nutritional concerns was developed on 8/28/15, "Risk for alteration in nutrition r/t (related to) tolerance of therapeutic diet, pain, impaired cognition." Included in the "Interventions" was "Honor food preferences; Notify physician and responsible party of significant weight changes; Weights as ordered."

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A thorough review of Resident #22's clinical record revealed the above mentioned care plan was the only care plan developed to address Resident #22's nutritional needs, even though she experienced a weight loss of 14%.

When interviewed 6/8/16 at 10;50 a.m., the RD (registered dietitian), stated she did not do anything with developing or updating care plans.

Additionally, upon admission to the facility Resident #22 was assessed as being at risk for falls. A care plan was developed on 8/18/15 that included, "At risk for falls due to impaired balance/poor coordination, history of falls, pain due to right hip fracture." Included in the "Interventions" was "Encourage to transfer and change positions slowly, Have commonly used articles within easy reach, Maintain bed in low position, Provide assistance to transfer and ambulate as needed."

On 10/7/15 Resident #22 was found sitting on the floor of her bedroom. An "Incident/Accident" form was completed and included in the interventions was "Matts (sp) bedside, Lowest position."

A thorough review of the care plan (including the CNA -certified nursing assistant-care plan) revealed no revision of the care plan occurred after the fall. No evidence was provided that the use of fall mats was ever instituted.

Guidance for the creation of an individualized care plan is provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, page 268:

In any health care setting a nurse is responsible for providing a written plan of care for all clients.

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The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another."

When interviewed, EMP. C (the ADON -assistant director of nursing) stated 6/8/16 at end of day meeting, she was unaware of how the care plan was revised.

The administrator, DON (director of nursing), and ADON were informed of the failure of the staff to revise Resident #22's care plans for safety measures after a fall and nutritional concerns for significant weight loss 6/8/16 at 4:06 p.m.

2. For Resident #4, the facility staff failed to review and revise the nutrition care plan.

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Resident #4, a 72 year old, was admitted to the facility on 12/12/08. Her diagnoses included dementia, Parkinson's disease, diabetes, anemia and high cholesterol.

Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/20/16. She was coded with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment and required extensive assistance with her activities of daily living.

On 4/13/16, a nutrition note completed by the Registered Dietitian (RD) documented Resident #4 experienced weight loss. The note read "Chart reviewed as weight loss noted at this time. Significant change noted x 6 months, and 3.8% down x 30 days. Wound healing again is issue. Weight remains high, BMI (Body Mass index) is above critical range. A change in resident noted, as affect more flat. Staff providing encouragement. Fair appetitive notes. S/S (signs/symptoms) of hypo hyperglycemia monitored. LCS (Low concentrated sweets) restriction continues. Vitamins and minerals are provided to promote healing and to prevent micronutrient depletion. Will suggest SF (sugar free) mighty shake bid (two times per day) at this time. Monitor tolerance. Supplement to provide energy and dietary protein to prevent further weight loss and promote healing."

On 6/6/16 at 12:30 p.m., Resident #4's lunch meal was observed. She was in bed, with head of bed elevated. She was fed by Certified Nursing Assistant K (CNA K). She did not have a divided plate or weighted utensils. She did not attempt to feed herself. CNA K stated that the

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resident used to be able to feed herself.

Resident #4's lunch meal consisted of vegetable lasagna, string beans, cake, mighty shake, and approximately 8 ounces of red juice. CNA K was asked if the juice had Propass added. CNA K stated that the kitchen mixed up a pitcher of Propass and brought it to the floor. The CNA's were responsible for pouring a glass of Propass juice for the residents who had an order.

Resident #4's care plan was reviewed. A care plan with the "focus" of "Nutritional Status: Potential weight change r/t (due to) cognitive impairment, impaired mobility, diagnosis of DM (diabetes). Resident has elevated BMI (body mass index), receives therapeutic, mechanically altered diet/ LCS (low concentrated sweets)" was initiated on 2/13/15 and revised on 3/24/16.

Interventions included:
- Adaptive equipment: plate guard, built up spoon, right handed cups as ordered (5/12/15)
- Encourage and assist as needed to consume foods and/or supplements and fluids offered at and between meals (5/12/15)
- Honor food preferences (5/12/15)
- Provide diet/ supplements as ordered (2/13/15)
- Weights as ordered (2/13/15)

The care plan had not been updated to address the following:
- did not address actual weight loss
- did not reflect that Resident #4 no longer fed herself
- did not reflect that she no longer required adaptive equipment
- did not reflect that she required assistance to eat and drink

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F 280	Continued From page 15 - did not reflect that the LCS (low concentrated sweets) diet had been discontinued (4/21/16) On 6/8/16 at 11:15 a.m., the RD was asked how often she updated the nutrition care plan. She stated that she did not update care plans. She was also asked if the resident could feed herself. She stated that staff began feeding the resident about a month ago. On 6/8/16 at 4:20 p.m., Resident #4's nutrition care plan was discussed with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). They were informed that the care plan had not been updated to reflect weight loss, changes in feeding assistance and diet order. They were informed that the RD stated that she does not update care plans. When asked who at the facility was responsible for updating care plans, the ADON stated the nursing staff or the MDS (Minimum Data Set) staff updated the care plans.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide services that meet professional standards of quality for two residents, Resident #9 and Resident #22 in a survey sample of 24 Residents.	F 281	F281 R#9 clinical record has been reviewed and plans of care reflect current needs of the residents. R#22 no longer resides in the center. Residents requiring wound documentation and those with Duragesic patches ordered by their physician were identified as those at risk from this alleged practice	

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F 281	Continued From page 16 1. For Resident #9, the facility failed to ensure an accurate clinical record. The Corporate Nurse altered a pressure ulcer tracking document. 2. For Resident #22, the facility staff failed to ensure Duragesic, a pain medication patch, was documented as having been administered. The findings included: Resident #9, a 61 year old, was admitted to the facility on 3/31/15. Her diagnoses included hemiplegia, dysphagia, diabetes, stroke, and chronic obstructive pulmonary disease. Resident #9's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/27/16. She was coded with moderate cognitive impairment. She was coded as 4/2 (total dependence, one person assist) for bed mobility and 4/3 (total dependence, two person assist) for transfers. She was not coded to have any skin issues. On 6/8/16, the facility provided photocopied information regarding Resident #9's sacral wound tracking. Many of the copies provided had already been photocopied on 6/6/16. Thus, duplicate wound tracking information was available. The following pressure ulcer record was originally photo copied for surveyors on 6/6/16. The form read "Between Buttocks", date of origin- 2/11/16. Facility acquired. Assessment date: 2/19/16. The area is documented as "Unstageable".	F 281	The nurse managers, and Clinical Services Coordinator (Corp Nurse) shall be educated on accurate documentation especially related to wound measurements, location and description. Licensed nurses shall be educated on the required documentation of medication administration of narcotics in both the controlled substances log and the MAR. Audits of weekly wound notes for throughness of documentation shall be completed for up to 5 records weekly for 4 weeks then monthly for 3 months by the DON/designee. Audits of the MAR/Controlled Substances log for complete documentation in both documents shall be completed weekly for up to 10 residents for 4 weeks then monthly for 3 months.	

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F 281	Continued From page 17 Measurements: 3 x 2 x 0.5. Wound bed= pink, dark pink/reddened tissue, Surrounding tissue= reddened, Exudate= serosanguineous, "treatment in progress". In attempts to provide an explanation of the wound development, the facility staff provided another copy of the "Between Buttocks" pressure ulcer record on 6/8/16. This same form (originally copied 6/6/16) had been altered from the original. On the 6/8/16 copy, the date of origin had been changed to 2/15/16 and the word "error" was written in next to where "unstageable" was documented. On 6/8/16 at approximately 9:45 a.m., the Director of Nursing (DON) was notified that the pressure ulcer record "Between Buttocks" had been altered from the original copy. She was asked to have which ever staff who had changed the document to come speak to the survey team. On 6/8/16 at 10:00 a.m., the Corporate Nurse arrived to speak with the survey team. She stated that she had changed the document in attempts to make the wound documentation make sense. Once the Corporate Nurse changed the wound record, the accuracy of the wound tracking in the clinical record was in question. The Corporate Nurse changed wound information documented four months ago and she changed information for which she was not the original author or observer. 2. For Resident #22, the facility staff failed to ensure Duragesic, a pain medication patch, was documented as having been administered.	F 281	Concerns identified from the audits shal be taken to the facility QAPI Committee for follow up and resolution. Date of Compliance 7-13-16	

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Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was coded as needing limited assistance. Resident #22's weight was coded as being 172 pounds.

Review of Resident #22's clinical record revealed a signed physician's order that included, "Duragesic Patch 25 mcg (microgram) transdermal q (every) 3 days." The order was included in the "Physician's Orders" signed on 9/30/15.

A corresponding entry was placed on the MAR (medication administration record) with guidance for the staff to apply the Duragesic patch every three days. Nurse's initials were evident that the pain patch was applied every three days with the exception of 9/25/15 and 9/28/15. Upon review of the "Controlled Drug Receipt/Record/Disposition Form" evidence was provided the Duragesic patch was applied on 9/25/15, however not on 9/28/15. The "Controlled Drug Receipt/Record/Disposition Form" is a record of medications that are deemed to be Schedule II medications or medications that have been

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determined to be at high risk of abuse. The staff sign and date whenever one of those medications are administered, with the form providing a running tally of medication administered and available.

When interviewed, EMP. C stated a Duragesic Patch was signed for on 9/25/15 on the "Controlled Drug" form and the staff failed to document the administration on the MAR. EMP. C further stated staff should document at the time of administration of medications, 6/8/16 at 4:08 p.m.

Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication
2. The right dose
3. The right client
4. The right route
5. The right time
6. The right documentation."

The administrator, DON (director of nursing), and ADON (assistant DON) were informed of the failure of the staff to ensure Duragesic patch was documented as having been administered on 9/25/15, 6/8/16 at 4:08 p.m.

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F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, complaint investigation and clinical record review the facility staff failed to maintain the highest practicable well-being for two residents (#6 and #22) resulting in harm for Residents #6. 1. For Resident #6, the facility staff failed to provide medical consultation for an arterial foot wound until it developed into a broken skin wound, resulting in harm. 2. For Resident #22, the facility staff failed to administer Ancef, an antibiotic, per physician's order. The findings included: 1. For Resident #6, the facility staff failed to provide medical consultation for an arterial foot wound until it developed into a broken skin wound, resulting in harm. Resident #6, a 60 year old female, was admitted to the facility on 4/14/2014 and readmitted on 2/5/2016. Her diagnoses included traumatic brain injury, contractures, dysphagia, hypertension, reflux, and aphasia. Resident #6 was the victim of a motor vehicle accident in 3/2014 resulting in a skull fracture and subdural hematoma. Her hands and feet were contracted and she was	F 309	F309 R#6 wound history has been reviewed with the primary physcian as well as the results of the studies. R#6 plan of care reflects current staus and needs R#22 no longer resides in the center. Residents with wounds have been identified at risk of this alleged practice. Residents who have need for IV antibiotics are also identified at risk. Licensed nurses and nurse managers shall be in-serviced on the importance of physician communication in events of new wounds for assessment and possible consultation, the importance of and expectation of giving IV antibiotics medications as ordered. Random Audits of weekly wound record for throughness of documentation shall be	

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F 309	Continued From page 21 nonverbal. Resident #6's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/9/16 was coded as an annual assessment. She was totally dependent on one person for her activities of daily living and was always incontinent of bowel and bladder. Resident #6 had a peg (percutaneous endogastric-feeding tube inserted through the skin and into the stomach) tube for nutrition, and a tracheostomy (tube placed into the throat through the neck) to facilitate breathing. Resident #6 was observed on 6/2/2016 at 11:00 AM in a reclining wheelchair in her room. CNA Certified Nursing Assistant) C had just finished dressing the Resident. Resident #6's toes were contracted at the first joint and an open wound on the knuckle of the right great toe was seen. CNA C stated that she was unsure when or how this wound developed. On 6/2/2016 at 1:20 PM Resident #6 was again observed with LPN D and the right toe wound was more closely examined. The wound was over the bony prominence of the first knuckle of the right great toe and measured 1.8 cm (centimeters) x 2.1 cm. The depth was not measureable. The wound bed contained moderate sero-sanguinous tissue with 100% granulation tissue. It was treated with calcium alginate and covered with a dry dressing daily. LPN D did not know the origin of the wound or how long the condition existed. The clinical record was then examined and revealed the following progress notes relating to the right foot wound: 2/7/2016 (First entry for this wound)- "Right great toe has open area" 2/7/2016- "Reddened area to right great toe." 2/9/2016-(by Nursing Management)- "Noted to	F 309	completed for up to 5 records weekly for 4 weeks then monthly for 3 months by the DON/designee. Audits of the MAR for complete documentation shall be completed weekly for up to 10 residents for 4 weeks then monthly for 3 months. Concerns identified shall be taken to the facility QAPI committee for follow up and resolution. Date of Compliance 7-13-16	

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have reddened area to right great toe ..."
2/11/2016- "Open area to right great toe appears to be getting progressively better."
5/9/2016- "Change in condition-culture of right great toe. Since this started it has gotten worse."
5/13/2016- "Culture MRSA (Methicillin-Resistant Staph Aureus) right great toe. Contact precautions started."
5/18/2016- "Right great tow (sic) measure 0.6 cm x 1.5 cm x 0.1 cm granular with small amount of drainage."
5/22/2016- "Resident on ATB (antibiotic) for MRSA in right great toe. No adverse reactions noted."
5/23/2016- "Resident on ABT for MRSA in right great toe, no adverse reactions noted, remains on contact precautions."
Facility skin condition records were examined and they showed no mention of the right great toe wound.
Activities of Daily Living (ADL) records were examined and there was no mention of the right great toe wound.
Physician Progress Notes from 1/13/2016 to 6/1/2016 were examined. One note (6/1/2016) stated "open area over right toe. No granulation tissue. Daily dressing wet to dry".
Initial admission assessment on 4/14/2014 did not indicate the presence of any skin problems.
Readmission assessment of 2/5/2016 also showed no skin problems.
On 6/2/2016 at 4:00 PM an interview was conducted with Employee B, Director of Nursing who was asked to comment on this wound. She stated that "We should have looked more closely at this wound before now".
On 6/6/2016 at 11:00 AM, Other A, Wound Care Physician examined Resident #6 and an interview was conducted with him. He stated that he felt

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that the wound was a result of poor arterial blood flow to the foot. He recommended a vascular surgery consult, bilateral arterial Doppler studies, and bilateral ABI (Ankle Brachial Index). These tests will confirm the diagnosis. He stated that the clinical record was difficult to follow, and sometimes contradictory, and that the facility should have called him at the very early stages of the development of this wound. He recommended the application of foam to the wound until tests were completed.

On 6/6/2016 at 3:10 PM an interview was again conducted with Employee B, Director of Nursing in the presence of the survey team. Regarding the Wound Care Physician, she stated that "I asked him to see the Resident because you were looking at her (Resident #6)".

On 6/6/2016 at 5:30 PM the Survey Team asked Employee B, Director of Nursing to describe the facility wound care process. She stated that "nurses do skin checks two times per week". She was further asked how Resident #6's wound escaped the assessment and why the wound care physician was not summoned in the early days of the wound development. She stated that "It is difficult for me to see what happened. We must have missed it."

Resident #6's Care Plan was examined and it contained no mention of the toe wound.

Facility "Skin Integrity Program: Identification and Prevention" stated:

"Identify New or Existing Wounds

4. Upon identification of a new pressure injury or lower extremity wound or when admitting a patient with a pressure injury or lower extremity wound:

4.1 The nurse will evaluate the area, notify the supervisor, practitioner, and patient or patient's representative.

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5. A comprehensive, interdisciplinary resident care plan will be developed and implemented based on identified risks and individual needs to avoid skin breakdowns and treat impaired skin integrity and existing ulcers.
6. The resident's skin will be observed daily during personal care; direct caregivers must promptly report any alterations in skin integrity to the nurse."

Administration was informed of the harm findings on 6/8/2016 at 6:00 PM and no other information was provided.
THIS IS A COMPLAINT DEFICIENCY

2. For Resident # 22, the facility staff failed to administer Ancef, an antibiotic, per physician ' s order.

Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was coded as needing limited assistance. Resident #22's weight was coded as being 172 pounds.

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F 309	Continued From page 25 Review of Resident #22's clinical record revealed she was diagnosed as having an infected left great toe on 9/24/15. Her physician ordered for a culture to be done of the toe and started Resident #22 on two different antibiotics, Daptomycin 350 mg (milligram) daily and Ancef 1 gram every 8 hours. Both antibiotics were to be administered IV (intravenously). Accompanying entries were noted on the MAR (medication administration record), with nurses initials indicating the medications were administered. Calculation of the doses administered of Ancef revealed Resident #22 was administered 33 doses of Ancef, from 6 a.m. on 9/25/15 through 10 p.m. on 10/5/15. Calculation of the number of doses that should have been administered by physician's order indicated Resident #22 should have received 30 doses of Ancef 1 gram. When interviewed, the DON (director of nursing) stated 6/8/16 at 4:08 p.m., she had counted the doses and Resident #22 did receive three doses too many. Additionally, the DON stated the staff should administer medications per physician's order. Guidance was provided at www.drugs.com for administration of Ancef, "Follow all directions on your prescription label. Do not use this medicine in larger or smaller amounts or for longer than recommended." The administrator, DON, and ADON (assistant DON) were informed of the failure of the staff to administer Ancef per physician's orders to Resident #22, 6/8/16 at 4:08 p.m.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 26 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for one resident, Resident #4, in a survey sample of 24 residents, to provide timely incontinence care. Resident #4 had dried bowel movement from the brief onto the sheet. The findings included: Resident #4, a 72 year old, was admitted to the facility on 12/12/08. Her diagnoses included dementia, Parkinson's disease, diabetes, anemia and high cholesterol. Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/20/16. She was coded with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment and required extensive assistance with her activities of daily living. On 6/3/16 at 10:50 AM, upon entering the room of Resident #4, there was a strong bowel movement odor in the room. After observing the heel wound of Resident #4, the sheet was pulled back, and the resident had a large amount of dried bowel movement from the brief onto the	F 312	F312 R#4 plan of care has been reviewed and she is receiving ADL asistance per that plan of care. Residents that require assistance with ADLs have been identified at risk from this alleged practice. Nursing staff shall be in-serviced on identification of needs of residents and proper care provision including incontinence care. Random observation of incontinent care shall be completed up to 5 times weekly for 4 weeks for proper technique and completion then monthly for 3 months. Concerns identified from the audits shall be taken to the facility QAPI committee for follow up and resolution. Date of Compliance 7-13-16	

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F 312	Continued From page 27 sheet. The two surveyors present left the room to allow the resident to be changed. On 6/8/16 at 5:30 PM, the unit manager, RN (registered nurse) A stated the following: "Incontinence care should be provided at least every 2 hours and after each incontinence episode. On 6/6/16 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings. This was a complaint deficiency.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 and clinical record review, the facility staff failed for three residents, (Resident #4, #9 and #5) in a survey sample of 24 residents, to prevent, assess, identify and treat three avoidable pressure ulcers resulting in harm for all three residents. 1. For Resident #4, the facility failed to identify an	F 314	F314 R#4,#5 and 9's wounds have been assessed and plans of care reviewed to meet current needs of each resident Residents at risk to develop avoidable pressure ulcers were idnetified as those at risk from this alleged practice. Braden scores have been reviewed for the need of interventions for those at high risk of skin breakdown	

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F 314	Continued From page 28 unstageable pressure ulcer to the left heel. On 2/5/16, the wound was first identified by the Wound Care Specialist as 100% eschar, unstageable, measuring 3.4 x 4 x not measurable centimeter. Discoloration to the heels was noted in November 2015. Interventions were not put into place to prevent the deterioration of the heel until 1/5/16 (off loading of the heels) and 1/26/16 (specialty mattress). 2. For Resident #9, the facility failed to identify an unstageable pressure ulcer to the sacrum. On 2/22/16, the wound was first identified by the Wound Care Specialist as unstageable, 70% yellow necrotic, 30% granulation tissue, measuring 3.4 x 1.8 x 0.1 centimeter. On 2/15/16, the facility first documented a skin condition present between the buttocks, the area they consider the origin of the wound. Interventions were not put into place to prevent the deterioration of the area until 2/20/16 (wedge for turning & positioning) and 2/23/16 (specialty mattress). 3. For Resident #5, the facility failed to identify a pressure wound until it had reached an unable to stage pressure wound. On 4/25/16, a new area measured 1.7 cm (centimeters) by 2.0 cm with no depth. Area was 100% slough. And the facility staff failed to follow wound care recommendations by the wound clinic physician. Resident #5 was observed in the gerichair on her back from 8:30 AM to 12:00 PM; this was a continual observation. There was no observation of the resident being repositioned. Wound care recommendations included " limit sitting for 30 minutes". The findings included:	F 314	Nursing staffshall be in-serviced on risk identification, interventions and monitoring residents at risk of developing pressure ulcers. Nursing staff also shall be in-serviced on what to do if/when they find a previously unidentified wound of any source. Random observations of up to 20 residents identified at high risk for interventions shall be completed weekly for 4 weeks then monthly for 3 months for intervention usage. Random audits of up to 5 residents weekly for 4 weeks for documentation of current wound status then monthly for 3 months Concerns identified from the audits shall be taken to the facility QAPI Committee for follow up and resolution. Date of Compliance 7-13-16	

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Resident #4, a 72 year old, was admitted to the facility on 12/12/08. Her diagnoses included dementia, Parkinson's disease, diabetes, anemia and high cholesterol.

Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/20/16. She was coded with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment and required extensive assistance with her activities of daily living.

An annual MDS with an ARD 10/13/15 (prior to the development of the heel wound) did not code Resident #4 to have any open skin areas. Resident #4 was coded as a 4/3 (total dependence with two person assistance) for both bed mobility and transfers.
During the initial tour of the facility on 6/1/16, the survey team was notified that Resident #4 had an acquired stage IV pressure wound to the left heel. Resident #4 was included in the survey sample.

The form "Braden Scale for Predicting Pressure Sore Risk" was completed 1/14/16. Resident #4 was assessed to have a score of 14 indicating "Moderate Risk." In section 4, "Mobility- ability to change and control body position", Resident #4 was assessed as "Completely Immobile: Does not make even slight changes in body or extremity position without assistance."

On 6/3/16 at 10:50 a.m., two surveyors observed Resident #4's heel wound in the presence of the wound care nurse and Unit Manager. The left heel dressing was not affixed to the heel when the sock was removed. The dressing was very moist and was hanging off the heel. The wound

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measured approximately 4 centimeters in diameter with 100% granulation of wound bed. The outer area surrounding the lower part of the wound had eschar. Two areas of discoloration (black), appearing as a deep tissue area, surrounded the wound. After the heel wound observation, the wound care nurse pulled the sock up over the open, raw wound. The wound did not have a dressing. The resident started to cry. The issue of pain assessment will be addressed in deficiency F309.

According to the wound care nurse, the CNA would complete the form titled "Skin and Body Alert Form" when a shower or bed bath was provided. They were to use the form to document any skin issues observed during care. The form read "Use any time a new area is found to document communication and initial interventions." All areas identified by the CNA were then supposed to be evaluated by a nurse.

Resident #4's Skin and Body Alert Forms were reviewed. There were no forms provided prior to January 2016. Resident #4's skin issues were documented as follows:

1/6/16- both heels
1/9/16- area right heel
1/16/16- right heel
2/10/16- dark areas on heels
2/13/16- open right heel
2/17/16- dark area on heels, left heel open
2/20/16- dark area on ankles

The licensed nurses performed the weekly skin checks. They documented their findings on the "Body Audit" form. Resident #4's Body Audit forms were reviewed. Most of Resident #4's

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weekly skin checks were completed by Licensed Practical Nurse C (LPN C). The area to Resident #4's left heel was documented as follows:

11/23/15- dark area both heels- completed by LPN C
12/7/15- dark area both heels (calloused)- completed by LPN C
12/14/15- dark calloused areas both heels- not signed
12/21/15- dark calloused areas both heels
12/28/15- dark calloused areas both heels- completed by LPN C
1/4/16- dark calloused areas both heels- completed by LPN C
1/11/16- both heels
1/18/16- dark calloused heels- completed by LPN C
1/25/16- dark calloused heels- completed by LPN C
2/1/16- skin check not completed
2/8/16- calloused areas both heels- completed by LPN C
2/15/16- calloused areas heels- completed by LPN C

On 2/5/16, the Wound Care Specialist evaluated Resident #4's heel. A "Wound Care Specialist Initial Evaluation" was completed. The evaluation read: present with an unstageable (due to necrosis) of the left heel of at least 1 days duration. Wound size = 3.4 x 4 x not measurable centimeter (cm). 100% black necrotic tissue. Peripheral vascular: no edema of the left or right extremity, pedal pulse of left and right: posterior tibial detected by portable doppler. Continue skin prep every shift and as needed, float heels while in bed, off- load wound, reposition.

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While the Wound Care Specialist documented the left heel wound as 100% eschar on 2/5/16, LPN C continued to document the area to the left heel as a callous on her 2/8/16 and 2/15/16 weekly skin checks.

On 6/6/16 at 4:00 p.m., LPN C was interviewed about Resident #4's heel. LPN C was asked to describe what the area to the left heel looked like. She described the area as a calloused, crusty area, darker brown than the normal skin tone. In addition, she stated that the area was flush with the skin, felt thick like dried skin and felt tough. When asked if Resident #4 could lift her leg, LPN C stated no. LPN C stated that Resident #4 was able to move her leg back and forth. When asked how Resident #4 could have developed a callous, LPN C stated she was not sure.

The "Body Audit" documentation was reviewed with LPN C. It was explained to LPN C that on 2/5/16, the Wound Care Specialist documented an unstageable pressure wound (due to necrosis) of the left heel, 100% black necrotic tissue. It was reviewed with LPN C that her weekly skin check for 2/8/16 and 2/15/16 documented the area to the left heel as a calloused area. LPN C was asked how she continued to assess the area to the left heel as a callous when it had been a documented wound with 100% eschar for at least 10 days. LPN C stated that no one told her the area was a pressure wound.

LPN C was asked to describe the process for wound identification at the facility. She stated that the Skin and Body Alert form was completed by the CNAs during a shower or bed bath. Skin areas of concern were to be noted on the form. LPN C stated that the nurses completed the Body

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Audit form weekly.

On 6/6/16 at 1:45 p.m., the Wound Care Specialist was interviewed. The Wound Care Specialist began work at the facility in the fall of 2015. He agreed that the facility had an issue with wounds and stated that wound treatments were not always done as recommended. When asked to define a callous, he stated it was a build up of skin. He stated it would be thickened and caused by rubbing. When asked how someone who did not move their legs could develop a callous on the heel, the Wound Care Specialist stated he was unsure how that would happen without movement.

Wound tracking documentation for the left heel was reviewed. The wound was documented as follows:

1/4/16- "Non-Pressure Skin Condition Record" was initiated for the "left heal". "Date first observed" is blank. The area is described as intact discoloration measuring 3.5 x 6 x 0 centimeters (cm). The sections titled "Exudate, Wound Bed, Surrounding Skin, Pain, Progress, Treatment, Speciality Interventions, Nutritional Interventions and progress Notes" were not completed. The "Nurse's Signature" section was blank. The assessment appeared to be incomplete.

1/13/16- "Non-Pressure Skin Condition Record" 3.5 x 6 x 0 cm, intact, no exudate, wound bed= dark pink/ red tissue, surrounding skin= discoloration/ darkened area, prevalon boots in place

1/18/16- "Non-Pressure Skin Condition Record"

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3.5 x 6 x 0 cm, characteristics= intact and partial thickness, wound bed= normal for skin, surrounding skin= normal for skin, interventions= speciality bed, bilateral boots, wedge cushion

1/25/16- "Non-Pressure Skin Condition Record" 3.5 x 6 x 0 cm, characteristics= intact, wound bed= normal for skin, surrounding skin= normal for skin, interventions= speciality bed, bilateral boots, wedge cushion, supplements, continue with skin prep

1/27/16- "Non-Pressure Skin Condition Record" 3.5 x 6 x 0 cm, intact, no exudate, Wound Bed= Eschar, Surrounding skin= dry, Progress= not changed, continue skin prep (***NOTE- facility documented eschar present and also noted the progress of the wound "unchanged.")

2/5/16- "Wound Care Specialist Initial Evaluation", present with an unstageable (due to necrosis) of the left heel of at least 1 days duration. Wound size = 3.4 x 4 x not measurable cm. 100% black necrotic tissue. Peripheral vascular: no edema of the left or right extremity, pedal pulse of left and right: posterior tibial detected by portable doppler. Continue skin prep every shift and as needed, float heels while in bed, off- load wound, reposition.

2/5/16- "Pressure Ulcer Record" initiated. Unstageable, measurements= 3.4 x 4 x 0 cm

As of the time of the survey, the wound was unhealed. Staff continued to assess the wound weekly. The most recent assessment was conducted on 6/6/16. The wound was documented as follows: wound not staged, Measurements= 1.9 x 2.6 x 0.2 cm, 100%

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hypergranulation tissue.

On 6/2/16 at 2:10 p.m., the wound care nurse was asked at what stage a pressure wound should be identified. She stated stage I. The wound care nurse was also asked if skin issues to the heel should be tracked on a "nonpressure" skin form. The wound care nurse stated no.

The wound care nurse explained that she started in her position in March 2016. She stated that there was no one in the role of wound care nurse for about a month prior to her start.

The wound care nurse stated that weekly skin checks should be completed on shower days. If a skin issue is identified, a SBAR (concern form) should be completed and treatment should be initiated. The floor nurse was responsible for initiating the pressure or nonpressure form. The forms were added to the treatment book. The wound care nurse stated that she reviewed the treatment book daily.

Resident #4's Care Plan was reviewed. A care plan "focus" addressed risk for alteration in skin integrity, initiated 5/12/15. Interventions dated 5/12/15 included diet and supplements per physician order, assist to reposition, pressure distributing device to bed and chair, speciality matress. Interventions dated 5/9/16 included: Consume fluids, labs as ordered, provide preventative skin care, suspend/ float heels as able.

Another care plan "focus" initiated on 1/5/16 addressed "actual alteration in skin related to left heel" Interventions dated 1/5/16 included: obtain labs, provide diet and supplement per order,

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specialty mattress, suspend heels, use pillows/ positioning devices as needed.

An order for the specialty mattress was provided. The order, dated 1/26/16, read "Air loss mattress check placement / function every shift."

An order for skin prep was provided. The order, dated 11/19/15, read "apply skin prep to lt (left) heel q (every) shift + PRN (as needed), apply skin prep to rt (right) heel q (every) shift + PRN (as needed)." At the end of day meeting on 6/6/16, the facility staff was asked why skin prep treatment had been initiated to the heels. The facility did not provide an answer.

No order for prevalon boots was located in the record or provided by the facility. The use of prevalon boots or heel floats was not documented on the Treatment Administration Record for January, February or March 2016.

The facility policy "Skin Integrity Program: Identification and Prevention" was reviewed. The policy read "Residents with risk factors for pressure injury development or any actual impairment in skin integrity will be identified, and a risk based interdisciplinary plan of care will be implemented." The section titled "Identify New or Existing Wounds" read "Upon identification of a new pressure injury or lower extremity wound; or when admitting a patient with a pressure injury or lower extremity wound: 4.1. The nurse will evaluate the area, notify the supervisor, practitioner, and patient or patient's representative." The section "Plan and Implement Care" read "The resident's skin will be observed daily during personal care, direct caregivers must promptly report any alteration in

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skin integrity to the nurse. The resident's skin will also be thoroughly observed by the nurse weekly, and findings documented."

The following definitions regarding pressure injuries and staging were accessed from the National Pressure Ulcer Advisory Panel website on 5/31/16 at 1:25 p.m.
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
"Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."
"Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed."

At the end of day meeting on 6/2/16, the Administrator and Director of Nursing were notified that the issue with the heal was being considered as a harm level deficiency. They were asked to provide all wound related information. The Administrator and Director of

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Nursing were given additional opportunities to submit wound related information at the end of day meeting on 6/6/16 and 6/8/16.

2. For Resident #9, the facility failed to identify an unstageable pressure wound to the sacrum. On 2/22/16, the wound was first identified by the Wound Care Specialist as unstageable, 70% yellow necrotic, 30% granulation tissue, measuring 3.4 x 1.8 x 0.1 centimeter. On 2/15/16, the facility first documented a skin condition present between the buttocks, the area they consider the origin of the wound. Interventions were not put into place to prevent the deterioration of the area until 2/20/16 (wedge for turning & positioning) and 2/23/16 (specialty mattress).

Resident #9, a 61 year old, was admitted to the facility on 3/31/15. Her diagnoses included hemiplegia, dysphagia, diabetes, stroke, and chronic obstructive pulmonary disease.

Resident #9's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/27/16. She was coded with moderate cognitive impairment. She was coded as 4/2 (total dependence, one person assist) for bed mobility and 4/3 (total dependence, two person assist) for transfers. She was not coded to have any skin issues.

Resident #9 also had an annual MDS with an ARD of 2/24/16. She was coded with moderate cognitive impairment. She was coded as 4/2 (total dependence, one person assist) for bed mobility and 4/3 (total dependence, two person assist) for transfers. She was coded to have one

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unstageable pressure wound.

The form "Braden Scale for Predicting Pressure Sore Risk" was completed 2/3/16. Resident #9 was assessed to have a score of 11 indicating "High Risk." In section 4, "Mobility- ability to change and control body position", Resident #4 was assessed as "Completely Immobile: Does not make even slight changes in body or extremity position without assistance."

On 6/3/16 at 1:35 p.m., Resident #9's sacrum was observed in the presence of Certified Nursing Assistant I (CNA I). Old scar tissue was observed at the sacral area. No open areas were observed.

During a review of Resident #9's clinical record, it was identified that the resident had a facility acquired pressure wound to the sacrum. The area healed on 4/18/16.

Skin issues were documented in the clinical record as follows:

On 2/15/16, a SBAR (concern note) was write regarding the buttocks. The note read "Change in condition noted related to Shredding between buttock." "SKIN: Noted to have the following skin conditions present: Between buttocks." The "Interventions" read "Zinc oxide mixed with calmoseptine cream."

The following telephone orders regarding the zinc treatment were written:
- 2/15/16 8:15 a.m. "Mix Zinc Oxide with Calmoseptine (housestock); apply mixture to excoriation between buttock until healed q (every) shift."

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- 2/15/16 3:00 p.m. "Order clarification: Zinc Oxide 2% ointment apply to excoriated/ shearing area between buttock."
- 2/20/16 3:00 p.m. "Order clarification: zinc oxide 20 % oint mixed with dermaseptin (housestock) to bet. (between) buttock area; cleanse with NS (normal saline); Apply mixture & dry dsg (dressing) until healed Q (every) day. 1) ~~Zinc oxide 20 % mixed mixed with dermaseptin to~~ Rt. (right) ischium area cleanse with normal saline; apply mixture & dry dressing Q (every) day/ PRN (as needed) until healed.

On 2/22/16, the Wound Care Specialist evaluated Resident #9 at the request of the facility doctor. The Wound Care Specialist notes were reviewed. The "chief complaint" read "patient has rash". "Incontinence Associated Dermatitis" was documented. The treatment read "Zinc paste to bilateral buttocks bid (two times per day) and prn (as needed).

During the 2/22/16 evaluation, in addition to assessing the rash on the buttocks, the Wound Care Specialist identified an unstageable pressure wound on the sacrum. Under "Assessment & Plan" the evaluation notes read "Unstageable (due to necrosis) of the sacrum-initial evaluation." The wound was assessed as unstageable necrosis greater than 1 day duration, etiology: pressure, 70% yellow necrotic, 30% granulation tissue, exudate: light serosanguinous, measurements: 3.4 x 1.8 x 0.1 cm. Treatment: santyl- once daily, dry protective dressing- once daily. "Recommendation: Limit sitting to 30 minutes, off-load wound, reposition per facility policy."

A skin note, written by the Assistant Director of

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Nursing (ADON) on 2/22/16, was the first time a skin impairment to the sacral area is documented in the progress notes. The note read "2/22/16, Skin Note: Res was seen by wound doctor ____ today for the UTS (unable to stage) area to sacrum" "res has light serosanguineous to the area 70% yellow necrosis and 30% granulation."

On 2/25/16, the facility doctor documented a visit with Resident #9 on the "Physician Progressive Notes." The note read "sacral ulcer stage II." This note was completed three days after the Wound Care Specialist documented the sacral ulcer as unstageable.

The floor nurses performed the weekly skin checks. They documented their findings on the "Body Audit" form. Resident #9's Body Audit forms were reviewed.
2/10/16- "clear"
2/17/16- "shearing " with treatment, area between buttocks indicated on form
2/24/16- open area: sacral, "wound with treatment" indicated the area between buttocks and "area with treatment" indicated the back of upper right leg.

Certified Nursing Assistants (CNAs) would complete the form titled "Skin and Body Alert Form" when a shower or bed bath was provided. They were to use the form to document any skin issues observed during care. The form read "Use any time a new area is found to document communication and initial interventions." All areas identified by the CNA were then supposed to be evaluated by a nurse.

There was no CNA report of any skin concerns for Resident #9 during the month of February

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2016. During the month, it was documented on the Activities of Daily Living flow sheet that Resident #9 received a bed bath at least daily.

The following "Pressure Ulcer Records" were available in Resident #9's clinical record:

1. "Right Buttock", date of origin: 2/15/16. Assessment date: 2/19/16. The area is not staged. Measurements: 1 x 0.5 x 0. Wound bed= pink, Surrounding tissue= reddened, Exudate= none, "treatment in progress". Signed by Licensed Practical Nurse F (LPN F).

2. "Right Buttock", date of origin- blank. Assessment date: 2/19/16. The area is not staged. Measurements: 0.5 x 0.5 x 0. Wound bed= pink, Surrounding tissue= reddened, Exudate= none, "treatment in progress". Signed by LPN F.

3. "Between Buttocks", date of origin- 2/11/16. Facility acquired. Assessment date: 2/19/16. The area is documented as "Unstageable". Measurements: 3 x 2 x 0.5. Wound bed= pink, dark pink/reddened tissue, Surrounding tissue= reddened, Exudate= serosanguineous, "treatment in progress". (NOTE: This form was originally photo copied for surveyors on 6/6/16. The facility provided an explanation of the wound development on 6/8/16, to include copies of wound tracking. This same form (originally copied 6/6/16) was provided on 6/8/16 and had been altered from the original. The date of origin had been changed to 2/15/16 and the word "error" was written in next to where "unstageable" was documented.) Signed by LPN F.

4. "Sacrum", date of origin- 2/19/16.

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Assessment date: 3/7/16. The area is documented as stage III. Small amount of serosanguinous exudate. Wound bed= dark pink/reddened tissue, Surrounding tissue= normal for skin. 100% granulation.

On 6/8/16 at approximately 9:45 a.m., the Director of Nursing (DON) was notified that the pressure ulcer record "Between Buttocks" had been altered from the original copy. She was asked to have which ever staff who had changed the document to come speak to the survey team.

On 6/8/16 at 10:00 a.m., the Corporate Nurse arrived to speak with the survey team. She stated that she had changed the document in attempts to make the wound documentation make sense. She stated that the four pressure ulcer records (noted above) were all the same wound, the sacral wound. It was reviewed with the Corporate Nurse that three of the four pressure ulcer tracking forms identified different locations for the wound. The Corporate Nurse stated that a new pressure ulcer form was started every month and that staff changed the name of the area. The Corporate Nurse stated that the sacral wound was first identified on 2/15/16, as documented in the SBAR. It was reviewed with the Corporate Nurse that the SBAR documented an area between the buttocks, not the sacrum. It was reviewed with the Corporate Nurse that the survey team continued to have difficulty understanding the wound tracking. The Corporate Nurse responded "This is a hot mess."

According to his assessment on 2/22/16, the Wound Care Specialist documented that Resident #9 had two separate skin issues, an unstageable sacral wound and incontinence

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associated dermatitis on the buttocks.

Resident #9's care plan was reviewed. A "Focus" area was created on 3/18/15 regarding risk for alteration in skin integrity. Interventions dated 3/18/15 read barrier cream to perianal/ buttocks as needed, diet and supplements per physician order, observe skin condition with care daily, provide preventative skin care routinely. Intervention dated 4/28/16 read use pillows/ positioning devises as needed.

The facility provided an order dated 2/20/16 for a wedge: "use wedge for turning & positioning q (every) shift." In addition, the facility provided an invoice for a specialty mattress. Resident #9 was first charged for the specialty mattress on 2/23/16.

Both interventions were put into place five days after the facility states they identified the skin issue as documented in the SBAR dated 2/15/16.

The facility policy "Skin Integrity Program: Identification and Prevention" was reviewed. The policy read "Residents with risk factors for pressure injury development or any actual impairment in skin integrity will be identified, and a risk based interdisciplinary plan of care will be implemented." The section titled "Identify New or Existing Wounds" read "Upon identification of a new pressure injury or lower extremity wound; or when admitting a patient with a pressure injury or lower extremity wound: 4.1. The nurse will evaluate the area, notify the supervisor, practitioner, and patient or patient's representative." The section "Plan and Implement Care" read "The resident's skin will be observed daily during personal care, direct

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caregivers must promptly report any alteration in skin integrity to the nurse. The resident's skin will also be thoroughly observed by the nurse weekly, and findings documented."

The following definitions regarding pressure injuries and staging were accessed from the National Pressure Ulcer Advisory Panel website on 5/31/16 at 1:25 p.m.:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
"Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."
"Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed."

At the end of day meeting on 6/2/16, the Administrator and Director of Nursing were notified that the issue with the sacral wound was being considered as a harm level deficiency. They were asked to provide all wound related

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information. The Administrator and Director of Nursing were given additional opportunities to submit wound related information at the end of day meeting on 6/6/16 and 6/8/16.

3. For Resident #5, the facility failed to identify a pressure wound until it had reached an unable to stage pressure wound. On 4/25/16, a new pressure area was identified (left superior ischium pressure wound) and measured 1.7 cm (centimeters) by 2.0 cm with no depth. The area was 100% slough. And the facility staff failed to follow wound care recommendations by the wound clinic physician. Resident #5 was observed in the gerichair on her back from 8:30 AM to 12:00 PM; this was a continual observation. There was no observation of the resident being repositioned. Wound care recommendations included " limit sitting for 30 minutes " .

Resident #5 was admitted to the facility on 9/11/07 with diagnoses which included, but not limited to, dementia, schizophrenia, high blood pressure and anxiety.

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Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/3/16. She was coded with a Brief Interview of Mental Status score of "0" out of a possible 15 indicating severe cognitive impairment. She required total assistance of one staff member for bed mobility and transferring. The resident was incontinent of bowel and bladder. The resident did not have recent weight loss.
The resident was not coded with any pressure sores.

On 6/2/16 at 8:30 AM, Resident #5 was observed up in her gerichair. A geri chair is a reclining lounge type chair.

On 6/2/16 at 10:00 AM, through continuous observation, Resident #5 remained in the hallway in gerichair, yelling out, on back in the gerichair.

On 6/2/16 at 10:30 AM, Resident #5 was taken back to her room, remained in gerichair, on her back.

On 6/2/16 at 11:35 AM, through continuous observation, Resident #5 remained in her room in her gerichair, remained on her back.

On 6/2/16 at 12:00 PM, the resident remains in the gerichair on her back. On the hallway where the resident resided, there was a strong, persistent urine odor.

On 6/2/16 at 1:10 PM, the resident was lying in bed on the right side, facing the door. A CNA (certified nursing assistant) "F" was in the room. CNA (F) stated, "I put her back to bed 5 minutes

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ago." The resident had received incontinence care at this time. CNA (F) went on to state that her usual routine was to get the resident up in the morning and put her back to bed after lunch. A housekeeper was observed spraying disinfectant in the hallway. Resident #5 had been up in the gerichair for approximately 4.5 hours.

Review of the resident's History and physical dated 12/7/15 (hospitalized for an abscess of the right ischium) documented the resident had "Surrounding pressure ulcers on both the ischial areas." Review of the wound tracking notes from the wound clinic, Resident #5 had healed stage 4 on the left ischium (the back lower portion of the hip bone) and an abscess of the left medial ischium had healed as of 1/11/16. All the wounds had been healed on 1/11/16.

On 4/18/16 (according to the skin and body alert form done by nursing) the form showed an open area (not measured) on the left ischium. No other information was available. On 4/18/16 wound clinic notes documented a stage 3 pressure wound of the left ischium measuring 0.9 cm by 0.1 cm with 20 % necrosis. This was the re-opening of the left lower ischium.

Further review of the wound tracking from the wound clinic revealed the resident had acquired a new, unable to stage left superior ischium pressure wound with 100% necrosis, on 4/25/16. The area measured 1.7 cm (centimeters) by 2.0 cm, depth not measurable. This was documented on the wound clinic notes for 4/25/16. Recommendations included: Limit sitting to 30 minutes, offload wound, reposition per facility protocol. On 5/23/16, according to the wound clinic notes, the left superior ischial wound

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had healed.

http://www.merriam-webster.com/dictionary/ischium
"the dorsal and posterior of the three principal bones composing either half of the pelvis"

www.NPUAP.com <http://www.NPUAP.com> defined an unstageable pressure ulcer as follows: "The goal for revising the definition of unstageable ulcers was to reduce the tendency to classify an ulcer with any necrotic tissue as unstageable, when the depth of the ulcer can be seen. The new definition is "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed." Note the phrase "the base of the ulcer" is used to denote the inability to determine the depth. If necrotic tissue is present, for example, on the edge of the ulcer, but the base is bone, the ulcer should be staged as a Stage IV. Further description of Stage IV ulcers include these phrases: "Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined."

On 6/2/16 at 2:15 PM, an interview was conducted with LPN (licensed practical nurse) B. LPN (B) was asked about the left superior ischial wound, she stated, "It would be an unable to stage because of the slough (dead, devitalized tissue). She stated, "I like to find at a stage 1

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(redness), should not find at an unable to stage." She went on to state that she knew the resident should be up for a "limited time, thought it was two hours."

Review of the care plan dated 3/3/1/16 revealed the following: "At risk for impaired skin integrity r/t (related to) incontinence." Goal was "Resident skin will be free of breakdown by next review." Interventions included: "Apply ointment to bottom as ordered. Assess and document weekly skin findings. Assist resident to turn and reposition every 2 hours for comfort meals toileting ADL's (activities of daily living)." A specialty mattress was not initiated until 5/9/16.

On 6/3/16 at 10:15 AM, wound care observation was done. Heels were intact without redness or open areas. The dressing was removed from the left ischial wound, dated 6/2/16. The left lower ischium was approximately 3 cm in diameter with approximately 25 % of slough. A new area near the stage 3 was identified during the dressing change and staged as a stage 2. This was a re-opened area on the left upper ischium. It was approximately 1.0 cm by 0.5 cm with no depth. Both areas were covered with the same dressing. Resident was comfortable during procedure.

On 6/6/16 at 1:50 PM, an interview with the wound clinic physician (other A) was done. He stated, Wound care is "not optimal, " and they were working hard to move forward from last year." He went on to state, "Treatments are not always done as recommended."

On 6/2/16 at 4:30 PM, the Administrator and DON (director of nursing) were notified of a harm level deficiency due to an acquired pressure wound,

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F 314	Continued From page 51 found at an unable to stage ulcer.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to implement safety measures to prevent injuries from falls for two Residents (#22 and #19 and #5) in a survey sample of 24 Residents and failed to provide an environment free from safety hazards on one of two floors. 1. For Resident #22, the facility staff failed to implement the use of fall mats after a fall; 2. Resident #19 sustained a fall during bed mobility as she was left unattended to get a brief and did not have two person assistance with bed mobility; 3. Resident #5 was left unattended during wound care, with the side rail down and the bed in a raised position; 4. The medication nurse left the medication cart unlocked, with full pill cards on top of the cart,	F 323	F323 R#19 and #22 no longer reside in the center. R#5 had no negative outcome from being left with SR down during wound care. Current residents were identified at risk from this alleged practice. Nursing staff shall be in-serviced on the need to maintain safety of the residents at all times such as beds in low position when leaving the resident, use of identified injury prevention interventions such as fall mats, preparing by gathering equipment needed before beginning so to not have to leave the resident. Licensed staff shall be in-serviced on locking treatment and medication carts at all times when leaving them unattended.	

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F 323	Continued From page 52 while entering a resident room to administer medication. The cart was not within the line of sight. The findings included: 1. For Resident #22, the facility staff failed to implement the use of fall mats after a fall. Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's. Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was coded as needing limited assistance. Resident #22's weight was coded as being 172 pounds. Review of Resident #22's clinical record revealed she had been assessed and determined to be at risk for falls. A care plan was developed 8/18/15 that included, "At risk for falls due to impaired balance/poor coordination, history of falls, pain due to right hip fracture." Included in the "Interventions" was "Encourage to transfer and change positions slowly, Have commonly used articles within easy reach, Maintain bed in low position, Provide assistance to transfer and ambulate as needed."	F 323	Random audits of medication and treatment carts shall be made throughout the week for security weekly for 4 weeks then monthly for 3 months. Random observations of up to 15 residents identified as high fall risk shall be completed weekly for 4 weeks then monthly for 3 months for interventions to prevent injury/falls being used. Concerns identified shall be taken to the facility QAPI Committee for follow up and resolution. Date of Compliance 7-13-16	

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Resident #22 was found on the floor by her bed 10/7/15 around 3:15 a.m.. Resident #22 was assessed as having no injuries and her responsible party and the physician were notified.

Review of the "Incident/Accident Form" indicated a recommendation of "Fall Mats and Lowest position (position of bed)" were recommended after the fall. A thorough review of the clinical record revealed no indication the use of "fall mats" were implemented. The care plan was not revised to include the use of fall mats.

Review of the CNA (certified nursing assistant) "CARE CARD" revealed no interventions were put in place. Options to choose for CNA guidance included "Side rails, Alarm, in chair, in bed, Belt Alarm, Perimeter Mattress, Wander Guard, Special Behavior Plan, Floor Mat, Lo bed, Special Toileting Plan, Restraint, Other." None of the above mentioned interventions were checked.

The DON stated while she remembered Resident #22's name, she could not remember any information about her, 6/8/16 at 1:47 p.m.

An attempt was made to interview a CNA that would have cared for Resident #22. No CNAs were still at the facility that would have cared for Resident #22. CNA E stated 6/8/16 at 2:32 p.m., she had been employed at the facility for "awhile." CNA E stated she knew how to care for her Residents by referring to the "CARE CARD."

Review of Resident #22's clinical record revealed she did not experience any other falls after 10/7/15 and her discharge from the facility on 10/14/15.

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The administrator, DON (director of nursing), and ADON (assistant DON) were informed of the facility staff failing to implement the use of "fall mats" after a fall, 6/8/16 at 4:08 p.m.

COMPLAINT DEFICIENCY

2. Resident #19 sustained a fall during bed mobility as she was left unattended to get a brief and she was not provided with two person assistance for bed mobility as coded on the MDS assessment and as care planned.

Resident #19 sustained a fall during bed mobility as she was left unattended to get a brief and did not have two person assistance with bed mobility.

Resident #19 was admitted to the facility on 8/10/12 with diagnoses which included, but not limited to, dementia, diabetes, stroke, and high blood pressure. The resident expired in the facility on 1/19/16.

Resident #19's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 8/24/15. She was coded with at having both short and long term memory deficits and severe cognitive impairment. She required total assistance of two staff members for bed mobility and one staff member for transferring.

Review of the clinical record revealed on 9/21/15 at 8:37 AM, the resident "fell from bell (sic) during ADL (activities of daily living) care. Review of the facility's investigation report dated 9/23/15 revealed the following: "On September 21, 2015, (name of resident) ...was receiving her ADL care

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and the assigned CNA (certified nursing assistant) was providing her bath. The resident was turned to her left side facing window and CNA went to turn to get brief and the resident sustained a fall by rolling over to the left side of the bed." The resident sustained a bruise to the left side of the forehead.

On 6/6/16 at 2:35 PM, an interview was conducted with RN (registered nurse) A (unit manager) stated, "The CNA rolled her over to the left side toward the window, she did not have side rails." She went on to state that "usually the resident would hold on to the side of the bed."

Review of the care plan dated 4/10/15 contained the following: "2 person assist with bed mobility." On 9/22/15, side rails (bilateral) were added.

3. Resident #5 was left unattended during wound care, with the side rail down and the bed in a raised position.

Resident #5 was admitted to the facility on 9/11/07 with diagnoses which included, but not limited to, dementia, schizophrenia, high blood pressure and anxiety.

Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 3/3/16. She was coded with a Brief Interview of Mental Status score of "0" out of a possible 15 indicating severe cognitive impairment. She required total assistance of one staff member for bed mobility and transferring. The resident was incontinent of bowel and bladder. The resident did not have recent weight loss.

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F 323	Continued From page 56 On 6/3/16 at 10:15 AM, wound care observation was done. Heels were intact without redness or open areas. The dressing was removed from the left ischial wound (the back lower portion of the hip bone), dated 6/2/16. The left lower ischium was approximately 3 cm in diameter with approximately 25 % of slough. RN (registered nurse) A walked away from the bedside (side rail was down and the bed had been raised), leaving the resident unattended. On 6/8/16 at 4:00 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 323	F325 R#9 plan of care has been reviewed and updated to meet current needs of the resident R#22 no longer resides in the center. Tube fed residents and those at risk of weight loss have been identified at risk from this alleged practice. Nursing staff shall be in-serviced on the process of weighing and re-weighing residents, 4 weekly weights on admission, communication to the RD, MD and RP as needed as well as appropriate interventions, and documentation of intake and refusals.	
F 325 SS=G	Complaint Deficiency 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed for 2 residents (Resident #9	F 325		

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F 325	Continued From page 57 and #22) of 24 residents in the survey sample to ensure residents were free from significant weight loss, resulting in harm for Resident #9. Resident #9 experienced an 11.2% weight loss in 180 days and developed an unstageable pressure wound to the sacrum. 1. For Resident #9, the facility failed to provide ~~adequate calories, protein, vitamin and minerals~~ resulting in harm (significant weight loss of 11.2% in 180 days and development of an unstageable pressure area to the sacrum). The Wound Care Specialist documented that poor wound healing was caused by nutritional compromise. 2. . For Resident #22, the facility staff failed to develop or implement nutritional strategies after the development of a significant weight loss. The Findings Included: Resident #9, a 61 year old, was admitted to the facility on 3/31/15. Her diagnoses included hemiplegia, dysphagia, diabetes, stroke, and chronic obstructive pulmonary disease. Resident #9's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/27/16. She was coded with moderate cognitive impairment. She was not coded to have weight loss. Resident #9 received 100% of her nutrition through a feeding tube. She was observed during the initial tour of the facility on 6/1/16. Her tube feeding, Glucerna 1.5, was running at 35 cc (cubic centimeters) per hour.	F 325	The RD shall be in-serviced on the expectations of assessing resident needs, comunicating concerns and following up if weight loss is a concern for any reswident by the VP of Food/Nutrition Random audits of up to 10 current tube fed residents shall be completed for following physician orders, (rate, timing and correct product) weekly for 4 weeks then monthly for 3 months Weekly weights on up to 10 new admissions shall be monitored to validate completion, assessment and needs for re-weigh, weekly for 4 weeks then monthly for 3 months. Concerns shall be taken to the facilty QAPI committee for follow up and resolution. Date of complianc 7-13-16	

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On 3/9/16, an SBAR (concern note) was documented in Resident #9's clinical record. The note read "Change in condition related to -10.0% change over 180 days. This change in condition started on 3/7/16." "Noted to have issues with edema or weight loss." "SKIN: Noted to have the following skin conditions present: Excoriation of sacrum."

A list of Resident #9's weights for the past year were requested.
Weights (in pounds):
6/10/15- 197.2
7/6/15- 195.4
8/10/15- 192.5
9/8/15- 195.6
10/9/15- 190.8
11/16/15- 184.8
12/7/15- 182.5
1/8/16- 181.3
2/5/16- 179.6
3/7/16- 173.6
4/11/16- 179.6
5/6/16- 181.4

Between the six month time frame of 9/8/15 (195.6) and 3/7/16 (173.6), Resident #9 lost 22 pounds. This loss equaled an 11.2% weight loss in six months, a significant weight loss.

On 6/8/16 at 11:15 a.m., the Registered Dietitian (RD) was interviewed. The RD stated that she was supposed to complete resident nutrition evaluations when the resident was first admitted to the facility and then annually. She was asked to provide the most current nutrition evaluation for Resident #9. An evaluation dated 4/1/15 was provided. The RD was asked if a nutrition evaluation had been completed in 2016, as the

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annual would have been due in April 2016. She stated that the 2015 evaluation was the most recent annual evaluation. When asked why she had not completed the annual evaluation in April 2016, the RD stated the facility had not told her that it needed to be completed. When asked who at the facility notified her to complete annual nutrition evaluations, the RD stated that the MDS (Minimum Data Set) staff made a list for her.

The "Nutrition Monitoring & Evaluation Form" dated 4/1/15 was reviewed. Caloric and protein needs were not calculated on this most recent annual evaluation.

The initial "Nutrition Assessment" completed on 7/7/14 calculated estimated caloric, protein, and fluid needs. The needs were calculated using a height of 62 inches and a weight of 196.5 pounds. Resident #9's daily needs were calculated as follows:
Energy: 1932 calories
Protein: 89 grams
Fluid: 2670 cc

Quarterly assessments were documented on the "Nutrition Monitoring & Evaluation Form". Tube feeding orders were documented as follows:
- 7/8/15: Glucerna 1.5 @ 40 cc/ hour (1440 calories, 78 gram protein, 1968 cc fluid) Goal for no significant weight change achieved this review. Weight stable. Tolerating tube feeding

- 10/7/15: Glucerna 1.5 @ 30 cc/ hour (1080 calories, 57 grams of protein) Goal for no significant weight change achieved despite change in tube feeding order. Blood sugar remains under good control. Will continue to

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monitor. Current tube feeding does not meet estimated energy needs. In the margin of the form, the RD wrote: Change in tube feeding rate noted. No doctor note relating to change.

Between the month of July 2015 and October 2015, Resident #9 lost 5 pounds. It is unclear when and why the tube feeding was decreased from 40 cc per hour to 30 cc per hour. The change from 40 cc to 30 cc per hour equals a decrease of 360 calories per day.

The following nutrition notes were documented in the progress notes:
1/13/16- Weight is stable, but above IBW (ideal body weight). BMI (body mass index) remains much above critical range. Good tolerance to current TF (tube feed) schedule Glucerna 1.5 at 30 cc per hour. A flush of 200 cc water every 4 hours provided. Recent A1c (measurement of quarterly blood sugar level via blood sample) at 6.0, indicating good blood sugar control. Current tube feed does not appear to meet estimated needs, but with stable nutritional status, is meeting needs. Will continue current regime, no new recommendations.

3/9/16- Slow weight loss noted this review, now triggering significant x 180 days. Weight loss is desired as weight remains above ideal body weight, BMI is above critical range. Tolerating TF at 30 cc per hour. Current regime does not meet estimated needs, but nutritional status has been stable in the past. Area of pressure noted, showing slow improvement. Vitamins and minerals are provided. Will suggest an increase in TF to 35 cc per hour, Glucerna 1.5, to provide 1260 calories. This remains below estimated needs. Will monitor for change.

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While the 3/9/16 nutrition progress note read "Area of pressure noted, showing slow improvement," the Wound Care Specialist documented on3/7/16 (2 days prior) that Resident #9's sacral wound was not healing due to nutritional compromise. The wound care note read: 3/7/16- Wound Care Specialist notes, Sacral wound: "Wound progress: deteriorated, Findings that indicate deterioration: Nutritional Compromise." Measurements: 3 x 2.4 x 0.1 cm. (centimeters) "Assessment & Plan" read "Deteriorated due to nutritional compromise: Optimize nutrition."

On 3/28/16, a second Wound Care Specialist note read "Wound progress: deteriorated, Findings that indicate deterioration: Nutritional Compromise." Measurements: 1 x 0.8 x 0.1 cm. "Assessment & Plan" read "Deteriorated due to nutritional compromise: Optimize nutrition."

The 3/9/16 nutrition progress note written by the RD also read, "Vitamins and minerals are provided." According to the physician orders, the multivitamin, zinc and vitamin C had been started the day prior on 3/8/16. Resident #9 had been receiving only iron supplementation (10/30/15) and vitamin D supplementation (1/4/16).

Product information for Glucerna 1.5 was accessed from the Abbott Nutrition website on 6/15/16 at 2:09 p.m. <http://static.abbottnutrition.com/cms-prod/abbottnutrition.com/img/Glucerna-1.5-Cal.pdf>

Per the Glucerna 1.5 product information "1500 cal provide at least 100% of the DV (daily value) for 24 key vitamins and minerals." During the

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time of the sacral wound development and significant weight loss, Resident #9 was receiving 1080 calories. If 1500 calories provided 100% of the daily vitamin and mineral need, it is calculated that Resident #9 was only receiving about 72% of her daily need of vitamin and minerals (except for iron and vitamin D) through tube feeding prior to 3/8/16.

Resident #9's vitamin and mineral needs were not being met through the tube feeding at the time of the wound development. She was not started on a multivitamin until 3/8/16.

At the time of the wound development, while on Glucerna 1.5 @ 30 cc per hour, Resident #9 was provided 57 grams of protein. Using a weight of 179.6 pounds or 81.6 kilograms (weight in kilograms= pounds/2.2) measured in February 2016, Resident #9's protein need was calculated to be at least 81.6 grams per day at the time the sacral wound developed (when using 1.0 gram per kilogram as used by RD in initial nutrition assessment). When multiplied by an injury factor of 1.2 grams per kilogram of body weight for wound healing (as used by facility RD), Resident #9's protein need is calculated as 97.9 grams of protein per day for wound healing.

According to the above calculations, Resident #9's protein need was not being met through the tube feeding at the time of the wound development.
81.6 grams (need) - 57 gram (actual)= 24.6 grams per day deficient.

Using a weight of 179.6 pounds or 81.6 kilograms measured in February 2016 and 21.5 calories per kilogram (as used by RD in initial nutrition

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assessment), Resident #9's calorie need during the month of February 2016 is calculated as 1754 calories per day.

According to the above calculations, Resident #9's caloric need was not being met through the tube feeding at the time of the wound development.
~~1754 calories (need) - 1080 (actual)= 674~~
calories per day deficient

In summary, during February 2016, the month that Resident #9 developed the sacral wound and triggered for significant weight loss, she lost five pounds. Per day, she received 674 calories less and 24.6 grams of protein less than her estimated needs.

The following nutrition information from the American Academy of Family Physician's document titled "Pressure Ulcers: Prevention, Evaluation, and Management" was accessed on 6/8/16 at 2:55 p.m. at www.aafp.org/afp/2008/1115/p1186.html#sec-4 <http://www.aafp.org/afp/2008/1115/p1186.html>
The section titled "Nutrition Evaluation" read "If oral dietary intake is inadequate or impractical, enteral or parenteral feeding should be considered, if compatible with the patient's wishes, to achieve positive nitrogen balance (approximately 30 to 35 calories per kg per day and 1.25 to 1.5 g of protein per kg per day)."
Table 3: Markers for Identifying Protein-Calorie Malnutrition in Patients with Pressure Ulcers
Unintentional weight loss of 5 percent or more in the previous 30 days or of 10 percent or more in the previous 180 days
Weight less than 80 percent of ideal
Serum albumin level less than 3.5 g per dL (35 g

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F 325	Continued From page 64 per L)* (grams/liter) Prealbumin level less than 15 mg per dL (150 mg per L)* Transferrin level less than 200 mg per dL (2 g per L) Total lymphocyte count less than 1,500 per mm3 (1.50 × 109 per L) *dehydration can falsely elevate	F 325		

Nitrogen balance is the state of the body in regard to the rate of protein intake and protein utilization. A negative nitrogen balance occurs when more protein is used by the body than is taken in. A positive nitrogen balance implies a net gain of protein in the body. Negative nitrogen balance can be caused by such factors as malnutrition, debilitating diseases, blood loss. Accessed on 6/16/16 at 9:30 a.m. at <<http://medical-dictionary.thefreedictionary.com/nitrogen+balance>>

"Albumin is a protein made by the liver. A serum albumin test measures the amount of this protein in the clear liquid portion of the blood. This test can help determine if a patient has liver disease, kidney disease, or if the body is not absorbing enough protein." Accessed at <https://www.nlm.nih.gov/medlineplus/ency/article/003480.htm on 6/15/16 at 3:09 p.m.

Two albumin levels were provided for Resident #9:
2/14/16- 4.3 grams per deciliter, (reference range: 3.0-4.5)
4/7/16- 3.4 gram per deciliter
While Resident #9's albumin level appeared in the normal range on 2/14/16, it is important to note that on the same date, Resident #9 was provided IV fluids for hydration. An order dated

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2/14/16 read 1/2 NS (normal saline) @ 70 milliliter per hour x 1 liter and increase peg tube flushes to 250 mililiter per hour every 4 hours. As noted above, dehydration can falsely elevate serum albumin. The 2/14/16 albumin level is most likely inaccurate (elevated).

Resident #9 had a weight loss of 10% in 180 days and she also had a serum albumin level less than 3.5 grams per deciliter. These are two markers of Protein-Calorie Malnutrition in patients with pressure ulcers according to Table 3 above.

The facility physician did not have knowledge that Resident #9 was losing weight. He documented the following note in "Physician Progressive Notes" on 3/8/16. The note read "1) Wt loss? Doubt as patient is on a tube feeding monitor weight closely" "3) Pressure Ulcer add MVI (multivitamin) B supplement."

On 6/8/16 at 11:15 a.m., the RD was asked why she was providing Resident #9 with a tube feeding that did not meet nutritional needs. She stated that the resident was obese and weight loss was desired. When asked if the resident's physician wanted the resident to lose weight, the RD stated yes. It was reviewed with the RD that there was no documentation in the clinical record documenting that the physician desired a weight loss for the resident. She was asked to provide documentation of the physician desired weight loss. No documentation was provided.

The RD was informed that the Wound Care Specialist felt that Resident #9's wound was not healing due to nutritional compromise. The RD stated that she disagreed.

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In addition to developing the sacral wound in February 2016, Resident #9 was diagnosed with pneumonia on 1/19/16, finishing a 10 day course of antibiotics on 1/29/16. On 2/2/16 an SBAR (concern form) was documented. It read "resident noted to have elevated temp." Resident #9 continued with the following elevated temperatures:
~~2/13/16- 102.7~~
2/13/16- 100.7
2/14/16- 100.7
2/14/16- 101.7
2/15/16- 100.0
2/18/16- low grade temp
2/21/16- 100.8

She was treated with additional antibiotics, completing antibiotic therapy on 2/24/16.

The following information regarding an increased need for protein during periods of infection is from the document "The Requirements of Protein & Amino Acid During Acute & Chronic Infections." Infectious episodes result in hypermetabolism and a negative nitrogen balance. The extent of the negative nitrogen balance varies with the type of infection and its duration; however, it is reasonable to suggest that the loss of body protein could be minimized by the provision of dietary nitrogen" accessed on 6/16/16 at 9:45 a.m. at www.ncbi.nlm.nih.gov/pubmed/17015927 <http://www.ncbi.nlm.nih.gov/pubmed/17015927>

During the 6/8/16, 11:15 a.m. interview with the RD, she was asked if she used an increased injury factor to determine protein needs for someone with an infection or wound. She stated she liked to use 1.2 grams of protein per kilogram body weight when assessing protein needs for

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wound healing. She also stated that she would work together with the doctor to determine protein needs. She did not say whether she provided increased protein during periods of infection. There is no evidence that the RD consulted either the primary physician or wound care physician in determining Resident #9's protein needs.

~~While the RD did increase Resident #9's tube~~ feeding on 3/9/16, she did not calculate a protein need to address wound healing and infection. Her note for 3/9/16 does not document the estimated need for protein or the amount of protein provided in Glucerna 1.5 @ 35 cc per hour.

Resident #9's care plan was reviewed. A focus area "Nutritional Status as evidenced by potential weight loss/gain related to enteral/parenteral nutrition, Swallowing difficulty" was initiated on 3/11/16. Interventions included: Administer vitamin/ mineral supplements as ordered, discuss weight loss desires with physician and make recommendations for supplements, enteral nutrition per physician orders.

On 6/8/16 at 11:15 a.m., the RD was asked how often she updated the nutrition care plan. She stated that she did not update care plans.

The facility policy titled "Skin Integrity Program: Identification and Prevention" was reviewed. The section titled "Identify New or Existing Wounds" read "4.3 Notify the dietician for nutritional interventions."

There is no evidence that the facility RD was not notified or consulted regarding the identification of Resident #9's sacral wound. The RD did

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document that Resident #9 had a wound when completing the assessment regarding the significant weight loss (3 weeks after the wound development).

On 6/8/16 at 4:20 p.m., Resident #9's significant weight loss was discussed with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON). They were notified that the deficiency was being considered as a harm level deficiency. At this time, the facility staff were asked if weekly weights were supposed to be performed once a resident had been identified with significant weight loss. The DON stated it depended on what the RD recommended. The ADON stated that weekly weights should be done for 4 weeks. They were informed that weekly weights were not done for Resident #9 after her significant weight loss was identified.

At this time, the DON stated that wounds were discussed in the weekly risk (We Care) meeting. She stated that the RD was present at the meetings. She stated that the RD should assess nutritional status after hearing about the wounds discussed in the meeting. The DON was notified that the RD did not assess Resident #9's nutritional needs after identification of the wound. The DON was notified that the RD completed an assessment for significant weight loss and mentioned the wound in her note. This note was completed three weeks after the wound was identified and did not address protein needs. The facility was asked to provide any information related to the significant weight loss and wound development.

In summary: It was documented by the RD that nutritional needs were not being met by the tube

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feeding rate being provided. Specifically, caloric needs, protein needs, and vitamin/ mineral needs were not being met. It was documented by the physician that he was unaware that Resident #9 had weight loss. It was documented by the wound care physician that Resident #9 was at nutritional compromise for wound healing. As a result of inadequate nutrition, Resident #9 experienced significant weight loss and the development of an unstageable sacral ulcer.

2. For Resident #22, the facility staff failed to develop or implement nutritional strategies after the development of a significant weight loss.

Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was coded as needing limited assistance. Resident #22's weight was coded as being 172 pounds.

Review of Resident #22's clinical record revealed upon admission she weighed 171.5 pounds and was 63 inches tall. Over the weeks of her stay at the facility, the following weights were noted:

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8/17/15 171.5 pounds
8/26/15 153.8 pounds
156.8 pounds reweighed
9/2/15 153 pounds
9/8/15 148 pounds
9/16/15 142.2 pounds
9/23/15 145.8 pounds
9/28/15 145.6 pounds
10/9/15 147.4 pounds

Review of Resident #22's discharge records from the hospital revealed her weight on 8/14/15 was 80.1 kg (kilogram) or 176.22 pounds.

Review of Resident #22's clinical record revealed the significant weight loss was not identified nor were any strategies developed to prevent any further weight loss.

EMP. F, the registered dietitian, stated 6/8/16 at 11:20 a.m., upon admission, Resident #22 should have had her weight obtain weekly for four weeks. Also the dietary tech, Other I enters all pertinent information into the facility's computerized system. EMP. F stated she completes an initial assessment and when informed, will reassess Residents for weight loss. EMP F stated that significant weight loss is flagged in the computer and the Resident is then discussed during "We Care" meetings held weekly. EMP. E stated the Resident should also have been reassessed at 14 days, 30 days, and 60 days after admission.

During the time of Resident #22's admission, EMP. F stated the reassessment would have been completed on a paper or hard chart form.

Review of Resident #22's clinical record revealed

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she had her initial "Nutrition Assessment" completed on 8/19/15. EMP. F entered that the goal should be for Resident #22 to have no significant weight change by the next review. Her diet was changed to a regular diet, however Resident #22 was on 1800 cc (cubic centimeter) fluid restriction due to hyponatremia (a low sodium level).

No evidence was present to indicate that after Resident #22 experienced a 17.7 pound weight loss on 8/26/15 that the significant weight loss was identified. While Resident #22's weight was repeated on 8/26/15, no information was evident that the weight loss had been referred to any staff.

By 9/16/15, Resident #22 had lost 29.3 pounds with a weight of 142.2 pounds. EMP. F entered a dietary note that included, "Spoke with resident on this day, r/t (related to) recent weight loss. Resident with dx (diagnosis) of dementia. Will need cueing with meals. States weight loss is "ok" Blood sugar well controlled. Restricted diet provided. With weight changes and progression of disease, will suggest D/C restricted diet, change to regular regime."

When interviewed, EMP. F stated she would only be aware of any Resident weight changes if "someone told me." EMP. F stated it would be up to either the dietary tech or one of the nurses to inform her of any significant weight loss. When asked about changing Resident #22's diet to regular on 9/16/15 EMP F stated she felt there was more information in the clinical record. Review of Resident #22's clinical record revealed her diet had been changed from a diabetic (low concentrated sweet) diet to a regular diet on

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8/19/15, shortly after Resident #22's admission to the facility.

Review of the notes from the "We Care" minutes 9/16/15 revealed Resident #22 was discussed at the meeting, however the only recommendation was for her diet to be changed to a regular diet (that had been changed shortly after admission).

Other I, the dietary tech, stated 6//6/16 at 3:14 p.m., she only was responsible for entering data into the computerized system. Other I stated it was the registered dietitian's responsibility to develop or recommend strategies for weight loss. Other I stated if she "happened" to notice a significant weight loss, she would "notify the dietitian."

Resident #22's physician only entered a note regarding her weight loss 8/26/15 when her weight was noted to be 153.8 pounds. The progress note written that day indicated, "not sure about wt (weight)." No other entries were evident from the physician that he had been informed regarding the significant weight loss Resident #22 experienced.

Review of her comprehensive care plan revealed the only care plan developed to address nutritional concerns was developed on 8/28/15, "Risk for alteration in nutrition r/t (related to) tolerance of therapeutic diet, pain, impaired cognition." Included in the "Interventions" was "Honor food preferences; Notify physician and responsible party of significant weight changes; Weights as ordered."

No other information was evident that indicated Resident #22 had been identified as having

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F 325	Continued From page 73 experienced a significant weight loss or that the staff had developed any nutritional strategies to prevent further weight loss. EMP. F stated even if a Resident had significant weight loss, she, as the facility registered dietitian was not involved in the formulation or revision of care plans. Guidance was provided at emedicine.medscape.com: "Nutritional screening has become a primary tool to identify at-risk patients and should be performed when the patient is admitted to a rehabilitation unit. While a standard nutritional screening tool has not been established, there are several tools available that can be incorporated easily into routine clinical practice. It is often necessary at a minimum to do a mini-nutritional assessment of the patient at the point of admission into a rehabilitation unit, since poor nutritional status could lead to greater debility and an inability to fully participate in intensive in-patient rehabilitation therapies." The administrator, DON (director of nursing) and ADON (assistant DON) were informed of the failure of the staff to identify Resident #22 experienced a significant weight loss and failure to develop and implement nutritional strategies to prevent further weight loss, 6/8/16 at 4:08 p.m.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		

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without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record review and complaint deficiency, the facility staff failed to ensure that one Resident (Resident #11) was free from the administration of unnecessary medication.
1. The facility staff failed to assure that blood pressure and pulse rate readings were recorded prior to the administration of hypertensive medications per physician ordered parameters.
Findings included:
Resident #11 was admitted to the facility on 5/28/2015 and readmitted on 10/3/2015 subsequent to an acute care hospital stay.
Resident #11's diagnoses included bowel

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R#11 medications have been reviewed b the primary physician with changes to plan of care as indicated.

Residents with medications that have parameters of pulse or blood pressure are identified at risk for this alleged practice.

Nursing staff shall be in-serviced on the need to follow all parameters and what to do if hold medication

Random audits of Medication Administration Records for up to 10 medications with parameters related to BP and pulse shall be completed weekly for 4 weeks then monthly for 3 months

Concerns identified from the audits shall be taken to the facility QAPI committee for follow up and respution.

Date of Compliance 7-13-16

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obstruction, dysphagia, hypertension, convulsions, anxiety and dementia.
Resident #11's MDS (Minimum Date Set) with an ARD (Assessment Reference Date) of 3/2/2016 was coded as a quarterly assessment. Resident #11 was coded a BIMS (Brief Interview of Mental Status) score of 4/15 indicating severe cognitive impairment. Resident #11 was coded as being totally dependent on one to two persons for her activities of daily living, and was coded as being always incontinent of bowel and bladder.
A review of the clinical record conducted on 6/2/2016 at 3:30 PM revealed the following physician orders:
"Atenolol Tab 50 mg (milligram)-take one tablet via peg (percutaneous endogastric-feeding tube) tube daily. Hold for systolic blood pressure < (less than) 110 or heart rate <50."
"Lisinopril tab 20 mg take one tablet via peg tube twice daily. Hold if systolic blood pressure <120."
Blood pressures and heart rate readings were rarely taken to determine if medications should or should not be given based on physician ordered parameters.
A review of the Medication Administration Record showed that these medications were given every day from 2/2016-5/2016.
Blood pressure and heart rate readings were taken as follows:
2/2016-21 times
3/2016-11 times
4/2016-3 times
5/2016-9 times
Total 44 times in four months
Based on the medication order, blood pressure and heart rate readings should take place two times per day, approximately 60 times per month, or 240 times in four months. Thus these antihypertension medications were given 196

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F 329	Continued From page 76 times in four months without knowing if the medication should be held. On 6/2/2016 at 5:00 PM Employee B was asked to comment on this discrepancy. She had no information to give. Facility Policy for "Administering Oral Medications" did not contain a policy/procedure for administering medications with physician ordered parameters. The facility stated that they use Lippincott as their nursing standard. Guidance also given from Potter and Perry, Fundamentals of Nursing, Eighth Edition page 584 read: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" Administration was informed of the findings on 6/8/2016 at 5:30 PM.	F 329		
F 367 SS=D	THIS IS A COMPLAINT DEFICIENCY 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician.	F 367		

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F 367	Continued From page 77 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed for 1 resident (Resident #4) of 24 residents in the survey sample to provide a physician ordered therapeutic diet. Resident #4 was not provided the ordered amount of Propass (protein supplement) and the mighty shake (supplement) order was not started until 8 days after it was recommended. The findings included: Resident #4, a 72 year old, was admitted to the facility on 12/12/08. Her diagnoses included dementia, Parkinson's disease, diabetes, anemia and high cholesterol. Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4/20/16. She was coded with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment and required extensive assistance with her activities of daily living. On 4/13/16, a nutrition note completed by the Registered Dietitian (RD) documented Resident #4 experienced weight loss. The note read "Chart reviewed as weight loss noted at this time. Significant change noted x 6 months, and 3.8% down x 30 days. Wound healing again is issue. Weight remains high, BMI is above critical range. A change in resident noted, as affect more flat. Staff providing encouragement. Fair appetitive notes. S/S (signs/symptoms) of hypo hyperglycemia monitored. LCS (Low	F 367	F367 R#4's nutritional needs have been reviewed and plan of care updated to meet the resident's current needs. Residents with RD recommendations related to nutritional needs are at risk for this alleged practice. Licensed nurses shall be in-serviced on the need for timely follow up for RD recommendations and documentation of the recommendations. Random audits of up to 5 RD recommendations shall be completed weekly for 4 weeks then monthly for 3 months related to follow up and documentation. Concerns identified from audits shall be taken to the facility QAPI committee for follow up and resolution Date of compliance7-13-16	

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concentrated sweets) restriction continues. Vitamins and minerals are provided to promote healing and to prevent micronutrient depletion. Will suggest SF (sugar free) mighty shake bid (two times per day) at this time. Monitor tolerance. Supplement to provide energy and dietary protein to prevent further weight loss and promote healing."

The mighty shake supplement was not ordered. The RD identified the issue as documented in the 4/20/16 nutrition note "No new order yet for supplemental calories." "Will suggest d/c (discontinue) LCS restriction and again suggest addition of SF mighty shakes bid."

The following telephone order was written on 4/21/16 "1) D/c (discontinue) LCS (Low concentrated sweets) restriction 2) SF mighty shake BID."

On 6/6/16 at 12:30 p.m., Resident #4's lunch meal was observed. She was in bed, with head of bed elevated. She was fed by Certified Nursing Assistant K (CNA K). She did not have a divided plate or weighted utensils. She did not attempt to feed herself. CNA K stated that the resident used to be able to feed herself.

Resident #4's lunch meal consisted of vegetable lasagna, string beans, cake, mighty shake, and approximately 8 oz of red juice. CNA K was asked if the juice had Propass added. CNA K stated that the kitchen mixed up a pitcher of Propass and brought it to the floor. The CNA's were responsible for pouring a glass of Propass juice for the residents who had an order.

The tray card on Resident #4's tray read

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"standing orders: mighty shake NSA (no sugar added), Propass protein powder (in drink)"

On 6/8/16 at 8:45 a.m., a dietary staff working at the steam table on the first floor (Employee H) was asked if she ever prepared Propass drink for the residents. She stated that she did occasionally. When asked how she prepared the mixture, she stated that she would fill the pitcher (32 ounce) and add 2 scoops. When asked if the scoops were large or small, she stated small. Employee H stated that she always had to ask someone how to prepare the Propass juice.

Prior to lunch service on 6/8/16, dietary staff were observed to prepare a pitcher of Propass. The staff stated that the pitcher contained 32 ounces of fluid. Six scoops of Propass was added to the 32 ounces of juice.

Propass mixing directions on the Propass container= 1 scoop + 4 oz water.

If the dietary staff used a pitcher of 32 ounces of juice, it is calculated that 8 scoops of powder should have been used to properly mix the Propass. The staff were observed to only use 6 scoops. The juice was prepared improperly.

Resident #4's physician orders were most recently signed on 5/31/16. The order for the Propass read "1 scoop protein powder po (by mouth) tid (three times per day) with liquid of choice.

Resident #4 was observed to have an 8 ounce glass of Propass juice. The juice had not been consumed. Per the physician order, the serving size of 1 scoop of powder was 4 ounces. She

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received double the ordered serving.

In addition to the pitcher of Propass juice being prepared incorrectly, there was a concern that the kitchen staff prepared a pitcher of Propass juice using whatever juice they chose. As indicated in the physician order, the Propass should be added to a liquid that the resident chooses. Allowing the resident to choose the beverage ensures the best opportunity for the Propass to be consumed.

Because the dietary staff were observed to mix the Propass incorrectly and Resident #4 was observed to have 8 ounces of Propass juice instead of 4 ounces, there is no way to measure if Resident #4 actually received the amount of protein she should have received.

On 6/8/16 at 11:15 a.m., Propass concerns were reviewed with the RD. Specifically, the concern regarding the improper mixing of the Propass by the kitchen staff, the concern that Propass is added to a liquid that a resident did not choose to drink, and the concern that the Resident #4 was given an 8 ounce serving of Propass juice rather than 4 ounces. The overall concern is that it is questionable how much protein supplement is even being provided for Resident #4 (or any resident) who may have a protein supplement order.

The RD stated that she understood the concerns and she preferred the use of liquid protein because it was easily measured. She stated that the facility had once used liquid protein but changed to the powder for cost purposes.

At the end of day meeting on 6/8/16, the Propass concerns were shared with the Administrator and

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F 367	Continued From page 81 Director of Nursing. No further information was provided.	F 367	F386 R#7 and R#17 physician orders were reviewed and signed and plans of care made current to meet needs. Current resident's are identified at risk from this alleged practice. Audit of physican orders completed for validation of compliance Medical Records staff and Administrator shall oversee process of tracking physician orders for signatures Physicians found to not be compliance shall be educated on the requirement timely signatures on orders. Random audits of physician orders for signatures shall be completed in up to 10 charts weekly for 4 weeks then monthly for 3 months. Concerns identified from the audits shall be taken to the facility QAPI committee for follow up and resolution. Date of compliance 7-13-16	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, the facility staff failed to ensure that physicians order sheets were signed timely for two residents (Resident # 7 and Resident # 17) in a survey sample of 24 residents. 1. For Resident # 7, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 3/1/2016 and 5/24/2016 resulting in 84 days between signatures. 2. For Resident #17, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 3/11/2016 and 6/2/2016 resulting in 83 days between signatures. Findings included: 1. For Resident # 7, the facility staff failed to	F 386		

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ensure that Physicians Order Sheets were signed timely between 3/1/2016 and 5/24/2016 resulting in 84 days between signatures.

Resident # 7 was admitted to the facility on 1/15/2015 with the diagnoses of, but not limited to, End Stage Renal Disease, Pressure Ulcers, Bilateral Below the Knee Amputation, History of Peripheral Vascular Disease and Dysphagia.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 4/20/2016. The MDS coded Resident # 7 with a BIMS (Brief Interview for Mental Status) of 12/15 indicating mild cognitive impairment; required limited to extensive assistance of one staff person with activities of daily living except total dependence and two person assistance with transfers. Resident # 7 was coded as always incontinent of bowel and bladder.

On 6/2/2016, a clinical record review was conducted. The record review included electronic and paper clinical records.

Review of the paper clinical record revealed monthly Medication Regimen Reviews (MRR) were done by the Pharmacy in January 2016 -May 2016. The actual dates of MRR were 1/18/2016, 2/16/2016, 3/10/2016, 4/14/2016 and 5/18/2016.

Review of the Physicians Orders in the medical record revealed the Physician Order Sheet (POS) for May 2016 and April 2016 were signed on 5/24/2016.

Further review of the clinical record revealed no

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other Physician Order Sheets in the clinical record.

An interview was conducted with the Unit Manager (RN A) who stated she would find out if the other POS sheets had been thinned out of the record. The Medical Record Assistant was also classified as a Certified Nursing Assistant (CNA B). CNA B presented copies of POS sheets for January 2016 signed in 1/18/2016 and POS sheets for February 2016 and March 2016 were signed on 3/1/2016. There were no other signed POS sheets.

Calculation of time frame between signed Physicians Order Sheets from 3/1/2016 and 5/24/2016 resulting in 84 days between signatures.

During the end of day debriefing on 6/3/2016, the Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Consultants were informed of Physicians Order Sheets not being signed timely.

2. For Resident #17, the facility staff failed to ensure that Physicians Order Sheets were signed timely between 3/11/2016 and 6/2/2016 resulting in 83 days between signatures.

Resident #17 was admitted to the facility on 5/18/2015 with the diagnoses of, but not limited to, Hypertension, Contracture of Right Hand, Pain in Fingers, Diabetes and Atrial Fibrillation.

The most recent Minimum Data Set (MDS) was a Quarterly assessment with an Assessment Reference Date (ARD) of 5/12/2016. The MDS

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coded Resident #17 with a BIMS (Brief Interview for Mental Status) of 10/15 indicating moderate cognitive impairment; required limited assistance of one staff person with activities of daily living except set up only for eating. Resident #17 was coded as always continent of bowel and incontinent of bladder.

On 6/6/2016, review of the clinical record was conducted.

Review of the Physicians Orders in the medical record revealed the Physician Order Sheets (POS) for June 2016 were signed on 6/2/2016.

Further review of the clinical record revealed no other Physician Order Sheets in the clinical record. There were no POS sheets in the record for January 2016 through May 2016.

An interview was conducted with the Unit Manager (RN A) who stated she would find out if the other POS sheets had been thinned out of the record. The Medical Record Assistant was also classified as a Certified Nursing Assistant (CNA B). CNA B presented copies of POS sheets for March 2016 were signed on 3/11/16. There were no other signed POS sheets presented to the surveyor.

Calculation of time frame between signed Physicians Order Sheets from 3/11/2016 and 6/2/2016 resulting in 83 days between signatures.

Review of the clinical record revealed monthly Medication Regimen Reviews (MRR) were done by the Pharmacy. During the last signed MRR review by Pharmacy on 5/18/2016, the Pharmacy staff did not identify or report there were no

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F 386	Continued From page 85 signed Physicians Order Sheets since March 2016. During the end of day debriefing on 6/6/2016 at approximately 5:30 PM, the Administrator, Director of Nursing, Assistant Director of Nursing and Corporate Consultants were informed of Physicians Order Sheets not being signed timely. The Director of Nursing stated the expectation was that physicians would sign Physicians Order Sheets every 60 days. No further information was provided.	F 386		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	F425 R#18's medications have been obtained per order and currently being administered. R# 22 no longer resides at the center Current residents are at risk of not having medications avaiable Licensed nurses shall be educated on the "medication not avaiable" flow chart, notification of nurse managers and medical director as needed to obtain medications.	

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F 425	Continued From page 86 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for two Residents (Residents' #18 and #22) in a survey sample of 24 Residents. 1. For Resident #18 Ipratropium nasal spray and Norco (Hydrocodone/Acetaminophen) were not available for administration; and 2. For Resident #22, Duragesic patch (for pain) was not available for administration 9/28/15. The findings included: 1. For Resident #18 Ipratropium nasal spray (nasal dryness) and Norco (Hydrocodone/Acetaminophen for pain) were not available for administration. Resident #18, a female, was initially admitted to the facility 8/10/09 and readmitted after a hospitalization 10/14/14. Her diagnoses included atrial fibrillation, anemia, hypothyroidism, type II diabetes mellitus, hyperlipidemia, depression, anxiety, arteriosclerotic cardiovascular disease, macular degeneration, emphysema, fibromyalgia, gastroesophageal reflux disease, and arthropathy. Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/15/16 was coded as an annual assessment. Resident #18 was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as being able to independently perform her activities of daily living.	F 425	Random audits of Medication Administration Records for up to 20 residents per week for 4 weeks then monthly for 3 months affirming medication administration orders shall be completed Concerns from the audits shall be taken to the facility QAPI committee for follow up and resolution. Date of compliance 7-13-16	

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Resident #18 was coded as having no pain during the look back period.

Review of Resident #18's clinical record revealed a signed physician's order that included, "6/17/12 Ipratropium spray 0.06% Place 2 sprays in each nostril every 6 hours for dryness. An entry was placed on the MAR (medication administration record) with nurses initials indicating the medication had been administered.

On the May, 2016 MAR the nurses' initials were circled for the doses for 6 p.m. on 5/14/16 through 6 a.m. on 5/18/16. Documentation on the back of the MAR revealed Ipratropium spray was not administered during the days noted as it was not available from the pharmacy. Notes indicated the pharmacy stated the medication was not able to be refilled as it was too early.

When interviewed, LPN (Licensed Practical Nurse) E stated 6/6/16 at 9:26 a.m., the staff should notify the pharmacy and check with the facility to see if the facility will pay for the medication when it has to be ordered early.

The DON (Director of Nursing) stated 6/8/16 at 10:02 a.m., staff should contact the pharmacy to have medication delivered stat (immediately) when it has run out. The DON also stated she would have to check to see why the staff failed to check to see if the facility would pay for the medication. As of the end of the survey, no further information was provided.

Resident #18 also had a signed physician's order for, "2/17/16 Hydroco/Apap (Norco) 5-325 mg 1 tablet by mouth three times daily." An entry was noted on the MAR for the administration of Norco

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three times daily for pain.

Documentation was evident Norco 5/325 was not administered 3/20/16 at 9 a.m. and 1 p.m. An entry in the nursing notes revealed, "MD made aware that resident missed x 2 doses of Norco 5/325 this shift. Due to resident is out of med. Pharmacy made aware and med will be sent out stat."

The DON stated 6/8/16 at 10:02 a.m. she could not determine why Resident #18 was "out of Norco 5/325 mg" on 3/20/16.

The administrator, DON, and ADON were informed of the failure of the staff to ensure Ipratropium nasal spray and Norco 5/325 mg were available for administration to Resident #18, 6/8/16 at 4:08 p.m.

2. For Resident #22, Duragesic patch (for pain) was not available for administration 9/28/15.

Resident #22, a female, was admitted to the facility 8/17/15 and discharged to an assisted living facility on 10/14/15. Her diagnoses included aftercare of fractured hip, muscle weakness, joint pain, cognitive deficit, dementia, depression, osteoarthritis, and Alzheimer's.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/24/15 was coded as an admission assessment. Resident #22 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance with her activities of daily living, with the exception of eating. For eating she was

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coded as needing limited assistance.

Review of Resident #22's clinical record revealed a signed physician's order, "Duragesic Patch 25 mcg (microgram) per hour(Fentanyl) Apply 1 patch tropically every 3 days." The order was initially written 8/28/15 and was on the most recently signed "Physician's Order" dated as signed 9/30/15.

An accompanying entry was placed on the MAR (medication administration record) with nurses' initials indicating the medication was administered every three days except for 9/25/15 and 9/28/15.

It was determined the medication had been administered on 9/25/15 as the staff had signed on the "Controlled Drug Receipt/Record/Disposition Form" the patch had been applied to Resident #22. The form is a means of accounting for the receipt and administration of any Schedule II or medications that require close control.

Review of the listing of emergency medications available revealed Duragesic patches were not within the emergency supply.

When interviewed, the DON (director of nursing) stated 6/8/16 at 4:08 p.m., she was unaware of any problems with the staff obtaining medications from the pharmacy.

The administrator, DON, and ADON (assistant DON) were informed of the failure of the staff to ensure Duragesic patches were available for administration to Resident #22, 6/8/16 at 4:08 p.m.

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 431	F431 No residents were identified in this citation Licensed staff shall be inserviced on the requirements for a permanently affixed medication box in the refrigerator on the second floor and if any concerns are identified related to said box the maintenance staff shall be called immediately Observation daily of the contents of the box shall validate that it remains secured to the refrigerator. Date of Compliance 7-13-16	

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F 431	Continued From page 91 facility staff failed to store refrigerated Lorazepam in a permanently affixed container in the refrigerator on one of two units (second floor). Two opened bottles of Lorazepam (an antianxiety medication) were observed sitting on the shelf in the medication refrigerator on the second floor. The findings included: The medication refrigerators were observed beginning 10:26 a.m. on 6/6/16. LPN (licensed practical nurse) A unlocked the medication refrigerator on the second floor. Located within the refrigerator, sitting on a shelf were observed two bottles of liquid Lorazepam, for two different Residents. When asked, LPN A stated that was where the liquid Lorazepam was stored on the second floor. LPN A said that was "how they always were" and further stated there was no permanently affixed container in the second floor medication refrigerator. When observed, the medication refrigerator on the first floor had a permanently affixed container with control medications within. The administrator and DON (director of nursing) were informed of the failure of the staff to ensure Lorazepam was stored in a permanently affixed container in the medication refrigerator on the second floor, 6/6/16 at the end of the day meeting.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F441 R#6 and R#9 were reviewed for potential infections and plans of care updated as indicated Wound Care nurse is no longer an employee of the facility	

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F 441	Continued From page 92 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	Current residents have been identified as at risk from the alleged practice Direct care staff shall be in-serviced on the current employee policy related to nails length. Licensed nurses and shall be in-serviced on the handwashing requirements during dressing changes and between residents. Random observations of up to 5 treatments shall be completed weekly for 4 weeks then monthly for 3 months. Random observation of direct Care staff for appropriate nail length per policy shall be completed weekly for 4 weeks then monthly for 3 months. Concerns from audits shall be taken to the facilty QAPI committee for follow up and resolution. Date of Compliance 7-13-16	

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Based on observation, staff interview, complaint investigation and clinical record review, the facility staff failed to implement an effective infection control program.

1. LPN (licensed practical nurse) B, the wound care nurse, failed to clean her hands between Resident #6 and Resident #9.

2. The facility staff failed to assure that fingernails were cut to a short length when providing care for residents on four direct care staff.

The findings included:

On 6/3/16 at 1:25 PM, wound care observation was completed for Resident #6. After the observation of the left foot, the bed was lowered. LPN (B) failed to clean her hands after removing her gloves and leaving the room.

On 6/3/16 at 1:35 PM, LPN (B) entered Resident #9's room (from upstairs) and donned gloves. She did not clean her hands prior to gloving and leaving the last resident (Resident #6's) room.

Guidance provided by the Center of Disease Control,
"Hygiene: Hand hygiene (e.g., handwashing, hand antisepsis, or surgical hand antisepsis) substantially reduces potential pathogens on the hands and is considered the single most critical measure for reducing the risk of transmitting organisms to patients and HCP (health care professionals). Hospital-based studies have demonstrated that noncompliance with hand hygiene practices is associated with health-care--associated infections and the spread of multiresistant organisms. Noncompliance also

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has been a major contributor to outbreaks. The prevalence of health-care--associated infections decreases as adherence of HCP to recommended hand hygiene measures improves."
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1.htm

On 6/8/16 at 4:00 PM, the Administrator and DON (director of nursing) were notified of above findings.

2. The facility staff failed to assure that fingernails were cut to a short length on four direct care staff. The following four direct care staff was observed with long fingernails.
RN (Registered Nurse) A was observed to have long artificial multicolored nails approximately ½" in length during wound care on 6/3/2016 at 10:15 AM.
LPN (Licensed Practical Nurse) B was observed to have long natural unpolished nails approximately ½" in length during wound care on 6/3/2016 at 10:15 AM.
Employee B, Director of Nursing (DON) was observed on 6/3/2016 at 2:35 PM to have long polished artificial nails approximately ½" in length.
LPN C was observed to have long chipped nails approximately 3/8" in length on 6/6/2016 at 10:26 AM during medication pass.
Employee B, Director of Nursing, had no comment when asked about her position on long fingernails.
Facility policy on Handwashing/Hand Hygiene stated:
"11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and is prohibited

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among those caring for severely ill or immunocompromised residents."
Guidance was given at www.cdc.gov, "Whether artificial nails contribute to transmission of health-care-associated infections is unknown. However, HCWs (health care workers) who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing (347--349). Whether the length of natural or artificial nails is a substantial risk factor is unknown, because the majority of bacterial growth occurs along the proximal 1 mm (millimeter) of the nail adjacent to subungual skin (345,347,348). Recently, an outbreak of P. aeruginosa in a neonatal intensive care unit was attributed to two nurses (one with long natural nails and one with long artificial nails) who carried the implicated strains of Pseudomonas spp. on their hands (350). Patients were substantially more likely than controls to have been cared for by the two nurses during the exposure period, indicating that colonization of long or artificial nails with Pseudomonas spp. may have contributed to causing the outbreak. Personnel wearing artificial nails also have been epidemiologically implicated in several other outbreaks of infection caused by gram-negative bacilli and yeast (351--353). Although these studies provide evidence that wearing artificial nails poses an infection hazard, additional studies are warranted."
Administration was informed of the findings on 6/8/2016 at 5:30 PM.

THIS IS A COMPLAINT DEFICIENCY

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F 514	Continued From page 96	F 514	F514	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for one Resident (Resident #4) in a survey sample of 24 residents, to maintain an accurate clinical record. LPN (licensed practical nurse) C documented on the MAR (medication administration record) that Tramadol was given rather than the Tylenol she had given. The findings included: Resident #4, a 72 year old, was admitted to the facility on 12/12/08. Her diagnoses included dementia, Parkinson's disease, diabetes, anemia and high cholesterol. Resident #4's most recent Minimum Data Set (MDS) assessment was a quarterly assessment	F 514	R#4 had no negative outcome from the documentation concerns brought forth in this citation Current residents were identified at risk from this alleged practice LPN C shall be in-serviced on accurate documentation and observed for accurate documentation during medication pass. Licensed nurses shall be in-serviced on the need to accurately record medications during medication passes. Audits of the MAR/Controlled Substances log for complete documentation in both documents shall be completed weekly for up to 10 residents for 4 weeks then monthly for 3 months. Concerns from the audits shall be taken to the facility QAPI committee for follow up and resolution Date of Compliance 7-13-16	

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with an assessment reference date (ARD) of 4/20/16. She was coded with a Brief Interview of Mental Status score of 1 indicating severe cognitive impairment and required extensive assistance with her activities of daily living.

Review of the MAR for May, 2016, revealed the nurses had documented 11 times on the MAR Tramadol had been given. However, review of the narcotic count sheet revealed that Tramadol was documented as given only 6 times in May, 2016. The DON (director of nursing) was notified; the narcotic count sheet matched with the 6 doses given in May.

On 6/8/16 at 3:30 PM, LPN (licensed practical nurse) C was interviewed. She stated, "I gave Tylenol, not Tramadol, but signed off as Tramadol for the month of May." She went on to state that she thought she was signing off the Tylenol, but signed off as Tramadol.

Resident #4 received Tramadol 50 mg (milligrams) on 6/3/16 at 9:35 AM, prior to the wound observation at 10:50 AM. For the month of May, 2016, Resident #4 received Tramadol 50 mg on the following dates per the narcotic record:
5/2/16 at 1:00 PM
5/2/16 at 7:00 PM
5/3/16 at (unable to read) 1:00 PM
5/6/16 at 9:00 AM
5/7/16 at 9:00 AM
5/(unable to read) /16 at 10:30 AM

LPN (D) documented the resident received Tylenol 650 mg on the following dates, but signed off as Tramadol:

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F 514	Continued From page 98 5/3/16 5/7/16 5/8/16 5/11/16 5/12/16 5/17/16 5/21/16 5/22/16 5/26/16 5/27/16 5/28/16 On 6/8/16 at 5:30 PM, the Administrator and DON were notified of above findings.	F 514		

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F 000	Initial Comments An unannounced Medicare/Medicaid standard and complaint survey and biennial State Licensure Inspection was conducted 6/1/16 through 6/3/16 to 6/6/16 and 6/8/16. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Five complaints were investigated during the survey. The census in this 130 certified bed facility was 103 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through Resident #18) and six closed record, (Resident #19 through Resident #24).	F 000	12VAC5-371-210 cross reference to F225 see F225 for POC 12VAC5-371-370 cross reference to F252 See F252 for POC 12VAC 5-371-250 cross reference to F279 See F279 for POC 12VAC 5-371-250 F cross reference to F280 See F280 for POC	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-210 (F.1) Cross Reference to F-225 no DHP check 12 VAC 5-371-370 (A) Cross Reference to F-252 12 VAC 5-371-250 (G) Cross Reference to F-279 12 VAC 5-371-250(F) Cross Reference to F-280 2 VAC 5-371-200 (B) Cross Reference to F-281 professional standard 12 VAC 5-371-220(A,B) Cross Reference to F-309 12 VAC 5-371-220(G) Cross Reference to F-312 12 VAC 5-371-220 (C.1) Cross Reference to F-314 12VAC 5-371-220 (A, B) Cross Reference to	F 001	12 VAC 5-371-200B cross reference to F281 See F281 for POC 12VAC 5-371-220 A/B cross reference to F309 See F309 for POC 12VAC 5-371-220G cross reference to F312 See F312 for POC 12VAC 5-371-220 c.1 cross reference to F314 See F314 for POC 12VAC 5-371-220 A/B cross reference to F323 See F323 for POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenneth R. Bowers — TITLE: ADMINISTRATOR — (X6) DATE: 6/30/16

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F 001	Continued From Page 1 F-323 12 VAC 5-371-220 (C.5) Cross Reference to F-325 12 VAC 5-371-220(A) Cross Reference to F-329 12 VAC 5-371-340 (D) Cross Reference to F-367 12 VAC 5-371-240 (E,F) Cross Reference to F-386 12 VAC 5-371-300(A) Cross Reference to F-425 12 VAC 5-371-300(B) Cross Reference to F-425 12 VAC 5-371-300(B) Cross Reference to F-431 12 VAC 5-371-180(A, B) Cross Reference to F-441 12 VAC 5-371-210 F.1 Nurse Staffing, cross Reference to F-225. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Based on employee record review, staff interview, and facility documentation review the facility staff failed to verify that 8 employees had a valid certification/License with the Department of Health Professions (DHP) prior to hire (Emp. #2, 7, 8, 9, 11, 14, 19, & #20) in a survey sample of 25 certified/licensed employees in the state sample. The findings included: Emp. #2, a CNA (certified nursing assistant) was hired by the facility on 3-21-16. Emp. #7 an RN (Registered Nurse) was hired by the facility on 12-7-15. Emp. #8, an LPN (Licensed Practical Nurse) was hired by the facility on 12-1-15. Emp. #9, an LPN (Licensed Practical Nurse) was hired by the facility on 11-24-15. Emp. #11, a CNA (certified nursing assistant) was hired by the facility on 8-2-15.	F 001	12VAC 5-317-220 C.5 cross reference to F325 See F325 for POC 12 VAC 5-371-220 A cross reference to F329 See F329 for POC 12 VAC 5-371-340 D cross reference to F367 See F367 for POC 12 VAC 5-371-240 E/F cross reference to F 386 See F386 for POC 12 VAC 5-371-300 A/B Cross reference to F425 See F 425 for POC 12 VAC 5-371-300B Cross reference to F 431 See F431 for POC 12 VAC 5-371-180 A/B cross reference to F441 See F441 for POC	

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F 001	Continued From Page 2 Emp. #14, an RN (Registered Nurse) was hired by the facility on 3-31-15. Emp. #19, an RN (Registered Nurse) was hired by the facility on 2-24-15. Emp. #20, a CNA (certified nursing assistant) was hired by the facility on 9-15-14. Review of the employee records revealed that CNA certification, and Nursing Licensure was not verified initially upon hire, for all eight above individuals. A thorough review of the employee records revealed the certification was verified days, months, years, or not at all after the employee was hired. Those verification dates for the 8 employees were as follows. Emp. #2, a CNA (certified nursing assistant) certification was verified on 3-24-16. Emp. #7 an RN (Registered Nurse) licensure was verified on 6-8-16. Emp. #8, an LPN (Licensed Practical Nurse) no licensure verification was found. Emp. #9, an LPN (Licensed Practical Nurse) no licensure verification was found. Emp. #11, a CNA (certified nursing assistant) certification was verified on 8-10-15. Emp. #14, an RN (Registered Nurse) licensure was verified on 2-25-16. Emp. #19, an RN (Registered Nurse) licensure was verified on 10-28-14. Emp. #20, a CNA (certified nursing assistant) certification was verified on 2-2-16. On 6-8-16 at 11:00 a.m. the "Payroll and benefits Coordinator" for the facility who was responsible for these employee records was interviewed. She stated that some verifications were late, and that she threw away all of the original/old verifications when she did a new verification, as licenses and certifications renewed. This statement, however, did not coincide with the document review, as 25	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495123	A. BUILDING _____ B. WING _____	06/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 001	Continued From Page 3 records were reviewed, and half of those records did include the initial verification. She had no response as to this inconsistency, and shrugged her shoulders when asked why this had occurred. She stated she had been in this role for the facility since April of 2015. Review of the facility's "Abuse Policy" included guidance: "Screening: interview, RN, LPN, CNA check, license check & verification, application specifies conviction, OIG (Office Inspector General), exclusion, 2 references, criminal background check..." The administrator, DON (director of nursing), and corporate RN consultant, were advised of the failure of the staff to verify 8 Employee licenses/certifications before hire. COV 32.1 - 126, (12 VAC 5-371-140) Management and Administration. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Based on staff interview, facility documentation review, and Chapter 5 of Title 32.1 of the Code of Virginia (COV), the facility staff failed to obtain a sworn statement disclosing any criminal convictions or any pending criminal charges and criminal records checks for six employees, (Employees #10, 19, 20, 21, 24, & 25) of 25 employees in the state sample. The findings included:	F 001		

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F 001	Continued From Page 4 During review of the employee records, 6 employee records revealed the following errors. 1) Employee #10's record revealed a hire date of 9-18-15. No documentation of a sworn statement or criminal record check were found. 2) Employee #19's record revealed a hire date of 10-27-14. The sworn statement was obtained 10-28-14. The criminal record check was timely. 3) Employee #20's record revealed a hire date of 9-15-14. The sworn statement was obtained 1-12-15. The criminal record check was obtained 2-2-16. 4) Employee #21's record revealed a hire date of 9-8-14. No documentation of a sworn statement was found. The criminal record check was timely. 5) Employee #24's record revealed a hire date of 6-30-14. No documentation of a sworn statement was found. The criminal record check was timely. 6) Employee #25's record revealed a hire date of 6-30-14. No documentation of a sworn statement was found. The criminal record check was timely. On 6-8-16 at 11:00 a.m. the "Payroll and benefits Coordinator" for the facility who was responsible for these employee records was interviewed. She stated that the sworn statements and criminal records checks had just not been done correctly, and she had no further documents to present. Review of the facility's "Abuse Policy" included guidance: "Screening: interview, RN, LPN, CNA check, license check & verification, application specifies conviction, OIG (Office Inspector General), exclusion, 2 references, criminal background check..." The Code of Virginia 32.1-126.01. A states, "Any	F 001		

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F 001	Continued From Page 5 person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or without the Commonwealth"....on or before hire. The employee shall also undergo a criminal records check from the Virginia State Police data base, ~~within 30 days of hire~~. The Administrator, Director of Nursing, and Corporate Registered Nurse Consultant, were informed of the failure of the staff to obtain a criminal background checks, and sworn statements for Employees on 6-8-16 at 3:30 p.m. No further information was available to be presented by the facility.	F 001		