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FORM APPROVED
OMB NO. 0938-0391

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
	495206	A. BUILDING _____ B. WING _____	R 06/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An unannounced Emergency Preparedness survey revisit to the standard survey conducted 3/12/18 through 3/19/18, was conducted 5/14/18 through 5/17/18. The facility was in compliance with applicable 42 CFR Part 483.73 Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 3/12/18 through 3/19/18, was conducted 5/14/18 through 5/17/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Uncorrected deficiencies are identified within the body of this report. Corrected deficiencies are identified on the CMS 2567-B. No complaints were investigated during the survey. The census in this 120 certified bed facility was 102 at the time of the survey. The survey sample consisted of 20 current record reviews (Residents #101-104, 106, 107, 109, 110, 112-119, and 121-124) and 4 closed resident reviews (Residents #105, 108, 111 and 120).	{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 herein. To remain in compliance with all state and federal regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegations of compliance. All alleged deficiencies have been or will be corrected by the date indicated RECEIVED MAY 29 2018 VDH/OLC	
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	{F 609}	1. Administrator met with Resident #112 to review any care concerns or concerns the resident may have. The administrator provided support and assured the resident was able to voice satisfaction and comfort with her current care plan and needs. -Staff member's # 2, #1 has had appropriate follow up action of: re-education coaching, counseling or appropriate performance action steps	06-01-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 5/29/18

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

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{F 609}	Continued From page 1	{F 609}	2. Those residents who reside in the facility could potentially be at risk of this practice. 3. The following practices have been initiated: a) Re-education has been provided to staff members and managers on reporting timeframes and guidelines per regulation b) A new staff questionnaire was developed and will be conducted with staff members on reporting guidelines and understanding of these guidelines monthly. c) A revision to the training schedule has been completed to include: Abuse education on hire, and quarterly going forward. 4. The Department managers will complete the monthly staff questionnaires and provide the findings to the Administrator. The Administrator will report summary findings monthly to QAPI for 6 months. 5. Date of Completion 6/1/18	06-01-18

are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 review of the facility's plan of correction, observations, resident and staff interviews, and review of the facility's documentation, the facility staff failed to immediately report to the Administrator or designee, as well as to the State survey and certification agency, an allegation of abuse, and that it was reported not later than 2 hours after the allegation was made for 1 of 24 residents (Resident #112) in the survey sample.

Resident #112 shared an alleged incident of verbal abuse to a member of the nursing staff on 4/21/18. The nursing staff failed to immediately share the details of the incident with the Administrator or designee. The resident made theAdministrator aware of the incident on 5/6/18,

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{F 609}	Continued From page 2 and the Director of Nursing (DON) reported the allegation of abuse to the State survey and certification agency on 5/7/18 which was also not in compliance with the 2 hour reporting timeframe for allegations of abuse. The findings include: Resident #112 was admitted to the nursing facility on 8/29/17 and readmitted on 11/28/17 with diagnoses that included stroke with left sided hemiplegia (weakness). The most recent Minimum Data Set assessment was a quarterly dated 5/5/18 and coded Resident #112 on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact with the skills necessary for daily decision making. She had no problems understanding the staff and was understood by them. The resident was assessed to require extensive assistance from one staff for transfers and personal hygiene . She required extensive assistance from two staff for positioning in bed, and was totally dependent with the assistance of one staff for bathing. The care plan that was operational at the time of the alleged abuse incident was dated as revised on 11/30/17 to identify impaired activities of daily living (ADL). The goal set by the staff for the resident indicated she maintain maximum level of functioning in ADL care. Some of the approaches the staff would implement to accomplish this goal included assisting the resident to complete ADL tasks that she is unable to complete independently. as well as extensive assistance in turning and repositioning.	{F 609}		

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{F 609}	Continued From page 3	{F 609}		

The initial Facility Reported Incident (FRI) indicated that on 5/8/18, Resident #112 told the Administrator of an incident that occurred on 4/21/18 when she asked Certified Nursing Assistant (CNA) #1 for assistance and the CNA said she needed to try harder to help herself and that she was "done with her." It was documented in the FRI that the resident further stated to the DON, based on the way she was treated, it made her afraid of CNA #1. The FRI indicated Resident #112 had also brought this incident to the attention of another CNA (#2) on 4/21/18, the day it allegedly occurred. The FRI indicated the alleged incident type was abusive to include intimidation and retaliation, as well as refusal to provide care. The allegation of abuse was reported to the State survey and certification agency on 5/7/18.

The facility's Plan of Correction (POC) indicated that as of 4/25/18 reporting requirements would be met for all alleged violations involving abuse. The POC referenced all staff was educated on mandated reporting requirements and timeframes to report alleged abuse that included allegations of abuse, neglect, or exploitation were to be reported to the Administrator of the facility immediately, but not later that 2 hours after the allegation is made, if the events of the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or result in serious bodily injury. All allegations of abuse, neglect, injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator, the State Survey agency, local abuse agency and to other officials in accordance with state law, by the abuse coordinator or designee. The CNA (#2)

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{F 609}	Continued From page 4 that was made aware of the complaints from the resident the day it occurred was educated on 3/16/18 and had signed acknowledgement of mandated reporter status on the same date of the inservice education, 3/16/18. The Administrator and DON signed individual acknowledgments of their mandated reporter status on 4/23/18. On 5/15/18 at 11:55 p.m., an interview was conducted with the Administrator and the Director of nursing (DON). They both stated the allegation of abuse on 4/21/18 was considered verbal with intimidation and retaliation, but thought once they found out if the allegation of abuse on 5/6/18 did not involve physical bodily harm they did not have to report it until 24 hours later. The Administrator stated she was under the impression the reporting time clock began when it was reported to them and did not consider CNA #2 who was the first one to know about the alleged abuse on 4/21/18, but failed to report it to the charge nurse and subsequently immediately to the Administrator or designee, as well as reported to the applicable State agencies, all within 2 hours after the allegation was made. They stated they misinterpreted the regulation and requirement that mandated all staff was responsible to report allegations involving abuse to them immediately within the 2 hours. The facility's failure to immediately report the incident to the Administrator or designee placed the resident at potential risk for further abuse. The CNA implicated in the alleged incident remained on the schedule to work until the DON took action to suspend CNA #1 on 5/6/18 pending investigation, which was 16 days after the allegation was made by the resident. The Administrator stated she interviewed the resident and was told by her CNA #1 was mean, rude, refused to reposition her and	{F 609}		

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{F 609}	Continued From page 5	{F 609}		

stated "I am through with you." The Administrator also stated the resident requested CNA #1 not be assigned to her in the future because she feared the CNA.

On 5/15/18 at 1:58 p.m., an interview was conducted with Certified Nursing Assistant (CNA) #1. The CNA confirmed she was assigned to Resident #112 on 4/21/18 and was suspended on 5/6/18 pending an investigation related to verbal abuse. The CNA stated she was no longer assigned to the resident because she feared her.

On 5/15/18 at 2:15 p.m., an interview was conducted with CNA #2. According to CNA#2, she observed Resident #112 sitting in her wheelchair in the hallway crying on 4/21/18. She stated she inquired of the resident why she was crying to which the resident stated her assigned CNA spoke to her harshly and stated she had to do for herself and if she didn't she was "through with her." The CNA further stated the resident said she was fearful of the assigned CNA. CNA #2 said she told the resident to tell someone about the incident because no one was in the building to report to since it was the weekend, but in looking back she said she should have informed the unit charge nurse. The CNA stated she had abuse training to include mandated reporter responsibilities and re-signed the mandated reporter form, since it was an issue on the last survey. She said, at the time, she did not make the connection and stated she would report any future allegations to the charge nurse or RN unit manager. CNA #2 stated the DON interviewed her on 5/7/18 about what she observed and what the resident shared with her about the incident on 4/21/18.

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{F 609}	Continued From page 6 On 5/15/18 at 2:35 p.m., an interview was conducted with the Chesapeake RN (#2) unit manager where Resident #112 resided. She stated it was her expectation that all allegations of abuse be reported to either her or the charge nurse, and it did not matter if it was the weekend or not. She stated allegations of abuse are to reported immediately to charge nurse and to her so that she can report it to the DON no later than 2 hours after the allegation of abuse so it can be properly investigated and the resident protected. According to RN #2 extensive training took place with all staff about reporting allegations of abuse . On 5/15/18 at 2:50 p.m., an interview was conducted with the Nansemond unit RN #3. She stated all allegations of abuse should be reported to her immediately within 2 hours so she could report it to the either the DON or the Administrator and she thought all staff understood the reporting requirements especially since the recent training over the last two months. She stated all nursing staff re-signed and dated the mandated reporter form. Further random CNA interviews were conducted regarding reporting requirements for abuse: On 5/15/18 at 3:00 p.m., CNA #4 from the Nansemond unit stated she had recent abuse training that indicated all allegations of abuse were to be reported to the charge nurse, "right away." On 5/15/18 at 3:10 p.m., CNA #3 from the Chesapeake unit said she too had recent abuse training and would report any complaints to the charge nurse and let the charge nurse proceed with any further actions.	{F 609}		

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(F 609)	Continued From page 7	(F 609)		

On 5/16/18 at 10:00 a.m., Resident #112 was interviewed regarding the alleged verbal abuse incident that was recorded to have occurred on 4/21/18. Resident #112 stated CNA #1 refused to reposition her left leg, which was impaired as a result of her stroke, as well as refusal to place the sling on her left arm, repeatedly telling her in a nasty way with each request to "do it yourself." According to the resident, Resident #112 stated CNA #1 told her to pull herself up in bed or wait for night shift, and stated, "I am through with you." After this interview, the resident began to cry and said she was fearful of the CNA and hoped that she never took care of her again. The resident's left arm was observed to be immobile and she wore a glove on her left hand to minimize swelling, as well as a sling to keep the arm in a 90 degree angle. The resident also wore a brace on the left leg and demonstrated she could bend her knee and lift her leg, but could not independently change positions without help from the nursing staff.

A pre-exit interview was conducted with the Administrator, DON and corporate RN on 5/17/18 at approximately 11:53 a.m. No further information was provided prior to exit.

The facility's policy revised on 12/2017 titled "Abuse Prohibition" indicated allegations of abuse, neglect, or exploitation are to be reported to the Administrator of the facility immediately, but not later that 2 hours after the allegation is made, if the events of the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or result in serious bodily injury. All allegations of abuse, neglect, injuries of

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{F 609}	Continued From page 8 unknown sources and misappropriation of resident property are reported immediately to the Administrator, the State survey agency, local abuse agency and to other officials in accordance with State law, by the abuse coordinator of designee.	{F 609}		
{F 687} SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record review, and review of the facility's policy the facility staff failed to ensure necessary specialized services and care was provided for 4 of 25 residents (Resident #101, 102, 123 and 117), in the survey sample. 1. The facility staff failed to ensure Resident #101 received podiatry care for long painful and broken toe nails. 2. The facility staff failed to ensure Resident #102 received podiatry care for painful, jagged and long toe nails.	{F 687}	1. Residents # 101,102,123. 117 have received appropriate follow up care for their podiatry/nail care needs. 2. Those residents residing in the facility could potentially be at risk for this practice. 3. The following systems and practices have been put in place: a) Current residents were reviewed and those residents with nail care needs have been identified with follow up needs addressed. b) Re-education has occurred on nail care needs and podiatry care needs to nursing staff, Mds staff, wound nurse, activity staff, social services and unit managers. c) A system revision has been identified weekly to review nail care needs on an ongoing basis. d) Nail care needs and process will be reviewed monthly at nursing staff meetings for the next 3 months. e) Outside podiatry services will be	06/01/18

			utilized until an internal podiatrist is established. 4. The Unit managers will audit weekly for any residents with nail care needs. The unit managers will provide a list to the DON with follow up appointments as needed to podiatry. The DON will present this list and outcome of this audit to QAPI monthly for 6 months. 5. Date of compliance 6/1/18	

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{F 687}	Continued From page 9 3. The facility staff failed to ensure Resident#123 received podiatry care for fungus infested, yellowish, long, and curved toe nails which resemble a ram's horn toe. 4. The facility staff failed to ensure Resident#117 received podiatry care for overgrown and thick toe nails. The findings included; 1. Resident #101 was originally admitted to the facility 8/5/13 and readmitted to the facility after an acute care hospital visit 3/16/16. The current diagnoses include diabetes and a stroke with right hemiparesis with use of anticoagulant therapy. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/26/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #101's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of 2 people with transfers, personal hygiene and bathing, total care of 1 person with toileting and locomotion, and extensive assistance of 2 people with bed mobility and dressing. On the physician's order summary was an order dated 4/24/18 which read; Consult podiatry as needed for routine evaluation and treatment. Clinical record documentation identified diabetes mellitus as the rationale for podiatry services for toenail care instead of the direct care staff	{F 687}		

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{F 687}	Continued From page 10	{F 687}		

providing the service.

The active care plan had a problem which read; I have a diagnosis of diabetes mellitus. The goals read; "I will be free from signs/symptoms of hyperglycemia through the review date 6/10/18. Another goal read; I will have no complications related to diabetes through the review date 6/10/18 and the final goal read; I will be free from signs/symptoms of hypoglycemia through the review date 6/10/18. One of the interventions read; Refer to the podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails".

Resident #101 was observed seated at bedside on 5/15/2018 at approximately 3:45 p.m. Licensed Practical Nurse (LPN) #2 and Certified Nurse Assistant (CNA) #3 accompanied the surveyor into the resident's room to observe her feet. Both feet were with plus 2 swelling, dry skin as well as long, hard and broken toenails, some protruding far beyond the toes. On the left great toe a dark area was observed to the tip on the toe. LPN #2 stated she would have the wound care nurse assess the discoloration to the left great toe determine if interventions were warranted.

An interview was conducted with Resident #101 directly after observation of her feet. The resident stated there was no foot pain related to the swelling in her legs and foot but, she had experienced pain related to the long toenails when her socks and shoes were applied. Resident #101 further stated it had been at least 5-6 months since the podiatrist had assessed her feet and cut her toenails. Resident #101 stated "I need him to cut my toenails".

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	R 05/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 687}	Continued From page 11 An interview was conducted with the Director of Nursing (DON) on 5/16/18 at approximately 12 p.m. The DON stated the Unit Manager (UM-Registered Nurse #3)) was not available therefore; she would gather all needed information regarding Resident #101 long and painful toenails. The DON stated the resident's long toe nails needs should have been identified during routine care or showers by the direct care staff. The DON also stated another opportunity for toe nail observation is during weekly skin assessments by the licensed nursing staff . Skin assessment were conducted on Resident 101's body on 4/25/18, 5/3/18, 5/10/18 and 5/16/18, yet there was no documentation, identifying the resident with long painful and broken toenails. An appointment for Resident #101, to receive podiatry services was scheduled for 6/5/18 at 2:30 p.m., on 5/17/18. The above findings were shared with the Administrator, Director of Nursing, Pharmacy representative and several corporate staff members on 5/17/18 at approximately 11:53 a.m. No additional information was provided and they stated they had no further questions concerning this information. 2. Resident #102 was originally admitted to the facility 1/11/18 and has never been discharged. The current diagnoses include peripheral vascular disease, diabetes mellitus, neuropathy and use of a blood thinner secondary to Deep	{F 687}		

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{F 687}	Continued From page 12	{F 687}		

Vein Thrombosis.

The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/2/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #102 cognitive abilities for daily decision making were intact.
In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of 2 people with bed mobility and transfers, extensive assistance of 1 person with locomotion, dressing, toileting, and personal hygiene and limited assistance with bathing.

On the Physician's orders summary was an order dated 4/24/18, which read; Consult podiatry as needed for routine evaluation and treatment.

Resident #102's active care plan included a problem which read; I have a diagnosis of diabetes mellitus. The goal read; I will have no complications related to diabetes through the review date 7/11/18. One of the interventions dated 5/15/18, read; Consult podiatry as needed for routine evaluation and treatment.

Clinical record documentation identified diabetes mellitus as the rationale for podiatry services for toenail care instead of the direct care staff providing the service.

Resident #102 was interviewed in her room 5/15/18 at approximately 2:50 p.m. She was observed with a dressing to the right leg with yellowish drainage on it. The resident's legs were with plus 2 edema and she wore socks and shoes. Resident #102 was asked about her

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{F 687}	Continued From page 13 toenails and she stated they had not been cut since she had been admitted to the nursing facility. The resident further stated her "toe nails were so bad, painful, jagged and long she begged a man to cut them". Resident #102 stated the man didn't cut them therefore she picked at them with her fingernails. The resident stated the staff "doesn't wash your feet, so why do you think they will cut my toenails". Directly after interviewing Resident #102, the Unit Manager (RN#3) came in to observe the resident's feet. The observation revealed the resident's bilateral great toe nails protruded far beyond the toes and all of the toenails were broken, uneven and painful to touch. The Unit Manager stated an appointment with a podiatrist was necessary for Resident #102 because of her vascular disease, diabetes and the resident required the use of a blood thinner. She stated an appointment would be scheduled as soon as possible. The Unit Manager was asked how does she identify individuals requiring toe nail services and how does she determine if it can be performed by the facility staff or podiatry ? The Unit Manager stated, some residents voice their need, others are identified during daily care or showers and others during skin assessments or reports by family members. An interview was conducted with the Director of Nursing (DON) on 5/16/18 at approximately 12 p.m. The DON stated they had not determined which residents could have toe nail care by the facility staff and currently they had not trained the facility staff to safely provide the service. The DON further stated they were actively seeking to	{F 687}		

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{F 687}	Continued From page 14	{F 687}		

obtain a podiatrist to render in-house services, but at this time they were scheduling appointments with a podiatrist office in the community.

Information regarding an appointment for Resident #102, to receive podiatry services was not provided to the survey team prior to the end of the survey.

The above findings were shared with the Administrator, Director of Nursing, Pharmacy representative and several corporate staff members on 5/17/18 at approximately 11:53 a.m. No additional information was provided and they stated they had no further questions concerning this information.

3. Resident #123 was originally admitted to the facility 5/1/17 and has never been discharged from the facility. The current diagnoses are Parkinson's disease and muscle spasms.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/17/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #123's cognitive abilities for daily decision making were intact.
In section "G" (Physical functioning) the resident was coded as requiring total care of 1 with bathing, extensive assistance of 2 people with bed mobility, and dressing, extensive assistance

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{F 687}	Continued From page 15 of 1 person with personal hygiene and toileting and limited assistance with walking. On the Physician's orders summary was an order dated 4/24/18, which read; Consult podiatry as needed for routine evaluation and treatment. Clinical record documentation identified no rationale why Resident #123 requires podiatry services for toe nail care instead of having the direct care staff providing the service. The Director of Nursing stated during an interview 5/16/18, at approximately 12:00 p.m., that the resident's toenail were too hard and overgrown for the nursing staff to manage. Resident #123's active care plan included a problem which read; I am at risk for pressure areas related to decreased mobility. The goal read; I will not develop a pressure ulcer as evidenced by intact skin through 6/3/18. One of the interventions dated 5/15/18, read; Consult podiatry as needed for routine evaluation and treatment. On 5/15/2018 at approximately 4:45 p.m., Unit Manager #3 accompanied the surveyor into the Resident #123 room to observe her feet. Both feet were observed to have with a yellowish, long, and curved toe nails which resemble a ram's horn.	{F 687}		

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An interview was conducted with Resident #123 as her toenails were observed. The resident stated she had a history of fungi to her toenails and at one time a physician in another state provided a laser treatment which resolved the fungus until currently. Resident #123 further stated she maintained her toe nails when residing in the community by having monthly pedicures at a spa. She also stated maintenance of her toenails had not occurred since admission to the nursing facility and her daughter didn't know of a podiatrist to take her to therefore; her daughter was supposed to ask the resident's roommate the name of her podiatrist.

The Unit Manager stated to the resident she would contact her daughter and give her the name of the roommate's podiatrist and assist with making the appointment if needed.

The appointment for Resident #123, to receive podiatry services had not been scheduled prior to the end of the survey.

On 5/17/18 at approximately 11:53 a.m.; the above findings were shared with the Administrator, Director of Nursing and Corporate consultant during the pre-exit briefing. No additional information or any concerns were voiced by the facility staff.

Mayo Clinic recommends if an individual is diabetic to check the feet daily for signs of ingrown toenails. To help prevent an ingrown toenail; trim your toenails straight across...

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{F 687}	Continued From page 17 (http://www.mayoclinic.org/diseases-conditions/ingrown-toenails/basics/prevention/con-20019655) Mayo Clinic also stated to prevent thick toenails to wash your hands and feet regularly and keep your nails short and dry and relatively minor injury to your feet - including a nail fungal infection - can lead to a more serious complication. (http://www.mayoclinic.org/diseases-conditions/nail-fungus/basics/complications/con-20019319). 4. Resident #117 was admitted to the facility on 1/17/18, diagnoses included but were not limited to acute kidney failure, ESRD (end stage renal disease), muscle weakness, malignant neoplasm of the prostate, hypertension, benign prostate hypertrophy (enlargement of the prostate gland), GERD (gastroesophageal reflux disease), and anemia. A care plan was prepared for resident #117 on 1/18/18 and revised on 1/30/18 Focus: I have impaired activities of daily living related to mobility deficits, ESRD, and generalized weakness/debility. Goal: I will attain maximum level of functioning in my ADL care needs by the review date. Interventions: Assist resident with washing their hair/showering as much of each ADL task as they are able to do. Do not rush resident, Encourage resident to choose their own clothing daily. Provide privacy during ADL care. Provide supplies for bathing/hygiene/oral care needs. Resident #117's quarterly MDS (Minimum Data Set 3.0) was completed on 4/12/18. The assessment coded resident #117 with a BIMS	{F 687}		

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{F 687}	Continued From page 18	{F 687}		

(Brief Interview for Mental Status) score of 14, indicating cognitively intact. Resident # 117's ADL (Activities of Daily Living) status was coded as extensive assistance needed for self-performance and staff assistance of two staff members for bed mobility; and supervision for self-performance with 1 staff member assistance with transfers, dressing, toilet use, and personal hygiene. He needed supervision and set up assistance for eating.

On 5/14/18 at 1:30 PM Resident #117 was interviewed upon initial touring of the facility. During the interview Resident #117's toenails were observed to be very long, thick, and jagged. 9 of 10 toenails were approximately ½ to ¾ of an inch past the end of his toes.

On 5/16/18 at 9:40 AM observation of resident #117 noted resting in bed with the sheet covering his toes. Surveyor asked to look at his feet and he said "they are bad." When Resident #117 was asked if he wanted to have his toenails trimmed he replied "yes, I asked a fellow here a month ago. He told me that they [the facility] doesn't have a podiatrist but as soon as they get one they will put me on the list." Resident #117 did not know the name of the staff member but did offer a description and stated he worked on the" dinner time shift." When asked if any staff member had offered to trim his toenails, or send him to an outside podiatrist he said "no, but I guess I could do that since I go to dialysis 3 times a week." Resident #117 stated his toes "hurt" when he tries to walk to the bathroom.

On 5/16/18 at 9:50 AM an interview with Licensed Practical Nurse (LPN) #1 was conducted where

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{F 687}	Continued From page 19 she stated Resident #117 is alert and oriented, and pleasant. When asked if he refuses care she stated "not resistive at all to care". LPN#1 was asked to examine Resident #117's toenails. She stated "they are long and he has a consult with podiatry. Check with the unit secretary." When LPN #1 was asked if staff can trim toenails she stated "yes, as long as they are not diabetic". Asked if a staff member would have been allowed to trim resident #117's toenails, she stated "yes, he's not diabetic." On 5/16/18 at 9:58 AM an interview with Registered Nurse (RN) #1 was conducted and she was asked if Resident #117 had an appointment to see a podiatrist. She looked in the appointment book and found none scheduled for him. She introduced unit secretary #1 who made resident appointments. Unit secretary # 1 was asked to discuss the process for getting podiatry services for the resident. Unit secretary #1 stated she "got an email from the unit manager to set up appointments with their podiatrist. There were 4 names on the list." Review of the list provided revealed that Resident #117's name was not on the list. 5/16/18 at 10:15 AM an interview was held with the DON (Director of Nursing) and corporate Quality Assurance nurse. The DON walked to resident #117 room to examine his toenails. DON stated "they are long, we will set up an appointment for him. The audit list is done, he should have an appointment pending". When asked what the process is to identify and obtain podiatry services for the residents was she responded "the unit manager does a weekly audit of the skin sheets and gives it to me". When asked if all the residents are reviewed weekly she	{F 687}		

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{F 687}	Continued From page 20	{F 687}		

said "the unit manager reviews the skin sheets, done weekly to identify residents who need podiatry care". The DON was informed that resident #117 is not on the list, and has no appointment pending. DON stated "if he doesn't have an appointment we pay for the transportation and the podiatry care if he can't pay".

On 5/16/18 at 11:52 a review of the audits completed for the plan of correction found a single audit sheet for Resident # 117's unit titled "May 2018" which noted 6 resident names listed. The audit showed 5 resident names have "pending" and one had an appointment on May 11, 2018. An additional list for Resident #117's unit was provided with 20 resident names. Resident #117 was not on either list provided.

On 5/16/18 at 11:55 AM an interview with the DON was conducted to review the plan of correction audits performed for compliance with deficiencies on the previous survey. She stated resident #117 "should be on the podiatry list. Staff can do some toenails, non-diabetic, non-vascular disease, and non-painful nails. We need a way to identify residents on admission." "Skin assessment sheets do not address nail care and we may need to ask the computer people how to add to the form (skin assessment form) on the computer".

On 5/16/18 at 1:50 PM a review of clinical record was conducted and noted Resident #117 had a physician's order for Podiatry consult as needed for routine evaluation and treatment written 4/24/18.

A review of Resident #117's Skin Check

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{F 687}	Continued From page 21 Evaluation (skin sheets) on 5/16/18 at 2:10 PM noted he was assessed by licensed nursing staff weekly and the skin checks noted: 4/25/18 at 3:15 AM No open areas or areas of impaired skin integrity noted 5/5/18 at 1:37 AM No open areas or areas of impaired skin integrity noted 5/9/18 at 7:07 AM No new areas of impaired skin integrity noted, but has areas currently being treated per physician's orders. On 5/16/18 at 2:45 PM an interview with LPN #1 who was assigned to Resident #117 was asked if she could have trimmed #117's toenails. She stated she "would have to check to see" if she could cut his nails. He has been referred to a podiatrist "because he has a consult. A podiatrist should cut them." When asked if she had received training on how to cut toenails she stated "no". On 5/16/18 at 2:50 PM an interview with Certified Nursing Assistant (CNA) #6 who was caring for resident #117 was asked about providing ADL care and the long condition of his toenails and she responded "they are really long." Asked if she can trim nails she stated "the nurses cut toenails." On 5/16/18 at 3:06 PM an interview conducted with LPN #1 revealed she had just attempted to clip resident #117's toe nails. When asked what prompted her to cut his toenails after she had been asked about her ability to trim his nails she responded she thought she "should try to cut his nails if I could". She "went in with another nurse and clipped some of his nails, but some are too thick."	{F 687}		

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5/16/18 at 4:00 PM Review of the facility policy titled "Nail Care" SNF -035, dated 12/2017 noted in part the following:

Purpose:
1. Review the resident's care plan to assess for any special needs of the resident.
2. Refer diabetic residents or residents with circulatory impairment, curved, mycotic (fungal infection) or other nail abnormalities to podiatrist PRN (as needed). Notify attending MD to obtain order for podiatry consult.

General Guidelines:
1. Nail care includes daily cleaning and regular trimming.
5. Stop and report to the nurse if there is evidence of ingrown nails, infections, pain, or if nails are too hard or thick to cut with ease.

The policy contains 24 steps in the procedure for providing nail care including:
12. Do not trim nails below the skin line or cut the skin.
13. Trim toenails straight across.
14. Smooth the nails with a nail file or emery board. Apply lotion as permitted.

On 5/17/18 at approximately 11:53 AM Pre-Exit review with Administrator, DON, corporate quality assurance nurse, corporate human resource representative, and corporate risk manager was held and they were informed of the failure to provide toenail care for resident #117. No additional information was provided by the facility.